RUNNING HEAD: PSYCHOSOCIAL CONSEQUENCES OF CHILD SEXUAL ABUSE…

# Psychosocial Consequences of Child Sexual Abuse on Abuse Survivor Female Children: The Case of Three Children Rehabilitation Centers in Addis Ababa.

Endeshaw Aynetu

A Thesis Submitted to the School of Graduate Studies of
Addis Ababa University in Partial Fulfillment of the Requirements for the
Degree of Masters of Social Work (MSW)

Advisor: Abebe Assefa (PhD)

Addis Ababa University
Addis Ababa, Ethiopia

March, 2015

# Psychosocial Consequences of Child Sexual Abuse on Abuse Survivor Female Children: The Case of Three Children Rehabilitation Centers in Addis Ababa.

Endeshaw Aynetu

Addis Ababa University

Graduate School of Social Work

March, 2015

## DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other University and that all sources of materials used for this thesis have been duly acknowledged

Endeshaw Aynetu

Signature _____ Date 15/05/11

**ADDIS ABABA UNIVERSITY**

**SCHOOL OF GRADUATE STUDIES**

This is to certify that the thesis prepared by Endeshaw Aynetu entitled: *Psychosocial Consequences of Child Sexual Abuse on Abuse Survivor Female Children: The Case of Three Children Rehabilitation Centers in Addis Ababa*, and submitted in partial fulfillment of the requirements for the degree of Masters of Social Work (MSW) complies with the regulations of the Uuniversity and meets the accepted standards with respect to originality and quality.

Approved by Examining Committee:

| | | |
|---|---|---|
| External Examiner: Abebaw M | Signature | Date: May 15 2015 |
| Internal Examiner: Ashenafi M. | Signature | Date: May 15/2015 |
| Advisor: Dr. Abebe Asrefu | Signature | Date: April 10/2015 |

**Acknowledgement**

First of all I would like to thank my advisor Dr. Abebe Assefa for his constructive comments and guidance throughout the production of this paper. I am very grateful for his kind, inspirational and friendly approach, most of all for his exemplary personality in enabling to view brighter future. My thanks also go to Dr. Zena Berhanu for his invaluable professional support in validating instruments of data collection. I am very thankful to all my friends for their material and moral support that helped me a lot for the accomplishment of the study.

I would like to express my sincere appreciation to all staffs of School of Social Work and who have made invaluable contribution to the knowledge, skill, and attitude I have as a professional social worker. I am also very grateful for all counselors and social workers of each rehabilitation centers who assisted me a lot in the overall data collection process and without their assistance it was difficult to gather needed information for my paper. God bless you all!

**Table of Contents**

## List of Tables

**Acronyms**

| | |
|---|---|
| ACPE | African Child Policy Forum |
| APA | American psychiatrically Association |
| CITES-R | Children's Impact of Traumatic Events Scale-Revised |
| CSA | Child Sexual Abuse |
| CPS | Children Protective Service |
| IFSO | Integrated Family Service Organization |
| ISPCAN | International Society for the Prevention of Child Abuse and Neglect |
| MOLSA | Ministry of Labor and Social Affairs |
| NCTSN | National Child Traumatic Stress Networks |
| OPRIFS | Organization for Prevention, Rehabilitation and Integration of Female Streets |
| PSTD | Post Traumatic Stress Disorder |
| ORC | Opinion Research Corporation |
| UNICEF | United Nations Children's Fund |
| USA | United States of America |
| WHO | World Health Organization |

**ABSTRACT**

This study was conducted to examine psychosocial consequences of child sexual abuse on abuse survivor children who are taking rehabilitation in three selected children rehabilitation centers in Addis Ababa. A total of 105 female participants for the study were taken from OPRIFS, IFSO, and Kechenie Children Rehabilitation Centers. Children's Impact of Traumatic Events Scale-Revised (CITES-R) were used to measure psychosocial dimensions of child sexual abuse (PSTD, social reactions, eroticism, and attributions about abuse). Additional questionnaires were also employed to know different forms and frequency of sexual abuse the victims faced and the nature of perpetrators affiliation with the victim. To analyze the collected data univarate, bivariate and multivariate analysis using correlation, multiple and hierarchical regression, and One-way analysis of variance (ANOVA) were used. Findings showed that demographic variables (except school level), and length of stay in the rehabilitation center are found to be significant predicators of psychosocial consequences of CSA among abuse survivor female children in the study area. All these variables, including school level, have negative contribution to psychosocial outcomes of CSA. Significant variation in psychosocial outcomes of child sexual abuse among children faced different forms of sexual abuse at various rate of exposure, and abused by perpetrators with different degree of affiliation was found. The combined effect of all independent variables also significantly predicted progressive change in the outcomes of the dependent variable in the study population. Therefore, the study implies that a lot has to be done on studying psychosocial consequences of CSA and rehabilitation of abuse survivor children. To this end, researchers, Social work practitioners, policy analysts have to work in collaboration with other stake holders to overcome such pervasive problem.

