DEVELOPMENTAL TOUCH THERAPY WITH SEXUALLY ABUSED CHILDREN

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DECLARATION

I hereby declare that this dissertation is my own work. It is being submitted in partial fulfillment of the requirements for the degree of M.Sc. (Counselling Psychology) at the University of the Free State, Bloemfontein. It has not been submitted before for any degree at any other university. I further cede copyright of the dissertation in favour of the University of the Free State.

Carlyn Lightfoot _____

Signed this _____ day of _____ 2005

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- *Children who participated in the study*
- *Parents, caregivers and teachers of participants*

READER'S ORIENTATION

In accordance with the regulations of the University of the Free State, this dissertation is presented in article format.

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DEVELOPMENTAL TOUCH THERAPY WITH SEXUALLY ABUSED CHILDREN

There is a limited amount of research available on the re-establishment of attachment bonds eroded by Child Sexual Abuse (CSA). One way of re-establishing these bonds could be through Developmental Touch Therapy (DTT). The aim of this study was to investigate the effectiveness of DTT with children who have been sexually abused. A multiple case-study design was used. Three girls and one boy, between the ages of five and eight years, participated in the study. DTT was implemented by means of 10 weekly individual therapy sessions. Pre- as well as post-tests were administered. The results were tested by computing nonparametric Wilcoxon T-tests. No significant differences were found between the pre- and post-tests. This might be attributed to the small sample size. A qualititative analysis indicated that the problem behaviours reported as clinically significant pre-therapy by caregivers and teachers had decreased to a level below clinical significance post-therapy for most children. Although sexual problems had decreased it was still present in most subjects. DTT seems to re-establish attachment bonds and enhances the sense of self, trust, and safety. However, DTT cannot be regarded as a holistic treatment and should be used in conjunction with integrative therapeutic treatment.

INTRODUCTION

The escalation of child sexual abuse (CSA) in South Africa is reaching extremes and is recognised as such, both because of its epidemic proportions and the traumatic impact thereof on the child, family and the larger community (Killian & Brakarsh, 2004). Despite the increased awareness of CSA in South Africa, research in this regard has been limited, or goes unpublished (Lachman, 1996). Improved understanding of this phenomenon and its treatment will enhance the effectiveness of therapeutic interventions in this regard (Killian & Brakarsh, 2004).

CSA occurs during the period of life when complex and ordered changes are occurring in the child's physical, psychological and social being. This leaves the child vulnerable to sustaining damage that will retard, pervert or prevent the normal developmental processes (Fergusson, Lynskey & Horwood, 1996a). CSA involves a breach of trust and/or exploitation of vulnerability (Mullen & Fleming, 1998). Apart from the immediate or short-term psychological sequelae

experienced by some child victims, the long-term effects could be far-reaching, impacting also on psychological functioning in adulthood (Kendall-Tacket, Williams & Finkelhor, 1993). It is evident that the development of sexually abused children may furthermore be significantly affected. This is especially related to the duration and frequency of abuse, coercive techniques employed, the nature of the abuse, and the relationship to the perpetrator (Kendall-Tackett et al., 1993).

One area of development that could be negatively affected by CSA is the establishment of attachment bonds (Freyd, Putnam, Lyon, Becker-Blease, Cheit, Siegel, & Pezdek, 2005). Attachment refers to the establishment and maintenance of an emotional bond with parents or other significant caregivers (Waters, Merrick, Treboux, Crowell & Albersheim, 2000). The presence of consistent, responsive, attuned and nurturing caregivers is required for the development of healthy attachment bonds and socio-emotional functioning. If the original experiences with primary care-giving adults involve fear, unpredictability, pain, and abnormal genital sensations, neural organisation in many key areas will be significantly, and detrimentally, altered. The core elements of healthy functioning and development throughout the life cycle will subsequently be altered. This means that the original templates (or representational models) for many future relationships may be corrupted and the child may have a lifetime of difficulty with intimacy, trust, touch, and bonding (Earl-Taylor & Thomas, 2000). Maltreated children are therefore more likely than other children to show an insecure-disorganised attachment, which is characterised by a mixture of approach and avoidance. Helplessness, apprehension, and general disorientation is subsequently displayed (Barnett, Ganiban & Cicchetti, 1999).

Representational models of oneself and others, which contain experience, knowledge, and expectations that carry forward to new situations, are significant (Cicchetti & Lynch, 1995). Children who have been sexually abused sometimes develop negative representational models of themselves and others based on a sense of inner badness, self-blame, shame, or rage, which impairs their ability to

regulate affect (Lewis, 1992). They therefore express feelings and impulses in a maladaptive manner.

In addition, existing literature states that attachment may also affect cognitive functioning. Security of attachment formed may affect the modulation of arousal and attention, impact on the quality of environmental exploration, and may be an essential stimulus for development of certain brain regions. Attachment has furthermore been shown to affect intelligence, attention, learning disabilities, and scholastic achievement (Lennert, 2001). When considering the negative effect of CSA on attachment it follows that sexually abused children may have problems with school adjustment. This contention has been verified by research. Sexually abused children are often described by teachers as more anxious, inattentive, unpopular and as having less autonomy and self-guidance in completing school work (Erickson, Egeland & Pianta, 1989). Child victims of sexual abuse are furthermore more likely than non-abused children to suffer in their academic performance and their ability to focus on tasks, to have histories of frequent school absenteeism, and to receive teacher ratings of shyness-anxiousness (Trickett, McBride-Chang, & Putnam, 1994).

While considering the above-mentioned, it is, however, important to note that one-third of sexually abused children do not report their abuse or exhibit any visible symptoms, and about two-thirds of those who do show symptoms recover significantly during the first 12-18 months following the abuse (Kendall-Tacket et al., 1993). The possibility of delayed emergence of symptoms is nonetheless becoming more widely recognised (Williams, 1994).

When considering the far-reaching effect of CSA, it is imperative that effective therapeutic interventions be introduced timeously. Intervention with children who have been victims of CSA is a complex and arduous task for even the seasoned therapist (Chop, 2003). It is agreed upon that successful interventions for sexually abused children should result in several important outcomes (Berliner, 1997): Treatment should help children to understand that what happened to them was abuse, that it was wrong, and that it may have caused them temporary

problems. Emotional and behavioural problems connected to the abuse should be addressed, and children should be equipped with the personal resources to handle future problems. Supportive relationships should be in place and the children should regain their normal rate of development (Mash & Wolfe, 2002). Existing treatment models include psychoanalytic play therapy, client-centred play therapy, gestalt play therapy, group therapy and community-based interventions (Killian & Brakarsh, 2004). The largest number of research trials, and evidence for best effect to date, comes from cognitive-behavioural therapy (Cohen & Mannarino, 1996; 1997).

Some child victims of sexual abuse may have a tremendous longing to be touched in a caring way, but may not always be equipped to ask for it as they have rarely, if ever, received it. Therapists often assume that caring touch will be too painful for or unacceptable to the child and tend to shy away from it (Brody, 1993). According to Oaklander (1988), it is through the basic modalities of sight, sound, touch, taste, and smell that we experience ourselves and make contact with the world. Although intellect is important, our minds are only a part of the total organism that we own and need to take care of, cultivate and use. Myrow (1997) suggests that touch from a loving, safe caregiver may promote healthy growth. It is assumed that the child will develop a sense of self as well as the ability to relate to others. The abilities of modulating affect, developing a belief system and self-worth, and mastery of the environment are enhanced. Furthermore, the symptoms of trauma and maladaptive coping strategies developed by a traumatised or abused child may be appropriately treated with touch.

