Victimization and Mental Health Problems of Children and Adolescents in Gondar Town, North Western Ethiopia

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

By

Mulat Asnake

April, 2015

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Mulat Asnake

Victimization and Mental Health Problems of Children and Adolescents in Gondar Town, North Western Ethiopia

This Dissertation is Submitted to the School of Psychology, Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in Applied Developmental Psychology

Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Mulat Asnake

Victimization and Mental Health Problems of Children and Adolescents in Gondar Town, North Western Ethiopia

Approval of the Board of Examiners

1. **Supervisor**

Name: ____________________________Signature: ____________Date:_____________

2. **Internal Examiner**

Name: ____________________________Signature: ____________Date:_____________

3. **External Examiner**

Name: ____________________________Signature: ______________Date:_____________

Abstract

Victimization and mental health problems of children and adolescents are major concerns of almost all societies worldwide. Previous studies have documented the magnitudes of the problems of victimizations and mental health problems in children and adolescents. However, in most cases those studies focused on few types of victimization and mental health problems. Accordingly, the major purpose of this study was to estimate prevalence of victimizations and mental health problems, identify factors that contribute to victimizations, and examine the association between victimization and mental health problems of children and adolescents in the elementary schools of Gondar town, North West Ethiopia. Analysis was made on a sample of 403 children and adolescents, randomly drawn from the target population using stratified sampling technique. Adapted measures of Juvenile Victimization Questionnaire (JVQ) and Achenbach Systems of Empirically Based Assessment (ASEBA) were employed to gather data on victimization experiences and mental health problems respectively. Percentage was used to determine the prevalence of victimizations and mental health problems whereas series of logistic regression analyses were run to examine the contributions of independent victimizations for the various dimensions of mental health problems of the respondents. The major findings indicate that nearly 80 % of the respondents experienced victimizations. The odds of males experiencing victimization was found to be 2.41(95% CI=1.41-4.12) times more than females and the probability of the occurrence of any form of victimization was higher for those who came from low income families by 3.23 (95% CI =1.06-9.80) times than respondents from high income families. The proportion of overall mental health problems among the respondents was 14.4%. Child maltreatment was found to be significantly contributing to manifestations of the symptoms of overall mental health and internalizing problems with odds ratios of 2.6 (95% CI=1.16-4.39) and 2.52 (95% CI=1.42-4.49) respectively. Conventional crime was significantly linked with internalizing problems with OR=.2.95 (95% CI=1.37-6.34). Furthermore, poly-victimizations were significantly associated with any mental health, $X^2(1,N=403)=17.02, p<.001$*;internalizing,* $\chi^2(1,N=403)=17.46,p<.001$*; and externalizing problems,* $\chi^2(1,N=403)=11.36, p<.05$*.The study concludes that exposures to victimizations put children and adolescents at the risks of developing mental and behavioral health problems. Finally, psycho-legal service implications and issues that require further inquiry are identified.*

Acknowledgments

I would like to thank all of those who supported me while I was conducting this study. I am very much grateful to Dr. Teka Zewdie, my PhD supervisor and mentor for his thoughtful and critical comments as well as generous professional guidance and support he provided me throughout the process of this work. His contribution to this study was really immense. My special thanks also go to Dr. Belay Tefera for the tremendous encouragement he gave me along the way. In addition, I would like to extend my sincere thanks to all staff in the School of Psychology, Addis Ababa University, for the moral and professional assistance they provided me. I am indebted to Abera Tibebu and Abebe Fekadu for their contributions in translating the tools of data collection and for the valuable comments they gave me during the expert discussion.

I appreciate the school principals and study participants of the selected elementary schools of Gondar town for their facilitation and willingness to participate in the study respectively. Finally, my special gratitude goes to my family members: My wife Hana and my little daughter Hebron, for their continuous support, encouragement and inspiration.

Table of Contents

Topics **Page**

Abstract ... iv

Acknowledgments ... v

Table of Contents ... vi

List of Tables ... ix

List of Figures ... xi

Acronyms ... xii

Chapter One: Introduction ... 1

1.1. Background ... 1

1.2. Statement of the Problem ... 10

1.3. Objectives of the Study ... 17

1.4. Significance of the Study ... 18

1.5. Delimitation of the Study ... 19

1.6. Operational Definitions of Variables ... 19

Chapter Two: Literature Review ... 23

2.1. Victimization, Victims and Victimology ... 23

2.2. Childhood and Adolescence Victimization ... 27

2.3. Mental Health Problems of Children and Adolescents ... 55

2.4. Victimizations and Mental Health Problems of Children and Adolescents ... 72

2.5. Protective Factors ... 81

2.6. Theories of Victimizations and Mental Health Problems ... 82

2.7. Summary of the Review and Conceptual Framework ... 86

Chapter Three: Methods 91
3.1. Study Design 91
3.2. Study Setting 92
3.3. Population, Sample, and Sampling 93
3.4. Variables of the Study 95
3.5. Measures.......... 96
3.6. Pilot Study 103
3.7. Procedures of Data Collection and Administration.......... 104
3.8. Scoring 105
3.9. Methods of Data Analysis 107
3.10. Ethical Considerations.......... 109
Chapter Four: Findings 111
4.1. Socio-demographic Characteristics of the Respondents 111
4.2. Prevalence of Victimizations among Children and Adolescents 114
4.3. Socio-demographic Characteristics and Victimization of the Respondents……... ...….116
4.4. Prevalence of Mental Health Problems of Children and Adolescents 123
4.5. Victimization Experiences and Mental Health Problems 125
4.6. Poly-victimizations and Mental Health Problems.......... 136
Chapter Five: Discussion 139
5.1. Prevalence of Victimization in Children and Adolescents.......... 139
5.2. Factors Contributing to Childhood and Adolescence Victimizations.......... 142
5.3. Prevalence of Mental Health Problems among Children and Adolescents.......... 149
5.4. Victimization and Mental Health Problems 154

Chapter Six: Summary, Conclusions, and Recommendations 165

6.1. Summary 165

6.2. Conclusions 168

6.3. Recommendations 170

References 177

Appendices 198

Appendix A: Socio-demographic Measure 198

Appendix B: Juvenile Victimization Questionnaire (JVQ-R2) 200

Appendix C: Achenbach Systems of Empirically Based Assessment (ASEBA): Youth Self Report for Ages 11-17 203

Appendix D: Achenbach Systems of Empirically Based Assessment (ASEBA) Teacher Report Form (7-10 Years) 208

Appendix E: Socio-demographic Measure (Amharic Version) 214

Appendix F: Juvenile Victimization Questionnaire (JVQ-R2)- Amharic Version 217

Appendix G: Achenbach Systems of Empirically Based Assessment (ASEBA): Youth Self Report for Ages 11-17 (Amharic Version) 220

Appendix H: Achenbach Systems of Empirically Based Assessment (ASEBA) Teacher Report Form for 7-10 Years (Amharic Version) 225

Declaration 232

List of Tables

Table Title **Page**

Table 1: Target Population by Number of Schools and Students (Gondar Town Education Office, 2005) 93

Table 2: Summary Table of the Samples by School Names and Grade Levels 95

Table 3: Internal Consistency Reliabilities for JVQ and its Sub Measures for the Original and Pilot Studies 100

Table 4: Original Internal Consistency Reliability of Achenbach System of Empirically Based Assessment (Youth Self Report and Teacher Report Form) 102

Table 5: Internal Consistency Reliability of Achenbach System of Empirically Based Assessment (Youth Self Report and Teacher Report Form) for the Pilot Study 103

Table 6: Socio-demographic Characteristics of the Respondents by Gender (N=403) 113

Table 7: Descriptive Statistics of Victimization Types (N=403) 114

Table 8: One Year Prevalence of Victimizations among the Respondents by Gender (N=403) 115

Table 9: Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Any Childhood and Adolescent Victimizations 117

Table 10: Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Conventional Crime in Children and Adolescents 118

Table 11: Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Child Maltreatment in Children and Adolescents 119

Table 12: Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Sibling and Peer Victimizations 120

Table 13: Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Sexual Victimizations in Children and Adolescents. 121

Table 14: Standard Logistic Regression Analysis of Socio-demographic Variables predicting Witnessing and Indirect Victimizations in Participants 122

Table 15: Descriptive Statistics of Mental Health Problems of Respondents (N=403). 123

Table 16: Prevalence of Mental Health Problems of the Respondents by Gender (N=403) 124

Table 17: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Any Mental Health Problems of Children and Adolescents. 126

Table 18: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Internalizing Problems of Children and Adolescents. 127

Table 19: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Externalizing Behavioral Problems of Children and Adolescents.129

Table 20: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Anxious/depressed Syndrome of Children and Adolescents. 130

Table 21: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Withdrawn Syndrome of Children and Adolescents. 131

Table 22: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Somatic Complaints of Children and Adolescents. 132

Table 23: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Social Problems of Children and Adolescents. 133

Table 24: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Thought Problems of Children and Adolescents. 134

Table 25: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Attention Problems of Children and Adolescents. 135

Table 26: Standard Logistic Regression Analysis of Individual Victimization Types Predicting Aggressive Behaviors of Children and Adolescents. 136

Table 27: Ch-square Analysis of any Mental Health Problems among Child and Adolescent Poly Victims. 137

Table 28: Ch-square Analysis of Externalizing Behavioral Problems among Child and Adolescent Poly Victims 137

Table 29: Ch-square Analysis of Internalizing Problems among Child and Adolescent Poly Victims. 138

List of Figures

Figures **Page**

Fig. 1: Conceptual framework showing associations among socio-demographic factors and victimizations 89

Fig.2: Conceptual framework showing associations among victimizations and mental health problems 90

Fig.3: Sketches of socio-demographic characteristics 97

Fig.4: Sketches of victimization types as measured by JVQ 98

Fig.5: Sketches of mental health problems measured using ASEBA 101

Acronyms

AB-Aggressive Behaviors

ACRWC-African Charter on the Rights and Welfare of the Child

A/D-Anxious/Depressed

AMHP-Any Mental Health Problems

AP-Attention Problems

ASEBA-Achenbach System of Empirically Based Assessment

CC- Conventional Crime

CM –Child Maltreatment

CRC-Convention on the Rights of the Child

EP-Externalizing Behavioral Problems

IP-Internalizing Problems

JVQ-Juvenile Victimization Questionnaire

NA-Not Available

NV-Not Victimized

PSV-Peer and Sibling Victimizations

RBB-Rule-Breaking Behaviors

SC –Somatic Complaints

SP- Social Problems

TP-Thought Problems

SV-Sexual Victimizations

WIV-Witnessing and Indirect Victimizations

WP-Withdrawn Problems

Chapter One: Introduction

1.1. Background

Child and adolescent developments do not always follow smooth and predictable trajectories (Skuse, Bruce, Dowdney & Mrazek, 2011). Against their right to develop in healthy, safe and protective environments and the entitlement of getting access to basic services, millions of children and adolescents throughout the world face maltreatment; emotional, physical and sexual abuse ;violence; neglect; and exploitation (Dussich, 2012; Finkelhor, 2008; Hartjen & Priyadarsini, 2012). Since children have only one chance of a childhood, they deserve protection from harm, enjoying good emotional, mental and physical health, and feeling that they belong in their homes, schools and communities (Hartjen & Priyadarsini, 2012). The worldwide victimization of young people does not have to occur, or, at least, its incidence can be greatly reduced if action is taken to do so (Hartjen & Priyadarsini, 2012). Furthermore, Hartjen and Priyadarsini (2012) stated that it is never too early or too late to offer a helping hand and to give the most disadvantaged youngsters the chance for a better life and a brighter future.

Children and adolescents are not only victims of violence, abuse, and maltreatment but also suffer from mental health problems. The risk of developing symptoms of mental health problems may be higher among children and adolescents with victimization experiences. In line with this, Claveirole and Gaughan (2011) asserted that many of the social ills that worry society including criminality, violence, drug and alcohol abuse, dysfunctional families, and child abuse have much to do with the mental health problems of children and adolescents.

1.1.1 Historical background

The history of childhood and adolescence suggests that (Archard, 1993; Schetky, 2002) youngsters have been cruelly treated for as long as there has been human society. Archard (1993) and Schetky (2002) documented that maltreatment and abuse of children were common throughout history and across cultures. Young people have been the victims of practices of abandonment, infanticide, sacrifice, mutilation, slavery, excessive discipline and exploitation at work (Archard, 1993; Schetky, 2002). Victimization of young people was common during the middle ages (Aries, 1962). In addition, Archard (1993) and Schetky (2002) noted that in the past terrorizing children was common and adults in general lacked empathy and emotional maturity. The same is true for the mental health problems of children and adolescents. There were evidences of childhood and adolescence mental health problems in the earliest times (Archard, 1993; Schetky, 2002).

Although it may differ in its form and shape, victimization experiences of children and adolescents are still rampant today and perhaps may continue to be practiced in the future. Even though academic conferences and special television documentaries are often brought to the attention of people, task forces are established, blaming guns on long lists of movies, no simple solutions have emerged so far (Perry, 2002). In fact, the world continues to be shocked, enraged, and confused by the horrors of violence in homes, schools, and streets (Perry, 2002). Some research evidences demonstrate that young people everywhere are not only subject to all forms of victimization experienced by adults, but also that they suffer host of victimizing acts not experienced by adults (Finkelhor, 2008; Hartjen & Priyadarsini, 2012). Now- a- days, children and adolescents are the most victimized segments of the society. They are beaten by family

members, bullied and attacked by schoolmates and peers, abused and raped by dating partners, and targeted by sex offenders in both physical and virtual realms (Finkelhor, 2008).

Results of some victimization studies indicate that although precise estimates of the rates of occurrence of victimization are difficult to obtain, due to the covert nature of the problem and other sampling and reporting biases (Cicchetti, 2006; Finkelhor, Ormrod, Turner & Hamby, 2012), the numbers appear to be large. For example, in USA crude official crime estimates indicate that about 1.3 million violent crimes against children and youth were reported to police in 2004 (Finkelhor, 2008). In addition, Finkelhor (2008) stated that victimization is a frequent occurrence in the United States, with 70% to 71% of the children and youth experiencing at least one type of victimization in the previous year.

Very few local anecdotes and studies on the subject indicate that many children and young people in Ethiopia have been experiencing different forms of victimizations in different places including homes, schools and neighborhoods (ANPPCAN-Ethiopia, 2009; The African Child Policy Forum, 2011). In a study conducted by Fekadu (2008), the prevalence of child abuse in Addis Ketema area of Addis Ababa was 43.9% and 17.2% among child laborers and non child laborers, respectively. Moreover, the Gondar Town Police Office Report (2012) indicated, that crimes were attempted against 172 children and youth in 2012. The report also indicated that 117 children and youth were victims of different crimes including murder, beating, trafficking, rape, and others.

Researchers suspected that offenses against children and adolescents are more undercounted than adult victimizations. Children and adolescents are the kinds of victims least likely to make a report to the police (Finkelhor, 2008; Finkelhor eta al., 2012). For example, Finkelhor (2008)

states that in the National Crime Victimization Survey of the United States, only 28% of crimes against children get reported to the police, compared to 44% of crimes against adults.

Varieties of reasons were mentioned for the inhuman treatment of children and adolescents at different times in human history. For example, in ancient Greek and Roman societies, children were usually scorned, abandoned, or put to death because if they were born with physical or mental handicaps, disabilities, or deformities since they were viewed as sources of economic burden or social embarrassment (Archard, 1993; Schetky, 2002). These days' childhood and adolescence victimizations are likely to occur due to several factors including children's developmental immaturity in controlling their own behaviors, society's tolerance for or weak legal measures for offenses against children, and children have limited ability to regulate, and choose who they associate and interact with (Finkelhor, 2008). Lewit and Baker (1996) also indicated that children and adolescents are more prone to victimization than adults because they are dependent on adults for their day-to-day care and can seldom choose where and with whom they will live and spend time. Lewit and Baker (1996) further pointed out that problems such as neglect, family abduction, and psychological maltreatment are strongly related to dependency, and these are much more common for children and adolescents than for most adults.

This study postulates that socio-demographic characteristics of children and adolescents could be contributing factors for childhood and adolescence victimizations. These include age, gender, parental education, family income and family structure. As there are contributing factors to childhood and adolescence victimizations, exposure to victimizations may contribute to mental health problems.

Hinshaw (2008) underscored that emotional and behavioral problems in children and adolescents are distressingly prevalent and often lead to serious impairments in such crucial life

domains as academic achievement, interpersonal competencies, and independent living skills. Moreover, according to World Health Organization (in Hartjen & Priyadarsini, 2012) report, the violence, abuse and neglect experienced by the world's children and young people are consequential. DeValve (2005) in this regard pointed out that the psychological impacts of criminal victimization can take the forms of non-existent to extreme, and can range from short- to long-term, depending on the type of victimization, amount of loss incurred, and trauma suffered. Hartjen and Priyadarsini (2012) on the other hand argued that childhood and youth victimization experiences are associated with a significant portion of the global burden of mental health problems that victims have while they are young. It was pointed out that victimizations lead to such psychological disturbances as post-traumatic stress disorder, anxiety and mood disorders, sleep disorders, conduct disorders, learning disorder, and attention deficit disorder (Caffo & Belaise , 2007); experiencing lowered self-esteem, somatization and hostility (DeValve, 2005).

Corcoran (2011) reported that the median estimate of the prevalence of child and adolescent mental health disorders is 12 % among the U.S. population. Limited studies conducted in Ethiopia indicated that children and adolescents who experienced victimization are at the risks of developing mental health problems. For example, in a study conducted by Fekadu (2008) the prevalence of any psychiatric disorder was 20.1% among child laborers.

Regarding factors contributing to the mental health problems of children and adolescents, Claveirole and Gaughan (2011) stated that inexorable pace of technological and cultural changes in an ever widening global context is making the task of growing up increasingly difficult. In this day and age, children and young people face challenges unknown to those of previous

generations (Claveirole & Gaughan, 2011). In addition, socio-demographic characteristics are also assumed to have some contributions to these problems.

The existence of widespread prevalence of childhood and adolescence victimizations and its potential risks for mental health problems of children call for immediate responses from the concerned bodies including researchers, child rights advocacy groups, legal professionals, mental health professionals, and psychosocial service providers. While modern society has gradually evolved from viewing children as property to recognizing that children have rights of their own, reforms for child protection have been slow to emerge (Archard, 1993). Although they are not adequate, some efforts pertaining to legal, theoretical and methodological developments have been made by some concerned officials, advocacy groups, academicians, researchers and clinicians.

1.1.2. Responses to victimizations and mental health problems

Among the various responses made, developing legal instruments and putting them into practice is one major move made by concerned bodies. The adoption of the Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power by the General Assembly of the United Nations on 29 November 1985 is the pioneer in this regard. The adoption was made based on the conviction that victims should be treated with compassion and respect for their dignity and that they are entitled to prompt redress for the harm that they have suffered, through access to the criminal justice system, reparation and services to assist their recovery (United Nations Office for Drug Control and Crime Prevention, 1999).

In addition, issues related to childhood and adolescence victimization are included in the Convention on the Rights of the Child. The Convention in its article 19 states that parties shall take all appropriate legislative, administrative, social and educational measures to protect the

child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse (United Nations, 2005). The Convention in its article 16 also mentioned that children should not be subjected to arbitrary or unlawful interference with their and unlawful attacks on their honors and reputations. Articles 27 and 39 of the Convention on the Rights of the Child provided similar legal provisions (United Nations, 2005).

Similarly, articles 23 and 25 of the Convention on the Rights of the Child (United Nations, 2005) address mental health issues of children and adolescents. In addition, the Federal Democratic Republic of Ethiopia, Ministry of Health (2012) developed a National Mental Health Strategy with the aim of addressing the mental health needs of all Ethiopians through quality, culturally competent, evidence-based, equitable and cost-effective care.

Although there are some gaps and problems of enforcement (Assefa, 2011), legal provisions related to childhood and youth victimization are reflected in the laws of Ethiopia. For example, according to the article 16 of the Constitution of the Federal Democratic Republic of Ethiopia (1995), each child has the right to life, be cared by parents or guardians, not to be subjected to exploitative practices, and to be free from corporal punishment or cruel and inhuman treatment.

Along with the adoption of legal provisions, attempts that aimed at the methodological and theoretical developments of victimization issues have been made. Regarding the recent theoretical and empirical statuses of victimization, introduction of the field of victimology in general and developmental victimiology in particular is worth mentioning. The study of victimology is relatively a new field. Although interest in victimology dated back to the 1940s, it was not until the 1960s that a heightened concern with human rights issues elevated the issue

(Dussich, 2012; Fattah, 2000; Karmen, 2010; Kostić, 2010). The status of victims of crime has altered significantly in the last century. The study of victims has moved from the margins of criminological theory to the discipline of victimology (Dussich, 2012; Dussich, 2006a; Fattah, 2000; Karmen, 2010). Crime surveys have extended their remit to include information concerning victims' experiences of the impact of crime and the responses of criminal justice agencies. The role of victims in the criminal justice system has also been reconsidered, as victims have become key players rather than forgotten actors in the criminal process (Karmen, 2010).

Efforts have also been exerted to develop the field of developmental victimilogy that studies victimization experiences from the developmental perspective. Understanding childhood and adolescence victimization requires a more encompassing framework, which Finkelhor (2007, 2008) characterizes as developmental victimology. Finkelhor (2008) argued that researchers seek to develop a developmental and holistic understanding of child and adolescent victimizations that examine the full spectrum of direct and indirect victimization across childhood and adolescence periods (Hoffman, 2008).

Likewise, new developments have been made in the areas of childhood and adolescence mental health problems. An attempt to view childhood and adolescence mental health problems from a developmental perspective is one example (Cicchetti, 2006; Parritz & Troy, 2011). In addition, studying normal development for better understandings of the deviations and taking interdisciplinary perspective are recent developments in the field (Cicchetti, 2006; Hinshaw, 2013).

In terms of methodological progress, the study of victimization experiences evolved from victimization surveys (Fattah, 2000). Since1960s, different countries have conducted their first

victimization surveys. To mention but few examples, United States in 1967, Finland in 1970, Netherlands in 1973, Australia in 1975, Sweden from 1978-79, Israel in 1979, and England in 1982 conducted victimization surveys (Brown, 2010). Among these, countries like England have been conducting the survey annually, and some others with intervals of some years. Victim surveys are regularly conducted in many other countries, including Canada, Italy and Switzerland (Brown, 2010). More than 70 countries have carried out at least one survey over the years (Brown, 2010). In Ethiopia, no victimization survey has been conducted so far.

An important methodological breakthrough in the study of childhood and adolescence victimization is the introduction of Juvenile Victimization Questionnaire (JVQ) developed by Hamby and Finkelhor (2001). The JVQ measure obtains reports on 34 forms of offenses against children that cover five general areas of concern: Conventional crime, child maltreatment, peer and sibling victimization, sexual assault, and witnessing and indirect victimization (Hamby & Finkelhor, 2001).

New developments have also been observed in assessing and classifying mental health problems of children and adolescents. Although the categorical based Diagnostic Statistical Manual of Mental Disorders system of classifications is widely used (American Psychiatrists 'Association, 2013), dimensional approach has been developed as an alternative classification system (Achenbach & Rescorla, 2001). In line with this dimensional classification, measures of emotional and behavioral problems of children and adolescents–Achenbach System of Empirically Based Assessment (ASEBA) Forms were developed. These include Child Behavior Checklist, Teacher Report Form and Youth Self Report (Achenbach & Rescorla, 2001).

Although all these legal, theoretical and methodological developments have been made in the field of childhood and adolescence victimization experiences and mental health problems,

lots of things remained to be done. The long existing victimization experiences of young people are still the challenges of the modern society, with serious implications for mental health problems of children and adolescents as well as the need for psycho-legal services. Moreover, studies conducted on these issues are scattered and fragmented. It is hardly possible to get comprehensive studies undertaken on victimization and mental health problems of children and adolescents.

Thus, the purpose of this study was to estimate the prevalence of victimizations and mental health problems as well as to identify the contributions of victimizations to the mental health problems of children and adolescents. In addition, the study aimed at identifying the contributions of socio-demographic variables to victimization experiences of children and adolescents.

1.2. Statement of the Problem

The Convention on Rights of the Child, one of the widely ratified legal instruments in the world stipulates that the rights of children must be respected as human beings (United Nations, 2005). In addition, the Convention is applicable to children in all cultures and societies and has particular relevance for those living in conditions of adversity (Belfer, Remschmidt, Nurcombe, Okasha & Sartorius, 2007). However, victimization is a substantial problem for children and young people (Cyr, Clément & Chamberland, 2013; Reid & Sullivan, 2009). Some researchers have attempted to document victimizations and mental health problems of childhood and adolescence. Yet, due to the huge and complex nature of the problems, still there are many things to be done. When previous research works are explored, it is not uncommon to observe varieties

of gaps including incomprehensiveness, inadequate attention to juvenile victims as compared to juvenile offenders, and less focus on developmental issues.

One major problem seen in the areas of victimizations and mental health problems of children and adolescents is linked with scarcity of researches and incomprehensiveness. Finkelhor (2008) argued that although children and adolescents are victimized segment of society, this reality has not been sufficiently explored (Finkelhor, 2008; Laye & Mykota, 2014) and there is little research on post-victimization reactions (DeValve, 2005). Finkelhor (2008) further stated that childhood and adolescence victimization has been neglected as a topic and underestimated as a phenomenon in part because it has been approached in a fragmented way. Furthermore, the fragmentation of the victimization topic has led to various problems including a partial and isolated understanding of the problems that may get in the way of devising enduring solutions; failure to recognize connections among risk factors and symptoms that can lead to a variety of problematic responses; misunderstandings about what is most damaging and deserving of priority treatment; failure to get practitioners targeted on the problem that most needs to be addressed; considerable inefficiency, duplication of effort, and unnecessary competition; and a dilution of impact (Finkelhor, 2008).

Like that of victimization problems, childhood and adolescence mental health concerns did not get adequate attention in the previous studies. Alem et al.(2006); Desta (2008); and Tadesse, Kebede, Tegegne, and Alem (1999) supported this claim by stating that although children and adolescents constitute larger proportion of the Ethiopian population, little information is available on their mental health problems. This problem is mainly a concern of low and middle income countries like Ethiopia that results in challenges of achieving United Nations Millennium Development Goals (Cortina, Sodha, Fazel & Ramchandani, 2012). Generally, Nurcombe et al.

(2007) stated that the mental health problem of children and adolescents is an area of global neglect.

A related gap of victimization experiences and mental health problems of children and adolescents studies have to do with focusing on only one or few forms of victimization and psychopathology out of the large spectrum of these problems (Cyr, Clément & Chamberland, 2013; Kilpatrick & Saunders, 1999; Reid & Sullivan, 2009; Uusitalo-Malmivaara, 2012). Most studies confined only to individual types of victimizations like sexual abuse (Czincz & Romano ,2013; Dussich, 2006b; French, Bi, Latimore, Klemp & Butler ,2013), child maltreatment (Cicchetti & Valentino, 2006; Cyr, Michel & Dumais, 2013), peer victimization (Bauman & Summers, 2009; Crosby,2011; Harper, 2012; Malcolm, Jensen-Campbell, Rex-Lea & Waldrip , 2006; Storch & Ledley, 2005), and bullying (Lester, Cross, Dooley & Shaw, 2013; Popp, 2012; Totura et al., 2009). With few exceptions such as studies by Cyr, Clément and Chamberland (2013) and Finkelhor, Ormrod, Turner and Hamby (2005), most of them did not explore about a broad range of victimizations. This creates the potential for several kinds of problems, particularly if children and adolescents who experience one kind of victimization are at greater risk of experiencing other forms of victimization. Furthermore, past studies exaggerate the contribution of a single type of victimization to mental health problems and do not delineate the interrelationships among victimizations and the contribution of these interrelationships to mental health problems (Finkelhor, Ormrod, & Turner, 2007). The focus on the specific victimization types of children underestimates the burden of victimization that young people experience (Finkelhor, Ormrod, Turner & Hamby, 2005). The emphasis on a single type of victimization may also have obscured the degree to which children suffer from multiple kinds of victimization (Kilpatrick & Saunders, 1999).

The problem of not taking the broader aspect into account is not only limited to victimization studies but also in the studies of childhood and adolescence psychopathology. Most studies have focused on the impacts of specific victimization type to a particular type of disorder like post traumatic disorder, anxiety, and depression. Studies typically documented the frequency of individual victimizations and the association of such experiences with single type of psychological and mental health outcomes (Finkelhor, Ormrod, Turner & Hamby, 2005; Fung & Lau, 2009; McGee & Baker, 2002; Perren, Ettekal & Ladd, 2013; Sabri, 2011; Silva, Graña & González-Cieza, 2014; Soler, Kirchner, Paretilla & Forns .2013). Furthermore, Finkelhor (2008) and Finkelhor, Ormrod, and Turner (2007) stressed that much of the work grows out of a theoretical framework based on the concept of traumatic stress. However, Finkelhor (2008) noted that as there are various victimization types, and poly-victimization, the impacts would be also covering wider spectrum of mental health problems (Finkelhor, 2008).

Another problem in the study of childhood and youth victimization has to do with competing stereotypes in the media and culture about the problems of juveniles and crime. For the most part, when the topic of crime intersects with a concern about juveniles, the focus is on juvenile offenders, not juvenile victims (Christiansen & Evans, 2005; Finkelhor, 2008). Finkelhor (2008) argued that unlike juvenile criminology, there is no similarly integrated and theoretically articulated interest characterizing the field of juvenile victimization. In comparison with that of juvenile delinquency, the field of juvenile victimization involves much less theory about who gets victimized and why and much less solid data about the scope and nature of the problem (Finkelhor, 2008; Reid & Sullivan, 2009). Marsh (2004) stressed that the academic obsession with the juvenile criminal has been at the expense of detailed consideration of the juvenile victim.

Together with the problems of scarcity and incomprehensiveness of previous researches, as well as less emphasis to the study of victims, studies of childhood and adolescence victimizations and mental health problems have given little attention to developmental issues. Available studies rarely have consistent information across a broad developmental spectrum from which conclusions can be drawn, and there are often contradictory findings (Chen, 2009; Finkelhor, Ormrod & Turner, 2009; Macmillan, 2001; Tillyer, 2013). Although some promising developments are observed recently, mental health studies did not take developmental issues into account seriously.

Besides all these limitations of the previous studies of young people's victimization and mental health problems, there are continental concerns. Most victimizations studies were conducted in western societies, mainly in America (Finkelhor, Ormrod & Turner, 2009). In Africa and Ethiopia, the situation becomes even worse. Few studies conducted in Africa (Famuyiwa, 1997; Mbagaya, Oburu & Bakermans-Kranenburg, 2013) were limited in terms of scope that focused mainly on child abuse and neglect. Due to these conditions, Cyr, Michel and Dumais (2013) and Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn and Alink (2013) have suggested an urgent need for more research on victimization, especially in low and middle-income countries such as in Africa and South America, where investigations are lacking.

Some victimization studies were conducted in Ethiopia. These include the predicaments of child victims of crime seeking justice in Ethiopia (Assefa, 2011), sexual abuse and exploitation of boy children in Addis Ababa (Belay, 2008), child sexual abuse in Addis Ababa high schools (Gobena ,1998), resilience in children exposed to sexual abuse and sexual exploitation in Merkato, Addis Ababa (Nissinen, 2010), the victimization of juvenile prostitutes in Ethiopia (Lalor, 2000), physical and psychological child abuse in Ethiopia (Mulatie, 2014),

the psychosocial consequences of child sexual abuse in Ethiopia (Wondie, Zemene, Taffesse, Reschke, & Schroder,2011), interpersonal violence in Addis Ababa secondary schools: An iceberg of challenges to the democratization of education in Ethiopia (Habtamu Wondimu,1998). However, these studies are scattered and fragmented. In terms of geographical locations, most of them were conducted in Addis Ababa. And in terms of domain, the emphasis was on few individual types of victimization including sexual abuse, physical abuse, and neglect.

With regard to mental health problems among Ethiopian children and adolescents, some studies were undertaken (Ashenafi, Kebede, Desta & Alem, 2000; Desta, 2008; Fekadu, Alem & Hagglo, 2006; Mulatu, 1995; Nicodimos, Gelaye., Williams, & Berhane, 2009; Tadesse et al., 1999). In many ways, these studies are also limited in scope in terms of areas of study and focuses. Most of these studies were conducted in Addis Ababa and the focus is on specific types of mental health problems of children and adolescents like anxiety and depression. Victimizations and mental health problems of children and adolescents in other parts of the country including Gondar deserve equal attention to be studied.

It is assumed that since Gondar town is a tourist destination and a major urban center in the North Western Ethiopia, children and adolescents may be vulnerable to different forms of victimizations that may in turn lead to the occurrence of more mental health problems. In addition, Gondar is a place where cultural beliefs and practices regarding the use of physical punishment for disciplinary purposes appear to be prevailing.

Although children and adolescents may be victimized in different settings, schools are major settings of public concerns (Harper, 2012; Lester, Cross, Dooley, & Shaw, 2013; Schreck, Miller & Gibson, 2003). Lester et al. (2013) stressed that during a student's school life there are periods of time when the risk of being bullied is higher than at other times. Particularly, the transition

from primary to secondary school provides challenges for children and adolescents as they experience environmental, physiological, cognitive and social changes (Lester et al., 2013). However, with all these possibilities of risk for victimizations and mental health problems of school children and adolescents in Gondar, no comprehensive study has been conducted so far.

To state the problem in a nutshell, the research needs in childhood and adolescence victimization and mental health problems are vast and urgent (Cyr, Michel & Dumais, 2013; Stoltenborgh et al., 2013), given the size of the problem and the seriousness of its impact on their lives (Finkelhor, 2008).Thus, conducting a study aimed at documenting the magnitudes of victimizations and mental health problems, identifying factors associated with victimizations, and examining the associations of victimizations and mental health problems of school children and adolescents in Gondar town is a timely one. Accordingly, this study was conducted to answer the following research questions.

1. What is the one year reported prevalence of childhood and adolescence victimizations in the elementary schools of Gondar town?
2. Do socio-demographic variables (age, gender, family structure, maternal education, and family income levels) contribute to victimization experiences of children and adolescents under study?
3. What is the reported prevalence of mental health problems of children and adolescents in the study area?
4. Which victimizations types (conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimization) contribute to the mental health problems (overall mental health, internalizing, externalizing,

anxious/depressed, withdrawn, somatic complaints, social, thought, attention, and aggressive behavior problems) of children and adolescents?

5. Are there associations among poly-victimizations and overall mental health, internalizing, and externalizing problems of children and adolescents in Gondar town?

1.3. Objectives of the Study

The major objective of the study was to estimate prevalence of victimizations and mental health problems, to identify the associations of socio-demographic variables with victimization experiences, and to examine the roles of victimization experiences on the mental health problems of children and adolescents in Gondar town elementary schools. The specific objectives were:

- Determine the one year prevalence of childhood and adolescence victimizations in the elementary schools of Gondar town.
- Examine the contributions of socio-demographic variables (age, gender, family structure, parental education, and family income) to childhood and adolescence victimizations in the study area.
- Determine the prevalence of mental health problems of children and adolescents in the study area.
- Identify the roles of one year exposure to different victimization types (conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimizations) on the overall mental health, internalizing, externalizing, anxious/depressed, withdrawn, somatic complaints, social, thought, attention, and aggressive behavior problems of children and adolescents.

- Examine the associations among poly-victimizations and mental health problems of children and adolescents in the elementary schools of Gondar town.
- Provide recommendations on ways of preventing the occurrences of victimization and mental health problems of children and adolescents.

1.4. Significance of the Study

The study on the victimization experiences and mental health problems of children and adolescents will have both theoretical and applied values. To begin with the theoretical significance, the theory of developmental victimology is found in its infancy stage. It is the belief of the researcher that the patterns of relationships among variables that were explored in this study add some basic knowledge so that it will contribute to the development of the field.

Moreover, the outcome of this study will have paramount practical utilities. The findings of this study will provide useful information for childhood and youth policy makers, mental health professionals, psychologists, counselors, sociologists, social workers, health professionals, legal professionals, and institutions involved in childhood and youth victimization and mental health issues. This will create a better opportunity to these actors to design preventive and rehabilitative programs in tackling the problems. In line with this, Hartjen and Priyadarsini (2012) stated that although the dimensions of the problem are being documented and childhood and adolescence victimization may never be eradicated, it can be greatly reduced, and often prevented. In this regard, the study will inform and motivate concerned bodies to achieve the goals of prevention of the occurrence of victimization and provision of intervention to already victimized ones and those with mental health problems. Above all, this study may pave the ways for the development of evidence-based psych-legal services provisions to victim children and

adolescents and those with mental health problems so that they could get better services than before.

1.5. Delimitation of the Study

Given the limited resources in terms of finance and time, delimiting the scope of any study is inevitable. In this study, the area, participants, and variables of the study were delimited. With regard to area delimitation, the study was conducted only in the primary school settings of Gondar town. As far as participant delimitation is concerned, the study was delimited to both male and female elementary school children and adolescents with the age ranges of 7- 17 years. Both government and private first and second cycle elementary school students in the selected schools were parts of this study.

The scope of this study in terms of variables focused on socio-demographic characteristics, victimization experiences and mental health problems. Victimization experience has five sub variables including conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimizations. In addition, poly-victimization was considered as one variable. In this study, internet victimization experiences were not considered. The mental health problem behaviors consist of the overall mental health problem; two broad-band scales: Internalizing and externalizing; and eight syndromes: Anxious/depressed, withdrawn, somatic complaints, social problems, thought problems, and attention problems, rule-breaking, and aggressive behavior.

1.6. Operational Definitions of Variables

Aggressive behaviors–types of mental health problems with symptoms of arguing a lot, destroying properties, being disobedient at school, getting in fights, and attacking people.

Anxious/Depressed-refers to psychological disturbances of anxiety and depression that are characterized by feelings of fear, worthlessness, nervousness, tension, worry, and guilt.

Attention problems-is a mental health problem with such manifestations as acting too young, failing to finish, lack of concentration, confusing, impulsiveness, and inattentiveness.

Child maltreatment-is a type of victimization characterized by physical offenses, psychological abuse, neglect, and family abduction that are committed on children and adolescents during the previous year.

Conventional crime-is one type of victimization that goes in line with offenses defined as crimes by governments including personal theft, robbery, vandalism, nonspecific assault, aggravated assault, attempted assault, and bias attack that are committed against children and adolescents during the previous year.

Externalizing behavioral problems–comprise mental health problems that involve conflicts with other people and with their expectations of the child and adolescent that include rule-breaking and aggressive behavioral problems as measured by Achenbach Systems of Empirically Based Assessment (ASEBA) sub-scale.

Family structure-refers to the family condition of children and adolescents with whom they live in i.e. with both parents, or in single parent, or relatives.

Internalizing problems–mental health problems that are within the self including anxious/depressed, withdrawn, and somatic complaints as measured by Achenbach Systems of Empirically Based Assessment (ASEBA) sub-scale.

Mental health problems- refer to a range of internalizing and externalizing behavioral and emotional problems as well as social, attention and thought related disturbances of children and

adolescents as measured by Achenbach Systems of Empirically Based Assessments (ASEBA) Teacher's Report Form and Youth Self- Report.

Peer and sibling victimizations-are offenses of peer or sibling assault, gang or group assault, dating violence, nonsexual genital assault, and bullying that children and adolescents have experienced during the previous year.

Rule-breaking behaviors–types of mental health problems with features of vandalism, truancy, breaking rules, cheating, running away, setting fire, sex related problems, stealing, and using tobacco and alcohol.

Sexual victimizations-refer to such offenses as nonspecific sexual assault, sexual assault by a known adult, sexual assault by peer, rape attempted or completed, exposure /exhibition, verbal sexual harassment, and statutory rape and sexual misconducts committed against children and adolescents during the previous year.

Social problems-are relationship problems characterized by too much dependency, loneliness, not getting along with others, accident proneness, getting teased, disliked, clumsiness, preferring to be with younger kids to their own age mates, and speech problems.

Socio demographic factors–are family and individual features of children and adolescents that include age, gender, household income, parental education, and parental family structure.

Somatic complaints–refer to mental health problems manifested in physical forms including headache, feeling dizzy, aches, pains, overtired, nausea, eye problems, skin problems, stomachache, and vomiting.

Thought problems-refer to mental health problem manifested in such behaviors as problems of sleeping, strange ideas, storing many unnecessary things, seeing and hearing things that are not there, and harming self.

Victimizations–conditions by which children and adolescents experience offenses committed by others during the previous year as measured by Juvenile Victimization Questionnaire (JVQ).

Withdrawn problems-refer to the condition by which the child or an adolescent preferring to be alone, enjoying little, refusing to talk, is secretive, shy, lacking energy, and feeling sad.

Witnessing and indirect victimizations-are offenses as witness to assault, domestic violence, parent assault of sibling, and witnesses of burglary of family household that have happened and committed on children and adolescents with the possibilities of resulting in psychological harm during the previous year.

Chapter Two: Literature Review

This chapter includes the up-to-date systematic reviews of the previous works regarding such topics as victimizations, victims and victimology; childhood and adolescent victimizations; mental health problems of children and adolescents; and the roles of victimizations on mental health problems of children and adolescents.

2.1. Victimization, Victims and Victimology

The understanding of victimization experiences of young people will not be complete without looking in to the broader accounts of the general victimization, victims and victimology. Hence, addressing the nature as well as the historical and theoretical backgrounds of victimization, victims and victimology is imperative.

Dussich (2012) conceptualized victimization as a process whereby an external force comes in contact with a person, rendering that person to feel pain, sometimes causing injury, either of which can be short-lived or which might cause extended suffering and sometimes death. As Dussich (2012) indicated the force for victimization can be legal or illegal, natural or manmade, biological or chemical, expected or unexpected, social or individual, civil or uncivil, intended or unintended; the list of possibilities is endless.

From a different angle, victimization is viewed from a wide range of experiences, including bullying, theft, and witnessing violence (Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Ormrod, Turner & Hamby, 2005; Rattelade, Farrell, Aubry, & Klodawsky, 2013). In contrast to the views of Dussich (2006b, 2012), Finkelhor (2008) has argued that in describing victimization, the central point to be taken is the interpersonal aspect. He asserted that victimization is different from other stresses and traumas, such as accidents, illnesses,

bereavements, and natural disasters because it involves the elements of malevolence, betrayal, injustice, and immorality. Moreover, Finkelhor (2008) underscored that interpersonal victimizations involve a particular set of institutions and social responses that are often missing in other stresses and traumas: Police, courts, agencies of social control, and efforts to reestablish justice.

Another important term that needs conceptual clarification is the term victim. When the original meaning of the term victim is considered, it was used to describe individuals or animals whose lives were destined to be sacrificed to please a deity and it did not necessarily mean pain or suffering, only a sacrificial role (Dussich, 2012; Karmen, 2010; Mrash, 2004; Turvey & Petherick, 2009) . However, through time, the meaning of the term was changed. Spalek (2006) stated that in the nineteenth century, the word victim was connected with the notion of harm or loss in general. Since then, similar conceptualizations have been given to victims with few exceptions. The differences are observed mainly in the cause of making a person to be a victim.

According to Spalek (2006), in the modern criminal justice system, the word victims describe persons who have experienced injury, loss, or hardship due to the illegal action of another individual, group, or organization. In congruence with this, United Nations Office for Drug Control and Crime Prevention (1999) defined victims as persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are violations of national criminal laws or of internationally recognized norms relating to human rights.

Dussich (2012) identified two types of victims: Primary and secondary victims. Primary victims are those persons who are the direct recipients of the external force, the ones who suffer

first, feel pain the most severely, and are usually injured the worst. Whereas secondary victims include other persons who are related to primary victims and are negatively affected, usually emotionally (Dussich, 2012).Victim conditions along with victimization experiences are scientifically studied within the discipline of victimology (Dussich, 2012; Kostić, 2010; Marsh, 2004).

According to Dussich (2006b) and Kostić (2010) victimology is an academic scientific discipline which describes and explains phenomena related to victimizations. Other scholars in the field such as Andzenge (in Kostić, 2010) defined victimology as a study of the ways in which an individual or a group of individuals perceive themselves as a victim or victims, which is a subjective perception which significantly affects the degree of their victimization. Studies of victimology include events leading to the victimizations, the victim's experience, its aftermath and the actions taken by society in response to these victimizations. In victimology precursors, vulnerabilities, events, impacts, recoveries, and responses by people, organizations and cultures related to victimizations are studied (Brown, 2010; Dussich, 2006b).

Karmen (2010) and Turvey and Petherick (2009) mentioned that the origin and formal beginning of victimology is attached with the works of a Romanian lawyer, Beniamin Mendelsohn, who first coined the term victimology in 1947. Because of his immense contribution, he is considered as the father of victimology. Von Hentig and Wertham are other contributors to the field in the 1940s.