*Keywords: Psychosocial Consequences of CSA, Forms and Frequency of Sexual Abuse, Length of Stay in the Rehabilitation Center, Age at Onset of Sexual Abuse.*

# CHAPTER ONE

# INTRODUCTION

## 1.1. Background of the Study

Sexual interactions between children and adults have existed throughout history, but most societies have not recognized these types of interaction as abusive until relatively recently (Wuretele & Miller, 1992). As various researchers pointed out, this is because of absence of universal definition for Child sexual abuse even if the central element of any abuse is stated as the dominant position of an adult that allows him/her to force a child in to sexual activity. As to Haugaard (2000), child sexual abuse has never been unequivocally defined, and this lack of consensus among professionals inhibited research, treatment and advocacy efforts. As to these authors, cultural variations in defining appropriate and inappropriate sexual behavior, and the variations in nature of circumstances by which sexual interactions become abusive are importantly challenging the definition of child sexual abuse. Despite problems in defining Child Sexual Abuse, researchers have made numerous efforts to determine the scope of the problem. Even if the accurate estimation about the increasing rate of the problem is difficult, tracing to various findings, Jane & Alankaar (2008), described that reports of child sexual abuse increased dramatically during the 1980s and early 1990s, and have declined since then. As these authors stated, the changes taking place within family; like increased divorce rates (that in turn lead to increased presence of stepfathers), and increased number of women in the workforce (that lead to increased presence of babysitters), contributed to children's vulnerability. But on the other hand, Jane & Alankaar (2008) also argued that actual increased public awareness about child sexual abuse resulted to the greater rate of reports of abuse following the legislative changes that warned the people to report as obligation. In line with this, Jones & Finkelhor (2003), alternatively, described possible indication for decreasing rate of actual incidence of child sexual

abuse, as a result of prevention and criminal justice efforts, public awareness campaigns discouraging abuse, and establishment of treatment interventions. But, the argument has a possibility for underestimating the extent of the problem, because there might be reluctance of victims, families to report abuse. Particularly, the possibility of disclosing the problem becomes minimal when the abusers are among family members or close relatives.

The afore-mentioned statements show the challenging nature of the issue for researchers, and other concerned bodies to have clear picture of the problem. Nevertheless, unarguably still child sexual abuse is painful reality behind closed doors having both immediate and long-term effects that span across individual's physical, cognitive, interpersonal, and emotional functioning. As literatures show abuse involving family members and high degree of physical force exhibit behavioral problems ranging from separation anxiety to posttraumatic stress disorder. It is going to be devastating when someone who loves and trusts become sexual abuser since such condition exposes the victim for extreme stress and can bring up intense feelings of shock, confusion, denial, and guilt (Tracy, 2002). This in turn, leads children who have been abused by family members possibly blame themselves for the abuse than those who are abused by someone outside of family unit. Because being abused by the one who are supposed to protect from harm, puts trusting people questionable, and knowing the abuser is loved one by other family members makes it more difficult for the victim to disclose the problem(Finkelhore,2003).

Since Child Sexual Abuse is worldwide phenomenon, Ethiopia is one of the countries where the problem is existing, but whose possibility of disclosure is minimal. In families and communities in which most of us are grown up the issue of sexuality is not spoken out. Even parents didn't make their children conscious about physical and emotional changes that take place during their puberty. This widens the gap not to report any forms of sexual abuse that

children face within and outside of family. As to Yematawet al., (2011), this silence encourages the abuser to continue the abuse and to maintain one's advantage in way of exposing the child for severe forms of sexual abuse. In this regard the problem might not be given much emphasis for a number of reasons in our society, but the victims are there and need psychosocial support from whom they want to share the situation and relief from their stress. Taking this in mind, this paper studied psycho social consequences of child sexual abuse on sexual abuse survivor female children who are currently inhabited in three children rehabilitation centers (OPREFS, IFSO, and Kechenie Children rehabilitation center) in Addis Ababa.