Developmental Touch Therapy (DTT) has been identified as a possible intervention strategy in working with sexually abused children and is based on attachment theory (Brody, 1993). It draws from the theoretical models of Theraplay (DeLauriers, 1962; Jernberg, 1979) and Touch Therapy (Field, 2003). Developmental Touch is defined as a therapy consisting of intense interactions between an adult and a child (Brody, 1993), which enhances development and

expressive communication. It is based on the theoretical premise that children who experience rich sensory experiences, nurturing physical affection and caring touch will develop a core sense of self and move toward healthy physical and socio-emotional development. An assumption is that a child who has been a victim of sexual abuse has most likely had one of his or her primary attachment relationships violated. DTT consequently focuses on the child establishing a meaningful relationship with an adult partner (Burt & Myrick, 1980).

More specifically, DTT is based on the following theoretical assumptions: The *bodily self* constitutes the earliest self-experience and is established through the physical contact and playful and loving attitudes the mother provides. The infant or young child comes to perceive parts of his or her body as distinct entities. It follows that the body has distinct boundaries that enclose the child and serve as a separation from the world. The bodily self lays the foundation for the subsequent development of the *psychological self*, which refers to a sense of I-ness or the centre within the individual that chooses and acts. Sensory stimulating contact (which is defined as any concrete touch that makes the child who is touched aware of his or her body, of being touched, and of who is touching him or her), is therefore implemented in DTT. It thus creates a relationship between the toucher and the one being touched (DeLauriers, 1962). Furthermore, the only way an individual develops a sense of self, or I, is by meetings with another person, or Thou (Buber, 1858). Adler (2002) introduced the concept of authentic movement in describing the therapeutic relationship. It is postulated that during therapy the child attends to his or her own body and expresses with his or her body the feelings and impulses that arise within the body. The therapist in turn observes the child and notes his or her own reactions to the child's expression. The true value of seeing and being seen is incorporated into the therapy (Brody, 1993).

Six guiding principles underlie the adult-child interactions in developmental play sessions: (1) A child who experiences herself of himself as touched develops a sense of self. (2) A capable adult must touch the child in order for him or her to

feel touched. (3) In order to be a toucher, an adult must first be willing to be touched. (4) A child has to allow him- or herself to be touched by an adult in order to experience the touching. (5) Children often feel validated most through touch. (6) The adult controls the activities that take place in order to provide the relationship the child needs to feel touched (Brazelton, 1990). The initiatives of the adult in DTT sessions consequently fall into four broad, but not exclusive categories: firstly, noticing the child; secondly, touching the child; thirdly, responding to the child's cues and lastly, focusing attention in an undeniable fashion on the presence of an adult who meets the child's needs (Brody, 1993).

A DTT session consists of three parts. The session starts with a beginning *Hello Time*, when the child is greeted and made aware by the therapist that he or she is being seen. A *Middle Time* of play activities, which is sometimes initiated by the therapist and sometimes initiated by the child, follows this. The session is ended with an *Ending Time* or *Cradling* (Brody, 1993). The DTT process is furthermore divided into four stages. The first stage is described as the *Honeymoon stage*. The goals during this stage are the development of positive emotional attachment between adult and child as well as learning that it is acceptable to enjoy one another. This is followed by the *Painful stage* during which a realisation of relationship and limits in play are discovered. The child begins to express positive and negative feelings freely. The third stage is that of *Separation versus Love*. During this stage, awareness that the partner is an individual separate from the self begins to develop. The child continues to express emotions freely. The last stage involves preparation for termination. The child is prepared for termination of the relationship several weeks in advance and is allowed to express feelings of anxiety and loss freely. Growth and accomplishments are recognised.

Very limited research pertaining to the effectiveness of DTT in treating sexually abused children is available. The only research in this regard to date was conducted by Mitchum (1987). Five participants were selected for the study. All the participants were four years of age and both genders were represented.

Each child had ten sessions with an adult partner. Sessions consisted of one-on-one adult-child play, a group game and circle time, and snack time. Parents reported positive results, with increased cooperation and playfulness at home. It furthermore seemed that DTT gave children an opportunity to build a new attachment relationship with an adult. Objective pre- and post-test measures were, however, not used in this study.

While recognising the effectiveness of certain therapeutic models in the treatment of CSA it should be considered, as mentioned previously, that CSA is potentially debilitating and damaging to the child's ability to engage in positive relationships with self and others. There have, however, been few research studies that address the efficacy of treatment modalities with regard to rebuilding a child's sense of trust and safety. Attachment theory helps to explain why CSA may lead to psychological impairment and offers a framework by which possible approaches to therapy can be synthesised (Mattei, 2004). Freud (1982) was of the opinion that affectionate attachment and positive transference with the therapist was a prerequisite to all work which was to be done with a child. The primary purpose of attachment is to provide soothing, security and safety. The therapeutic relationship should thus be structured in such a way that the therapist fulfils this purpose (Pistole, 1989). When a client is able to attach to a therapist, a secure base effect is seen. The client may then be able to take risks, mask anxiety, and practise new behaviour patterns that might not have been attempted previously (Sadock & Sadock, 2003). Attachment thus furthermore offers a perspective by which individual therapy can be used to formulate treatment strategies and techniques for CSA victims (Mattei, 2004). The current research therefore aims to investigate the efficacy of DTT, which is based on the theory of attachment, as a treatment modality in this regard.

METHOD

Research Design

A multiple case study design was used. A case study is directed at the understanding of the effect of a specific intervention with a specific case, while considering the uniqueness and complexity thereof (Huysamen, 2001). It is thus an intensive description and analysis of a single unit or bounded system such as an individual or intervention, for example (Henning, Van Rensburg & Smit, 2004). It is furthermore an empirical enquiry that attempts to bring an understanding of a complex issue or object and subsequently extend experience and add strength to what is already known through previous research. Case studies emphasise detailed contextual analyses of a limited number of events or conditions and their relationships. It is extremely useful in situations in which the boundaries between the phenomenon and context have not yet been defined (Yin, 2003).

When conducting case study research it is firstly important to establish a firm research focus (Tellis, 1997; Yin, 2003). The focus of the study is established by forming questions about the situation or problem to be studied and by determining a purpose for the study. The questions are often targeted at a limited number of events or conditions and their inter-relationships. A literature review is conducted to assist in targeting and formulating the questions. Careful definition of the questions at the onset indicates where to look for evidence and assists in determining the methods of analysis to be used in the study. Literature on the sequelae of CSA suggests that attachment bonds may be eroded. One way of re-establishing these bonds could be through DTT. The current research thus aimed to investigate the effectiveness of DTT with children who have been sexually abused.

The research object in a case study is a person, or a group of people. Four children participated in this study. A strength of the case study method involves the researcher being able to use multiple sources and techniques in the data-gathering process. Evidence to be gathered and analysis techniques to be used

with the data to answer the research questions are determined in advance. Data gathered is normally largely qualitative, but it may also be quantitative. In this study, both of these measures were employed. The object of the case study is thus investigated in depth by using a variety of data-gathering methods to produce evidence that leads to understanding of the case and that answers the research questions.

During the design phase of case study research, the researcher determines what approaches to use in selecting single or multiple real-life cases to examine in depth and which instruments and data gathering approaches to use. When using multiple cases, each case is treated as a single case. The conclusions pertaining to each case can then be used as information contributing to the whole study. This approach was followed in the current research in that each participant's case and therapeutic process was viewed and investigated individually. Process notes and video recordings were made of the therapeutic process to aid in the qualitative description and external supervision of the therapeutic process followed with each participant. The purpose is thus to present a situation that is likely to be seen in the clinician's experience. The management and evaluation performed by the researcher in the present study are represented in a sequential manner that simulates a therapeutic situation.

It is important to ensure that the study is well constructed. Construct validity, internal validity, external validity, and reliability are consequently ensured (Tellis, 1997). The limited number of participants and measuring instruments used in the current study, as well as the absence of a control group, did however make the establishment of these factors difficult.

