Children who sexually abuse other children

A South African Perspective

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Sheri Errington

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Kristy Errington

Kristy Errington received most of her training as a young dancer through the instruction of Martin Schonberg, and was privileged to train and perform with the Ballet Theatre African dance company for a period of four years. In 2003 Kristy competed in the international dance competition Prix de Lausanne, in Switzerland, where she was exposed to many great teachers and choreographers. It is from this experience that Kristy draws from as a dance instructor and choreographer. In 2008 Kristy graduated with a BA from Wits University. In 2009 she went on to complete her Honours in Psychology at Wits. As the designer and facilitator of a dance diversion programme for young offenders at the Teddy Bear Clinic and an arts programme called HEART for HIV/AIDS communities, as well as a dance teacher in Johannesburg, Kristy has continued to work within the fields of Arts and Human development. She aspires to share her passion for the Arts as a form of care and support in more South African communities, and as such is always eager to take part in the training and development of such practices.

Sheri Errington

Sheri Errington is the Director of Operations at The Teddy Bear Clinic for Abused Children, where she has worked for 6 years. She has an MA in Research psychology and is registered with the Health Professions Council of South Africa. Sheri specialises in Monitoring and Evaluation with a special focus on programme development. She has lead the development of The Teddy Bear Clinic's Monitoring and Evaluation systems, and been involved in the on-going assessment of these services, with a special interest in the Diversion Programme. Sheri has presented research on The Teddy Bear Clinic's service-level impact at both local and international conferences.

Victor Mbinga

Victor obtained his BA in Health Sciences and Social Services with Specialisation in Psychological Counselling from the University of South Africa, with a Distinction for Psychology. He worked at The Teddy Bear Clinic from 2008 to 2010 as the Coordinator of the Diversion Programme and represented the Clinic at the Provincial Child Justice Forum. In 2010, Victor moved on to become the Child and Youth Development Coordinator at SOS Children's Villages.

Shaheda Omar

Shaheda Omar has a doctorate in Social Work with a thesis on young sex offenders, master's in Mental Health, BA honours degree in Social Work, diploma in Marriage Guidance and Counselling, Forensic Assessment of child victims of abuse.

Shaheda Omar has been working at the Teddy Bear Clinic for Abused Children for 12 years. During this time she has developed the professional standard of services offered by the clinic. Shaheda has driven the diversion programme for young sex offenders since its inception and continues to drive the programme from strength to strength. She completed her PHD and graduated in June 2011. This body of knowledge adds value to the programme as it focuses on the diversion programme. We now have one of the most progressive diversion programmes in the country.

She has experience in therapeutic and forensic investigation. Shaheda has presented at numerous conferences (national and international) such as SASPCAN, SAALED, IATSO, SAYSTOP, SVRI, IMA (medical convention), ACOPAB (psychiatry conference) and many others.

She has also been appointed to sit on the SAPSAC committee, Shukumisa Campaign (working group for sexual offences legislation) and on the accreditation committee for diversion.

Shaheda has been invited on numerous television panels and other shows concerning child abuse issues. She has appeared on Carte Blanche *(Mnet)*, 3Talk, and 3rd Degree *(SABC 3)*, as well as on other television programmes. She is often consulted by the media for her expertise and opinions on various matters pertaining to abuse.

Helen Oosthuizen

Helen Oosthuizen is a music therapist registered with the Health Professions Council of South Africa (HPCSA). She completed her Master's degree in music therapy at the University of Pretoria in 2005, where she currently serves as a part-time academic supervisor. Since graduating, Helen has worked as a music therapist in Gauteng and Cape Town in schools, hospitals, community centres and in private practice. She currently facilitates music therapy groups with young sexual offenders at the Teddy Bear Clinic and serves as an African editor for the international online journal *Voices: A World Forum for Music Therapy*. She has published journal articles on music therapy work in South Africa and is a co-editor of the book, '*Taking Music Seriously: Stories from South African Music Therapy*'.

Ntombifuthi Sangweni

Ntombifuthi Sangweni is a community art counsellor. She did three year training at Lefika Laphodiso (The art Therapy Centre). She has a three year background in visual art. Ntombi did her initial placement at JPCCC for 4 months where she implemented Art Counselling skills with children from Observatory Girl's Primary School. Facilitated at Phumula Gardens Primary School did a bereavement process. She facilitated a group from the 'Buyela Ekaya'/Missing Bones project for families who lost their loved one during Apartheid struggle. In 2007/8 facilitated in GDE educators project which took place in Soweto, Lenesia and Orange Farm. In 2008/9 facilitated an aftercare group of orphans and vulnerable children at Umkhathizwe Primary school and Maphanzela Primary school in Thokoza. Ntombi facilitated another group of vulnerable children in Mogobeng Primary School After care project. She also facilitated a group of offenders who attended diversion programme at Teddy Bear Clinic. She volunteered to facilitate at the Boksburg intervention refugee camp.

Elizabeth Steenkamp

Elizabeth Steenkamp was born in Stellenbosch and grew up in the Western Cape. She matriculated at Hoêrskool Riviersonderend in 1987. She studied Social Work at Hugenote College in Wellington. In 1993 she obtained a University Diploma in Social Work at UNISA. She is married with two children.

Elizabeth has a passion for working with Juvenile Sex offenders and believes that by therapeutic intervention of the Juvenile Sex Offender further child abuse will be prevented. During her professional career of 19 years she worked at various NGO's and 8 years at Wo+men Against Child Abuse where she compiled the Youth Development Program, diversion program for Juvenile sex offenders ,facilitated Juvenile Sex offender groups, trained facilitators and presented workshops with regards to related topics.

At present she is part time employed by iThemba Rape and Crisis Centre in Benoni and runs a Private practice.

Introduction

Diversion is the process of channelling children away from the formal court system into a programme that makes them accountable for their actions and gives young sex offenders an opportunity to repair the damage caused by their crime, within themselves, through an intensive therapeutic programme.

The increasing prevalence of child-on-child sexual offending has been confirmed by a pilot study on sexual violence among 9 300 learners in urban and rural schools by the Community Information Empowerment and Transparency Project which found that many learners admitted to raping other children (Magojo & Collins, 2002:2). The study found that 12-20% of boys and 5-13% of girls in both urban and rural areas admitted to having forced sex with children. The girls in the study made some shocking revelations, where sexual behaviour was forced by a girl on another girl or boy by a group of girls. This was not found to be uncommon. The study also illustrated that by the age of 18 years 30% of school children have been victims of sexual abuse by other children. This shows that child-on-child rape and gang rape are a growing occurrence in South Africa (as cited in Omar, 2010).

As a child protection organisation, the Teddy Bear Clinic has developed a programme called SPARC (Support Programme for Abuse Reactive Children) for youth sexual offenders because of the capacity that this work has to impact on our aim of breaking the cycle of abuse. Research in South Africa shows that child sexual offenders who go untreated, are likely to go on victimising with increasing severity throughout their lives. The rationale is that by investing in the treatment of one child who has abused another child, we are potentially preventing further cases of sexual abuse against children. The bottom line being that serious consideration needs to be given to working towards establishing effective interventions that can be implemented with these children as early as childhood.

Traditionally, diversion programmes have used only conventional group therapy approaches. The Teddy Bear Clinic's approach, and most others, uses a combined approach drawing from principles of psycho-educational and cognitive-behavioural therapy, which is conducted in a group setting. Although there is evidence of the positive impact that conventional therapies have in the rehabilitation of youth offenders, particularly in terms of encouraging acknowledgment of responsibility, victim empathy and self-awareness, a number of limitations have been identified. These limitations include:

- The focus of these therapies is on the offence.

- The child is limited to expressing only that which can be articulated in words.
- The child's psychosocial needs and past trauma are only addressed on a cognitive level.

These limitations suggest that conventional therapies on their own are not enough, which is the rationale behind the incorporation of alternative therapies into the Teddy Bear Clinic's Diversion programme.

The alternative therapies serve to enhance the SPARC programme, by building onto the themes that are addressed in this programme in a more positive, practical and expressive way. We propose that this integrated approach, in conjunction with a support group for the parents of these children is an effective intervention for the rehabilitation of children who sexually abuse other children.

Aim of the handbook:

To equip all therapists, teachers and childcare workers with the knowledge, skills and resources to manage cases of child on child sexual abuse.

Chapter 1

Preparing the practitioner

"Child abuse is a widespread problem affecting all sectors of the community. The problem is complex and the work very stressful to both health workers and the child protection services. However, the mental and physical health of thousands of children is dependent on the competent management of child abuse."

Lorna B. Jacklin (1997)

Section 1: Understanding child sexual abuse

1.1 Definition of child abuse (WHO)

Child maltreatment, sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child's health, development or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.

1.2 Categories of child abuse

- *Physical abuse*

The physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of an interaction that is reasonably within the control of a parent or person who is in a position of responsibility, power or trust in relation to the child. There may be single or repeated incidents.

Within physical abuse the behavioural signs include injuries that cannot be explained, inconsistent explanations, absconds, being fearful when touched, aggressiveness and withdrawal, attention seeking behaviour and becoming overly compliant and scared when others cry.

Signs and symptoms of physical abuse:

Physical signs	Behavioural and emotional signs
A history which is: ◆ incompatible with the degree or nature of the injury; ◆ developmentally impossible; ◆ vague as to how or when it occurred; ◆ changes when it is repeated to different people; ◆ changes when parents are interviewed separately; ◆ the child may say something when interviewed alone to support your suspicions; ◆ bruises in unusual sites; ◆ surface marking which show the imprints of the object; ◆ old scars in a child with acute injuries; and ◆ symmetrical burns on both hands and feet, or lower legs and perineum.	A history which is: ◆ a significant delay between the time of the injury and when help was sought; ◆ an inappropriate concern for the severity of the injury; and ◆ poor parent-child interaction.

◆ *Emotional abuse*

Emotional abuse includes the failure to provide a developmentally appropriate, supportive environment, including the availability of a primary attachment figure, so that the child can develop a stable and full range of emotional and social competencies commensurate with her or his personal potentials and in the context of the society in which the child dwells. There may also be acts towards the child that cause or have a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. These acts must be reasonably within the control of the parent or person in a relationship of responsibility, trust or power. Acts include restriction of movement, patterns of belittling, denigrating, scapegoating, threatening, scaring, discriminating, ridiculing or other non-physical forms of hostile or rejecting treatment.

Behavioural signs within emotional abuse include aggression, depression, withdrawal, sudden extreme compliance and attention seeking behaviour, too neat or clean, exerting control with normal activities and they seem to suppress their feelings. Physical indicators of emotional abuse include enuresis (bedwetting), encopresis (soiling) and continual psychosomatic complaints.



Signs and symptoms of emotional abuse:

Physical signs	Behavioural and emotional signs
◆ Lags in physical development ◆ Failure to thrive	◆ Extremely poor self-concept ◆ Inability to relate to others ◆ Speech disorders ◆ Begging or stealing food ◆ Emotional disorders ◆ Habit disorders ◆ Conduct disorder ◆ Neurotic traits ◆ Behavioural extremes ◆ Overly adaptive behaviour ◆ Developmental lags

◆ *Neglect and negligent treatment*

Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions, in the context of resources reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development. This includes the failure to properly supervise and protect children from harm as much as is feasible.

Signs and symptoms of neglect:

Physical signs	Behavioural and emotional signs
◆ Consistent hunger ◆ Poor hygiene ◆ Inappropriate dress ◆ Lack of supervision ◆ Unattended physical needs ◆ Abandonment	◆ Extended stays at school ◆ Consistent fatigue ◆ Alcohol/drug abuse ◆ Delinquency ◆ States that there is no caregiver ◆ Little range of emotion

◆ *Exploitation*

The various ways in which children are induced or coerced to engage in any unlawful sexual activity include:

- The exploitative use of child in prostitution or other unlawful sexual practices.
- The exploitative use of children in pornographic performances and materials.
- Commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others.

This includes, but is not limited to, child labour and child prostitution. These activities are to the detriment of the child's physical or mental health, education, or spiritual, moral or social-emotional development (WHO, 1999).

- *Sexual abuse*

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.

- *Types of sexual abuse*
  - Penetration: vaginal or anal intercourse and oral sex.
  - Fondling: touching/kissing child's genitals, making child fondle an adult's genitals.
  - Violation of privacy: forcing child to undress, or spying on the child in the bathroom, etc.
  - Exposing children to adult sexuality: performing sexual acts in front of child, exposing genitals, telling "dirty" stories, showing pornography to child.
  - Exploitation: selling a child's services as a prostitute or forced performance in pornography.

Signs and symptoms of sexual abuse:

Physical signs	Behavioural and emotional signs
◆ Difficulty in walking/sitting ◆ Torn, stained or bloody clothing ◆ Bruises/bleeding in the genital/anal area ◆ Pain when passing urine ◆ Sexually transmitted diseases ◆ Psychosomatic problems ◆ Bed wetting or soiling ◆ Pregnancy ◆ Vaginal tears, abrasions and contusions ◆ Hymenal tears, dilated hymenal ring ◆ Anal dilation, erythema and tears ◆ Presence of sperm or semen in the vagina or surrounding areas	◆ Not willing to change for physical education class ◆ Withdrawal, fantasy or infantile behaviour ◆ Inappropriate sexual knowledge ◆ Poor peer relations ◆ Learning difficulties, deterioration in school ◆ Delinquency, runaway, truancy ◆ Attempted suicide ◆ Reports sexual assault ◆ Shy, reserved, fearful

Behavioural signs in regards to sexual abuse includes excessive crying, increased irritability and tantrums, fear of an object or a person, aggression, sexualised play, unexpected and sudden

changes in behaviour, fear of being left alone, nightmares, inappropriate sexual vocabulary and fear of seduction from the opposite sex. To continue the signs of sexual abuse one also has to include sudden deterioration in school, poor relationships, regression, suicide attempts, antisocial behaviour such as setting fires, cruelty towards animals, stealing and lying and alcohol and drug abuse and enuresis or encopresis.

Within sexual abuse the physical indicators that may point out the possibility of sexual abuse includes pain or itching in the genital area, torn or blood-stained underwear, injuries to the genitals, STDs, difficulty sitting or walking, throat irritations, regular urinary infections, skipping of menstrual cycle, pregnancy and foul mouth discharges.

- *Pornography and images of child sexual abuse*

Pornography is a presentation, whether live, simulated, verbal, pictorial, filmed or videotaped, or otherwise represented, of sexual behaviour in which one or more participants are coerced, overtly or implicitly, into participation; or are injured or abused physically or psychologically; or in which an imbalance or power is obvious, or implied by virtue of the immature age of any participant or by contextual aspects of the presentation, and in which such behaviour can be taken to be advocated or endorsed. (Mackinnon, 1983:32)

According to Mackinnon (1983), pornography is the sexually explicit subordination of women, graphically depicted, whether in pictures or in words, that also includes one or more of the following:

- women are presented dehumanised as sexual objects, things or commodities; or
- women are presented as sexual objects who enjoy pain or humiliation; or
- women are presented as sexual objects who experience sexual pleasure in
- being raped; or
- women are presented as sexual objects tied up or cut up or mutilated or
- bruised or physically hurt; or
- women are presented in postures of sexual submission; or
- women's body parts – including but not limited to vaginas, breasts, and
- buttocks – are exhibited, such that women are reduced to these parts; or
- women are presented as whores by nature; or
- women are presented as penetrated by objects or animals; or
- women are presented in scenarios of degradation, injury, abasement, torture, shown as filthy or inferior, bleeding, bruised, or hurt in a context that makes these conditions sexual
- women are presented as sexual objects who enjoy pain or humiliation; or
- women are presented as sexual objects who experience sexual pleasure in being raped; or

- women are presented as sexual objects tied up or cut up or mutilated or bruised or physically hurt, or as dismembered or truncated or fragmented or severed into body parts; or
- women are presented being penetrated by objects or animals; or
- women are presented in scenarios of degredation [sic], injury, abasement, torture, shown as filthy or inferior, bleeding, bruised, or hurt in a context that makes these conditions sexual;
- women are presented as sexual objects for domination, conquest, violation, exploitation, possession, or use, or through postures or positions of servility, or submission or display.

Section 2: The effects of abuse on development

2.1 Child development

Child development refers to the growth, adjustment and changes, which children go through during developmental stages in childhood. This section will only give a brief overview about the importance of child development because knowledge about this is essential and relevant to work with children from a protection context. As children grow they learn many functions, which we as adults take for granted expecting them to know.

- *Normal growth and development*

Age: 0-3 years	
Physical development	◆ Double their height between birth and age three. ◆ Triple their weight between birth and age three. ◆ Develop teeth and the ability to eat solid foods. ◆ Develop 75% of their brain capacity. ◆ Learn to crawl and walk. ◆ Begin to take off and put on clothes. ◆ Begin to control body functions through toilet training.
Cognitive development	◆ Learn language and communication skills and advance from using single words to phrases to complete sentences. ◆ Develop an imagination and begin to create imaginary scenarios and friends. ◆ Understanding the world primarily through their family. ◆ Begin to interact with peers through imitation (although some children at this age do not yet play directly with each other, they often engage in parallel play).

	◆ Think concretely; retain some information and process information primarily through their five senses by seeing, touching, hearing, tasting and smelling. ◆ Identify with and begin to imitate their same sex parent or guardian. ◆ Begin to understand the differences between male and female (gender differences and gender roles). ◆ Imitate the language and behaviour of trusted adults.
Emotional development	◆ Develop trust for caregivers who fulfil their needs, such as responding when the child is hungry, wet, etc. ◆ Begin to test independence and explore limits, but still seek closeness to primary caregiver. ◆ Have relationships primarily with family members who are the most important people in the child's life at this time. ◆ Physically demonstrate feelings, such as kissing and hugging to show love and hitting to show anger. ◆ Master the idea of being happy, sad or angry, but will generally choose to express emotions physically rather than verbally. (The "terrible two's" occur when a child is developing a sense of sense of self outside of and distinct from others and expresses this individuality by saying "no" and by insisting on doing things him-/herself.)
Sexual development	◆ Be curious and explore their own body and other's bodies. ◆ Experience an erection or vaginal lubrication. ◆ Touch their genitals for pleasure. ◆ Talk openly about their bodies. ◆ Be able to say and understand when taught, the appropriate names for body parts (head, nose, stomach, penis, vulva, etc.).
Moral development	◆ Do not have a well-developed sense of moral code. ◆ Cannot distinguish between truth and lies. ◆ Conform to moral teachings because of consequences to actions.

Age: 4-5 years	
Physical development	◆ Continue to grow, but at a slower rate than previously. ◆ Reach at least 50% of their adult height and 20% of their adult weight by five years old. ◆ Develop more coordinated large motor skills, enabling them to skip, run, and climb up and down stairs. ◆ Develop fine motor skills, enabling them to tie shoelaces, button shirts, use scissors and draw recognisable figures. ◆ Continue significant brain development, completing 90% of such development by five years old. ◆ Develop increased lung capacity and the ability to breathe more deeply.