### 1.2. Statement of the Problem

Child sexual abuse is a pervasive problem that has affected health, social and physical wellbeing of children globally (Pinheiro, 2006). Yet little is known about the prevalence of violence against children, and figures vary widely depending on the definitions used and how information is collected (Finklhor, Ormord & Turner, 2009). In line with this, Candice et al., (2009) described that legal definition of childhood sexual abuse vary across jurisdictions and sexual exploitation of children and adolescents is a criminal act. Accordingly, they stated that widely agreed childhood sexual abuse involves the following; 1) sexual acts with children and youth who lack the maturity and emotional and cognitive development to understand or to consent, and 2) an abusive condition; like coercion or a large age gap between participants . Other scholars also defined child sexual abuse as "an abuse of power, where older, stronger, and more knowledgeable persons take advantage of children for their own sexual and emotional gratification and sometimes for financial gain (Jane & Alankaar, 2008). As to these researchers, it is both a physical and psychological experience which involves touch and non-touch behaviors

(physical experience), and abuse of power and authority (psychological experience) where perpetrators satisfy themselves emotionally and sexually and children are hurt and confused.

Various factors potentially contribute to the children's vulnerability to child sexual abuse. In relation to this, WHO (2010), stated that societal and cultural norms related to the social position of children, child rearing practices, as well as the breakdown of immediate and extended family systems, orphaned children and child-headed households are contributing factors. Additionally, Whitaker et al., (2008), described that history of sexual abuse, harsh discipline as a child, and difficulty with intimate relationships, antisocial behavior and loneliness were found to be positively associated.

The perpetrators of child sexual abuse are not merely outsiders; rather it can take within family by a parent, step-parent, siblings, or other relatives. As stated by Makoae *et al.*, (2009), the perpetrators are mainly male adults and youth who are known to the child, in particular relatives and acquaintances. The involvement of family members in such horrible act makes it largely a silent and witness-free crime often leaving no physical signs and actively hidden by perpetrators, which makes its detection very difficult (Finkelhore, 2003). In such case, the victims are important sources for investigation of abuse. But, in their finding Jane & Alankaar (2008), described that many children do not tell about abuse, and families may not report to authorities when children tell. Because, shame, stigma, social ostracism, and other severe consequences for survivors, for families, and for perpetrators are reasons for not letting anyone know and not reporting to authorities (Jane & Alankaar , 2008). For instance, 'Human Rights Watch' study of child sexual abuse in India (2013), described the consequences of disclosing the problem by stating that "victims who do come forward to make complain often suffer as a result". Anyway, most children did not disclose immediately, with the majority fearing the

response of parents and caregivers and expecting to be blamed (Mathews, 2009). This shows that addressing child sexual abuse is a challenge all over the world, with significant degree of variation of responses across countries

Child sexual abuse has a profound impact on the physical and mental health of its victims, with both immediate, as well as longer-term consequences and is of major concern (WHO, 2001). The effects of abuse during early childhood have shown to negatively affect the development of the brain, with consequent cognitive, psychological and social impairment (Perry, Hodges, & Egan 2001). Depression, suicidal thoughts and/ or attempts, as well as alcohol and drug abuse have also been associated with emotional, physical and sexual abuse. A range of psychological and social factors contribute to the development of psychopathology, particularly family dysfunction is associated with negative psychological outcomes (Briere & Elliot, 1993). While other factors such as gender, age when abused, type and severity of abuse, cognitive abilities, and relationship to the perpetrator also influence the child's immediate and long-term mental health response to victimization (Maniglio, 2009). Supportively, Killian & Brakarsh (2004) described that the impact of CSA can be understood in terms of whom the perpetrator is, the duration of the abuse and the age of the child at onset and responses to disclosure. As a result, its effect is profound, when the perpetrator is most likely someone known to the child and the abuse manifests in a relationship of trust and affection. Despite of this, psychological and social effects of child sexual abuses by the family members or close relatives, by members from extra familial affiliation, and different forms of sexual abuse in various degree of exposure were not extensively studied. The existing literatures which I went through have focused on studying various forms of child abuse, but psychosocial consequences of child sexual abuse on abuse survivor children are not taken in to consideration. At least studying immediate and long-term

effects of child sexual abuse was important for devising effective treatment strategies and also would have crucial role for further research. Based on such intention, I studied psychosocial consequences of Child Sexual Abuse on abuse survivor children by taking three children rehabilitation centers; namely OPRIFS, IFSO, and Kechenie Children rehabilitation center as areas of study.