Participants

The study consisted of four subjects referred for therapy by a social worker. Three girls and one boy, between the ages of five and eight years, participated in the study. The sample can be described as an availability sample. This implies that it was difficult to control for the time of onset, duration of abuse, relationship

to the perpetrator and type of abuse - factors that could have contributed to the type and severity of symptoms, as well as the effect of the therapeutic process.

Quantitative data collection

Pre- as well as post-tests were administered by the researcher by making use of the *CBCL/4-18* (parent report form) (Achenbach, 1991a) and *the CBCL/5-18* (teacher report form) (Achenbach, 1991b).

The *CBCL*/4-18 (parent report form), of which the internal reliability was calculated as 0.84 in a cross-cultural South African study on CSA (Louw, 2000), was used in this study. The *CBCL*/5-18 (teacher report form) of which the internal reliability was indicated as 0.97 in a cross-cultural South African study on CSA (Louw, 2000) was furthermore administered. Regarding the construct, criterion, discriminant and content validity, both checklists were found to be valid (Achenbach, 1991a,b). In addition, these checklists have been used in more studies on CSA in the USA than any other standardised measure (Waterman & Lusk, 1993).

The *CBCL/4-18* (parent report form) consists of a Competence scale which includes three subscales that measure the child's activities, as well as social and academic competencies. The checklist furthermore includes a Syndrome/Problem scale, which consists of the following nine subscales: Withdrawn, Somatic complaints, Anxious/Depressed, Social problems, Thought problems, Attention problems, Delinquent behaviour, Aggressive behaviour and Sexual problems. These scales are grouped into Internalising and Externalising behaviour and a total score is calculated.

The *CBCL/5-18* (teacher report form) was developed to measure the academic and adaptive functioning of children, as well as certain problems or syndromes. The Syndrome and Problem scales and related subscales included in the parent report form, are included in this checklist. Sexual behaviour is however excluded. Internalising and Externalising scores and a total score is furthermore

calculated. The subscale Attention problems is subdivided into Attention deficit and Hyperactivity scales respectively.

For the purpose of this study, only the Problem/Syndrome scales were used.

The rationale of both tests is that parents, or parent surrogates and teachers, are among the most important sources of information about children's social and academic competencies, as well as about their behavioural and emotional problems (Achenbach, 1991a).

Problems inherent to checklists are related to the fact that the individuals who complete them are not always objective with regard to the child. The child is consequently sometimes evaluated unnecessarily negatively or, in certain instances, too positively (Achenbach, 1991a,b).

Qualitative data collection

DTT was implemented with the participants. Children received 10 weekly individual therapy sessions in a therapy room at the Department of Psychology at the University of the Free State. The room contained a blanket, rocking chair, table and chair, paper, crayons, pencil, skin lotion, water and soap. The room was free of other distractions. A typical session consisted of the following sequence: (a) *Hello Time*, when the child was greeted and made aware of being seen by the therapist. (b) *Middle Time,* during which play activities were incorporated, (c) An *Ending Time* or *Cradling.*

The following activities were incorporated during the various stages (*Honeymoon, Painful, Separation versus Love, Termination stages)* of therapy: (1) Simple touching or Hello game (therapist described each of the child's body parts as they touched); (2) Washing (using a small bowl of water and a washcloth, therapist and child took turns washing each other's hands, arms and feet); (3) Gingerbreadman game (child was encouraged to lie down while the therapist rolled his or her body with a rolling pin as if the child were a piece of

dough. Imagination was used to bake gingerbread boy or girl); (4) Hide-and-seek (the child would hide in the room, without disturbing it, while the therapist would try to find him or her); (5) Chase game (the child would run away from the therapist, who would chase after the child and catch him or her); (6) Playing baby (therapist would hold and rock the child as if he or she were a baby); (7) Playing hurt (therapist would fantasise a hurt and act it out. Roles were sometimes reversed); (8) Magic button game (therapist would touch certain parts of the child's body until finding the magic button, which produced certain sounds. The child would then touch the same part of the therapist's body. Different body parts were subsequently touched); (9) Modified Simon Says (therapist pantomimed while the child would copy); (10) Slippery hand (therapist and child took turns to put cream on each other's hands. Therapist would catch child's arm, which was constantly slipping away); (11) Leapfrog (therapist and child lined up next to each other. Both in turn leapfrogged to the front until a specific target was reached); (12) Sculpting (child and therapist took turns to "sculpt" each other. Sculpting was done by moulding the other person's hands, arms and legs. The partner had to hold position of the mould); (13) Body drawing and colouring (a piece of paper larger than the child was placed on the floor. The therapist then traced the child's body. Details and colour were drawn in the figures); (14) Circus acrobatics (therapist and child would line up and do the same trick); (15) Rowing game (therapist would hold child while pretending to row a boat); (16) Countdown (toward the end of the sessions the therapist initiated a countdown, during which the child was made aware of the number of sessions remaining, as well as the therapist's emotions regarding the termination); (17) Favourite game (the child could choose to repeat his or her favourite play activity).

Procedure

Participants were referred for therapy by social workers. An intake interview was conducted with the primary caregivers of the respective children. Aspects regarding the referral reason, family history, child development and symptomology were covered. A pre-test was administered by making use of the

CBCL/4-18 (parent report form) and the *(CBCL)/5-18* (teacher report form). DTT was thereafter implemented with the participants. If possible, a feedback session was held with the primary caregiver of each particpant. Lastly, a post-test was administered by once again making use of the *CBCL/4-18* (parent report form) and the *CBCL /5-18* (teacher report form).

Data analysis

Quantitative analysis

The *CBCL/4-18* (parent report form) and the *CBCL /5-18* (teacher report form) are completed according to a three-point scale. Raw scores for individual scales are obtained. *T*-scores are thereafter calculated. High scores (above the calculated cut-off points of *T* between sixty and sixty-three) are considered as a clinically significant indication that a problem related to a specific scale is present. However, only raw scores were calculated for the purpose of this study. The different subscales were totalled, and the results were tested by computing nonparametric Wilcoxon T-tests for the subscales and the scale totals, using the Statistical Package for the Social Sciences (SPSS) (SPSS inc., 1990).

Qualitative analysis

A qualitative description of the therapeutic intervention as experienced by the therapist was made. Process notes were kept and video recordings of sessions made to facilitate the external supervision of the process.

Ethical considerations

Social workers and caregivers were informed of the nature and purpose of the study. Although it was originally planned to incorporate a control group, with whom DTT would be implemented at a later stage, social workers and caregivers felt that most of the available participants needed therapy immediately, therefore therapy could not be postponed. Due to the ethical implications it was therefore not possible to incorporate a control group in the time frame available for this study.

A pseudoname* is used for the qualitative description of the therapeutic intervention with each child. Anonymity is consequently assured.

RESULTS

Quantitative results

CBCL/4-18 (Parent form)

The results for the *CBCL/4-18 (parent forms*) are shown in **Error! Reference source not found.**.

Table 1 *CBCL/4-18 (Parent Form*): Pre- and Post-Test

Scale	Z	Asymp. Sig. (2-tailed)
I (Withdrawn)	-1.732	.083
II (Somatic complaints)	-.447	.655
III (Anxious/Depressed)	-1.826	.068
IV (Social problems)	-.816	.414
V (Thought problems)	.000	1.000
VI (Attention problems)	-1.095	.273
VII (Delinquent behaviour)	-1.134	.257
VIII (Aggressive behaviour)	-1.633	.102
IX (Sex problems)	-1.000	.317
Internalising	-1.342	.180
Externalising	-1.826	.068
Total score	-1.095	.273

CBCL/5-18 (Teacher form)

The results for the *CBCL/5-18 (teacher)* forms are shown in **Error! Reference source not found.**2.