Physical development	◆ Lose their "baby look" as their limbs grow longer. ◆ Appear about the same size, regardless of gender. ◆ Increase in overall health and gain resistance to germs.
Cognitive development	◆ Interact with and learn about the world through play activities. ◆ Begin to experience the world through exploration and feel inquisitive about self and surroundings. ◆ Begin separation from family as they experience less proximity to caregivers and more independence. ◆ Understand what is good and bad (though they may not understand why) and be able to follow the rules. ◆ Be able to understand and accomplish simple activities to be healthy, such as brushing teeth or washing hands. ◆ Understand the concept of privacy.
Emotional development	◆ Still rely on caregivers, while no longer needing or waiting as much physical contact with caregivers as they received before. ◆ Continue to express emotions physically and seek hugs and kisses. ◆ Socialise with peers, begin to develop relationships and learn to recognise some peers as friends and others as people they don't like. ◆ Have more opportunities to interact with peers, either through school or recreational activities and will play with other children.
Sexual development	◆ Experience vaginal lubrication or erection. ◆ Touch their genitals for pleasure. ◆ Feel curiosity about everything and ask about where babies come from and how they were born. ◆ Feel curiosity about everything and ask about where babies come from and how they were born. ◆ Feel curiosity about bodies and may play games such as doctor. ◆ Feel sure of their own gender and have the ability to recognise males and females. ◆ Begin to recognised traditional male and female gender roles and to distinguish these roles by gender. ◆ Become conscious of their own body, how it appears to others and how it functions.
Moral development	◆ Begin to develop a conscience. ◆ Struggle to differentiate between fact and fantasy. ◆ Internal locus of control develops.

Ages: 6-8 years	
Physical development	◆ Experience slower growth of approximately 6,35 cm and 3,6 kg per year. ◆ Grow longer legs relative to their total height and begin resembling adults in the proportion of legs to body.

	◆ Develop less fat and grow more muscle, and increase in strength. ◆ Lose baby teeth and begin to get adult teeth. ◆ Use small and large motor skills in sports and other activities.
Cognitive development	◆ Develop the skills to process more abstract and complex ideas (e.g. pregnancy, addition/subtraction, etc.). ◆ Begin elementary school. ◆ Spend more time with peer group and turn to peers for information (they need information sources outside of family and other adults become important in their lives). ◆ Be able to focus on the past and future as well as the present. ◆ Develop an increased attention span. ◆ Improve in self-control, being able to conform to adult ideas of what is "proper" behaviour and to recognise appropriateness in behaviour. ◆ Understand the concepts of normality/abnormality, feel concern with being normal and curiosity about differences. ◆ Begin to develop as an individual. ◆ Think for themselves and develop individual opinions, especially as they begin to read and to acquire information through the media.
Emotional development	◆ Become more modest and want privacy. ◆ Develop relationships with and love people outside the family as their emotional needs are met by peers as well as family. ◆ Develop less physically demonstrative relationships. Express love through sharing and talking (embarrassed by physical affection). ◆ Need love and support, but feel less willing to ask for it. ◆ Understand more complex emotions, like confusion and excitement. ◆ Want more emotional freedom and space from parents. ◆ Become better at controlling feelings and concealing feelings. ◆ Begin to form broader self-concept and recognise their own strengths and weaknesses, especially social, academic and athletic skills. ◆ Have friends and sustained peer group interactions.
Sexual development	◆ Prefer to socialise with their own gender almost exclusively and maintain a fairly rigid separation between male and females. ◆ Recognise the social stigmas and taboos surrounding sexuality, especially if parents are nervous about the subject and will be less open about asking questions. ◆ Understand more complex ideas with regard to sexuality and begin to understand intercourse apart from making a baby. ◆ Look to peers, media and other sources for information about sex. ◆ Understand gender role stereotypes as such. ◆ May engage in same-gender sexual exploration. ◆ Have a stronger self-concept in terms of gender and body image. ◆ Has developed a conscience.

Moral development	◆ Can differentiate between fact and fantasy. ◆ Has developed a stronger internal locus of control.

Age: 9-12 years	
Physical development	◆ Experience a growth spurt with significant weight gain, muscle growth and genital maturation. ◆ Enter puberty, a time when hormones produced in the pituitary gland trigger production of testosterone in males, oestrogen/progesterone in females. (This usually begins earlier in girls, 9-12, than boys, 11-14.) ◆ During puberty: 1. Skin becomes oilier and develops pimples. 2. Sweating increases and youth may have body odour. 3. Hair grows under arms, on pubis and in males on face and chest. 4. Body proportions change (hips widen in females and shoulders broaden in males). 5. Joints may ache due to rapid growth. 6. In males, genitals mature, scrotum darkens, voice deepens, sperm is produced and erections, ejaculation and wet dreams are more frequent. 7. In females, genitals mature, breasts develop, vaginal lubrication increases and ovulation and menstrual cycle begin. ◆ Masturbate and may fantasise about others and sexual intimacy.
Cognitive development	◆ Move toward independence as they progress to middle/junior high school. ◆ Continue developing skills in making decisions as they become more independent. ◆ Begin to consider future careers and occupations. ◆ Shift their school focus from play-centred activities to academics. ◆ Begin to look to peers and media for information and advice. ◆ Develop increasing capability for social conscience and abstract thought, including understanding complex issues like poverty and war. ◆ Take on increased responsibility, such as family jobs and babysitting.
Emotional development	◆ Relate to both same-gender and opposite-gender peers and may develop sexual feelings for other as a new dimension within relationships. ◆ Develop the capacity to understand the components of caring, loving relationship. ◆ Experience feelings of insecurity and begin to doubt self-concept and previous self-confidence.

	◆ Struggle with family relationships and desire privacy and separation from family. ◆ Experience mood swings, especially evident in family relationships. ◆ Develop infatuations or "crushes" and may begin dating.
Sexual development	◆ Have a emerging sense of self as a young adult. ◆ Feel conscious of their sexuality and how they choose to express it. ◆ Understand jokes with sexual content. ◆ Feel concerns about being normal, such as whether it is normal to masturbate, have wet dreams, etc. ◆ Feel anxious about puberty, when it will happen, how it will occur, how to be prepared, etc. ◆ Feel shy about asking questions of caregivers, especially regarding sexuality and may act like they already know all the answers. ◆ Value privacy highly.
Moral development	◆ Has a well-developed a conscience. ◆ Can easily differentiate between fact and fantasy. ◆ Has developed a stronger internal locus of control.

Age: 13-17 years	
Physical development	◆ Complete puberty and the physical transition from childhood to adulthood. ◆ Reach nearly their adult height, especially females. (Males continue to grow taller into their early twenties.)
Cognitive development	◆ Attain cognitive maturity – the ability to make decisions based on knowledge of options and their consequences. ◆ Continue to be influenced by peers. ◆ Build skills to become self-sufficient. ◆ Respond to media messages but develop increasing ability to analyse messages those messages. ◆ Develop increasingly mature relationships with friends and family. ◆ Seek increased power over their lives. ◆ Learn to drive, increasing their independence
Emotional development	◆ Have the capacity to develop long-lasting, mutual and healthy relationships, if they have the foundations for this development – trust, positive past experiences and an understanding of love. ◆ Understanding their own feelings and have the ability to analyse why they feel a certain way. ◆ Begin to place less value on appearance and more personality.
Sexual development	◆ Understand that they are sexual and understand the options and consequences of sexual expression.

Sexual development	◆ Choose to express their sexuality in ways that may or may not include sexual intercourse. ◆ Recognise the components of healthy and unhealthy relationships. ◆ Have a clear understanding of pregnancy and of HIV and other sexually transmitted infections and the possible consequences of sexual intercourse and have the ability to make reasoned choices about sex based on knowledge. ◆ Recognise the role media play in propagating views about sex. ◆ Have the capacity to learn about intimate, loving, long-term relationships. ◆ Have an understanding of their own sexual orientation.
Moral development	◆ Has learnt that wrongful acts are linked to moral issues (society's views of behaviour).

Age: 18 years and older	
Physical development	◆ Complete the process of physical maturation, usually attaining full adult height. (Secondary sexual characteristics, such as size of penis and breasts, are completed.)
Cognitive development	◆ Move into adult roles and responsibilities and may learn a trade, work and/or pursue higher education. ◆ Fully understand abstract concepts and be aware of consequences and personal limitations. ◆ Identify career goals and prepare to achieve them. ◆ Secure their autonomy and build and test their decision-making skills. ◆ Develop new skills, hobbies and adult interests.
Emotional development	◆ Move into adult relationships with their parents. ◆ See the peer group as less important as a determinant of behaviour. ◆ Feel empathetic. ◆ Have greater intimacy skills. ◆ Complete their values framework. ◆ Carry some feelings of invincibility. ◆ Establish their body image.
Sexual development	◆ Enter into intimate sexual and emotional relationships. ◆ Understand their own sexual orientation, although they may still experiment. ◆ Understand sexuality as connected to commitment and planning for the future. ◆ Shift their emphasis from self to others. ◆ Experience more intense sexuality.

2.3 Sexual development

- *Normative sexual exploration versus abusive sexual behaviour*

When treating abuse-reactive children, professionals in the field are faced with two questions: what is normal sexual play, and when is sexual acting out between young children considered abuse.

Typically, children with sexual behaviour problems are those under 12 years of age or younger and who demonstrate developmentally inappropriate or aggressive sexual behaviour such as excessive masturbation and coerced or forced sexual acts upon other children. Although the word "sex" is used to describe these children's behaviour, their motivation for their behaviours may be unrelated to sexual gratification. Sexual behaviour between children is considered problematic when the behaviour:

- Interferes with the child's social or cognitive development.
- Occurs with coercion, intimidation or force.
- Occur at a high frequency.
- Is associated with emotional distress.
- Occurs between children of significantly different ages or developmental abilities.
- Repeatedly occurs in secrecy after adult intervention.

Although some sexual play among children is not harmful and quite normal, like playing doctor and peering at private parts, these same behaviours can become abnormal and harmful of done aggressively or intrusively. According to research done by Chaffin and Friedrich it indicates that about 20% of children with Sexual behaviour problems go on to commit sexual offences as adolescents and about 5-15% of adolescent sexual offenders go on to commit sexual acts as adults. Much of these depend on the constructs of the personality. For example, if an adolescent has a pedophiliac interest, this is likely to persist into adulthood. Versus an adolescent with psychosocial deficits (low social skills, depression, anxiety) which has low sexually deviant traits.

Professionals in the field have developed a continuum of sexual behaviours that discern between normal sexual play and problematic sexual behaviour:

Abnormal sexual play vs problematic sexual behaviour

Normal sexual play	Problematic sexual behaviour
◆ It is exploratory and spontaneous. ◆ It may occur after being exposed/witnessing sexual material/behaviours (e.g. exposed to media or sexual activities). ◆ It may occur once or twice and by mutual agreement (developmental curiosity).	◆ It is frequent, repeated and compulsive, indiscreet and indiscriminate. ◆ It may occur frequently and between children who do not know each other well. ◆ It may occur between children of same and different ages, different gender and of different development levels.

Normal sexual play	Problematic sexual behaviour
◆ It may occur with children of similar age, image size or development level. ◆ It is not associated with fear, anxiety or anger. ◆ The behaviour decreases when redirected by an adult. ◆ This behaviour can be controlled by increased supervision. *(Although it is normal, it requires parents to come in to teach and help with the learning of appropriate sexual expression.)*	◆ It may be associated with fear, anxiety or anger and as a means to assume power and control. ◆ Use manipulation to lure the victim (bribery and trickery). ◆ May use aggression, force or coercion to enlist co-operation by the victim. ◆ The behaviour does not decrease after the child is told to stop the behaviour and given consequences. ◆ The behaviour may cause harm to the child or others. ◆ Secretive behaviour (manipulation and planning). *(May result in the sexual abuse of other children.)*

One method used by therapists to assess whether sexual behaviours are developmentally appropriate or cause for concern includes four basic levels:

- Frequency of the behaviour;
- Intensity of the behaviour;
- Duration of the behaviour;
- Pattern i.e. the context in which the behaviour occurs.

Abnormal sexual development

School age and pre-adolescence (5-12 years)	Puberty and adolescence
◆ Lack of interest in other children, emotionally withdrawn. ◆ Excessive sexual stimulation of self/ masturbates with objects. ◆ Excessive enuresis or encopresis (or other disturbing toilet behaviours such as smearing faeces). ◆ Anxiety over relationships with people. ◆ Sexual exploration among children of different ages, size and/or development level. ◆ Continues sexual behaviours in spite of clear redirection.	◆ Apprehension or guilt towards. ◆ Impulsive or aggressive sex. ◆ Sexual preoccupation. ◆ Poor or absent relationships. ◆ Coaxing, bribing or tricking a child younger in age or developmental level. ◆ An on-going impulsive interest. ◆ Inability to postpone self-gratification. ◆ Precocious sexual behaviour. ◆ Inappropriate touching of self. ◆ Colitis, menstrual disorders. ◆ Inappropriate touching of other children or people.

School age and pre-adolescence (5-12 years)	Puberty and adolescence
◆ Seductive or sexually responsive toward adults. ◆ Obsessive-compulsive sexual fantasy. ◆ Excessive sexual exhibitionism and/or eroticism. ◆ Puts mouth on sexual parts. ◆ Makes sexual sounds. ◆ Simulates adult sexual intercourse (with or without clothes on). ◆ Refuses to leave people alone while in restrooms. ◆ Puts objects in rectum or vagina. ◆ Asks or watches others take their clothes off, repeatedly. ◆ Wants to watch movies with nudity or sex. ◆ Cannot distinguish between sexual and non-sexual touching. ◆ Negative feelings about own body. ◆ Asks to engage in sex acts.	◆ Sex is used to gain friendship within relationships. ◆ Self-worth dependent on sex. ◆ Seductive and clingy towards other people. ◆ Vulnerable to exploitation. ◆ Uses sexual behaviour. ◆ Self-mutilation, especially genitals. ◆ Exhibits confusion or distortions other in regard to sexual behaviour.

*Adapted from South Carolina Guardian Ad Litem Program, and work by Toni Cavanagh Johnson (PhD).

Chapter 2

Understanding the offender

Much research has been conducted on the child offender to try and establish the contributing factors that give arise to this criminal behaviour. The primary features of this research are the combination of eco-systemic characteristics common amongst child sexual offenders and the eternal debate between the influences of nature and nurture.

Section 3: Characteristics of the child sexual offender

3.1 Individual characteristics:

- Sexual histories and beliefs of victims of abuse.
- Exposure to pornography.
- Academic performance not promising/satisfactory.
- Cognitive distortions and attributions denial of impact of responsibilities by shifting of blame – defence mechanisms using; rationalisation, minimising, and projection.
- Mental health symptoms and disorders (will be explained more in detail later in manual).
- Substance abuse.
- Conduct and antisocial personal disorders.

3.2 Family and home environments of the youth sex offenders:

- History of sexual abuse and physical abuse.
- Dysfunctional.
- Exhibiting high rates of parental separation.
- Domestic violence.
- Attachment issues.
- Substance abuse.
- Highly sexualised environments, e.g. exposing children to sexual activities.
- Pornography.
- Covert and/or overt sexual abuse.

- Poor role models.
- Unsatisfactory parent-child relationships.
- Parental histories of childhood abuse.

Section 4: Theories on child sexual offending

4.1 Post-traumatic stress disorder (PTSD)

Although post-traumatic stress reactions have been documented and observed in adults for many years, the recognition of PTSD in children is a relatively new phenomenon. When theoretical explanations involving PTSD are applied to child perpetrators, they obviously apply to children who, themselves were traumatised at very young ages. Their sexually aggressive behaviour is viewed as a trauma response to their own previous abuse (Green, 1985). Breer (1987) applied this conceptual model to adolescent sex offenders when he described their behaviour as an attempt to recreate their own traumatic molestation or abuse in ways that allow them to develop mastery and control over their feelings.

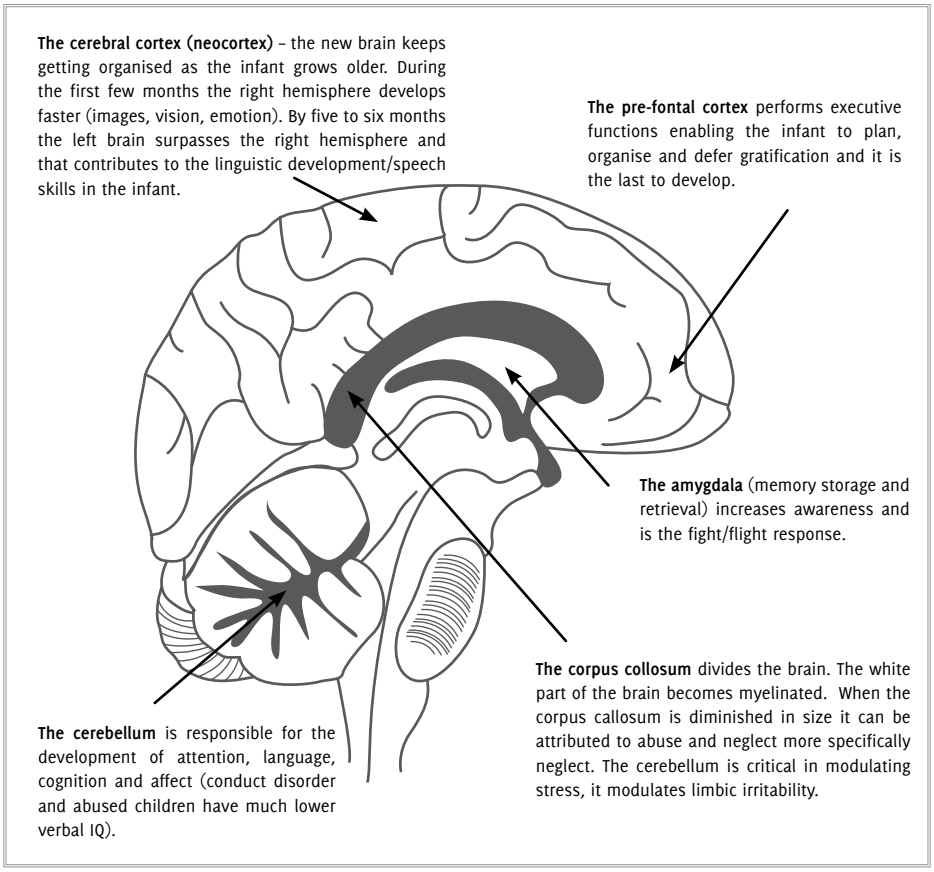
Failure to master a childhood trauma can create a need to repeat or re-enact the trauma throughout developmental life stages. For abuse-reactive children, the unresolved emotional pain from their own victimization may vary widely. For some, this pain may be so intense that aggressive sexual acting out becomes the compulsive behaviour used to rid themselves of their feelings of shame and helplessness or to compensate for feelings of inadequacy. Of course, their abusiveness may be experienced as shameful as well but too often it is not enough of a deterrent to inhibit their compelling need to protect themselves from the residue of vulnerability by their victimisation. Once the initial reaction to trauma becomes repetitive, it may not only become difficult to extinguish, but the sexual stimulation itself becomes a powerful re-enforcer, and it may progress to compulsivity.

Overwhelming demands are placed upon the physiological system that result in a profound felt sense of vulnerability and/loss of control – such as, the expectation that terrible things are going to happen as they go through life. Trauma destroys the capacity for hope, something changes in the brain. The front part of the brain shuts down (fight/flight/freeze response). People continue to react even after the trauma because the emotional brain does not know it is over – the limbic system is not available to reason.

- *Stress and structures in the brain*

What happens to a person in their environment (experience) causes brain cells (the neurons) to fire. Neurons which fire together will survive together and wire together (Hebb's law, 1949). If an infant is constantly exposed to stress, the infant is likely to become anxious which may lead the infant to become more fearful. The brain is sculpted/shaped by the effect of early experiences. It thus becomes an enhanced response to stress. Before the birth of a baby there are two to three

times more neurons primed to fit that world. From birth to five years the brain triples in mass and the pre-fontal cortex matures only in the twenties. Excess stress increases cortisol levels (stress hormone) which reduces brain weight and interferes with brain development.