Victimology has undergone a rapid and fundamental evolution in the last two or more decades (Fattah, 2000). In its beginning, it was essentially the victimology of specific crimes: Victimology of violent crimes, including homicide; victimology of sexual offences and victimology of property crimes (Fattah, 2000; Karmen, 2010; Turvey & Petherick, 2009; Young,

2006). However, later on it came to encompass the scientific study of victims and victimization, including the relationships between victims and offenders, investigators, courts, corrections, media, and social movements (Brown, 2010; Fattah, 2000).

In addition, the discipline of victimology has become more applied than before characterized by endeavors aimed at alleviating the plight of victims, and at providing them with the services, aid and assistance that would help them cope with, and recover from, the harmful and traumatic effects of victimization (Fattah, 2000). Furthermore, Fattah (2000) stated that during the 1980's and 1990's, victimology was characterized by a period of consolidation, data gathering theorization, new legislation, victim compensation, mediation, and support.

Contemporary victimology has a wider scope addressing such issues as crime victims, disaster victims, and a special category referred to as abuses of power victims including persons injured as a result of genocide, torture, or ethnic cleansing (Dussich, 2012). In addition, it is a subject with many subcategories of theoretical; need based applied research and practice (Turvey & Petherick, 2009).This orientation has directed towards the perceptions of victims and calls for a scientific methodology for victims' expressing their needs and interests (Karmen, 2010).

Victimology is an interdisciplinary field drawing knowledge from such areas as law, criminology, psychology, sociology, anthropology, and political science (Dussich, 2012). In studying victimization experiences, there are different approaches followed by scholars in the field including developmental dimensions. Taking this developmental dimension in to consideration has led to the birth of developmental victimology.

According to Finkelhor (2007) developmental victimology is a field intended to help promote interest in the understanding of the broad range of victimizations that children and young people suffer from and to suggest some specific lines of inquiry that such an interest

should take. In describing the field of developmental victimology, Finkelhor (2007,2008) proposes that the victimizations of young people embrace three categories including: Conventional crimes in which children and adolescents are victims, which are referred to as crimes; acts that violate children's welfare statues, including some of the most serious and dangerous acts committed against children and adolescents, such as abuse and neglect, but also some less frequently discussed topics such as the exploitation of child labor, which are referred to as child maltreatment; and acts that would clearly be crimes if committed by adults against adults but which by convention are not generally of concern to the criminal justice system when they occur among or against young people, such as sibling violence and assaults between peers; which are referred as noncriminal juvenile crime equivalents, or non crimes, for short.

Victimization experiences of children and adolescents have central places in the field of developmental victimology. In support of this claim, Finkelhor (2007, 2008) indicated that understanding the basis for the social construction of victimization across the span of childhood and adolescence should be one of the key areas for developmental victimology. An optimal understanding of childhood and youth victimization becomes possible after characterizing the major developmental patterns and features of children and adolescents.

2.2. Childhood and Adolescence Victimization

In this section, the general developmental patterns of childhood and adolescence development, legal frameworks regarding childhood and adolescence victimization, types and prevalence, theories, and risk factors for childhood and adolescence victimization are reviewed.

2.2.1. Childhood and adolescence development

Developmental psychologists characterize and explain childhood and adolescence development in different ways. This characterization and explanation of the developmental process is mainly made based on the dimensions of development including physical, cognitive, social, and emotional. The emphasis they gave on factors influencing child and adolescent development also differs as result of the theoretical positions of the theorists. The different theoretical positions have also an important implication in the promotion and maintenance of healthy and positive development as well as in the prevention and rehabilitation of problematic and disordered areas of development. Since it is assumed that the developmental features of children and adolescents will have an influence on their victimization experiences and mental health statuses, identifying the major characteristics of development during these crucial periods is important. So as to do these, major theories of development including psychodynamic, cognitive, moral, attachment, ecological, and dynamic system theories are considered.

Psychodynamic tradition of development underscores the importance of early experiences and the roles of unconscious, defense mechanism and stages of development in understanding childhood and adolescence development (Keenan, 2002; Lamb, 2003; Miller, 2002). To describe and explain the developmental features of children and adolescents within the scope of this study, Freud categorized individuals from 7-11 and 12-17 years in his latency and genital psychosexual stages of development respectively. The other theorist in the perspective, Erikson asserted that individuals from 7-11and 12-17 are found in industriousness versus inferiority and identity versus role confusion stages of psychosocial development respectively. Attachment theorists give more emphasis to the importance of early relationships as central influential factors for future development (Keenan, 2002; Lamb, 2003; Miller, 2002).

According to the known cognitive theorist, Piaget (in Keenan, 2002; Lamb, 2003; Miller, 2002) individuals from the ages of 7-11 and 12-17 years of age are found in the concrete operational and formal operational stages of development respectively. Kohlberg also has tried to depict the moral developments of children and adolescents (Milford, 2006). Ecological theories of development focus on the roles of social, historical, and cultural factors in molding child and adolescence development (Miller, 2002). Cochiti and Valentino (2006) asserted that ecological-transactional perspective views child development as a progressive sequence of age-and stage-appropriate tasks in which successful resolution of tasks at each developmental level must be coordinated and integrated with the environment. These tasks according to Cochiti and Valentino (2006) include the development of emotion regulation, the formation of attachment relationships, the development of an autonomous self, symbolic development, moral development, the formation of peer relationships, adaptation to school, and personality organization.

Finally, dynamic system theoretical approach to the study of development assumes that child and adolescence development can only be understood as the multiple, mutual, and continuous interaction of all the levels of the developing system, from the molecular to the cultural (Thelon and Smith, 2006). These authors indicated further that development need to be understood as nested processes that unfold over many timescales from milliseconds to years (Thelen & Smith, 2006).

Many theories of development indicate that children and adolescents are still in the process of growing and developing. Rowling (2006) asserted that young people face demands, expectations and challenges which are more numerous and carry larger risks. Since these periods are characterized by major life changes, the experiences of these age groups may create vulnerabilities to victimizations and trigger mental health problems. Several disorders are

identified as having their onset at these stages (Rowling, 2006; Skuse et al., 2011; Tilford, 2006). For example, middle childhood is a challenging time as relationships with peers, school and the wider social world become ever more complex due to emerging and increasingly wide range of difficulties and disorders (Skuse et al., 2011). In addition, adolescence is a period when the adolescent and family need to negotiate issues of individuation, autonomy and parental authority and it is a time when significant internalizing and externalizing psychopathology are likely to emerge (Skuse et al., 2011). Furthermore, Cicchetti and Valentino (2006) argued that the failure of the required environment that is represented by victimizations culminates in its effects on children's ontogenic development. At the level of psychological ontogenic development, the negotiation of central tasks of each developmental period organizes one's developmental trajectory toward subsequent competence or incompetence (Cicchetti & Valentino, 2006).

Due to these reasons, young people need to be cared and protected by parents and the state. One way of achieving this is establishing a legal system that addresses child and adolescent focused legal provisions. Accordingly, laws stipulated in the international and national legal provisions regarding childhood and youth victimization and mental health problems are considered in the review.

2.2.2. Legal frameworks on victimizations and mental health problems

Scott and Woolard (2004) described that assumptions about the vulnerability, incompetence, and dependency of children and young ones result in a complex set of regulations that accord children and adolescents unique status in law. Policy makers have multiple goals including protection of children, promotion of parental responsibility, and ensuring that children mature into productive adults (Scott & Woolard, 2004).

Being cognizant of this fact, various international and national legal instruments have been developed and an attempt to put them in place is made. The need for young ones to be protected against all forms of abuse and exploitation because of their vulnerability and immaturity first appeared in the 1924 League of Nations Declaration of the Rights of the Child (International Association of Prosecutors Model Guidelines, cited in Assefa, 2011). Subsequently, the United Nations Universal Declaration of Human Rights, adopted in 1948, proclaimed that children are entitled to special care and assistance (Art. 25).

The adoption of the United Nations Convention on the Rights of the Child in 1989 brought into being a clear statement of the rights of and special treatment for the child (Assefa, 2011). For example, article 3(1) of the United Nations Convention on the Rights of the Child states that the best interest of the child as one of the main criteria to be employed whenever adopting measures regarding a child. In addition, article 6(2) of the CRC (United Nations, 2005) highlighted the need to guarantee the development of children to the maximum extent possible. The same thing is provided in the article 5(2) of ACRWC (1999). Furthermore, article 39 of the CRC (United Nations, 2005) also states that state parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Article 34 of the CRC (United Nations, 2005) also underscores the importance of protecting the child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent the inducement, coercion or encouragement of a child to engage in any sexual activity; the use of children in prostitution or other sexual practices; and the use of children in pornographic activities, performances and materials.

In Ethiopia, article 36 (1) of the Ethiopian Constitution (1995) states that children have rights to be free from corporal punishment and article 258 (1) of the revised Family Code (2000) states about the responsibilities of parents for appropriate child upbringing. Besides, ad hoc initiatives to introduce victims to a child-friendly justice process and child protection units exist in some of urban areas (Assefa, 2011).

Although it appears that no adequate coverage was given for mental health issues of children and adolescents, the Convention on the Rights of the Child included some provisions. In its article 23(1), the Convention stated that mentally or physically disabled children should enjoy full and decent lives, in conditions which ensure dignity, promote self-reliance, and facilitate their active participation in the community (United Nations, 2005).

The concern of age becomes important particularly with the increased number of child victims (Ferreira, 2008). In Ethiopia, for a better protection of victims, the crucial age categories have been determined. The crucial age categories for child victims' are below 13 years and from 13- 18 years and in both cases aggravating grounds should be considered (UNICEF- Ethiopia, 2008). Although conventional age categories are used in different countries, in the study of the developmental characteristics of children, age is treated differently by different psychologists (Ferreira, 2008).

Although these and other legal instruments have been developed and an attempt to implement them is made by legal bodies, the Ethiopian justice process has permitted the subjection of child victims to cycles of victimization during investigation, prosecution, and trial phases of cases in which they are involved. Ethiopia does not have laws that require the special treatment of children who are victims or witnesses of crime (Assefa, 2011). Due to these and other related factors, the problems of children and adolescents victimization seem to be rampant.

2. 2. 3. Types and prevalence of childhood and adolescence victimizations

Different researchers identified various types and forms of childhood and adolescence victimization experiences. For example, it is not uncommon to hear about primary and secondary victimization experiences (Dussich, 2012). In this study, the classification made by Finkelhor (2008) who identified five major types of childhood and youth victimization is used. These include conventional crime, child maltreatment, peer and sibling victimization, sexual victimization and, witnessing and indirect victimizations.

Most victimization forms were studied in the west mainly in USA (Laye & Mykota, 2014) and they focused on specific types of childhood and adolescence victimization such as sexual abuse (Czincz & Romano, 2013; Dussich , 2006a; French et al., 2013), child maltreatment (Cicchetti & Valentino , 2006; Cyr, Michel & Dumais , 2013), peer victimization (Bauman and Summers, 2009; Harper, 2012; Malcolm, et al., 2006; Storch & Ledley, 2005), and bullying (Lester et al., 2013; Popp , 2012; Totura et al., 2009). But they reflect something about the prevalence and magnitude of the problem.

The estimated prevalence of childhood and adolescence victimization varies remarkably across studies. Such variations are often attributed to differences in operational definitions of what constitutes victimization; data sources (self-reports versus parental or teacher reports); and sampling procedures followed in the different studies (Mbagaya, Oburu & Bakermans-Kranenburg, 2013). For example, self report measures yield higher victimization prevalence than parent and teacher report measures (Mbagaya, Oburu & Bakermans-Kranenburg, 2013).

Finkelhor, Ormrod, Turner, and Hamby (2005) reported that experiences of violence were pervasive: More than half of the respondents included in their studies had experienced some type of violent assault during the previous year. In addition, an estimated of 6.2 million young people

in the United States of America with the age ranges of 10–16 experienced some form of completed assault or abuse each year (Turner, Finkelhor & Ormrod, 2005a). In another study, children and adolescents were found to be the most victimized age groups in the United States, experiencing violent victimization at a rate of two and half (Reid & Sullivan, 2009) to three times (Christiansen & Evans, 2005) higher than adults. Research also found that about 30% to 50% of the participants experienced some type of victimization in a year (Christiansen & Evans, 2005). Moreover, Finkelhor (2008) stated that victimization is a frequent occurrence, with 70% to 71% of the children and youth experiencing at least one type of victimization in the previous year. The mean number of victimizations for a child or youth with any victimization was 3.0 (Turner, Finkelhor & Ormrod, 2005a).

Since most victimization prevalence studies addressed specific types of victimization experiences, looking at the magnitudes of the independent types of victimizations separately is essential. Accordingly, the descriptions and prevalence rates of conventional crime, child maltreatment, peers and sibling victimization, sexual assault, and witnessing and indirect victimization are reviewed. Finally, the natures and the prevalence of poly-victimization exposures of children and adolescents are stated.

1. Conventional crimes

According to Finkelhor (2008) conventional crimes are victimizations types that go in line with offenses that are defined by governments as crimes. They are the most important crime categories in virtually police districts. Conventional crime includes such major offenses as personal theft, robbery, vandalism, nonspecific assault, aggravated assault, attempted assault and bias attack (Hamby & Finkelhor, 2001).

Childhood and adolescence victimization resulted from conventional crime is widespread. For example, Finkelhor, Ormrod, Turner and Hamby (2005) reported that more than one half of the children and youth had experienced property victimization in the study year. In a study conducted in Canada, property victimization was experienced by almost a third of the sample of children from 2- 11 years (30%), mostly in the form of vandalism, with 22% having a belonging broken or destroyed on purpose (Cyr, Clément & Chamberland, 2013). Moreover, it was reported by the CDC (cited in Seifert, 2012) that, in 2007, 5,764 young people aged 10 to 24 years were murdered with an average of 16 each day. The report showed also that homicide was the fourth leading cause of death among children aged 1 to 14 (Seifert, 2012).

The prevalence of the problem in Ethiopia is also not something to be underestimated For example, more than half of the street boys in Addis Ababa reported being regularly physically attacked (Lalor, 1999). In another study conducted by Lalor (2000), 83% of the juvenile prostitutes in Addis Ababa have had things stolen from them while living on the streets.

2. Child maltreatment

Child maltreatment consists of offenses that are concerns of child protection agencies and they specifically include mention of victimization by caregivers (Finkelhor, 2008). In a similar way, Seifert (2012) broadly defined child maltreatment as physical abuse, psychological abuse, sexual abuse, and/or neglect that are committed by a parent or caretaker. Furthermore, it was stated by Fontes (2005) and Seifert (2012) that the labeling of a given act as maltreatment necessarily involves cultural components and value judgments. The major components of child maltreatment are physical abuse by caregiver, psychological/emotional abuse, neglect, and family abduction (Cicchetti & Valentino, 2006; Cyr, Michel & Dumais, 2013; Finkelhor, 2008; Hamby & Finkelhor, 2001; Leeb, Lewis & Zolotor, 2011).

Child maltreatment in all its forms is a global phenomenon with alarming prevalence, touching the lives of millions of children. This is happening despite the United Nation's Convention on the Rights of the Child (1989), ratified by 194 countries explicitly stating that they shall take all appropriate legislative, administrative, social, and educational measures, nationally, bilaterally, or multilaterally, in order to protect children from maltreatment (Bakermans-Kranenburg, & van IJzendoorn, 2013; Stoltenborgh, et al., 2013). It is a terrible fact that maltreatment is affecting the lives of millions of children all over the world, whether these children are from low- or high-income countries and regardless of culture (Bakermans-Kranenburg, & van IJzendoorn, 2013; Cyr, Michel & Dumais, 2013; Stoltenborgh, et al., 2013). Tragically, child maltreatment is committed on children and adolescents by their parents (Seifert, 2012).

Regarding the prevalence of child maltreatment, different studies reported varying figures. For example, it was found out that prevalence rates of physical abuse was reported in individual studies ranging from 0.0092% (Sibert et al. in Stoltenborgh et al., 2013) to 95.7% (Milner, Robertson, & Rogers in Stoltenborgh., 2013).

According to Cicchetti and Valentino (2006), 60.5% of documented child maltreatment victims experienced neglect, 18.6% were physically abused, and 6.5% were emotionally maltreated. In a study that compared the prevalence of self-reported childhood physical abuse and neglect among Kenyan, Zambian, and Dutch students, results showed that physical abuse was highly prevalent in Kenya (59%) and Zambia (40%), and neglect was even more prevalent than physical abuse in Zambia and The Netherlands at 59%, 54%, and 42% for the Kenyan, Zambian, and Dutch samples respectively (Mbagaya, Oburu & Bakermans-Kranenburg, 2013).

A study conducted by World Health Organization (2009) portrayed that about 37% of the youths surveyed in Egypt had been beaten or tied up by parents with 26% suffering physical injuries as a consequence. It was also indicated that in South Korea two-thirds of the parents who responded to a survey, admitted whipping their children while 45% said they had hit, kicked, or beaten a child. In addition, in Romania nearly one-half of the parents surveyed said they regularly beat their children. By looking into all these figures, one will not be wrong to say that the use of physical punishment by parents and other adults is by no means a limited or socially and culturally specific phenomenon (Hartjen & Priyadarsini, 2012).

Some studies depicted the prevalence rate of child maltreatment in Ethiopia. For instance, study conducted by Ketsela and Kebede (1997) in Addis Ababa and Adami Tulu indicated that 80% and 76% of urban and rural children respectively experienced physical punishment. It was also reported in the same study that 21 % of urban and 64% of rural had skin bruises and swelling of body as a result of physical punishment (Ketsela & Kebede, 1997). In addition, Fekadu and Giorgis (2008) reported 43.9% and 17.2% prevalence rates of child abuse among child laborers and controls, respectively (OR=3.7, 95% CI: 2.74, 5.09; p<0.001). Similarly, sizeable proportion of children in Gondar town faced psychological abuse in the form of being seen as worthless/ useless/ by parent/caregiver (53.9%) and negative comments by comparing with others (62.1%) (Mulatie, 2014).

3. Peer and sibling victimizations

Finkelhor (2008) pointed out that peer and sibling victimization covers the common offenses of childhood and adolescence, many of which are not typically considered as crimes. Peer victimization is the repeated exposure and experience of being a target of peers' aggressive behaviors (Daniels, Quigley, Menard & Spence, 2010; Malcolm et al., 2006; Storch & Ledley,

2005).These are the forms of victimizations that are of most interest to professionals in schools and similar settings. The sub types of peer and sibling victimization are peer or sibling assault, gang or group assault, dating violence, nonsexual genital assault, bullying, and emotional bullying (Hamby & Finkelhor, 2001).

Regarding the prevalence of the problem, there are evidences indicating that a substantial number of children and youths are regularly harassed by their peers at school and other settings (Strohmeier, Karna, & Salmivalli, 2011). With regard to the prevalence of the problem, large-scale community studies suggest that as many as 20% to 30% of children and adolescents are severely victimized by peers (Storch & Ledley, 2005). Similarly, Bauman and Summers (2009) reported that approximately 23% of students in the sample were victimized. Furthermore, a study undertaken in Canada depicted that among the youth with 11 to 15 years of age, 17% of boys and 18% of girls reported having been the target of aggression at least twice in the past school week, whereas about one third (34% of boys and 27% of girls) reported having been victimized at least once in the past 6 weeks (Craig & Pepler in Daniels et al., 2010). Although it is common across all age groups from 3- to 18years-old, peer victimization appears to be particularly common in middle school (Daniels et al., 2010).

4. Sexual victimizations

Child sexual abuse entails any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child (American Psychiatric Association, 2013). The types of sexual victimization according to Hamby and Finkelhor (2001) includes sexual assault by known adult, sexual assault by unknown adult, sexual assault by peers/siblings, forced sex (including attempts), flashing/sexual exposure, verbal sexual harassment and statutory rape and sexual misconduct .

Childhood and adolescent sexual victimization occurs in virtually all countries of the world regardless of religious, social, cultural, and other factors (French et al., 2013; Quinn, 2002). Rates indicating sexual violence are not something to be underestimated. Finkelhor (2008) and Hartjen and Priyadarsini (2012) indicated that the prevalence of child and adolescent sexual victimization ranged from as low as 3% for males and 7% for females to as high as 29% for males and 36% for females. Moreover, there are assertions that the problem would be more than what has been reported because, there may be cases remaining unreported (Finkelhor, 2008; Hartjen & Priyadarsini, 2012).

Even though most of the evidences are obtained from western nations, eastern societies are by no means immune from sexual victimization of young people (Hartjen & Priyadarsini, 2012). For example, findings in Japan revealed that 54.7% of students had experienced at least one of the illegal children sexual abuse acts (Dussich, 2006a). In addition, in Kenya over a two year period more than 1,000 teachers were fired for sexually abusing girls in their care (Hartjen & Priyadarsini, 2012).

Few and scattered sexual victimization studies were conducted in some specific areas of Ethiopia, mainly Addis Ababa. The focuses of these studies were also some specific groups of children like street children and juvenile prostitutes that may lead to the overestimation of problem. In any case, they show something about the magnitude of the problem. According to a study conducted in Addis Ababa, street life has been found highly victimogenic for street girls' sexual victimization (Lalor, 1999). Lalor (1999) further reported that 44% had been raped and a further 26% had been sexually attacked. Another study, which was conducted in Addis Ababa on male street children revealed that 28.6% of them were sexually abused (Getnet Tadele, cited in Assefa, 2011). A different study conducted in ten sub cities of Addis Ababa, about 21.56% of all

forms of sexual abuse of children in Addis Ababa were inflicted against male children and the remaining 78% were on girls (Belay Hagos, 2008).

5. Witnessing and indirect victimizations

Witnessing and indirect victimizations are offenses against others that can have psychological impacts on children and adolescents. The common types of witnessing and indirect victimization according to Hamby and Finkelhor (2001) and Finkelhor (2008) are witness to assault, witness to aggravated assault, witness to domestic violence, witness to parent assault of sibling, and burglary of family household.

According to a study conducted by Finkelhor, Ormrod, Turner and Hamby (2005), more than 1 in 3 had been a witness to violence or experienced another form of indirect victimization. Besides, Kilpatrick and Saunders (1999) reported that 39.4% of the sample of children and adolescents in their study reported having witnessed one or more serious incidents of violence. Kilpatrick and Saunders (1999) also mentioned in the same study that nearly one in 20 adolescents actually had seen someone shot with a gun, and one in 10 actually had seen someone stabbed or cut with a knife. Similarly, Slovak and Singe (cited in Sullivan, Farrell, Kliewer, Vulin-Reynolds. & Valois, 2008) stated that among children in grades 3 through 8 living in a rural Ohio community, approximately 50% reported witnessing someone being threatened or physically assaulted.

A more recent study conducted by Laye and Mykota (2014) showed that a large percentage of adolescents (78%) were exposed to physical violence as a witness or victim of one or more times. In this study, of all the violent events that were witnessed, seeing someone they know being beaten up was the most common, with more than 60% witnessing this to occur. The second most common event was seeing a stranger being beaten up (Laye & Mykota, 2014).

There is also an indication that the problem of witnessing violence prevails in Ethiopia. For instance, according to Nicodimos et al. (2009) approximately 22.7% of female students and 27.1% of the male students in Hawasssa reported witnessing parental violence.

6. Poly-victimizations

There are research evidences depicting those children and adolescents who have faced problems of one type of victimization are more likely to experience other types as well, making them poly-victims (Finkelhor, Ormrod, Turner, and Holt, 2009). Poly-victimization is the condition by which victims experience different kinds of victimization in different episodes over the course of a year such as an assault and a robbery on different occasions (Finkelhor, 2008). With so many children experiencing so many kinds of victimizations, it is obvious that there must be considerable overlap of these victimization incidents (Finkelhor, 2008; Finkelhor, Ormrod, Turner,& Holt, 2009). The authors further mentioned that from the children and adolescents who experienced any form of victimization in the previous year, two-thirds had experienced two or more victimizations. The average number of victimizations for a victimized child or adolescent was three in the previous year, while the total number of victimizations ranged all the way up to 15 (Finkelhor, 2008). Finkelhor, Ormrod and Turner (2007) pointed out that children experiencing four or more different kinds of victimizations in a single year (poly-victims) comprised 22% of the sample. Since, poly-victims may be subjected to experience more serious mental health problems; it should be of particular concern to professionals (Finkelhor, 2008). Thus, there is a need to consider a wide range of victimization experiences when attempting to assess risk factors for mental illness (Turner, Finkelhor, & Ormrod, 2005).

2. 2. 4. Theories of childhood and adolescence victimizations

The data accumulated through victimization surveys have paved the ways for the development of theories and models of childhood and adolescence victimizations. Fattah (2000) mentioned that models and theories were developed to provide possible explanations for the variations in victimization risks, for the clustering of victimization in certain areas and certain groups, and for unraveling the intriguing phenomenon of victimization. Although the earliest theories emphasized more on a single precursor of victimization, recent ones have come to realize about the importance of incorporating varieties of perspectives including individual, community, and social and political dynamics related factors (Seifert, 2012). In this section, major theories of childhood and adolescence victimizations are reviewed.

1. Ecological theories

By using ecological theories, it is possible to identify risk and protective factors of childhood and adolescence victimizations. According to this theory, risk and protective factors occur at multiple ecological levels (Alink, Euser, van IJzendoorn & Bakermans-Kranenburg, 2013; Cicchetti & Valentino, 2006; Tillyer, 2013; Walsh & DiLillo, 2011). At the victim level, characteristics of the initial abuse and its psychological sequelae can contribute to risk for victimizations by increasing distress and maladaptive coping responses, such as impulsive behavior and substance abuse. In turn, these problems may increase difficulties in identifying risky situations. At the microsystem level, factors involving the context of the abuse, such as the perpetrator's perception of the victim as an easy target, may increase the risk for victimizations (Alink et al., 2013; Cicchetti & Valentino, 2006; Tillyer, 2013; Walsh & DiLillo, 2011).

Furthermore, exosystem factors, such as low socio-economic resources and living in a risky neighborhood, may increase the likelihood of experiencing victimizations due to exposure to

potential perpetrators and limited safety resources. For example, in single-parent, low-income families, caregivers may have difficulty providing an adequate level of supervision (Finkelhor, 2008; Walsh & DiLillo, 2011). Finally, macrosystem factors reflecting cultural and social forces like rape myth acceptance, victim blaming, and patriarchal views are all likely to contribute to sexual abuse and assault by increasing the acceptance of abuse and mistreatment of victims (Alink et al., 2013; Cicchetti & Valentino, 2006; Tillyer, 2013; Walsh & DiLillo, 2011).

2. ***Life course theory***

Age is important in influencing the types of victimization experiences that children and adolescents encounter in their lives. Victimizations are experiences young people encounter (Chen, 2009; Finkelhor, 2008; Macmillan, 2001). In line with this view, Finkelhor (2008) suggests that a life course/developmental approach need to be adopted to study childhood and adolescence victimizations. Life course theory proposes a theoretical framework that focuses on three distinct domains: Age-structured nature and rate of victimization, developmental changes that affect risk of victimizations and developmental processes that affect individuals' reactions to victimizations (Chen, 2009).

Finkelhor (2008) asserts that the nature, quantity, and impact of victimizations vary across childhood with the different capabilities, activities, and environments characteristic of different stages of development. The life course perspective is especially useful in understanding victimizations among adolescents because this period is characterized by rapid change in physical appearance, cognitive development, and domains of social activities. These changes in turn correspond to the change in victimization experiences (Chen, 2009; Seifert, 2012).

Finally, following life course/developmental victimology approach is required to address victims' reactions to victimizations (Finkelhor, 2008; Macmillan, 2001). It needs to be thought

that these life course consequences of victimization may be mediated by the change in victims' sense of agency, self-efficacy, and perceptions of others in the social world (Chen, 2009; Macmillan, 2001).

3. Victim resistance and compliance theory

This theory posits that the behaviors of victims may influence the perpetrator's behavior (Brown, 2010; Schneider, 2001; Turvey, 2002). Turvey (2002) suggests that the degree to which a victim complies or resists is a feature of that individual's life history, experiences, and personality. Compliance implies acquiescence and may involve the victim proactively asking what the offender wants (Turvey, 2002).

4. Lifestyle theory

Hindelang, Gottfredson and Garofalo (cited in Fattah, 2000) developed life style theory of victimization in1978 and this theory assumes that the likelihood that an individual will suffer victimization depends heavily on his/her lifestyle. According to lifestyle theory, victimizations occur where there is a convergence in time and space of likely offenders, suitable targets, and absence of capable guardians, which is suggestive of risk for victimization (Finkelhor, 2008; Schneider, 2001). Hindelang, Gottfredson, and Garofalo (cited in Schreck, Miller & Gibson, 2003) argued that demographic variables indirectly influence victimization risk through their effect on lifestyle. In addition, demographic characteristics determine risk factors, such as levels of exposure and guardianship, which in turn are responsible for demographic variation in victimizations (Macmillan, 2001; Schreck, Miller & Gibson, 2003). In short, the life style theory of childhood and adolescence victimization stresses that a deviant lifestyle evokes an elevated risk of victimization (Schneider, 2001).

5. Routine activities theory

Cohen and Felson (cited in Fattah, 2000) developed another explanatory theory to young people's victimizations. This theory states that victimizations happen when there are direct physical contacts between offenders and children or adolescents who could be possible victims (Cohen & Felson, 1979 in Fattah, 2000). Moreover, Cohen and Felson (cited in Fattah, 2000) underscored that the occurrence of victimization is the outcome of the conference in space and time of three elements including motivated offenders, suitable targets, and absence of capable guardians. The central factors underlying the routine activity approach are opportunity, proximity/ exposure, and facilitating factors (Fattah, 2000; Schneider, 2001). Since the availability or absence of guardians influence their probability of facing victimization, the roles of teachers, other school personnel and students are very essential (Schreck, Miller & Gibson, 2003).

6. Opportunity theory

The opportunity theory attempts to explain childhood and adolescent victimization by incorporating elements from both the lifestyle and routine activity perspectives. The theory assumes that the risk of victimization depends largely on people's lifestyle (micro level approach) and routine activities (macro level approach) that bring them and/or their property into direct contact with potential offenders in the absence of capable guardians (Popp, 2012). Cohen, et al. (cited in Fattah, 2000) asserted that the probability of victimization is influenced by such four factors as exposure to potential offenders, proximity to potential offenders, absence guardianship against victimization, and attractiveness as a target.

Like other approaches, the lifestyles, routine activities, and opportunity theories have pitfalls that limit their elucidations of the complex phenomena of childhood and adolescence

victimization (Christiansen & Evans, 2005; Finkelhor, 2008; Schreck, Miller & Gibson, 2003). One is that they have been fairly limited in their abilities to account for the diverse types of children and youth who get victimized because many victims are not involved in risky lifestyle and routine activities, and they also do not create opportunities for their offenders (Finkelhor, 2008). Secondly, they are not well suited to account for acquaintance and intra family offenses, which constitute a considerable portion of the victimizations children experience (Finkelhor, 2008).Thirdly, their explanations lead to blaming victims. Therefore, researchers who are trying to explain children's victimization by acquaintances and family members have tended to ignore these theories and relied on others (Finkelhor, 2008).

Finkelhor (2008) indicated that other contributing factors such as gender, living in a stepparent family, having parents who fight or are distant and punitive, receiving too little parental supervision, and suffering emotional deprivation make children and youth vulnerable to victimizations. So as to address such factors, Finkelhor (2008) developed a comprehensive dynamic model for explaining childhood and adolescence victimizations.

7. Comprehensive dynamic model

The comprehensive dynamic model of childhood and adolescence victimization attempts to take the previously mentioned elements one step further and add a dynamic dimension. The model brings the factors considered by the life style and routine activities theories and other additional ones together in a model with some sequence and order. Finkelhor (2008 pp.62-63) stated:

> *The model breaks down the offense victimization experience into three sequential processes: Instigation, selection and protection processes. Instigation processes are mechanisms that increase the likelihood or motivation for offending, while the selection processes are mechanisms that govern the choice of particular victims out of a universe*

of all possible victims. Finally, protection processes are mechanisms whose absence diminishes the ability of particular victims to ward off, deter, or escape victimization. These processes occur in a temporal and logical sequence. The mechanisms in these processes can be further subdivided into two levels including the environmental level, in which victims live and interact, and the victim level and the capacities of victims.

According to the comprehensive dynamic model (Finkelhor, 2008), in the first stage many of the conventional offense-instigation factors are considered to increase criminal offending behavior, including conflicts, adversities, and offense-promoting norms (environmental instigation processes). Another aspect of the instigation process factor in the model incorporates victim behaviors (victim-level instigation processes). Victim level instigation process may include the irritability of a small child who arouses the anger of parents, the aggressive behavior of a victim of bullying who provokes peers, or the sexualized behavior of a youth who makes overtures to adults online.

The second process has to do with the selection processes. When instigator processes occur at the environmental level, offenders come to select particular children out of all possible targets. At the environmental level, children are placed at risk by living in more dangerous neighborhoods, going to more dangerous schools, and growing up in more dangerous families. There are also selection processes that might be seen as being more at the level of victim characteristics (target gratifiability) that include gender and age. In the case of sex offenses particularly, many offenders are looking for a victim of a specific gender and age (Finkelhor, 2008).

In the final process, at the environmental level, the protection web surrounding victims are the qualities of supervision and social connectedness. At the victim level, some of the main

components of protection are physical capacities that allow resistance, deterrence, and flight. Other protection components at the victim level are emotional and cognitive capacities that allow individuals to assess danger, stand up for themselves, negotiate with potential offenders, and plan and execute escape and avoidance strategies (Finkelhor, 2008).

2. 2. 5. Factors contributing to childhood and adolescence victimizations. Researchers have identified a number of individual, familial, community and environmental level factors leading to victimizations of young people. Among these, factors that are directly related to this study including age, gender, socio-economic factors, and family structure are considered.

1. Age and victimizations of children and adolescents

Studies have documented age variations in victimization experiences of young people. Hindelang's (cited in Finkelhor, 2008) identified the links between age and victimizations in 1976 in the study of criminal victimization in eight American cities that examined personal crime. This study pointed out that rates of victimization increased from 87 per 1,000 people for respondents 12 to 15 years of age to 114 per 1,000 for persons 16 to 19 years of age and then declined with increasing age. Likewise, data from the National Crime Victimization Survey indicated relationship between age and violent victimization (Bureau of Justice Statistics in Finkelhor, 2008). When these data are disaggregated by offense type, all show a similar relationship with age. Data from other nations show similar age-differentiation in victimization risk (Macmillan, 2001). Macmillan (2001) found greatest risk during childhood and adolescence periods when a variety of life course trajectories are formed.

Although both age groups are the most victimized segments of the population, there are differences in the prevalence of victimization between children and adolescents. The difference

is a complex one because it is highly affected by types of victimization and gender. Finkelhor (2008) showed that the overall victimizations increased slightly for adolescents. The Developmental Victimization Survey of the victimization experiences of 2,030 children from ages 2 to 17 showed that the overall mean number of victimizations during a single year increased with age, as did the percentage of children with poly-victimizations (Finkelhor, Ormrod & Turner, 2009). The study further indicated that the proportion of children with any victimization increased from ages 2–5 to ages 6–9 but subsequently increased only slightly for boys and stayed relatively constant for girls. The mean number of different kinds of victimizations, however, did increase continuously from about 1.7 for 2- to 5-year-olds to 3.4 for 14- to 17-year-olds, with boys experiencing more kinds of victimizations than girls in the 6–9 and 10–13 age groups. Increases with age were also notable for the number of youth who reported four or more different kinds of victimizations (Finkelhor, Ormrod & Turner, 2007). The increase in poly-victimization was most dramatic for boys older than 6–9 years and for girls older than 10–13 years (Finkelhor, Ormrod & Turner, 2009).

Generally, it appears that violent victimizations are strongly concentrated in the early life course. While all stages of the life cycle are significant, the early life course is particularly important. Childhood and adolescence are the periods in which the personal and psychological resources that guide cognition and decision-making are developed (Macmillan, 2001). It is also the period in which individuals accumulate the various capitals, human, social, and cultural, that shape the content of later lives. Violence occurring during this critical period may have important developmental and psychological implications (Macmillan, 2001).

The type of victimization is another source of age differences. With regard to conventional crimes, risk of physical assault increases with age earlier in life (Macmillan, 2001). Similarly,

Finkelhor, Ormrod, Turner and Hamby (2005) reported that certain types, including assault with injury, kidnapping, and bias attacks were higher for the teenage group (Finkelhor, Ormrod, Turner & Hamby, 2005). In addition, murder rates were highest (46%) among juvenile murder victims aged between 15 to 17 years (Seifert, 2012).

As far as child maltreatment is concerned, there are inconsistent research outcomes. According to some studies such as Finkelhor, Ormrod and Turner (2009), surprisingly and unexpectedly, child maltreatment rose with age mainly for girls. On the contrary, Seifert (2012) found out that the youngest children are the most vulnerable to maltreatment (Seifert, 2012). The rates for older adolescents (aged 15–17 years) follow similar patterns and decrease significantly thereafter. Rates for all other age groups do not vary much (Seifert, 2012).

Regarding sibling and peer victimizations, sibling assaults were found to be the highest prior to adolescence and then declined. A study conducted by Finkelhor et al. (2005) showed that dating violence was to be teenage phenomenon. Peer assault had different developmental patterns by gender that increased in adolescence for boys but not for girls (Finkelhor, Ormrod & Turner. 2009). For the sexual victimization, a different age pattern was observed to be higher among adolescents (Finkelhor, 2008) than children. According to the Department of Justice, annual rates of sexual assault were 0.9 for ages 12 through 15 years and 0.6 for ages 16 through 19 years (Seifert, 2012).

Finally, Finkelhor (2008) found that witnessing and indirect victimization experiences were more common during the period of adolescence than childhood period. Similarly, teenagers were more likely than younger children to witness victimizations or experience indirect victimizations, with the exceptions of witnessing domestic violence or physical abuse (Finkelhor, Ormrod et al, 2005).

2. *Gender and childhood and adolescence victimizations*

Gender variations in victimization rates were documented in previous studies. Generally, with the exception of sexual victimization, boys overall suffer more victimizations than girls (Bauman & Summers, 2009; Esbensen, Peterson, Taylor & Freng, 2010; Storch & Ledley, 2005; Uusitalo-Malmivaara, 2012). For example, Bauman and Summers (2009) reported that more than one-half of the boys (58%) reported having been victims of violence in the preceding year, compared with approximately one-third of the girls (39%). In addition, among victims of violence during the previous year, boys reported having been victimized 4.8 times, while girls reported 3.8 violent victimizations (Esbensen et al., 2010). When only serious victimizations were considered, the sex differences were more pronounced. Approximately 20 percent of boys had been victims of serious violence during the previous year, compared with 9 % of girls (Esbensen et al., 2010).

Regarding conventional crimes, boys typically experience more serious violent victimizations than do girls, although the magnitude of the difference varies by age and type of victimization (Esbensen et al., 2010). The only type of assault victimization, significantly higher for girls, was attempted and completed kidnapping, which tends to be associated with sexual assaults (Finkelhor et al, 2005). Higher prevalence of conventional victimization among male children and adolescents could be seen from studies conducted on homicide, robbery, property victimization and other related assaults (Finkelhor, et al, 2005). The ratio of homicide, sub type of conventional crime involving boys to those involving girls is 2.3:1; for assault, it is 1.7:1, and for robbery it is 2:1(Esbensen et al., 2010). The annual rates for robbery for boys were higher than those for girls with approximately three male victims for each female victim (Esbensen et al., 2010). In addition, findings revealed that 14% of boys reported having been victims of aggravated assault and 12 % had been robbed, compared with 7%t and 4% of girls respectively

(Esbensen et al., 2010). Boys experienced more property victimization than girls (Finkelhor et al , 2005).

In the cases of child maltreatment, researchers observed similar patterns of male and female differences. For example, according to a study conducted in the town of Gondar by Mulatie (2014), there was statistically significant difference between male and female children in experiencing psychological abuse in the form of being threatened with severe punishment and in name calling. More proportion of boys experienced threatening with severe punishment and name calling as compared to girls (Mulatie, 2014).

In terms of peer victimization, Uusitalo-Malmivaara (2012) stated that girls and boys were not equally victimized and the outcomes associated with victimization may differ by gender. For the sexual assault, females were more than six times as likely as males to be victims of sexual assaults (Snyder, 2000). More specifically, 86% of all victims of sexual assault were females. The relative proportion of female victims generally increased with age. For example, 73% of female victims were under age 12 and 82% of all juvenile were under age 18 years (Snyder, 2000). Additionally, studies depicted that girls suffer a vastly more incidents of rape: 8.1 female victims for every 1 male (Esbensen et al., 2010). In the case of witnessed and indirect victimizations, with few exceptions, more girls reported being close to someone who was murdered, a fact that may reflect the larger social networks that girls have or identify with (Finkelhor et al, 2005). Since gender differentiation increases as children get older, a plausible developmental hypothesis might be that victimizations are less gender specific for younger children than for older children because gender roles and attributes are less specific (Esbensen et al., 2010).

3. Socio-economic factors and victimization of children and adolescents

Family factors like socio-economic status of the family including income and educational levels have roles in victimization experiences of young people. Studies showed that low socio-economic status is strongly associated with exposure to victimizations (Seifert, 2012; Stoltenborgh et al., 2013; Turner, Finkelhor & Ormrod, 2005). Stoltenborgh et al. (2013) elucidated that poverty or low income might be a factor contributing to a higher childhood and adolescence victimization prevalence. Finkelhor et al. (2005) mentioned that household income was significantly associated with assault with a weapon, attempted assault, multiple peer assault, completed or attempted rape, and emotional abuse. In addition, witnessing or indirect victimization was found to be more common in the lower income group (Finkelhor et al, 2005). Interestingly, bullying was significantly higher for children or youths in households with high incomes (Finkelhor et al, 2005).

Parental educational backgrounds are other aspects of socio-economic status of the family that may influence victimization experiences of young people. Cyr, Michel and Dumais (2013) came up with findings indicating the association of low parental educational level and victimization experiences.

4. Family structure and victimization of children and adolescents

Turner, Finkelhor, and Ormrod (2007) and Finkelhor (2008) indicated that children and youth living in less conventional family situations such as with a single parent, and a step-parent experienced higher rates of several different kinds of victimizations compared with children and youth living with two biological parents. Children from single-parent families were at increased risk for victimization compared to children from two-parent homes (Cicchetti & Valentino, 2006; Turner, Finkelhor & Ormrod, 2007). Furthermore, young people living in stepfamilies had

the highest overall rates of victimization and the greatest risk from family perpetrators, including biological parents, siblings, and stepparents (Finkelhor 2008; Savolainen, 2007; Turner, Finkelhor & Ormrod, 2007). Similarly, separation and divorce may put children and adolescents at the risk of victimizations (O'Hagan, 2006).

It is important to note that it is not family structure in itself that produces more victimization; rather, other variables accounted for the family structure differences in victimization prevalence (Turner, Finkelhor & Ormrod, 2007). Some of those condition that my aggravate the victimizations of young people coming from non intact families include lower socio-economic status, parental dysfunction, problems with the monitoring of children, residential mobility, and exposure to more dangerous neighborhood conditions (Finkelhor, 2008).

Among other factors, exposure to victimizations may contribute to the manifestations of mental health problems in children and adolescents. The role of victimizations in this regard could be seen in those types of childhood and adolescence mental health problems including overall mental health problems, internalizing problems, externalizing behavioral problems, anxious/depressed, withdrawn problems, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors.

2.3. Mental Health Problems of Children and Adolescents

2.3.1. Natures of childhood and adolescence mental health problems

Mental health problems of children and adolescents are major concerns of humans. For a better conceptualization of the mental health problems of children and adolescents, there is a need to have a clear conception of mental illness. Professionals have different conceptualizations of mental illness. For example, Leigh (2010) described mental illness as conditions that interfere

with the sense of wellbeing or function of the individual in emotional, behavioral, or cognitive aspects. In addition, Maddux, Gosselin and Winstead (2008) described mental illness as statistical deviance, maladaptive behaviors, subjective distress and disability, harmful dysfunctions, and deviations from the societal norms. Moreover, American Psychiatrists' Association (2013 p.20) defined mental illness as:

> *A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviors (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual.*

Now a days, a relatively increased attention is given to the study of childhood and adolescence mental illness due to some driving forces. In the first place, many children and adolescents experience significant mental health problems that interfere with their normal developments and functioning (Mash & Wolfe, 2003). Secondly, the frequency of some childhood and adolescence disorders may be increasing as the result of societal changes and conditions that create growing risks for children (Mash & Wolfe, 2003).These conditions are chronic poverty; family breakup; single parenting; child abuse; homelessness; problems of the rural poor; and the impact of HIV, cocaine, and alcohol on children's growth and development (Mash & Wolfe, 2003).

Because of these conditions, researchers in the fields of developmental psychopathology, clinical child psychology, and child psychiatry are becoming attentive to the social policy implications of their work and in effecting improvements in the identification of services for children and youth with mental health needs (Cicchetti, 2006; Mash & Wolfe, 2003).