Table 2 *CBCL/5-18 (Teacher Form)*: Pre- and Post-Test

Scale	Z	Asymp. Sig. (2-tailed)
I (Withdrawn)	-1.604	.109
II (Somatic complaints)	-1.342	.180
III (Anxious/Depressed)	-1.604	.109
IV (Social problems)	-1.342	.180
V (Thought problems)	-.447	.655
VI (Attention problems)	-.816	.414
VII (Delinquent behaviour)	-.447	.655
VIII (Aggressive behaviour)	-.535	.593
Internalising	-1.604	.109
Externalising	-.272	.785

Total score	-1.069	.285

Combined results

The results for the combined parent and teacher forms (excluding subscale IX—Sex problems) are shown in **Error! Reference source not found.**3.

Table 3 Combined results: Pre- and Post-Test

Scale	Z	Asymp. Sig. (2-tailed)
I (Withdrawn)	-1.826	.068
II (Somatic complaints)	-.730	.465
III (Anxious/Depressed)	-1.841	.066
IV (Social problems)	-1.300	.194
V (Thought problems)	-1.289	.197
VI (Attention problems)	-1.461	.144
VII (De linquent behaviour)	-1.461	.144
VIII (Aggressive behaviour)	-.730	.465
Internalising	-1.604	.109
Externalising	-1.095	.273
Total score	-1.461	.144

It is evident from **Error! Reference source not found.**–3 that none of the results are significant. This is not entirely surprising, given the small sample size.

Qualitative results

Case 1

Background Information: Justin* is a five-year old boy who comes from a middle class family and lives with his parents, younger sister and grandmother. The marital, family and parent-child relationships are reportedly stable and firmly established. Although both his parents are very involved in his life, they are not always able to provide the quality of attention that they would like to. Justin generally spends more time with his father than his mother.

Referral Reason: Justin was sexually abused by a 13-year-old boy when he was three years old. The sexual contact consisted of masturbation and oral stimulation. The case was not tried in court, however. Justin received therapy

after the incident took place. Information with regard to the therapeutic model followed could, however, not be obtained.

Assessment Pre-therapy: Aggressive behaviour was reported as clinically significant by his parents. Justin furthermore reportedly engaged in inappropriate sexual touching. No clinically significant problem behaviour was reported by his teacher.

Therapeutic Process:

Session 1: It was apparent that rapport and trust would not easily be established. Although very energetic, Justin was extremely uncomfortable with physical touch and was reluctant to particpate in most of the suggested Developmental Touch activities. This was pervasive throughout much of the initial stages of therapy. Although he allowed the therapist to touch body parts other than his face, Justin refused to engage in any activity involving his touching the therapist. He would consciously avoid touching by incorporating objects, for example using a towel to make a pancake (in a game like the gingerbread game, where body parts are supposed to be used). Justin did however respond very well to the slippery hand game, which was incorporated as part of the handwashing activity. He did not respond well to limit-setting. He constantly challenged the limits, for instance by playing outside the designated play area of the blanket or threatening to throw out the water used during the hand-washing game. Features unique or special to Justin, for example a small nose with only a few freckles, were constantly verbally affirmed in an attempt to accentuate his uniqueness and establish differentiation from the therapist. This was continued throughout the therapeutic process. Therapy oscilated between the *Honeymoon* and *Painful* stages for most of the first four sessions.

Session 2: The facilitation of a dynamic, active and creative intervention was necessary. Justin once again refused to participate in Developmental Touch activities. He was however willing to draw. A game of touching was initiated in

that Justin was asked to physically touch the therapist and thereby identify the body part he had drawn. The therapist proceeded to do the same with Justin. Although he washed the therapist's hands, Justin did not allow his own hands to be washed. When the gingerbreadman game was played, Justin allowed the therapist to "bake him". He seemed quite comfortable with this touching. The hide-and-seek game led to chasing. Justin proceeded to fall onto the therapist. Close facial proximity was established. Justin did however break this close contact rapidly.

Session 3: Justin introduced an imaginative game, which was played throughout the remainder of therapy. He imagined himself to be a superhero with special powers and a special home in which only he could live. The therapist "died" when attempting to come near him. The therapist kept her physical distance while maintaining a constant verbal seeking of the child and confirmation of how much she enjoyed playing with him and missed him. Justin once again challenged the limits set. He continued with this behaviour for two sessions, during which he also sometimes acted aggressively and threw objects. He was constantly reminded of the limits set at the onset of therapy. Although Justin expressed his emotions freely from the onset of therapy, it appeared that he had now entered the *Painful stage* with regard to discovering the relationship and the limits of play.

Session 4: Justin requested to wash the therapist's hands, which he did with great gentleness and care. Justin made reference to something sexual for the first time. He requested the therapist to "greet" his genital area during the *Hello* activity. His request was reflected. He merely laughed and subsequently avoided the subject. This request was also made during the following two sessions, but subsided spontaneously thereafter.

Session 5 and 6: Justin's imagination was once again utilised to adapt some of the traditional Developmental Touch games, for example "chasing", "cradling",

"saving", "feeding" and "hide-and-seek". Close physical touching was comfortably incorporated and was also requested in this regard, with Justin also spontaneously touching the therapist. An oscillation between seeking nurturance and rejection was however still present.

Session 7: It was possible for the therapist to incorporate some form of touching despite Justin's resistance. For example, when he insisted on drawing a road instead of participating in Developmental Touch activities, Justin's body was used as a bridge with which to connect the roads. Justin's emotional expression shifted from predominantly negative, to more positive emotions. He was more comfortable with facial touching. Preparation for the *Termination stage* was started and continued throughout the following three sessions.

Session 8: Justin had entered the *Separation versus Love* stage and reminded the therapist of his unique features. The awareness that the therapist was an individual separate from himself had developed. Justin still used his superhero home to maintain a physical distance between himself and the therapist. The therapist had, however, now also received "special powers" and could sometimes enter his home. Justin would constantly save her from the villains. They now fought together and the imaginary characters changed from more aggressive individuals engaging in violent behaviour to strong, powerful and invincible but gentle characters depicting the traditional "superhero". Justin was visibly more gentle and caring toward the therapist and assumed a protective and nurturing role.

Session 9: Justin was very comfortable with close physical touch and actively initiated it. He lay on the therapist after the rowing game and pretended to be watching the stars from his boat. He remained in this position for quite some time. The imaginary "superhero" game was played for the remainder of the session.

Session 10: Although prepared well in advance, Justin displayed some anxiety at termination. His achievements and growth were acknowledged and the focus was on empowerment. Regret was expressed by the therapist with regard to the ending of the therapeutic relationship. Justin selected the hide-and-seek game as his favourite game. This was thus played during the final session.

Assessment Post-therapy: Justin showed an improvement in all psychometrically- and clinically-assessed areas. Aggressive behaviour was below the level of clinical significance. An improvement in the mother-child relationship, with increased gentleness, lovingness and care shown by the child was reported. Sexual behaviour and inappropriate sexual touching had also subsided.

Case 2

Background Information: Tamsin* is a seven-year old girl. She was removed from her mother's care and placed in a foster home. Despite this, Tamsin showed positive interaction with her mother, brother and her mother's boyfriend.

Referral Reason: Tamsin was referred for therapy after exposure to pornographic material and sexual stimulation by her mother's partner one year earlier. The case had not been tried in court. A forensic-psychological assessment was performed, but Tamsin had not yet received therapy.

Assessment Pre-therapy: Tamsin was preoccupied with babies, pregnancy and motherhood. She masturbated excessively and sometimes acted in a sexual way toward other children. Social problems, attention problems, delinquent behaviour, aggressive behaviour and sexual problems were furthermore reported as problematic and clinically significant by her caregiver. No clinically significant problem behaviours were reported by her teacher.