When there is excessive stress in infancy vasopressin occurs which means that early stress produces changes in all of the above (different parts of the brain). However should there be early maltreatment or neglect in the infant inducing high levels of stress it will induce changes in all of the above parts in the brain. This can result in permanent sequalae in the form of symptomatology such as: depression, post-traumatic stress disorder, attention deficit hyperactivity disorder, borderline personality disorder (diminished right/left hemisphere) and substance abuse. If a person has suffered early abuse he is more likely to become a drug addict or alcoholic.

When there is excessive stress (the primary chemical effect is on the hippocampus and amygdale, which is responsible for emotional memory and cognitive processing). Stress is like a toxic agent

which interferes with normal development in infancy and has long term effects. As described above the brain changes and all parts of the brain can modify their functioning in response to specific patterns of stress. These changes in the brain result in changes in cognition (basis for learning), emotional functioning (social adaptation skills), motor vestibular functioning (how to write, type and ride a bike) and state regulation capacity (resting heart rate). Changes in the brain do not occur without it being activated. The traumatised child experiences significant impairment in social and emotional functioning. Social and emotional capabilities are learned via experiences which may not always be positive.

Hyper-vigilant children often develop remarkable non-verbal skills in proportion to their verbal skills (street smarts). It is common that they read too much into non-verbal cues, where eye contact means threat; an innocent touch may be interpreted as the beginning of a seduction process. This may be accurate in the world they come from (previous trauma) but in a normal setting it is inaccurate (Perry, 1997).

As described by Perry the midbrain becomes conditioned to a state of hyper-arousal resulting in the child becoming hyperactive (unable to stay focused, fidgety, restless, inability to concentrate). This also hinders the process of attachment when the limbic system and the amygdala are in a constant state of arousal. This as a result impedes the process of normal growth and development where children learn to play, relax and enjoy, manage their arousal levels appropriately, develop a sense of understanding others and identifying with their pain (empathy) and be more compassionate of others as well as themselves (not have unrealistic expectations).

4.2 Addiction model

The addiction model traces its roots to learning theory. There is no doubt that sexual orgasm is a powerful reinforcement of behaviour. According to Breer (1987), reinforcement can occur as a result of actual behaviour (e.g. masturbation or sexual touching with another child) or in response to a fantasy about molesting behaviour. In addition, Breer (1987) hypothesises that adolescent sex offenders seem to work themselves up to the act of molestation in reality by creating them first in fantasy.

Carnes (1983) has applied the addiction model directly to disorders of sexuality. In his book *Out of the Shadow*, he lists the following signs of sexual addiction:

1. Preoccupation with sex thoughts
2. Ritualisation
3. Sexual compulsivity
4. Secretive
5. Pain relieving quality
6. Sex activity devoid of a caring relationship

7. Despair and shame
8. Progressive addictions
9. Massive denial

The active behaviour model has its place in the dynamic of child sexual offending. Sexual preoccupation is one of the common reasons children come to attention in the first place. While secretive and massive denial keeps too many children from getting the help they need. While concepts of addiction are usually associated with adults as well as with items or substance outside behaviour, they may also apply to the behaviour of children.

This model, through identification and treatment for children in the early stages of repetitive sexual acting out, aims to deter the likelihood and/or minimise the development of compulsive/addictive sexual behaviour before it becomes intractable.

4.3 Sexual abuse cycle theory

Sandy Lane, treatment coordinator of Redirecting Sexual Aggression, has described youthful offenders as each having a unique "sexual abuse cycle". The cycle includes antecedent thoughts, feelings, and behaviours culminating in sexually abusive acts as a response to situations the child perceives as threatening (Lane, 1991). It consists of: (i) an event that is – or is perceived as threatening in some way; (ii) an emotional response representing an intolerable set of feelings for that youth; and (iii) an attempt to compensate for the initial reaction with substitute feelings of rage and revenge, allowing the youth to feel in control again. The youth then makes a conscious or unconscious decision to increase his/her sense of being in control through actions that include molestation or rape. Upon completing the assault, the young offender rationalises the reason for the offence.

This theory, in part, also describes the younger child offender or abuse-reactive child perpetrator. In our work with over 1 000 of these children we have found that they generally suffer from low self-esteem and feelings of inadequacy; they struggle against intolerable feelings of vulnerability and victimisation; and they attempt to compensate in front of others by exhibiting sexual or physically aggressive behaviour.

It should be noted that in aspects of the theoretical model involving the role of sexual fantasy outside of clinical experiences, it is still with regards to child fantasies about images that they had been exposed to e.g. sexual scenes on television or direct exposure of sexual scenes witnessed. This is normalised for them and an element of grandiosity is attached to it, hence, giving permission to the children to re-enact this behaviour. Thus giving impetus to the execution of this fantasy which may then result in secondary gain, and reinforcing sexualised behaviour. This may or may not prove to be applicable, since the sexual fantasy development of very young children (whether or not they have been abused) is still unclear.

4.4 Attachment theory

Attachment may be defined as the capacity that a child develops to bond with caregivers and others. Secure attachment occurs when a caregiver is sensitive and responds to the child appropriately and consistently. Insecure attachment/Impaired attachment occurs when the caregiver is unresponsive, insensitive to the needs of the child (constantly cold) and is inconsistent in responding to the child.

The child seeks comfort, protection, support and nurturance from the relationship with a preferred caregiver. Preferred attachment is more evident in the latter part of the first year of life by the appearance of separation, protest and stranger wariness. At around seven months infants are reluctant to go to strangers or unfamiliar people whereas previously it was not a problem and they protest separations from familiar caregivers. It is when these behaviours manifest themselves that the infant is said to form an attachment.

The literature cites that infants become attached to caregivers with whom they have had considerable interaction. These attachment figures appear to be arranged hierarchically in terms of strength of preference, so that the infant has a most preferred caregiver, a next most preferred caregiver, and so forth (Bowlby, 1982). Preferred attachments usually develop between seven and nine months provided the caregiver has become sufficiently involved with the infant. It is very rare to find a lack of attachment to an attachment figure in a responsive and nurturing environment. Infants who have not been subject to neglect or maltreatment may have displayed serious impaired attachment or more specifically reactive attachment disorder (RAD).

- *Reactive attachment disorder (RAD)*

RAD is seen in infants who have suffered extreme neglect or maltreatment and there is no identifiable preferred attachment figure. These children have been shunted from institution to institution or have been abused, neglected or traumatised and hence, display impaired attachment.

According to academics RAD is a disturbance of social interaction and relatedness based on the neglect of the child's physical or emotional needs or multiple changes in the caregivers' needs preventing appropriate bonding (Smith, 2007). Whilst secure attachment minimises the risk of aberrant behaviour patterns in children, insecure attachment increases the risks of such behaviour. Hence, secure attachment – protective factor and insecure attachment-risk factor. When children form insecure attachments with their caregivers the risks are high and this has negative consequences. The behaviours that are manifested include: a lack of responsiveness, excessive inhibition, hyper-vigilance, indiscriminate attachment/non- selective attachment.

There are two subtypes of RAD, referred to as inhibited or emotionally withdrawn and dis-inhibited or indiscriminate. Children with the inhibited type of RAD do not seek comfort from a preferred attachment figure nor do they respond to any comfort being offered. These responses are not isolated but characteristic patterns of behaviour. "This pattern of RAD have been identified in children with histories of maltreatment" (Boris *et al*., 1998, 2004; Zeanah *et al*., in

press) "and in children who are being reared in institutions" (Smyke *et al*., 2002). These children also have difficulties with regulation of emotions, they display; blunted affect, crying outbursts, chronic irritability and aggression in response to being comforted.

The dis-inhibited type of RAD displays non-selective attachment where strangers are approached for comfort or they wander away from their attachment figure without looking back. This subtype is prevalent in children who have been maltreated and institutionalized. "In fact, indiscriminate behaviour is one of the most persistent signs of social abnormalities in young children adopted out of institutions" (Zeanah, 2000). The literature cites that children with histories of severe neglect or maltreatment display signs of RAD even after more normative caregiving environments are provided (Zeanah, 2000). Impaired attachment relationships are typically characteristic of self-destructive, fearful, vigilant and overly compliant behaviour.

> *"What cannot be communicated to the (m)other cannot be communicated to the self" (Bowlby, 1991).*

According to Bowlby (1991), parents who are unavailable to the child or are inconsistently unavailable or constantly cold, will find that these children will stop communicating their distress to the parents by the age of 12 months. The implication is that the infant's ability to form relationships is severely impaired. Zeanah *et al*., (1993:338) proposed that disturbances of attachment become clinical disorders when the emotions and behaviour displayed in attachment relationships are so disturbed as to indicate or substantially to increase the risk for persistent distress or disability in the infant. Neglect and/or abuse in infancy can have long-term effects even if a child is later placed in a good home.

The most important thing for people is the capacity to form and maintain relationships. For any person to survive, learn, work, love and procreate these relationships need to be maintained.

> *"The capacity and desire to form emotional relationships is related to the organization and functioning of specific parts of the human brain" (Perry, 1997).*

It is the brain that allows one to see, taste, smell, talk and allow movement and the organ that permits one to love or not. These sensations are developed during infancy and the first years of life. It is during infancy that the capacity to form intimate and healthy relationships is formed (bonding or an emotional connection to another).

The most important relationship in a child's life is the attachment to a primary caregiver (usually the mother). This first relationship determines all other future relationships (biological and emotional template). Thus, a healthy attachment to the caregiver in infancy provides a solid foundation for further healthy relationships and impaired attachments can result in a faulty foundation for future relationships (nature vs. nurture), confirming that social structure influences the development of the brain.

RAD can manifest in the form of a number of different behaviours, such as:

- Eating habits: Children with impaired attachment are likely to hoard food, hide food in their rooms, eat everything in sight as if they will not receive more food even if they have received consistent nourishment. These children may display failure to thrive, vomiting, swallowing problems and later in life eating behaviours that are somewhat irregular and may often be diagnosed as anorexia nervosa.
- Soothing behaviour: These children resort to bizarre forms of soothing behaviour. They are more likely to cut or poke themselves, pull their hair out, bite themselves, bang their head and rock and chant.
- Emotional functioning: Emotional problems present in these children include depressive and anxiety symptoms. A common behaviour noted in these children is indiscriminate/disinhibited attachment. When children are in a threatening situation they seek comfort and safety. In impaired attachment these children seek attachment from anyone including a stranger (hugging a total stranger).
- Socialisation: Children re-enact what they have been exposed to. It becomes a socially conditioned or learned response. Hence, children with impaired attachments display poor social skills and experience problems in their social interactions with adults other children. This child may be a loner and not part of a peer group in which a lot of skills are developed and the value of friendship will not be understood.
- Aggression: Children suffering from impaired attachment often have a need to lash out and hurt others – often somebody in a less significant position of power. They lack insight or feeling the pain of others (lack victim empathy). Although they may experience regret they do not show remorse or feel remorse when confronted about the aggressive behaviour.

It is found that these children lack the ability to trust others and often respond aggressively to those who try to engage their trust (Van der Kolk, 2007).

Children who have been exposed to abuse or neglect in infancy lack the ability of processing anxiety, impulsivity and emotional pain which is connected to their memory bank. It is memory that enables a person to anticipate an event and cope with it based on past coping resolutions, or mechanisms. According to Van der Kolk (2007), children who have suffered undue trauma become immobilised and stuck or frozen in their traumatic memories, which prevents them from responding to the present situation.

Children who have suffered impaired attachment do not have the capacity to form a relationship with others. They may display socially indiscriminate behaviour towards their new caregivers – latching onto total strangers. These children are not able to distinguish between clear and healthy boundaries, which give rise to confusion about normal and healthy social interactions. These children also display poor social skills and this continues in all their relationships. Even when these children have been adopted into loving families there seems to be little hope for

them because they continue to display insecure and disorganised behaviour, such as: aggression, lack of impulse control and lack of victim empathy.

In view of all of the above one can safely conclude by stating that early attachment has a strong impact on the development of the brain which has long-term implications on the well-being of the child despite the fact that further opportunities may be provided.

Section 5: Incidence and prevalence of child-on-child abuse

International research conducted around both the incidence and prevalence of child-on-child abuse is limited (Hoghughi, 1997), and South African studies are now also exploring this phenomena. Data on the incidence and prevalence of juvenile sexual offending stems primarily from the United States of America (James & Neil, 1996). There has been a significant increase in reports of juvenile sexual aggression and sexual abuse over the past few years. Sexual assault is among the fastest growing violent crimes in the United States of America and South Africa. It is estimated that 1 out of every 3 women and 1 out of 7 men are sexually victimised before 18 years of age. From 2001-2009 more than 1 000 offenders were seen at the Teddy Bear Clinic from 6-17 years and WMACA from 5-18 years old.

Bezuidenhout & Joubert (2003) state that less than half of all sexual assaults against children in South Africa are committed by children younger than 13 years of age. This trend is supported by international research undertaken by the American Academy of Child and Adolescent Psychiatry (2000; 1999) and by authors such as Hoghughi 1997) and Oates (1990) who found that offenders are usually between the ages of 14 and 15 years old, but that perpetrators as young as five years have been identified, as cited by Omar (2010).

While adolescents comprise only of 6% of the US population, they are responsible for 25% of index crimes including homicide, arson, robbery, manslaughter, aggravated assault, larceny and forcible rape (Shaw *et al*., 1999) Victim surveys and arrest statistics have concluded that 20% of all rapes and approximately 30% to 50% of child molestations in the United States are perpetrated by youths younger than 18 years of age (Racey, Lopez & Schneider, 2000).

In a research study exploring trends in a national sample of sexually abusive youths, Ryan *et al*. (1996) found that 90% of sexually abusive youths were between 10 and 18 years of age with the modal age being 14 years. Males represented 97,4% and females only 2,6% of the sample.

Despite the absence of formal South African studies, the Correctional Services Department of South Africa has compiled a document including the numbers of prisoners currently in custody for various criminal offences. Up until July 2001, a total of 168 497 prisoners were in custody in South Africa, 21 751 (12,91%) of which were charged or convicted for sexual offences. In the year 2000, a total of 5753 juveniles were in custody for sexual offences. Thus, 26,45% of sexual offenders in custody were juveniles. Of these juvenile offenders in custody, 99,41% were male and 0,59% were female (Joubert, 2001).

All statistics share the dual error of containing certain items that should not be included and of historically excluding others that should be included. In the case of child sexual abuse statistics, inclusion occurs when non-abusive, normative sexual experimentation is labelled as abuse, while exclusion of necessary statistics are frequently the result of an under reporting of sexual abuse by victims for fear of negative repercussions (Hoghughi, 1997). According to James and Neil (1996), as many as 80% of indecent assaults and rapes in the United Kingdom may go unreported. Anecdotal evidence by Van Niekerk also confirms these findings in South Africa (Childline National Training and Advocacy Manager, November 2009).

Johnson (1993) reported that most sexually aggressive children who have been studied were victims of sexual abuse themselves, although the abuse had generally occurred years before they began molesting other children. All had been emotionally abused and most had been severely punished by caregivers. All of these children lived in home environments marked by sexual stimulation and lack of boundaries and virtually all witnessed extreme physical violence between their primary caregivers, most parents of these children also have been sexually abused in their family history as well as physical and substance abuse.

These children have paired intense feelings of loneliness, rage and fear (each child has one or more such feelings) with sex, which itself has been paired with aggression. When they feel loneliness, they want to decrease the anxious and uncomfortable sensations and think they can do so by acting-out sexually and aggressively. Although they experience momentary release, virtually all these children feel worse after acting-out and the intensity of the feelings remains, according to Johnson (1993).

Chapter 3

Working with the offender

Section 6: Laws governing children

South African Law defines the context within which one can work. There are several laws that are addressing work with children and those are found in the following legislative document:

- Children's Act No. 38 of 2005
- Domestic Violence Act No. 75 of 1998
- Sexual Offenders Act No. 23 of 1957
- Constitution of the Republic of South Africa Bill, Act No. 108 of 1996
- Child Justice Act No. 75 of 2008

Their biggest impact is seen when addressing the ages of consent. These give us a clear picture of when is there a need for intervention.

6.1 Legal terms and definitions

As stated by the Criminal Law (Sexual offences and related matters) Amended Act No. 32 of 2007:

- *Child pornography*
  - Real or simulated, where participants are depicted, presented or are under 18, either erotic purposes or not.
  - Includes acts of sexual offence, penetration, self-masturbation, simulated sex act, etc.

- *Mental disability*
  - Cannot appreciate nature or consequences, cannot resist, or cannot communicate non-permission.

- *Sexual penetration*
  - Genitals, anus and mouth, any part of body;
  - Sexual violation (touching);
  - Genitals, anus and mouth, any part of body;

- Consent not possible if: Threats made to harm third party or property, abuse of position of authority, pretending to be other person, victim asleep or unconscious, alcohol, drugs, child below 12, mentally disabled.

- *Rape*
  - Defined as: "Act of sexual penetration without consent."
  - Compelled rape: Third person assist to rape.

- *Sexual assault*
  - Direct – sexual violation without consent.
  - Indirect – make a person believe that sexual violation will occur.
  - Compelled sexual assault – third person assists sexual assault.

- *Compelled self-assault*
  - Forcing the victim to masturbate, self-penetrate, etc.
  - Cause/compel child to witness sexual act, offence or self-masturbation;Engaging in sexual act for reward;
  - Applies to client, customer and facilitator, act does not have to happen.

- *Incest*
  - Consent remains relevant (difficult sections of law applies, multiple charges);
  - Blood relationship – ascendants and descendants in direct line;
  - Affinity – relationships by marriage;
  - Adopted children;
  - Bestiality;
  - Penetration of mouth, genitals or anus of animal and/or human and masturbation.

- *Sexual act with a corpse*
  - Consensual sexual penetration or violation of children;
  - Consent relevant (multiple charges);
  - Children between 13 and 15 – NDPP must authorise prosecution where both parties are children. Both must be charged. Less than two-year gap between children will be considered – so look at life-skills rather than criminal.

- *Sexual exploitation of children*
  - Financial or other rewards given to child or third party – person who may benefit from reward. Third party also accountable for inviting or persuading child to comply.

- *Grooming*
  - Make possess, supplies, displays or helps – articles, publications or films of child porn or porn for the intention of sexual abuse of a child is illegal. Also encourage, enable, instruct a child to perform a sexual act or sex in front of children, etc.

- *Display of pornography (child or adult porn)*
  - Child cannot consent.

- *Flashing to children*
  - Sexual gratification not required, include genitalia, anus or female breasts;
  - Report commission of sexual offences to children and mentally disabled persons;
  - Any person must report knowledge of child abuse.

- *Violent pornography*
  - A film that concurrently depicts both sexual explicitness and physically violent acts between or among those engaged in the sexual activity.

- *Sexual explicitness*
  - Human genitals in a state of sexual stimulation or arousal;
  - Acts of human masturbation, sexual intercourse, or sodomy, or fondling or other erotic touching of human genitals, pubic region, buttock, or female breast.

- *Physically violent acts*
  - assault
  - battery
  - murder
  - rape
  - torture
  - coercion by physical force

The following acts shall be violations of this ordinance:

- *Production*

It shall be a violation to participate in any capacity in the production of violent pornography. Participation means:

1. filming
2. directing

3. acting (playing a role in the film)
4. coercing another to play a role in the film
5. creating manuscripts for production
6. editing films
7. knowingly supplying the financial backing for producing the film*
8. knowingly supplying the studio or other place where the film is to be
9. made* or
10. knowingly supplying actors for such a film, such as an agent, or parent
11. or relative of a minor*

*(The standard for knowledge shall be the "reasonable person" standard, i.e. the defendant knew or should have known).