**1.3. Rationale and Significance of the Study**

As family is primary institution in perpetuating and socializing generations, it should be safe place for children's physical, psychological, social and spiritual development. But now a day, families are becoming the arenas of violence and maltreatment of children in various forms. Since the violence and abuse occur behind closed doors, it is relatively challenging to disclose the problem and to provide treatment for the victim children. Fortunately, some children may get chance to reveal the problem and get psychosocial treatment being inhabited in some rehabilitation centers. Even if researchers mostly studied prevalence and nature of sexual abuse, there are no enough studies conducted to examine psychological and social effects of child sexual abuse on survivor children. Taking this in to account I wanted to examine traumatic effects of child sexual abuse on survivor children who are taking treatment in respective rehabilitation centers. Thus, this study has various roles in investigating the nature of abusers and techniques employed for abusing children, which might remind families to care for their children and to reduce children's exposure from abusers. The study also has important implication for social workers, psychologists, lawyers, and other professionals to provide psychosocial treatment and other services for the victim children. Most importantly, it serves as reference for other researchers who are interested in studying perpetrators profile, forms of sexual abuse that victims mostly face, and psychosocial consequences of child sexual abuse on survivor children. Thus, the

study enables researchers who need to do further research in this area, and also help institutions which are working in child care and rehabilitation to devise better treatment and rehabilitation models to reduce traumatic effects of sexual abuse among victim children.

## 1.4. Objectives of the Study

### 1.4.1.General Objective

The overall objective of this study is to examine traumatic effects of child sexual abuse on survivor female children in selected children rehabilitation centers in Addis Ababa.

### 1.4.2 . Specific Objectives

The specific objectives of this study include;

- To examine the relationship between demographic variables (age, age at onset of abuse, school level) and psychosocial effects of child sexual abuse among abuse survivor female children.
- To compare psychosocial outcomes of child sexual abuse across different forms of sexual abuse in abuse survivor female children.
- To examine the relationship between length of stay in the rehabilitation center and psychosocial consequences of child sexual abuse.
- To compare psychosocial outcomes of child sexual abuse among survivor female children abused by perpetrators from intrafamily, extra family, and members from both familial units.
- To assess differential effects of frequency of sexual abuse on psychosocial effects of sexual abuse in abuse survivor female children.
- To examine the combined effect of all independent variables on the psychosocial outcomes of sexual abuse on abuse survivor female children in the study area.