2.3.2. Classification of childhood and adolescence mental health problems

Generally, there are two types of classification systems of childhood and adolescence mental health problems (Haslam, 2003; Rutter, 2011). These are the categorical (American Psychiatrists' Association, 2000, 2013) and the empirical or dimensional types of classifications (Achenbach & Rescorla, 2001).

a) Categorical classification

The American Psychiatrists 'Association (2013) identified six major types of childhood and adolescence disorders that are classified under the umbrella of neurodevelopmental disorders. American Psychiatrists' Association (2013 p. 31) defined neurodevelopmental disorders as:

> *Group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence.*

The six major types of neurodevelopmental disorders include intellectual disabilities, communication disorders, autism spectrum disorders, attention deficit hyperactivity disorders, motor disorders, and learning difficulties (American Psychiatrists' Association, 2013). The Diagnostic Statistical Manual (DSM) approach initially grew out of the subjective impressions

and descriptions of experienced clinicians (American Psychiatrists' Association, 2013). Over the years, dimensional approach, which is a more objective strategy for conceptualizing childhood and adolescence disorder, has emerged.

b) Dimensional approach

Achenbach and Rescorla (2001) characterize the empirical approach to classification as a bottom-up process involving the collection of data from children with normal and abnormal adjustments followed by attempts to statistically group the many distresses and dysfunctions into meaningful dimensions of disorder (Achenbach & Rescorla, 2001).This classification is made based on statistical techniques that identify key dimensions of children's functioning and dysfunction, with the assumption that all children and adolescents can be described along these dimensions (Achenbach, 2010; Achenbach, 2005; Achenbach & Rescorla, 2001). Differences reflect variations in degree of a dimension, rather than differences in kinds of dimensions (Parritz & Troy, 2011).

Based on the dimensional classification style of Achenbach and Rescorla (2001), there are two broader classifications: Internalizing problems and externalizing behavioural problems. In addition, there are eight specific syndromes including anxious /depressed, withdrawn, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviors ,and aggressive behaviors (Achenbach & Rescorla, 2001). Among the eight specific syndromes, anxious/depressed, withdrawn, and somatic complaints are categorized under the internalizing problems, which are with over controlled behaviors that are often directed toward the self (Achenbach & Rescorla, 2001). Besides, rule-breaking behaviors and oppositional or aggressive behaviors are classified under externalizing behavioral problems, which are with under controlled behaviors that are often directed at others (Achenbach & Rescorla, 2001). The

three remaining syndromes: Social problems, thought problems, and attention problems are not included in either the internalized or externalized problems because of their deviations during item loading (Achenbach & Rescorla, 2001; Parritz & Troy, 2011).

The Achenbach classification system is used to address issues in this study. This approach is chosen for various reasons. In the first place, Achenbach (2010, 2005) suggested this classification system is both relevant and robust across different cultures. With respect to a variety of cultures, there are only small differences in both the estimates of disorder and the underlying dimensions of disorder in children, and there is overall similarity associated with gender and socio-economic factors (Parritz & Troy, 2011). Secondly, this classification has the benefit of reducing the large number of categories of disorder to fewer dimensions, and a better reflection of the reality of continuous models of adjustment/ maladjustment (Achenbach, 2005; Parritz & Troy, 2011). Thirdly, this dimensional approach to the classification of problem behaviors has received strong empirical support (Achenbach 2005; Serafica & Vargas, 2006).

2.3.3. Types and prevalence of mental health problems of children and adolescents

In this part, first the nature of overall mental health problems of children and adolescents with prevalence and risk factors are indicated. Next, the two broad categories of childhood and adolescent adjustment problems (internalizing problems and externalizing behavioral problems) with their basic features, prevalence and possible risk factors are described. After that the eight syndromes: Anxious/depressed, withdrawn, somatic complaint, social problems, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors with their features and magnitudes are addressed.

1. Overall mental health problems of children

Studies have documented prevalence rates of childhood and adolescence mental health problems indicating that the problems are widely prevailing (Corcoran, 2011; Rescorla, 2007). For example, the median estimate of the prevalence of child and adolescent mental health disorders is 12 % of the U.S. population (Corcoran, 2011). Similarly, the prevalence rates in India, Philippines and Colombia were found to be 12 %, 15 % and 29 % respectively (Giel et al. cited in Desta, 2008).

Evidence also suggests that considerable levels of mental health problems exist among children and adolescents in sub-Saharan Africa. A meta analysis study indicated 14.3 % prevalence rate of childhood and adolescent psychopathology (Cortina, Sodha, Fazel & Ramchandani, 2012). With regard to the prevalence of the problem in some specific African countries, the rates were 8 % and 12 % in Sudan (Cederblad cited in Desta, 2008), 15% in Nigeria (Abiodun cited in Desta 2008), 15.2 % in South Africa (Robertson et al. cited in Desta, 2008), and 20 % in Keneya (Kangethe & Dhadphle cited in Desta, 2008).

Few studies conducted in some parts of Ethiopia indicate high rates of overall mental health problems in children and adolescents since 1960s. In a pioneer study, Giel, Bishaw, and van Luijk (1969) reported a prevalence rate of 5.2% among 381 Ethiopians aged less than 20 years. Furthermore, in the same year of 1969 Giel and van Luijk (cited in Fekadu, Alem & Hagglo, 2006) identified a prevalence of 11.3% among 373 children aged 4–20 years in Ethiopia on the basis of interviews.

According to a study conducted in the major cities of Ethiopia on 5-14 years of children and adolescents, overall mental health problem prevalence of 5.5% was obtained (Alem, et al., 2006). Besides, of the surveyed children in Butajira area of Ethiopia, 3.5% had at least one or more

mental or behavioral disorders (Ashenafi et al., 2001). In another study of 5000 children in Addis Ababa, Desta (2008) obtained 17 % weighted prevalence for any mental health problems. Similarly, in a study conducted in Amobo town, the prevalence of childhood behavioral disorder in children was found to be 17.7% (Tadesse et al., 1999). Furthermore, Fekadu, Alem, and Hagglo (2006) reported a 16.5% aggregate prevalence rate of any childhood emotional and behavioral disorders. A study conducted by Mulatu (1995) also indicated 21.45% prevalence for boys and 25.17 % for girls.

The prevalence of the problem varies with the nature of the research participants. The mental health problems prevalence of children in difficult circumstances is higher than that of the samples taken from community or general population. For instance, the prevalence of mental illness among orphan children in six regions of Ethiopia was 31.3% (Deyessa, Wondemagegn, Tefera, Asnake, Bahiretibebe & Abesha, 2012). Furthermore, comparison of any mental illness by six regions of residence showed that prevalence of any mental illness was higher among orphan children from Amhara Regional State (Deyessa et al., 2012). Generally, all these figures indicate that childhood and adolescence mental health problems are serious concerns.

Various factors are found to be related with the mental and behavioral health problems of children and adolescents. These include gender, age, socio-economic status, and cultural factors (Ashenafi et al., 2000; Desta, 2008; Mash & Dozois, 2003; Tadesse et al., 1999). Research has confirmed that there are important gender differences in the prevalence, expression, accompanying disorders, underlying processes, outcomes, and developmental course of psychopathology with more problems in boys than girls (Mash & Dozois, 2003). However, not all studies have reported significant sex differences in overall rates of problem behavior. For example, Tadesse et al. (1999) noted that although boys appeared to have a higher risk of having

behavioral disorders than girls in the crude analysis, the association was not statistically significant and decreased further when other variables were adjusted for in a multivariate model. Similarly, Cortina et al. (2012) found no evidence of a difference in prevalence rates of disturbance between boys and girls.

Evidences indicated that as age increased, the risk of behavioral disorder increased. For example, Achenbach (2005) identified that there was a general decline in overall problems with age, whereas similar studies of clinical samples have found an opposite trend (Mash & Dozois, 2003). Socio-demographic factors including socio economic status have been found to be related with mental health problems. Amaddeo, Donisi, Grigolett and Rossi (2013) reported that people from a more deprived social background, with a lower socioeconomic status, are more likely to have a higher psychiatric morbidity. In addition, 20% or more of children in North America are poor and that as many as 20% of children growing up in inner-city poverty are impaired to some degree in their social, behavioral, and academic functioning (Mash & Dozois, 2003). However, although the reported relationships between socio economic status and child psychopathology are statistically significant, the effects are small (Achenbach, 2005).

The values, beliefs, and practices that characterize a particular ethnocultural group contribute to the development and expression of childhood distress and dysfunction (Mash & Dozois, 2003). Since the meaning of children's social behavior is influenced by cultural beliefs and values, the form, frequency, and predictive significance of different forms of child psychopathology vary across cultures (Mash & Dozois, 2003). So it is important that research on child and adolescence psychopathology should not be generalized from one culture to another, unless there is support for doing so (Mash & Dozois, 2003).

2. *Internalizing problems*

Internalizing problems are core disturbances in emotional problem behaviors that are inner directed and reflect internal distress that is not directly expressed in overt action but indirectly through social withdrawal, anxiety, somatic complaints, or depressed mood (Achenbach & Rescorla, 2001; Mash & Wolfe, 2003; Sabri, 2011; Serafica & Vargas, 2006; Totura et al., 2009). In addition, internalizing problems result from behaviors that are over controlled and over inhibited problems (Sabri, 2011; Wilmshurst, 2013).

A national assessment conducted on the mental and behavioral health problems of orphan children in Ethiopia depicted that 30.6% had internalizing problems (Deyessa et al., 2012). When the role of gender is considered, it was identified that internalizing problems are more prevalent in females than males (Mash & Dozois, 2003).Various forms of adversity (Davidson, and Adams, 2013) and war related conditions (Betancourt, McBain, Newnham & Brennan, 2013) are risk factors for internalizing problems.

3. *Externalizing behavioral problems*

Externalizing behavioral problems are problem behaviors that entail acting out or under-controlled behavior such as aggression, anti-social behaviors, and opposition. Correspondingly, disorders characterized by symptoms that are external are considered externalizing disorders (Serafica & Vargas, 2006). In addition, externalizing disorders are described as outer directed or under controlled and are related to moving against the world. Individuals with externalizing disorders are at odds with society (Mash & Wolfe, 2003; Totura et al., 2009).

Epidemiological studies conducted by Brandenburg, Friedman, & Silver and et al. (cited in Wilmshurst, 2013) documented that the prevalence rates of externalized problems in community samples have ranged from 2% to 20% of the population. Nearly similarly, the prevalence rates of

externalizing disorders in Europe are said to be between 4% and 23% (Andrés et al. in Desta, 2008). In Ethiopia, the prevalence of the problem was found to be 29.3% (Deyessa et al., 2012). Regarding gender differences, males were found more at the odds of developing externalizing problems than females (Mash & Dozois, 2003). In terms of age variation, Achenbach (2005) found that externalizing problems showed a decline with age relative to internalizing problems, but only for those children who had been referred for treatment (Mash & Dozois, 2003). There are both risk and protective factors of externalizing problems (Loukas & Prelow, 2004). Low income is for example a risk factor for externalizing behavioral problems (Loukas & Prelow, 2004).

4. Anxious /Depressed

The dimensional approach in the study of an anxious/depressed syndrome is concerned with depression and anxiety as a constellation of behaviors and emotions identified empirically through the reports of children and adolescents and other informants like parents and teachers (Achenbach & Rescorla, 2001). Anxious/depressed comprises of symptoms reflecting a mixture of anxiety and depression (Compas & Oppedisano, 2000). Studies conducted in the United States and the Netherlands using large samples indicated that a more pure depressive or anxious syndrome did not emerge in the reports of parents, teachers, and adolescents (Compas & Oppedisano, 2000). Although symptoms of sleep disturbance, appetite problems, and concentration difficulties were included in the measures, they did not load on the Anxious/depressed syndrome (Compas & Oppedisano, 2000).

Prevalence of anxious/depressed syndrome are greater for girls than for boys, although this difference is far more pronounced in clinically referred than in non referred samples (Corcoran, 2011; Mash & Dozois, 2003). In most of the previous studies, anxiety and depression were

studied separately. Thus, in order to have a better picture of the epidemiology of the anxious/depressed syndrome, figures depicting prevalence rates of anxiety and depression separately are considered as follows.

a) Anxiety disorder

Anxiety disorders are among most common mental health problems in young people (Mash and Wolfe, 2003). The overall prevalence rates for anxiety disorders in children range from about 6–18% (Mash & Wolfe, 2003). Rates vary as a function of whether functional impairment is part of the diagnostic criteria, with the informant, and with the type of anxiety disorder (Mash & Wolfe, 2003). Moreover, in a study undertaken in Butajira area of Ethiopia, the prevalence rate of anxiety disorders among children and adolescents was 1.6 % (Ashenafi et al, 2001). In another study, Desta (2008) reported a 5.6% prevalence rate of anxiety disorders in Addis Ababa, Ethiopia.

The risk factors that lead to the development of anxiety disorders include biological, psychological and social influences. Corcoran (2011) reported that although biological factors explain about 40 % of the variation in the development of anxiety, other factors, including social influences, account for the majority of the variation. In addition, gender difference in experiencing anxiety was found with more manifestations in females than males (Corcoran, 2011; Mash & Dozois, 2003). Social factors associated with the onset of childhood anxiety include the family, stressful life events, and societal conditions that have changed over time (Corcoran, 2011). With regard to socio-economic status, it has been found that the lower the socio-economic statuses the higher were the rates of anxiety for youth between 10-15 years (Corcoran, 2011).

b) Depressive disorder

As indicated by the American Psychiatrists Association (2013), a major depression is a period of two weeks or longer during which a person experiences a depressed mood or loss of interest in nearly all life activities and dysthymic disorder represents a general personality style featuring symptoms that are similar to, but less intense than, those of major depression. Prevalence studies of depression have shown different figures. For instance, in a study conducted by Costello, Erkanli, & Angold (in Corcoran, 2011), the prevalence of depressive disorders in children was 2.8 % and in adolescents it was 5.7 %. In addition, 9% of 13-18 year-old children in Nigeria suffered from depression (Adewuya & Ologun cited in Desta, 2008). In Butajira, the prevalence of mood disorders was 1% (Ashenafi, eta al., 2001).

The development of depression is linked to biological, psychological, and environmental factors. Although heritability accounts for a moderate amount (about 40 %) of the variance explained for depression (Corcoran, 2011), other factors comprise a majority of the variance (about 60 %). Concerning gender differences, females are at greater risk of being diagnosed with depression (Corcoran, 2011; Mash & Dozois, 2003).

When the relationships between socio-economic status and depression are observed, differing results were obtained. In a systematic review on depression for youth aged 10–15 years, lower compared to higher socio-economic status youth had a higher prevalence of depression (Amaddeo, et al., 2013). However, in a study made by Twenge and Nolan-Hoesksema (in Corcoran, 2011), there was no relationship between socio-economic status and depression.

5. Withdrawal problem

Rubin, Burgess, Kennedy and Stewart (2003) described that the child who interacts with peers at a less than normal rate and the child who is observed or rated by others to spend more than an average amount of time alone is often referred to as socially withdrawn. Social withdrawal can be construed as isolating oneself from the peer group, whereas social isolation indicates isolation by the peer group (Rubin et al., 2003). Social withdrawal can be taken as a warning flag for subsequent social and emotional problems of an internalizing nature (Rubin et al., 2003). Childhood and adolescence withdrawn syndrome was found to be one of the most common mental health problems among orphan children in six regions of Ethiopia with a prevalence of 11.2% (Deyessa et al., 2012).

6. Somatic complaints

American Psychiatrists' Association (2013) describes somatisation as the expression of psychological distress through somatic symptoms. Furthermore, somatoform disorders collectively represent physical and somatic complaints that do not have a medical or organic basis. In individuals with somatoform disorders, emotional distress is experienced as physical or somatic discomfort and pain (American Psychiatrists' Association Manual, 2013).

Carr (1999) asserted that children tend to communicate with their bodies, and may therefore be likely to express their distress somatically, even while saying that things are fine. Achenbach (2005) reported that multivariate studies of the child behavior checklist have identified somatic complaints syndrome as a narrow-band factor falling within the broader dimension of internalizing behavior problems. Carr (1999) showed that children and adolescents aged 4–18, manifest somatic complaints that includes aches, stomach problems, nausea, vomiting, headaches, dizziness, tiredness, eye problems, and skin problems.

With regard to the prevalence of the problem, Wilmshurst (2005) stated that it is not uncommon for children to complain of aches and pains that do not have a medical basis. For example, functional somatic complaints, with medically unexplained symptoms, account for approximately 20% of child visits to pediatric clinics (Robinson, Greene, & Walker cited in Wilmshurst, 2005). In addition, Garralda (2011) reported that in the general population, 2–10% of children have aches and pains, which are mostly unexplained, and 5–10% of children and adolescents report distressing somatic symptoms or are regarded by their parents as sickly. A study conducted in Ethiopia yielded 14.1% prevalence rate of somatic complaints among orphan children living in the major regions of Ethiopia (Deyessa et al., 2012). There are variations in the types of somatic complaints. For example in one study, it was identified that children and adolescents who were high somatizers tended to endorse such somatic categories as headaches (25%), low energy (21%), sore muscles (21%), and abdominal discomfort (17%) (Garber et al, cited in Wilmshurst, 2005).

In some studies, age and gender differences in the prevalence rates of somatic complaints were found. In terms of age, there was increased reporting of multiple symptoms among older children (Uusitalo-Malmivaara, 2012; Wilmshurst, 2005). Regarding gender differences, Garber and colleagues (cited in Wilmshurst, 2005) reported that approximately 11% of adolescent boys and 15% of adolescent girls reported multiple somatic complaints. Offord and colleagues (cited in Wilmshurst, 2005) found that 11% of females and 4% of males (12 to 16 years) were identified as having recurrent and distressing somatic complaints. The gender difference is also observed in the types of somatic symptoms. For example, boys report more headaches at a younger age, while girls report more headaches as teens (Wilmshurst, 2005).

Regarding risk factors, somatic symptom disorder is more frequent in individuals with few years of education and low socio-economic status, and in those who have recently experienced stressful life events (American Psychiatrists' Association, 2013).Wilmshurst (2005) indicated that a relationship can be established between the onset of the somatic complaint and the introduction of psychosocial stressors like victimization.

7. Social problems

Social problems are relationship problems characterized by too much dependency, loneliness, inability to get along with others, accident proneness, getting teased, disliked, clumsiness, preferring younger kids to their own age mates, and speech problems (Achenbach & Rescorla, 2001).

8. Thought problems

Thought problems are mental health problems manifested in displaying strange ideas, storing things, seeing and hearing things that are not there, and harming self (Achenbach & Rescorla, 2001). Flouri and Panourgia (2014) indicated that there is a possibility for adolescents to experience negative automatic thoughts.

9. Attention problems

Attention problems are types of childhood and adolescence mental health problem with such manifestations as acting too young, failing to finish, inability to concentrate, confusing, impulsiveness, and inattentiveness (Achenbach & Rescorla, 2001). In addition, according to the American Psychiatrists' Association (2013), attention deficit hyperactivity disorder is characterized by a chronic pattern of inattention or hyperactive/ impulsive behavior (or both) that is more severe than what is typically observed in peers.

The prevalence of attention problems worldwide is about 5 % (American Psychiatrists' Association, 2013). Similarly, Polanczyk, de Lima, Horta, Biederman, & Rohde (in Corcoran, 2011) reported 5.29% of worldwide prevalence. Center for Disease Control (cited in Corcoran, 2011) reported a 7.8 % prevalence of attention problems among children and adolescents aged 4–17 years. Furthermore, European rates are similar to those of the United States whereas rates in Africa and the Middle East were lower (Corcoran, 2011). In support of this geographical distribution, Ashenafi et al. (2001) showed that the prevalence rate of attention deficit hyperactivity disorder in Butajira-Ethiopia was 1.5%, which was at a lower rate in comparison with the worldwide figure. Similarly, Deyessa et al. (2012) reported that the least prevalent mental health problem was identified in orphan and vulnerable children who participated in the study was attention problem (1.6%).

The distribution of attention problems vary with age and gender with the evidences of more risks for male and older children than females and adolescents respectively (Carr, 1999). Mash and Wolfe (2003) confirmed and strengthened these findings by reporting that attention problems occur with estimates ranging from 6–9% for boys and from 2–3% for girls in the 6- to 12-year age range. Furthermore, in adolescence, the overall rates of attention problems drop for both boys and girls (Mash & Wolfe, 2003). Similarly, in a study conducted on 1477 children in Butajira area, age was significantly associated with attention deficit hyperactivity disorder (Ashenafi et al., 2000). Previous studies have documented that both biological and environmental risk factors are attributed to the development of attention problems in children and adolescents (American Psychiatrists' Association, 2013; Corcoran, 2011).

10. Rule- breaking behaviors

Rule- breaking behaviors are types of externalizing mental health problems in children and adolescents with features of vandalism, truancy, breaking rules, cheating, running away, setting fire, being involved in sex related problems, stealing, and using tobacco and alcohol (Achenbach & Rescorla , 2001). Rule-breaking behaviors could be taken as aspects of conduct disorders, pyromania or fire setting problem, and kleptomania or theft problem (American Psychiatrists' Association, 2013).

Conduct disorders are repetitive and persistent patterns of behaviors in which the basic rights of others or major age-appropriate societal norms or rules are violated (American Psychiatrists' Association, 2013). These include theft, robbery, property destruction, deceiving, often staying out at night despite parental prohibitions, running away from home overnight at least twice while living in the parental or parental, often truancy from school (American Psychiatrists' Association, 2013).

Regarding the prevalence of conduct disorders, one-year population prevalence estimates range from 2% to more than 10%, with a median of 4% (American Psychiatrists' Association, 2013). However, Ashenafi, et al. (2001) reported that the prevalence of conduct disorders in Butajira, Ethiopia was 1.5%. Evidences indicate that there are also figures that go beyond 10%. For instance, there is a study that reported 16% prevalence rate of conduct disorders among pre-adolescent boys (Carr, 1999). Carr (1999) stated that conduct disorders are more prevalent in boys than in girls, with male: Female ratios varying from 4:1 to 2:1 and the rates of conduct disorder decline for boys but not for girls as they mature. The prevalence rates of pyromania and kleptomania were 1.13% and 0.3-0.6 % respectively (American Psychiatrists' Association, 2013).

Biological, social influences and family conditions are found to be risk factors for rule-breaking behaviors of young people. Among the biological factors, genetics, male gender and temperament are the major ones (Corcoran, 2011). Family problems, deviant peers, and low socio-economic status are social risk factors that may lead to rule-breaking behaviors (American Psychiatrists' Association, 2013; Carr, 1999; Corcoran, 2011; Serafica & Vargas, 2006).

11. Aggressive behaviors

Aggressive behaviors are types externalizing behavioral problems with symptoms of arguing a lot, destroying properties, being disobedient at school, getting in fights, and attacking people (Achenbach & Rescorla, 2001). Oppositional defiant disorder (American Psychiatrists' Association, 2013) has many commonalities with aggressive behaviors. Because, the diagnostic criteria of oppositional defiant disorder are patterns of angry/irritable mood, argumentativeness/defiant behavior (American Psychiatrists' Association, 2013), which are similar symptoms with aggressive behaviors. Similarly, Wilmshurst (2013) mentioned that aggressive behaviors have many things in common with oppositional defiant disorders.

According to Mash and Wolfe (2003) during elementary school years particularly with the age range of 8-12 years, oppositional defiant behaviors may take the forms of serious aggressive behaviors. Different studies documented the epidemiology of aggressive behaviors among children and adolescents. American Psychiatrists' Association (2013) stated that the prevalence rates of oppositional defiant disorder ranges from 1% to 11%, with an average prevalence estimate of around 3.3%. Corcoran (2011) estimated the prevalence rate lies between 2% and 16%.

Gender differences were indentified pointing that males were more at odds with the disorder than females (American Psychiatrists' Association, 2013; Corcoran, 2011; Mash & Dozois,

2003). The association of socio-economic status on aggression can be explained mostly by stressful life events and by beliefs that are accepting of aggression (Mash & Dozois, 2003). Environmental factors such as harsh, inconsistent, or neglectful child-rearing practices contribute to the development of aggressive behaviors in children and adolescents (American Psychiatrists' Association, 2013).

2.4. Victimizations and Mental Health Problems of Children and Adolescents

There are various risk factors that may lead to mental health problems of children and adolescents. Victimization experiences are one of such risk factors that compromise the mental health conditions of children and adolescents. Accordingly, evidences that showed the roles of exposure to overall victimizations; independent victimization types (conventional crime, child maltreatment, peer and sibling victimizations, sexual victimizations, and witnessing and indirect victimizations); and poly-victimizations, to the mental health problems of children and adolescents are indicated in this section. The types of mental health problems considered here are overall mental health problems, internalizing problems, externalizing behavioral problems, anxious/depressed, withdrawn problems, and somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors

2.4.1. Overall victimization experiences and mental health problems

Although most studies have focused much on the effect of specific victimization types like sexual abuse, some studies have indicated the negative impacts of victimizations on the mental health problems of children and adolescents. The findings of these un-evenly distributed studies showed that victimization experiences have negative immediate, medium, and long term consequences on the survivors (Miller, 2008; Springera, Sheridanb, Kuoc & Carnes, 2013;

Turner, Finkelhor & Ormrod, 2005b). Turner, Finkelhor and Ormrod (2005b) found that victimizations over a child's life-course represent a substantial source of mental health risk. In addition, Miller (2008) indicated that victimization compromises the psychological wellbeing of children and adolescents.

Previous studies have documented that victimization experiences are risk factors for developing different types of internalizing and externalized behavioral problems in children and adolescents (Peltonen, Ellonen, Larsen, & Helweg-Larsen, 2010; Sabri, 2011; Uusitalo-Malmivaara, 2012). For example, Sabri (2011) asserted that victimization experiences can lead to internalizing and externalizing problems among adolescents. Besides, Peltonen and colleagues (2010) discovered in their studies of adolescents from Finland and Denmark that more severe forms of parental violence were associated with higher levels of internalizing and externalizing problems.

However, the impacts of victimization on internalizing and externalizing problems could be influenced by the severity, duration and timing (recent or distant) of victimizations. For example young people with more severe victimization experiences, longer duration/frequent victimizations, multiple victimizations, and recent victimizations may be at greater risk of internalizing problems and externalizing behavioral problems than adolescents with less severe or no victimization experiences (Sabri, 2011). Furthermore, victimizations by a trusted person were linked to internalizing disorders (Sabri, 2011).There appear to be gender differences related to the influence of victimizations on the internalizing and externalizing problems of children and adolescents.

Previous research findings revealed that victimization experiences can lead to anxiety (Christiansen & Evans 2005; Miller, 2008; Corcoran, 2011) and depression (Christiansen &

Evans 2005; Sabri, 2011; Laye & Mykota, 2014). One impact of victimization is that it may lead to anxiety problems, characterized by extreme, intense, almost unbearable fear that disrupts social or occupational functioning (Christiansen & Evans 2005; Corcoran, 2011). The victim experiences a continual state of free-floating anxiety or nervousness. In addition, according to Miller (2008), there is a constant apprehension that something terrible is about to happen largely based on the fact that something terrible has already happened. Miller (2008) further asserted that the victim maintains an intensive hyper vigilance, scanning the environment for the least hint of impending threat or danger. Occasionally, victims manifest symptoms of panic attacks (Miller, 2008).

Sabri (2011) asserted that victimization experiences contributed to depression symptoms of children and adolescents. In another study, Christiansen and Evans (2005) showed that child and adolescent victimization has been associated with depression and suicidal ideation. Females were found experiencing depression more than males (Laye & Mykota, 2014).

According to Laye and Mykota (2014), victimization experiences contribute to the development of somatic complaints in boys and girls. It was also asserted that female victims were more likely to experience somatic complaints than male victims (Laye & Mykota, 2014). Victimization experiences of childhood and adolescence are risk factors for experiencing symptoms of rule-breaking behavior problems. In this regard, Sabri (2011) stated that victimization experiences can lead to criminal and deviant behaviors. Few studies conducted on the issue indicate that childhood and adolescence aggressive behaviors could be predicted from victimization experiences (Sabri, 2011; Laye & Mykota, 2014). Sabri (2011) noted that victimization experiences can lead to violent behaviors.

2.4.2. Conventional victimizations and mental health problems

The role of conventional crime as a risk factor for any mental health problems of children and adolescents is documented in the studies of Melchert (2006) and Miller (2008). Melchert (2006) stated that many types of criminal victimizations are highly linked to mental health difficulties of young people. Moreover, Miller (2008) underscored that more than an accidental injury, more than a serious illness, and more than a natural disaster, the trauma of crime victimizations go beyond physical and psychological injury by robbing the very faith victims have in the human world.

Miller (2008) argued that victims of crime encounter unique challenges by shattering the victims' mind, body, and soul. Victimizations violate the victims' sense of security and stability; yank the existential ground right out from under their feet. The previously trusting perspective of victims on human goodness surely is threatened (Miller, 2008). Miller (2008) further indicated that the victims' assumptions of justice and the legal system can be contested in ways that defy how they can order their personal world. Victimization acts can nick, dent, and occasionally pierce the psychic shell of security victims envelop in to get themselves through the day (Miller, 2008). According to Miller (2008), the crime victim shuns friends, neighbors, and family members and just wants to be left alone. Moreover, they have no patience for the petty, trivial concerns of everyday life, gossip, news events, and get annoyed at being bothered with these piddling details. The hurt feelings this engenders in those may spur retaliatory avoidance, leading to a vicious cycle of rejection and recrimination (Miller, 2008).

Melchert (2006) stated the linkage between the internalizing and externalizing adjustment disorders of childhood and adolescence with the experience of crime victimization including vandalism, property victimization, theft, and other illegal assaults. Melchert (2006) asserted that

many types of conventional crime are stressful. Besides, the suddenness, randomness, and fundamental unfairness of such attacks can overwhelm victims with helplessness and despair (Miller, 2008). Finally, Miller (2008) stated that conventional crime victim children and adolescents experience various forms of thought problems including impaired concentration and memory, avoidance and denial, and atypical cognitive disturbances.

2.4.3. Child maltreatment and mental health problems

Child maltreatment may lead to mental health problems in children and adolescents (Hendry & Macinnes, 2011; Melchert, 2006). Studies have documented the roles of various forms of child maltreatment on the experiences of internalizing and externalizing behavioral symptoms (Laye & Mykota, 2014; Martinez, Gudin˜o & Lau, 2013; Sabri, 2011; Wimsatt et al., 2013). The findings of Wimsatt et al. (2013) indicate that harsh/physical and inconsistent disciplines are associated with increased circumstances of child internalizing and externalizing behavior. The significant effect of child maltreatment on both internalizing and externalizing problems is nearly a global phenomenon (Martinez, Gudin˜o & Lau, 2013). In addition, maltreated children were found experiencing symptoms of social problems (Cicchetti, 2006; Mash & Dozois, 2003; Wimsatt, Fite, Grassetti & Rathert, 2013) and thought problems (Cicchetti, 2006; Mash & Dozois, 2003).

Miller (2008) indicated that victims of child maltreatment were found to manifest emotional disturbances deeper than expected. Fergusson, Beautrais, and Horwood (in Corcoran, 2011) showed a significant relationship between depression and childhood physical abuse. High levels of corporal punishment were associated with the highest levels of depressive symptoms (Wimsatt et al, 2013). Besides, maltreated children were found experiencing symptoms of social problems (Mash & Dozois, 2003; Cicchetti, 2006; Wimsatt et al, 2013). Child abuse and neglect were also correlated with subsequent attention problems (Dozois, 2003; Cicchetti, 2006; APA, 2013),

thought problems (Dozois, 2003; Cicchetti, 2006), and aggressive behaviors (Dozois, 2003; Cicchetti, 2006) of children and adolescents.

2.4.3. Peer and sibling victimization and mental health problems

Some studies showed the links between peer victimization and the mental health problems of children and adolescents (O'Hagan, 2006; Rubin et al., 2003; Totura et al., 2009). O'Hagan (2006) indicated that children and adolescents who were bullied by peers experienced a miserable life. A study conducted by Totura et al. (2009) showed that children and adolescents bullied by their peers, reported high levels of both internalizing and externalizing difficulties.

Peer victimizations among children and adolescents were found consequential to anxious/depressed syndrome (Totura et al 2009; Uusitalo-Malmivaara, 2012). In a study conducted on the Finnish adolescents, victims of peer violence were more depressed than the non-victims. In another study, female victims reported increased levels of depressive and anxious symptomatology (Totura et al, 2009). Peer victimization events lead to fear of classmates, and ultimately to further withdrawal from peer interaction and possibly from school-related activities (Rubin et al., 2003). Withdrawn children may be involved in close relationships with others who are also victimized, thereby making the social quality of their individual and relationship lives less than optimal (Rubin et al., 2003).

It has been found out that somatic complaints are linked with peer victimization experiences (Wilmshurst, 2005; Miller, 2008; Uusitalo-Malmivaara, 2012). The victimized had significantly more psychobiological symptoms than the non-victimized, poly-victims with the highest number of symptoms in somatization (Uusitalo-Malmivaara, 2012). Although the peer victimized seemed to have more symptoms of somatization than the other groups, statistical significance was not reached (Uusitalo-Malmivaara, 2012). The association between peer

victimization and somatic complaints could be mediated by other factors such as depression (Uusitalo-Malmivaara, 2012).

O'Hagan (2006) indicated that the mental faculties of those children and adolescents who were bullied by peers were seriously impeded and impaired, because they cannot think freely or objectively. In addition, their memories are often dominated by the pain and humiliation of the past; their imaginations are often dominated by the anticipations of the terrors to come; their perception and perceptual antennae are primarily engaged in the fear-inducing action of searching for and pinpointing the precise source and nature of the next attack (O'Hagan, 2006). O'Hagan (2006) further showed the faculty of attention of those children and adolescents who were bullied by peers was adversely affected, seriously curtailing their day-to-day progress.

2.4.4. Sexual victimization and mental health problems

Researchers such as Finkelhor, Ormrod and Turner (2007), Finkelhor (2008) and Itzin, Taket, and Barter-Godfrey (2010) investigated the influential roles of sexual victimizations to the overall mental health problems of children and adolescents. Itzin, Taket, and Barter-Godfrey (2010) reported that childhood sexual abuse, rape and sexual assault, and sexual exploitation through prostitution, pornography and trafficking can have many significant adverse impacts on a survivor's mental health status.

Sexual victimization was found to be associated with the development of anxious/depressed syndromes. For example, according to Spataro, Mullen, Burgess, Wells, and Moss (in Walsh & DiLillo, 2011), the prevalence of anxiety disorders including phobias, separation anxiety disorder, and obsessive-compulsive disorder were significantly higher in sexually victim children and adolescents than in non abused comparisons with the prevalence

rate of 12% versus. 3%. Sexual victimization was found to be a risk factor for somatic complaints (Wilmshurst, 2005)

Studies indicated that aggressive behaviors were associated with the risks of sexual victimizations (Turner, Finkelhor & Ormrod, 2005; Finkelhor, 2008; Walsh & DiLillo, 2011). Walsh and DiLillo (2011) found that children and adolescents who experienced sexual victimizations tended to lack skills to self-regulate angry and aggressive tendencies, which can lead to repercussions in the form of criminal justice involvement. For example, among adolescents entering the juvenile justice system, 25% reported a history of sexual abuse (Walsh and DiLillo, 2011). In addition, sexual assault made contributions to levels of aggression (Turner, Finkelhor & Ormrod, 2005; Finkelhor, 2008). .

2.4.5. Witnessing and indirect victimization and mental health problems

Laye and Mykota (2014) reported that hearing reports of physical violence seemed to be associated with symptoms of psychopathology. However, witnessing violence did not improve the prediction of any of the internalizing problems, externalizing behavior problems, and depression syndromes (Laye & Mykota, 2014). Few studies conducted in Ethiopia reported different findings. For example, a study conducted by Nicodimos et al. (2009) indicted that in Hawassa, females who witnessed parental violence were twice as likely to report moderate depression.

Wilmshurst (2005) and Miller (2008) stated that children and adolescents who witnessed the assault or homicide of a friend or family member, displayed symptoms of somatic complaints (Wilmshurst, 2005). It has been pointed out that victimization types like witnessing family violence, and other major violence exposure each made independent contributions to levels anger/aggression (Turner, Finkelhor & Ormrod, 2005). Finkelhor et al (2007) and Laye and

Mykota (2014) identified the influential roles of exposure to community violence, and witnessing domestic violence to mental health problems.

2.4.6. Poly-victimization and mental health problems

Poly-victimization is the most closely associated one with mental health problems and bad outcomes, and that poly-victims are harbor the greatest amount of distress (Finkelhor et al, 2005; Finkelhor, Ormrod & Turner 2007; Sabri, 2011; Uusitalo-Malmivaara, 2012). Children and adolescents who experienced multiple kinds of victimization from multiple sources have difficulties to recover (Finkelhor, Ormrod & Turner, 2007).

The link between poly-victimization exposures and types of mental health problems of children and adolescents was also documented in the works of Sabri (2011) who stated that adolescents who encountered with multiple types of victimizations were more likely to develop internalizing and externalizing behavioral problems. Furthermore, Uusitalo-Malmivaara (2012) indicated that the poly-victims had the highest number of symptoms in depression, somatization, and violent ideation, but the difference reached statistical significance only in depression. The frequency of experiencing peer poly-victimization was associated with more severe symptoms (Uusitalo-Malmivaara, 2012).

In addition to the frequency of victimization, severity, and recent nature of the victimization exposures were found to escalate the mental and behavioral problems of children and adolescents such as internalizing and externalizing symptoms (Sabri, 2011). Finally, it was portrayed by Sabri (2011) that if adolescents were victimized by someone whom they trusted, more symptoms of internalizing problems were reported than externalizing ones.

2.5. Protective Factors

The operation of risk processes need to be considered in the context of protective factors that the developing individual may also experience. Developmental psychopathology is centrally involved in the search for what have been called protective factors—those variables and processes that mitigate risk and promote more successful outcomes than would be expected (Sroufe, Duggal, Weinfield & Carlson, 2000). Protective factors are associated with positive adaptation and technically, a protective factor, when present, moderates the impact of a risk variable; that is, protection is always particular to specific risks like victimization (Fiese,Wilder & Bickham, 2000).

Investigations of protective factors also focus on the various characteristics associated with better outcomes (Fiese, Wilder & Bickham, 2000; Ingram and Price, 2010; Sroufe et al, 2000). Individual and relationship experiences may moderate the impact of victimization risks or alter their impact. In other circumstances, relationships may be the mechanism through which a certain risk factor has its impact. The most frequently noted protective factors have to do with individual's personality characteristics, family characteristics, peer relationships, social factors, and the availabilities of social support systems (Fiese, Wilder & Bickham, 2000; Ingram & Price, 2010; Sroufe et al, 2000).

One thing that needs to be noted is that not all children and young people who experienced victimizations go on to develop psychological difficulties (Eggum, Sallquist, & Eisenberg, 2010; Finkelhor, 2008; Hendry & Macinnes, 2011; Laye & Mykota, 2014). Hendry and Macinnes (2011) stated the protective role of resilience factors and the greater risk conditions of the frequency and severity of the abuse, and the co-occurrence of more than one type of victimization. There are also conditions that may mediate the association among

victimization experiences and development of mental and behavioral health problem symptoms. For example, such conditions as appraisal, types of coping strategies, the nature of developmental tasks, and environmental buffers might place children and adolescents at increased or diminished risk for encountering negative experiences and outcomes associated with corporal punishment (Finkelhor, 2008; Wimsatt et al., 2013). Moreover, victimizations affect different children and adolescents differently depending on how the child was victimized and those capacities pertain to the child's age and stage of development (Finkelhor, 2008). These variations are explained by different theories of victimizations and mental health problems of children and adolescents.

2.6. Theories of Victimizations and Mental Health Problems

Various theories and models have addressed different factors in explaining the links between victimizations and the development of short- and long-term negative mental health outcomes in children and adolescents. These include resilience theories, sense of coherence theory, traumagenic dynamics model, and developmental dimensions model.

1. Resilience theories

According to resilience theories, not all child and adolescent victims manifest negative mental health conditions (Cicchetti, 2006; Mash & Dozois, 2003). It is because of the fact that some of them could overcome adverse conditions and life experiences. They may have both internal and external resources that help them to cope up victimization experiences (MacDonald, 2006). There are a number of resilience factors that can affect the mental health conditions of victims that includes easy temperament; early coping strategies; high intelligence; and scholastic competence; effective communication and problem-solving skills; positive self-esteem and

emotions; high self-efficacy; and the will to be or do something (Mash & Dozois, 2003). Protective factors may moderate the effects of risk exposure on the psychological wellbeing of young people. Finkelhor (2008) underscored that when risk factors and vulnerabilities outweigh or overcome factors that are protective or that increase resilience, mental disorder can result.

2. **Sense of coherence theory**

Sense of coherence theory suggests that there is a need to look at those who stay well despite being high on risk factors. By taking ideas from salutogenic theory of health, the theory assumes that humans are subject to unavoidable entropic processes-the damage and deterioration caused by life (MacDonald, 2006). From his research, Antonovsky (cited in MacDonald, 2006) identified a range of factors that seemed to play a role in helping individuals to cope and survive. There are generalized resistive resources that facilitate successful coping with the inherent stressors of human existence (MacDonald, 2006). The theory stresses that someone (or some collective) with a strong sense of coherence will believe the challenge is understood (comprehensibility), believe that the resources to cope are available (manageability), and wish to and be motivated to cope (meaningfulness) (MacDonald, 2006).

3. **Traumagenic dynamics model**

Traumagenic dynamics model is the most prominent theory relating victimization (particularly sexual victimization) to negative mental health outcomes of children and adolescents (Walsh & DiLillo, 2011). This model suggests that the impact of childhood and youth victimization could be accounted for by the dynamics of betrayal, trauma, stigmatization, and powerlessness, which are said to alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities (Walsh & DiLillo, 2011). Furthermore, the dynamic of betrayal may come into play following victimization when victims

come to realize that an adult often a trusted adult or family member has violated (Walsh & DiLillo, 2011).

4. Developmental dimensions model

Developmental dimensions model posits that explanations regarding the contributions of victimization on the mental health outcomes of children and adolescents need to address a developmental contexts and broad range of effects, including effects that do not necessarily fall within the realm of psychopathology. Understanding how victimization impacts differ at different developmental stages and trajectories. Finkelhor (2008) argued that critical periods and phases of development when reactions to victimization may have some special potential for impact need to be addressed. For instance, victimizations at certain critical periods may have a heightened effect on social problems and aggressive behaviors (Finkelhor, 2008). Generally, developmental differences can affect four relatively distinct dimensions with bearing on how victimizations impact the psychological wellbeing of children and adolescents. These four dimensions are appraisal, developmental tasks, coping strategies, and environmental buffers (Finkelhor, 2008).

a) Appraisals

Finkelhor (2008) asserted that children and adolescents at different stages appraise victimizations differently and tend to form different expectations based on those appraisals such as wrongness, dangerousness, and self-blame. Appraisals concern the cognitions about what is happening in a victimization and why. Appraisals are affected by developmental considerations (Finkelhor, 2008). Finkelhor (2008) further suggested that pain-mediated victimization (such as assault) can presumably be appraised as noxious at an earlier developmental stage than meaning-mediated

victimization (such as theft). It has been identified that the belief that one could have been seriously injured or killed are associated with more harm and more symptoms (Finkelhor, 2008).

b) Developmental tasks

Developmental tasks dimension deals with questions of whether there are sensitive periods with regard to various developmental tasks, and whether victimization during these periods has a unique capacity to cause permanent developmental distortions (Finkelhor, 2008; Macmillan, 2001). Overall, violent victimization in early life seems an important precursor to long term or recurring psychological distress over the life course (Macmillan, 2001).

Finkelhor (2008) suggested that victimization may impact developmental tasks in three conceptually distinct ways. First, victimization can interrupt or substantially delay the accomplishment of the task. Second, victimization can distort or condition the way in which the developmental task is resolved. Third, victimization can result in regression, so that the achievements of a previously resolved developmental task are disrupted. Newly acquired achievements are those most vulnerable to disruption. The implication of this is that victimization can result in departures from normal development (Finkelhor, 2008).

c) Coping strategies

Children and adolescents found at different stages of development have different coping strategies with which to respond to the stress and conflict produced by victimization including avoidance, somatization, and cognitive processing. Finkelhor (2008) suggested that some coping strategies are relatively confined to certain developmental stages, and others cut across stages.

d) Environmental buffers

The social and family contexts operate on children and adolescents of different stages differently which can alter how the victimization affects them (Finkelhor, 2008). Finkelhor (2008) further

noted that the responses of parents, peers, siblings, teachers, psychologists, social workers, mental health professionals, police officers, prosecution officers, lawyers, and significant others influence the conditions that victimization contributes to the mental health problems of children. The presence of psychological, social, and legal support systems of victims and immediate responses to victimization may buffer the immediate and long-term psychological consequences (Finkelhor, 2008). Thus, victim services need to concentrate on children and adolescents and attempt to restore the sense of agency and trust that victimization undermines (Macmillan, 2001).