It shall be a violation to deal in violent pornography.

Dealing means:

1. selling films
2. buying films
3. exhibiting films
4. distributing films

- *Sanctions*

The following criminal and civil actions shall apply to the forgoing violations:

- Criminal sanctions: It shall be a crime to violate this ordinance.
- Penalties shall be determined by the appropriate legislative bodies.

Civil sanctions: A civil action is created and treble damages shall be awarded for torts such as assault, battery, and false imprisonment that occur in production of the film.

Pornography is a depiction, in any medium, of violence directed against, or pain inflicted on, an unconsenting person or child, for the purpose of anyone's real or apparent sexual arousal or gratification, in a context suggesting endorsement or approval of such behaviour, and that is likely to promote or encourage similar behaviour in those exposed to the depiction.

SUPREME COURT ("MILLER"): This is not a pornography definition per se, but a definition of "obscenity" – a particular subspecies of pornography that is deserving of censorship and considered unprotected speech under the First Amendment. It is found in *Miller v. California*, 413 US 15, 24-25 (1973):

The basic guidelines for the trier of fact must be:

- whether "the average person, applying contemporary community standards", would find that the work, taken as a whole, appeals to the prurient interest;
- whether the work depicts or describes, in a patently offensive way, sexual conduct specifically defined by the applicable state law; and
- whether the work, taken as a whole, lacks serious literary, artistic, political, or scientific value.

6.2 Ages of consent

The following fact sheet has been adapted and updated from the Prinslean Segeel of the Children's Institute:

	Old Law	New Law
Age of majority: The age of majority sets the age at which a child becomes an adult. A child who reaches the age of majority is able to conclude valid contracts without parental assistance. (E.g. Marriage contract, employment contracts.)		
Age	General law: 21 Majority status can also be acquired by concluding (see the marriage section) or an 18-year old can apply to the High Court to be declared an adult.	18

	Old Law	New Law
Source of the law	Common law Age of Majority Act No. 57 of 1972 Section 1 and 2	Children's Bill (B70B-2003) Section
Voting: The age at which a child can vote.		
Age	18	
Source of the law	Electoral Act No. 73 of 1998 Section 1	
Alcohol: Age at which a child may be sold/served alcohol		
Age	18	
Source of the law	The Liquor Act No. 59 of 2003 Section 10(1)	
Gambling: Age at which a child may gamble.		
Age	18	
Source of the law	National Gambling Act No. 7 of 2004 Section 12	
Drive a car: Age at which a child can drive a car		
Age	18 (17 with a learner's license and an adult in the passenger seat)	
Source of the law	National Road Traffic Act No. 93 of 1996 Section 15	
Smoking: Age at which a child may access or be sold cigarettes		
Age	16	
Source of the law	Tobacco Products Control Act No. 83 of 1993	
Firearms: Age which A child can legally possess a firearm		
Age	21	
Source of the law	The Firearms Control Act No. 60 of 2000 Section 9	
Passport: Age at which a child can apply for a passport		
Age	16 Under 16, with signature of the parent(s) (Called a child passport)	
Source of the law	South African Passport and Travel Documents Act No. 4 of 1994 Section 2 and 3 respectively	

	Old Law	New Law
Identity Document: Age a child which can apply for an Identity Document		
Age	16 Under 16, with signature of the parent(s) (Called a child passport)	
Source of the law	South African Passport and Travel Documents Act No. 4 of 1994 Section 2 and 3 respectively	
Identity Document: Age a child which can apply for an Identity Document		
Age	16	
Source of the law	Identification Act No. 68 of 1997 Section 15	
Civil law marriage: Age which a child may enter into marriage in terms of the civil law		
Age	21 (without parents' consent) Girls under 21 need their parents' consent to get married. If they are under the age of 15, they also need the Minister's consent. Boys under 21 need their parents' consent to get married. If they are under the age of 18, they need the consent of the Minister. The Marriage Act No. 25 of 1961 Section 26(1)	18 (without parents' consent)
Source of the law	The Guardianship Act No. 192 of 1993 Section 1(2)	Children's Bill (B70B-2003) Section 17
Customary law marriage: Age at which a child may enter into a marriage in terms of customary law		
Age	21 (without parents' consent) Children under 21 need their parents' consent to get married. If they are under the age of 18, they also need the consent of the Minister or a public officer.	18 (without parents' consent)
Source of the law	Recognition of Customary Marriages Act No. 120 of 1998 Section 3 read with section 9	Children's Bill (B70B-2003) Section 17
Bank account: Age at which a child can open and operate a bank account		

	Old Law	New Law
Age	16 The 16-year-old can be a depositor at a bank where the deed of establishment or statutes of the bank makes provision for it. He/she can execute the necessary documents, give the necessary acquaintances and cede, pledge, borrow against and generally deal with his/her deposit and enjoy all the privileges and be liable for all the obligations and conditions applicable to depositors as if he/she was a major.	
Source of the law	The Banks Act No. 94 of 1990 Section 87(1) And Mutual Banks Act 124 of 1993 Section 88(1)	
Insurance policy: Age at which a child can take out an insurance policy in their own name.		
Age	18 The 18-year-old can enter/vary or deal with a long-term policy under which he/she is the beneficiary as if he/she was a major	
Source of the law	Long-term Insurance Act No. 52 of 1998 Section 58	
Wills: Age at which a child can make a valid will		
Age	16	
Source of the law	The Wills Act No. 7 of 1953 Section 4	
Legal contracts: Age at which a child can sign and enter a legal contract		

	Old Law	New Law
Age	A child's capacity to contract is determined either by statute or by common law: General: 21 is the age at which contractual capacity is acquired. A child (under the age of 21)can fully (w/o parental consent) enter into a contract in which he/she acquires rights but no obligations If parental consent is granted then a child under 21 can enter into a contract where he/she acquires both rights and obligations. However there are certain agreements into which under 21 cannot enter even with parental consent. Such as employment contracts where the child is under 15	18
Source of the law	Common law	Children's Bill (B70B of 2003) Section 17
Work: Age at which a child may perform labour		
Age	15 Children below the minimum school leaving age may not be employed. In terms of the Schools Act the minimum school leaving age is 15 or ninth grade whichever comes first.	Subject to the BCEA and with certain proviso's a child (under 15) Can perform labour for advertisements, sport or in an artistic or cultural event. And a child can perform labour carried out within the framework of a programme registered into the NPO Act No. 71 of 1997.
Source of the law	Basic Conditions of Employment Act No. 75 of 1997 Section 43	Children's Bill B-2003 Section 76 Bill Section 141
Starting school: Age at which compulsory school attendance starts (a child must be in school at this age or else the parents will be guilty of an offence)		
Age	7 years old	
Source of the law	South African School Act No. 84 of 1996 Section 3(1) read with Section 6(a)	
Leaving school: The age at which compulsory school attendance, as required by law, ends(a parent is not guilty of an offence if the child is no longer in school after the prescribed period)		
Age	15 or Grade 9	

	Old Law	New Law
Source of the law	South African Schools Act No. 84 of 1996 Section 3(1)	
Admission to school: Age at which a child may be admitted to primary school		
Age	5 years old for Grade R 6 for Grade 1 (The child can be 5 but must be turning 6 during the year of admission to Grade 1)	
Source of the law	South African Schools Act No. 84 of 1996 Section 5	
Surgical operations: Age at which a child may consent to surgical operations on him/herself and consent to such operations on his/her own child.		
Age	18	18 (without need for parents' consent) 12 and of sufficient maturity and mental capacity to understand the benefits, risks and social implications of the operation: Child can consent but must be assisted by his or her parent or guardian. Under 12: Parents must consent on child's behalf.
Source of the law	Child Care Act No. 74 of 1983 Section 39(4)	Children's Bill (B70B-2003) Section 129
Medical Treatment: Age at which a child may consent to his/her own medical treatment as well as medical treatment for his/her own child		
Age	14	12 and of sufficient maturity and mental capacity to understand the benefits, risks and social implications of the treatment.
Source of the law	Child Care Act No. 74 of 1983 Section 39(4)	Children's Bill (B70B-2003) Section 129
Terminating a pregnancy: Age at which a child may terminate her pregnancy		
Age	Any age the Termination of Pregnancy Act defines a woman as: "any female of any age". If further states that only the women's consent is needed for the TOP and in the case of a minor, only the minor's consent is needed subject to advising such a minor to consult with the parents.	New Law
Source of the law	Choice on Termination of Pregnancy Act No. 92 of 1996. Section5(3) and 5(2)	

	Old Law	New Law
Access to contraceptives: Age at which a child may access or buy condoms or other contraceptives		
Age	In terms of the National Contraception Policy of 2001 'children of any age can approach a clinic for sexual and reproductive health information and condoms. Furthermore girls of 14+ can be prescribed any form of medical contraceptive without the assistance or knowledge of their parents/guardians. Girls under 14 need the consent of their parent/guardians before being supplied with the pill or prescription forms of contraceptive. However adolescence who may be sexually active and/or request contraception but are willing or unable to obtain their parents/guardian's consent should have their health and social needs met.	12 for condoms 12 for other contraceptives with the addition that proper medical advice must be given to the child and a medical examination must be performed.
Source of the law	National Contraception Policy Guidelines: within a reproductive health framework. Department of Health August 2001 page 15	Children's Bill (B70B-2003) Section 134
HIV testing: Age at which a child can consent to an HIV test		
Age	14	12 Under 12 if child is mature enough to understand the benefits, risks and social implications of the test.
Source of the law	Child Care Act No. 74 of 1983 Section 39(4)	Children's Bill (B70B-2003) Section 130
Disclosing HIV status: Age at which a child can consent to disclosure of his/her HIV status		
Age	14	12 Under 12 if child is mature enough to understand the benefits, risks and social implications of such disclosure.
Source of the law	National Heath Act No. 61 of 2003 Section 14 (read in conjunction with the definition of user in Section 1)	Children's Bill (B70B-2003) Section 133
Donation of bodily organs (after death): Age at which a child can agree to donate his/her body or any specific tissue thereof in the event of his/her death		
Age	16	
Source of the law	The National Health Act No. 61 of 2003 Section 62	

	Old Law	New Law
Use of organs from a living person: Age at which a child can consent to use of his/her organs (e.g. kidneys) while alive.		
Age	18 The Act states that a person cannot remove tissue (which includes organs) without the written consent of the person from who the tissue is taken. It then further states that tissue which is not replaceable by natural process cannot be withdrawn for medical or dental purposes from a person younger than 18.	
Source of the law	The National Health Act No. 61 of 2003 Section 56(2)	
Adoption: Age at which a child can consent to his/her own adoption or the adoption of his/her child		
Age	At 10 a child can consent to his/her own adoption. At any age a child can consent to the adoption of his/her own child without assistance from his/her guardian.	A 10 a child can consent to his/her own adoption. Under 10 a child can consent to his/her own adoption if child is mature and developed enough to understand the implication of such consent. Under 18 a child can consent to the adoption of his/her own child. Provided that the child is assisted by his/her guardian. 18 years and older a child can consent to the adoption of his/her own child.
Source of the law	Child Care Act No. 74 of 1983 Section 18	Children's Bill(B70B-2003) Section 233
Accommodation of child prisoners: Ages at which prisoners should be detained separately.		
Age	Child prisoners (under 18) must be detained separately from adults prisoners(above 18 years) Prisoners between 18-21 should be detained separately from prisoners over 21.	

	Old Law	New Law
Source of the law	Correctional Services Act No. 111 of 1998 Section 7(c) Read with the Correctional Services Regulations: GNR.914 or 30 July 2004: Section 3(2)(h). See also The Constitution of the Republic of South Africa Act No. 108 of 1996 Section 28(g)(i)	
Accommodation of child prisoners: Ages at which prisoners should be detained separately.		
Age	Child prisoners (under 18) must be detained separately from adult prisoners (above 18 years) Prisoners between 18-21 should be detained separately from prisoners over 21.	
Source of the law	Correctional Services Act No. 111 of 1998 Section 7(c) Read with the Correctional Services Regulations: GNR.914 or 30 July 2004: Section 3(2)(h). See also The Constitution of the Republic of South Africa Act No. 108 of 1996 Section 28(g)(i)	
Criminal capacity: Age at which a child can be tried and convicted for a criminal act.		
Age	Under 7 the child cannot be tried and convicted of a crime because they are considered incapable of knowing the difference between right and wrong. Between the ages 7 and14 the child can be tried and convicted but there is a rebuttable presumption that they did not know the difference between right and wrong. The prosecution bears an onus to prove that they did know the difference between right and wrong. Age 14 years and older the child is considered fully aware of the difference between right and wrong and they can therefore be tried and convicted.	Under 10 the child cannot be tried and convicted of a crime because they are considered incapable of knowing the difference between right and wrong. Between the ages of 10 and 14 the child can be tried and convicted but there is a rebuttable presumption that they did not know the difference between right and wrong and did not have the capacity to act accordingly. The prosecution bears an onus to prove that they did know the difference between right and wrong. Aged 14 years and older the child is considered fully aware of the difference between right and wrong and they can therefore be tried and convicted.

	Old Law	New Law
Source of the law	Common Law	Child Justice Bill B49-2002 Section 5(1) and (2)
Litigation: Age at which a child can sue or be sued in his/her own name.		
Age	21 (without assistance) Under 21: The minor must be assisted by his parents/guardian or a curator ad litem must be appointed by the court. Note however that it is the minor who is the party to the proceedings and any rights or obligations flowing from it accrue to the minor and not the parent/guardian. In general the court is the upper guardian of minors and will assist a minor where the parents refuse or are not available. However a child has full capacity to litigate in certain instances e.g. where the child applies to be declared an adult, where a child is sued for maintenance of his/her child or where a minor applies to the court for a protection order in terms of the Domestic Violence Act.	18 (without assistance). Due to change in the age of majority. Under 18: Every child has a right to bring and to be assisted in bringing a matter to court. The general rule of the court being the upper guardian of all minors will also apply here.
Source of the law	General: Common Law Other sources: Various Statutes	Children's Bill B70B-2003) Section 17, Section 14 and 53
Domicile of choice: Definition: The residence where you have your permanent home or principal establishment and to where, whenever you are absent, you intend to return; every person is compelled to have one and only one domicile at a time. Children will be required to state their domicile when filling in contracts or when instituting legal proceedings. Age at which a child can acquire a domicile of choice.		
Age	18 Under 18 with majority status. On condition that he/she have the mental capacity to make that choice. Note that children under 18 (who don't have majority status) in foster care or in an orphanage or in other forms of custody are domiciled at the place with which he/she is most closely connected. That would be e.g. the orphanage.	
Source of the law	The Domicile Act No. 3 of 1992 Section 1(2)	
Service of court papers: Age at which court papers can be served on a child		
Age	16	

	Old Law	New Law
Source of the law	Rule regulating the conduct of the proceedings of the Several Provincial and local Divisions of the Supreme Court of South Africa (i.e. the Uniform rules of Court) Rule 4	
Social grants (child support grant): Age at which a child can access a CSG in their own name for themselves or their own child or their younger siblings.		
Age	16 (The Act and Regulations do not stipulate expressly for the situation when an application is made by the child for the child herself. The age of 16 refers to applications made the child for his or her dependents only.)	
Source of the law	Social Assistance Act No. 13 of 2004 Section 6 read with section 1(definition of primary care giver) and read with section 4 of the Regulations into the Act (No. R 162 February 2005)	
Social grants (care dependency grant): Age at which a child can access a CDG in their own name for themselves or their own child or their younger siblings.		
Age	16 (The Act and Regulations do not stipulate expressly for the situation when an application is made by the child for the child self. The age of 16 refers to applications made by the child for his or her dependents only.)	
Source of the law	Social Assistance Act No. 13 of 2004 Section 7 read with Section 1 (definition of primary care giver) and read with Section 6 of the Regulations into the Act (No. R 162 of 2005)	
Social grants (disability grant): Age at which a child can access a disability grant for his/herself.		
Age	18	
Source of the law	Social Assistance Act No. 13 of 2004 Section 9 read with Section 3 of the Regulations into the Act (No. R 162 of 2005)	
Social grants (foster child grant): Age at which a child can access a FCG in their own name for their siblings.		

	Old Law	New Law
Age	18 if the child has been placed in his/her custody by the Court in terms of the Child Care Act. According to the Department of Social Development (personal communication): A foster parent is any person (except a parent/guardian) in whose custody a child has been placed in terms of the Act. If an 18 year old is taking care of his 9-year sibling and they don't have parents the 18 year old can with the assistance of a social worker get the court to declare the 9-year-old child a child in need of care in terms of the Act. After the court enquiry as to whether the child is a child in need of care the court can make a finding that the child remain in the custody of the person in whose custody he/she was before the commencement of the proceedings (e.g. the 18 year old), under the supervision of the social worker.	
Source of the law	Child care Act No. 74 of 1983 Section 1 read with sections 10,14 and 15, Social Assistance Act No. 13 of 2004 Section 8 read with Section 10 of the Regulations into the Act (No. R 162 of 2005)	
Sex: Age at which a child is considered mature enough to engage in sex. Any adult having sex with a child under this age is committing a crime.		
Age	16 for heterosexual sex 19 for homosexual sex It is a defence for an accused against a charge under this section if at the time of the offence, (a) the victim was a prostitute, or (b) the accused was under 21 and it's his/her first offence.	16 or 18 (as yet undecided) According to the Bill it is an offence to have sex with a child who is over 12 but under 16 years old, even with that child's consent. Note also that it is a defence to a charge of committing an indecent act with a child below the age of 16 (with the consent of the child) if the accused was below the age of 16 and the age of the accused did not exceed the age of such child by more than three years at the time of the alleged commission of the offence.
Source of the law	Sexual Offences Act No. 23 of 1957 Section 14	Criminal Law (Sexual Offences) Amendment Bill B-2003 Section 10

6.3 Responsibility according to the law

There following legislative documents mention all the people who are expected to intervene when there are matters relating to children. They also make mention of how to intervene, especially when it comes to young offenders.

6.3.1 Mediators of child abuse cases

Children's Amendment Act [41 of 2007]

Section 110: Reporting of abused or neglected child and child in need of care and protection.

> *110 (1) Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, MUST REPORT THAT CONCLUSION in the prescribed form (Form 25) to a designated Child Protection organisation, the Provincial Department of Social Development or a police official.*

6.3.2 Handling a disclosure

- (2) Any person who on reasonable grounds believes that a child is in need of care and protection MAY report that belief that belief to a designated Child Protection organisation, the Provincial Department of Social Development OR a police official.
- (3) The persons referred to in Section (1) or (2) must substantiate their conclusion or belief and if they make the report in good faith, they cannot be sued.
- A child who obtains condoms, contraceptives or contraceptive advice, in terms of Act No. 41 of 2007, is entitled to confidentiality in this respect, subject to Section 110. (Act No. 41 of 2007).

6.3.3 Handling an offending youth

THE CHILD JUSTICE ACT NO. 75 OF 2008

(Information from presentation to the Directors of Public Prosecution on provisions of Child Justice Act as adopted by National Assembly on 2008-06-25 presented 30 October 2008.)

The Child Justice Act No. 75 of 2008 was passed by the National Assembly on 2008-06-25, and by the NCOP on 2008-09-25 and the president for signature. The implementation date is 2010-04-01.