Therapeutic Process:

Session 1: Although wary at first, Tamsin participated in the Developmental Touch activities enthusiastically. The therapeutic relationship was established within a short time period, and Tamsin expressed her enjoyment of therapy. This continued throughout the therapeutic process. Despite frequently initiating contact, facial touching made Tamsin extremely uncomfortable. She had a problem with eyesight and had to wear glasses. She was very self-conscious in this regard. Her wearing of glasses was subsequently identified by the therapist as unique to the child. The gingerbreadman game was played for most of this session. When asked by the therapist which parts of the gingerbreadman she was permitted to eat, Tamsin explicitly indicated the genital areas as off limits. Tamsin oscilated between the *Honeymoon* and *Painful* stages for much of the first six sessions and requested to play the same games throughout the therapeutic process. She was very much attached to structure in this regard. This could be attributed to the security this provided in contrast to the instability in her own life.

Session 2: In contrast to her gentleness during the first session, Tamsin became somewhat aggressive and took part in activities with considerable force, which was indicative of her entering the *Painful* stage. In contrast to the previous session, Tamsin indicated the genital area when asked by the therapist which part of the cookie she was permitted to eat during the gingerbreadman game. It appeared that she was subtly testing the therapeutic relationship by engaging in behaviours that might normally evoke adult disapproval.

Session 3: Tamsin had returned from a visit to her mother and was very resistant and reluctant to participate in activities. This, however, subsided rapidly. After this session Tamsin was very tearful and upset. She requested to be able

to live with the therapist permanently. Her longing to be with her mother was subjectively reported and objectively observed.

Session 4: Despite Tamsin's need to be nurtured she preferred to nurture. This was to be expected when considering her previously mentioned preoccupation with pregnancy, motherhood and babies. Tamsin freely suggested activities, but was quite satisfied to respect and accept boundaries. She welcomed the physical touching faciliated by the hand-washing and rowing activities and even facilitated additional touching by falling on the therapist. This was to be expected, however, considering the fact that she found the seperation from her mother very distressing and consequently welcomed nurturing.

Session 5: Tamsin's discomfort with facial touching had subsided significantly. She initiated close facial proximity and touching. Tamsin playfully placed light kisses on the therapist's face. She described her glasses as a unique and special feature rather than something to be ashamed of. She initiated cradling during this session.

Session 6: Imagination was introduced by Tamsin in some of the Developmental Touch activities She pretended that her hands were small birds and dogs during the hand-washing activity. Elements of fragility, shyness, fear, and physical discomfort were present at the beginning of this game. She nurtured and fed these creatures until they felt no fear and were physically comfortable.

Session 7: The therapeutic process became more energetic. Games like "hide-and-seek" and "magic button" were incorporated, and Tamsin responded enthusiastically. She frequently and verbally distinguished between herself and the therapist with regard to physical features. She was thus spontaneously entering the *Seperation versus Love* stage. Preparation for the *Termination* stage was started and continued throughout the remainder of sessions.

Session 8: At this stage of the therapeutic process information was received regarding Tamsin's excessive masturbation and sexual behaviour exhibited toward other children. It was therefore decided to focus on the naming of some of her body parts. When enquiring about specific touches pertaining to certain body parts, Tamsin was visibly uncomfortable and reluctant to provide information. She drew individuals kissing and referred to them lying on top of each other, getting married and having babies. Details in this regard were not given, however.

Session 9: Tamsin engaged in very gentle touching of the therapist during the hand-washing game and cradling, of which this session consited. She verbally expressed positive emotions toward the therapist.

Session 10: Upon termination of therapy it was apparent that attachment to an adult figure had been established. Tamsin responded well to termination and did not display any distress or anxiety. Her achievements and growth were acknowledged and the focus was on empowerment. Regret was expressed by the therapist with regard to the ending of the therapeutic relationship. Tamsin selected the rowing game as her favourite game. This was thus played during the final session.

Assessment Post-therapy: All problem areas initially reported as problematic by her caregiver were reported to have decreased to a level below clinical significance. Although sexual touching had decreased, it was still present.
Although not indicated as clinically significant pre-therapy, Tamsin's teacher reported an increase in delinquent- and aggressive behaviour to a clinically significant level post-therapy. This might be attributed to the fact that she had only known Tamsin for a short while when the initial evaluation (pre-test) was carried out and could therefore not provide a true reflection of the child's behaviour.

Case 3

Background Information: Denise* is an eight-year old girl. She was removed from the care of her biological mother at the age of two due to neglect. She had been living with her foster parents ever since. The living circumstances in this regard were not ideal and were characterised by instability caused mainly by the stress created by other children in the house. Denise moved into her school's residence during the course of therapy. She still had frequent contact and visits with her biological and her foster parents.

Referral Reason: Denise was referred for therapy after being exposed to sexual stimulation, which included masturbation and penetration, by an older sibling one year earlier, at the home of her biological mother. A forensic assessment was conducted, but the case was not tried in court. She had attended sessions with a social worker in which she was given the opportunity to ventilate. No further therapeutic intervention was conducted, however.

Assessment Pre-therapy: Anxiety and depression were psychometrically reported as clinically significant problems by her caregiver. She was reportedly experiencing scholastic problems and found it challenging to complete her tasks. She furthermore attempted to engage in inappropriate touching behaviour with other children and adult males. Excessive masturbation was also problematic.

Therapeutic Process:

Session 1: Upon first meeting Denise she was a spontaneous and a seemingly happy little girl who chatted constantly. She was very relaxed and comfortable with physical touch and remained in the *Honeymoon* stage for much of the first five sessions. She responded to limit-setting well and even contributed in this

regard. Limitations were accepted without any objections. It became apparent that Denise had become accustomed to behaving in ways that would gain adult approval. During most of the first session Denise washed and put cream on the therapist's hands. In accordance with the adult-role she so often assumed, Denise preferred to do the nurturing. She was extremely gentle and caring in this regard. Denise was extremely neat and reorganised the objects utilised in therapy and packed them away neatly after the session. She paid great attention to detail when a game, for instance the gingerbreadman game, was played. She focused on naming and touching body parts correctly and in detail. These behaviours were also present during the second session.

Session 2: Denise once again spent much of the session completing the hand-washing activity. Her interaction with the therapist was much as it had been during the first session. Hygiene and cleanliness were again very important to Denise. She constantly removed loose threads from her clothing. Denise reported that she had fought with one of her friends at school. She spoke about this incident for much of the session, but was not able to express her feelings in this regard. Her dialogue remained factual.

Session 3: Denise had returned from a visit with her biological father. She seemed to enjoy her interaction with him and spent much of the session talking fondly about him and her brothers, while washing the therapist's hands. The rowing game was played and Denise was very comfortable with the close physical proximity facilitated by this game. Denise slowly moved out of the adult role and became more playful She constantly tickled the therapist, which led to cradling. She pretended to be a baby and requested a bottle. She was then covered with a blanket, fed with an imaginary bottle and gently rocked. She reported that she would love to be a baby, since she would have no responsibilities and would never be punished. She was comfortable with this closeness for a short period, but then quickly distanced herself from the therapist. Denise's constant attempts to tidy the therapy room were no longer present and

she was much more relaxed. She imagined that her clothing was merely hungry, which was why it constantly “ate” the carpet in the therapy room.

Session 4: Denise was very relaxed within the therapeutic relationship. The hand-washing activity was once again played. Denise talked about the neglect she had suffered when being cared for by her biological mother. The sibling who had sexually molested her seemed to be central in caring for her during this time. Her reluctance to connect him to something negative, like the abuse, is thus understandable. She deliberately avoided the subject of sexual abuse.

Session 5: The hand-washing activity was played. Denise spoke about a friend at school who had told her that she disliked her intensely. Although she constantly shared the facts of the incident, she could not verbalise her feelings. The rowing game once again led to tickling and subsequent cradling. Denise expressed the wish that the therapist were her sister.