2.7. Summary of the Review and Conceptual Framework

Throughout the history of human society, children and adolescents are victims of different forms of victimization including conventional crime, child maltreatment, sibling and peer victimizations, sexual victimizations, and witnessing and indirect victimizations.

Fragmented studies on these young people indicate that sizeable proportions of them were exposed to victimizations that occur in different settings including home, schools, and community. Different theories and models such as ecological, victim resistance and compliance, life style, routine activities, opportunity theories, and compressive dynamic model were identified to explain the likelihood of the occurrences of victimizations. Socio-demographic risk factors like low family income, low level of parental education, and unconventional family structure that may contribute to childhood and adolescence victimizations were taken into account. In addition, gender and age were considered. What makes victimization experiences to be worse is its association with different types of childhood and adolescence mental health problems.

In order to have a better picture of the problem of the link between victimizations and psychopathology in children and adolescents, looking into the natures of the overall mental health problems and their epidemiology is essential. The fragmented and un-evenly distributed studies conducted previously indicated that the prevalence of childhood and adolescence mental health problems varies depending on the types of studies, methods used, and natures of the participants, and study areas. However, most of those studies depicted that there are children and adolescents, who developed broader forms of mental health problems including internalizing problems and externalizing behavioral problems as well as specific syndromes (anxious/depressed, withdrawn problem, somatic complaints, social problems, and attention problems, thought problems, rule-breaking behaviors, and aggressive behaviours). Moreover, there are indications that victim children and adolescents are more at the risks of manifesting psychopathology than the non victims. Some theories and models such as resilience theory, sense of coherence theory as well as traumagenic and developmental dimensions models were used to explain the developments of childhood and adolescence mental and behavioral health problems in victim children.

Most of the previous studies conducted on the problems of victimizations and mental health problems are fragmented and un-evenly distributed. They focused on the studies of particular types of victimization such as sexual victimization or peer and sibling victimizations and its contributions to a single type of mental health problem of children and adolescents such as depression, post traumatic stress disorder or anxiety. However, for the sake of better understanding of these problems, a comprehensive study that addresses various victimization types and their contributions to different forms of mental health problems is required. Accordingly, this study attempted to address these gaps by examining the contributions of socio-

demographic variables to victimization types and also the links between victimization types with mental health problems of children and adolescents. In so doing, developing conceptual frameworks showing the associations of these variables is essential.

Based on the theoretical ideas obtained from the literatures of childhood and adolescence victimization experiences and mental health problems, conceptual frameworks showing the relationship of the variables considered in the study were developed. The conceptual frameworks severed as guides for identifying the objectives, clarifying the problems, farming the reviews, designing the methods, and interpreting the results.

Since, one of the objectives of the study was to examine how the socio-demographic variables were associated with victimization, the first conceptual frame work attempted to depict the relations of age, gender, family income, maternal education, and family structure with victimization types including overall victimization, conventional crime, child maltreatment, sibling and peer victimization, sexual victimization, and witnessing and indirect victimization.

The second conceptual framework addressed the contributions of individual types of childhood and adolescence victimizations to the manifestations of mental health problems (any mental health problems, internalizing problems, externalizing behavioral problems, anxious/depressed, withdrawn, somatic complainants, and social problems, attention problems, thought problems, rule-breaking behaviors and aggressive behaviors).

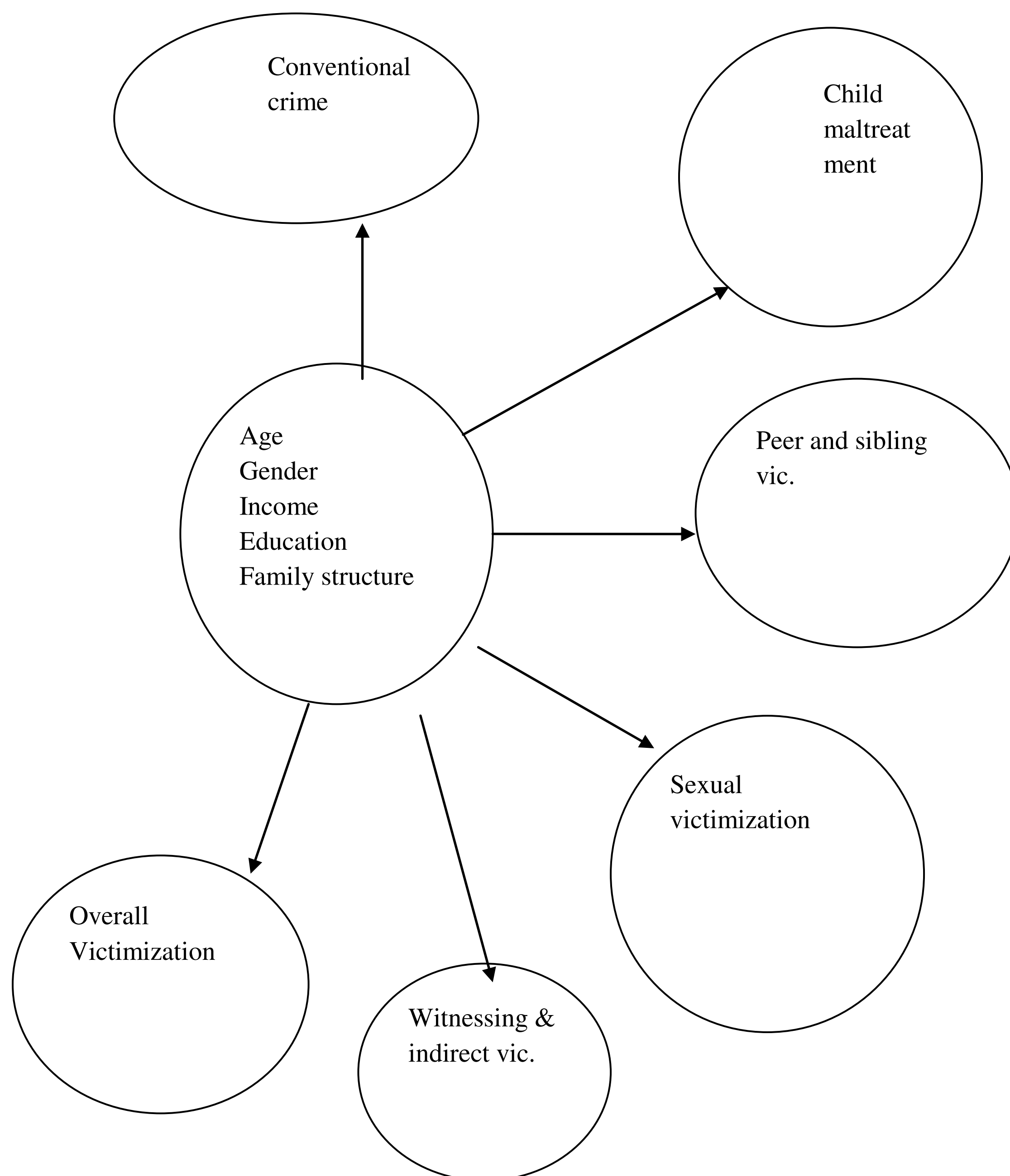

Fig 1

Conceptual framework showing associations among socio-demographic factors and victimizations

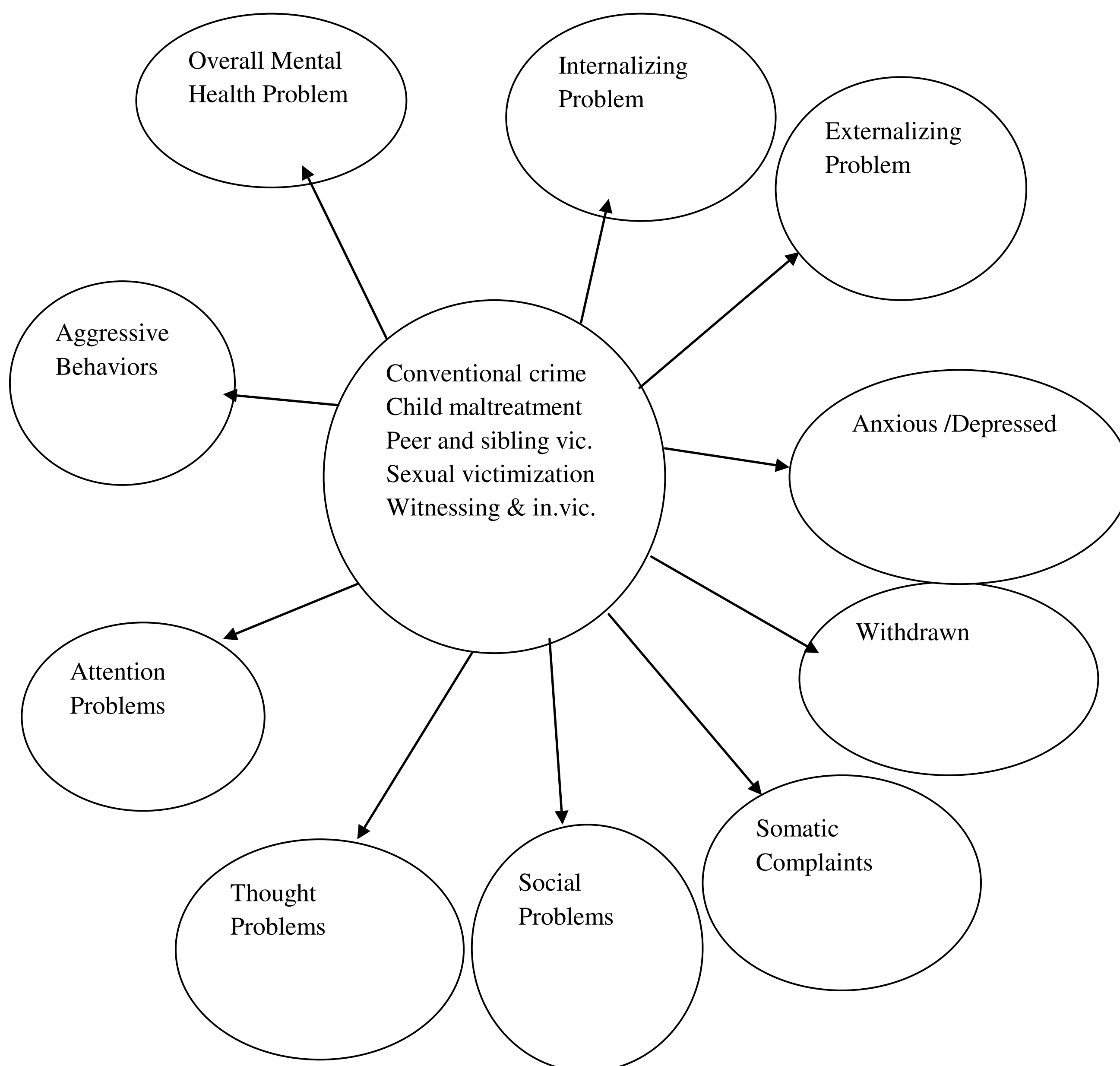

Fig. 2

Conceptual framework showing associations among victimizations and mental health problems

Chapter Three: Methods

This chapter presents the methods of the study consisting of the overall design, study setting, target population, sampling techniques, tools of data collection, procedures of data collection, methods of data analysis, and ethical considerations.

3.1. Study Design

The present study adopted descriptive and correlational cross-sectional survey design. The choice of the descriptive approach results from its relevance in determining the prevalence rates of childhood and adolescence victimization and mental health problems. Furthermore, the descriptive survey design was found to be suitable to outline the victimization experiences and mental health conditions of children and adolescents of different age brackets at a time. In support of this, Dussich (2006b) indicated that the most important types of victimological descriptive research are victimization survey and these surveys have become the backbone of victimological studies. To be more specific, local victimization survey method was used because the study was confined to the elementary school students' population of Gondar town. This type of survey has also proven to be highly valuable supplements to national research endeavors (Schneider, 2001).

The correlational design was preferred to other designs for its appropriateness to examine the relationships among socio-demographic factors and childhood and adolescence victimization experiences. Besides, correlational design was found to be suitable to gauge the associations among victimization experiences and mental health problems of the participants in the study. In line with the design, quantitative data was gathered using standardized scales and the data was analyzed using both descriptive and inferential statistical techniques.

3.2. The Study Setting

The study was conducted in the Town of Gondar. Gondar is an old town founded by Emperor Fasiledes around the year 1635. Previously, Gondar served as the capital of both the Ethiopian Empire and the subsequent Begemder and Semen Province. It is now a capital of North Gondar Zone of the Amhara Regional State. Geographically, Gondar is located in the northwestern part of Ethiopia: Precisely North of Lake Tana and southwest of the Simien Mountains. It is situated at about 740 km away from the capital Addis Ababa.

. The population size of Gondar Town is rapidly increasing. According to the 2007 National Census (CSA, 2007), Gondar had a total population of 207,044 (98,120 males and 108,924 females), among whom 100,984 of them were young people below the ages of 20 years. The number of those who were attending schooling constituted 76 051.The city of Gondar has institutions that offer services to the community: Kindergartens, elementary schools, high schools, university, a government referral hospital, and clinics. The town of Gondar is known in its cultural heritages and tourist attraction sites like the castle of Fasiledes, many churches, and Baptismal Sea. These heritages make Gondar to remain as one of the impressive visible reminders of the Ethiopian past (Levine, 1965).

The town of Gondar was selected, because it is a major urban center in the North Western part of Ethiopia. In addition, since it is a tourist destination, there are a number of people who are moving to the town and away from it. It is assumed that these conditions may have something to do with victimization experiences of children and adolescents. In addition, the social, cultural and economic conditions of the area may have roles in victimizations (e.g. physical punishment) that in turn may lead to mental health problems of elementary school children and adolescents.

3.3. Population and Sampling Techniques

3.3.1 Target population

The target population of the study included a total of 43,351 children and adolescents with the age ranges of 7-17 years who were attending formal education in 58 primary schools of Gondar town during 2005 E.C. academic year. The numbers of male and female students were 21,698 and 21,653 respectively. Both private and government elementary school students were parts of the target population. 36,046 of them were students from government schools where as the remaining 7,305 of them were private school students. The 2005 E.C. data was taken into account to select the samples, because the 2006 E.C. data from Gondar town Woreda Education Office was not yet ready at the time of data collection.

Table 1

Target Population by Number of Primary Schools and Number of Students (Gondar Town Education Office, 2005 E.C)

School type	No. of schools	No. of students
Government	41	36046
Private	17	7305
Total	58	43351

3.3.2. Sample size determination and sampling techniques

Following the sampling formula developed by Krejcie & Morgan (1970) and taking 95 % confidence level, 5 confidence interval and 10 % of non response rate, a sample of 420 children and adolescents were drawn from the target population. The sample included both male and female children and adolescents who were attending in the chosen schools of Gondar town.

In order to draw the sample from the target population, stratified random sampling technique was employed. A stratified random sampling technique was preferred to other sampling methods because the ages of children in the schools vary depending on their grade levels. Accordingly, the stratification was made based on grade levels. Starting from grade one to grade eight, a total of eight strata were formed. Three elementary schools consisting of two governmental schools (Tsadiku Yohnnes and Abiyot Fire Elementary Schools) and one private school (Debreselam Elementary School) were selected using simple random sampling technique. By taking nearly closer number of samples in each stratum, 12 to 19 students were randomly drawn from each grade level (grade one to grade eight levels) of the three selected schools.

By doing so, the data was collected from 420 children and adolescents. From the 420 children and adolescents, the mental health status of 150 children was rated by teachers while the rest 270 responded in a self report format. This was done because according to Achenbach & Recoria (2001), for children below the ages of 11 years, the measure needs to be administered in Teacher Report Form. Accordingly, to collect data on the mental health problems of children from one to three grades, 27 teachers (three from each grade and nine from each school) were selected using purposive sampling method. Teachers who repeatedly taught selected students (at least twice) and those who taught more than one subjects were chosen in consultation with

school directors of the selected schools. Each of the 27 teachers was given six questionnaires to respond on the mental and behavioral health conditions of six selected children.

However, final analysis was conducted on 403 children and adolescents because 17 cases were discarded during the data cleaning process. These cases were removed because they were filled inappropriately and more missing cases were found. The summary of the sample taken from each school and grade levels is shown in Table 2.

Table 2

Summary Table of the Sample by School Names and Grade Levels

Grade levels	**Schools**			**Total**	**Reporting format for ASEBA**	**No. of teachers**
	Tsadiku Yohannes	Abiyot Fire	Debreselam			
Grade 1	18	17	17	52	Teacher	9
Grade 2	18	17	17	52	Teacher	9
Grade 3	18	12	16	46	Teacher	9
Grade 4	17	19	18	54	Self	-
Grade 5	18	19	18	55	Self	-
Grade 6	17	19	16	52	Self	-
Grade 7	18	19	17	54	Self	-
Grade 8	18	18	19	55	Self	-
Total	141	141	138	420	-	27

3.4. Variables of the Study

The variables considered in the study were socio-demographic characteristics, victimization experiences, and mental health problems of children and adolescents under investigation. In the

socio-demographic characteristics, gender, age, family income, maternal education, and family structure were taken into account. Any victimizations, conventional crime, child maltreatment, sibling and peer victimizations, sexual victimizations, witnessing and indirect victimizations, and poly-victimizations were the specific variables addressed in the victimization experiences. The mental health problems were classified into three major problem types: Any mental health problems, internalizing problems, externalizing behavioral problems, anxious/depressed, withdrawn, somatic complaints, and social problems, thought problems, attention problems, and aggressive behaviors. In examining the contributions of victimizations to the mental health problems of children and adolescents, victimization types were the independent variables whereas mental health problem types served as outcome variables.

3.5. Measures

Different types of measures were employed to collect the required data from the participants. These included Socio-demographic Questionnaire, Juvenile Victimization Questionnaire and Achenbach Systems of Empirically Based Assessment (ASEBA) Youth Self- Report and Teacher Report Forms.

1. **Socio-demographic Questionnaire**

The Socio-demographic Questionnaire was used to measure the socio-demographic characteristics of respondents that consist of age, gender, parental education, household income, and family structure of the participants. For the purpose of this research, age levels of the respondents were classified into two groups: 7- 11 years and 12- 17 years. To identify the gender of the respondents, an item asking for gender to be rated either as male or female was included. Items for parental educational background of the respondents were prepared based on responses

to be rated as no formal education, elementary school education, high school education, and higher education. In order to get information regarding the income levels of the respondents' family, an item asking for the income level to be rated as high, medium or low was included. Finally, parents' family structure was defined by the current composition of the household. Specifically, three groups were constructed: Living with parents, single parent, and relatives.

The socio-demographic questionnaire was a self-constructed measure. First the English version of the instrument was prepared and finally, it was translated into Amharic language for the sake of better understanding of the items by the respondents. In this category, there were 10 items. The sketch of the socio-demographic measure is indicated as follows.

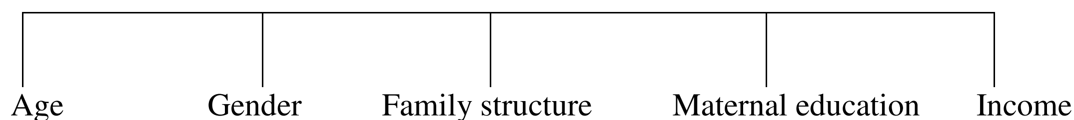

Fig 3. Socio-demographic characteristics

2. Juvenile Victimization Questionnaire (JVQ).

To measure the victimization experiences of children and adolescents, child self-report version of Juvenile Victimization Questionnaire, 2nd Revision (JVQ-R2) developed by Hamby and Finkelhor (2001) was used. The Juvenile Victimization Questionnaire is an inventory of childhood and youth victimizations which cover five general areas: Conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimizations (Hamby & Finkelhor, 2001). In the screener version, there are 34 items that require 'yes' or 'no' responses. The JVQ is chosen for an obvious reason that it is the most comprehensive measure of victimization experiences. Moreover, it is useful in assessing children of various ages including children from 7-17 years. The reason why the basic screener type is used is because items in the full JVQ-R2 form are too much to administer. Moreover, the main

interest in this study was to collect some key incidents such as types and prevalence of the problem that are covered in this shortened form of the questionnaire (Hamby & Finkelhor, 2001). The sketch of the Juvenile Victimization Questionnaire is indicated as follows.

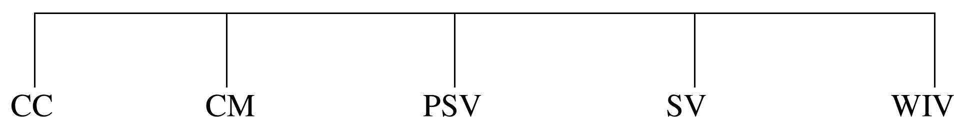

Fig 4. Sketches of victimization types as measured by JVQ

With regards to the psychometric characteristics of the measure, encouraging results have been found. The reliability and validity of juvenile victimization questionnaire have been demonstrated in a number of ways. Construct validity has been shown in numerous studies comparing juvenile victimization with psychological and sociological constructs such as depression and neighborhood crime rates. One of the major and consistent findings from the victimization literature is that victimization is associated with trauma-related symptomatology (Finkelhor, 2008; Hamby & Finkelhor, 2001). Overall, the correlations suggest that the JVQ screeners, modules and composites behave as other victimization instruments do and are measuring victimizations of the sort that concern criminologists and mental health professionals.

Two PhD students from social psychology and social work programs of Addis Ababa University, conducted back and forth translations from English language to Amharic language and vice versa. After the translation was made, a team of experts consisting of the researcher and two psychology and social work professionals discussed the appropriateness of the items of the instrument for the Ethiopian context, that ensures the content and face validities of the instrument. Based on the ideas of the translators and experts, possible adjustments in the Amharic and English versions of the instrument were made. Moreover, one of the 34 screener items was deleted during the expert discussions. The 34th item was removed because, it was

found irrelevant for the study context. As a result to measure the victimization experiences of children and adolescents, 33 items were used.

The instrument showed adequate test-retest reliability in a 3 to 4 week re-administration (Finkelhor, Hamby, Ormrod, & Turner, 2005). The Juvenile Victimization Questionnaire (JVQ) has shown evidence of good test–retest reliability across a wide spectrum of developmental stages (Finkelhor, Hamby, Ormrod, & Turner, 2005). The overall α for the JVQ for respondents answering all 34 items is .80, which is very good one.

In addition to the original reliabilities, the internal consistency of the items was checked using the sample who participated in the pilot study. Accordingly, series of Chronbach alphas were run and it has been found that the instruments are dependable. The alpha results for the total items and subscales of the original reliabilities and alpha values from the pilot study are indicated in Table 3.

Table 3

Internal Consistency Reliabilities for JVQ and its Sub Measures for the Original and Pilot Studies

Measures	No. of Items	Original α value	α value of the pilot	Remark
Conventional crime	9	.61	.632	Acceptable/acceptable
Child maltreatment	4	.39	.513	Unacceptable/poor
Peer & sibling victimization.	6	.55	.673	Poor/acceptable
Sexual victimization	7	.51	.580	Poor/poor
Witnessing & indirect victimization	7	-	.734	-/Good
Full JVQ	33	.80	.855	Good/good

3. Achenbach System of Empirically Based Assessment (ASEBA) School –Age Teacher's Report Form and Youth Self-Report.

In order to measure the mental health status of children and adolescents, the Achenbach Systems Empirically Based Assessment (ASEBA) School–Age Teacher's Report Form and Youth Self-Report Forms were employed. These instruments were developed to assess child's behavioral and emotional problems generally (Achenbach & Recoria, 2001). The Teacher's Report Form was used for children from 7-10 years, while the Youth Self-Report Form (YSR) was employed for participants from 11-17 years old.

Both the Youth Self- Report and the Teacher's Report Form of the Achenbach Systems Empirically Based Assessment (ASEBA) assess problem behaviors. The Youth self-Report Form has 112 items whereas the Teacher's Report Form has 113 items. Since item number 56 includes

sub items in it, the total number of items for the full scale is 120 items. From these, a total of 87 items that are common for both the Youth Self Report and Teacher's Report Forms were used in the study. Report response format for problem behaviors is from 0 ("not true") to 2 ("very true"). The problem behavior items load onto two broad-band scales (internalizing and externalizing) and eight narrow-band scales (Rule-breaking, aggressive behavior, withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, and attention problems) (Achenbach & Recoria, 2001). Problems measured by Achenbach Systems Empirically Based Assessment (ASEBA) measures are indicated as follows.

Internalized problems			Externalized problems		Attention, social and thought problems		
Anxious/depressed	Withdrawn problems	Somatic complaints	Aggressive behaviors	Rule –breaking behaviors	Attention problems	Social problems	Thought problems

Fig 5. Mental health problems measured using ASEBA

The Achenbach Systems of Empirically Based Assessment (ASEBA) measures have good psychometric characteristics in terms of validity and reliability. Content validity for the original version of the measure was established by generating an initial item pool for the measure from clinicians and from the research literature (Achenbach & Rescorla, 2001). To assure the content validity of instruments, expert discussion consisting of two psychology and social work PhD students was conducted. The expert discussion was conducted after back and forth translation was made.

Two-week test-retest reliability for the Teacher Report Form was reported to range from .60 to .95. Internal consistency was generally reported to be high across all versions given that scales were derived via factor analysis techniques (Achenbach & Rescorla, 2001). Reliabilities

ranged from moderate to high, with the highest agreement obtained on scales assessing externalizing behaviors. In addition to the promising original reliabilities, encouraging internal consistency of the items was found from the pilot study that ranges from acceptable to excellent ratings. Alpha values for the original and the pilot study of the measures are indicated in Tables 4 and 5 respectively.

Table 4

Original Internal Consistency Reliabilities of Achenbach System of Empirically Based Assessment (Youth Self Report and Teacher Report Form)

Measures	YSR α	TRF α	Remark
Anxious /depressed	.84	.86	Good
Withdrawn problems	.71	.81	Good
Somatic complaints	.80	.72	Good
Social problems	.74	.82	Good
Thought problems	.78	.72	Good
Attention problems	.79	.95	Good; Excellent
Rule-breaking behaviors	.81	.95	Good; Excellent
Aggressive behaviors	.86	.95	Good; Excellent
Internalizing problems	.90	.90	Excellent
Externalizing problems	.90	.95	Excellent
Total ASEBA	.90	NA	Excellent; NA

Table 5

Internal Consistency Reliability of Achenbach System of Empirically Based Assessment (Youth Self Report and Teacher Report Form) for the Pilot Study

Measures	No of items	α	Remark
Anxious /depressed	13	.737	Good
Withdrawn	8	.686	Acceptable
Somatic complaints	9	.820	Good
Social problems	11	.664	Acceptable
Thought problems	10	.723	Good
Attention problems	9	.732	Good
Rule-breaking behaviors	11	.763	Good
Aggressive behaviors	16	.643	Acceptable
Internalizing problems	30	.891	Good
Externalizing behavioral problems	27	.853	Good
Any mental health problems	87	.964	Excellent

3.6. Pilot Study

To check the procedures of data collection, administration, and scoring and analysis, pilot study was conducted. The pilot study was conducted on 112 children and adolescents with the age ranges of 7- 17 years who were students of Hibret and Bekafa Elementary Schools in Gondar town during 2013/14 academic year. The data was collected from September 24- 26, 2013. Based on the results of the piloting, the procedures of data collection, administration, scoring and

analysis were checked. In addition, the reliabilities of the instruments were checked using Cronbach Alpha.

3.7. Procedures of Data Collection and Administration

The process of data collection began by getting permissions from the school principals of the selected schools which was followed by selecting students of various grades levels and sections. The purpose of the study was clearly communicated to the participants and written consent was ensured. Conducive physical and psychological environmental conditions were created. In order to ensure privacy of the participants, rooms were identified with the collaboration of the school directors and the data collection and administration process was conducted in classrooms. An attempt to make participants motivated and feel comfortable to answer the questions freely and accurately was made.

After the physical and psychological conditions of the setting were arranged, the questionnaires were distributed to the selected respondents. In so doing, for older participants from grades four to eight (who were expected to be with the age ranges of 11-17), the questionnaire set containing all the components of the measures (Socio-demographic Questionnaire, Juvenile Victimization Questionnaire, and ASEBA Youth Self-Report) were distributed and administered in a self-report form. The Teacher's Report Form of the Achenbach Systems of Empirically Based Assessment (ASEBA) was used to collect data on the mental health status of younger children from one to three grade levels (who were expected to be with the age ranges of 7 to 10 years). To collect the data on the victimization experiences and socio-demographic characteristics of those children whose mental health behaviors were rated by teachers, the measures were administered in a child interview format. This was done because; for

one thing children with this age category can give information by themselves and secondly teachers may not have adequate information regarding the victimization experiences and socio demographic characteristics of these students. Although the standard child-interview format of Juvenile Victimization Questionnaire is used for children from 8 to 12 years, it is also suggested that six and seven year's old children could provide adequate data using the child- interview format (Hamby & Finkelhor, 2001). Moreover, forensic research showed that children are more than 90% accurate in details of self-report down to age four (Hamby & Finkelhor, 2001).

The whole process of the data collection and administration was undertaken by the researcher with the assistance of one health psychology graduate student from Addis Ababa University. To obtain the data using for children from 7- 10 year through interview, the assistant was oriented and used for conducting the interview. Finally, all the completed socio-demographic, juvenile victimization, and mental health problems questionnaires were returned back and the data became ready for scoring.

3.8. Scoring

The data collected using all the measures were entered in to SPSS version 20. In order to obtain the total sum of the scores of each variable, the data collected using the socio-demographic characteristics were scored item by item. The responses that were obtained from the administration of the juvenile victimization questionnaire were scored based on module scores. Module scores were used as dichotomous scores. Thus, a "yes" or 1 for a module indicates that at least one form of victimization on that module was reported, whereas a "no" or zero indicates that no forms of victimizations on that module were reported. The module scores

included scores for conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimization (Hamby & Finkelhor, 2001).

For the Achenbach Systems of Empirically Based Assessment (ASEBA) measures, a total problems score comprising the sum of all the scores on the behavior items was obtained. In addition, ratings of internalizing and externalizing behaviors were scored. The internalizing score rates fearful, inhibited, or over controlled behavior while the externalizing score rates aggressive, antisocial, or under controlled behavior. In each case, the score is based on the sum of the scores on the items comprising each scale. Eight syndrome scores, labeled anxious/depressed, withdrawn, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors provide ratings in more specific areas.

In using the syndrome profiles, the total score for each syndrome scale was computed by summing the scores of 1 and 2 for the common items of the Youth Self Report and Teacher's Report Forms (Achenbach & Rescorla, 2001). High scores on the syndrome scales indicate important deviance, because they reflect numerous problems. Regarding the scoring procedure based on internalizing and externalizing syndromes, the sub types in each were identified. Internalizing consists of three syndromes and the externalizing one has two syndromes. There are also three other syndromes that are not included in either of the two: Social, thought and attention problems. The internalizing score was computed by summing the scores for the three internalizing syndromes of anxious/depressed, withdrawn, somatic complaints, whereas the externalizing score was calculated by summing the scores for the two syndromes of rule-breaking and aggressive behaviors (Achenbach & Rescorla, 2001).

When the ranges of the scores are considered, a total of 18 and 24 are starting scores for the internalizing problems of boys and girls respectively (Achenbach & Rescorla, 2001). For the

externalizing problems, total scores of 20 and 21 (Achenbach & Rescorla, 2001) are beginning problem ranges for boys and girls respectively. For the overall mental health problems, 62 for boys and 70 for girls are the beginning problem ranges (Achenbach & Rescorla, 2001). Scores of 12 and 15, 9 and 10, 8 and 12 are the beginning problem ranges for anxious/depressed, withdrawn, and somatic complaints of boys and girls respectively. Scores of 10 and 12 are the starting points of the social and attention problems respectively for both boys and girls. 11 and 13 are starting scores of thought problems for males and females respectively. Finally, 13 and 14 for rule-breaking and 16 and 18 for aggressive behaviors of boys and girls respectively are beginning scores for problem ranges (Achenbach & Rescorla, 2001).

In order to see the whole picture of the problem, the use of total problem score is important. The total problems score was obtained by summing 1 and 2 scores on the specific problem items. The total problems score was computed by summing the scores for the internalizing, externalizing, and the other three syndromes (Achenbach & Rescorla, 2001).

3.9. Methods of Data Analysis

In line with the research questions, both descriptive and inferential statistical techniques of data analysis were used. As part of the descriptive analyses, the socio-demographic characteristics of the respondents as well as the prevalence of victimization experiences and mental health problems of the respondents were estimated using percentages. Descriptive statistics including percentages mean, maximum, minimum, and standard deviation were employed to describe victimizations and mental health problems of victimized children and adolescents.

In order to see the association of socio-demographic variables with victimizations of children and adolescents, direct or forced logistic regression analysis was used. In addition, in

order to see the associations of the various socio-demographic factors with each independent victimization type (conventional crime, child maltreatment, peer and sibling victimization, sexual victimizations, and witnessing and indirect victimization) separately, series of logistic regression analyses were computed. Similarly, to explore the relative independent effects of individual types of victimization on any mental health measure, internalizing problems, externalizing behavioral problems, and eight specific syndromes, series of logistic regression analyses were executed. Series of logistic regression analyses were used because when the socio-demographic variables were used to predict victimizations, the overall victimization and independent types of victimizations were dichotomous variables (Afifi & Clark, 1997; Leech, Barrett & Morgan, 2005; Tabachnick & Fidell, 2013). In addition, when the independent victimization types were used to predict variables for the mental health problems, all the outcome variables and the predictors were dichotomous. Furthermore, logistic regression analyses were used because the data was not normally distributed (Afifi & Clark, 1997; Leech, Barrett & Morgan, 2005; Tabachnick & Fidell, 2013).

Before running the analysis, the assumptions of logistic regression such as large sample size, absence of multicollinearity, absence of outliers, and independence of observations were checked. In order to look into the effect size, the Nagelkerke measure that adjusts Cox and Snell's to get a value of 1 was used (Leech, Barrett and Morgan, 2005; Tabachnick & Fidell, 2013). Odds ratio was employed to interpret the results. Odds ratios greater than 1 reflected the increase in odds of an outcome of 1 (the response category) with a one-unit increase in the predictor; odds ratios less than one reflect the decrease in odds of that outcome with a one- unit change (Afifi & Clark, 1997; Tabachnick & Fidell, 2013).

Finally, in order to examine the associations of poly-victimizations with the overall mental health problems, internalizing problems and externalizing behavioral problems, Chi-square test analyses were conducted. To test the significance association among variables in the study, .001 and .05 alpha levels were employed.

3.10. Ethical Considerations

While conducting a study like this, addressing ethical principles is imperative. The concern of ethical issue is more visible when the variables of the study are victimization and mental health problems which are sensitive by their very natures. Moreover, there is a need to consider issues seriously when the participants are children and young people. In order to address these concerns, basic ethical principles were followed.

1. **Informed consent**-Before collecting the data from children, adolescent and teacher respondents, informed consent was secured from the school directors and the participants themselves. Written consent was given by each participant of the study. In addition, participants were informed that participation is made with their willingness and they can withdraw any time from the data collection process.
2. **Confidentiality-** For the sake of keeping the information secret, all participants were instructed not to write their names on the questionnaires. The participants were also assured that the information taken from them will be used only for the sake of this study and were informed that the information that they provided will not be disclosed to anyone.
3. **No deception-** At any condition, an attempt to deceive the participants was not made.

4. **Protect participants from psychological harm-** With all possible means; protecting the participants from psychological harm was given considerable attention.
5. **Debriefing** –At the end of the data collection process, the purpose of the study was again explained to the participants. This was done for the sake of removing misconceptions, if any, regarding the data collection.

Chapter Four: Findings

The data collected from 403 elementary school children and adolescents of Gondar town was analyzed using both descriptive and inferential statistics. Analyses were conducted to provide descriptive information about the prevalence and descriptive characteristics of major study variables. As part of these descriptive analyses, socio-demographic characteristics of the respondents are presented. In addition, prevalence of victimizations and mental health problems broken down by gender are indicated. Moreover, the mean and standard deviation of the victimization experiences and mental health problems are included.

In order to see the contributions of socio-demographic variables to the victimization experiences of children and adolescents, series of standard logistic regression analyses were conducted. Furthermore, standard logistic regression analyses were run to examine the contributions of the independent victimization experiences to the mental health problems of the respondents. Chi-square test was used to identify the association of poly-victimizations with that of mental health problems.

4.1. Socio-demographic Characteristics of the Respondents

Table 6 depicts the socio-demographic characteristics of the respondents broken down by gender. Age, family structure, father education, mother education, and family income of the participants are presented. Nearly equal proportion of males (50.87%) and females (49.13%) participated in the study. Similarly, approximately equal proportion of child (49.63%) and adolescent (50 .37%) participants were included in the study.

With regard to the respondents' family structure, the majority (62.53%) of them came from intact families, followed by single parents (22.33%). The lowest proportion (15.14%) was

for respondents living with other relatives other than both parents and single parent. In terms of the respondents' fathers' educational background, most of them (40.94%) did not have formal education. The second highest proportion (23.57%) of fathers had trainings in higher education including certificate, diploma, and degree and above educational levels. The lowest proportion (14.6%) of fathers attended some form of elementary school education. Respondents 'mothers with no formal education constituted the highest proportion (45.2%) and the least proportion (15.14%) of respondents' mothers had higher educational levels.

Finally, the majority (68.73%) of child and adolescent respondents came from families with average income level. Nearly, equal proportions of the respondents were living with families with high (16.38%) and low (14.89%) levels of income.

Table 6

Socio-demographic Characteristics of the Respondents by Gender (N=403)

Socio-demographic characteristics		**Prevalence (n, %)**		
		Male	**Female**	**Total**
Age	7-11	93 (45.4)	107 (54.0)	200 (49.63)
	12-17	112 (54.6)	91 (46.0)	203 (50.37)
	Sub total	205 (50.87)	198 (49.13)	403 (100)
Family structure	Both parents	131(63.9)	121(61.1)	252 (62.53)
	Single parent	50 (24.4)	40 (20.2)	90 (22.33)
	Relatives	24 (11.7)	37 (18.7)	61 (15.14)
	Sub total	205 (50.87)	198 (49.13)	403 (100)
Father educ.	No formal education	81(39.5)	84 (42.55)	165 (40.94)
	Elementary education	38 (18.55)	28 (14.1)	66 (16.38)
	Secondary education	42 (20.5)	35 (17.7)	77 (19.11)
	Higher education	44 (21.5)	51 (25.8)	95 (23.57)
	Sub total	205 (50.87)	198 (49.13)	403 (100)
Mother's educ.	No formal education	116 (56.6)	66 (33.3)	182 (45.2)
	Elementary education	30 (14.6)	43 (21.7)	73 (18.1)
	Secondary education	41(20)	48 (24.2)	89 (22.1)
	Higher education	18 (8.8)	41 (20.7)	59 (14.6)
	Sub total	205 (50.87)	198 (49.13)	403 (100)
Family income	High	25 (12.2)	41 (29.7)	66 (16.38)
	Medium	142 (69.3)	135 (68.2)	277 (68.73)
	Low	38 (18.5)	22 (11.1)	60 (14.89%)
	Sub total	205 (50.87)	198 (49.13)	403 (100)

4.2. Prevalence of Victimizations among Children and Adolescents

Table 7

Descriptive Statistics of Reported Victimization Types (N=403)

Victimization types	**N**	**Minimum**	**Maximum**	**Mean**	**SD**
Conventional crime	403	0	9	1.92	1.943
Child maltreatment	403	0	4	.51	.724
Sibling & peer victimization	403	0	5	.90	1.209
Sexual victimization	403	0	5	.26	.653
Witnessing & indirect victimization	403	0	7	1.57	1.803
Overall victimization	403	0	22	5.21	4.895

The minimum and maximum scores, means, and standard deviations of the frequency of total victimization and individual types of victimization experiences of the respondents were examined. The mean of the overall victimization experience was found to be 5.21 (*SD*=4.90). The actual maximum score for the total victimization was 22, while the minimum was 0. Since the number of items for the overall victimization experience is 33, the possible maximum score is 33.

Table 8

One Year Prevalence of Reported Victimizations among the Respondents by Gender (N=403)

Victimization	**Prevalence (n, %)**						χ^2	P-value
	Male		**Female**		**Total**			
	Victimized	**NV**	**Victimized**	**NV**	**Victimized**	**NV**		
CC	150 (73.25)	55 (26.8)	118 (59.6)	80 (40.4)	268 (66.5)	135(33.5)	8.33*	.004
CM	101(49.3)	104 (50.75)	59 (29.8)	139(70.2)	160 (39.7)	243(60.3)	15.95*	.000
PSV	121(59)	84 (41)	70 (35.4)	128(64.6)	191(47.4)	212(52.6)	22.64*	.000
SV	22 (10.7)	183 (89.3)	56 (28.3)	142(71.7)	78 (19.4)	325(80.6)	19.88*	.000
WIV	140 (68.3)	65 (31.7)	94 (47.50	104(52.5)	234 (58.1)	169(41.9)	17.93*	.000
VT	178 (86.80	27 (13.2)	142 (71.7)	56 (28.3)	320 (79.4)	83 (20.6)	14.07*	.000

From the total of 403 respondents, 320 (79.4%) of them reported that they experienced at least one form of victimization during the previous year. When the one year prevalence of the five independent types of victimizations were examined, the highest value was for conventional crime (66.5%) followed by witnessing and indirect victimizations (58.1%), peer and sibling victimizations (47.4%) and child maltreatment (39.7%). The lowest victimization reported was sexual victimization with one year prevalence of 19.4%. Regarding gender difference, 178 (86.80%) males experienced overall victimization as compared to that of females in which case the prevalence rate was 142 (71.7%). The gender difference was statistically significant, χ^2 (1, *N*=403) =14.07, *p*<.05. With the exception of sexual victimization, the prevalence of all other victimization types was higher for males than for females. The Chi-square tests indicated that there were significant male and female differences for the individual victimization types

including conventional crime, χ^2 (1, N=403)=8.33, p<.05, child maltreatment, χ^2 (1, N=403)=15.95, p<.001, peer and sibling victimizations, χ^2 (1, N=403)=22.64, p<.001, sexual victimization, χ^2 (1, N=403)=19.88, p<.001, and witnessing and indirect victimizations, χ^2 (1, N=403)=17.94, p<.001.

4.3. Socio-demographic Characteristics and Victimizations of the Respondents

Six consecutive standard logistic regression analyses were run to examine the associations among socio-demographic variables and victimization types. The predictors were age, gender, maternal education, family structure and family income. The ages of the participants were classified in to two groups: One ranging from 7-11 years (children) and the other from 12-17 years (adolescents). Maternal education was broken-down in to three dummy variables including no maternal formal education versus higher education, maternal elementary school education versus higher education, and maternal secondary school education versus higher education. Family structure was divided in to two dummy variables: Single parent versus both parents and relatives versus both parents. Family income was also categorized as low income versus high income levels and medium income versus high income levels.

The dichotomous outcome variables considered in these successive logistic regression analyses were any victimizations, conventional crime, child maltreatment, sibling and peer victimizations, sexual victimizations, and witnessing and indirect victimizations. The responses for the outcome variables were coded as 0 (none victimized) and 1(victimized).

4.3.1. Socio-demographic variables and any victimization experiences of children and adolescents

Table 9

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Any Childhood and Adolescent Victimizations (N=403)

Variable	*B*	*SE*	*P-value*	*Exp(B)*	*95% C.I .for EXP(B)*	
					Lower	*Upper*
Age (7-11=0, 11-17=1)	.226	.265	.394	1.254	.746	2.108
Gender (F=0, M=1)	.878*	.274	.001	2.407	1.407	4.115
Single parents vs both parents FS.	.199	.347	.566	1.220	.619	2.406
Relatives vs both parents FS.	-.162	.351	.645	.851	.428	1.692
Mothers' no formal vs higher educ.	.123	.369	.739	1.131	.549	2.329
Mothers' elementary vs. higher educ.	.654	.454	.150	1.923	.790	4.685
Mothers' secondary vs higher educ.	.031	.401	.939	1.031	.470	2.261
Low vs high family income	1.172*	.567	.039	3.228	1.063	9.801
Medium vs high family income	.296	.323	.360	1.344	.714	2.532
Constant	.342	.420	..416	1.408		

Note R^2=.061(Cox and Snell), .095 (Nagelkerke). Model χ^2 (9) =25.31, *p*<.05. * *p*<.05.

From the nine predictor variables considered in the regression equation, gender and low versus high family income were found significant predictors of the overall victimization experiences of children and adolescents. Regarding gender, the odds of males in experiencing victimization increases by 2.41(95% CI=1.41-4.12) times than females. In addition, the probability of the occurrence of any form of victimization was higher for those who came from

low income families by 3.23 (95% CI =1.06-9.80) times than respondents from high income families. Such variables as age, maternal education, and family structure did not significantly predict the outcome variable.