The purpose of the Child Justice Act is to establish a criminal justice system for children, who are in conflict with the law and are accused of committing offences, in accordance with the values underpinning the Constitution and the international obligations of the Republic as well as others, to provide a mechanism for dealing with children who lack criminal capacity outside the criminal justice system and to make special provision for securing attendance at court and the release or detention and placement of children.

Provisions of the Child Justice Act:

- Assessment of all children who are arrested and charged and brought before a court.
- Every child who is alleged to have committed an offence must go to a preliminary inquiry, which is deemed to be the first court appearance.
- Diversion: all children who commit crimes, no matter how serious, qualify to be considered for diversion.

- *Diversion*

Children who commit Schedule 1-offences (less serious offences), can be diverted by a prosecutor in terms of Chapter 6 before a preliminary inquiry. The matter is taken to a magistrate in chambers for the diversion option selected to be made an order of court.

Children who commit Schedule 1-offences and who are not diverted by a prosecutor and children who commit Schedule 2-offences (more serious offences), go to a preliminary inquiry, at which the prosecutor decides whether the matter can be diverted or not. Where the prosecutor indicates that the matter can be diverted, the presiding officer at the preliminary inquiry makes a diversion order.

In line with the Portfolio Committee-approach that all child offenders qualify to be considered for diversion, the Bill now provides the a child who has committed a Schedule 3-offence, can only be diverted at a preliminary inquiry or during a trail in a Child Justice Court.

- If the Director of Public Prosecutions having jurisdiction, indicates in writing that exceptional circumstances exist.
- As determined in directives by the National Director of Public Prosecutions, which justify diversion of the matter.
- The Director of Public Prosecutions may, however, only indicate that that a serious matter may be diverted after he or she has:
    - Considered the views of the victim whether the matter should be diverted or not, and if so, the victim's views on the nature and content of the diversion option being considered and the possibility of including in the diversion option, a condition relating to compensation or the rendering of a specific benefit or service by the offender.
    - Consulted with the police official responsible for the investigation of the matter.

Matters that are not diverted proceed to trial in a Child Justice Court.

6.3.4 Minimum age of criminal capacity

- The minimum age of criminal capacity has been raised from 7 to 10 years.
- Provision has been made for the Parliament to review this aspect five years after the commencement of the Act, that is, by April 2015.
- The Act therefore provides for the review of the minimum age of criminal capacity in the future, after receipt of a report by the Department of Justice and Constitutional Development of Parliament.

Release of children awaiting trial at preliminary inquiry or Child Justice Court:

- The Act allows a court to release a child in respect of any offence, into the care of a parent or appropriate adult.
- The Portfolio Committee argued that the current legal position, as set out in Section 72 of the Criminal Procedure Act, 1977, allows this and should be retained.
- Release on own recognisances by a court, is only allowed in the case of Schedule 1- and 2-offences.

6.3.5 Placement of children in detention awaiting trail by police officials

- Police officials must, in the case of children:
  - who are under 14 years and who commit any offence, consider their placement in a suitable child and youth care centre or if this is not possible in a police cell;
  - who are 14 years or older and commit Schedule 1- or 2-offences, consider their placement in a suitable child and youth care centre, or if this is not possible in a police cell; and
  - who are 14 years or older and who commit Schedule 3-offences, detain them in a police cell.
- The Portfolio Committee argued that this is largely in line with the current legal position as set out in Section 29 of the Correctional Services Act, 1959, which should be retained.
- The Committee, after hearing the views of the stakeholders during the public hearings, particularly the Department of Correctional Services, was of the view that placement of a child offender in a prison before first court appearance, is not in line with current practice and is not feasible.

6.3.6 Placement of children in child and youth care centres/prison

- The Child Justice Act allows a court to place a child who has committed any offence, in a child and youth care centre after taking into consideration certain factors spelt out in the clause.
- Committee again argued that this is largely in line with the current legal position as set out in Section 29 of the Correctional Services Act 1959, which should be retained.

- Provided that the child is 14 years or older, a child who has committed a Schedule 1- or 2-offence, can be placed in a prison, if there are substantial and compelling reasons for doing so.
- The Committee again argued that this is largely in line with the current legal position as set out in Section 29 of the Correctional Services Act 1959, which should be retained.
- The Bill retains the provision allowing for the placement of children who commit Schedule 3-offences in prison.
- The Bill, however, prohibits the placement of a child under the age of 14 years who has committed a Schedule 3-offence, in a prison.
- The Bill further only allows for the placement of a child who is 14 years or older but under 16 years in a prison, if the Director of Public Prosecutions issues a written confirmation that such a child is to be charged with Schedule 3-offence, stating that there is sufficient evidence to proceed with the prosecution.

6.3.7 Time limits relating to postponements by Child Justice Court

- The Bill provides that a matter, prior to commencement of a trail, may not be postponed by a child justice court for longer than 14 days at a time if child is in prison;
- The Act further provides that in the case of a child who is detained in a child and youth centre, the child justice court may not postpone the matter. Prior to the commencement of a trail, for longer than 30 days at a time; and
- In the case of a child who has been released from detention, the child justice court may not postpone the matter, prior to the commencement of a trail, for longer than 60 days at a time.

6.3.8 Postponements and time limits relating the conclusion of trails

- The 2007-version of the Bill provided for the release children from prisons if their trails had not been concluded within a period of two years from when they first detained in a prison or if their trials had not been concluded within one year after they have pleaded o the charges against them.
- Such release could only take place if they were not being charged with certain serious Schedule 3-offences.
- The adopted 2008 Committee Bill deleted this provision.
- The Committee was of the view that all trails of children must be concluded as speedily as possible and that the time limits for the conclusion of the trails must be dealt with on a case by case basis, rather than having rigid timeframes.

6.3.9 Sentences for children

A whole new chapter on Sentencing for Children, has been provided for, which includes taking into consideration the impact of the offence on the victim; and pre-sentence reports.

The following sentence options have been provided for:

- Community-based sentences;
- Restorative justice sentences;
- Fine or alternatives to fine;
- Sentences involving correctional supervision;
- Sentence of compulsory residence in child and youth care centre;
- Sentence of imprisonment;
- Postponement or suspension of passing of sentence; and
- Provisions relating to the failure to comply with certain sentences.

6.3.10 Sentence of imprisonment and compulsory residence in a child and youth care centre

- The Child Justice Act now prohibits sentences of imprisonment of children who are under 14 years.
- The Committee was of the view that children who are under 14 years should not be sentenced to imprisonment and must be accommodated in child and youth care centres.
- In order to deal with children who commit outrageous and violet Schedule 3-offences, the Committee has added a provision for such children, to serve their sentences in a child and youth care centre and then to continue their sentences in prison once they turn 18 years old, in the case of exceptional circumstances and if substantial and compelling reasons exist.
- A Child Justice Court can sentence any child 14 years or older to a sentence of imprisonment for up to 25 years in the following cases:
    - In the case of a Schedule 3-offence;
    - A Schedule 2-offence if substantial and compelling reasons exist; and
    - A Schedule 1-offence if the child has a record of relevant previous convictions or diversions and substantial and compelling reasons, exist.

6.3.11 Legal representation

All children who land up in a Child Justice Court who do not have legal representation of their own, must now be referred to the Legal Aid Board to be considered for legal aid at state expense.

6.3.12 Expungement of records

- Criminal records of children who have committed Schedule 1- or 2-offences, are expunged after the expiry of five years in the case of a Schedule 1-offence and 10 years in the case of a Schedule 2-offence, unless the child has been convicted of a similar or more serious offence during the period in question.
- The Act provides for the Minister to authorise expungement of a criminal record of a child before the expiry of the five or 10 year periods, if substantial reasons exist and the Minister

is satisfied that the child's future will be affected in a material way if the child's record is not expunged.

- The Bill's provisions have been adapted to bring them into line with the Criminal Procedure Amendment Bill approved in the National Assembly on 22 October 2008, which also deals with the expungement of certain criminal records.
- The application procedure to the Director-General: Justice and Constitutional Development for expungement of criminal records in that Bill have been incorporated into the Child Justice Bill.

6.4 Schedules of offences

- Schedule 1: Less serious offences, which can be diverted by a prosecutor and where the child can be released on own recognisances or into parents or caregivers care, from detention;
- Schedule 2: More serious offences, which can be diverted by preliminary inquiry; and where the child, if not released into parents or caregivers care, should be detained in a Child and Youth Care Facility; and
- Schedule 3: Most serious offences, which can be diverted by a child justice court, in terms of very limited guidelines to be drafted by the National Director of Public Prosecutions; and where the child should be detained in prison whilst awaiting trial, if 14 years or older, except if certain prescribed circumstances exist.

6.5 Diversion options

(Ann Skelton, Centre for Child Law 1-2 December 2008, Pretoria)

- Diversion options are set in three levels;
- The levels are linked to the schedules which contain lists of offences;
- Broadly speaking, level 1 contains minor offences, level 2 serious offences and level 3 most serious offences; and
- There are also maximum time limits for diversion (where applicable) – which are linked to both the level and the age of offender.

6.5.1 Section 53(2) time limits

Level 1 applies to Schedule 1-offences, and if time period is applicable, may not exceed:

- 12 months in case of children under 14,
- 24 months for older children.

Level 2 applies to Schedule 2- and 3-offences, and if time period is applicable, may not exceed:

- 24 months in case of children under 14,
- 48 months for older children.

(See Section 53(5) for time frames.)

6.5.2 Section 53(3) level 1 diversion options

- Oral or written apology
- Formal caution, with or without conditions
- Placement under:
  - supervision and guidance order
  - reporting order
  - compulsory school attendance order
  - family time order
  - peer association order
  - good behaviour order
  - order prohibiting visiting of frequenting places
- Referral to counselling or therapy
- Compulsory attendance of vocational, educational or therapeutic programme
- Symbolic restitution(defined)
- Restitution of specified object
- Community service
- Provision of some service or benefit to persons, community, charity, welfare organisation
- Payment of compensation
- Family group conference or victim-offender mediation

6.5.3 Section 53(4) level 2 diversion options

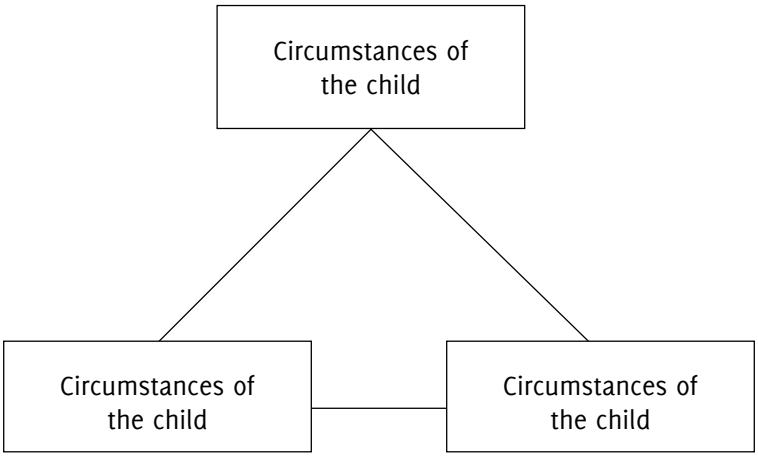
- Compulsory attendance of vocational, educational or therapeutic programme, which may include period of temporary residence.
- Referral to intensive therapy, which may include period of temporary residence.
- Placement under supervision of parents on conditions which may include restriction of movement without prior written approval.

6.5.4 Selection of diversion option

The following factors are to be considered:

- Appropriate level of diversion option.
- Child's culture, religion and language.
- Child's educational level, cognitive ability and other circumstances.

- Proportionality of option to child's circumstances, nature of offence and interests of society.



- Diversion options may be used in combination.
- Individual diversion option meeting the objectives of diversion may be developed.

Child on child abuse is emerging as a big problem in South Africa. The perpetrators of child on child abuse are getting younger as reflected in the statistics of Women Against Child Abuse as well as Teddy Bear Clinic, offenders as young as five years old are being reported.

Correspondingly these findings are confirmed in international studies (Erooga & Masson, 1999; Gil & Johnson, 1993; Hoghughi, 1997; Laws, 1989; Righthand & Welch, 2001) of adult and adolescent sex offenders suggested that many of these offenders began their sexually abusive behaviour in their youth years.

The sexual behaviours of children who abuse other children go far beyond developmentally appropriate childhood exploration or sex play. These children's thoughts and actions are often pervaded with sexuality. Typical behaviours these children may include (but are not limited to) oral copulation, vaginal intercourse, and/or forcibly penetrating the vagina or anus of another child with fingers, sticks and/or objects. These behaviours continue and increase over time and are part of a consistent pattern rather than isolated incidents. Even if their activities are discovered, they do not and cannot stop without intensive and specialised treatment (Johnson, 1993).

A child between the age 10 and 14 years may only be prosecuted for a sexual offence if it was proved beyond a reasonable doubt that the child did have the capacity to differentiate between right and wrong and act accordingly. Most sexual offences by children go unreported to authorities or are not recognised or dealt with.

The dilemma of unreported youth sex offences fuels a perception that youth sex offences are not a crime or claim impunity from the law. Without appropriate intervention these children often continue to commit indecent acts with others. For this reason the reporting of all child abuse cases, to the SAPS, are very imported to ensure the necessary intervention and to prevent a circle of child abuse.

Diversion is the channelling of children away from the formal court system into programmes that make them accountable for their actions and give juvenile sex offenders an opportunity to repair the damage caused by their crime, within themselves. Diversion can only take place if the child acknowledges responsibility for his or her wrongdoing.

By participating in the diversion programme, the child avoids the stigmatising and brutalising effects of the criminal justice system and does not obtain a criminal record. A diversion programme is part of the answer, not only dealing with young offenders but also in making serious inroads in combating child abuse in general. According to Noordam (1970:8), children are born, but people are made. For this reason all available time and resources need to be utilised to help young sex offenders, as they are at the end of the day still children and the future of our country South Africa.

Section 7: Treatment for child sexual offenders

7.1 Intake and assessment

The decision as to what intervention to offer is informed by the intake and assessment session. This is considered the most important aspect in dealing with young sex offenders. In this the facilitator makes use of an intake and assessment form similar to the one used below (please refer to the attached form).

7.2 Classifications

The classification is divided into the categories of **OFFENCE, OFFENDER** and **SITUATION**.

The **offences** are classified into the following:

- Nature – refers to the act as atypical and spontaneous or premeditation and manipulation.
- Aggression – refers to the use of force or no force.
- Intensity – refers to the extent of the abuse ranging from touching to attempted penetration and penetration.
- Frequency – refers to the number of incidents ranging from a single incident to repeated incidents.
- Duration – refers to the time the incident lasted, for instance, short time span or long time span.

The **offender** is classified into the following:

- Age – refers to below10 years at 10 or above 10 years.
- Honesty – refers to the child participating openly and being truthful during the intervention.
- Responsibility – refers to the acknowledgement of his/her actions.
- Empathy – refers to the child identifying with another.
- Clinical history – refers to the progress observed during the intervention programme.
- Own abuse – refers to previous history of sexual victimisation.
- Schooling – refers to progress at school or the presence of learning problems.
- Influence – refers to acting independently or peer influence.
- Social skills – refers to the lack or presence of social skills (social competence or social incompetence).

The **situation** is classified into the following:

- Family pathology – refers to functional or dysfunctional family patterns (pro-social, rigid and chaotic).
- Family support – refers to the family being compliant with the intervention and ensuring regular attendance.

7.3 Classification of risk

Each child is classified according to the level of risk they present to society. The categories are low risk, medium risk and high risk. The following is a risk analysis table and is used as a guide when assessing the level of risk that the child presents.

Classification	Low risk	Medium risk	High risk
Nature	A-typical and spontaneous	Premeditation and Manipulation	Sophisticated premeditation and manipulation (well organised and executed)
Aggression	No force used	Minor force used	Severe force used
Intensity	Fondling/touching on genitalia	Attempted penetration	Penetration
Frequency and number of victims	One or two incidents, one victim	Three to four incidents, two to three victims	More than four incidents, more than three victims
Duration	Short time span	Longer time span	A very long time span
Age	10 years and below (young and unsophisticated)	Above 10 years (young or unsophisticated)	Above 10 years (neither young nor unsophisticated)

Classification	Low risk	Medium risk	High risk
Honesty	Open and honest	Lies	Lies and steals
Denial of responsibility, awareness and impact	Takes responsibility for actions	Denies responsibility for actions	Denial of responsibility on more than one level, and shifts blame to victim
Empathy	Shows concern for victim	Shows a little concern	Shows no concern
Clinical history	Good progress	Slow and little progress	No progress
Own abuse	No history of sexual abuse	Some history of sexual abuse	Chronic history os sexual abuse
Schooling	Coping at school	Learning problems (some questionable progress)	No progress
Influence	Acted independently	Peer influence	Easily influenced by Media
Social skills	Social competence	Lacks social competence (skills)	Social incompetence
Family pathology	Pro-social family	Some deviance (dysfunctional)	Severe family dysfunction
Family support and supervision	Co-operate with treatment and consistent supervision	Inconsistent cooperation and inconsistent supervision	No co-operation and no supervision

7.4 The levels of risk

7.4.1 High risk

Multiple offences, lacks empathy, multiple victims, displays no remorse, does not acknowledge responsibility for his actions, substance abuse, lack of parental supervision, parents and child not compliant for intervention, behavioural problems at school, denial on various levels (awareness, impact and responsibility), refuses to participate in group and displays aggression.

7.4.2 Medium risk

Does not take responsibility for his actions, more than one offence, more than one victim, parents not always compliant for treatment, denial on various levels, displays remorse, displays victim empathy, sometimes disruptive in group and initial aggression but soon settles down.

7.4.3 Low risk

One to two incidents, one victim, displays remorse, displays victim empathy, acknowledges responsibility for actions, both parents and child compliant for treatment, parental supervision, participates in group and no aggression. After the information is entered into the decision matrix guide the level of risk is determined. This is derived by adding the total sum in each column

that is the levels of low, medium and high risk. The risk level is then scored by adding the total sum in each column that is the levels of low, medium and high risk and the largest total sum indicates the level of risk. This then informs the intervention and sentencing option which is then recommended in the court report.

7.5 Treatment options

7.5.1 High-risk offenders

High-risk offenders would be considered for psychiatric evaluation and possible institutionalisation, wherein they could be put on medication to help manage their behaviour.

Typical examples of such children:

- A 6-year-old boy who is fidgety (jumps all over), aggressive, restless, has difficulty in concentrating and remaining focused – hence poor school performance. This child has been diagnosed with attention deficit /hyperactivity disorder (ADHD). Stimulants (such as Ritalin and Strattera) are used to improve the attention and reduce impulsivity, hyperactivity and aggressive behaviour.
- A 15-year-old girl who is very promiscuous, lacks impulse control, rebels against authority figures, intense fluctuations in mood, runs away, tells lies, aggressive towards peers and others and she is cutting herself. This child has been diagnosed with borderline personality disorder and would not respond to traditional therapy and would require medication.
- A 17-year-old boy who is rebellious, aggressive, feels little anxiety, lies, steals, vandalises property, lacks impulse control and displays violent behaviour towards others. This child has been diagnosed with anti-social personality disorder and would require medication. Thus traditional treatment approaches, which require the cooperation of the client, have not been very effective. Medication would include drugs with tranquilising effects (phenothiazine and Dilantin) have been helpful in reducing antisocial behaviour.
- A 16-year-old girl who has been a victim of sexual abuse at the age of 10. She displays weight loss, lack of interest in activities she previously enjoyed, insomnia, excessive crying, withdrawn behaviour and several suicide attempts. The symptoms are present for six months. This child has been diagnosed with Bipolar Disorder Type II and would require medication. Medication would include a mood stabiliser such as an anti-depressant (such as ciprolex or cipromal). If the child is not responsive to other forms of pharmacotherapy cautious use of antidepressants may be necessary start low and go slow. The tricyclic antidepressants are still considered the more effective and they seem to be more especially effective in endogenous forms of depression.
- A 15-year-old girl who is exercising vigorously, not eating, avoiding meal times, obsessed with her weight and has a distorted view of her body image. This girl has been diagnosed with anorexia nervosa and would require medication. Medication would include a mood stabiliser and an anti-depressant.