### 1.5. Conceptual Framework

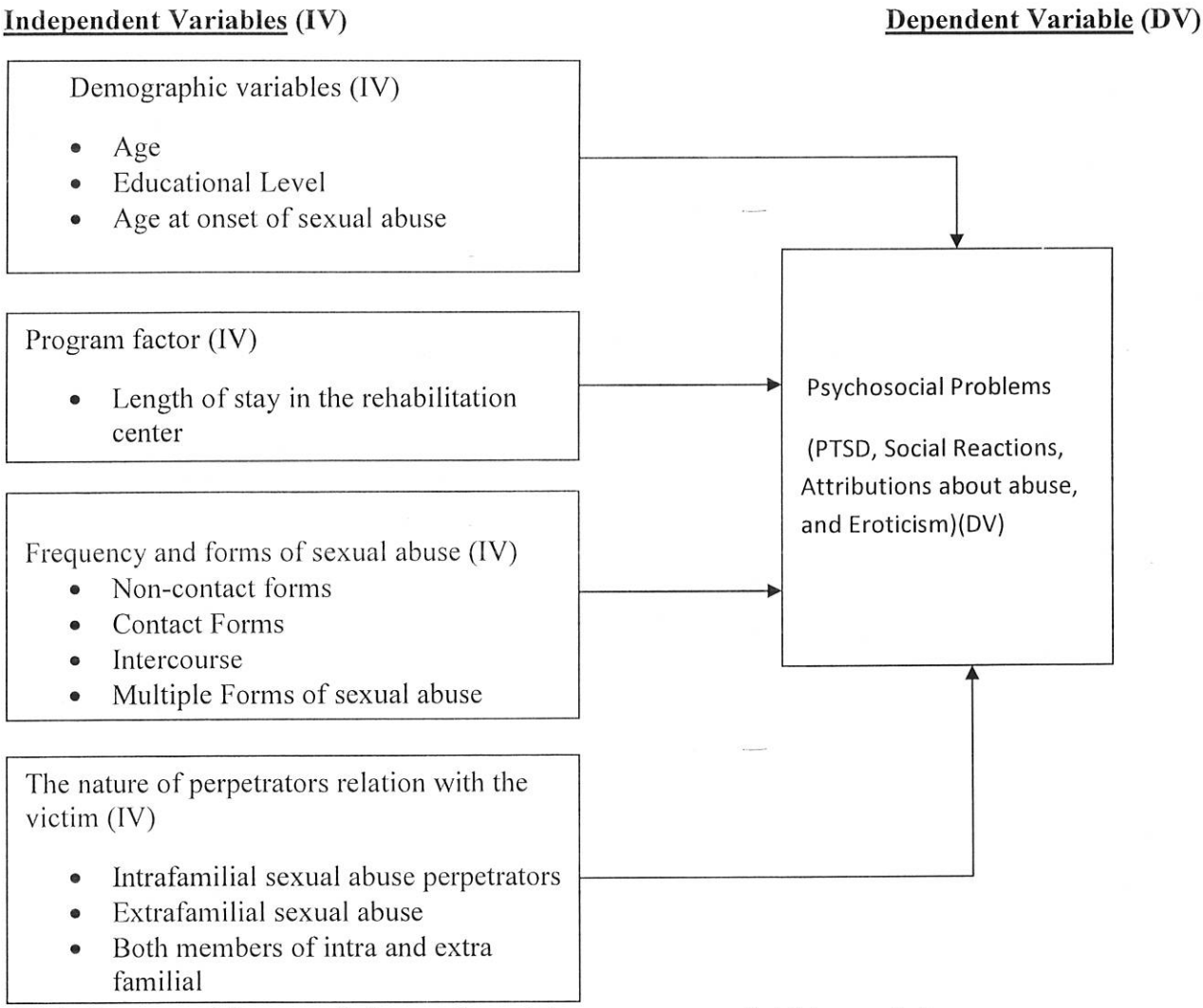


Fig1: Conceptual framework for psychosocial consequences of child sexual abuse

### 1.6. Conceptual and Operational Definition of the Terms.

#### 1.6.1. Conceptual Definition of Terms

The Children's Impact of Traumatic Events Scale-Revised (CITES-R) is a 78-item standardized instrument specifically designed for sexually abused children by Wolfe, & Gentile (1991). It measures PTSD symptoms (i.e. intrusive thoughts, avoidance, hyper arousal and sexual anxiety), eroticism, and social reactions (i.e., social support and negative reactions by

others) and abuse attributions (personal vulnerability, self-blame/guilt, a perception of the world as dangerous, and empowerment) among the abuse survivor children.

**Intrafamilal sexual offenders**: sexual abuse is categorized as intrafamilial when there is blood relationship between the victim and offender or relationship by marriage between the offender and the victim's family. Besides if the offender lives within the household without any blood or marital relationships is coded as intrafamilial (Kathleen, 1989).

**Extrafamilial sexual offenders**: it indicates those perpetrators who didn't have any blood or marital relationship with the victim's family, and they don't live with the victim's family in the same household (Kathleen, 1989).

**Forms of Sexual Abuse**: a group of researchers, Gavin, A., Justine, C., Tim, S., Cathy, I., & Heather, S. (2000) categorized CSA in to Non-contact, contact, intercourse and multiple forms. Non-Contact forms of sexual abuse encompasses a range of acts and includes inappropriate sexual solicitation or indecent exposure; Contact forms of sexual abuse includes, touching or fondling buttocks, breasts, or genitals; Intercourse includes oral, anal or vaginal intercourse, and multiple forms refers to more than one of the above forms of sexual abuse.