4.3.2. Socio-demographic variables and conventional crime

Table 10

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Conventional Crime among Children and Adolescents (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Age (7-11=0, 11-17=1)	.300	.224	.180	1.350	.870	2.095
Gender (F=0, M=1)	.605*	.227	.008	1.832	1.174	2.858
Single parents vs both parents FS	.086	.280	.758	1.090	.630	1.886
Relatives vs both parents FS	.093	.314	.768	1.097	.593	2.028
Mothers' no formal educ.vs higher educ.	-.192	.330	.122	.561	.825	.432
Mothers' elementary vs. higher educ.	.304	.389	.837	.434	1.356	.633
Mothers' secondary vs higher educ.	-.134	.361	.561	.711	.875	.431
Low vs high family income	.796	.423	.060	2.216	.968	5.074
Medium vs high family income	.344	.288	.233	1.410	.801	2.482
Constant	-.064	.381	.867	.938		

Note R^2=.044 (Cox and Snell), .061 (Nagelkerke). Model χ^2 (9) =18.23, p<.05. * p<.05.

With the exception of gender, all other predictors did not significantly predict conventional crime committed against children and adolescents. Gender was a significant predictor of conventional crime with the odds ratio of 1.83(95% CI=1.17-2.86) indicating that

males are 1.83 times higher at the odds of experiencing conventional victimization than female respondents.

4.3.3. Socio-demographic variables and child maltreatment

Table 11

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Child Maltreatment among Children and Adolescents (N=403)

Variable	B	*SE*	*P-value*	*Exp(B)*	*95% C. I. for EXP(B)*	
					Lower	***Upper***
Age (7-11=0, 11-17=1)	-.074	.220	.738	.929	.604	1.430
Gender (F=0, M=1)	.820**	.223	.000	2.270	1.467	3.514
Single parents vs both parents FS	.646*	.266	.015	1.907	1.133	3.210
Relatives vs both parents FS	.540	.304	.076	1.716	.945	3.116
Mothers' no formal vs higher educ.	.610	.352	.083	1.840	.923	3.667
Mothers' elementary vs. higher educ.	.877*	.393	.026	2.404	1.113	5.192
Mothers' secondary vs higher educ.	.543	.384	.157	1.720	.811	3.648
Low vs high family income	-.002	.394	.996	.998	.461	2.159
Medium vs high family income	-.045	.298	.879	.956	.533	1.714
Constant	-1.581**	.413	.000	.206		

Note R^2=.069 (Cox and Snell), .094 (Nagelkerke). Model χ^2 (9) =28.96, p<.05. * p<.05, **p<.001

Gender, single parent versus both parents' family structure, and maternal elementary education versus higher education predictors showed significant relationships with child maltreatment. The odds of being victims of child maltreatment increased by 2.27 (95% CI=1.47-

3.51) times for males, 1.91(95% CI=1.13-3.21) times for respondents coming from single parents, and 2.40 (95% CI=1.11-5.19) times for those whose mothers are in their elementary school education than those of females, respondents coming from intact families, and those whose mothers' education level is higher education.

4.3.4. Socio-demographic variables and sibling and peer victimizations

Table 12

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Sibling and Peer Victimization among Children and Adolescents (N=403)

Variable	*B*	*SE*	*P-value*	*Exp(B)*	*95% C.I. for EXP(B)*	
					Lower	*Upper*
Age (7-11=0, 11-17=1)	-.253	.216	.243	.777	.508	1.187
Gender (F=0, M=1)	1.025**	.219	.000	2.786	1.814	4.280
Single parents vs both parents FS	-.245	.265	.355	.782	.465	1.316
Relatives vs both parents FS	.140	.301	.642	1.150	.637	2.075
Mothers' no formal vs higher educ.	.162	.328	.622	1.175	.619	2.233
Mothers' elementary vs. higher educ.	.673	.373	.071	1.959	.943	4.069
Mothers' secondary vs higher educ.	.252	.358	.482	1.286	.637	2.595
Low vs high family income	.294	.390	.451	1.342	.624	2.883
Medium vs high family income	.198	.291	.496	1.219	.689	2.157
Constant	-.904*	.385	.019	.405		

Note R^2=.070 (Cox and Snell), 094 (Nagelkerke). Model χ^2 (9) =29.46, p<.05. *p<.05,** p<.001.

Table 12 indicates that gender was a significant predictor of sibling and peer victimization. Males were more victims of sibling and peer victimizations than females by 2.79 (95% CI =1.81-4.28) times. All other variables were not statistically significant predictors of the outcome variable.

4.3.5. Socio-demographic variables and sexual victimizations

Table 13

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Sexual Victimization among Children and Adolescents (N=403)

Variable	*B*	*SE*	*P-value*	*Exp(B)*	*95% C.I. for EXP(B)*	
					Lower	*Upper*
Age (7-11=0, 11-17=1)	1.236**	.298	.000	3.441	1.918	6.172
Gender(M=0, F=1)	1.331**	.300	.000	3.785	2.104	6.809
Single parents vs both parents FS	-.188	.368	.610	.829	.403	1.706
Relatives vs both parents FS	.448	.351	.201	1.566	.787	3.115
Mothers' no formal vs higher educ.	-.439	.392	.263	.645	.299	1.390
Mothers' elementary vs higher educ.	-.708	.467	.130	.492	.197	1.231
Mothers' secondary vs higher educ.	-.512	.438	.242	.599	.254	1.413
Low vs high family income	.746	.572	.192	2.109	.687	6.474
Medium vs high family income	.867	.456	.057	2.380	.974	5.816
Constant	-3.277**	.622	.000	.038		

Note R^2=.123 (Cox and Snell), .196 (Nagelkerke). Model χ^2 (9) =52.68, p<.05. ** p <.001.

As expected, age and gender were significantly associated with sexual victimizations. The highest contribution was made by gender with the odds ratio value of 3.79 (95% CI=2.10-6.81), followed by age with odds ratio value of 3.44 (95% CI=1.92-6.17). The occurrences of sexual victimization in females and adolescent respondents were 3.79 and 3.44 times higher than males and child respondents respectively. Other variables were not significantly associated with sexual victimizations.

4.3.6. Socio-demographic variables and witnessing and indirect victimizations

Table 14

Standard Logistic Regression Analysis of Socio-demographic Variables Predicting Witnessing and Indirect Victimization among Children and Adolescents (N=403)

Variable	***B***	***S.E.***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Age (7-11=0, 11-17=1)	.114	.217	.597	.1.121	.733	1.715
Gender (F=0, M=1)	.833**	.219	.000	2.301	1.499	3.533
Single parents vs both parents FS	.237	.271	.381	1.268	.745	2.158
Relatives vs both parents FS	-.194	.298	.516	.824	.459	1.478
Mothers' no formal vs higher educ.	.006	.320	.985	1.006	.537	1.884
Mothers' elementary vs higher educ.	.359	.369	.330	1.433	.695	2.953
Mothers' secondary vs higher educ.	.226	.353	.521	1.254	.628	2.503
Low vs high family income	.693	.403	.085	2.000	.908	4.403
Medium vs high family income	.261	.287	.362	1.299	.741	2.277
Constant	-.556	.3.75	.1.38	.573		

Note R^2=.063 (Cox & Snell), .085 (Nagelkerke). Model χ^2 (9)= 26.26, p<.05. ** p<.001.

Table 14 signifies that the contribution of gender was significant in predicting witnessing and indirect victimization with the odds ratio of 2.30 (95% CI=1.50-3.53), indicating that males were 2.30 times higher at the odds of experiencing witnessing and indirect victimization. The rest of the independent variables were not significantly related with witnessing and indirect victimizations.

4.4. Prevalence of Mental Health Problems of Children and Adolescents

Table 15

Descriptive Statistics of Reported Mental Health Problems of Respondents (N=403)

Types of MH problems	**N**	**Minimum**	**Maximum**	**Mean**	**SD**
Anxious/depressed	403	0	22	6.16	4.738
Withdrawn	403	0	14	4.21	3.115
Somatic Complaints	403	0	18	2.74	3.154
Social Problems	403	0	19	4.33	3.943
Thought Problems	403	0	16	3.78	3.540
Attention Problems	403	0	16	4.26	3.527
Rule Breaking Behaviors	403	0	15	3.16	3.158
Aggressive Behaviors	403	0	28	6.29	5.091
Internalizing Problems	403	0	43	13.11	9.269
Externalizing Problems	403	0	40	9.45	7.647
Total Mental Health Problems	403	0	110	34.93	24.479

The mean of the overall mental health problems of the respondents was 34.93 (SD=24.48) with a minimum and maximum scores of 0 and 110 and respectively. Internalizing and externalizing problems of the respondents were reported with mean values of 13.11 (SD=9.27) and 9.45 (SD=7.65) respectively. When the specific mental health problems of the respondents were considered, maximum mean value was observed in the aggressive behaviors syndrome (6.29 with SD of 5.09) followed by anxious/ depressed syndrome (6.16 with SD of

4.74). Lower mean values were reported for somatic complaints (2.74 with SD of 3.15), rule breaking behaviors (3.16 with SD of 3.16) and thought problems (3.78 with SD of 3.54).

Table 16

Prevalence of Reported Mental Health Problems of the Respondents by Gender (N=403)

MHPs	Prevalence (n, %)							
	Male		Female		Total		χ^2	p
	Yes	No	Yes	No	Yes	No		
A/D	30 (14.6)	175 (85.4)	12 (6.1)	186(93.9)	42(10.4)	361 (89.6)	7.93*	.005
WP	27 (13.2)	178 (86.8)	12 (6.1)	186(93.9)	39(9.7)	364 (90.3)	26.53*	.000
SC	18 (8.8)	187 (91.2)	3 (1.5)	195(98.5)	21(5.2)	382 (94.8)	10.76*	.001
SP	27 (13.2)	178 (86.8)	21(10.6)	177(89.4)	48(11.9)	355 (88.1)	.631	.427
TP	16 (7.8)	189 (92.2)	2 (1)	196(99)	18(4.5)	385 (95.5)	10.90*	.001
AP	11(5.4)	194 (94.6)	5 (2.5)	193(97.5)	16(4)	387 (96)	2.13	.144
RBB	3 (1.5)	202 (98.5)	0 (0)	198(100)	3(.7)	400 (99.3)	2.92	.088
AB	17 (8.3)	188 (91.7)	6 (3)	192(97)	23(5.7)	380 (94.3)	5.18*	.023
IP	58 (28.3)	14 7(71.7)	25(12.6)	173(87.4)	83(20.6)	320 (79.4)	15.12*	.000
EP	30 (14.6)	175 (85.4)	18 (9.1)	180(90.9)	48(11.9)	355 (88.1)	2.95	.086
TMHP	37 (18)	168 (82)	21(10.6)	177(89.4)	58(14.4)	345 (85.6)	4.53*	.033

Table 16 shows that the proportion of overall mental health problems among the respondents was 14.4%. The proportion of internalizing problems (20.06%) was higher than that of the prevalence rate of externalizing problems (11.9 %) of the respondents. When the eight syndrome scales were considered, the highest was social problems (11.9%) followed by

anxious/depressed (10.4%), and withdrawn (9.7%). The lowest prevailing syndrome was rule breaking behaviors (.7%), followed by attention problems (4%) and thought problems (4.5%). In all cases, the prevalence of the mental health problems of males was found to be higher than that of females. The prevalence rate of the overall mental health problem of males was 18%, where as for female respondents, it was 10.6%. The Chi-Square test showed that, there was a statistically significant gender difference in the total mental health problems, χ^2 (1, *N*=403) =4.53, *p*<.003. In addition, statistically significant gender difference was found for internalizing problems, χ^2 (1, *N*=403) =15.12, *p* <.001). However, male and female difference in externalizing problems was not statistically significant, χ^2 (1, *N*=403) =2.95, *p* <.086. With regard to gender differences in the eight syndromes, anxious/depressed, χ^2(1, *N*=403)=7.93, *p* <.005; withdrawn depressed, χ^2(1,*N*=403) =26.53, *p* <.000; somatic complaints, χ^2(1, *N*=403)=10.76, *p* <.001; thought problems, χ^2(1,*N*=403)=10.9, *p* <.001; and aggressive behaviors, χ^2(1,*N*=403)=5.18, *p* <.023 were statistically significant. Male and female respondent differences for social problems, χ^2 (1, *N*=403) =631, *p* <.427; attention problems, χ^2 (1, *N*=403) =2.13, *p* <.144; and rule-breaking behaviors, χ^2 (1, *N*=403) =2.92, *p* <.088 were not statistically significant.

4.5. Victimization Experiences and Mental Health Problems

Ten series of direct logistic regression analyses were run to see the contributions of the five independent types of victimization (conventional crime, child maltreatment, peer and sibling victimization, sexual victimization and witnessing and indirect victimization) to any mental health problems, internalizing problems, externalizing behavioral problems, and the eight specific syndromes: Anxious/depressed, withdrawn problems, somatic complaints, social

problems, thought problems, attention problems, rule-breaking behaviors, and aggressive behaviors.

4.5.1. Victimization experiences and any mental health problems

Table 17

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Any Mental Health Problems of Children and Adolescents (N=403)

Variable	**B**	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.807	.458	.078	2.242	.914	5.498
Child maltreatment (No=0, Yes, 1)	.814*	.339	.016	2.256	1.161	4.386
Sibling & peer victimization (No=0, Yes, 1)	.415	.372	.264	1.515	.731	3.137
Sexual victimization (No=0, Yes, 1)	.063	.345	.856	1.065	.541	2.093
Witnessing & indirect vict. (No=0, Yes, 1)	.506	.405	.211	1.659	.750	3.669
Constant	-3.435	.442	.000	.032		

Note R^2=.079 (Cox & Snell), .14 (Nagelkerke). Model χ^2 (5)= 33.19, $p<.05$. $^*p<.05$.

Direct logistic regression analysis was computed to identify the roles of individual victimization types on the manifestations of the overall childhood and adolescence mental health problems. Omnibus Tests of Model Coefficients showed that, the general model was statistically significant, χ^2 (5, *N*=403) =33.19, $p<.05$, indicating that the predictor variables all together predict overall mental health problems of children and adolescents. The model summary showed that approximately 14 % (Nagelkerke, which is the recommended one to be used) of the variance in whether or not children and adolescents manifested any mental health problem can be predicted from the linear combination of the five independent variables. When all the five

variables were considered together, only child maltreatment predictor was found significantly contributing to any mental health problems of the respondents with OR=2.6 (95% CI=1.16-4.39). This indicates that children and adolescents who experienced child maltreatment were 2.6 times at the odds of developing any mental health problems compared to those who did not experience child maltreatment.

The other four predictor variables including conventional crime, peer and sibling victimization, sexual victimization, and witnessing and indirect victimization were not statistically significant at p value less than 0.05.

4.5.2. Victimization experiences and internalizing problems

Table 18

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Internalizing Problems of Children and Adolescents (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C. I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	1.082*	.390	.006	2.950	1.373	6.337
Child maltreatment (No=0, Yes, 1)	.925*	.295	.002	2.521	1.415	4.491
Sibling & peer vict. (No=0, Yes, 1)	.209	.317	.511	1.232	.661	2.295
Sexual victimization (No=0, Yes, 1)	.049	.315	.876	1.050	.567	1.947
Witnessing & indirect vict. (No=0, Yes, 1)	.200	.333	.548	1.222	.636	2.348
Constant	-2.889**	.360	.000	.056		

Note R^2=.10 (Cox & Snell), .16 (Nagelkerke). Model χ^2 (5)= 42.03, p<.05. * p<.05, ** p<.001.

Standard logistic regression analysis was run to see the contributions of independent victimization types to the internalizing mental health problems of the respondents. A test of the

full model with all five predictors against a constant-only model was statistically significant, χ^2 (5, N = 403) = 23.24, $p < .001$, indicating that the predictors, as a set, significantly distinguished between children and adolescents experienced internalizing problems and those who did not experience internalizing problems with 16 % effect size.

From the five predictors, two of them: Conventional crime and child maltreatment showed statistical differences in predicting the outcome variable of internalizing problems. The odds ratios of conventional crime and child maltreatment were 2.95(95% CI=1.37-6.34) and 2.52 (95% CI=1.42-4.49) respectively. These odds ratios are indications that the odds of developing internalizing problems were 2.95 and 2.52 times higher for those victims of conventional crime and child maltreatment than the non victims respectively. Peer and sibling victimization, sexual victimization, and witnessing and indirect victimizations were not significant predictors of the outcome variable.

4.5.3. Victimization experiences and externalizing behavioral problems

Forced entry logistic regression analysis indicated that the overall model was statistically significant, χ^2 (5, N=403) =20.61, $p<0.05$. When the predictors entered into the equation alone, all but sexual victimization were significant. However, when all the individual victimization types were considered together, all the predictors were not statistically significant in predicting whether or not victimized children and adolescents developed externalizing problems at alpha level of 0.05.

Table 19

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Externalizing Behavioral Problems of Children and Adolescents (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C. I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.429	.453	.343	1.535	.632	3.728
Child maltreatment (No=0, Yes, 1)	.708	.365	.052	2.031	.993	4.153
Sibling & peer victimization (No=0, Yes, 1)	.711	.413	.085	2.036	.906	4.576
Sexual victimization (No=0, Yes, 1)	.024	.375	.948	1.025	.491	2.137
Witnessing & indirect vict. (No=0, Yes, 1)	.102	.415	.805	1.108	.491	2.499
Constant	-3.173**	.413	.000	.042		

Note R^2=.050 (Cox & Snell), .096 (Nagelkerke). Model χ^2 (5) =20.61, *p*<.05. ***p*< .001.

4.5.4. Victimization experiences and anxious/depressed problems

The standard logistic regression analysis showed that the general model was statistically significant, χ^2 (5, *N*=403) =24.19, *p*<.05. When each predictor was entered in to the equation, all other predictors except sexual victimization and witnessing and indirect victimization showed significant association with the outcome variable: Anxious/depressed syndrome. However, when all the predictors were considered together, only child maltreatment and sibling and peer victimization showed significant relationship with the probability of developing anxious/depressed problem. The odds ratio of developing anxious/depressed problem among those who experienced child maltreatment was 2.71 (95% CI= 1.24-5.95) times higher than those who did not experience child maltreatment. In addition, the proportion of those who reported

anxious/ depressed problem was 2.77 (95% CI= 1.12-6.82) higher among victims of peer and sibling victimization

Table 20

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Anxious/depressed Problems(N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C. I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.443	.484	.360	1.558	.603	4.024
Child maltreatment (No=0, Yes, 1)	.999*	.401	.013	2.714	1.238	5.954
Sibling & peer vict. (No=0, Yes, 1)	1.017*	.460	.027	2.766	1.122	6.819
Sexual victimization (No=0, Yes, 1)	-.018	.401	.964	.982	.448	2.156
Witnessing & indirect vict. (No=0, Yes, 1)	-.483	.428	.260	.617	.267	1.428
Constant	-3.323**	.442	.000	.036		

Note R^2=.058(Cox & Snell), .12 (Nagelkerke). Model χ^2 (5) =24.19, *p*<.05. **p*<.05. ***p*< .001.

4.5.5. Victimization experiences and withdrawn problems

As indicated in Table 21, only child maltreatment predictor was found significantly associated with withdrawn syndrome at 0.05 alpha level with odds ratio value of 2.32 (95% CI=1.04-5.20). This indicated that the probability of developing withdrawn problem was 2.32 times higher for child maltreatment victims than the non victims. The remaining four predictors: Conventional crime, sibling and peer victimizations, sexual victimizations, and witnessing and indirect victimizations had *p* values > 0.05 indicating the absence of significant association with the outcome variable.

Table 21

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Withdrawn (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.343	.489	.483	1.409	.541	3.670
Child maltreatment (No=0, Yes, 1)	.842*	.411	.040	2.322	1.038	5.196
Sibling & peer victimization (No=0, Yes, 1)	.304	.446	.495	1.356	.565	3.251
Sexual victimization (No=0, Yes, 1)	.632	.394	.108	1.882	.870	4.070
Witnessing & indirect vict. (No=0, Yes, 1)	.012	.459	.979	1.012	.412	2.487
Constant	-3.279**	.438	.000	.038		

Note R^2=.044(Cox & Snell), .093 (Nagelkerke). Model χ^2 (5) =18.10, p<.05. * p<.05. **p< .001.

4.5.6. Victimization experiences and somatic complaints

The direct logistic regression analysis showed that all the five predictors: Conventional crime, child maltreatment, sibling and peer victimization, sexual victimization, and witnessing and indirect victimization, when all are considered together, were not significantly related with somatic complaints. Even when each predictor was entered alone in the equation, except sexual victimization, all others were insignificant in predicting the outcome variable.

Table 22

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Somatic Complainants (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.622	.638	.330	1.863	.533	6.512
Child maltreatment (No=0, Yes, 1)	.540	.534	.311	1.716	.603	4.884
Sibling & peer vict. (No=0, Yes, 1)	-.242	.565	.669	.785	.259	2.378
Sexual victimization (No=0, Yes, 1)	.868	.536	.105	2.383	.834	6.808
Witnessing & indirect vict. (No=0, Yes, 1)	-.237	.577	.681	.789	.255	2.443
Constant	-3.583**	.538	.000	.028		

Note R^2=.016(Cox & Snell), .047 (Nagelkerke). Model χ^2 (5)= 6.48, p<.05. ***p*< .001.

4.5.7. Victimization experiences and social problems

Direct logistic regression analysis was run to see the contributions of the five independent victimization types in predicting social problems of children and adolescents. It was found that child maltreatment was a significant predictor of social problems with OR=2.25 (95% CI=1.10-4.61) showing that victims of child maltreatment are 2.25 times at the odds of experiencing social problems.

Table 23

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Social Problems (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.276	.436	.527	1.318	.560	3.099
Child maltreatment (No=0, Yes, 1)	.811*	.366	.027	2.250	1.098	4.609
Sibling & peer vict. (No=0, Yes, 1)	.419	.399	.294	1.520	.695	3.326
Sexual victimization (No=0, Yes, 1)	-.241	.388	.534	.786	.367	1.680
Witnessing & indirect vict(No=0, Yes, 1)	.444	.423	.294	1.559	.680	3.571
Constant	-3.097**	.400	.000	.045		

Note R^2=.045(Cox & Snell), .087 (Nagelkerke). Model χ^2 (5) =18.62, p<.05. * p<.05. **p< .001.

4.5.8. Victimization experiences and thought problems

Although conventional crime and child maltreatment were significantly associated with the dependent variable of thought problem when entered alone, none of them were significant predictors of the outcome variable when all the independent variables were considered together.

Table 24

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Thought Problems (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	1.941	1.081	.073	6.968	.837	58.019
Child maltreatment (No=0, Yes, 1)	1.161	.602	.054	3.194	.981	10.403
Sibling & peer vict. (No=0, Yes, 1)	-.096	.599	.873	.909	.281	2.937
Sexual victimization (No=0, Yes, 1)	.279	.564	.621	1.321	.438	3.989
Witnessing & indirect vict. (No=0, Yes, 1)	-.329	.616	.593	.720	.215	2.407
Constant	-5.131**	1.034	.000	.006		

Note R^2=.033(Cox & Snell), .11 (Nagelkerke). Model χ^2 (5) =13.63, $p<.05$.**$p< .001$.

4.5.9. Victimization experiences and attention problems

The data in Table 25 connotes that the independent variables of conventional crime, child maltreatment, sibling and peer victimizations, sexual victimizations and, witnessing and indirect victimizations did not have significant relationships with that of the dependent variable of attention problems of children and adolescents.

Table 25

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Attention Problems (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	.248	.669	.711	1.281	.346	4.751
Child maltreatment (No=0, Yes, 1)	1.116	.613	.069	3.053	.919	10.143
Sibling & peer vict. (No=0, Yes, 1)	.030	.635	.962	1.031	.297	3.577
Sexual victimization (No=0, Yes, 1)	-.927	.803	.248	.396	.082	1.909
Witnessing & indirect vict. (No=0, Yes, 1)	-.158	.634	.803	.854	.247	2.955
Constant	-3.696**	.560	.000	.025		

Note R^2=.013(Cox & Snell), .047 (Nagelkerke). Model χ^2 (5)= 5.37, p<.05. **p< .001.

4.5.10. Victimization experiences and aggressive behaviors

The data in Table 26 denotes that conventional crime, child maltreatment, sibling and peer victimizations, sexual victimizations, and witnessing and indirect victimizations did not have significant associations with aggressive behaviors at alpha level of 0.05.

Table 26

Standard Logistic Regression Analysis of Individual Victimization Types Predicting Children and Adolescents' Aggressive Behaviors (N=403)

Variable	***B***	***SE***	***P-value***	***Exp(B)***	***95% C.I. for EXP(B)***	
					Lower	***Upper***
Conventional crime (No=0, Yes, 1)	1.331	.798	.096	3.784	.791	18.099
Child maltreatment (No=0, Yes, 1)	.450	.493	.361	1.569	.598	4.119
Sibling & peer vict. (No=0, Yes, 1)	.321	.542	.554	1.379	.476	3.991
Sexual victimization (No=0, Yes, 1)	-.158	.523	.763	.854	.306	2.382
Witnessing & indirect vict. (No=0, Yes, 1)	.317	.584	.587	1.373	.437	4.318
Constant	-4.472**	.752	.000	.011		

Note R^2=.027(Cox & Snell), .026 (Nagelkerke). Model χ^2 (5)= 10.99, p<.05. **p< .001

4.6. Poly-victimizations and Mental Health Problems

Three series of Chi-square analyses were run to explore the associations of poly-victimizations with symptoms of any mental health problems, internalizing problems, and externalizing behavioral problems of the respondents.

4.6.1. Poly-victimizations and any mental health problems.

The data presented on Table 27 showed that the estimate of poly-victimizations (four or more victimization types) among children and adolescents of Gondar town was 54.3%. Among these, 21% of them developed symptoms of any mental health problems, significantly higher than the non poly-victims among whom only 6.5 % manifested symptoms of psychopathology, χ^2 (1, N=403)=17.02,p<.001, Phi=.21. The phi value indicated that there was small effect size. Using

odds ratio, poly victims were found to manifest any mental health problems by 3.71 higher than the non poly-victims.

Table 27

Chi-square Analysis of Any Mental Health Problems among Child and Adolescent Poly-victims (N=403)

Variable		Poly-victimization		
		Yes (%)	No (%)	Total (%)
Any Mental Health Problems	Yes (%)	46 (21)	12 (6.5)	58 (14.4)
	No (%)	173 (79)	172 (93.5)	345 (85.6)
	Total (%)	219 (100)	184 (100)	403 (100)
Chi-square (χ^2)	**17.02			
**p< .001				

4.6.2. Poly-victimizations and internalizing problems of children and adolescents

Table 28

Chi-square Analysis of Internalizing Problems among Child and Adolescent Poly-victims (N=403)

Variable		Poly-victimization		
		Yes (%)	No (%)	Total (%)
Internalizing Problems	Yes (%)	62 (28.3)	21 (11.4)	83 (20.6)
	No (%)	157 (71.7)	163 (88.6)	320 (79.4))
	Total (%)	219 (100)	184 (100)	403 (100)
Chi-square (χ^2)	**17.46			
**p< .001				

Table 28 depicts that the prevalence of internalizing problems among those who have experienced poly-victimization was 28.3 %. Moreover, there was statistical differences between poly- victims and non poly-victims, χ^2 (1, *N*=403) =17.46, *p*<.001). As the Phi value (.21) shows, there was a small effect size. Using the odds ratio, poly-victim children and adolescents experienced internalizing problems 3 times higher than the non poly-victims.

4.6.3. Poly-victimizations and externalizing behavioral problems

From the 219 (54.3%) of those children adolescents who experienced poly-victimization, 16.9% of them displayed manifestations of externalizing behavioral problems. This was also a statistically significant difference with Chi-square value of, $\chi2$= (1, *N*=403) =11.36, *p*<.05. The effect size was small with Phi value of .17. When odds ratio was used to see the effect size, poly-victims manifested externalizing problems 3.33 times higher than the non poly victims.

Table 29

Chi-square Analysis of Externalizing Behavioral Problems among Child and Adolescent Poly - victims (N=403)

Variable		Poly-victimization		
		Yes (%)	No (%)	Total (%)
Externalizing Problems	Yes (%)	37 (16.9)	11 (6)	48 (11.9)
	No (%)	182 (83.1)	173 (94)	355 (88.1)
	Total (%)	219 (100)	184(100)	403 (100)
Chi-square (χ^2)	*11.36			

*p< .05

Chapter Five: Discussion

In this chapter, the major findings of the study are discussed based on evidences from the literatures of victimizations and mental health problems of children and adolescents. The main topics of discussion are prevalence of reported victimizations and mental health problems in children and adolescents, the roles of socio-demographic factors for childhood and adolescence victimizations, and the contributions of independent victimization types on the manifestations of various forms of childhood and adolescence mental health problems including overall mental health problems, internalizing problems, externalizing behavioral problems, and specific syndromes. Finally, discussions on the associations of poly-victimizations with the overall mental health problems and the two broad band mental health problems (internalizing and externalizing problems) are made.

5.1. Prevalence of Victimization in Children and Adolescents

Findings of the present study showed that victimizations are widely prevailing among children and adolescents living in Gondar town. This finding is consistent with the findings of Finkelhor, Ormrod, Turner and Hamby (2005) who reported that experiences of violence were pervasive in other countries too. The present study found that nearly 80 % of the respondents experienced at least one type of victimization. When this finding is compared with previous research outcomes, there are some differences in the figures. However, in general it is possible to say that it is compatible with previous findings. For example, Finkelhor (2008) stated that victimization is a frequent occurrence, with 70% to 71% of the children and youth experiencing at least one type of victimization in the previous year. In addition, Finkelhor, Ormrod, Turner and Hamby (2005)

showed that more than half of the respondents experienced some type of violent assault during the previous year.

Regarding the frequency and level of the occurrence of victimization, the mean of the overall victimization experience was found to be 5.21 (SD=4.90), which is a bit higher than the rate reported by Finkelhor et al.(2005) which was 3.0. The levels of victimizations among children and adolescents of Gondar town was identified that 219 (54.34%) of the respondents have experienced four or more victimization types.

When the one year prevalence rates of the five independent victimization types were observed, the highest report was on conventional crime (66.5%). This result is supported by most of the previous evidences (Cyr, Clément & Chamberland, 2013; Finkelhor et al, 2005; Lalor 2000). The finding of Finkelhor, Ormrod, Turner and Hamby (2005) indicated that childhood and adolescence victimization resulting from conventional crime is widespread, where more than one half of the children and youth had experienced property victimization in the study year. In another study conducted by Lalor (2000), 83% of the juvenile prostitutes in Addis Ababa have had things stolen from them whilst living on the streets. The few differences observed between the present findings and the previous ones could be attributed to variations in measures, nature of the participants, and data sources.

Witnessing and indirect victimization was found to be the second highest rate (58.1%). This finding is nearly close to the result obtained by Slovak and Singe (cited in Sullivan, et al, 2008), who stated that, among children in grades 3 through 8 living in a rural Ohio community, approximately 50% reported witnessing someone being threatened or physically assaulted. However, the outcome of this study has some differences with the findings of other studies (Laye & Mykota 2014; Nicodimos, Williams & Berhane, 2009) which reported 78 % and around 25%

prevalence rates of witnessing or indirect victimizations respectively. The variations among these figures might have happened due to methodological differences.

Peer and sibling victimization is another victimization type that prevailed among children and adolescents in the study setting (47.4%) which is higher than rates obtained by other researchers including Storch and Ledley (2005), Bauman and Summers (2009) and Craig and Pepler (in Daniels, Quigley, Menard & Spence, 2010) who reported prevalence rates of 20-30%, 23%, and 27-30 % in their respective studies. The difference might have happened due to variations in the patterns and frequency of peer interactions.

The other victimization type common to children and adolescents was child maltreatment which accounted for 39.7% one year prevalence rate. Similarly, different studies came with varying figures ranging from the lowest rate of 0.0092% (Sibert et al. in Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn & Alink, 2013) to the highest prevalence rate of 95.7% (Milner, Robertson, & Rogers in Stoltenborgh, Bakermans-Kranenburg, van IJzendoorn & Alink, 2013).

From the five victimization types, the one year epidemiology of sexual victimization in the study groups was the lowest (19.4%). However, it was the lowest only when it is compared with other victimization types; otherwise, the figure by itself is not the lowest in contrast with previous findings. Research outcomes of previous studies support this finding. For example, according to Finkelhor (2008) and Hartjen and Priyadarsini (2012) the prevalence of child and adolescent sexual victimization ranged from as low as 3% for males and 7% for females to as high as 29% for males and 36% for females. Moreover, there are assertions that the problem would be more than what has been reported because, there may be cases remaining unreported (Finkelhor, 2008; Hartjen & Priyadarsini, 2012).

5.2. Factors Contributing to Childhood and Adolescence Victimizations

5.2.1 Factors contributing to childhood and adolescence overall victimizations

Consistent with the previous research findings, gender and family income were significant predictors of any victimization experiences of young people. In the present study, male respondents were found to be more at the odds of experiencing victimization by 2.41(95% CI=1.41-4.12) time than females that was consistent with findings of Esbensen et al. (2010) who reported that among victims of violence during the previous year, boys reported having been victimized 4.8 times, while girls reported 3.8 violent victimizations. Clearly, many of these experiences for both boys and girls involved an assault.53 % of boys and 36 % of girls reported having been a victim of simple assault during the previous year, with male victims averaging approximately 3.7 assaults and female victims averaging 3.4 assaults (Esbensen et al., 2010).

With regards to family income, the probability of the occurrence of any form of victimization was higher for those who came from low income families by 3.23 (95% CI =1.06-9.80) times than respondents from high income families. This finding is also consistent with the works of previous scholars. For example, Stoltenborgh et al. (2013) elucidated that poverty or low income might be one factor contributing to a higher childhood and adolescence victimization prevalence, because a lack of resources causes stress for parents and this could in turn increase the use of harsh and abusive physical discipline.

All other variables including age, maternal education and family structure were not significant predictors of overall victimization experiences in children and adolescents who participated in the study. These results, generally do not go in line with the findings of the previous studies (Cyr, Michel & Dumais, 2013; Finkelhor, 2008; Finkelhor, Ormrod & Turner, 2009; Finkelhor, Ormrod & Turner, 2007; Turner, Finkelhor, & Ormrod, 2007). Possible

reasons why age was not a significant predictor in this study may be attributed to different age classification scheme used in the studies. In addition, the differences observed are slight and other variables such as gender might have influenced the association. Moreover, the life course consequences of victimization might have been mediated by the change in victims' sense of agency, self-efficacy, and perceptions of others in the social world (Chen, 2009; Macmillan, 2001).

Variations in terms of maternal education level could have resulted from different classification of education schemes used by studies. Finally, family structure differences observed between this study and previous others might have been because of the fact that it is not family structure itself that matters, instead other associated conditions (Finkelhor, 2008). Some of those condition that my aggravate the victimizations of young people coming from non-intact families include lower socio-economic status, parental dysfunction, problems with monitoring of children, residential mobility, and exposure to more dangerous neighborhood conditions (Finkelhor, 2008).

5.2.2. Factors contributing to childhood and adolescence conventional crime

With the exception of gender, all other predictors were not significant predictors of conventional crime. Gender was a significant predictor of conventional crime with the odds ratio of 1.83 (95% CI=1.17-2.86) indicating that males are 1.83 times higher at the odds of experiencing conventional victimization than female respondents. The gender difference in experiencing conventional victimization is supported by evidences from previous findings. In this regard, Esbensen et al. (2010) mentioned that boys typically experience more serious violent victimization than do girls. Similarly, findings revealed that 14% of boys reported having been victims of aggravated assault and 12 % had been robbed, compared with 7%t and 4% of girls

respectively (Esbensen et al., 2010). Boys experienced more property victimization than girls (Finkelhor et al, 2005).

As far as the variables which were not statistically significant in predicting conventional victimization is concerned, it is possible to explain from various angles. When age is considered, different findings are observed from the previous studies. One of such finding is that the magnitude of the differences varies by type of conventional victimization (Esbensen et al., 2010). For instance, the prevalence rates of attempted and completed kidnapping, which tend to be associated with sexual assaults, were significantly higher for girls than boys (Finkelhor et al, 2005). Moreover, although Finkelhor et al. (2005) indicated that physical assaults overall occurred at a higher rate for elementary school-age children (age 6 to 12 years) than teenagers, it was however, noted that certain types, including assault with injury, kidnapping, and bias attacks were higher for the teenage group (Finkelhor et al, 2005). Thus, when all types of conventional victimization are taken together, the age difference may be neutralized, which might have made age to be a non significant variable.

Family income was the other variable which did not significantly predict conventional victimizations in children and adolescents of the study area. This may be due to the nature of the types of conventional crime. A case in point is property victimization. Although generally children from low income are at the risk of conventional victimization, property victimization that includes robbing and theft appears to be more prevalent among children and adolescents with high income. This explanation is supported by the comprehensive dynamic model in the sense that offenders choose those who gratify them financially and by other means (Finkelhor, 2008). Furthermore, Finkelhor et al. (2005) mentioned that household income and property victimization were not significantly associated to one another. Likewise, the absence significant

association between maternal education and conventional crime could have been influenced by the family income.

Although previous studies documented that unconventional family structure predicts conventional crime in young people, in this study no significant association was found. This variation might have emanated from the moderational and mediational roles of other variables including gender, age, and situational factors.

5.2.3. Factors contributing to child maltreatment

Gender, single parent family structure, and maternal elementary education predictors showed significant relationship with child maltreatment. The odds of being victims of child maltreatment increased by 2.27 (95% CI=1.47-3.51) times for males, 1.91 (95% CI=1.13-3.21) times for respondents coming from single parents and 2.40 (95% CI=1.11-5.19) times for those whose mothers were in their elementary school education than those of females, respondents coming from intact families and those whose mothers' education level was higher education. These results are consistent with findings elsewhere in the literature. For example, it was reported that, with the exception of sexual victimization, males outnumber in any other victimization types including child maltreatment (Finkelhor, 2008). In addition, the roles of family structure and education in predicting child maltreatment are well documented in other studies. To mention some examples, Cyr, Michel and Dumais (2013) came up with findings indicating the association of low education and victimization experiences. Furthermore, Finkelhor (2008) and Turner, Finkelhor, and Ormrod (2007) stated that children and youth living in less conventional family situations such as with a single parent, in a family including a stepparent, experienced higher rates of several different kinds of victimization compared with children and youth living with two biological parents.

Age and income were not significantly associated with child maltreatment. In the association between age and child maltreatment, inconsistent research findings were identified. According to some studies such as Finkelhor, Ormrod and Turner (2009) who indicated that surprisingly and unexpectedly, child maltreatment rose with age mainly for girls. The reason for this may be the case that the maltreatment of younger children is difficult to access or verify both in surveys and among cases known to professionals, who are less likely to have contact with younger children (Finkelhor, 2008). On the contrary, Seifert (2012) found out that the youngest children are the most vulnerable to maltreatment (Seifert, 2012). The absence of significant association between income and child maltreatment in the present study may occur due to cultural reasons.

5.2.4. Factors contributing to peer and sibling victimizations

The present study obtained that gender was a significant predictor of sibling and peer victimization. Males were more victims of sibling and peer victimization than females by 2.79 (95% CI =1.81-4.28) times. Previous studies confirm this finding. Uusitalo-Malmivaara (2012) stated that girls and boys were not equally victimized and the outcomes associated with victimization may differ by gender.

All other variables were not statistically significant to the outcome variable. The possible reason why age was not significantly related with peer and sibling victimization may be due to the influence of gender. In line with this argument, Finkelhor, Ormrod and Turner (2009) pointed out that peer assault had different developmental patterns by gender that increased in adolescence for boys but not for girls. With regard to household income, although there are negative significant associations between income and peer and sibling victimization, this is not always the case. Finkelhor et al. (2005) substantiated this claim with their findings by stating that bullying was significantly higher for children or youths in households with high incomes. The

role of parental education might have been affected by family income. In addition, the role of family structure in peer and sibling victimizations might have been influenced by the various factors including time of studies, social, and cultural factors.

5.2.5. Factors contributing to childhood and adolescence sexual victimizations

As expected and consistently reported from the previous findings, gender and age were significantly associated with sexual victimization in the current study. The highest contribution was made by gender with the odds ratio value of 3.79 (95% CI=2.10-6.81), followed by age with odds ratio value of 3.44 (95% CI=1.92-6.17). The occurrences of sexual victimization in females and adolescent respondents were 3.79 and 3.44 times higher than males and child respondents respectively. Studies repeatedly documented and reported that, females were more victims of sexual victimization than boys (Snyder, 2000; Esbensen et al., 2010). Snyder (2000) indicated that females are more than six times as likely as males to be the victims of sexual victimization. More specifically, it was mentioned by CDC Youth Risk Behavior Surveillance study (in Seifert, 2012) that 10.5% of girls reported ever having been physically forced to have sex, versus 4.5% of boys. Additionally, studies depicted that girls suffer vastly more incidents of rape (8.1 female victims for every 1 male (Esbensen et al., 2010).

Previous research outcomes support the age difference. Finkelhor (2008) found higher rates of sexual victimization among adolescents. According to the Department of Justice, annual rates of sexual assault per 1,000 persons (male and female) were 0.9 for ages 12 through 15 years and 0.6 for ages 16 through 19 years (Seifert, 2012). The present finding could be explained using the comprehensive dynamic model of victimization that states perpetrators select victims that are attractive to them. In this case, females and adolescents appear to be their choices (Finkelhor, 2008).

5.2.6. **Factors contributing to witnessing and indirect victimizations**

The contribution of gender was significant in predicting witnessing and indirect victimizations with the odds ratio of 2.30 (95% CI=1.50-3.53), indicating that males were 2.30 times higher at the odds of experiencing witnessing and indirect victimization. Similar findings were obtained from other studies (Finkelhor et al, 2005).

The rest of the independent variables were not related with witnessing and indirect victimizations. Regarding the role of age, the present result appears to be inconsistent with the findings of other researchers. One example is that witnessing and indirect victimization experiences were more common during the period of adolescence than childhood period (Finkelhor, 2008). However, there are some exceptions. Finkelhor et al (2005) stated that teenagers were more likely than younger children to witness victimizations or experience indirect victimizations. In addition, the age pattern of witnessing and indirect victimizations could have been affected by gender (Esbensen et al., 2010).

Unlike previous findings, socio-economic variables and family structure were found to be not significant to predict witnessing or indirect victimization. These differences might have happened due to the fact that with the exception of domestic violence, most children and adolescents coming from all socio-economic status levels might have experienced violence occurring in the community and neighboring areas. Moreover, since physical punishment of children seems commonly practiced in the study area, most of the participants might have seen such kinds of incidents regardless of their socio-economic conditions. .

5.3. Prevalence of Mental Health Problems among Children and Adolescents

The prevalence of overall mental health problems, internalizing and externalizing problems and eight syndromes are discussed here in line with the previous research findings.

5.3.1. Overall mental health problems

The proportion of any mental health problems among elementary school children and adolescents of Gondar town was 14.4%. A recent meta analysis study indicated 14.3 % prevalence of childhood and adolescent psychopathology (Cortina, Sodha, Fazel & Ramchandani, 2012) which is nearly the same as the present finding. In addition, childhood and adolescence mental health problems prevalence in USA (12%), India (12%), and Philippines (15%) (Giel et al. cited in Desta, 2008) are very close to the current finding. However, the prevalence of this finding was higher than the findings of Ashenafi et al. (2001) and Alem, et al. (2006) who reported 3.5% and 5.5% prevalence of overall mental health problems respectively and lowers when it is compared with the results of Deyessa et al. (2012), Mulatu (1999), Tadesse et al. (1999), Desta (2008) and Fekadu, Alem, and Hagglo (2006) who came with prevalence of 31%, 21.45%, 17.7%, 17 % and 16.5% respectively. These variations might have occurred due to methodological differences, particularly the differences in the measures used. In addition, the differences in the samples might have had an effect on this variation.

The Chi-Square test of the current study showed that there was a statistically significant gender difference in the total mental health problems (χ^2=4.53, *df*=1, *N*=403, *p*<.003) indicating that males showed more mental health problems than females. The prevalence of the overall mental health problem of males was 18%, where as for female respondents, it was 10.6%. When these findings were compared with previous findings, there are inconsistent results. For example, the crude analysis made by Tadesse and colleagues (1999) showed that boys appeared to have a

higher risk of having behavioral disorders than girls supporting the present finding. However, Cortina et al (2012) did not obtain significant differences. All these indicate discrepancies with the present finding that might have happened due to methodological and cultural differences that exist between the present and other studies.