7.5.2 Personality disorders

A personality disorder is identified by a pervasive pattern of experience and behaviour that is abnormal with respect to any two of the following: thinking, mood, personal relations and the control of impulses.

The character of a person is shown through his/her personality – by the way an individual thinks, feels and behaves. When the behaviour is inflexible, maladaptive and antisocial then that individual is diagnosed with a personality disorder. Most personality disorders begin as problems in personal development and character which peak during adolescence and then are defined as personality disorders.

The *diagnostic and statistical manual of mental health disorders DSM-IV-TR*, published by the American Psychiatric Association, defines a personality disorder as an enduring pattern of inner experience and behaviour that deviates markedly from the expectation of the individual's culture, is pervasive and flexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.

Currently there are 10 distinct personality disorders identified in the *DSM-IV*. According to the Mayo Clinic, among the 10 conditions that are considered personality disorders, some have very little in common. Doctors typically group the personality disorders that have shared characteristics into one of three clusters: In our clinical experience it has been evident that many of the children displayed attachment issues and it therefore needs to be discussed.

- *Paranoid personality disorder*
  - Belief that others are lying, cheating, exploiting or trying to harm you.
  - Perception of hidden, malicious meaning in benign comments.
  - Inability to work collaboratively with others.
  - Emotional detachment.
  - Hostility toward others.

- *Schizoid personality disorder*
  - fantasising
  - extreme introversion
  - emotional distance, even from family members
  - fixation on your thoughts and feelings
  - emotional detachment

- *Schizotypal personality disorder*
  - Indifference to and withdrawal from others.

- "Magical thinking" the idea that you can influence people and events with your thoughts.
- Odd, elaborate style of dressing, speaking and interacting with others.
- Belief that messages are hidden for you in public speeches and displays.
- Suspicious or paranoid ideas.

- *Histrionic personality disorder*
  - Excessive sensitivity to others approval.
  - Attention-grabbing often sexually provocative clothing and behaviour.
  - Excessive concern with your physical appearance.
  - False sense of intimacy with others.
  - Constant, sudden emotional shifts.

- *Narcissistic personality disorder*
  - Inflated sense of-and preoccupation with-your importance, achievements and talents.
  - Constant attention-grabbing and admiration-seeking behaviour.
  - Inability to empathise with others.
  - Excessive anger or shame in response to criticism.
  - Manipulation of others to further your desires.

- *Antisocial personality disorder*
  - Chronic irresponsibility and unreliability.
  - Lack of regard for the law and for other's rights.
  - Persistent lying and stealing.
  - Aggressive often violent behaviour.
  - Lack of remorse for hurting others.
  - Lack of concern for the safety of yourself and others.

- *Borderline personality disorder*
  - Difficulty controlling emotions or impulses.
  - Frequent, dramatic changes in mood, opinions and plans.
  - Stormy relationships involving frequent, intense anger and possibly physical fights.
  - Fear of being alone despite a tendency to push people away.
  - Feeling of emptiness inside.
  - Suicide attempts or self-mutilation.

- *Avoidant personality disorder*
  - Hypersensitivity to criticism or rejection.
  - Self-imposed social isolation.
  - Extreme shyness in social situations, though you strongly desire close relationships.

- *Dependent personality disorder*
  - Excessive dependence on others to meet your physical and emotional needs.
  - Tolerance of poor, even abusive treatment in order to stay in relationships.
  - Unwillingness to independently voice opinions, make decisions or initiate activities.
  - Intense fear of being alone.
  - Urgent need to start a new relationship when one has ended.

- *Obsessive-compulsive personality disorder*
  - Excessive concern with, rules, schedules and lists.
  - Perfectionism, often so pronounced that you cannot complete tasks because your standards are impossible to meet.
  - Inability to throw out even broken. Worthless objects.
  - Inability to share responsibility with others.
  - Inflexibility about "right" ethics, ideas and methods.
  - Compulsive devotion to work at the expense of recreation and relationships.
  - Financial stinginess.
  - Discomfort with emotions and aspects of personal relationships that you can't control.
  - Obsessive-compulsive personality disorder is not the same as obsessive-compulsive disorder an anxiety disorder that shares some symptoms but is more extreme and disabling.

There is no cure for these conditions, but therapy and medication can help. The symptoms of some personality disorders also may improve with age.

- *Risk factors for personality disorders*

The following are the risk factors associated with the development of personality disorders:

- A history of childhood verbal, physical or sexual abuse.
- A family history of schizophrenia.
- A family history of personality disorders.
- A childhood head injury.
- An unstable family life.

People with personality disorders are at significantly increased risk of:

- Social isolation
- Suicide
- Substance abuse
- Depression, anxiety and eating disorders
- Self-destructive behaviour
- Violence and homicide
- Incarceration

◆ *Medications*

People with personality disorders often experience serious mental and emotional strain, causing additional mental health problems, such as depression, phobia and panic. Medications may help alleviate these related conditions, but they cannot cure the underlying disorder. Therapy aimed at building new coping mechanisms must be the cornerstone of treatment.

Medications that may offer support during therapy include:

- *Antidepressants:* Doctors commonly prescribe selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac, Sarafem), sertraline (Zoloft), citalopram (Celexa), paroxetine (Paxil), nefazodone and escitalopram (Lexapro) or the related antidepressant venlafaxine (Effexor) to help relieve depression and anxiety in people with personality disorders. Less often, monoamine oxidase inhibitors such as phenelzine (Nardil) and tranylcypromine (Parnate) may be used.
- *Anticonvulsants:* These medications may help suppress impulsive and aggressive behaviour. A doctor may prescribe carbamazepine (Carbatrol, Tegretol) or valproic acid (Depakote), topiramate (Topamax), an anticonvulsant that is being studied as an aid in managing impulse-control problems.
- *Antipsychotics:* People with borderline and schizotypal personality disorders are at risk of losing touch with reality. Antipsychotic medications such as risperidone (Risperdal) and olanzapine (Zyprexa) can help improve distorted thinking. For severe behaviour problems, doctors may prescribe haloperidol (Haldol).
- *Other medications:* Doctors sometimes prescribe anti-anxiety medications such as alprazolam (Xanax) and clonazepam (Klonopin) and mood stabilisers such as lithium (Eskalith, Lithobid) to relieve symptoms associated with personality disorders.

7.5.2 Medium and low risk

◆ *Treatment plan*

It appears that the most effective treatment plan for children with sexual acting-out may be consistent with the treatment provided to older children, adolescents and adults who commit

sexual offenses that is a combination of individual, group and family treatment. Group therapy is the pivotal component of effective treatment.

7.6 Treatment goals for child sex offenders

- Dealing with trauma.
- Focusing on personal needs.
- Addressing dysfunction in the family.
- Developing realistic expectations/cognitive distortions.
- Developing empathy.
- Teaching positive sex education.
- Developing anger management skills.
- Developing impulse control.
- Developing social skills.
- Learning about relapse prevention.
- Learning to accept responsibility.
- Developing hope for the future.
- Unlearning deviant pattern and re-learning acceptable patterns of behaviour.

7.7 Principles for effective diversion programmes

- Risk principle: Match offender levels with the intensity of the intervention.
- Need principle: Focus on factors that cause, support or contribute to offending behaviour.
- Responsivity principle: Staff should use a warm, flexible and enthusiastic interpersonal style and a firm but fair approach. Staff and offender learning styles should be matched. Active participatory methods rather than either didactic or unstructured experiential methods should be used.
- Key elements of effective programmes: anti-criminal modelling, reinforcement of desired outcome behaviours, concrete problem solving, pro-social skills training, verbal guidance and clear explanations.
- Community based principle: Programmes that have close links with the child's community are most effective – promotes real-life learning and generalisation of positive skills.
- Multi-modal intervention principle: The most effective programmes are multimodal and social skills oriented. Highly structured, cognitive – behavioural treatments directed at development of concrete skills have been shown to be at least twice as effective as other interventions and to have more lasting effects.
- Intervention integrity principle: Indicators of integrity are: the intervention should be research-based throughout have sufficient resources to achieve objectives; objectives

should be linked to intervention components and desired outcomes; and the intervention should be systematically monitored and evaluated.

Section 8: SPARC diversion programme

An important aspect of dealing with children who molest other children is therapy. Of primary concern is the selection of the therapist who is most qualified and equipped to work with child offenders. Individuals who have been victims of sexual abuse may find it very difficult to work with these children if they have not completed their own work in therapy. Therapists who have suffered emotional or physical abuse may also experience difficulty, since children who molest have often experienced this type of abuse and their behaviours and psychological defences may remind therapists of their own (Johnson, 1993). Therapists need to deal with their own issues of transference and counter- transference in order to be effective helpers.

Individual therapy is a very useful adjunct to group therapy for both children and parents, who can use individual time to deal with their issues and interpersonal family dynamics.

Primary goals of individual therapy:

- Establishing a working therapeutic relationship.
- Assessing the child's readiness and preparing for group therapy.
- Obtaining specificity about the problem sexual behaviours.
- Obtaining information about risk factors across settings.

- Stopping the molesting behaviours.
- Assessing a history of victimisation or other relevant issues.
- Understanding children's perceptions of family dynamics.
- Process material generated in group.

Secondary goals of individual therapy:

- Improving children's self-concept and self-esteem.
- Decreasing children's feelings of helplessness and vulnerability.
- Exploring issues of relatedness (attachment, dependency).
- Teaching children appropriate social skills.
- Helping children and get needs met.
- Encouraging children's realistic view of family and family roles.
- Helping children become future oriented (Gil, 1993)

However individual therapy is a luxury and not always affordable, many therapists cannot provide and group work has been found to be more challenging to the young offender with regard to his cognitive distortions and insight in his behaviour.

The following is a flow diagram, which illustrates the proposed structure and flow of the programme.

INSERT attached flow diagram "SPARC Visio 2012 here"

(Please provide diagram, there is no image for a Flow diagram on the CD)?

8.1 Cognitive-behavioural group therapy

In group therapy, behaviour management is a vital part of the therapeutic process. Abuse-reactive children often lack both impulse control and the skills to be able to contain their behaviour or their emotions.

The results of feelings can be frightening for the child and upsetting for the therapist. In order for children to benefit from the therapeutic process, they must be able to feel in the group. They must feel that someone will be able to set limits and control their behavioural. Therefore behaviour management skills are essential. One of the first group activities should be the establishment of group rules, developed with the children's participation and agreement.

- *Group rules*

The following list contains suggestions for basic group rules:

1. Respect the body space of all group members, no hitting or hurting other group members.
2. Stay together: no leaving the room, unless given permission by an adult.
3. Respect other's property: no breaking toys or furniture in the room or the room itself; no taking toys or other group items.
4. If you begin to feel anxious or angry, you can talk about it, ask a therapist to take you to a quiet place, write about it, or draw a picture about it.
5. Listen and take part during a structured activity.
6. Always be honest – be truthful.
7. Always try to be on time.
8. Do all activities given (homework).

Positive reinforcement is extremely important when dealing with abuse-reactive children. Reinforcement is needed every 15 minutes to shape young children's behaviour. For example, if younger children only are taking part in a structured activity and acting appropriately or if they talk about their anger instead of acting it out, rewarding them with coloured stickers placed on the backs of their hands or in a jar is an effective way to reinforce appropriate behaviour.

When a group rule is broken, a consequence should occur immediately. A time-out is often the most effective, immediate consequences. For a time out the child is taken to separate area and asked to sit and think about why he/she is there. If the child refuses to sit alone, or the behaviour begins to escalate, he/she may need to be gently held in place. While some therapists feel that physically holding a child who has been abused is traumatising, our experience suggests that abused children need to know that someone can hold them or touch them or touch them in a non-sexual and non-abusive way. A time-out done correctly can give them this message. It can also be very comforting for children to know that someone can help them control themselves.

Consistency is the key to behaviour management. Continuing the same reinforcement schedule every week is vital. Since many of these children have not had consistent environments or authority figures, your consistency will help them learn to manage their own behaviour.

In order to be successful, treatment must be specific and focused on sexual issues. Although these children all feel anxious when sexual topics are discussed, the anxiety is less when more children are present. Group therapy is more effective than individual therapy because each member is seen as co-therapist challenging each other. In clinical practice it has been found that children who abuse other children often feel victimised, but a group environment provides a safe therapeutic climate/not alone in this situation.

- *Group format*

Group members must be addressed in his or her own home language to ensure their participation during the group therapy, as a child will only be able comfortable to express his/her feelings in their home language.

- *Duration*

Because of the need for concentrated effort on the issues and time to socialise, one and a half hours is a good period for both children's groups as well as parents groups according to research done by Johnson (1993).

- *Group configuration*

Because the dynamics of victim and victimiser are important to monitor and process during group therapy, the group configuration is important not only as it relates to age but also size, development and emotional level. Homogeneous groups are preferred as mixing of girls and boys are generally not advised. According to Johnson (1993) due to the volatility of these children both in the sexual and aggressive spheres, it is generally most beneficial to have four, perhaps six children in a group.

- *Setting*

Although there are many suitable configurations, the easiest room to use is one large enough to have an adequate desk-height table and chairs as well as space to do activities, but not too large. If the room is too large children will struggle to remain focused or get easily distracted. Keep minimum objects in the room to prevent distraction of the participants.

- *Group structure*

It is usually helpful to have a ritual that the group goes through every week. In this way, children know exactly what to expect and can learn to conform to expectations. This is often in direct contrast to their home life in which little remains constant or predictable

Be aware of subgroups, manipulative participants, attention seekers, "clowns" and sexualised behaviour by the participants.

- *Contract*

Both parent and child must sign a working agreement to regular attendance, punctuality, code of conduct, completion of talks assigned to the child during the sessions where the parent may be accepted to assist the child at home. This is to inform the therapist timeously of any absences from the program. A copy of the signed contract must be given to both the parent and the child.

- *Confidentiality*

Confidentiality is very important as it is the fundamental principle of any therapeutic relationship. Parents can be given information regarding their child's progress without specific communications being revealed. They can also be guidelines and support on the management of their child's behaviour.

- *Support systems*

An important aspect in treatment of children who molest other children is the balance between managing children's behaviour and having children learn to manage their own behaviour. After completion of the programme, both parents and group members will be addressed in support groups to prevent re offending behaviour.

- *Relapse prevention*

According to the Centre of Sex Offender Management, the Relapse Prevention Model, of sex offending is the result of a common chain of events that ultimately leads to offending, beginning with the person experiencing some type of negative emotional state. This is followed by deviant fantasies, thoughts – feelings, action or behaviour and the use of cognitive distortions to justify or rationalise these fantasies. In turn, the fantasies lead to covert planning about an offence. And finally, after disinheriting himself in some way, the individuals commit a sex offence.

Chain of events that precede behaviour is as follow:

THOUGHTS ► FEELINGS ► ACTION/BEHAVIOR

8.2 Arts-based therapies

Although there is evidence of the positive impact that conventional therapies have in the rehabilitation of youth offenders, particularly in terms of encouraging acknowledgment of responsibility, victim empathy and self-awareness, a number of limitations have been identified, namely that:

- The focus of these therapies is on the offence.

- The child is limited to expressing only that which can be articulated in words.
- The child's psychosocial needs and past trauma is only addressed on a cognitive level.
- The child needs long term intervention to have positive lasting effects.

These limitations suggest that conventional therapies on their own are not enough, which is the rationale behind the development of the alternative therapies for the children coming through the SPARC programme.

8.2.1 The history and development of arts-based therapies

The therapeutic benefits of artistic expression were originally conceptualized by Jung through a technique called active imagination (Chodorow, 1991; Jung, 1977). In 1916 Jung circulated his ideas about the active imagination as a pathway into the unconscious as he described how artistic expression through dance, music, painting and other creative mediums could be used to gain access to the unconscious (Chodorow, 1991; Jung, 1977). Jung's ideas gained considerable therapeutic standing when arts-based therapies were introduced for patients who were unable to benefit from traditional "talk" therapies in psychiatric wards (Chodorow, 1991; McNiff, 1981; Schaverien & Odell-Miller, 2005). The success of this intervention in 1957 encouraged more and more theorists to investigate the power of arts-based therapies as an alternative form of psychotherapy (Schaverien & Odell-Miller, 2005).

8.2.2 The mechanism of arts-based therapies

The benefits of arts-based therapies are supported by a substantial amount of American research particularly that of Dr Bessel van der Kolk (2006) of the Boston Trauma Centre. Dr Van der Kolk's (2006) research shows that these alternatives to talking therapy allow children to access and work through the non-verbal components of their behaviour and emotions, facilitating healing and personal growth to a much larger extent. This is because these forms of therapy access the more basal areas of the brain, which are responsible for processing our "fight or flight" responses, as well as our emotions.

As creative mediums of expression, alternative therapies:

- Do not focus on the offence committed. Instead, the focus is on the child's psychosocial needs.
- Build on the strengths of the child.
- Provide an alternative means of expression.
- Provide an alternative means to channel energy.
- Address psychosocial needs on a non-verbal level.
- Provide alternative ways in which trauma can be processed.
- Leave the child with a positive experience of the criminal justice system.
- Expose the child to positive role models.

- Create opportunities for them to build on their self-esteem.
- Validation of the child.

The alternative therapies programme at The Teddy Bear Clinic for Abused Children consists of art, dance and music. All of these programmes have a number of factors in common, in their approach:

- They expose them to possibilities for expression through a creative medium (creating art, dancing, or playing music).
- They are all facilitated in a group setting to mimic a microcosm of society, creating the opportunity to make friends with peers who have similar interests.
- They all encourage creative thinking and problem solving.
- They all provide a means of exploring emotional and developmental themes and experiences, as well as ways of expressing them.
- They all address respect for themselves and respect for others.

These programmes follow-on from the SPARC programme, and are intended to build on the themes that are addressed in this programme in a more positive, practical and expressive way. So, there is a continuity in intervention but in a more creative and enjoyable way.

8.2.3 Arts-based therapy groups

Ideally, the first session of the arts-based therapy group includes the child and their parents. This provides the opportunity for the facilitators to meet the child's parents, and involve them in the contractual agreements of the programme. The parents are included to enlist their support and get a "buy in" from them.

- *Contract*

Depending on the type of arts-based therapy, and the way in which the particular therapist conducts their sessions, a suitable contract will be drawn up. These contracts typically include clauses relating to practical considerations that contribute to the running of the programme, such as:

  - issues pertaining to confidentiality,
  - attendance,
  - informing each other of any changes to the sessions, or the child's attendance at these sessions,
  - any necessary contact information, and
  - any rules that the child is expected to comply with, in these groups.

The rules for the group, as is the norm in most group therapy processes, are established by the group members themselves. These are usually established formally in the initial sessions of a group. The group member's work together to identify and agree upon the rules that they

would like to guide the group process. These rules include practical considerations, in addition to considerations pertaining to how group members will treat one another. To alleviate any fears and anxieties that they may have regarding the intervention process. As mentioned above, these rules form part of the contract for the programme.