### 1.6.2. Operational Definition of Terms.

**Perpetrators relation with the victim**: perpetrators can be both related by blood, marriage, or adoption and live within the same household, or they may not be related at all. In some cases, victims can be abused by both interfamilial and Extrafamilial perpetrators.

**Length of stay in the rehabilitation centers**: refers to the amount of months victim children stayed in respective rehabilitation centers after the event has happened.

**Age**: refers to the number of years that children lived when the data collection took place. It is continuous and ranged from 11-17 for the purpose of this study

**Age at onset of sexual abuse**: refers to the first time sexual abuse has happened. In cases of multiple forms of abuse and multiple perpetrators, the child's age when the first offender first abused is taken.

**School level**: refers to maximum grade levels of victim children when the study was conducted and it is continuous variable.

**Psychosocial consequences of sexual abuse**: it refers to sexual abuse survivor children's behavior as measured by Children's Impact of Traumatic Events Scale-Revised (CITES-R). It is continuous variable with three point likert scale with 78 minimum score and 234 maximum score. PSTD, attributions about abuse, Social reactions, and eroticism are the main scales that measure psychosocial consequences of child sexual abuse; and they are described below:

**Post traumatic stress disorder**: it is one of the psychosocial dimensions of sexual abuse and measured in terms of intrusive thoughts, avoidance, hyper arousal and sexual anxiety experiences of victim children. It is one of the main scales in CITES-R with 26 items and thus, the possible minimum score is 26 and maximum score is78.

**Attributions about abuse**: it is one of the main scales in CITES-R and is measured in terms of self-blame/guilt, perception of the world as dangerous, personal vulnerability and empowerment experiences of victim children. It consists of 33 items whose possible minimum score is 33 and maximum of 99.

**Social reactions**: Another dimension of psychosocial consequences of child sexual abuse which can be measured in victim children's negative reaction to others, and their perception of social support. It has possible minimum score of 15 and 45 maximum score.

**Eroticism**: this is the main scale which has least items in CITES-R with 4 possible minimum score and 12 maximum score.

### 1.7. Research Hypothesis

**Hypothesis 1:** Psychosocial outcomes of Child Sexual Abuse differ by the forms of Child sexual abuse

**Hypothesis 2:** Psychosocial outcomes of Child Sexual Abuse differ by nature of perpetrators' relation with the victim.

**Hypothesis 3:** Psychosocial outcomes of Child Sexual Abuse differ by the frequency of sexual abuse.

**Hypothesis 4:** There is significant relationship between the demographic factors (age, age at onset and school level), and length of stay in rehabilitation center, and psychosocial consequences of CSA.

**Hypothesis 5:** Each independent variable can uniquely predict change on psychosocial outcomes of child sexual abuse when their effects are examined in sequential combination

### 1.8. Scope of the Study

Geographically this study is limited to Addis Ababa city with specific focus on three child rehabilitation centers (OPRIFS, IFSO and Kechenie Child rehabilitation Center). The study mainly tried to cover the psychosocial consequences of child sexual abuse on survivor children in the study area. Thus, PTSD, social reactions, attributions about abuse, and eroticism among 105 sexually abused survivor children in the study area are assessed.

### 1.9. Limitation of the Study

Though this study tried to reveal existing psychological and social problems among sexual abuse survivor female children by employing a standardized instrument specifically designed for sexual abuse survivor children, it is important to note that it has some limitations. The participants are only taken from three children rehabilitation centers in Addis Ababa. Due to

the sensitive nature of the issue other organizations that are working on rehabilitation and caring of children didn't allow me to include their children in the study. This implied that the finding of this study only represents children who were participated in the study area; and thus, couldn't be used for generalization of other victim children who were not included in the study. Besides, the study merely focused on abuse survivor female children, but, the results could have been better if abuse survivor male children were included. In fact, this is partly due to minimum number of male survivors as opposed to female counter parts, as findings showed, as well as the closed organizational policy of some organizations that are working with rehabilitation of abuse survivor children to researchers. For instance, RETRUCK Ethiopia which is working on the rehabilitation of male abuse survivor children didn't allow me to take its clients as participants of this study. It is reasoned out by the head of the organization that they don't want to expose children to researchers and let them psychologically disturbed.