5.3.2. Internalizing problems

The proportion of internalizing problems of the present study was 20.06%, with statistically significant gender difference (χ^2=15.12, *df*=1, *N*=403, *p*<.000). This result is lower than the prevalence Deyessa et al. (2012) obtained, which was a 30.6 % among orphan children in Tigray, Amhara, Oromia, Southern Nations and Nationalities Regions and Administrative Cities of Addis Ababa and Diredawa. Differences in the two samples may be the reason why variation in the findings of the two studies was observed. The samples in Deyessa et al. (2012) were orphans who might have been more at risk of developing psychopathology than the present samples who were drawn from the general population in elementary schools.

5.3.3. Externalizing behavioral problems

The prevalence of externalizing problems among the participants of this study was 11.9 %., which is supported by previous empirical evidences. In a community samples, the magnitude of the problem ranges from 2 % to 20 % (Brandenburg, Friedman, & Silver; Offord et al. cited in Wilmshurst, 2013). The prevalence of externalizing behavioral problems of the samples in Gondar town was found to be lower than the proportion Deyessa et al. (2012) found, which was 29.3%. It appears that the difference occurred because of differences in the samples of these two studies: Orphan samples in the previous study and community samples in the present study.

.

5.3.4. Anxious/ Depressed

For the anxious/depressed syndrome of the current sample, the prevalence was 10.4%. This finding is consistent with previous findings. For example, a meta analysis study showed that the prevalence of anxiety disorder ranges from 6-18 % (Costello & Angold, cited in Corcoran, 2011). With regard to depression, studies showed different prevalence rates. For instance, in a study conducted by Costello, Erkanli, & Angold (in Corcoran, 2011), the prevalence of depressive disorders in children was 2.8 % and in adolescents it was 5.7 %. In addition, the present finding varies with the results obtained by Asehnafi et al. (2001) in Butajira (1%). The prevalence in the present study was found higher than the prevalence of those studies. Methodological conditions such as measures of data collection, sampling, and study areas might have contributed to these variations.

With regard to gender differences, anxious/depressed was statistically significant (χ^2=7.93, *df*=1, *N*=403, $p < .005$) showing that males have experienced more symptoms of anxious/depressed than females. Surprisingly, this finding is against the prevalence estimations of other previous studies. To mention, one example, Kessler (in Corcoran, 2011) reported that females are at greater risk of being diagnosed with depression. This gender gap, which emerges by age 14 years, is found internationally across Canada, Great Britain, and the United States and persists across the lifespan. This gender variation may be explained by social-cultural and methodological factors.

5.3.5. Withdrawn problems

The present study estimated a 9.7% prevalence of withdrawn behaviors of children and adolescents in Gondar town, which is more or less similar with the works of Deyessa et al (2012) who reported a prevalence of 11.2% childhood and adolescence withdrawn syndrome.

Unexpectedly male children and adolescents were found to report significantly more symptoms of withdrawn syndrome than female respondents (χ^2=26.53, *df*=1, *N*=403, *p* <.000). This might have happened because of methodological differences. The nature of the samples and measures used might have brought this surprising variation.

5.3.6. Somatic complaints

This study found out that the prevalence of somatic complaints was 5.2% (with 8.8 % males and 1.5 % females). Although there are variations of estimation across studies and specific types of somatic complaints, mainly it falls within the ranges of 2-10 % (Garralda, 2011). Against the findings of this study, in some studies the prevalence rate of the problem could reach 50% (Garber et al. in Wilmshurst, 2005).The deviation might have occurred due to cultural and sampling variations.

In contrast with previous research evidences (Garber and colleagues in Wilmshurst, 2005), males reported more somatic symptoms than females. This might have been occurred due to variations in subjective perceptions of males and females while reporting their bodily symptoms.

5.3.7. Social problems

The prevalence of social problems among the present samples was found to be higher (11.9%) than the other eight syndromes. The reason for this might have been because the child rearing practices that make children be dependent on parents and other adults.

5.3.8. Thought problems

The prevalence of thought problems among the participants was 4.5%, which is lower than the rates of social problems, anxious/depressed, withdrawn and somatic complaints. The low magnitude of thought problem might have occurred due to the nature of the problems. Thought problems are characterized by severe forms of problems including hearing and seeing things that others do not sense as well as experiencing strange ideas and behaviors (Achenbach and Rescorla, 2001).

5.3.9. Attention problems

Four percent of those children and adolescents attending their elementary school education in Gondar town reported that they have symptoms of attention problems. American Psychiatrists' Association (2013) and Polanczyk, de Lima, Horta, Biederman, & Rohde (in Corcoran, 2011) reported nearly similar rates: 5% and 5.29% respectively. However, this finding is higher than the results that Ashenafi et al (2001) obtained which was 1.5 % prevalence rate in Butajira.

Even though it was not significant, male participants (5.4%) outnumber their female counterparts (2.5%). This is supported by the findings of Mash and Wolfe (2003) who reported that attention problems occur with estimates ranging from 6–9% for boys and from 2–3% for girls in the 6- to 12-year age range.

5.3.10. Rule-breaking behaviors

Unexpectedly, the prevalence rate of rule breaking behaviors in this sample was .7%, lower than the conduct disorder reports of Carr (1999), APA (2013) and Ashenafi (2001), which were 16%, 2-10% and 1.5% respectively. However, this finding is nearly similar with the prevalence rate of kleptomania (DSM based disorder with some common symptoms of rule-breaking behaviors) that ranges from 0.3-0.6 % (American Psychiatrists'Association, 2013).

With regard to gender differences, the prevalence of rule-breaking behaviors in male respondents was 1.5 %. However, none of the female respondents experienced rule-breaking behaviors. Carr (1999) stated that conduct disorders are more prevalent in boys than in girls, with male: female ratios varying from 4:1 to 2:1.

5.3.11. Aggressive behaviors

The present study portrayed that a 5.7% (8.3 % males and 3% females) of the primary schools children and adolescents in Gondar town reported symptoms of aggressive behaviors.

This finding is compatible with the prevalence of oppositional defiant disorder that range from 1 % to 11% (American Psychiatrists Association, 2013) and 2 % to 12% (Corcoran, 2011). In line with the reports of previous literatures (American Psychiatric Association, 2013; Corcoran, 2011), male respondents reported significantly more aggressive behavior symptoms than females (χ^2=5.18, df=1, N=403, p <.023).

5.4. Victimization and Mental Health Problems

In this section, the roles of independent victimization types to the manifestations of the various types of mental health problems in children and adolescents that include overall mental health problems, internalizing problems, externalizing behavioral problems, and the eight specific mental health problems are presented. Some selected theories that explain the development of mental health problems in victim children and adolescents are used to discuss the findings. Finally, the links of poly-victimizations with the overall mental health problems, internalizing problems, and externalizing behavioral problems are discussed.

5.4.1. Victimizations and overall mental health problems

The finding of the present study showed that with the exception of child maltreatment, all other individual victimization types including conventional crime, peer and sibling victimization, sexual victimization, and witnessing and indirect victimization were not significantly related with the overall mental health problem of children and adolescents. Child maltreatment was found to be contributing to the overall mental health problem of the respondents. Similar research findings were found from previous studies. For example, Melchert (2006) established the effects of child maltreatment on childhood and adolescence psychopathology. In addition, child maltreatment was found to be a significant predictor of mental health problems of children and adolescents because it consists of many things including physical abuse, psychological abuse and neglect.

However, the absence of significant associations among conventional crime and overall mental health problems is against the findings obtained by others such as Melchert (2006) and Miller (2008). For instance, Melchert (2006) reported that many types of criminal victimization are highly linked to over all mental health difficulties of young people.

Possible explanations for the variations between the present findings and the previous ones may be seen from the perspectives of resilience and senses of coherence theories. According to resilience theories, children and adolescents might have overcome those victimization experiences (Cicchetti, 2006). In addition, as the sense of coherence theory says, victim children and adolescents might have had generalized resistive resources that facilitated successful coping with victimizations (MacDonald, 2006). Furthermore, the levels and types of conventional crimes experienced by the present samples may be minor ones including stealing educational materials and other minor forms.

The findings of the present study also showed that peer and sibling victimization was not significantly associated with the overall mental health problems. This finding contradicts with previous research outcomes like the findings obtained by Totura et al. (2009). The deviation of the findings of this study from others could be attributed to such conditions as less severity of the victimization and distant nature of the occurrence of the victimization in terms of time. The natures of appraisal for example absence of self blame, the use of positive coping strategies and the availability of environmental buffers might have contributed for the better mental health conditions of victims of peer and sibling victimizations.

Surprisingly, sexual victimization was not significantly linked with the overall mental health problems of the present sample. The finding of this study is inconsistent with most of the previous research outcomes. As indicated in the literature, researchers such as Finkelhor, Ormrod, and Turner (2007), Finkelhor (2008), and Itzin, Taket, and Barter-Godfrey (2010) reported significant roles of sexual victimization to the overall mental health problems of children and adolescents. The contradiction might have occurred because of cultural differences. In the culture where this study was conducted, non-penetrative sexual acts may not be taken as elements of sexual victimization. Many other factors like, appraisal, coping strategies, resilience, protective factors, and availability of generalized resistive resources might have mediated the relationship between sexual victimizations and mental health problems. In addition, the relatively lower percentage of sexual victimizations than other victimization types in the present study might have contributed to the discrepancy.

Witnessing and indirect victimization was also not a significant predictor of the overall mental health problems of the respondents. The finding of this study are consistent with the research outcomes of Laye and Mykota (2014) who reported that for male children and

adolescents, witnessing violence did not improve the prediction of any mental health problems. Besides the roles of individual victimization types on the mental health problems, the association of poly-victimizations with the overall mental health problem was checked using Chi-square test.

The findings of the Chi-square analysis indicated that the estimate of poly-victimizations (with four or more victimizations) among the present sample was 54.3%. Among these poly-victims, 10.9% of them manifested symptoms of mental health problems. Moreover, there was statistically significant differences in the prevalence of overall mental health problems (χ^2=16.9, *df*=1, *N*=403, *p*<.001) between poly- victims and non poly-victims. These finding is consistent with findings from the previous studies. Studies indicated that poly-victimizations are closely associated with childhood and adolescence mental health problems and bad outcomes, and that poly-victims are harboring the greatest amount of distress (Finkelhor, Ormrod & Turner, 2007; Finkelhor et al, 2005; Sabri, 2011; Uusitalo-Malmivaara, 2012). Moreover, Finkelhor, Ormrod and Turner (2007) asserted that children and adolescents who experienced multiple kinds of victimization from multiple sources have difficulties to recover.

5.4.2. Victimizations and internalizing problems

Conventional crime and child maltreatment were found to be significantly predicting internalizing problems of the respondents. The significant contribution of conventional crime to internalizing problems in this study is supported by previous research evidences. For example, Melchert (2006) stated the linkage between the internalizing adjustment disorder of childhood and adolescence with the experience of crime victimization including vandalism, property victimization, theft, and other illegal assaults.

The contribution of child maltreatment to the manifestation of internalizing problems also has support from previous studies. Various forms of child maltreatment were found to be

linked with internalizing problems (Laye & Mykota, 2014; Martinez, Gudin˜o & Lau, 2013; Sabri, 2011; Wimsatt et alt, 2013).

The findings of the present study showed that peer and sibling victimization was not significantly related with internalizing problems. This finding contradicts with previous research outcomes like the findings obtained by Totura et al. (2009). The deviation of the findings of this study from others might have been occurred due to methodological differences.

Unexpectedly, sexual victimization was not a significant predictor of internalizing problems of childhood and adolescence mental health problems of the present sample. The finding of this study is different from previous research outcomes. Finkelhor, Ormrod, and Turner (2007), Finkelhor (2008) and Itzin, Taket, and Barter-Godfrey (2010) reported significant roles of sexual victimization to the internalizing problems of children and adolescents. The contradiction might have happened due to cultural and methodological differences.

In this study, witnessing and indirect victimization did not predict internalizing problems. The finding of this study was consistent with the research outcomes of Laye and Mykota (2014) who reported that for male children and adolescents, witnessing violence did not improve the prediction of any of the internalizing/externalizing problems.

Regarding the role of poly-victimization on the manifestation of internalizing problems, 14 % of those ploy-victims reported symptoms of internalizing problems. There was also a statistically significant difference in the prevalence of internalizing problems (χ^2=17.68, df=1, N=403, p <.001) between poly- victims and non poly-victims. Consistent with this finding, Sabri (2011) indicated that adolescents with multiple types of victimization experiences were more likely to develop internalizing problems.

5.4.3. Victimizations and externalizing behavioral problems

All the independent variables including conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing and indirect victimization did not predict externalizing behavioral problems of children and adolescents who participated in this study. With regard to the role of witnessing and indirect victimization, similar research evidence is available in the literature. Laye and Mykota (2014) reported that for male children and adolescents, witnessing violence did not improve the prediction of externalizing problems.

However, for the rest of the variables, previous studies documented findings that contradict with the present finding. Conventional crime (Melchert, 2006), peer and sibling victimization (Totura et al., 2009), child maltreatment (Finkelhor, 2008), and sexual victimization (Finkelhor, Ormrod, & Turner, 2007; Itzin, Taket, & Barter-Godfrey, 2010) contributed to externalizing behavioral problems. Various reasons could be given for getting incompatible findings. One may be due the lowest prevalence of rule-breaking behaviors (.7 %), which is one of the components of externalizing behaviors. Other reasons may include the availability of protective factors, cultural differences, and methodological variations.

The findings of the Chi-square tests indicated that 8.4 % of the poly-victims showed symptoms of externalizing behavioral problems. There was statistical significant differences in externalizing behavioral problems (χ^2=9.19, *df*=1, *N*=403, *p* <.001) between poly-victims and non poly-victims. Furthermore, the link between poly-victimization exposures and externalizing behavioral problems was documented in the works of Sabri (2011) who stated that adolescents with multiple types of victimization experiences tended to manifest externalizing behavioral problems.

5.4.4. Victimizations and anxious/depressed

In the present sample, child maltreatment and peer and sibling victimizations significantly predicted anxious/depressed syndrome. However, the other three independent variables: Conventional crime, sexual victimization, and witnessing and indirect victimization were not significant predictors of the outcome variable.

The significant role of child maltreatment in predicting anxious/depressed is well established (Miller, 2008; Wimsatt et al, 2013; Laye & Mykota, 2014). Child maltreatment was found significant predictor of more mental health syndromes of young people than other victimization types; because for one thing child maltreatment consists of many things including physical abuse, psychological abuse and neglect. Another reason is that in relative terms, it is a global phenomenon that occurs regardless of any culture and ethnicity.

The significant association between peer and sibling victimization and anxious/depressed syndrome has the support from other studies conducted by Totura et al (2009) and Uusitalo-Malmivaara (2012) who reported that the victims of peer violence were more depressed than the non-victims.

Conventional crime was not statistically significant predictor of anxious/depressed syndrome which is different from the works of the other researchers such as Miller (2008) who indicated that conventional victimizations lead to anxious/depressed syndrome. Possible explanations for the variations between the present findings and the previous ones may include different conceptualizations of conventional crime and the natures of conventional victimization experienced by the respondents. Conceptualization of conventional crime in Gondar town may not be the same as the way it is conceptualized in the western countries, where previous studies were conducted. In addition, the levels and types of conventional crimes experienced by the

present sample may be minor ones including stealing educational materials and other minor assaults.

Although its contribution is well documented in the previous studies (Walsh & DiLillo, 2011), sexual victimization did not predict anxious/depressed mental health problem of children and adolescents in the present sample. Cultural, social, and methodological differences might have contributed for obtaining this surprising result. Finally, opposite to previous findings, witnessing and indirect victimization failed to predict anxious/depressed problems. Nicodimos and colleagues (2009) reported that females who witnessed parental violence were twice as likely to report moderate depression, or 3-times as likely to report moderately severe depression as compared with those who did not witness parental violence. The contradiction might have been occurred due to the roles of moderator and mediator variables such as gender and age. In addition, the ages of the participants in these studies were different from those of the previous ones.

5.4.5. Victimizations and withdrawn problems

As expected, child maltreatment was found to be a significant predictor of withdrawn syndrome of the respondents. However, all other four variables did not significantly contribute to withdrawn problems of children and adolescents. Regarding conventional crime, although Miller (2008) stated that conventional victimization lead to withdrawn problems of young people, this study found an opposite result. The same was true for peer and sibling victimization, which was inconsistent with the finding of O'Hagan (2006). The contributions of sexual victimization and witnessing and indirect victimization were not significant predictors of withdrawn syndrome. Such variations might have resulted from socio-cultural and methodological differences between the present study and the previous ones.

5.4.6. Victimizations and somatic complaints

All the individual types of victimizations including conventional crime, child maltreatment, sibling and peer victimization, sexual victimization, and witnessing and indirect victimization did not predict somatic complaints. The absence of significant correlation of peer and sibling victimization with somatic complaints was supported by a study conducted Uusitalo-Malmivaara (2012). However unlike the present study, sexual victimizations (Wilmshurst, 2005) and witnessing and indirect victimizations (Wilmshurst, 2005; Miller, 2008; Uusitalo-Malmivaara, 2012) contributed to somatic symptoms. Conceptual differences and methodological variations might have caused such deviations of the present findings with the previous research evidences. It might have also been influenced by the specific types of somatic complaints. For example, eye problems, skin problems, and vomiting many may not be always contributed by victimizations.

5.4.7. Victimizations and social problems

From the five independent variables, child maltreatment was found to be significantly linked with social problems. This finding is consistent with what Wimsatt et al. (2013) obtained.
The absence of significant relationships of social problems with other types of victimizations like sexual victimizations and witnessing and indirect victimizations contradicts with the previous research findings. For example, Wilmshurst (2005) found the contribution of sexual victimizations for social problems. In addition, witnessing and indirect victimization exposures were found to be contributing to symptoms of somatic complaints (Wilmshurst, 2005; Miller, 2008; Uusitalo-Malmivaara, 2012). The contradictions might have happened due to the relatively small proportion of respondents who were exposed to sexual victimizations. In addition, social and cultural differences of conceptualizing sexual victimization might have contributed. With regard to witnessing and indirect victimization experiences, the participants in this study might

have been exposed to minor violence that might have been taken as normal day to day experiences of individuals.

5.4.8. Victimizations and thought problems

Unlike previous research evidences, all victimization types were not statistically related to thought problems. Against the present finding, Miller (2008) asserted that conventional victimizations lead to thought problems and it was reported that thought syndrome (O'Hagan, 2006) was significantly associated with peer victimization exposures. The deviation of the findings of this study from others could be attributed to the smaller proportion of participants who manifested symptoms of thought problems (4.5%). In addition, it might have happened due to less severe nature of victimizations that may have little to do with thought problems which is relatively more severe mental health problem than other types.

5.4.9. Victimizations and attention problems

All the independent variables did not predict attention problems of the present sample. This finding is different from previous research outcomes. For example, O'Hagan (2006) reported that peer victimization exposure predicted attention problems. One possible explanation for this discrepancy might have been due to the lower proportion of the participants with this problem. Next to the prevalence of rule-breaking behaviors (.7%), attention problem was the second least prevalence (4%) reported.

5.4.10. Victimizations and aggressive behaviors

Conventional crime, child maltreatment, peer and sibling victimization, sexual victimizations, and witnessing and indirect victimization did not significantly contribute to the manifestation of aggressive behaviors among the present sample. This result is different from the findings of the previous studies. For instance, sexual victimization was found to be linked with aggressive

behaviors (Turner, Finkelhor & Ormrod, 2005; Finkelhor, 2008; Walsh & DiLillo, 2011). In addition, witnessing and indirect victimization exposures were related to aggressive behaviors (Turner, Finkelhor & Ormrod, 2005). These variations might have occurred because of methodological variations. The nature of samples, sample size, sampling methods, and measurement issues seemed to bring those differences.

Generally, when the associations of victimization experiences and mental health problems of children and adolescents are considered, there are various possibilities. In some circumstances, victims develop symptoms of psychopathology, while in others situations not (Finkelhor, 2008; Hendry & Macinnes, 2011; Laye & Mykota, 2014). Similarly, DeValve (2005) pointed that the psychological impacts of victimization can take the forms of non-existent to extreme, and can range from short- to long-term, depending on the type of victimization, amount of loss incurred, and trauma suffered.

These variations might have occurred due to reasons such as the presence of poly-victimization, recent victimization occurrences, and severity of the victimizations, and the nature of the perpetrators, for example a trusted adult (Sabri, 2011). Moreover, the roles of protective and resilient factors should not be underestimated (Hendry & Macinnes, 2011). Other conditions such as appraisal of victimization, types of coping strategies used by victims, developmental tasks to be achieved at certain periods, and availability of environmental buffers and victim supports might have protected victims from developing mental health problems (Finkelhor , 2008; Finkelhor, Ormrod & Turner 2007).

Chapter Six: Summary, Conclusions, and Recommendations

In this final chapter, summary, conclusions, and recommendations of the study are presented. The research questions and respective findings of the study were considered in identifying major points of the summary, conclusions, and recommendations.

6.1. Summary

Children and adolescents, throughout human history have been the victims of practices of abandonment, infanticide, sacrifice, mutilation, slavery, excessive discipline and exploitation at work (Archard, 1993; Schetky, 2002). Although it may differ in its shape, victimizations of children and youth is still rampant today and perhaps it may continue to be practiced in the future. Even though academic conferences, congressional hearings, special documentaries are conducted together with issuing opinions, creating task forces, blaming guns, movies, and parents, no simple solutions have emerged so far. The world continues to be shocked, enraged, and confused by the horrors of violence in homes, schools, and streets (Perry, 2002). Some local studies on the subject indicate that many children and young people in Ethiopia experience different forms of victimizations in different places including homes, schools, and neighborhood areas (ANPPCAN-Ethiopia, 2009; The African Child Policy Forum, 2011).

WHO (in Hartjen & Priyadarsini, 2012) reported that the violence, abuse and neglect experienced by the world's children and young people are consequential. DeValve (2005) also pointed out that the psychological impacts of victimization can take the forms of non-existent to extreme, and can range from short- to long-term, depending on the type of victimization, amount of loss incurred, and trauma suffered.

Researchers have attempted to document victimizations and mental health problems of childhood and adolescents. Yet, due to the huge and complex nature of the problem, these endeavors are not adequate. When previous research works are explored, it is not uncommon to observe varieties of gaps including incomprehensiveness, inadequate attention to juvenile victims as compared to juvenile offenders, and less focus on developmental issues.

Thus, the purpose of this study was to examine the prevalence of childhood and adolescence victimizations and mental health statuses of the victims and to investigate the associations between victimization experiences and mental health problems of children and adolescents. In addition, the study aimed at investigating the contributions of socio-demographic variables on victimization experiences of children and adolescents. It is the expectation of the researcher that a study on the victimization experiences and mental health problems of children and adolescents will have a number of benefits both in terms of theoretical and applied values.

To find out what has been done in the areas of victimizations and mental health problems of children and adolescents, previous research works were reviewed in line with the research questions raised earlier. Accordingly, the review section included topics in victimizations and mental health problems of children and adolescents with particular emphasis on the types and prevalence, theories, and contributing factors of both problems.

In order to conduct the study smoothly and to obtain dependable findings, sound methodological design was employed. It was a cross-sectional survey design that followed quantitative methods of data collection and analysis. The study was conducted in the school settings of Gondar town, Amhara Regional State. The sample included 403 elementary school children, who were randomly drawn from the target population using stratified random sampling technique. Socio-demographic measure, Juvenile Victimization Questionnaire, and Achenbach

System of Empirically Based Assessment (ASEBA) Youth and Teacher Report Forms were used to collect the data. The validities of these measures were checked using expert discussions. To ensure the reliabilities of the measures, pilot study consisting of 112 children and adolescents was conducted and promising alpha values were obtained. Mean, percentages, Chi-square, and logistic regression analysis were used to analyze the data of the main study. Since victimization and mental illness issues are sensitive ones, appropriate ethical considerations were addressed.

The major findings of the study indicated that considerable proportion of children and adolescents in the study area experienced victimizations with the prevalence of 79.4%. When the one year prevalence rates for the five independent types of victimization are observed, the highest was conventional crime (66.5%) followed by witnessing and indirect victimization (58.1%), peer and sibling victimization (47.4%) and child maltreatment (39.7%).

Regarding the roles of socio-demographic factors on victimizations of the sample, gender and family income were found significant predictors of the overall victimizations. Gender showed significant associations with all independent types of victimizations consistently. In addition, family structure and maternal educational background were significantly related with child maltreatment while age was linked significantly with sexual victimization.

The proportion of overall mental health problems among the respondents was 14.4%. The proportion of internalizing problems (20.06%) was higher than that of the prevalence rate of externalizing problems (11.9 %) of the respondents. When the specific mental health problems were considered, the highest was social problems (11.9%) followed by anxious/depressed (10.4%), and withdrawn (9.7%). In all cases, the prevalence rates of the mental health problems of males were found higher than that of females.

Child maltreatment contributed to the mental health symptoms such as overall mental health problems, internalizing problems, anxious/depressed, withdrawn, and social problems. Conventional crime also predicted internalizing problems. In addition, conventional crime and sibling and peer victimizations predicted internalizing problems and anxious/depressed syndrome respectively. Finally, poly-victimizations were significantly related with any mental health problems, internalizing problems, and externalizing behavioral problems.

6.2. Conclusions

The majority of children and adolescents attending elementary school education in Gondar town reported at least one form of victimization during the previous year. Among the various types of victimization exposures, children and adolescents highly experienced conventional crime followed by witnessing and indirect victimization, peer and sibling victimization and child maltreatment. The lowest victimization reported was sexual victimization. Nearly more than half of the respondents experienced poly-victimization-four or more victimization types with a mean of 5.21. The implication is that children and adolescents in Gondar town were victims of various forms of victimizations, which call for the provision of psycho-legal services. When psychological and legal services are designed and implemented for preventing victimization and rehabilitating the victims, there is a need to consider the overall victimizations, individual types of victimizations, and above all poly-victimizations.

Gender was found to be a significant predictor of all victimizations including any victimization, conventional crime, child maltreatment, sibling and peer victimization, sexual victimization, and witnessing and indirect victimization. In all but sexual victimization, males were found to be more at risks of experiencing victimizations. In the case of sexual

victimization, females reported more at risk of victimization exposures. Family income statistically predicted any victimization experiences-the probability of the occurrence of any form of victimization was higher for those who came from low income families than for respondents from high income families. Family structure and maternal education showed significant relationship with child maltreatment. The risks of being victims of child maltreatment increased for male respondents, children and adolescents lived in single parents, and those whose mothers were in their elementary school education level than those of females, respondents coming from intact families, and those who had mothers' with higher education level. Finally, age was significantly associated with sexual victimization. The occurrences of sexual victimization were higher in adolescent respondents than in child respondents. Preventions of victimization and victim assistance programs are required to take gender and other pertinent variables into account.

The highest proportion of overall mental health problems reported among children and adolescents of Gondar town were internalizing problems, followed by externalizing and overall mental health problems. Regarding the syndromes, the highest was social problems followed by anxious/depressed and withdrawn problems. The lowest prevailing syndrome was rule-breaking behaviors followed by attention problems and thought problems. In all cases, the prevalence rates of the mental health problems of males were found to be higher than that of females. There was a statistically significant gender difference in the total mental health problems and internalizing problems. With regard to gender differences in the eight specific syndromes, male respondents manifested more problems than their female counterparts. The implication of these findings is that mental health and psychological services are expected to address the types of the mental health problems as well as the gender of the mental health service beneficiaries.

Child maltreatment was found to be contributing to the development of the symptoms of any mental health problems, internalizing problems, anxious/depressed, withdrawn, and social problems of the respondents. This implies that psycho-legal services need to focus on the prevention and intervention activities of child maltreatment and associated mental health problems of children and adolescents. Conventional crime was significantly linked with internalizing problems and sibling and peer victimization was found to be contributing to anxious/depressed syndrome. Furthermore, mental health problems of respondents were associated more with poly-victimization types than with single types of victimizations.

To put it in a nut shell, highly prevailing victimization experiences and associated mental health problems of children and adolescents have implications for the psychological and legal services. Childhood and adolescence victimization and mental illness prevention and rehabilitation programs need to consider types of victimizations, contributing factors to victimization, poly-victimizations, types of mental health problems, and the associations between victimizations and mental health problems.

6.3. Recommendations

Based on the findings of the study, an attempt to identify realistic recommendations is made. By doing so, suggestions on the needs of preventing victimizations and mental health problems of children and adolescents are indicated. In addition, recommendations regarding the importance of providing mental health, psychological, social, and legal support for those children and adolescents who experienced the problems already are forwarded. Finally, issues that require further inquiry are proposed.

6.3.1. Design prevention and intervention programs

It was observed from the findings of this study that considerable proportion of elementary school children and adolescents experienced various forms of victimizations. In addition, the magnitude of childhood and adolescence mental health problems in study sample is not something to be underestimated. Moreover, some victimization types were associated with the mental health problems of the study participants. Therefore, taking measures that aim at preventing and intervening victimizations and mental health problems of young people is imperative. These can be done giving awareness training to the concerned bodies as well as by providing psychotherapy, social, and legal support to those children and adolescents with victimization and mental health problems.

1. ***Give awareness raising trainings***

For obvious reasons, preventing victimizations before they occur and impact young people's psychological lives need to be given priority. On time preventive programs and activities need to avert or deter victimizations from taking place at all by doing something that blocks young people from being harmed. Typically, the general public, service providers, and decision makers need to raise their awareness about the problem and legal issues as well. The primary prevention of child and adolescent victimization should be conducted at the local, state, and national levels by employing prevention messages via the media, as well as community resources to contact for help. Information should be provided through television public service announcements, brochures, announcements on radio, advertisements in newspapers and magazine articles, billboards, and through the internet. Since some victimization forms like the physical punishment type of child maltreatment may have something to do with the cultural and social roots, any real or meaningful impact on prevention programs should address the underlying causes, the social-

cultural ideologies and conditions that support or allow individual behavior. In addition, victimization reduction program such as trainings should be given to children and adolescents to promote their behaviors and to resolve conflicts using peaceful strategies.

The findings of this study showed that considerable victimization occurs in elementary schools of Gondar Town. In addition, large numbers of young people are found in schools, that makes delivery of programs cheap and efficient. School personnel know about effective education, and students are used to learning in that environment, so prevention education modalities are familiar and appropriate in the schools. Therefore, awareness and information sessions need to be provided in schools as part of the personal, social, and health education curriculum.

In addition to the importance of primary prevention, secondary prevention programs that target at deterring the occurrences of victimizations by working on young people who are potentially at risks of experiencing victimizations and associated mental health problems of young people is essential. Prevention strategies should focus on such socio-demographic contributing factors of victimizations as gender and socio-economic status of the family. Since, types of victimizations such as child maltreatment and poly-victimizations were found significant predictors of most forms of childhood and adolescence psychopathology, prevention programs should prioritize to tackle such kinds of victimizations. Service provisions should be designed to reduce the harm caused by victimization (mental health problems) and prevent future incidences of victimizations. Secondary prevention programs should include providing counseling, psychotherapy, information, referrals services as well as arranging support groups for both boys and girls and parents with low socio-economic status. The provisions of these services should be available as early as possible and they need to be offered in schools.

2. ***Provide psychotherapy, social support and legal services***

As the findings of the present study indicated, there were children and adolescents who already experienced victimizations and showed symptoms of mental and behavioral health problems. Thus, to reduce such negative impacts, these children and adolescents should get timely and age appropriate services including mental health counseling or psychotherapy, social support, and legal services.

a) *Provide mental health counseling services*

- In order to build the self-esteem of victims and those who developed mental health problems, counselors and other mental health professionals should give counseling or psychotherapy services.
- Counselors or other mental health professionals should be able to help victims and young people with psychological disturbances in solving problems and meeting the immediate needs as well as provision of appropriate referrals to mental health professionals.
- Since most children and adolescents with child maltreatment and poly-victimization exposures were found to manifest mental health problems, mental health professionals should give priorities to these types of victims and offer special mental health services to victims of child maltreatment and poly-victimization.
- Teachers and other school personnel in the schools should be involved in referring victim children and adolescents and those with mental health problems to mental health professionals.

b) Provide social support

- Since, young people commonly rely on the support of others in everyday circumstances, informal support systems such as friends and family need to offer emotional encouragement to victims and those who have portrayed symptoms of mental and behavioral problems.
- Psychologists, mental health professionals, social workers, and teachers should provide formal social support to victims and those who manifested psychopathology.

c) Provide legal services

It is a clear fact that when children experienced victimizations, mainly crime victimizations, they may go to the police, prosecution office, and courts. Thus, these legal institutions should provide need based legal services by focusing on the following issues.

- The child protections units and the juvenile victim justice systems should be strengthened at various levels. This includes a comprehensive set of measures that should include legal and administrative reforms; training of justice personnel; and building of appropriate court rooms, police stations, and offices for prosecutors and other relevant staff working with child and adolescent victims.
- Police officers, prosecution officers and, judges should give such legal services as guarantying confidentiality and privacy of court proceedings involving child and adolescent victims, documentation of cases, legal aid advice, victim compensation, and appropriate referrals for mental health assessment and treatment.
- Mental health professionals should give trainings to police and prosecution officers as well as judges involved in child victim cases so that they can be child sensitive and provide age appropriate services.

- The legal provisions included in both national and internal legal instruments that are pertinent to child and adolescent victimizations should be implemented as stipulated.

All the mental health, social, and legal services should be offered to the needy by taking the principles of evidence-based practice, comprehensiveness of services, focus on the best interest of the victim, strength –based approach, age appropriate support, multi professional service (multi disciplinary team approach) and cultural competency into account. Finally, these supports should be provided in collaboration with and partnership among relevant stakeholders. Because so many victimizations come to the attention of school authorities, it is crucial that schools should be connected to multidisciplinary resources, including mental health, social service, and law enforcement resources.

6.3.2. Limitations of the study and the need for further research

Like any other research endeavor, there are some limitations of this study that may decrease its generalizability to all children and adolescents of Gondar town. These are mainly methodological concerns. In the first place, the study design was a cross-sectional one in nature. Secondly, this study did not include children and adolescents who were out of school. Thirdly, triangulation of both quantitative and qualitative data was not done. Qualitative methods were not used because of the practical challenge the researcher faced- particularly difficulty of staying in the study setting due to its long distance from Addis Ababa. It is because qualitative data collection requires the researcher to be there in the study area for longer duration. The inadequacy of the financial support obtained from the University was another serious limitation for not opting qualitative methods.

Another methodological limitation of this study was that it did not address the roles of mediator and moderator variables in the predictions of victimizations on mental health problems.

Finally, although parents may be important sources of data, the data were collected from children and adolescents themselves and their teachers only. This was not done because it was very challenging to get the parents of the selected children. Generally, all these things were not considered in the study simply for practical reasons.

Besides the limitations of the study, some surprising and unexpected findings that contradict with the previous research findings were obtained. These include the absence of significant associations among sexual victimization and mental health problems of children and adolescent sample. In addition, witnessing and indirect victimization was not significantly related with any of the mental and behavioral problems. Thus, by taking the limitations of this study and the gaps between findings of the present study and previous findings into account, the following possible areas of future research are pointed out.

- Researchers need to conduct comprehensive and longitudinal studies on childhood and adolescence victimizations and associated mental health problems by including samples from non-school settings. In doing so, qualitative methods need to be employed together with quantitative ones and the sources of data need to include parents. Moreover, variables that mediate and moderate the link between victimizations and mental health problems need to be addressed in future studies.
- Further studies on the contributions of sexual victimization and witnessing and indirect victimizations to mental health problems need to be conducted.

References

Achenbach, T. (2005). Achenbach system of empirically based assessment. In Thomas Grisso , Gina Vincent, Daniel Seagraves (Eds.), *Mental health screening and assessment in juvenile justice* (pp.187-204) . New York: A Division of Guilford Publications, Inc.

Achenbach, T.M. (2010). Multicultural evidence-based assessment of child and adolescent psychopathology. *Transcultural Psychiatry, 47*, 707-726.

Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for ASEBA school age forms & profiles.* Burlington, VT: University of Vermont Research Center for Children, Youth and Families.

Afifi, A.A. & Clark, V. (1997). *Computer aided multivariate analysis* (3rd ed.). By Chapman and Hall CRC .

Alem, A., Zergaw, A., Kebede, D., Araya, M., Desta, M., Muche, T., Chali, D. & Medhin, G. (2006). Child labor and childhood behavioral and mental health problems in Ethiopia. *Ethiop.J.Health Dev. 20* (2), 120-126.

Alink, L.R., Euser, S., van IJzendoorn, M. H. & Bakermans-Kranenburg, M.J. (2013). Is elevated risk of child maltreatment in immigrant families associated with socioeconomic status? Evidence from three sources. *International Journal of Psychology, 48(*2), 117–127.

Amaddeo, F. , Donisi,V. Grigoletti, L. & Rossi, A. (2013). Innovative epidemiological methods. In Graham Thornicroft, Mirella Ruggeri, and David Goldberg (Eds.), *Improving mental health care: The global challenge* (pp. 229-246). London: John Wiley & Sons, Ltd.

American Psychiatric Association (2000). *DSM IV-TR: Diagnostic and statistical manual of mental disorders--Text Revision* (Fourth ed.). Washington, D.C.: American Psychiatric Association.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders 5th edition.* Washington, DC: by American Psychiatrists Association.

ANPPCAN-Ethiopia (2009). Study on the systems of child protection and data collection on abused children and children in conflict with the law in Ethiopia. Addis Ababa.

Archard, D. (1993). *Children: Rights and childhood* (2nd ed.). New York: by Routledge.

Aries, P. (1962). *Centuries of childhood. A social history of family life.* New York :Random House.

Ashenafi,Y., Kebede, D., Desta, M. & Alem, A.(2000).Socio-demographic correlates of mental and behavioral disorders of children in Southern Ethiopian. *East Africa Med J, 77*(10), 565-569.

Ashenafi,Y., Kebede, D., Desta, M. & Alem, A.(2001). Prevalence of mental and behavioral disorders in Ethiopian children. *East Afri Med J, 78(*6), 308-311.

Assefa, G. W. (2011). The predicaments of child victims of crime seeking justice in Ethiopia: a double victimization by the justice process. A*frika Focus* , *24* (1), 11-31.

Bakermans-Kranenburg, M.J. & van IJzendoorn, M.H. (2013). It should not hurt to be a child. *International Journal of Psychology*, *48(*2), 79–80. By Routledge

Bauman, S. & Summers, J.J. (2009). Peer victimization and depressive symptoms in Mexican American middle school students: Including acculturation as a variable of interest. *Hispanic Journal of Behavioral Science*, *31*(4), 515–535.

Belay Hagos (2008). Sexual abuse and exploitation of boy children in Addis Ababa. Bright for Children Voluntary Association (BCVA), Addis Ababa, Ethiopia.

Belfer, M., Remschmidt, H., Nurcombe, B., Okasha, A. & Sartorius, N. (2007). A global programme for child and adolescent mental health: A challenge in the new millennium. In Helmut Remschmidt (Editor), *The mental health of children and adolescents: An area of global neglect* (pp.1-12). Chichester: John Wiley & Sons.

Betancourt, T. S., McBain, R., Newnham, E.A. & Brennan, R.T. (2013). Trajectories of internalizing problems in war-affected Sierra Leonean youth: Examining conflict and post conflict factors. *Child Development*, *84 (*2), 455–470. By SRCD.

Brown, J.M. (2010). Victimology. In Jennifer M. Brown and Elizabeth A. Campbell (Eds.), *The Cambridge handbook of forensic psychology (*pp.732-738). Cambridge University Press.

Caffo, E. & Belaise, C. (2007). Violence and trauma: Evidence-based assessment and intervention in children and adolescents: A systematic review, in H. Remschmidt, B. Nurcombe, M. Belfer, N.Sartorius, A. Okasha (Eds.), *The Mental health of children and adolescents: An area of global neglect* (pp.137-164). Chichester: John Wiley & Sons.

Carr, A. (1999).*The handbook of child and adolescent clinical psychology: A contextual approach*. London: published by Routledge.

Central Statistics Agency. (2007). Household Income, Consumption and Expenditure (HICE) Survey Analytical report. *Statistical Bulletin.* Addis Ababa.

Chen, X. (2009).The linkage between deviant lifestyles and victimization: An examination from a life course perspective. *Journal of Interpersonal Violence, 24* (7), 1083-1110. By SAGE Publications.

Christiansen, E .J., & Evans, W.P. (2005). Adolescent victimization: testing models of resiliency

by gender. *Journal of Early Adolescence*, *25*(3), 298-316.

Cicchetti, D. (2006). Development and psychopathology. In D. Cicchetti and D. J. Cohn (Eds.), *Developmental psychopathology, 2nd ed. Volume One: Theory and method* (pp.1-23). New Jersey: John Wiley & Sons, Inc.

Cicchetti, D. & Valentino, K. (2006). An ecological–transactional perspective on child maltreatment: Failure of the average expectable environment and its influence on child development. In Dante Cicchetti and Donald J. Cohen (Eds.), *Developmental psychopathology 2nd edition : Risk, disorder, and adaptation (* pp.129-202). New Jersey: by John Wiley & Sons, Inc.

Claveirole, A. & Gaughan , M. (2011). *Understanding children and young people's mental health*. United Kingdom: John Wiley & Sons Ltd.

Compas, B.E. & Oppedisano, G. (2000). Mixed anxiety/depression in childhood and adolescence. In Arnold J. Sameroff, Michael Lewis and Suzanne M. Miller (Eds.), *Handbook of developmental psychopathology, 2nd edition* (pp.531-548). New York. By Springer.

Constitution of the Federal Democratic Republic of Ethiopia, 21 August 1995, available at: http://www.unhcr.org/refworld/docid/3ae6b5a84.html [accessed 14 December 2012]

Corcoran, J. (2011). *Mental health treatment for children and adolescents.* Oxford: by Oxford University Press, Inc.

Cortina, M. A., Sodha, A., Fazel, M., & Ramchandani, P. G. (2012). Prevalence of child mental health problems in Sub-Saharan Africa A systematic review. *Arch Pediatr Adolesc Med*, *166*(3):276-281.

Crosby, J. (2011). Peer victimization and post-traumatic stress disorder in children and adolescents. In Michele A. Paludi (Ed.), *The Psychology of teen violence and victimization* : *From bullying to cyberstalking to assault and sexual violation* , 1, 3-16.

Cyr, K., Clément, M. & Chamberland, C. (2013). Lifetime prevalence of multiple victimizations and its impact on children's mental health. *Journal of Interpersonal Violence, 29*(4), 616–634. BY Sage.

Cyr, C., Michel, G. & Dumais, M. (2013). Contemporary child maltreatment as a global phenomenon: From trauma to prevention. *International Journal of Psychology, 48* (2), 141–148. By Routledge.

Czincz, J. & Romano, E. (2013). Childhood sexual abuse: Community-based treatment practices and predictors of use of evidence-based practices. *Child and Adolescent Mental Health, 18(*4), 240–246.

Daniels, T., Quigley, D., Menard, L. & Spence, L. (2010). My best friend always did and still does betray me constantly": Examining relational and physical victimization within a dyadic friendship context. *Canadian Journal of School Psychology, 25*(1) 70–83. By SAGE Publication.

Davidson, S. & Adams, J. (2013). Adversity and internalizing problems among rural Chinese adolescents: The roles of parents and teachers. *International Journal of Behavioral Development, 37*(6), 530–541. By Sage Publication.

Desta, M. (2008). *Epidemiology of child psychiatric disorders in Addis Ababa, Ethiopia (Doctoral dissertation)*. Umeå University, Umeå, Sweden.

DeValve, E. Q. (2005). A qualitative exploration of the effects of crime victimization for victims of personal crime. *Applied Psychology in Criminal Justice, 1*(2), 71-89.

Deyessa, N., Wondemagegn D., Tefera, D., Asnake, M., Bahiretibebe, Y. & Abesha, Y. (2012). Assessment of mental health services in USAID-Ethiopia's HIV/AIDS and health programs.

Dussich, J.P. (2006a). Japanese childhood victims of sexual abuse and their social perceptions: Comparisons with children in Germany, Greece and the USA. *International Review of Victimology, l3*, 99-113.

Dussich, J.P (2006b).Victimology--Past, present and future. In Simon Cornell, (ed.). *From Resource Material Series*, *70*, 116-129.

Dussich, J.P. (2012).The challenges of victimology: Past, present and future. *Resource material series*, 81.

Eggum, N.D., Sallquist, J. & Eisenberg, N. (2010). Then it will be good: Negative life events and resilience in Ugandan youth. *Journal of Adolescent Research, 26*(6), 766–796. By Sage.

Esbensen, F. A, Peterson, D., Taylor, T.J. & Freng, A. (2010). *Youth* v*iolence: Sex and race differences in offending, victimization, and gang membership*. Philadelphia, PA: Temple University Press.

Famuyiwa, O.O. (1997). Child abuse and neglect in sub-Saharan Africa. *Psychiatric Bulletin*, *21*, 336-338. By Royal College of psychiatrists.

Fattah, E.A. (2000). Victimology today: Recent theoretical and applied developments. In, Hiroshi Iitsuka and Rebecca Findlay-Debeck (Eds.), *Resource Material Series, 56*, 60-70. Tokyo: United Nations Asia and Far East Institute for the Prevention of Crime and Treatment of Offenders.