After the contracts are discussed and negotiated, they are signed by the children and their parents. Copies of this contract are kept by the facilitators, the children and their parents. This process ultimately facilitates the child's compliance in the alternative therapies, and provides the facilitators, as well as the children and their parents with a mechanism of accountability.

- *Practical considerations for the group*

The configuration, duration, setting and materials for the groups is highly dependent on the nature of the arts-based therapy, the preferences of the facilitator and the available resources. However, the following points are suggested as guidelines:

- *Group configuration*

Group configuration relates to the composition of the group in terms of age, as well as physical, social and emotional development. These are variables that influence the dynamics of the group, particularly the victim-victimiser dynamic that child sexual offenders are likely to engage in. It is therefore ideal to have groups consisting of children of similar ages, and who are at approximately the same stages of physical, social and emotional development. Furthermore, Johnson (1993) insists that these groups consist of four to six members, given the volatility of child sexual offenders.

- *Duration*

For a number of reasons, it is preferable for the arts-based therapies to be run over 12 once per week sessions. This is to coincide with the intake and termination of the SPARC groups, ensuring that as a SPARC group is terminated, the children can begin their alternative therapies, as soon as the following week. This eliminates any long gaps between the SPARC programme and the alternative therapies.

It is also possible to run additional open classes. Although these open classes are likely to continue to have the benefits of the alternative therapies, they are not therapeutic, or a part of the alternative therapies programme. Rather, these open classes, are intended to be for the benefit of those children who do not ordinarily have access to these sorts of programmes, and who would like to continue to participate in the arts.

- *Setting*

It is important to ensure that there is an adequate space in which to conduct the intended form of arts-based therapy. For example, a dance movement therapy programme will require a sufficiently large space for children to move around freely, and floors that are suitable for dancing

and movement exercises. A music therapy programme, will not require as much space, but will need to be in an area that can accommodate the often loud sound of music, and a storeroom for the musical equipment. The arts-based therapist facilitating the groups will be able to provide guidelines as to the type of setting that they require in order running their programme.

- *Material*

As mentioned above, the material needed for the arts-based therapy, will be highly dependent on the nature of the programme, the specific preferences of the facilitator, and the available resources. An art programme will require materials; pencils, scissors, paint and paper depending on the materials that the facilitator incorporates into their sessions. A music programme will require musical instruments, and a dance programme will require a music player, again dependent on the specific needs of the facilitators. The arts-based therapist will be able to provide a list of things that they will need in order to run their programme.

8.2.4 Different forms of alternative therapies

- *Art therapy*

Art therapy can be described as the therapeutic use of creating art, within a professional therapeutic relationship. This is a relationship in which people who experience the need for support as a result of psychological distress, are able to seek personal healing and growth through creating art (Rubin, 1999). Through the creation of art and reflecting on this artwork, people are able to experience an increased awareness of themselves, and others, ultimately informing their perceptions of, responses to, and ability to cope with their life struggles (Judith, 1999).

Art therapy, from the roots of Jung's interpretation of the active imagination, sprouted most popularly through the work of Margeret Naumberg (Rubin, 1999). Naumberg believed that the creation of art work is equivalent to language, in terms of self-expression (Rubin, 1999). Fundamental to Naumberg's understanding is that the most fundamental thoughts and feelings originating from the unconscious aspects of a person, are symbolic or expressed as images rather than as words (Rubin, 1999), and this is supported by research on hearing impaired individuals (Sacks, 2000). Traditionally, the therapeutic value of art has existed for centuries and continues to thrive in many African cultures (Gioia, 2006), which makes it particularly practical within the South African context. It is however considered, in contemporary life South Africa, as a relatively new human therapeutic service (Open Society Foundation for South Africa, 2003). It also promotes unity in diversity as is specific to the South African context. This is aligned to the human rights charter.

Art therapy is a psychotherapeutic intervention in which art therapists attempt to mediate their client's personal exploration through the creation of art (Schaverien & Odell-Miller, 2005). Art work that is created during a therapeutic art therapy session represents the client's unconscious struggles or distress (Schaverien & Odell-Miller, 2005). Through this process, clients are able to tangibly harness their emotional distress, as their unconscious experiences are expressed on paper (Schaverien & Odell-Miller, 2005). Art therapy seeks to support people in gaining access and insight into their personal struggles through the mediation of art materials (Schaverien & Odell-Miller, 2005).

A typical session:

Check in:	At the beginning of a session Counsellors will generally check-in with group members, in order to ascertain everyone's wellbeing, and quickly assess particular themes or issues, which are currently affecting the group and the dynamics. Through such a discussion and assessment, the Art Counsellor is then able to consider the current needs of the group and provide an art-based activity. Such an activity would provide space for freedom and creativity, but also a degree of structure and holding for the group to feel comfortable to express themselves. Once the group has completed their art making, or the designated time is complete, the group reforms to explore and discuss the process.
Image making:	This process allows participants to visualise or process feelings by creating images based on a dormant theme. These themes are aligned to the SPARC group themes.
Reflection:	In the last process the participants gather as a big group to reflect on images. This allows for the sharing of feelings and experiences, and encourages group cohesiveness through members witnessing each other's artwork and stories. It also enables group members to model the psychotherapeutic process and begin to provide support and containment for each other, as participants are encouraged to explore each other's imagery, and to share their thoughts and responses.

- *Dance-movement therapy*

Dance-movement therapy is the psychotherapeutic use of movement for self-exploration and healing. It is based on the notion that the body and mind are in a constant give-and-take interaction (Chodorow, 1991). For this reason, dance therapists believe that one's unconscious thoughts are harboured in one's body, physical behaviour, and movements (Chodorow, 1991).

Dance-movement therapy has also been brought forward under the work of Jung (Chodorow, 1991). In 1916 Jung circulated his ideas about the connection between body and psyche in a paper that explored expressive body movement as one of the ways in which the unconscious may take form (Chodorow, 1991). Mary Whitehouse a pioneer of dance therapy in the 1960's took the theoretical notions proposed by Jung and began to develop them further through her involvement in dance therapy as a growing therapeutic technique for self-exploration (Chodorow, 1991). The notion that dancing can be used as a technique capable of healing echoes long-standing beliefs about dance as a ritual art form (Chodorow, 1991). In particular, dance rituals are still quite prevalent to the spiritual practice of African cultures (Gioia, 2006).

Therapists believe that as clients become encouraged to experience a wider range of physical expressiveness, so too do they start to express and experience a wider range of emotions (Chodorow, 1991). Therapists note that as the range of one's movement increases, so one tends to become more confident in one's social interactions with others (Chodorow, 1991). Dance therapy

is ultimately thought to have a significant impact on the development of physical interactions within one's environment, as a result of the tendency to become more comfortable within one's body, while interacting meaningfully with others (Chodorow, 1991). Full expression and extension of one's range of emotions through improvised movement gives participants access to learning about non-verbal aspects of both personal and social interactions (Chodorow, 1991).

Dance therapists promote the opportunity for their clients to explore their own physicality through their active imagination (Chodorow, 1991). This involves the use of improvisation (Chodorow, 1991). The overarching aim of this approach is to extend the participant's range of both personal and social movements (Chodorow, 1991). Consideration in dance therapy is therefore, also given to the social aspects of movement and subsequently the social aspects of those of who partake (Chodorow, 1991).

A typical session:

Warm up:	Each person gets a chance to warm the bodies of everybody in the class. The focus is on getting the body warm, stretched, and ready for the dance class. This exercise requires the participants to go home and plan a warm up routine – during this time, participants are encouraged to find members of their community that they can practice with.
Mirroring & identification:	The next part of the class consists of an exercise called follow the lead. Each participant has a turn to make up a jump or step across the room that everybody copies. In this exercise participants should be able to identify (on some level – whether consciously or unconsciously) with others in the class. It is a fun exercise which facilitates mirroring and identification.
Group dance:	This stage of the class is focused around learning dance combinations that the participants can perform together as a cohesive unit and as such requires that participants are attentive to the dynamics of not only themselves but of those around them as well. In the first few sessions, dance combinations are put together by the instructor, but as participants start becoming more comfortable in the sessions they are encouraged through various interactive exercises to explore their own range of movement and choreographic interpretations. In such sessions, imagery of concepts is key. After exploring their own choreographic interpretations, participants need to work together to put the dance combinations together and this includes the choice of music.
Reflection:	In the last process the participants gather as a big group to reflect on their dance. This allows for the sharing of feelings and experiences, and encourages group cohesiveness through the members' discussion of their group dance. It also enables group members to model the psychotherapeutic process and begin to provide support and containment for each other, as they are encouraged to explore each other's movements and contributions to the dance, and to share their thoughts and responses about this.

- *Music therapy*

Music therapy has strong theoretical roots in Winicottian frameworks. The therapeutic relationship is often paralleled to the mother-infant relationship. In the mother-child relationship, communication takes place through cries, gestures and facial expressions that

all have characteristics such as dynamics (loud or soft), pitch (high or low), intensity that can be seen as musical qualities. Thus a music therapist is trained to listen to and respond to the music made by a participant whilst gaining some idea of the participants needs and potential and reflecting this back to the client both through the developing musical relationship, and also at times verbally (Pavlicevic, 1997).

Music therapy, like the other two arts therapies discussed above, is also widely known as a psychotherapeutic intervention. Practitioners of music therapy believe that the role of a music therapist should parallel that of a mother in early mother-hood (Schaverien & Odell-Miller, 2005). In this way, music therapists need to demonstrate the ability to listen, understand, and bring meaning to their client-therapist relationship without the use of words (Bunt, 1996; Schaverien & Odell-Miller, 2005). However, words can be used to reflect on musical experiences, sometimes helping to clarify these experiences when working with verbal participants. But, as music doesn't require the use of words it can offer a safe and helpful medium for encouraging participants to express and explore some difficult emotions or experiences. Further, when reflecting verbally on a clients musical expressions, it is possible that they can come to a deeper awareness of themselves. Music therapy is therefore said to be based on the concept of one's early interactions with the world (Schaverien & Odell-Miller, 2005), this is interesting since hearing is the first sense to experience the world from the womb during one's foetal development. Though throughout life we continue to use primary communicative means such as gestures when communicating meaningfully – so music therapy isn't only based on early interactions but actually taps into how we communicate ourselves daily. For this reason, music therapists typically act as emotional cushions that seek to facilitate their client's ability to gain insight

through music into the core of a person's worries and or emotional difficulties (Schaverien & Odell-Miller, 2005).

As mentioned briefly above, improvisation is often the main focus of a music therapy session. Active participation in music making serves to echo the client's present emotional state and can therefore lead the client to a better understanding and interpretation of themselves (Schaverien & Odell-Miller, 2005). This is later thought to serve as the means in which clients are able to gain perspective of their internal, external, interpersonal, and intrapersonal facets, which empowers individuals to seek change within themselves (Schaverien & Odell-Miller, 2005). Music therapy can be carried out in group or individual settings, again depending on the purpose of therapy and the particular client or clients (Gioia, 2006).

A typical session:

Drumming circle:	Music therapy groups begin with a drumming circle, where group members all play the same beats together to offer a sense of togetherness and to lessen anxiety for those who may not feel able to make music. The drumming circle also offers opportunity for individuals to communicate how they are doing to the group and to offer their own individual drum beats and expressions – so that each individual is heard and valued within the group. As each individual introduces new beats, the others echo these beats – encouraging the development of important social skills such as attention and listening.
Main musical activity:	Each session contains one main activity – which may include listening to and discussing recorded music, creating a story based on excerpts of recorded music, song-writing, creating music to depict different emotions or ideas. These activities are planned based on the therapist's assessment of group needs and progress and offer time for group reflection and discussion.
Improvisation:	Each week, group members are encouraged to improvise on a range of percussion instruments, allowing them a space to express important musical, emotional and personal ideas by creating music together as they like. This is an important part of the session as it offers a real sense of how group members are, and the progress of the group. Whilst group members are encouraged to make music together "freely", there is some structure offered to manage improvisations – this may include ideas such as asking group members to role play certain characters or depict certain ideas, emotions or events through their music. Group members may also be given turns to lead the groups' music, or may be encouraged to attempt to play music in different ways or to try playing different instruments – offering them different possibilities and musical sounds. Time is given for reflecting verbally on the music made.
Ending:	The group ends with an ending ritual where group members are each offered a brief opportunity to reflect on how they felt about the session, and to play an instrumental solo as a way to end their music-making. This is held within the structure of a song.

8.2.5 Group norms, relationship building and social problem-solving skills

The alternative therapies are facilitated in a group setting, which mimics a microcosm of society, and this exposes the child to experiences relating to group norms and peer pressure. In addition, the shared experiences resulting from this form of group work provides children with opportunities to build relationships with other children, and in turn facilitates the development of the child's social problem solving skills. For example, all of the therapies involve instances in which the children have to work together towards a common goal. Whether it is coordinating multiple instruments to create a piece of music, or movements that make up a dance, the children are put into situations where they have to form relationships with others in order to achieve the goals set out in the group work. In this sense, a key component of the programme is to monitor these relational processes within the group. As maladaptive social problem-solving skills arise, the facilitator creates an awareness of them and introduces and reinforces healthy ways of social problem solving with the children.

8.2.6 Group themes

Fundamental to the alternative therapies, regardless of the specifics relating to the running of the programme are the themes to be covered.

- *Self-esteem*

At the most basic level, by learning to create art, dance, play music, or box, children is learning something new or refining and mastering a skill they have already learnt. Where there is the mastery of a new skill, this sense of achievement facilitates the development of self-esteem, especially when it is within a therapeutic environment. For example, through art the children may learn how to create depth in their art by using shading, or through dance the children may learn choreographing skills as they plan a routine with each other. In both cases, because the results of their efforts are physically evident, the accomplishments of the hard work that they put into the programme are clearly visible, and thus have the potential to impact greatly on their self-esteem. An important component in the alternative therapies is to ensure that the children are given the opportunity to try new things and praised for their achievements. What is most important is that the alternative therapies work with what children offer. For example, in music therapy, if a child comes up with a strange drum beat this is included in part of the groups sequence and suddenly becomes an important part of the product. If a boy has written down some of his thoughts roughly, the group takes it and together forms them into a poetic rap that the boy can then proudly perform with support from beat-boxing or drumming group members etc.

- *Aggression and social skills conflict management*

As primarily expressive mediums of therapy, the arts and sports based alternative therapies provide the children with an alternative means of expression. In their own ways, each type of therapy gives the child another avenue through which they can express their feelings and

emotions. For example, through music the children express their aggression by beating the drums hard, and in boxing they will punch the bags, releasing all of those pent up emotions that they cannot express in words. Within the alternative therapies, it is important to create a safe environment that facilitates opportunities allowing for this spontaneous release of raw emotions through the intended medium of the programme, being art, music, dance or boxing. Through expressing themselves in these ways, children often gain additional insights into their expressions and how to manage them.

- *Victim empathy*

The alternative therapies are intended to be more focused on the psychosocial needs of the child, as opposed to the offence, so victim empathy is not a primary theme addressed through the intervention. However, if the therapist assesses a need within a group to address victim empathy, this concept can be reflected on through creative processes. For example, in quite a few music therapy groups the therapist divides group members into two sub-groups – one representing a more powerful figure (for younger groups possibly a lion or cheetah) and the others represent a lesser figure (such as a zebra or rabbit). The group is then asked to depict a meeting of the two or a chase through music. In some groups, the two sub-groups are also given a chance to swap roles. Reflections of this activity offer much insight into what it might be like to be a victim or offender – and how difficult it can be for an offender to stop once beginning to take power over someone more vulnerable. However, the development of empathy and the capacity for dispositional empathy is facilitated within the child by the nature of the programmes. Given that the children are in an environment in which they are learning new skills, as well as facing problems together, their experiences are shared experiences, which ultimately creates an environment for the development of empathy.

- *Sex and sexuality*

Given that the alternative therapies are primarily needs focused, as opposed to offence focused, sex and sexuality are not directly addressed through this intervention. If issues relating to sex and sexuality arise during the programme, then the facilitator can openly work through the issues with the children within the therapeutic environment. At the same time, it is important to keep in mind that, as young sexual offenders, the offences committed by participants are both a response to certain pressures faced in their lives and the result of these offences has further influenced how they are perceived by others and at times even their own self perceptions. Whilst many participants might find it difficult to address such issues directly and might avoid these if offered an opportunity, it is important for the therapist/facilitator to keep this in mind and offer opportunities to reflect not only generally but also specifically on concepts including sex and sexuality. As group members often arrive at session expecting this focus, reflection of creative activities does at times easily tend towards a discussion around offences and thus also around sex or sexuality. In music therapy, discussions of explicitly sexual lyrics (as occurs in a large amount of rap music) in songs brought by group members or the therapist can lead

to some discussion around sexuality. Further, when themes emerging from songs or stories group members have created are discussed, this often includes some allusion towards sex/sexuality or experiences surrounding the participants offence. In such circumstances it becomes important to address and reflect on these issues as an important and meaningful part of the group process. In such circumstances the creative exploration of sex and sexuality tends to offer participants deeper insights into their sexuality and offences which in turn influences how they are able to process these experiences further in the rest of the diversion programme.

All of the above creative mediums give the child an alternate way of learning to communicate in a respectful manner. It also gives the child a feeling of mastery and control and a sense of validation of who they are. Thus, this second phase has become an integral part of the intervention process and is therefore compulsory component of the diversion programme.

Chapter 4

Appendices

Group work exercises

The following are some of the exercises used to promote the achievement of the aforementioned goals.

The Paper Tower Exercise

Aim of the exercise is to build a relationship between the group members.

- The group members receive a stack of newspapers and a roll of masking tape.
- Allow the group members 10 minutes to plan a paper tower that would be judged on the basis of three criteria: height, stability and beauty. No physical work is allowed during this planning period.
- Allow 15 minutes for the actual construction of the paper tower.

After completion of the paper tower it is very important to acknowledgment each group members input as well as the team work to ensure a positive relationship.

The Toothbrush

Show group members an old toothbrush.

- Tell them it's yours.
- Ask them if they would like to brush their teeth with it.
- Get their reaction.
- Ask group member's reason why they don't think it is suitable to use somebody else's toothbrush.
- Explain to the group members that we do not use something as personal as a toothbrush from somebody else.
- The same applies to their bodies.

Relationship Building

- Let group members identify relationships they are in and then let them think how important their relationships are.
- Hand each group member a blank piece of paper.

- Let them create a collage of their own relationships.
- After completion discuss the importance of good relationships and what acceptable behaviour within these relationships is.
- Ask group members to complete the following written tasks:
  - Their dreams
  - Life goals
  - Where do I want to be in five years?
  - Where do I want to be in 10 years?
  - Let them share above with group.
- Explain to the group members their responsibility to look after themselves for therefore be able to reach their dreams and life goals!

"Myths about rape"

Answer true or false to the following questions.
Do not censor your first response

No.	Statements	True	False
1.	Rape is part if male nature.		
2.	A prostitute cannot be raped.		
3.	A man can raped.		
4.	Most women secretly want to be raped.		
5.	A man can't really tell when a woman means no because women often say no and mean yes.		
6.	A woman causes her own rape when she walks in a bad neighbourhood or goes into a bar or nightclub on her own.		
7.	If a couple have had sex before, forced intercourse between them at a later stage is not rape.		
8.	Women get raped when they wear revealing clothes.		
9.	All men are potential rapists.		
10.	Most rapes occur between strangers.		
11.	All rapists are mentally ill.		
12.	Men do not rape for sex.		
13.	A raped woman is usually bruised and scarred.		
14.	A woman can be raped by her husband.		
15.	At a certain point an aroused man cannot control himself.		