Session 6: Although not having entered the *Painful* stage as yet, Denise entered the *Seperation versus Love* stage. She constantly referred to differences between herself and the therapist. She especially focused on attributes of the therapist that she found special. The I//Thou distinction was thus made.

Session 7: Denise became more comfortable with receiving nurturing as opposed to giving it. She allowed the therapist to wash her hands, feed her during the gingerbreadman game, and even save and care for her during hide-and-seek and chasing games. Preparation for the *Termination stage* was started and continued throughout the remaining sessions. This led to Denise requesting longer and more frequent sessions.

Session 8: It appeared that Denise had entered the *Painful* stage for a short period of time. She became overtly aggressive and resistant during play and refused to cooperate in most activities. Her return to the *Seperation versus Love*

stage was however rapid. She proceeded to put cream on the therapist's hands and to write messages, which consisted of her expression of positive feelings toward the therapist.

Session 9: Denise made more attempts than usual to initiate close contact with the therapist. She would constantly get onto the therapist's lap and hug her. There had again been an incident at school and she verbalised the hurt she experienced in this regard.

Session 10: Denise responded well to termination and did not seem distraught. She did, however, report that she experienced sadness with the ending of the therapeutic relationship. Her achievements and growth were acknowledged and the focus was on empowerment. Regret was expressed by the therapist with regard to the ending of the therapeutic relationship. Denise selected the gingerbreadman game as her favourite game. This was thus played during the final session.

Assessment Post-therapy: Denise's anxiety and depression as reported by her caregiver had subsided and were below the clinically significant level. She was also more able to establish and maintain friendships with her peer group. Although inappropriate sexual touching had decreased, masturbation was still present.

Case 4

Background Information: Joan* is an eight-year old girl. Her parents are divorced. Although the socio-economic status of her family was low, Joan was being well cared for by her biological mother and stepfather. Joan was not allowed contact with her biological father at the time of therapy.

Referral Reason: Joan had been sexually abused by the older boys of her biological father's girlfriend on two separate occasions, one of which had taken

place three years and the other seven months before the onset of therapy. The sexual contact consisted of oral-genital contact as well as penetration. Although there was medical evidence supporting the fact that abuse had taken place, it had not been judicially proven. Joan had received play therapy for a period of two years from an occupational therapist.

Assessment Pre-therapy: Joan was reported to be extremely withdrawn, anxious and depressed. She furthermore experienced social as well as thought problems. These problems were reported in the school setting and seemed to be absent when she was at home. She was reportedly preoccupied with boys, relationships and kissing in the latter setting.

Therapeutic Process:

Session 1: Joan was extremely uncertain and hesitant at the onset of therapy. She separated from her mother readily, but it was clear that she did not trust easily. She was extremely uncomfortable with physical touch and she felt more comfortable with drawing. Her drawings reflected her preoccupation with having a husband or boyfriend and participating in activities like kissing. Although she seemed to understand the reason, she expressed her sadness about not being allowed to see her biological father. Joan would constantly belittle herself and her drawing abilities. It thus appeared that Joan was expressing her positive and negative emotions freely, as is characteristic of the *Painful* stage. This emotional expression was pervasive throughout therapy. Features unique or special to Joan, for example her skin colour and long hair, were constantly verbally affirmed in an attempt to accentuate her uniqueness and to establish differentiation from the therapist.

Session 2: Joan entered the *Honeymoon* stage during the second session. Although she was sometimes still fearful and inhibited, she was slowly but surely starting to trust. She doubted her ability to participate in the Hello game, but became more comfortable when the therapist led the touching. Hide-and-seek

was played, to which Joan responded with limited energy. Her unique ability to find the therapist within a short period of time was continuously validated. Joan responded very well to the gingerbreadman game. She seemed to feel more comfortable with activities which incorporated touch but still allowed her to avoid eye contact. She allowed cradling, but avoided making eye contact with the therapist. Joan revealed the sexual acts to which she had been exposed. She appeared to have insight with regard to the inappropriateness of the acts performed. Joan's trust in people had been severely damaged and she reported being afraid of most people.

Session 3: Joan was still very uncertain and inhibited. She allowed the therapist to greet her during the Hello activity, but did not feel comfortable with greeting the therapist. It did, however, seem that her reluctance could be attributed to her inability to remember the order followed in certain activities, for instance the hello activity, rather than her not wanting to be touched. The therapeutic activities were adjusted to focus more on body movement and subsequent touching. This led to a significant shift in the therapeutic relationship and Joan was more comfortable with being touched. While playing games like "leapfrog", "circus acrobatics", "Simon says" and "sculpting", the therapist would constantly comment on Joan's abilities in this regard. This seemed to empower her tremendously. Joan requested cradling during the "Bye" activity and established eye contact spontaneously.

Session 4: Although she preferred washing the therapist's hands, Joan was comfortable with her hands being washed. The gingerbreadman game was combined with the drawing of Joan's outline on a large sheet of paper. She was requested to fill in the detail. Joan continuously criticised herself with regard to her physical appearance and drawing abilities. She reported that she enjoyed her time spent with the therapist tremendously. Joan requested to play hide-and-seek. This seemed to be an activity in which she trusted her abilities.

Session 5: Joan constantly expressed her admiration and affection toward the therapist. She would, however, belittle herself with regard to her clothes and appearance. A race was initiated by rolling across the carpet. Joan always won this activity. She reported that this made her extremely proud.

Session 6: Joan had entered the *Separation versus Love* stage. In contrast to her extreme negative attitude toward herself and her appearance and abilities at the onset of therapy, she now identified many of her unique and positive features and characteristics, which were constantly affirmed by the therapist. Joan's abilities in the hide-and-seek game were something that she was especially proud of. She initiate this activity throughout the whole session. Although the therapist led the therapeutic process, Joan was allowed to suggest activities, since it was an area in which growth was needed.

Session 7: Joan requested to wash the therapist's hands. She allowed the therapist to wash her hands and requested to continue with this activity many times. She spontaneously initiated the slippery-hand game when putting cream on the therapist's hands. Joan initiated hide-and-seek and reflected on her above average abilities in this regard. She oscillated between praising and criticising herself. Verbal affirmation from the therapist was constantly sought. Preparation for the *Termination* stage was started and continued throughout the remaining sessions.

Session 8: Joan's self-talk was increasingly positive. She was more positive toward herself and she increasingly allowed eye-contact and closer facial proximity during the rowing game and cradling.

Session 9: Joan was visibly more relaxed and reported characteristics that she had previously considered as making her an outcast, now as attributes that established her uniqueness. She once again initiated hide-and-seek, which was played for the remainder of the session.

Session 10: Joan responded well to termination, although expressing her reluctance to end the therapeutic process. Her achievements and growth was acknowledged and the focus was on empowerment. Regret was expressed by the therapist with regard to the ending of the therapeutic relationship. Joan selected the hide-and-seek game as her favourite game. This was thus played during the final session.

Assessment Post-therapy: Joan showed an improvement in all psychometrically- and clinically-assessed areas. Her scores on the Withdrawn scale, as well as her social problems and thought problems were below the level of clinical significance after therapy. Although her anxiety and depression scores had decreased, these problems were still clinically significant. Her preoccupation with boys was still present after the termination of therapy.

DISCUSSION

This study was prompted by the limited amount of research available on the re-establishment of attachment bonds eroded by CSA. According to Mattei (2004) attachment offers a perspective by which individual therapy can be used to formulate treatment strategies and techniques for CSA victims. The current research therefore aimed to investigate the efficacy of DTT, which is based on the theory of attachment, as a treatment modality with victims of CSA.

The current research found that most participants had a tremendous longing to be touched in a caring way and were comfortable with physical touch. This concurs with Brody's (1993) contention in this regard. Only one participant (Case 1) did not initially welcome this. Since he was the only particpant who lived in a stable family environment and received adequate attention, his need for physical touch might have been less pronounced than that of the other participants. He might thus initially have experienced it as excessive and intrusive.