Federal Democratic Republic of Ethiopia Ministry of Health (2012). National mental health

strategy 2012/13 - 2015/16.

Fekadu, D. (2008). C*hild Labor in Addis Ketema, Ethiopia. A study in mental health (Doctoral dissertation).* Umea University.

Fekadu, D., Alem, A. & Ha¨gglo, B.¨(2006). The prevalence of mental health problems in Ethiopian child laborers. *Journal of Child Psychology and Psychiatry, 47(*9), 954–959.

Fiese, B.H., Wilder, J. and Bickham, N.L. (2000). Family Context in Developmental Psychopathology. In Arnold J. Sameroff, Michael Lewis and Suzanne M. Miller (Eds.), *Handbook of Developmental Psychopathology* (2nd ed.), PP; 115-134. New York. By Springer.

Ferreira, N. (2008). Putting the age of criminal and tort liability in to context: A dialogue between law and psychology. In M, Freeman and P, Veeerman(Eds.), *The International Journal of Children's Rights*, *16* (29-54). Lieden: By Marttinus Nijhoff Publishers.

Finkelhor, D. (2007). Developmental victimology: The comprehensive study of childhood victimizations. In Davis, R.C., Luirigio, A.J. and Herman, S. (Eds.), *Victims of crime, 3rd edition* (pp. 9-34). Thousand Oaks, CA: Sage Publications.

Finkelhor, D. (2008). *Childhood victimization: Violence, crime, and abuse in the lives of young people:* Oxford University Press, Inc.

Finkelhor, D., Hamby, S. L., Ormrod, R. & Turner. H. (2005). The juvenile victimization questionnaire: Reliability, validity, and national norms. *Child Abuse & Neglect*. *29*(4), 383–412.

Finkelhor D., Ormrod, R. K. & Turner, H.A. (2009). The developmental

epidemiology of childhood victimization. *Journal of Interpersonal Violence. 24* (5), 711-731. By Sage Publications.

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization trauma. *Child Abuse & Neglect, 31*, 7-26.

Finkelhor, D., Ormrod, R. K., Turner, H. A., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment*, *10*(1), 5–25.

Finkelhor, D, Ormrod, R. ,Turner, H. & Hamby, S.L. (2012). Child and youth victimization known to police, school, and medical authorities. U.S. Department of Justice Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention..

Finkelhor, D., Ormrod, R., Turner, H., & Holt, M. (2009). Pathways to poly victimization. *Child Maltreatment, 14(*4*)*, 316-329.

Flouri, E. & Panourgia, C. (2014). Negative automatic thoughts and emotional and behavioral problems in adolescence. *Child and Adolescent Mental Health, 19(*1), 46–51. By ACAMH.

Fontes, A. (2005). *Child abuse and culture*: *Working with diverse families.* New York: The Guilford Press A Division of Guilford Publications, Inc.

French, B.H., Bi, Y., Latimore, T. G., Klemp, H.R. & Butler, E.E. (2013). Sexual victimization using latent class analysis: Exploring patterns and psycho-behavioral correlates. *Journal of Interpersonal Violence*, *XX*(X), 1– 21. By Sage.

Fung, J. J. & Lau, A.S. (2009). Punitive discipline and child behavior problems in Chinese-A merican immigrant families: The moderating effects of indigenous child-rearing ideologies. *International Journal of Behavioral Development,* 33: 520. By Sage Publication.

Garralda,E.(2011). Somatization and somatoform disorders. In David Skuse, et al (Eds.), *Child psychology and psychiatry: Frameworks for practice, 2nd edition* (pp.147-152). USA: By John Wiley & Sons, Ltd.

Giel, R., Bishaw, M. & van Luijk, J. (1969). Behavior disorders in Ethiopian children. *Psychiatr Neurol Neurochir, 72,* 395-400.

Gobena Daniel (1998). Child sexual abuse in Addis Ababa High Schools. Forum On Street Children –Ethiopia (FSCE). Addis Ababa.

Habtamu Wondimu (1998). Interpersonal violence in Addis Ababa secondary schools: An iceberg of challenges to the democratization of education in Ethiopia. *In the Proceedings of Quality Education in Ethiopia: Visions for the 21st Century*.AAU: IER/AAU.

Hamby, S. L., & Finkelhor, D. (2001). *The juvenile victimization questionnaire (JVQ): Administration and scoring manual.* Durham, NH: Crimes Against Children Research Center.

Harper, B. D. (2012). Parents' and children's beliefs about peer victimization: Attributions, coping responses and child adjustment. *Journal of Early Adolescence, 32*(3), 387–413.

Hartjen, C. A. & Priyadarsini, S. (2012). *The global victimization of children problems and solutions*. Dordrecht: Published by Springer.

Haslam, N. (2003). Categorical versus dimensional models of mental disorder: The taxometric evidence. *Australian and New Zealand Journal of Psychiatry*, *37,*696–704.

Hendry, J. & Macinnes, M. (2011). Child abuse and child protection. In Anne Claveirole and Martin Gaughan (Eds.), *Understanding children and young people's mental health* (pp.132-148). United Kingdom: John Wiley & Sons Ltd.

Hinshaw, S. P. (2008). Developmental psychopathology as a scientific discipline: Relevance to behavioral and emotional disorders of childhood and adolescence. In Theodore P. Beauchaine Stephen P. Hinshaw (Eds), *Child and adolescent psychopathology* (pp.3-26). New Jersey: John Wiley & Sons, Inc.

Hinshaw, S.P. (2013).Developmental psychopathology as a scientific discipline. In Theodore P. Beauchaine Stephen P. Hinshaw (Eds.), *Child and adolescent psychopathology, 2nd edition* (pp.3-28). New Jersey: John Wiley & Sons, Inc.

Ho, M.Y. & Cheung, F.M. (2009). The Differential Effects of Forms and Settings of Exposure to Violence on Adolescents' Adjustment. *Journal of Interpersonal Violence, 25*(7), 1309–1337. By SAGE Publication.

Hoffman, B. (2008).The science and politics of reducing child victimization. *Journal of Contemporary Criminal Justice*, *24* (2), 103-113.

Ingram, R.E. and Price, J.M.(2010). Understanding Psychopathology: The Role of Vulnerability. In Rick E. Ingram Joseph M. Price (Eds.), *Vulnerability to Psychopathology Risk across the Lifespan*, PP 3-17. New York: The Guilford Press A Division of Guilford Publications, Inc.

Itzin C., Taket, A. & Barter-Godfrey, S. (2010). *Domestic and sexual violence and abuse: Tackling the health and mental health effects*. New York: by Routledge.

Karmen, A. (2010). *Crime victims: An introduction to victimology, Seventh Edition*. USA: By Wadsworth.

Keenan, T. (2002). *An introduction to child development*. Oliver's Yard: By SAGE Publications, Inc.

Ketsela, T. & Kebede, D. (1997). Physical punishment of elementary school children in urban

and rural communities of Ethiopian. *Ethiop Med J, 35,* 23-33.

Kilpatrick, D. G. & Saunders, B.E. (1999). *Prevalence and consequences of child victimization: Results from the national survey of adolescents Final report.*

Kostić, M. (2010).Victimology : A contemporary theoretical approach to crime and its victim. *Law and Politics*, *8*(1), 65 – 78.

Krejcie, R.V. and Morgan, D. W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement*, 30, 607-610.

Lalor, K.J. (1999). Street children: A comparative perspective. *Child Abuse and Neglect, 23*(8), 759–770.

Lalor, K. (2000). The victimization of juvenile prostitutes in Ethiopia. *International Social Work, 43*(2), 227-242. .

Lamb, M. (2003). Child development and the law. In Irving B. Weiner (Eds.). *Handbook of psychology (Volume 6): Developmental psychology* (pp. 559-578). New Jersey: by John Wiley & Sons, Inc.

Laye, A. M. & Mykota, D. B. (2014). Rural Canadian youth exposed to physical violence. *Canadian Journal of School Psychology*, *29*(1), 21–39. By SAGE.

Leeb, R.T.,Lewis, T. & Zolotor, A.J. (2011). A Review of physical and mental health consequences of child abuse and neglect and implications for practice. *American Journal of Lifestyle Medicine, 5*(5), 454-468.

Leech, N. L., Barrett, K. C. & Morgan, G. A. (2005). *SPSS for intermediate statistics; Use and interpretation (Second Edition).* New Jersey: by Lawrence Erlbaum Associates, Inc.

Leigh, H. (2010).*Genes, memes, culture, and mental Illness: Toward an integrative model*. New York: Springer.

Lester, L., Cross, D., Dooley, J. & Shaw, T. (2013). Bullying victimisation and adolescents: Implications for school-based intervention programs. *Australian Journal of Education, 57*(2), 107–123. By SAGE Publication.

Levine, D.N. (1965). *Wax and gold: Tradition and innovation in Ethiopian culture.* Chicago and London: University of Chicago Press.

Lewit, E.M. & Baker,L.S.(1996). Children as victims of violence. *The Future of Children, 6*(3), 147-156.

Loukas, A. & Prelow, H.M. (2004). Externalizing and internalizing problems in low-income Latino early adolescents: Risk, resource, and protective factors. *The Journal of Early Adolescence, 24,* 250-273. By Sage Publication.

MacDonald, G. (2006). What is mental health? In Mima Cattan and Sylvia Tilford (Eds.), *Mental health promotion: A lifespan approach,* (pp. 8-32). New York: McGraw Hill, Inc.

Macmillan, R. (2001). Violence and the life course: The Consequences of victimization for personal and social development. *Annual Review Social, 27*, 1-22.

Maddux J.E., Gosselin, J.T. & Winstead, B.A. (2008). Conceptions of psychopathology: A social constructionist perspective. In James E. Maddux And Barbara A. Winstead (Eds.), *Psychopathology: Foundations for a contemporary understanding* (pp.3-18). New York: Taylor & Francis Group, LLC.

Malcolm, K. T., Jensen-Campbell, L. A., Rex-Lear, M. & Waldrip, A.M. (2006). Divided we fall: Children's friendships and peer victimization. *Journal of Social and Personal Relationships, 23*(5), 721–740. By SAGE Publications.

Martinez, J.I., Gudino, O. G. & Lau, A.S. (2013). Problem-specific racial/ethnic disparities in pathways from maltreatment exposure to specialty mental health service use for youth in child welfare. *Child Maltreatment*, *18*(2), 98-107. By Sage.

Marsh, I. (2004). *Criminal justice: An introduction to philosophies, theories and practice*. New York: by Taylor & Francis e-Library.

Mash, E. J. & Dozois, D.J. (2003). Child psychopathology: A developmental systems perspective. In Eric J. Mash and Russell A. Barkley (Eds.), *Child psychopathology , 2nd edition* (pp.3-74). New York, NY: By Guilford Publication Inc.

Mash, E. J. & Wolfe, D. A. (2003). Disorders of childhood and adolescence. In George Stricker Thomas A. Widiger (Eds), *Handbook of psychology (Volume 8): Clinical psychology (*pp. 27-64). New Jersey: by John Wiley & Sons, Inc.

Mbagaya, C., Oburu, P. & Bakermans-Kranenburg, M.J. (2013). Child physical abuse and neglect in Kenya, Zambia and the Netherlands: A cross-cultural comparison of prevalence, psychopathological sequelae, and mediation by PTSS. *International Journal of Psychology, 48(*2), 95–107, By Routledge.

McGee, Z.T. & Baker,S.R. (2002). Impact of violence on problem behavior among adolescents: Risk factors among an urban sample. *Journal of Contemporary Criminal Justice, 18,* 74-93.

Melchert, T. P.(2006). *Foundations of professional psychology: The end of theoretical orientations and the emergence of the biopsychosocial approach*. London: Elsevier Inc.

Miller, L. (2008). *Counseling crime victims: Practical strategies f or mental health professionals.* New York: Springer Publishing Company, LLC.

Miller, P. (2002). *Theories of developmental psychology* (4th). New York, NY:

By Worth Publishers.

Mulatie, M. (2014). Physical and psychological child abuse in Ethiopia: Implications for intervention. J *Psychol Psychother* 4: 137. doi: 10.4172/2161-0487.1000137.

Mulatu, M. S. (1995). Prevalence and risk factors of psychopathology in Ethiopian children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34*, 100–109.

Naing, L., & Winn, T. Rusli, B.N. (2006). Practical issues in calculating the sample size for prevalence studies. *Archives of Orofacial Sciences. 1*, 9-14.

Nicodimos, S., Gelaye, B. S., Williams, M. A. & Berhane, Y. (2009). Associations between witnessing parental violence and experiencing symptoms of depression among College students. *East Afri J Public Health, 6*,184-190.

Nissinen, S. (2010). Summary report on resilience in children exposed to sexual abuse and sexual exploitation in Merkato, Addis Ababa, Ethiopia, conducted by Gebre Yntiso , Ayalew Gebre , Rahel Shiferaw and Hiwot Workineh in 2009. London.

Nurcombe, B. and et al. (2007). Prevention of mental health disorders in children and adolescents. In Helmut Remscheid (Ed.), *The mental health of children and adolescents: An area of global neglect (pp.51-191)*. West Sussex : John Wiley & Sons Ltd.

O'Hagan, K. (2006). *Identifying emotional and psychological abuse: A guide for childcare professionals.* New York: Open University Press.

Organization of African Unity (July 11, 1990). *African charter on the rights and welfare of the child*, available at: http://www.unhcr.org/refworld/docid/3ae6b38c18.html [accessed 14 December 2012].

Parritz, R.H. & Troy, M.F. (2011). *Disorders of childhood: Development and psychopathology*. By Wadsworth.

Peltonen, K., Ellonen ,N., Larsen, H. B. & Helweg-Larsen, K. (2010). Parental violence and adolescent mental health. *Eur Child Adolesc Psychiatry, 19,* 813-822.

Perren, S., Ettekal, I. & Ladd, G. (2013). The impact of peer victimization on later maladjustment: Mediating and moderating effects of hostile and self-blaming attributions. *Journal of Child Psychology and Psychiatry 54(*1), 46–55. Association for Child and Adolescent Mental Health.

Perry, B.D. (2002). Neurodevelopmental impact of violence in childhood. In Diane H. Schetky and Elissa P. Benedek (Eds.). *Principles and practice of child and adolescent forensic psychiatry* (pp.191-2014). Washington, DC: American Psychiatric Publishing, Inc.

Popp, A. M. (2012). The effects of exposure, proximity, and capable guardians on the risk of bullying victimization. *Youth Violence and Juvenile Justice*. *10*(4), 315-332. By Sage Publication.

Quinn, K.M. (2002). Interviewing children for suspected sexual abuse. In D, H, Schetky, E, P, Benedek (Eds.), *Principles and practice of child and adolescent forensic psychiatry* (pp.149-160). American Psychiatric Publishing, Inc.

Rattelade, S., Farrell, S. Aubry, T. & Klodawsky, F. (2013). The Relationship between victimization and mental health functioning in homeless youth and adults. *Journal of Interpersonal Violence, XX*(X), 1– 17. By Sage.

Reid, J.A. & Sullivan, C.J. (2009). A latent class typology of juvenile victims and exploration of risk factors and outcomes of victimization. *Criminal Justice and Behavior, 36* (10), 1001-1024. By SAGE Publication.

Rescorla, L. (2007). Behavioral and emotional problems reported by parents of children ages 6 to 16 in 31 societies. *Journal of Emotional and Behavioral Disorders, 15,* 130-142. By Hammill Institute and Sage.

Rowling, L. (2006). Adolescence and emerging adulthood (12–17 years and 18–24 years). In Mima Cattan and Sylvia Tilford (Eds.), *Mental health promotion: A lifespan approach* (pp. 101-136). New York: McGraw Hill, Inc.

Rubin, K.H., Burgess, K.B., Kennedy, A.E. & Stewart, S.L. (2003). Social withdrawal in childhood. In Eric J. Mash and Russell A. Barkley (eds), *Child psychopathology,* 2nd edition (pp.372-408). New York: The Guilford Press A Division of Guilford Publications, Inc.

Rutter, M. (2011). Research Review: Child psychiatric diagnosis and classification: Concepts, findings, challenges and potential. *Journal of Child Psychology and Psychiatry*, *52*(6), 647–660.

Sabri, B. (2011). Severity of victimization and co-occurring mental health disorders among substance using adolescents. *Child Youth Care Forum, 41,* 37–55. By Springer.

Savolainen, J. (2007). Family structure and adolescent victimization in Finland: Investigating the stepfamily as a source of risk. *Research on Finnish Society, 1,* 17–27.

Schetky, D. (2002). History of child and adolescent forensic psychiatry. In D, H, Schetky, and E, P, Benedek (Eds.), *Principles and practice of child and adolescent forensic psychiatry* (pp.3-6). American Psychiatric Publishing, Inc.

Schneider, H.J. (2001). Victimological developments in the world during the past three decades: A study of comparative victimology. *International Journal of Offender Therapy and Comparative Criminology*, *45*(4), 449-468. By Sage Publication.

Schreck, C. J., Miller, J. M. & Gibson, C. L. (2003). Trouble in the school yard: A study of the risk factors of victimization at school. *Crime and Delinquency, 49* (3), 460-484. By Sage Publications.

Scott, E.S., & Woolard, J.L. (2004). The legal regulation of adolescence. In R, M, Lerner & L, Steinberg (Eds.), *Handbook of adolescent psychology (*pp.523-552). New York: Wiley.

Seifert, K. (2012). *Youth violence: Theory, prevention, and intervention.* New York: Springer Publishing Company, LLC.

Serafica, F.C. & Vargas, L.A. (2006). Cultural diversity in the development of child psychopathology. In Dante Cicchetti and Donald J. Cohen (Eds), *Developmental psychopathology 2nd Edition* (*Volume One): Theory and method,* (pp.588-626). New Jersey: by John Wiley & Sons, Inc

Silva, T., Graña, J.L. & González-Cieza, L. (2014). Self-reported physical and emotional abuse among youth offenders and their association with internalizing and externalizing psychopathology: A Preliminary study. *International Journal of Offender Therapy and Comparative Criminology*, *58*(5), 590– 606. By Sage Publication.

Skuse, D., Bruce, H., Dowdney, L. & Mrazek, D.A. (2011). Preface. In . David Skuse, Helen Bruce ,Linda Dowdney, David A. Mrazek(Eds), *Child psychology and psychiatry frameworks for practice*, *2nd ed.* by John Wiley & Sons, Ltd

Snyder, H. N. (2000). *Sexual assault of young children as reported to law enforcement: Victim, incident, and offender characteristics.* Washington, DC: US Department of Justice, Bureau of Justice Statistics.

Soler, L., Kirchner, T., Paretilla, C. & Forns, M. (2013). Impact of poly-victimization on mental health: The mediator and/or moderator role of self-esteem. *Journal of Interpersonal Violence*, *28*(13), 2695– 2712. BY SAGE.

Spalek, B. (2006). *Crime victims: Theory, policy and practice.* Basingstoke: Palgrave macmillan

Springera, K.W., Sheridanb, J., Kuoc, D. & Carnes, M. (2013). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population based sample of men and women. *Child Abuse Neglect, 31*(5), 517–530.

Sroufe, L.A., Duggal, S., Weinfield, N. and Carlson, E. (2000). Relationships, Development, and Psychopathology. In Arnold J. Sameroff, Michael Lewis and Suzanne M. Miller (Eds.), *Handbook of Developmental Psychopathology* (2nd ed.), PP; 76-92. New York. By Springer.

Staudt, M. M. (2003). Mental health services utilization by maltreated children: Research findings and recommendations. *Child Maltreatment, 8*, 195-203. By Sage Publication.

Stoltenborgh, M., Bakermans-Kranenburg, M.J., van IJzendoorn, M.H. & Alink, L. R.A. (2013). Cultural–geographical differences in the occurrence of child physical abuse? A meta-analysis of global prevalence. *International Journal of Psychology, 48*(2), 81–94 .By Routledge.

Storch, E. A. & Ledley, D . R. (2005). Peer victimization and psychosocial adjustment in children: Current knowledge and future directions. *Clinical Pediatrics, 44,* 29-38.

Strohmeier, D., Karna, A. & Salmivalli, C. (2011). Intrapersonal and interpersonal risk factors for peer victimization in immigrant youth in Finland. *Developmental Psychology, 47* (1), 248–258. Vienna: University of Vienna.

Sullivan, T. N., Farrell, A. D., Kliewer, W., Vulin-Reynolds, M. & Valois, R.F. (2008). The impact of self-restraint, witnessing violence, and victimization on aggression and drug use. *Journal of Early Adolescence, 27*(3), 296-323.

Tabachnick, B. G. & Fidell, L.S.(2013). *Using multivariate statistics (Sixth Ed.).* Boston; by Person Education, Inc.

Tadesse, B. , Kebede, D., Tegegne, T. & Alem, A. (1999). Childhood behavioral disorders in Arnbo district, western Ethiopia. I. Prevalence estimates. *Actu Psyhiutr*, *100*, 92-97. AClTA PSYCHlATRlCA SCANDINAVICA.

Taket, A., Barter-Godfrey, S. & Itzin, C. (2010). Tackling sexual and domestic violence and abuse: Moving towards improved prevention and early intervention. In Catherine Itzin, Ann Taket and Sarah Barter-Godfrey (Eds.), *Domestic and sexual violence and abuse tackling the health and mental health effects* (pp.171-183). London and New York: by Routledge.

The African Child Policy Forum (2009). Child–friendly laws in Africa. Addis Ababa, Ethiopia.

The African Child Policy Forum (2011). Violence against children in Africa: A compilation of the main findings of the various research projects conducted by the African Child Policy Forum (ACPF) since 2006.

The Federal Democratic Republic of Ethiopia (4 July 200). *The Revised Family Code*. Available at: http://www.unhcr.org/refworld/docid/4c0ccc052.html [accessed 14 December 2010].

Thelen, E.and Smith, L. B. (2006). Dynamic systems theories. In Richard M. Lerner (Ed.), *Handbook of Child Psychology (6th ed.): Theoretical models of human development (Volume One), (*pp. 258-312). New Jersey: John Wiley & Sons, Inc.

Tilford, S. (2006). Infancy and childhood (0–5 years and 6–12 years). In Mima Cattan and Sylvia Tilford (Eds.), *Mental health promotion: A lifespan approach* (pp. 64-99). New York: McGraw Hill, Inc.

Tillyer, M.S. (2013). Violent victimization across the life course: Moving a victim careers agenda forward. *Criminal Justice and Behavior, 41,* 594-613.

Totura, C.M. MacKinnon-Lewis, C., Gesten, E.L. Gadd, R., Divine, K. P. Dunham, S. & Kamboukos, D. (2009). Bullying and victimization among boys and girls in middle school: The influence of perceived family and school contexts. *Journal of Early Adolescence*, *29* (4), 571-609. By SAGE Publications.

Turner, A., Finkelhor, D. & Ormrod, R. (2005a). The effect of lifetime victimization on the mental health of children and adolescents. *Social Science & Medicine. 62,* 13-27.

Turner, A., Finkelhor D. & Ormrod, R. (2005b). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment. 10*(1), 5-25.

Turner, H.A., Finkelhor, D. & Ormrod, R. (2007). Family structure variations in patterns and predictors of child victimization. *American Journal of Orthopsychiatry, 77*(2), 282-295. By the American Psychiatrists' Association.

Turvey, B. & Petherick, W. (2009). *Forensic victimology: Examining violent crime victims in investigative and legal contexts.* San Diego: Elsevier Inc.

UNICEF-Ethiopia (2008). In-service trainers manual on justice for children.

United Nations (2005). Convention on the rights of the child.

United Nations Office for Drug Control and Crime Prevention (1999). *Handbook on justice for victims.* New York.

United Nations Office on Drugs and Crime and United Nations Economic Commission for

Europe (2010). *Manual on victimization surveys.* Geneva: United Nations.

Uusitalo-Malmivaara, L. (2012). Finnish sixth graders as victims of adult, peer, and co-occurring adult and peer violence: Depression, somatization, and violent ideation in relation to victimization. *Journal of Early Adolescence, 33*(6), 845–866. By Sage.

Walsh, K. & DiLillo, D. (2011). Child sexual abuse and adolescent sexual assault and revictimization. *The psychology of teen violnce and victimization:* F*rom bullying to cyberstalking to assault and sexual violation*, *1*, 203-220.

Wilmshurst, L. (2005). *Essentials of child psychopathology.* New Jersey: Published by John Wiley & Sons, Inc,

Wilmshurst, L. (2013). *Clinical and educational child psychology: An ecological-transactional approach to understanding child problems and interventions.* USA: John Wiley & Sons, Ltd.

Wimsatt, A.R., Fite, P.J., Grassetti, S.N. & Rathert, J. L. (2013). Positive communication moderates the relationship between corporal punishment and child depressive symptoms. *Child and Adolescent Mental Health, 18*(4), 225–230.

Wondie, Y., Zemene , W., Tafesse, B., Reschke, K & Schroder, H. (2011). The psychosocial consequences of child sexual abuse in Ethiopia: A case control comparative analysis. *Journal of Interpersonal Violence, 26*(10), 2025-2041. By Sage.

World Health Organization (2009). Improving health systems and services for mental health. Geneva.

Young, M.A. (2006). A history of the victims' movement in the United States. *Resource Material Series, 70*. UNAFEI Fuchu, Tokyo, Japan.

Appendices

Appendix A: Socio-demographic Measure

Addis Ababa University

School of Psychology

General Instruction

The purpose of this questionnaire is to gather data on victimization experiences and mental health problems of elementary school children and adolescents in the town of Gondar. The questionnaire has three parts that include measures of socio-demographic characteristics, victimization experiences, and mental health problems of participants. You are selected and requested to participate in this study. It is hoped that you will provide adequate information which is vital for the successful completion of the study. Before responding to the questions, please note the following points.

1. You are not required to write your name in any page of the questionnaire
2. The questions do not have correct or wrong answers, instead they address something that you know and experienced or did not experience.
3. You will participate in this study only if you are voluntary and willing

Do you agree to participate in the study?

1. Yes : Signature:______________________________
2. No

Socio-demographic Measure

The purpose of the socio demographic measure is to get information regarding your socio demographic characteristics. For the items with alternatives, circle the number with your choice and for the items without alternatives, write the response that you think is right on the space provided.

Name of School: ____

1	Your age	___________ Years
2	Your gender	1.Male 2.Female

3	Where do you live?	1. Urban 2. Rural
4	With whom you are living currently?	1.Both parents 2.Single parent 3.Step parent 4.Others: specify :________
5	What is your current grade level?	_______________
6	What is your father's highest level of Education?	1.Illiterate 2. Reads and writes only 3. Elementary education 4. High school education 5. Certificate or diploma 6. Degree and above
7	What is your mother's highest level of education?	1 .Illiterate 2. Reads and writes only 3. Elementary education 4. High school education 5. Certificate or diploma 6. Degree and above
8	What is your father's occupation?	1.Employed 2.Trading 3.Farming 4.Others: Specify ______
9	What is your mother's occupation?	1.Employed 2. Trading 3. Farming 4.Others : Specify _______
10	How much is your family's monthly income?	1. High 2. Medium 3.Low

Appendix B: Juvenile Victimization Questionnaire (JVQ-R2)

Now I am going to ask you about some things that might have happened in the last year. If the event happened, circle number '1' and if not number '2'.

s/n	Items	Response	
	In the last year		
1	Did anyone use force to take something away from you that you were carrying or wearing?	1	2
2	Did anyone steal something from you and never give it back? Things like a backpack, money, watch, clothing, bike, or anything else?	1	2
3	Did anyone break or ruin any of your things on purpose?	1	2
4	Did anyone hit or attack you on purpose with an object or weapon? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	1	2
5	Did anyone hit or attack you without using an object or weapon?	1	2
6	Did someone start to attack you, but for some reason, it didn't happen? For example, someone helped you or you got away?	1	2
7	Did someone threaten to hurt you when you thought they might really do it?	1	2
8	Did anyone try to kidnap you?	1	2
9	Have you been hit or attacked because of your skin color, religion, or where your family comes from? Because of a physical problem you have?	1	2
10	Not including spanking on your bottom, did a grown-up in your life hit, beat, kick, or physically hurt you in any way?	1	2
11	Did you get scared or feel really bad because grown-ups in your life called you names, said mean things to you, or said they didn't want you?	1	2
12	Were you neglected?	1	2
13	Did a parent take, keep, or hide you to stop you from being with another parent?	1	2
14	Did a group of kids or a gang hit, jump, or attack you?	1	2
15	Did any kid, even a brother or sister, hit you? Somewhere like at home, at school, out playing, in a store, or anywhere else?	1	2
16	Did any kids try to hurt your private parts on purpose by hitting or kicking you there?	1	2

17	Did any kids, even a brother or sister, pick on you by chasing you or grabbing you or by making you do something you didn't want to do?	1	2
18	Did you get scared or feel really bad because kids were calling you names, or saying they didn't want you around?	1	2
19	Did a boyfriend or girlfriend or anyone you went on a date with slap or hit you? Skip for children below 12 years	1	2
20	Did a grown-up you know touch your private parts when they shouldn't have or make you touch their private parts? Or did a grown-up you know force you to have sex?	1	2
21	Did a grown-up you did not know touch your private parts when they shouldn't have, make you touch their private parts or force you to have sex?	1	2
22	Did another child or teen make you do sexual things?	1	2
23	Did anyone try to force you to have sex; that is, sexual intercourse of any kind, even if it didn't happen?	1	2
24	Did anyone make you look at their private parts by using force or surprise, or by "flashing" you?	1	2
25	Did anyone hurt your feelings by saying or writing something sexual about you or your body?	1	2
26	Did you do sexual things with anyone 18 or older, even both of you wanted? Skip for children below 12 years.	1	2
27	Did you SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?	1	2
28	Did you SEE a parent hit, beat, kick, or physically hurt your brothers or sisters, not including a spanking on the bottom?	1	2
29	In real life, did you SEE anyone get attacked on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else?	1	2
30	In real life, did you SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt?	1	2
31	Did anyone steal something from your house that belongs to your family or someone you live with? Things like a TV, stereo, car, or anything else?	1	2

32	Was anyone close to you murdered, like a friend, neighbor or someone in your family?	1	2
33	Were you in any place in real life where you could see or hear people fight in groups and attack each other?	1	2

Appendix C: Achenbach Systems of Empirically Based Assessment (ASEBA): Youth Self Report for Ages 11-17

Below is a list of items that describe children and youths. For each item that describes you ***now or within the past two months***, please circle 2 if the item is ***very true or often true*** of you. Circle 1 if the item is ***somewhat or sometimes true*** of you. If the item is not true of you, circle the **0**.

0= not true (as far as you know)

1= somewhat or sometimes true

2= very true or often true

1	I act too young for my age	0	1	2
2	I drink alcohol without parents approval	0	1	2
3	I argue a lot	0	1	2
4	I fail to finish things I start	0	1	2
5	There is very little I enjoy	0	1	2
6	I like animals	0	1	2
7	I brag	0	1	2
8	I have trouble concentrating , or paying attention	0	1	2
9	I cannot get my mind off certain thoughts	0	1	2
10	I have trouble sitting still	0	1	2
11	I am too dependent on adults	0	1	2
12	I feel lonely	0	1	2
13	I feel confused or in a fog	0	1	2
14	I cry a lot	0	1	2
15	I am pretty honest	0	1	2
16	I am mean to others	0	1	2
17	I daydream a lot	0	1	2
18	I deliberately try to hurt or kill myself	0	1	2
19	I try to get a lot of attention	0	1	2

20	I destroy my own things	0	1	2
21	I destroy things belonging to others	0	1	2
22	I disobey my parents	0	1	2
23	I disobey at school	0	1	2
24	I do not eat as well as a I should	0	1	2
25	I do not get along with other kids	0	1	2
26	I do not feel guilty after doing something I shouldn't	0	1	2
27	I am jealous of others	0	1	2
28	I break rules at home, school or elsewhere	0	1	2
29	I am afraid of certain animals, situations, or places other than school	0	1	2
30	I am afraid of going to school	0	1	2
31	I am afraid I might think or do something bad	0	1	2
32	I feel that I have to be perfect	0	1	2
33	I feel no one loves me	0	1	2
34	I feel that others are out to get me	0	1	2
35	I feel worthless or inferior	0	1	2
36	I accidentally get hurt a lot	0	1	2
37	I get in many fights	0	1	2
38	I get teased a lot	0	1	2
39	I hang around with kids who get in trouble	0	1	2
40	I hear sound or voices that other people think are not there	0	1	2
41	I act without stopping to think	0	1	2
42	I would rather be alone than with others	0	1	2
43	I lie or cheat	0	1	2
44	I bite my fingernails	0	1	2
45	I am nervous or tense	0	1	2
46	Parts of my body twitch or make nervous movements	0	1	2
47	I have nightmares	0	1	2
48	I am not liked by other kids	0	1	2

49	I can do certain things better than most kids	0	1	2
50	I am too fearful or anxious	0	1	2
51	I feel dizzy or lightheaded	0	1	2
52	I feel too guilty	0	1	2
53	I eat too much	0	1	2
54	I feel overtired without good reason	0	1	2
55	I am overweight	0	1	2
56	Physical problems without known medical cause	0	1	2
	a. Aches or pains(not stomach or headaches)	0	1	2
	b. Headaches	0	1	2
	c. Nausea, feels sick	0	1	2
	d. Problems with eyes, not if corrected by glasses	0	1	2
	e. Rashes or other skin problems	0	1	2
	f. Stomachaches	0	1	2
	g. Vomiting, throwing up	0	1	2
57	I physically attack people	0	1	2
58	I pick my skin or other parts of body	0	1	2
59	I can be pretty friendly	0	1	2
60	I like to try new things	0	1	2
61	My school work is poor	0	1	2
62	I am poorly coordinated or clumsy	0	1	2
63	I would rather be with older kids than kids of my own ages	0	1	2
64	I would rather be with younger kids than kids of my own age	0	1	2
65	I refuse to talk	0	1	2
66	I repeat certain acts over and over	0	1	2
67	I run away from home	0	1	2
68	I scream a lot	0	1	2
69	I am secretive, keeps things to self	0	1	2
70	I see things that people think are not there	0	1	2

71	I am self-conscious or easily embarrassed	0	1	2
72	I set fire	0	1	2
73	I can work well with my hands	0	1	2
74	I show off or clown	0	1	2
75	I am too shy or timid	0	1	2
76	I sleep less than most kids	0	1	2
77	I sleep more than more kids during day and/or night	0	1	2
78	I am inattentive or easily distracted	0	1	2
79	I have a speech problem	0	1	2
80	I stand up for my rights	0	1	2
81	I steal at home	0	1	2
82	I steal from places other than home	0	1	2
83	I store up too many things I don't need	0	1	2
84	I do things other people think are strange	0	1	2
85	I have thoughts that other people would think are strange	0	1	2
86	I am stubborn	0	1	2
87	My moods or feelings change suddenly	0	1	2
88	I enjoy being with people	0	1	2
89	I am suspicious	0	1	2
90	I swear or use dirty language	0	1	2
91	I think about killing myself	0	1	2
92	I like to make others laugh	0	1	2
93	I talk too much	0	1	2
94	I tease others a lot	0	1	2
95	I have a hot temper	0	1	2
96	I think about sex too much	0	1	2
97	I threaten people to hurt	0	1	2
98	I like to help others	0	1	2
99	I smoke, chew or sniff tobacco	0	1	2

100	I have trouble sleeping	0	1	2
101	I cut classes or skip school	0	1	2
102	I do not have much energy	0	1	2
103	I am unhappy, sad or depressed	0	1	2
104	I am louder than other kids	0	1	2
105	I use drugs for nonmedical purpose (don't include alcohol or tobacco)	0	1	2
106	I like to be fair with others	0	1	2
107	I enjoy a good joke	0	1	2
108	I like to take life easy	0	1	2
109	I try to help other people when I can	0	1	2
110	I wish I were of the opposite sex	0	1	2
111	I Keep from being involved with others	0	1	2
112	I worry a lot	0	1	2

Appendix D: Achenbach Systems of Empirically Based Assessment (ASEBA) Teacher Report Form (7-10 Years)

Addis Ababa University

School of Psychology

General Instruction

The purpose of this questionnaire is to gather information on the mental health problems of elementary school children in Gondar town. So as to collect the required data, here is a questionnaire measuring mental health problems of children between the ages of 7-10 years. You are selected and requested to respond to the items in the questionnaire about pupils in your school because children below the age of 11 years may not be able to fully respond by themselves to those items. It is hoped that you will provide adequate information which will be vital for the successful completion of the study. Before responding to the items, please consider the following points.

- You are not required to write your name in any page of the questionnaire
- The questions do not have correct or wrong answers; instead they address something that you know your students in the school.
- You will participate in this study only if you are voluntary and willing

Do you agree to participate in the study?

1. Yes : Signature ______________________
2. No

General Information

1.1. Name of the School :_______________________________________
1.2. Student's Code Number :______________________________
1.3. Student's Gender :________________
1.4. Student's Grade level:_______________ Section :____________________
1.5. Your Gender :_______________________________
1.6. Your position in the School :_______________________

Achenbach Systems of Empirically Based Assessment (ASEBA) Teacher Report Form (7-10 Years)

Below is a list of items that describe pupils. For each item that describes the pupil now ***or within the past two months***, please circle the ***2*** if the item is ***very true or often true*** of the pupil. Circle the ***1*** if the item is ***somewhat or sometimes true*** of the pupil. If the item is ***not true*** of pupil, circle the ***0***. Please answer all the items as well as you can, even if some do not seem to apply to this pupil.

0= not true (as far as you know)

1= somewhat or sometimes true

2= very true or often true

1	Acts too young for his/her age	0	1	2
2	Hums or makes other odd noises in class	0	1	2
3	Argues a lot	0	1	2
4	Fails to finish things he/ she starts	0	1	2
5	There is very little that he/she enjoys	0	1	2
6	Defiant, talks back to staff	0	1	2
7	Bragging, boasting	0	1	2
8	Cannot concentrate, cannot pay attention for long	0	1	2
9	Cannot get his/ her mind off certain thoughts; obsessions	0	1	2
10	Cannot sit still, restless or hyperactive	0	1	2
11	Clings to adults or too dependant	0	1	2
12	Complains of loneliness	0	1	2
13	Confused or seems to be in a fog	0	1	2
14	Cries a lot	0	1	2
15	Fidgets	0	1	2
16	Cruelty, bullying or meanness to others	0	1	2
17	Daydreams or gets lost in his/ her thoughts	0	1	2
18	Deliberately harms self or attempts suicide	0	1	2

19	Demands a lot of attention	0	1	2
20	Destroys his/ her own things	0	1	2
21	Destroys property belonging to others	0	1	2
22	Difficulty following directions	0	1	2
23	Disobedient at school	0	1	2
24	Disturbs other pupils	0	1	2
25	Does not get along with other pupils	0	1	2
26	Does not seem to feel guilty after misbehaving	0	1	2
27	Easily jealous	0	1	2
28	Breaks school rules	0	1	2
29	Fears certain animals, situations or places other than school	0	1	2
30	Fears going to school	0	1	2
31	Fears he/she might think or do something bad	0	1	2
32	Feels he or she has to be perfect	0	1	2
33	Feels or complains that no one loves him/her	0	1	2
34	Feels others are out to get him/her	0	1	2
35	Feels worthless or inferior	0	1	2
36	Gets hurt a lot, accident – prone	0	1	2
37	Gets in many fights	0	1	2
38	Gets teased a lot	0	1	2
39	Hangs around with others who get in trouble	0	1	2
40	Hears sound or voices that are not there	0	1	2
41	Impulsive or acts without thinking	0	1	2
42	Would rather be alone than with others	0	1	2
43	Lying or cheating	0	1	2
44	Bites fingernails	0	1	2
45	Nervous, high-strung or tense	0	1	2
46	Nervous movements or twitching	0	1	2
47	Over conforms to rules	0	1	2

48	Not liked by other pupils	0	1	2
49	Has difficulty in learning	0	1	2
50	Too fearful or anxious	0	1	2
51	Feels dizzy or lightheaded	0	1	2
52	Feels too guilty	0	1	2
53	Talks out of turn	0	1	2
54	Overtired without good reason	0	1	2
55	Overweight	0	1	2
56	Physical problems without known medical cause	0	1	2
	a. Aches or pains(not stomach or headaches)	0	1	2
	b. Headaches	0	1	2
	c. Nausea, feels sick	0	1	2
	d. Problems with eyes, not if corrected by glasses	0	1	2
	e. Rashes or other skin problems	0	1	2
	f. Stomachaches	0	1	2
	g. Vomiting, throwing up	0	1	2
57	Physically attacks people	0	1	2
58	Picks nose, skin, or other parts of body	0	1	2
59	Sleeps in class	0	1	2
60	Apathetic or unmotivated	0	1	2
61	Poor school work	0	1	2
62	Poorly coordinated or clumsy	0	1	2
63	Prefers being with older children or youth	0	1	2
64	Prefers being with younger children	0	1	2
65	Refuses to talk	0	1	2
66	Repeats certain acts over and over, compulsions	0	1	2
67	Disrupts class discipline	0	1	2
68	Screams a lot	0	1	2
69	Secretive, keeps things to self	0	1	2

70	Sees things that are not there	0	1	2
71	Self-conscious or easily embarrassed	0	1	2
72	Messy work	0	1	2
73	Behaves irresponsibly	0	1	2
74	Showing off or clowning	0	1	2
75	Too shy or timid	0	1	2
76	Explosive or unpredictable behavior	0	1	2
77	Demands must be met immediately, easily frustrated	0	1	2
78	Inattentive or easily distracted	0	1	2
79	Speech problem	0	1	2
80	Stares blankly	0	1	2
81	Feels hurt when criticized	0	1	2
82	Steals	0	1	2
83	Stores up too many things he/she doesn't need	0	1	2
84	Strange behavior	0	1	2
85	Strange ideas	0	1	2
86	Stubborn, sullen or irritable	0	1	2
87	Sudden changes in mood or feelings	0	1	2
88	Sulks a lot	0	1	2
89	Suspicious	0	1	2
90	Swearing or obscene language	0	1	2
91	Talks about killing self	0	1	2
92	Underachieving, not working up to the potential	0	1	2
93	Talks too much	0	1	2
94	Teases a lot	0	1	2
95	Temper tantrums or hot temper	0	1	2
96	Seems preoccupied with sex	0	1	2
97	Threatens people	0	1	2
98	Tardy to school or class	0	1	2

99	Smokes, chews or sniffs tobacco	0	1	2
100	Fails to carry out assigned tasks	0	1	2
101	Truancy of unexplained absence	0	1	2
102	Underactive, slow moving or lacks energy	0	1	2
103	Unhappy, sad or depressed	0	1	2
104	Unusually loud	0	1	2
105	Uses alcohol or drugs for nonmedical purpose (don't include tobacco)	0	1	2
106	Overly anxious to please	0	1	2
107	Dislikes school	0	1	2
108	Is afraid of making mistakes	0	1	2
109	Whining	0	1	2
110	Unclean personal appearance	0	1	2
111	Withdrawn, does not get involved with others	0	1	2
112	Worries	0	1	2

Appendix E: Socio-demographic Measure (Amharic Version)

አዲስ አበባ ዩኒቨርስቲ

የሳይኮሎጅ ትምህርት ቤት

አጠቃላይ መመሪያ

የዚህ ማጠይቅ ዋና አላማ በጎንደር ከተማ ወስጥ በሚኙ የአንደኛ ደረጃ ት/ቤቶች በሚማሩ ተማሪዎች የተለያዩ ጥቃቶች ሰለባነትና ተያያዥ አዕምሮአዊና ባህሪያዊ ጤና ሁኔታዎች በተማለከተ ጥናት ለማካሄድ ነው፡፡ በጉዳዩ ላይ አስፈላጊወን መረጃ ለማሰብሰብ አንተ/ች ለዚህ ጥናት ተሳታፊ እንድትሆን/ኝ ተመርጠሀል/ሻል፡፡ ስለዚህ በሚቀርቡት ጥያቄዎች መሠረት ተገቢውን ምላሽ እንድትሰጠን/ጭኝ እየጠየቅን ለምታደርግልን/ጊልን መልካም ትብብር በቅድሚያ እናመሰግናለን፡፡

መረጃውን ከማስጠትህ/ሽ በፊት ልትገነዘባቸው/ቢያቸው የሚገቡ መሠረታዊ ነጥቦች፡

1. በዚህ ማጠይቅ ማንኛውም ገጽ ላይ ስም መጻፍ አያስፈልግም፡፡
2. ጥያቄዎቹ ስለተከሰተ ነገር ወይም ሁኔታ ምላሽን የሚጠይቁ በመሆናቸው ትክክለኛ ወይም ስህተት የሚባል መልስ የላቸውም፡፡
3. በዚህ ጥናት የምትሳተፈው/ፊው መሉ ፈቃደኞ ስትሆን/ኝ ነው፡፡

አንተ/ች በዚህ ጥናት ለመሳተፍ ፈቃደኛ ነህ/ሽ?