Bumby Cognitive Distortions Scale	Strongly Disagree	Disagree	Agree	Strongly Disagree
	1	2	3	4
I believe that sex with children can make the child feel closer to adults.	1	2	3	4
Since some victims tell the offender if feels good when the offender touches them, the child probably enjoys it and it probably won't affect the child much.	1	2	3	4
Many children who are sexually assaulted do not experience any major problems because of the assaults.	1	2	3	4
Sometimes, touching a child sexually is a way to show love and affection.	1	2	3	4
Sometimes children don't say no to sexual activity because they are curious about sex or enjoy it.	1	2	3	4
Having sexual thoughts and fantasies about a child isn't all that bad because at least it is not really hurting the child.	1	2	3	4
If a person does not use force to have sexual activity with a child, it will not harm the child as much.	1	2	3	4
Some people are not "true" child molesters – they are just out of control made a mistake.	1	2	3	4

Bumby Cognitive Distortions Scale	Strongly Disagree	Disagree	Agree	Strongly Disagree
	1	2	3	4
Just fondling a child is not as bad as penetrating a child and will probably not affect the child as much.	1	2	3	4
Some sexual relations with children are a lot like adult sexual relationships.	1	2	3	4
Sexual activity with children can help the child learn about sex.	1	2	3	4
I think child molesters often get longer sentences than they really should.	1	2	3	4
Kids who get molested by more than one person probably are doing something to attract adults to them.	1	2	3	4
Society makes a much bigger deal out of sexual activity with children than it really is.	1	2	3	4
Sometimes molesters suffer the most, lose the most, or are hurt the most as a result of a sexual assault on a child more than a child suffers or is hurt.	1	2	3	4
It is better to have sex with one's child than to cheat on one's wife.	1	2	3	4
There is no real manipulation or threat used in a lot of sexual assaults on children.	1	2	3	4
Some kids like sex with adults because it makes them feel wanted and loved.	1	2	3	4
Some men sexually assaulted children because they really thought the children would enjoy how it felt.	1	2	3	4
During sexual assaults on children, some men ask their victims if they like it because they really want to please the child and make them feel good.	1	2	3	4
Children who have been involved in sexual activity with an adult will eventually get over it and go on with their lives.	1	2	3	4
Some children can act very seductively.	1	2	3	4
Trying to stay away from children is probably enough to prevent a molester from molesting again.	1	2	3	4
A lot of times, sexual assaults on children are not planned ... they just happen.	1	2	3	4
Many men sexually assaulted children because of stress, and molesting helped to relieve that stress.	1	2	3	4
A lot of times, kids make up stories about people molesting them because they want to get attention.	1	2	3	4
If a person tells himself that he will never molest again, then he probably won't.	1	2	3	4
If a child looks at an adult's genitals, the child is probably interested in sex.	1	2	3	4
Sometimes victims initiate sexual activity.	1	2	3	4
Some people turn to children for sex because they were deprived of sex from adult women.	1	2	3	4

Bumby Cognitive Distortions Scale	Strongly Disagree	Disagree	Agree	Strongly Disagree
	1	2	3	4
Some young children are much more adult-like than other children.	1	2	3	4
Children who come into the bathroom when adult is getting undressed or going to the bathroom are probably just trying to see the adult's genitals.	1	2	3	4
Children can give adults more acceptance and love than other adults.	1	2	3	4
Some men who molest children really don't like molesting children.	1	2	3	4
I think the main thing wrong with sexual activity with children is that it is against the law.	1	2	3	4
If most child molesters hadn't been sexually abused as children, then they probably never would have molested a child.	1	2	3	4

Name of child: Date:

The questions ask you to consider the impact of you offending behaviour upon your victim(s). Please read each statement carefully. Then, show how much you AGREE or DISAGREE with each statement by CIRCLING the number which best matches you view. Please answer all questions.

The Victim Empathy Scale	Strongly Agree			Strongly Disagree	
	1	2	3	4	5
I didn't see any obvious signs of damage at the time of my offending, so I think the effects have been that bad.	1	2	3	4	5
I can imagine my victim has feeling or fear and anxiety as a result of my abuse.	1	2	3	4	5
My victim is likely to be feeling dirty and ashamed because of what I have done.	1	2	3	4	5
My victim is probably feels let down and betrayed as a result of my abuse.	1	2	3	4	5
There's a lot of talk about the long-term effects of sexual abuse, but it is all exaggerated.	1	2	3	4	5
My victim probably finds it hard to trust others because of what I have done.	1	2	3	4	5
It's likely that my offending behaviour will, in future years result in my victim having low self-confidence.	1	2	3	4	5

The Victim Empathy Scale	Strongly Agree			Strongly Disagree	
	1	2	3	4	5
At the time of my offending, my victim didn't seem to show too many problems, so I don't think my abuse will cause them any future problems.	1	2	3	4	5
My victim is likely to be having nightmares and difficulty sleeping because of what I have done.	1	2	3	4	5
In future years, my offending behaviour is likely to have a negative impact on the ability of my victim to have close relationships with others.	1	2	3	4	5
What I did will probably affect my victim's faith and trust in people in years to come.	1	2	3	4	5
My offending behaviour is likely to have a bad effect on the emotional development of my victim.	1	2	3	4	5
In years to come, my victim will probably have feeling of powerlessness and vulnerability because of what I have done.	1	2	3	4	5
I haven't heard much about how my victim has been going, so I can't really say what the effects have been.	1	2	3	4	5
My victim is likely to have problems in seeking help in dealing with what I have done.	1	2	3	4	5
In years to come, it's likely that my victim will struggle with low self-esteem and little self-respect because of what I have done.	1	2	3	4	5
My victim is probably feeling guilty and responsible for my offence.	1	2	3	4	5
It's likely that my victim is confused about sexual issues as a result of my offending behaviour.	1	2	3	4	5
My victim will probably have trouble coping with memories of what I have done.	1	2	3	4	5
My offending behaviour will probably have a negative impact on the long-term sexual development of my victim.	1	2	3	4	5
The distress caused as a result of my offending behaviour is, at some stage, likely to have a bad effect on the physical heath of my victim.	1	2	3	4	5

MAKE SURE YOU HAVE CIRCLED ALL 21 ANSWERS ON BOTH PAGES

Now, read over each statement again, and this time place an "X" over the number which matches the way you would have answered before others became aware of your sexual offences.

SPARC worksheet

Worksheet: What was going on inside me before I hurt my victim?

I was thinking . . .
I was feeling . . .
I said . . .
I was doing . . .

SPARC worksheet

Information Sheet "Changes as you grow"

Changes in boys	What causes the change
Broadening shoulders and increasing muscle	The male hormone testosterone promotes muscle growth
Enlargement of the penis, testicles and scrotum	The male hormone testosterone promotes the enlargement of the sex organs
Sperm production begins	Testosterone influences the development of sperm cells in the testicles
Increased sweating	The sweat glands are stimulated by the hormones to produce increased amounts of sweat
Pimples on face	Changing levels of hormones in the body cause the fat glands to produce more oil which plugs the pores and causes pimples
Growth of facial and body hair	Pubic hair, the underarm hair begins to grow because of changing hormones. Facial hair will begin to grow later and then other body hair
Deepening of the voice	The vocal cords lengthen owing to testosterone. The voice will become uneven and will move up and down in pitch as the vocal cords mature
Frequent erections and ejaculations	The penis often times becomes erect because of changing hormones. When the boy is producing sperm, ejaculations can happen when he is sexually stimulated
Wet dreams	Semen containing many sperm cells is ejaculated from the penis while the boy is sleeping. This is common an normal

SPARC worksheet

Information Sheet
"Mood chart"

SPARC worksheet

The crime which I committed

Answer the following questions:

- What was the crime that you committed?

- What was your victim's name?

- Did you know who your victim was?

- How old was your victim?

- Where was the offence committed?

- Who else was there at the time?

- What do think your victim may have felt at the time?

- What do you think your victim is feeling now about what happened?

Monitoring & Evaluation Forms

The following forms are forms that can be used for the on-going administration, monitoring and evaluation of the programme.

SPARC assessment form

PART ONE: TO BE COMPLETED BY THE INTAKE WORKER

Interviewer:	Date:
Group code:	

CHILD IDENTIFYING DETAILS:

Child's surname:	Child's name:
Date of birth:	Age:

Gender: Female ☐ Male ☐ Race: Black ☐ White ☐ Coloured ☐ Asian ☐

Nationality:	Language:

CONTACT DETAILS

Parents of child			
Name of mother:		Name of father:	
Surname:		Surname:	
Contact no.:	(H)	Contact no.:	(H)
	(W)		(W)
	(C)		(C)
Address:		Address:	

Name of place of safety:		Name of caregiver/ house mother:	

Name of social worker:		Contact no.:	

FAMILY GENOGRAM:

FAMILY BACKGROUND:

REFERRAL DETAILS:

Referred by:	Referral date:
Reason for referral:	

CRIMINAL STATUS OF THE CASE

What is the accused pleading?	
How far is the court proceeding?	
Legal representative:	Contact no.:
Investigation Officer:	Contact no.:
Name of school:	Contact no.:
Name of Prosecutor/Probation Officer	Contact no.:
Name of Court:	Court Case no.:

PRESENTING PROBLEM: (According to the CHILD)

IF CLIENT WAS ABUSED, PLEASE COMPLETE THE FOLLOWING:

Have you ever been abused before?	Nature of abuse:
How often were you abused?	When did it occur?
Offender's name:	Relationship to abuser:
Gender:	Age:
How old were you at the time:	
What was the child's reaction to the abuse:	
Was the abuse disclosed?	Has a case been opened?
If not, why not:	
If yes, what is the progress/outcome:	
How do you think that the abuse has affected his/her life?	
Has the sexual functioning been affected and how?	
What is the nature of the sexual dysfunction?	

RISK FACTORS:

Gang involvement:

Substance use:

Adult involvement:

Socio-economic status:

Peer pressure:

Previous involvement in crime:

RISK ASSESSMENT:

OFFENDER						
Age:	10 years and below (young and unsophisticated)				Above 10 years (young or unsophisticated)	
Honesty:	Open and honest		Lies		Lies and steals	
Responsibility:	Takes responsibility for his/her actions		Denies responsibility for his/her actions		Denial on more than one level and shifts responsibility to victim	
Empathy:	Shows concern for victim		Shows a little concern		Shows no concern	
Clinical history:	Good progress		Slow and little progress		No progress	
Own abuse:	No history of abuse		Some history of abuse		Chronic history of abuse	

Schooling problems:	Coping at school		Learning problems (some questionable progress)		Not coping at school and no progress	
Influence:	Acted independently		Peer influence		Easily influenced by media	
Social skills:	Social competence		Lacks social competence (skills)		Social incompetence	
OFFENCE						
Nature:	A-typical and spontaneous		Premeditation and manipulation		Sophisticated premeditation and manipulation (well organised and executed)	
Aggression:	No force used		Minor force		Severe force	
Intensity:	Fondling/touching of genitals		Attempted penetration		Penetration	
Frequency and number of victims:	One to two incidents with one victim		Repeated incidents (three or four times) with two to three victims		Compulsive (more than four) with more than three victims	
Duration:	Short time span		Longer time span		A very long time	
SITUATION						
Family pathology:	Pro-social family		Some deviance (dysfunctional)		Severe family dysfunction	
Family support:	Co-operate with treatment and consistent supervision		Insufficient co-operation and inconsistent supervision		No co-operation and no supervision	
Community context (violence, or wealthy, etc.):						
Risk category	Low risk		Medium risk		High risk	

EVALUATION:

What is the child's level of insight?
What is the child's reaction to the interview?
What is the child's attitude towards the therapist?
What is the therapist's reaction to the child?
What is the child's level of remorse?
How would you describe the child's willingness to be involved in the intervention programme?

Facilitator's name:	Signature:	Date:

- I HEREBY DECLARE THAT THE INFORMATION GIVEN ABOVE IS THE TRUTH AND REALISE THAT ANY FALSE INFORMATION GIVEN BY ME COULD AFFECT THE DESIRED OUTCOME OF THE GROUP.
- I UNDERSTAND THAT INFORMATION GIVEN BY ME HERE OR IN THE GROUP MAY BE USED FOR RESEARCH PURPOSES TO ENHANCE THE SERVICES OFFERED. I UNDERSTAND THAT THE INFORMATION WILL BE TREATED ANONYMOUSLY AND I WILL NOT BE IDENTIFIED IN ANYWAY.
- I THEREFORE DECLARE MY COMMITMENT TO THE PROGRAMME AND TO COMPLY WITH ANY REQUIREMENTS FROM THE PROGRAMME. IN THE EVENT THAT I DO NOT DO AS REQUIRED, I ACCEPT THAT THE MATTER WILL BE REFERRED BACK TO THE REFERRAL AGENT FOR DECISION BY THEM.

Client's signature:	Parent/guardian's signature:

Group process note form

Date of session:	Group no.:	Session no.:
Venue:	Time:	Duration:

Facilitator/co-facilitator:	Persons present/interpreter:

Theme of the session:

Goals of the session:

Process account of the group:

Aids used in the session:

Group members individually:

Sociogram:

Assessment of the session:

Plan of action: theme and details of the approach to address this theme

Facilitator's signature:	Date:

SPARC parent process note form

Date of session:	Group no.:	Session no.:
Venue:	Time:	Duration:

Facilitator/co-facilitator:	Persons present/interpreter:

Feedback from last session:

Aims of current session (specific theme or activities):

Summary of session:

Facilitator's signature:	Date:

Facilitator's final evaluation form

Name of evaluator: Name of child:		Date:	

1. Communication of personal responsibility to victim					
Says he/she is sorry (in session or parent's report).	1	2	3	4	5
Has written a letter of apology.	1	2	3	4	5
Has admitted fault in a recon tact session.	1	2	3	4	5
Talking in group (Social Skills)					
Talks a little	1	2	3	4	5
Talks when asked questions	1	2	3	4	5
Talks on his/her own	1	2	3	4	5
Talk about problems (Accountability)					
a. Does not talk about own problems	1	2	3	4	5
Talks about own problems if asked questions	1	2	3	4	5
Talks about own problems on his/her own	1	2	3	4	5
Sensitivity in group (Empathy)					
Does not show awareness of other's feelings.	1	2	3	4	5
Sometimes shows awareness of other's feelings and needs.	1	2	3	4	5
Sensitive to other group members: pays attention to what they say.	1	2	3	4	5
Co-operation with therapist (Impulsiveness and Social Skills)					
Co-operates only after repeated direction.	1	2	3	4	5
Sometimes cooperates fully, but often needs repeated direction.	1	2	3	4	5
Usually cooperate without repeated direction.	1	2	3	4	5
Discussion of touching (Accountability)					
Denies touching (says he/she did not do it).	1	2	3	4	5
Admits to touching, but only if pushed to do so.	1	2	3	4	5
Talks about touching, and tells whole story.	1	2	3	4	5
Talks about being a victim (Prior Trauma)					
Does not talk about being a victim.	1	2	3	4	5
Talks about how he/she was a victim.	1	2	3	4	5
Expresses feelings/thoughts about being a victim.	1	2	3	4	5
Ways of forcing victim (Accountability)					
Does not accept responsibility for touching.	1	2	3	4	5
Talks about how he/she set up victim.	1	2	3	4	5
Talks in detail about how he/she took advantage of victim.	1	2	3	4	5
Talks about victim's feelings (Empathy)					
Does not talk about how his/her victim(s) felt.	1	2	3	4	5
States how victim(s) likely felt.	1	2	3	4	5
Talks about problems victim(s) may have experienced since being touched.	1	2	3	4	5

How touching happens (Accountability)					
Does not talk about how touching occurred.	1	2	3	4	5
Talks about situations in which touching can occur.	1	2	3	4	5
Talks about situations and feelings that lead to touching.	1	2	3	4	5

Thoughts about touching (Accountability)					
Denies thinking again about touching	1	2	3	4	5
Admits to thoughts about touching.	1	2	3	4	5
Tells how he/she is changing thinking in order to stop touching.	1	2	3	4	5

The following ratings will be completed on individual s ages 9 and older.

Gives feedback to other group members (Social Skills)					
Does not give feedback to others.	1	2	3	4	5
Piggybacks on other's comments	1	2	3	4	5
Gives helpful feedback to other group members.	1	2	3	4	5

Understanding how needs were met by the touching (Empathy)					
Does not talk about how needs led to touching.	1	2	3	4	5
Talks about how some needs are met by the touching.	1	2	3	4	5
Talks about how he/she used touching to meet needs.	1	2	3	4	5

Relationship with group member (Empathy)					
Does not act in a caring way with group members.	1	2	3	4	5
Sometimes acts in a caring way with group members.	1	2	3	4	5
Consistently acts in a caring way with group members.	1	2	3	4	5

Danger signs and safety (Accountability)					
Denies talking about further problems.	1	2	3	4	5
Talks about danger signs but has no plan in place to prevent further touching.	1	2	3	4	5
Talks about danger signs and has a good plan to prevent further touching.	1	2	3	4	5

The following ratings will be completed on individuals ages 13 and older

Relationships with family members (Accountability)					
Denies any family problems.	1	2	3	4	5
Talks about family problems without saying how he/she is a part o the problem.	1	2	3	4	5
Talks about own part in family problems.	1	2	3	4	5

Responsibility (Accountability)					
Superficially accepts responsibility for molestation but minimizes or rationalizes it.	1	2	3	4	5
Verbalizes personal responsibility without minimization or rationalization.	1	2	3	4	5
Demonstrates acceptance of full responsibility with appropriate affect.	1	2	3	4	5

Personality style /thinking errors (Accountability)					
No understanding of thinking errors.	1	2	3	4	5
Able to recognize thinking errors in others.	1	2	3	4	5
Full understanding of thinking errors and how they related to molestation.	1	2	3	4	5

Relationship with age-appropriate girlfriends/boyfriends (Empathy)					
Interacts in a non-caring manner.	1	2	3	4	5
Sometimes interacts with girlfriend/boyfriend in an empathetic manner.	1	2	3	4	5
Evidence of consistent empathetic interaction with girlfriend/ boyfriend	1	2	3	4	5

Therapist/evaluator's signature:	Date:

An example of the structure of a Diversion Court Report

Date:

The Prosecutor/Magistrate

(Name of Court and Address) EG. Department of Justice Private Bag X Randburg 2194

Reference: Case No.:

Mas No.:

Our Ref:

1. Identifying details:

a) Full name	Gender	Date of birth

b) Home address:

2. Nature of report:

(What kind of report is it? How long has the participant been attending?)

3. Assessor:

(Details of the assessors qualifications, relevant experience and current position.)

4. Introduction:

(What is the report about?)

5. Family background:

(Details about the child's family background: information about parents, siblings, living situation, school situation and psychosocial skills.)

6. Assessment results:

(The assessors perception of what may have led to the offending behaviour.)

7. Treatment themes that were dealt with included the following:

(List and describe each of the themes addressed during the child's participation in the programme.)

8. Theoretical aspects:

(Explain the theory upon which the above assessment and themes are based.)

9. Evaluation and assessment:

(The assessors evaluation of the child's intervention outcomes and level of risk for future offending behaviour.)

10. Recommendations:

In light of the abovementioned information, it is respectfully recommended that the presiding officer of the Child Justice Court consider: (List recommendations)

Yours faithfully

_____

Name of evaluator

(Position)

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