When considering the outcomes established by Mash and Wolfe (2002) for interventions with sexually abused children, DTT did not reach them all. When considering the outcome that treatment should help children understand that what had happened to them was abuse, that it was wrong, and that it might have caused them temporary problems, DTT did not enable all participants to understand the dynamics or the wrongfulness of the abuse, or the impact thereof on them.

Although certain symptoms of trauma and maladaptive coping strategies were appropriately treated with touch, it cannot be said that all symptoms were addressed. When considering the quantitative data analysis, no significant change in problem behaviours after the therapeutic intervention was present. However, this could be attributed to the small sample size. The qualititative results indicated that problem behaviours reported by caregivers and teachers, such as aggressive behaviour, social problems, withdrawal, attention problems, delinquent behaviour, anxiety and depression had decreased to a level below clinical significance post-therapy. Although the anxiety and depression reported in Case 4 had decreased, it was still clinically significant post-therapy. In addition, although sexual problems had decreased, they were still present in all subjects, excluding Case 1.

As found by Myrow (1997), the current research indicated that DTT increased the participants' abilities to modulate certain affective responses, for instance aggression, withdrawal, depression and anxiety. In support of the research conducted by Mitchum (1987), it appears that there was an increase in cooperation and decrease in problem behaviours in the home settings. The problems that had remained unchanged or increased in two of the cases, were reported to occur in the school setting. However, as stated elsewhere, rater bias could have skewed the results.

Cognitive restructuring was incorporated in that negative aspects were reframed as unique attributes. The cognitive restructuring was, however, not directly related to sexual abuse-related cognitive distortions or the teaching of skills.

An attachment bond was established with all participants, which should thus, according to Earl-Taylor and Thomas (2000), equip them to handle future relationships and establish the abilities to be comfortable with intimacy, trust, touch, and bonding. Participants were therefore equipped to establish supportive relationships, such as enhanced parent-child and peer interactions.

The findings of the current research support Burt and Myrick (1980), Myrow (1997) and Oaklander (1988) in that they also found that children who experience rich sensory experiences, nurturing physical affection and caring touch will develop a core sense of self. This was reflected in the participants' entering of the *Honeymoon stage*, in which the goal is the development of positive emotional attachment between adult and child, the *Painful stage*, in which the goal is to express positive and negative feelings freely, as well as the *Separation versus Love stage*, in which the child develops an individual identity, separate from that of the adult therapist. The current research furthermore found that self-worth and the mastery of the environment were enhanced.

In conclusion, it appears that DTT does re-establish attachment bonds which have been severed by CSA. It furthermore enhances the development of a sense of self, trust, and safety. An increase in self-esteem and interpersonal functioning could be seen in all participants. Although most of the clinically significant behavioural and emotional problems reported before therapy were below the clinically significant level after therapy for individual participants, anxiety and depression were not entirely relieved. DTT does not directly address children's cognitions with regard to CSA. Future skills outside of an enhanced self-esteem and interpersonal functioning are not taught. Sexual behaviours are not addressed. Although effectively addressing many symptoms of CSA, DTT cannot be seen as a holistic treatment approach in this regard. It can however be valuable as part of an integrative therapeutic treatment of victims of CSA.

LIMITATIONS AND RECOMMENDATIONS

The small number of cases used, the exclusion of a control group and the inability to control for confounding and extraneous variables, make the reliability and generability of the findings in the current study less conclusive. The limited amount of research available on DTT furthermore made the establishment of construct and internal validity difficult. The use of a within-subject design did, however, promote the establishment of external validity. The intense exposure of the researcher to the study of the cases, as well as the subjective involvement of individuals who completed the questionnaires, may have biased the findings.

This study can be regarded as exploratory research in the use of DTT in CSA treatment. It contributes to the scant body of research on the treatment of CSA. The qualitative nature of the research provides a window into the uniqueness of each child.

REFERENCES

Achenbach, T.M. (1991a). *Manual for the Child Behavior Checklist/4-18.* Burlington, VT: University of Vermont, Department of Psychiatry.

Achenbach, T.M. (1991b). *Manual for the Teacher's Report Form.* Burlington, VT: University of Vermont, Department of Psychiatry.

Adler, J. (2002). *Offerings from the conscious body: the discipline of authentic movement.* Rochester, VT: Inner traditions.

Barnett, D., Ganiban, J., & Cicchetti, D. (1999). Maltreatment, negative expressivity, and the development of Type D attachments from 12 to 24 months of age. *Monographs of the Society for Research in Child development, 64,* 97-118.

Berliner, L. (1997). Trauma-specific therapy for sexually abused children. In D.A. Wolfe, R.J. McMahon, & R. Peters (Eds.), *Child abuse: new directions in prevention and treatment across the lifespan* (pp. 147-176). Thousand Oaks, CA: Sage Publications.

Brazelton, T. B. (1990). Saving the bathwater. *Child Development, 61*, 1661-1671.

Brody, V. (1993). *The dialogue of touch: Developmental Play Therapy.* Florida: Developmental Play Training Associates.

Buber, M. (1958). *For the Sake of Heaven.* New York: Meridian Books.

Burt, M., & Myrick, R.D. (1980). Developmental play: What is it all about? *Elementary School Guidance and Counselling, 15*, 14-21.

Chop, S.M. (2003). Relationship therapy with child victims of sexual abuse placed in residential care. *Child and Adolescent Social Work Journal, 20*, 297-301.

Cicchetti, D., & Lynch, M. (1995). Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental psychopathology: vol. 2. risk, disorder, and adaptation (*pp. 32-71). New York: Wiley.

Cohen, J.A., & Mannarino, A.P. (1996). A treatment outcome study for sexually abused preschool children: initial findings. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 42-50.

Cohen, J.A. & Mannarino, A.P. (1997). A treatment outcome study for sexually abused preschool children: outcome during one-year followup. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 1228-1235.

DeLauriers, A.M. (1962). *The experience of reality in childhood schizophrenia.* CT: International University Press.

Earl-Taylor, M. & Thomas, L. (2000). The long term neurological and developmental effects of sexual abuse on infant children. *Science in Africa, March 2003.* Retrieved 10 January 2005 from http://www.scienceinafrica.co.za/2003/ march/abuse.htm.

Erickson, M.F., Egeland, B., & Pianta, R. (1989). The effects of maltreatment on the development of young children. In D. Cicchetti & V. Carlson (Eds.), *Child maltreatment: theory and research on the causes and consequences of child abuse and neglect* (pp. 647-684). New York: Cambridge University press.

Fergusson, D.M., Lynskey, M.T., & Horwood, L,J. (1996a). Childhood sexual abuse and psychiatric disorders in young adulthood: Part I: The prevalence of sexual abuse and the factors associated with abuse.*Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1355-1365.

Field, T. (2003). *Touch.* Miami: MIT press.

Freud, A. (1982). *Introduction to the technique of child analysis.* New York: Nervous and Mental disease publishing.

Freyd, J.J., Putnam, F.W., Lyon, T.D., Becker-Blease, K.A., Cheit, R.E., Siegel, N.B., & Pezdek, K. (2005) Response. *Science*, *309*, 1183-1185.

Henning, E., Van Rensburg, W., & Smit, B. (2004). *Finding your way in qualitative research.* Pretoria: Van Schaik.

Huysamen, GK. (2001). *Methodology for the social and behavioural sciences.* Cape Town: Oxford.

Jernberg, A. (1979). *Theraplay.* San Fransisco: Jossey-Bass.

Kendall-Tacket, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: a review and synthesis of recent empirical studies. *Psychological Bulletin, 113*, 164-180.

Killian, B., & Brakarsh, J. (2004). Therapeutic approaches to sexually abused children. In L. Richter, A. Dawes, & C. Higson-Smith (Eds.), *Sexual abuse of young children in Southern Africa.* Cape Town, South Africa: HSRC Press.