1. አዎ ፈቃደኛ ነኝ፣ ፊርማ-----------------------------
2. ፈቃደኛ አይደለሁም

የጥናቱ ተሳታፊዎች አጠቃላይ ሁኔታ ማጠይቅ

መመሪያ ፡ የሚከተሉት ጥያቄዎች የአንተን/ችን አጠቃላይ ሁኔታ በተመለከተ መረጃ ለማሰብሰብ የተዘጋጁናቸው፡፡ ጥያቄዎቹን በማንበብ ከተሰጡት አማራጮች አንዱን በማክበብ መልሱን ስጥ/ጭ፡ አማራጭ ለሌላቸው ጥያቄዎች ደግሞ መልሱን በተሰጠው ቦታ ላይ አስቀምጥ/ጭ፡፡

1	እድሜ	----------------------አመት
2	ጾታ	1.ወንድ 2. ሴት
3	የቤተሰብ የመኖሪያ አድራሻ	1. ገጠር 2. ከተማ
4	በአሁኑ ጊዜ የምትኖረው/ሪው ከማን ጋር ነው?	1. ከእናትና አባት ጋር 2. ከአንድ ወላጅ ጋር ብቻ 3. ከአንጀራ አባት/እናት ጋር 4. ሌላ ካለ ይገለጽ፡ -----
5	የስንተኛ ክፍል ተማሪ ነህ/ሽ?	------------------ክፍል
6	የአባትህ/ሽ የትምህርት ደረጃ ምን ያህል ነው?	1. ያልተማረ 2. ማንበብና መጻፍ የሚችል 3. የአንደኛ ደረጃ ትምህርት 4. የሁለተኛ ደረጃ ትምህርት 5. ዲፕሎማ ወይም ሠርቲፊኬት 6. የመጀመሪያ ዲግሪና ከዚያ በላይ
7	የእናትህ/ሽ የትምህርት ደረጃ ምን ያህል ነው?	1. ያልተማረች 2. ማንበብና መጻፍ የምትችል 3.የአንደኛ ደረጃ ትምህርት 4. የሁለተኛ ደረጃ ትምህርት 5.ዲፕሎማወይም ሠርቲፊኬት 6.መጀመሪያ ዲግሪና ከዚያ በላይ
8	የአባትህ/ሽ የሥራ አይነት ምንድን ነው?	1. በመንግስት ወይም በሌላ ድርጅት ተቀጥሮ የሚሠራ 2. በንግድ የሚተዳደር 3. በእርሻ /በግበርና ሥራ የሚተዳደር 4. ሌላ ካለ ይገለጽ _____________
9	የእናትህ/ሽ የሥራ አይነት ምንድን ነው?	1. በመንግስት ወይምበሌላ ድርጅት ተቀጥራ የምትሠራ 2. በንግድ የምትተዳደር 3. እርሻ/ግበርና የምትተዳደር

		4. ሌላ ካለ ይገለጽ ____________
10	የቤተሰቡ የወር ገቢ ምን ያህል ነው?	1. ከፍተኛ 2. መካካለኛ 3. ዝቅተኛ

Appendix F: Juvenile Victimization Questionnaire (JVQ-R2)- Amharic Version

የጥቃት ሰለባነት ሁኔታ ማከያ

መመሪያ ፡ ከዚህ በታች የተዘረዘሩት ጥያቄዎች ባለፈውአንድ አመት ጊዜ ወስጥ ስላጋጠሙህ/ሽ ክስተቶች ምላሽ የሚጠይቁ ናቸው፡ ፡ በመሆኑምእያንዳንዱን ጥያቄ በጥሞና በማንበብ አጋጥሞህ/ሽ የሚያወቅ ከሆነ "1" ቁጥርን ካላጋጠሞህ/ሽ ደግም" 2" ቁጥርን በማክበብ መልስ/ሽ፡ ፡

ተ.ቁ	ባለፈው አንድ አመት ጊዜ ወስጥ ጥያቄ	ሚስ	
1	ለብሰኸው/ሽው ወይም ይዘኸው/ሽው የነበረውን ነገር ከአንተ/ች ለማዘረፍ ወይም ለመውሰድ ኃይል የተጠቀመ ሰው ነበር?	1	2
2	ቦርሳ፣ ገንዘብ፣ ሰዓት፣ ልብስ ወይም ሌላ ነገር ሰርቆ ሳይመልስልህ/ሽ የቀረ ሰው ነበር?	1	2
3	የአንተ/ች የሆነውን ነገር ሆን ብሎ የሰበረብህ/ሽ ወይም የአበላሸብህ/ሽ ሰው ነበር?	1	2
4	በዱላ፣ በድንጋይ፣ በጠበንጃ፣ በጩቤ ወይም ሊጎዳህ/ሽ በሚችል ማንኛውም ነገር ሆን ብሎ ጥቃት ያደረሰብህ/ሽ ሰው ነበር?	1	2
5	ዱላ ፤ ድንጋይ ወይም ሌላ ምንም ዐይነት ነገር ሳይጠቀም ጥቃት ያደረሰብህ/ሽ ሰው ነበር?	1	2
6	የሆነ ሰው ሊያጠቃህ/ሽ ሞክሮ በሆነ ምክንያት ለምሳሌ ሌላ ሰው ረድቶህ/ሽ ወይም አምልጠህ/ሽ ሳይሳካለት ቀርቷል?	1	2
7	ሰዎች በእውነት ሊጎዱህ/ሽ እንደሚችሉ እያሰብክ/ሽ እያለ የሆነ ሰው እንደሚጎዳህ/ሽ አስፈራርቶሃል/ሻል?	1	2
8	ሊጎዳኝ ይችላል ብለህ/ሽ የምታስበው/ቢው ሰው ወደሚትፈልገው/ጊው አካባቢ አፍኖ ወስዶህ/ሽ ያውቃል?	1	2
9	በቆዳ ቀለምህ/ሽ፣ በሃይማኖትህ/ሽ፣ በመጣህበት/ሽበት ቤተሰብ ወይም ባለብህ/ሽ አካላዊ ወስንነት ችግር ምክንያት ጥላቻ ወይም ጥቃት ደርሶብሃል/ሻል?	1	2
10	በአዋቂ የእድሜ ክልል ወስጥ የሚገኝ ሰው ከፍተኛ ሀይል በመጠቀም በድብደባ፣ በርግጫ ወይም በሌላ መንገድ አካላዊ ጉዳት አድርሶብሃሻለ/ሻል?	1	2
11	በአዋቂ የእድሜ ክልል ወስጥ የሚገኙ ሰዎች የማይፈልጉህ/ሽ መሆኑን በመናገራቸው፣ ወይም ቅጽል ስም በማውጣታቸው ምክንያት መጥፎ ስሜት ተሰምቶሃል/ሻል?	1	2
12	ወላጆችህ/ሽ ወይም አሰዳጊዎችህ/ሽ በቂ ምግብ ባለማስጠት፣ ስትታመም/ሚ ወደ ሐኪም ቤት ባለመውሰድ ወይም ሌሎች አስፈላጊ የሆኑ ነገሮችን ባለማሟላት እንክብካቤ ሳያደርጉልህ/ሽ ቀርተው ያውቃሉ?	1	2
13	ወላጆች/ሽ አንተ/ች እንድትሆን/ኚ ወይም እንድትኖር/ሪ የሚፈልጉትን ቦታ ለመወሰን ባለማስማማታቸው ምክንያት አንዱ ወላጅህ/ሽ ከሌላኛው ወለጅህ/ሽ ጋር እንዳትሆን/ኚ ደብቆ ወስዶህ/ሽ ያውቃል?	1	2
14	ልጆች በቡድን ሆነው ድብደባ ወይም ጥቃት አድርሰውብህ/ሽ ያውቃሉ?	1	2
15	በቤት፣ በትምህርት ቤት ፣ በሚጫወቻ ቦታ እና በሌሎች ማሰል ቦታዎች ወንድምና አህትን ጨምሮ ሌሎች ልጆች መትተውህ/ደብድበውህ ያውቃሉ?	1	2
16	ሆን ብሎ በመምታት ወይም በማስደንገጥ የተደበቁ የአካል ክፍሎችህ/ሽ ላይ ጉዳት ያረሰብህ/ሽ ልጅ ነበር?	1	2

17	ወንድምና እህትን ጨምሮ ሌላ ልጅ ከምትጫወትበት/ችበት ቦታ በማበረር ወይምየማትፈልገውን/ጊውን ነገር በማሥራት ጉዳት አድርሶብሃል/ሻል?	1 2
18	ልጆች ለአንተ/ች ቅጽል ስምበማውጣታቸው፣ ወይምየማይፈልጉህ/ሽ መሆኑን በማናገራቸውምክንያት ከልብ መጥፎ ስሜት ተሰምቶሃል/ሻል?	1 2
19	ሴት ወይምወንድ ጓደኞችህ ወይምለማዝናናት አብረኸው/ሽውየ ወጣኸው/ሽውማንኛውምሰው መትቶሃል/ሻል ወይምአስፈራርቶሃሻለ/ሻል?(12 አመት እና ከዚያ በላይ ለሆናቸውብቻ)	1 2
20	የምታውቀው/ቂውማንኛውምለአካለ ማጠን የደረሰ ሰውመንካት የሌለበትን ድብቅ የአካል ክፍሎችህን/ሽን ነክቶብሃል/ሻል ወይምየርሱን አንድትነካ/ኪ አድርጎሃል/ሻል ወይምወሲብ እንድትፈጽም/ሚ አስገድዶሃል/ሻል?	1 2
21	የማታውቀው/ቂውማንኛውምለአካለ ማጠን የደረሰ ሰውመንካት የሌለበትን ድብቅ የሆኑ የአካል ክፍሎችህን/ሽን ነክቶብሃል/ሻል ወይምየርሱን አንድትነካ/ኪ አድርጎሃል/ሻል ወይምየተቃራኒ ጾታ ግንኙነት እንድታደርግ/ጊ አስገድዶሃል/ሻል?	1 2
22	በትምህርት ቤት ያሉ ልጆች ወይምጓደኞችህ/ሽ ወይምበአሥራዎቹ የእድሜክልል ወስጥየሚገኙ ጎረምሶች ወሲባዊ የሆኑ ድርጊቶችን እንድትፈጽም/ሚ አድርገውሃል/ሻል?	1 2
23	ባይሳካለትምእንኳን የተቃራኒ ጾታ ግንኙነት እንደታደርግ/ጊ ለማስገደድየሞከረ ሰውነበር?	1 2
24	በማስገደድ ወይምበማስገረምወይምበድንገት ብልጭብጭ የሚደረግ ድብቅ የሆኑ የአካል ክፍሎቹን እንድታይ አድርጓሃል/ሻል?	1 2
25	አንተን/ችን ወይምአካልህን/ሽን በተመለከተ ወሲባዊ የሆነ ነገር በማናገር ወይምበመጻፍ ስሜትህን/ሽን የጎዳ ሰውነበር?	1 2
26	ምንም እንኳን ሁለታችሁም ፈልጋችሁ ወይም ተስማምታችሁ ያደረጋችሁት ቢሆንም አሥራ ስምንት ዓመትና ከዚያ በላይ ዕድሜካለውሰውጋር የተቃራኒ ግንኙነት አድርገሃል/ሻል?(12 አመት እና ከዚያ በላይ ለሆናቸውብቻ)	1 2
27	አንዱ ወላጅህ/ሽ በሌላኛውወላጅህ ሲገፈተር/ስትገፈተር፣ በጥፊ ሲመታ/ስትመታ፣ በቡጢ ሲደበደብ/ስትደበደብ አይተሃል/ሻል?	1 2
28	ወላጅህ ወንድሞችህን ወይም እህቶችህን በሀይል ሲመታ፣ ሲደበድብ፣ ወይምአካላዊ ጉዳት ሲያደርስ አይተሃል/ሻል?	1 2
29	በዱላ፣ በድንጋይ፣ በጠበመንጃ፣ በጩቤ ወይም በሌላ ነገር ጥቃት ሲደርስበትና ሲጎዳ ያየኸው/ሽው ሰውነበር?	1 2
30	ዱላ፣ ድንጋይ፣ ጠበመንጃ፣ ጩቤ ወይምሊጎዳ የሚችል ሌላ ነገር ሳይጠቀም በሌላ ሰውላይ ጥቃትና ጉዳት ሲያደርስ ያየኸው/ሽውሰውነበር?	1 2

31	በቤተሰቦችህ ወይምበምትኖርበት/ሪበት ሰውቤት ወስጥ ቴሌቪዥን፣ ሬዲዮ፣ መኪና ወይምሌላ ነገር ሲሰርቅ አይተሃል/ሻል?	1	2
32	ለአንተ/ች ቅርብ የሆነ ጓደኛ፣ ጎረቤት ወይምየቤተሰብ አባል በሌላ ሰውአደጋና ጉዳት ሲደርሰበት/ባት አይተህ/ሽ ታውቃለህ/ቂያለሽ?	1	2
33	በምትኖርበት/ሪበት አከባቢ ወይምበሌላ አካባቢ ሰዎች በሚያስደነግጥ ሜልኩ በቡድን ሆነ ውሲጣሉ ፤ ሁከት ሲፈጥሩ ሲጎዳዱአይተህ /ሽ ታውቃለህ/ሽ?	1	2

Appendix G: Achenbach Systems of Empirically Based Assessment (ASEBA): Youth Self Report for Ages 11-17 (Amharic Version)

ስነ –አእምሮአዊና ባህሪያዊ መጠይቅ (ከ11 ዓመት - 17 ዓመት)

መመሪያ፡ ከዚህ በታየ ተዘረዘሩት ባህሪያት አንተን/ቺን በአሁኑ ሰዓት ወይምባለፉት ሁለት ወራት ጊዜ ወስጥ ምን ያህል እንደሚገልጽህ/ሽ ከቀረቡት አማራጮች መካከል በማሚጥና በማክበብ ሜለስ ስጥ/ጭ፡ የአማራጭቁጥሮች ትርጓሜ እንደሚከተለውነው።

0 = እውነት አይደለም።

1 = አልፎ አልፎ ወይምአንዳንድ ጊዜ ብቻ እውነት ነው።

2 =በአብዛኛውእውነት ነው።

1	ከእድሜዬ በታች የሆኑ ነገሮችን አደርጋለሁ	0	1	2
2	ወላጆቼ ሳያወቁ የሚያሰክሩ ማጠጦችን እጠጣለሁ	0	1	2
3	መከራከር አበዛለሁ	0	1	2
4	የጀመርኳቸውን ነገሮች ሜጨረስ ያቅተኛል	0	1	2
5	የምደሰትባቸውነገሮች ጥቂት ናቸው	0	1	2
6	እንስሳትን እወዳለሁ	0	1	2
7	እጎርራለሁ/ጉራ አበዛለሁ።	0	1	2
8	ትኩረቴን/ሀሳቤን ማሰብሰብ እቸገራለሁ	0	1	2
9	አንዳንድ ሀሳቦችን ከአእምሮዬ ማውጣት /ማስብ መተው/ያቅተኛል	0	1	2
10	በአንድ ቦታ ተረጋግቼ/ፀጥ ብዬ መቀመጥ እቸገራለሁ	0	1	2
11	ካለአዋቂ ሰዎች እገዛ ነገሮችን ለማከናወን አልችልም	0	1	2

12	ብቸኝነት ይሰማኛል	0	1	2
13	ግራ የመጋባት ስሜት ይሰማኛል	0	1	2
14	ብዙ ጊዜ አለቅሳለሁ	0	1	2
15	ታማኝ ነኝ	0	1	2
16	ለሰዎች ክፉ ነኝ	0	1	2
17	ብዙ ጊዜ በቁሜበወኔ እቃዣለሁ	0	1	2
18	ሆን ብዬ ራሴን ለመጉዳት ወይምለማጥፋት እሞክራለሁ	0	1	2
19	ሰዎች ትኩረታቸውን እኔ ላይ እንዲያደርጉ ብዙ እጥራለሁ	0	1	2
20	የራሴ የሆኑ ነገሮችን አወድማለሁ	0	1	2
21	የሌሎች ሰዎች የሆኑ ነገሮችን አወድማለሁ	0	1	2
22	ለአሰሪዎቼ/ለድርጅቱ ሰራተኞች ታዛዥአይደለሁም	0	1	2
23	የማስራበትን ቤት/የአለሁበትን ድርጅት ህግና ደንብ አላከብርም	0	1	2
24	መማ ብያለብኝን ያህል አልማ ብም	0	1	2
25	ከሌሎች ልጆች ጋር አብሬ አልሆንም	0	1	2
26	ማስራት የሌለብኝን ነገር ከሰራሁ በኋላ የጥፋተኝነት ስሜት አይሰማኝም	0	1	2
27	በሌሎች እቀናለሁ	0	1	2
28	በቤት፣ በት/ቤት፣ ወይምበሌላ ቦታ ደንብ አላከብርም	0	1	2
29	የተወሰኑ እንስሳትን፣ ሁኔታዎችን፣ ወይምቦታዎችን(ከ ት/ቤት ውጭ) እፈራለሁ	0	1	2
30	ወደ ማጠናከሪያ ት/ቤት ወይምወደ መደበኛ ያልሆነ ት/ቤት ለመሄድ እፈራለሁ	0	1	2
31	መጥፎ ነገር አስባለሁ ወይምእፈጽማለሁ ብዬ እፈራለሁ	0	1	2
32	ምንምዓይነት ስህተት ማስራት እንደሌለብኝ ይሰማኛል	0	1	2
33	አንድምየሚወደኝ ሰውእንደሌለ ይሰማኛል	0	1	2
34	ሌሎች ሰዎች ሊያጠቁኝ የሚከታተሉኝ ይመስለኛል	0	1	2
35	ዋጋ የለሽነት ወይምየበታችነት ስሜት ይሰማኛል	0	1	2
36	ድንገተኛ አደጋዎች በብዛት ያጋጥመኛል	0	1	2
37	በብዙ/በቡድን ጸብ ወስጥ እሳተፋለሁ	0	1	2
38	ብዙ ጊዜ ሰዎች ያሾፉብኛል	0	1	2
39	የባህሪ ችግር ካለባቸውልጆች ጋር አብሬ እሆናለሁ/አሳልፋለሁ	0	1	2
40	አብረወኝ ያሉ ሰዎች የሚሰማቸውነገር በሌለበት ሁኔታእኔን የሚሰማኝ ድምጽ አለ	0	1	2

41	ቆምብዬ ሳላስብ ነገሮችን እፈጽማለሁ	0	1	2
42	ከሰዎች ጋር ከመሆን ይልቅ ብቻዬን መሆን እመርጣለሁ	0	1	2
43	እዋሻለሁ ወይም አታልላለሁ	0	1	2
44	የእጆቼን ጥፍሮች በጥርሴ እበላለሁ	0	1	2
45	ሚጋጋት ያቅተኛል/እጩኄ ቃለሁ	0	1	2
46	አንዳንድ የሰውነት ክፍሎቼ (ለምሳሌ ቅንድብ፣ ከንፈር) ይንቀጠቀጣሉ	0	1	2
47	በእንቅልፌ እቃዣለሁ	0	1	2
48	በሌሎች ልጆች የምወደድ አይደለሁም	0	1	2
49	አንዳንድ ነገሮችን ከብዙ ልጆች በተሻለ ሁኔታ ማስራት እችላለሁ	0	1	2
50	በጣምፈሪ ወይም ድንጉጥ ነኝ	0	1	2
51	እራሴን የማዞር ስሜት ይሰማኛል	0	1	2
52	የጥፋተኝነት ስሜት በከፍተኛ ሁኔታ ይሰማኛል	0	1	2
53	ከማጠን በላይ እማ ባለሁ	0	1	2
54	ያለበቂ ምክንያት ከፍተኛ የድካምስሜት ይሰማኛል	0	1	2
55	በጣምወፍራምነኝ (ከማጠን ያለፈ ክብደት) አለኝ	0	1	2
56	የህክምና ምክንያት ሊሰጣቸውየ ማይችሉ አካላዊ ችግሮች	0	1	2
	ሀ. የህማምስሜት (ከራስ ምታት ወይምከጨጓራ ህማምውጭየሆነ)	0	1	2
	ለ. የራስ ምታት	0	1	2
	ሐ. ማቅለሽለሽ	0	1	2
	መ. የአይን ችግር (በመነጽር ሊስተካከል የማይችል)፤	0	1	2
	ሰ. የቆዳ ላይ ሽፍታ/እከክ ወይምሌላ የቆዳ ችግር	0	1	2
	ረ. የጨጓራ ህማም	0	1	2
	ሠ. ማስመለስ	0	1	2
57	ሰዎች ላይ አካላዊ ጥቃት/ጉዳት አደርሳለሁ	0	1	2
58	ቆዳዬን ወይምሌላ የሰውነት ክፍሌን እነጫለሁ/እቧጥጣለሁ/እቧጨራለሁ	0	1	2
59	ተግባቢ ሰውመሆን እችላለሁ	0	1	2
60	አዳዲስ ነገሮችን ማጣር እወዳለሁ	0	1	2
61	የማጠናከሪያ ት/ት ወይምየመደበኛ ያልሆነ ት/ት ውጤቴ ዝቅተኛ ነው	0	1	2
62	አካሌን የማዝዝና የማቀናጀት ችግር አለብኝ	0	1	2

63	ከእድሜእኩዮቼ ጋር ከማሆን ይልቅ ከታላላቆቼ ጋር ማሆን እመርጣለሁ	0	1	2
64	ከእድሜእኩዮቼ ጋር ከማሆን ይልቅ ከታናናሾቼ ጋር ማሆን እመርጣለሁ	0	1	2
65	ለማውራት ፈቃደኛ አይደለሁም	0	1	2
66	አንዳንድ ድርጊቶችን ደግሜደጋግሜአደርጋለሁ/እፈጽማለሁ	0	1	2
67	ወደ ሌላ ቦታእኮበልላለሁ/እጠፋለሁ	0	1	2
68	ብዙ ጊዜ ድምጼን ከፍ አድርጌ እየጮሁ አለቅሳለሁ	0	1	2
69	ሚስጥሬን ለሰውአወጥቼ አልናገርምወይምድብቅ ነኝ	0	1	2
70	አብረወኝ ያሉ ሰዎች ምንምየማይታያቸውነገር በሌለበት ሁኔታእኔን የሚታየኝ ነገር አለ	0	1	2
71	ሰዎች የእኔን ድክመት ወይምእንከን ያወቁብኛል ብዬ እጨነቃለሁ	0	1	2
72	ብዙ ጊዜ እሳት እለኩሳለሁ	0	1	2
73	በእጆቼ በደንብ ማስራት እችላለሁ	0	1	2
74	እዩኝ እዩኝ እላለሁ ወይምለታይታነገሮችን አደርጋለሁ	0	1	2
75	በጣምአይናፋር ነኝ	0	1	2
76	ብዙ ልጆች ከሚተኙት ያነሰ ሰዓት እተኛለሁ/እንቀላፋለሁ	0	1	2
77	ብዙ ልጆች ከሚተኙት የበለጠሰዓት ቀንምሆነ ማታ እተኛለሁ/እንቀላፋለሁ	0	1	2
78	ሀሳቤ በቀላሉ ይበተናል	0	1	2
79	የመናገር ችግር አለብኝ (ለምሳሌ ማንተባተብ፣ መድገም፣ መቆራረጥ)	0	1	2
80	ለመብቴ እቆማለሁ	0	1	2
81	እቤቴ ስርቆትን እፈጽማለሁ	0	1	2
82	ከቤቴ ውጭ(ከሌላ ቦታ) ስርቆትን እፈጽማለሁ	0	1	2
83	የማያስፈልጉኝን ብዙ ነገሮች አጠራቅማለሁ/አስቀምጣለሁ	0	1	2
84	ሌሎች ሰዎች ያልተለመዱ/እንግዳ ብለውየሚያስቧቸውን ነገሮች አደርጋለሁ	0	1	2
85	ሌሎች ሰዎች ያልተለመዱ/እንግዳ የሚሏቸውሀሳቦች አሉኝ	0	1	2
86	የሰውን ሀሳብየማልቀበል (ደረቅ)ነኝ	0	1	2
87	ስሜቴ በድንገት ይለዋወጣል	0	1	2
88	ከሰዎች ጋር ማሆን ያስደስተኛል	0	1	2
89	ተጠራጣሪ ነኝ (ያለ በቂ ምክንያት)	0	1	2
90	ጸያፍ ቃላትን እጠቀማለሁ (ሰዎችን ለማናደድ፣ ለማስቆጣት)	0	1	2
91	ራሴን ለማጥፋት አስባለሁ	0	1	2

92	ሰዎችን ማነቅ እወዳለሁ	0	1	2
93	ብዙ አወራለሁ	0	1	2
94	በሰዎች ላይ በብዛት አሾፋለሁ	0	1	2
95	በቀላሉ ወይም ወዲያውኑ እናደዳለሁ	0	1	2
96	ስለወሲብ በብዛት አስባለሁ	0	1	2
97	ሰዎችን ለመጉዳት አስፈራራለሁ	0	1	2
98	ሌሎችን መርዳት እወዳለሁ	0	1	2
99	ሲጋራ አጨሳለሁ ወይም የትምባሆ ቅጠል አኝካለሁ/አሽታለሁ	0	1	2
100	እንቅልፍ ለመተኛት እቸገራለሁ	0	1	2
101	ከማጠናከሪያ ት/ት ወይም ከመደበኛ ያልሆነ ት/ት እፎርፋለሁ ወይም እቀራለሁ	0	1	2
102	አቅም አጣለሁ (ከጉልበት ማነስ ጋር ሳይሆን ተነሳሽነት ከማጣት ጋር በተያያዘ)	0	1	2
103	ደስተኛ አይደለሁም፣ አዝናለሁ	0	1	2
104	ከሌሎች ልጆች የበለጠ በጩኸት/በኃይል እናገራለሁ	0	1	2
105	ከሲጋራና አልኮሆል ውጭ ሌሎች አደንዛዥ ዕፆችን እጠቀማለሁ	0	1	2
106	ሁሉንም ሰው በእኩል ዓይን መመልከት ወይም አለማዳላት እወዳለሁ	0	1	2
107	ጥሩ ቀልዶች ያዝናኑኛል	0	1	2
108	ህይወትን ቀለል አድርጎ መመልከት እወዳለሁ	0	1	2
109	በተቻለኝ ማጠን ሌሎችን ለመርዳት እጥራለሁ	0	1	2
110	ወንድ/ሴት ብሆን ኖሮ ብዬ እመኛለሁ	0	1	2
111	ከሌሎች ሰዎች ጋር ላለመሆን እራሴን አገላለሁ	0	1	2
112	በጣም እጨነቃለሁ	0	1	2

Appendix H: Achenbach Systems of Empirically Based Assessment (ASEBA) Teacher Report Form for 7-10 Years (Amharic Version)

አዲስ አበባ ዩኒቨርስቲ

የሳይኮሎጅ ትምህርት ቤት

አጠቃላይ መመሪያ

የዚህ ማጠይቅ ዋና አላማበጎንደር ከተማወስጥ በሚኙ የአንደኛ ደረጃ ት/ቤቶች በሚማሩ ተማሪዎች የተለያዩ ስነ - አዕምሮአዊ ጠፍ ሁኔታዎች በተማለከተ ጥናት ለማካሄድ ነው፡ ፡ በጉዳዩ ላይ አስፈላጊውን መረጃ ለማብሰብ እርስዎ ተመርጠዋል፡ ፡ ስለዚህ በሚቀርቡት ጥያቄዎች መሠረት ተገቢውን ምላሽ እንዲሰጡን እየጠየቅን ለሚያደርጉልን መልካም ትብብር በቅድሚያ እናመሰግናለን፡ ፡

መረጃውን ከመስጠትዎ በፊት ሊገነዘቧቸውየሚገቡነ ጥቦች፡

- በዚህ ማጠይቅ ማንኛውምገጽ ላይ ስምመጻፍ አያስፈልግም፡ ፡
- ጥያቄዎቹ ስለተከሰተ ነገር ወይምሁኔታ ምላሽን የሚጠይቁ በመሆናቸውትክክለኛ ወይምስህተት የሚባል መልስ የላቸውም፡ ፡
- በዚህ ጥናት የሚሳተፉት ሙሉ ፈቃደኞ ሲሆኑ ብቻነው፡ ፡

እርስዎ በዚህ ጥናት ለመሳተፍ ፈቃደኛ ነዎት?

1 .አዎ ፈቃደኛ ነኝ፡ ፊርማ -----------------------------

2 .ፈቃደኛ አይደለሁም

አጠቃላይ መረጃዎች

የትምህርት ቤቱ ስም፡ --

የተማሪውየኮድ ቁጥር፡ ------------------------

የተማሪውጾታ፡ - ወንድ-----------ሴት------------------

የተማሪውየትምህርት ደረጃ፡ ---------------------ሴክሽን፡ --------------------------

በትምህርት ቤቱ ወስጥ ያለዎት የሥራ ድርሻ፡ -----------------------------------

የአእምሮ ጠፍ ሁኔታዎች ማለኪያ

ከዚህ በታች የተዘረዘሩት ዓረፍተ ነገሮች የተማሪዎችን ባህሪያት ይገልጻሉ ተብለውየታሰቡ ናቸው፡ ፡ ተማሪው/ዋ አሁን ወይምባለፉት ሁለት ወራት ወስጥ የነበረውን/ራትን ባህርይ በጣም ይገልጻል በሚሉት እያንዳንዱ ዓረፍተ ነገር ፊት ለፊት ከተዘረዘሩት ቁጥሮች ወስጥ" 2" የሚለውን ያክብቡ፡ ፡ ዓረፍተ ነገሩ የልጁን/ጅቷን ባህርይ በመጠኑ ወይም አልፎ አልፎ ይገልጻል ብለውካሰቡ" 1" ቁጥርን ፤ ምንምአይገልጽም ብለውከአሰቡ ደግሞ " 0" የሚለውን ያክብቡ፡ ፡ ምንምእንኳ አንዳንዶቹ ዓረፍተ ነገሮች ልጁን/ቷን የማይመለከቱ ቢመስሉምእባክዎ በተቻለ ማጠን ሁሉንምጥያቄዎች ይመልሱ፡ ፡

ተ.ቁ	ጥያቄ	መልስ		
1	ከዕድሜው/ዋ በታች የሆኑ ነገሮችን ያደርጋል/ታደርጋለች	0	1	2
2	በክፍል ውስጥ ያለመቋረጥ ያጉረመርማል/ታጉረመርማለች ወይም ያልተለመዱ ድምጾችን ያሰማል/ ታሰማለች	0	1	2
3	መከራከር ያበዛል/ታበዛለች	0	1	2
4	የጀመሯቸውን/ቻቸውን ነገሮች አይጨርስም/አትጨርስም	0	1	2
5	የሚደሰተው/የምትደሰተው በጣም በጥቂቱ ነው	0	1	2
6	ለመምህራን አይታዘዝም/አትታዘዝም, በንቀት ምላሽ ይሰጣል/ትሰጣለች	0	1	2
7	ጉራ ያበዛል/ታበዛለች	0	1	2
8	ረዘም ላለ ጊዜ ትኩረት ማስጠት ወይም ሀሳቡን/ቧን ማሰብሰብ አይችልም/አትችልም	0	1	2
9	አእምሮው/ዋ የተማሰጠባቸውን/የተማሰጠችባቸውን ሐሳቦች መተው ወይም ማቋረጥ አይችልም/አትችልም	0	1	2
10	ረፍት የለሽ ወይም ቀዥቃዣ ስለሆነ/ች አንድ ቦታ ተረጋግቶ/ታ መቀመጥ አይችልም/አትችልም	0	1	2
11	አዋቂዎች/ጎልማሶች ላይ ጥገኛ ይሆናል/ትሆናለች	0	1	2
12	ብቸኝነትን ያማርራል/ታማርራለች	0	1	2
13	ይወዛገባል/ትወዛገባለች ወይም ግራ የመጋባት ስሜት ውስጥ ያለ/ች ይመስላል	0	1	2
14	በጣም ያለቅሳል/ታለቅሳለች	0	1	2
15	ይቁነጠነጣል/ትቁነጠነጣለች	0	1	2
16	ሌሎችን ያሰቃቃል/ታሰቃቃለች፣ ያስፈራራል/ታስፈራራለች ወይም ያስከፋል/ታስከፋለች	0	1	2
17	ብዙ ጊዜ በውኑ/ኗ ወይም በቁማማኒ ይቃዣል/ትቃዣለች	0	1	2
18	ሆን ብሎ/ላ ራሱን/ሷን ይጎዳል/ትጎዳለች ወይም ራሱን/ሷ ለማጥፋት ይሞክራል/ትሞክራለች	0	1	2
19	ከፍተኛ የሆነ ትኩረት እንዲሰጠው/ጣት ይፈልጋል/ትፈልጋለች	0	1	2
20	የራሱ/ሷ የሆኑ ነገሮችን ያወድማል/ታወድማለች	0	1	2
21	የሌሎችን ንብረት ያወድማል/ታወድማለች	0	1	2
22	መመሪያ መከተል ወይም ማክበር ይቸገራል/ትቸገራለች	0	1	2
23	በትምህርት ቤት ውስጥ ታዛዥ አይደለም/አይደለችም	0	1	2
24	ሌሎች ተማሪዎችን ይረብሻል/ትረብሻለች	0	1	2
25	ከሌሎች ተማሪዎች ጋር አብሮ/ራ አይሔድም/አትሄድም ወይም አይስማማም/አትስማማም	0	1	2

26	በአጠፋው/ችውጥፋት የጥፋተኝነት ስሜት አይሰማውም/ትም	0	1	2
27	በቀላሉ ይቀናል/ትቀናለች	0	1	2
28	የትምህርት ቤት ደንቦችን ይጥሳል/ትጥሳለች	0	1	2
29	የተወሰኑ እንስሳትን፣ ሁኔታዎችን ወይምከትምህርት ቤት ውጭያሉ ቦታዎችን ይፈራል/ትፈራለች	0	1	2
30	ወደ ትምህርት ቤት ማዞድ ይፈራል/ትፈራለች	0	1	2
31	መጥፎ ነገር ላስብ ወይምልፈጽምእችላለሁ ብሎ/ላ ይፈራል/ትፈራለች	0	1	2
32	ፍጹም መሆን ወይምምንምስህተት ማስራት እንደሌለበት/ባት ይሰማዋል/ታል	0	1	2
33	አንድምየሚወደኝ ሰውየለምብሎ/ላ ያማርራል/ታማርራለች ወይምይሰማዋል/ታል	0	1	2
34	ሌሎች ሰዎች ሊያጠቁት/ቋት የሚከታተሉት/ሏት ይመስለዋል/ላታል	0	1	2
35	ዋጋ የለሽነትና የበታችነት ስሜትይሰማዋል /ታል	0	1	2
36	በጣምይጎዳል/ትጎዳለች ወይምአደጋ ይበዛበታል/ባታል	0	1	2
37	በቡድን ጸብ ወስጥ ይሳተፋል/ትሳተፋለች	0	1	2
38	ብዙ ጊዜ ሰዎች ያሾፉበታል /ያሾፉባታል	0	1	2
39	የባህሪ ችግር ካለባቸውልጆች ጋር አብሮ/ራ ያሳልፋል/ታሳልፋለች	0	1	2
40	አብረወት/ዋት ያሉ ሰዎች የሚሰማቸውነገር በሌለበት ሁኔታየሚሰማው/የምትሰማው ድምጽ አለ	0	1	2
41	ቆምብሎ/ላ ሳያስብ/ሳታስብ ድርጊቶችን ይፈጽማል /ትፈጽማለች	0	1	2
42	ከሌሎች ጋር ከሚሆን/ከምትሆን ብቻውን/ዋን መሆን ይመርጣል/ትመርጣለች	0	1	2
43	ይዋሻል/ትዋሻለች ወይምያታልላል /ታታልላለች	0	1	2
44	የጣቶቹን/ቿን ጥፍር ይነክሳል/ትነክሳለች	0	1	2
45	ይርበተበታል/ትርበተበታለች፣ ይደነግጣል/ትደነግጣለች ወይምይጨነቃል/ትጨነቃለች	0	1	2
46	ሰውነቱ/ቷ ይንዘፈዘፋል ወይምይንቀጠቀጣል	0	1	2
47	ለሕግ እና ደንብ ከማጠን በላይ ይገዛል/ትገዛለች	0	1	2
48	በሌሎች ተማሪዎች አይወደደም/አትወደደም	0	1	2
49	ለመማር ይቸገራል/ትቸገራለች	0	1	2
50	በጣምይፈራል/ትፈራለች ወይምይጨነቃል/ትጨነቃለች	0	1	2
51	የዞረበት/ባት ወይምየደነዘዘ/ች እንደሆነ ይሰማዋል/ታል	0	1	2
52	የጥፋተኝነት ስሜት በከፍተኛ ሁኔታ ይሰማዋል/ታል	0	1	2
53	ከተራው/ዋ ውጭያወራል/ታወራለች	0	1	2
54	ያለ በቂ ምክንያት በጣምይደከመዋል/ማታል	0	1	2

55	ከማጠን በላይ ያለፈ ክብደት አለው/አላት	0	1	2
56	የህክምና ምክንያት ሊሰጣቸውየ ሚይችሉ አካላዊ የ ጤና ችግሮች			
	ሀ) የ ራስ ወይምየ ጨጓራ ያልሆነ ሕመም	0	1	2
	ለ) የ ራስ ሕመም	0	1	2
	ሐ) ማቅለሽለሽ	0	1	2
	መ) በማ ጽር ማስተካከል የ ሚይችል የ ዓይን ችግር	0	1	2
	ሠ) የ ሰውነ ት ሽፍ ማኀት ወይምሌላ የ ቆዳ ችግር	0	1	2
	ረ) የ ጨጓራ ሕመም	0	1	2
	ሸ) ማስመለስ	0	1	2
57	በሰዎች ላይ አካላዊ ጥቃት ያደርሳል /ታደርሳለች	0	1	2
58	አፍንጫውን/ዋን ቆዳውን/ዋን ወይምሌላ የ አካል ክፍሉን/ሏን ይቧጥጧል/ትቧጥጣለች	0	1	2
59	በክፍል ወስጥ ይተኛል /ትተኛለች	0	1	2
60	ደንታ ወይምወስጣዊ ማ ሳሳት የ ለውም/የ ላትም	0	1	2
61	ያለው/ያላት የ ትምህርት ውጤት ዝቅተኛ ነ ው	0	1	2
62	አካሉን/ሏን የ ማዝዝና የ ማቀናጀት ችግር አለበት/ባት	0	1	2
63	ከእድሜእኩዮቹ/ቿ ጋር ከመሆን ይልቅ ከታላላቆቹ/ቿ ጋር መሆንን ይመርጣል/ትመርጣለች	0	1	2
64	ከእድሜእኩዮቹ /ቿ ጋር ከመሆን ይልቅ ከታናናሾቹቿ ጋር መሆንን ይመርጣል/ትመርጣለች	0	1	2
65	ለመሥራት ፈቃደኛ አይደለም/አይደለችም	0	1	2
66	አንዳንድ ድርጊቶችን ደግሞ/ማደጋገሞ/ማይፈጽሟል/ትፈጽማለች	0	1	2
67	የ ክፍል ስነ ሥርዓትን ይረብሻል/ትረብሻለች	0	1	2
68	በጣምይጮሃል/ትጮሃለች	0	1	2
69	ነ ገ ሮችን ለራሱ/ሷ ብቻ በምስጢር ይይዛል /ትይዛለች	0	1	2
70	የ ሌሎ ነ ገ ሮችን ያያል /ታያለች	0	1	2
71	በጠምአይነ አፋር ነ ው/ነ ች	0	1	2
72	ሥራው/ዋ የ ተዝረከረከ ነ ው	0	1	2
73	ኃላፊነ ት በጎ ደለውስሜት ሥራ ይሠራል/ትሠራለች	0	1	2
74	እዩኝ እዩኝ ይላል/ትላለች ወይምለታይታ ነ ገ ሮችን ያደርጋል/ታደርጋለች	0	1	2
75	በጣምዓይነ አፋር ነ ው/ች	0	1	2
76	ባህርዩ/ዋ በቀላሉ የ ሚቀያየ ር ወይምሊተነ በይ የ ሚችል ነ ው	0	1	2

77	የጠየቃቸው/የጠየቀቻቸውን ነገሮች ወዲያው ካለተሟሉ በቀላሉ ተስፋ ይቆርጣል/ትቆርጣለች	0	1	2
78	ትኩረት የለውም/የላትም ወይም ሀሳቡ/ቧ በቀላሉ ይበተናል	0	1	2
79	የመናገር ችግር አለበት/አለባት	0	1	2
80	አንድን ነገር ፍዝዝ ብሎ/ላ ወይም ምንም ዓይነት ስሜት ሳይኖረው/ራት ለረጅም ጊዜ ያያል/ታያለች	0	1	2
81	ትችት ሲሰጠው/ሲሰጣት የመጎዳት ስሜት ይሰማዋል/ታል	0	1	2
82	ይሰርቃል/ትሰርቃለች	0	1	2
83	የማያስፈልጉ ብዙ ነገሮች ያጠራቅማል/ታጠራቅማለች	0	1	2
84	ያልተለመደ ባህርይ ያሳያል/ታሳያለች	0	1	2
85	ያልተለመዱ ሐሳቦች አሉት/አሏት	0	1	2
86	የሰውን ሀሳብ የማይቀበል/ትቀበል ግትር (ደረቅ) ነው/ች	0	1	2
87	ስሜቱ/ቷ በድንገት ይለዋወጣል	0	1	2
88	ብዙ ጊዜ ያኮርፋል/ታኮርፋለች	0	1	2
89	ያለ በቂ ምክንያት ተጠራጣሪ ነው/ች	0	1	2
90	በሆነ ባልሆነ ውመህላ ወይም ፀያፍ ንግግር ያዘወትራል/ታዘወትራለች	0	1	2
91	ራሱን/ሷን ስለማጥፋት ያወራል/ታወራለች	0	1	2
92	ስኬቱ/ቷ ዝቅተኛ ነው ወይም በሙሉ አቅማ/ሟ አይሠራም/አትሠራም	0	1	2
93	በጣም ያወራል/ታወራለች	0	1	2
94	በሰዎች ላይ በብዛት ያሾፋል /ታሾፋለች	0	1	2
95	በቀላሉ ወይም ወዲያው ይናደዳል/ትናደዳለች	0	1	2
96	ስለወሲብ በብዛት ያስባል/ታስባለች	0	1	2
97	ሰዎችን እንደሚጎዳ/ትጎዳ ያስፈራራል/ታስፈራራለች	0	1	2
98	ወደ ትምህርት ቤት ወይም ክፍል ሲገባ/ስትገባ ይዘገያል/ትዘገያለች	0	1	2
99	ትምባሆ ያጨሳል/ታጨሳለች፣ ያኝካል/ታኝካለች ወይም ያሸታል/ታሸታለች	0	1	2
100	የተሰጠውን/የተሰጣትን ሥራ አይፈጽምም/አትፈጽምም	0	1	2
101	ያለፈቃድ ከትምህርት ቤት ይቀራል/ትቀራለች	0	1	2
102	አነስተኛ ንቃት፣ አዝጋሚ እንቅስቃሴ ወይም ጉልበት ማጣት ይታይበታል/ባታል	0	1	2
103	ደስተኛ አይደለም/ችም። ያዝናል/ታዝናች ወይም ድብር ይለዋል/ይላታል	0	1	2
104	ያልተለመደ ጩኸት ያሰማል/ታሰማለች	0	1	2
105	ያለህክምና ዓላማ ከትንባሆ ውጭ ያሉ መድሃኒቶችን እና አልኮልን ይጠቀማል/ትጠቀማለች	0	1	2

106	ሰዉን ለማስደሰት በጣም ይጨነቃል/ትጨነቃለች	0	1	2
107	ትምህርት ቤት አይወድም/አትወድም	0	1	2
108	ስህተት መሥራት ይፈራል/ትፈራለች	0	1	2
109	ያላዝናል/ታላዝናለች ወይም ያለቅሳል/ታለቅሳለች	0	1	2
110	አካለዊ ገጹ/ጿ ወይም ሁኔታው/ዋ ንጹህ አይደለም/ችም	0	1	2
111	ከሌሎች ሰዎች ጋር ላለመሆን እራሱን/ሷን ያገላል/ታገላለች	0	1	2
112	በጣም ይጨነቃል/ትጨነቃለች	0	1	2

Declaration

I, the undersigned, declare that this dissertation is my original work and has not been presented for any degree in any other university and all the sources used in this work have been duly acknowledged.

Name: Mulat Asnake

Signature: __________

Date: ___________________

This dissertation has been submitted for final dissertation defense with my approval as a supervisor.

Supervisor's Name: Teka Zewdie (PhD)

Signature:_______________________

Date:____________________________