Lachman, P. (1996). Child protection in Africa: the road ahead. *Child abuse and Neglect, 20*, 67-77.

Lennert, L.C. (2001). The effects of attachment disruptions on cognitive ability and academic success in adolescents. *Dissertation Abstracts International: Section B: The Sciences & Engineering*, *61*, 5597.

Lewis, M. (1992). *Shame: the exposed self.* New York: Free Press.

Louw, A.E. (2000). Die identifisering van seksuele molestering by kinders: 'n kruiskulturele studie. Ongepubliseerde Ph.D. proefskrif, Universiteit van die Vrystaat.

Mash, E.J., & Wolfe, D.A. (2002). *Abnormal child psychology.* Belmont: Wadsworth.

Mattei, S.B. (2004). Attachment theory as a model for developing new therapeutic strategies and interventions in the individual treatment of sexual abuse in children. *Dissertation Abstracts International, 64,* 5525.

Mitchum, N.T. (1987). Developmental Play Therapy: A treatment approach for child victims of sexual molestation. *Journal of Counseling and Development, 65*, 320-321.

Mullen, P. & Flemming, J. (1998). Long-term effects of child sexual abuse. Child abuse prevention, Issue paper No. 9. *Australian Institute of Family Studies*. National Clearing House Publications: Melbourne. Retrieved 4 November 2005 from http://www.aifs.gov.au/institute/afrc9/higgins.rtf.

Myrow, D.L. (1997). In touch with theraplay. *The Theraplay Institute Newsletter*, No. 9. Retrieved 27 July 2004 from http://www.theraplay.org/articles/article19.htm.

Oaklander, V. (1988). *Windows to our children.* Highland, NY: The Gestalt Journal Press.

Pistole, C. (1989). Attachment: Implications for counsellors. *Journal of Counselling and Development, 68,* 190-193.

Sadock, B.J., & Sadock, V.A. (2003). *Kaplan and Sadock's Synopsis of psychiatry* (ninth edition). Philadelphia: Lippinicott Williams & Wilkins.

SPSS inc. (1990). *SPSS® Reference Guide [SPSS for Unix].* Chicago: SPSS inc.

Tellis, W. (1997). Introduction to case study research. *The Qualitative Report, 3.* Retrieved 10 October 2005 from http://www.nova.edu/sss/QR/QR3-2tellis1.html.

Trickett, P.K., McBride-Chang, C., & Putnam, F.W. (1994). The classroom performance and behaviour of sexually abused females. *Development and Psychopathology, 6,* 183-194.

Waterman, J., & Lusk, R. (1993). Psychological testing in evaluation of child sexual abuse. *Child Abuse and Neglect, 17,* 145-159.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: a twenty-year longitudinal study. *Child Development, 71*, 684-689.

Williams, L.M. (1994). Recall of childhood trauma: A prospective study of women's memories of childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 62*, 1167-1176.

Yin, R. K. (2003). *Case study research, design and methods*. Thousand Oaks, CA: Sage Publications.

SUMMARY

There is a limited amount of research available on the re-establishment of attachment bonds eroded by Child Sexual Abuse (CSA). One way of re-establishing these bonds could be through Developmental Touch Therapy (DTT). The aim of this study was to investigate the effectiveness of DTT with children who have been sexually abused. A multiple case-study design was used. Three girls and one boy, between the ages of five and eight years, participated in the study. DTT was implemented by means of 10 weekly individual therapy sessions. A qualitative description of the therapeutic intervention as experienced by the therapist was made. Process notes and video recordings of sessions facilitated the external supervision and evaluation of the process. Pre- as well as post-tests were administered by making use of the *Child Behavior Checklist (CBCL)/4-18* (parent report form) (Achenbach, 1991a) and *the Child Behaviour Checklist (CBCL)/5-18* (teacher report form) (Achenbach, 1991b). The different subscales were totalled, and the results were tested by computing nonparametric Wilcoxon T-tests for the subscales and the scale totals. No significant results were found from the pre- or post-tests. This might be attributable to the small sample size. The qualititative results indicated that the problem behaviours reported as clinically significant pre-therapy by caregivers and teachers had decreased to a level below clinical significance post-therapy for most participants. Although sexual problems had decreased they were still present in most subjects. DTT does re-establish attachment bonds which have been severed by CSA. It furthermore enhances the development of a sense of self, trust, and safety. An increase in self-esteem and interpersonal functioning could be seen in all participants. However, DTT does not directly address children's cognitions with regard to CSA. Skills regarding problematic sexual behaviours

are not addressed. Although affectively addressing many symptoms of CSA, DTT cannot be seen as a holistic treatment approach in this regard. It could however be valuable as part of an integrative therapeutic treatment of victims of CSA.
Keywords: Developmental Touch Therapy; Child sexual abuse; Attachment; Child Behaviour Checklist; Case Study; Interventions; Treatment; Touch; Attachment bonds; Problem behaviours

OPSOMMING

Navorsing ten opsigte van die herstel van gehegtheidsbande, verbreek deur die seksuele mishandeling van kinders, is beperk. Ontwikkelingsaanrakingsterapie word voorgestel as ‘n metode om hierdie bande te herstel. Die doel van hierdie studie was om die effektiwiteit van Ontwikkelingsaanrakingsterapie met seksueel-mishandelde kinders te ondersoek. ‘n Veelvuldige gevallestudie-ontwerp is gebruik. Drie meisies en een seun, tussen die ouderdomme van vyf en agt jaar het aan die studie deelgeneem. Ontwikkelingsaanrakingsterapie is deur 10-weeklikse individuele terapiesessies geïmplementeer. ‘n Kwalitatiewe beskrywing van die terapeutiese intervensie, soos beleef deur die terapeut, is gemaak. Prosesnotas en video-opnames is gebruik om die eksterne supervisie en evaluering van die proses te fasiliteer. Voor- en natoetsings is geadministreer deur gebruik te maak van die *Gedragskontrole merklys/4-18* (ouer-verslagvorm) (Achenbach, 1991a) en die *Gedragskontrole merklys/5-18* (onderwyserverslagvorm) (Achenbach, 1991b). Die verskillende subskale is bymekaargetel en die resultate is getoets deur gebruik te maak van ‘n nie-parametriese Wilcoxon-T toets vir die subskale en die skaaltotale. Geen beduidende resultate is gevind in die voor- of natoetsing nie. Dit kan moontlik toegeskryf word aan die klein steekproef. Die kwalitatiewe resultate dui aan dat die probleemgedrag voor terapie, soos deur sowel die versorgers en onderwysers gerapporteer, in die meeste gevalle tot onder die vlak van kliniese beduidendheid gedaal het na terapie. Alhoewel seksuele probleme verminder het, was dit steeds na terapie in meeste gevalle teenwoordig. Dit was ook duidelik dat Ontwikkelingsaanrakingsterapie gehegtheidsbande wat deur die seksuele mishandeling van kinders verbreek is, herstel. Dit bevorder verder die ontwikkeling van ‘n kind se selfpersepsie, vertroue en gevoel van veiligheid. Verhoogde selfbeeld en interpersoonlike funksionering is verder gerapporteer. Ontwikkelingsaanrakingsterapie spreek egter nie direk kognisies met betrekking tot seksuele mishandeling aan nie. Vaardighede ten opsigte van die hantering van problematiese seksuele gedrag word ook nie aangespreek nie. Alhoewel

Ontwikkelingsaanrakingsterapie talle simptome van kinders wat seksueel mishandel is aangespreek het kan dit nie as ‘n holistiese behandeling in hierdie verband voorgehou word nie. Dit kan egter waardevol wees as deel van ‘n geïntegreerde terapeutiese behandeling vir die slagoffers van seksuele mishandeling.