Moreover, since all measures were self report questionnaires which were based on views of the children only, self bias might have influenced the accuracy of the information given by the respondents. For some forms of sexual abuse, like non-contact forms, children might not remember for how long they faced them and this also influences the accuracy of the information. Thus, it is suggested that further investigation should be done using mixed method approach which include parents and/or significant others in the study. Finally, the study is also limited to tell the behavioral changes being observed among children who are taking psychosocial treatment in respective rehabilitation centers since its design is cross-sectional.

# CHAPTER TWO

# REVIEW OF RELATED LITERATURES

## 2.1. Scope and Nature of Child Sexual Abuse

As the National Child Traumatic Stress Network (NCTSN), (2009) defined; *Child Sexual abuse is any interaction between a child and an adult or older child in which the child is used for the sexual stimulation of the perpetrator or an observer.* It often involves direct physical contact, touching, kissing, fondling, rubbing, oral sex, or penetration of the vagina or anus. Sometimes a sex offender may receive gratification just by exposing himself to a child, or by observing or filming a child removing his or her clothes or exposing the child to pornography. Different researchers, (Finkehlor (1984) and smith (2002), gives slightly different explanation about child sexual abuse which becomes the base of developing operational understanding of the problem. For instance, according to Finkehlor (1984), child sexual abuse refers to sexual behavior between a child who is dependent and developmentally immature and an adult who is significantly older. Similarly, Smith (2002) also defined the term child sexual abuse as: "Child sexual abuse encompasses a lot of activities like exposing a child to verbal sexual advances, kissing children in a socially unacceptable manner, fondling or touching breasts, buttocks and genitals, exhibitionism, penetration of vagina or anus with sexual organs or with objects without the consent of the person. And hence, in this study child sexual abuse means contact and non-contact forms of sexual abuse, and attempted or completed oral, vaginal, anal intercourse with a person under the age of 18 including. Child sexual abuse typically occurs in private, under a cloak of secrecy, and most often produces no physical signs, making detection difficult (Finkelhor, 1994). Thus, unless secrecy is somehow broken, there is very little that can be done to protect many of the victims of sexual abuse or stop the offenders.

Epidemiological studies on child sexual abuse (CSA) consistently show that it continues to be a major global public health concern. The pioneering review of the prevalence studies of CSA from 1970 to 1990 (Finkelhor, 1994), and a similar review conducted over a decade later (Pereda et al., 2009), confirm that the international epidemiology of CSA is comparably prevalent. Though growing body of researchers believe that child sexual abuse is dangerously growing worldwide, prevalence rate of cases vary depending on studies done in different places and time. And it is difficult to determine its prevalence for a variety of reasons and estimates vary considerably. Finkelhor (1994) found that internationally, estimates vary from between 7% and 36% for women, and 3% and 29% for men.

Although systematic and representative epidemiological studies on CSA are limited in Ethiopian context, some national and international organizations' reports as well as small scale studies show that the problem is on the increase (CSA-Ethiopia & ORC Macro USA, 2005; UNICEF, 2001). Notably also, rates of incest and abuse by family acquaintances are presumed to be high and have not been adequately researched or reported (MoLSA, 2005; UNICEF, 2001). A cross-sectional study conducted in Addis Ababa identified child sexual abuse prevalence rate of 38.5 % among the general public, out of which 29% were committed by victims' family members and 68% of them were victimized by adults that children knew (*Jibril J. et al, 2012*). A similar study done in South west Ethiopia also revealed that 68.7% of High School girls have reported that they were sexually abused including verbal or physical contacts (Dereje, Abebe & Jayalakshmi, 2005). In similar study samples of hospital reports showed that 61.7% of alleged sexual abuse cases were targeted against children. Nevertheless, the fact that few researches being conducted; negative societal attitude of reporting the incidence and limited access to health

facilitates created difficulty in presenting accurate estimation of child sexual abuse in developing countries including sub-Saharan Africa (Lakew, 2001).

**2.2. Child Sexual Abuse and its Psychosocial Consequences**

The sexual abuse of children is a major societal problem because of its high prevalence and devastating impact on the victimized child (Babiker & Herbert, 1998). It affects both girls and boys in all kinds of neighborhoods and communities, and in countries around the world. Children who have been sexually abused often exhibit elevated anxiety, depressive symptomatology, inappropriate sexual behavior, nightmares, social withdrawal, sleep difficulties, anger, shame/guilt and school problems (Finkelhor, 1994). It may reveal numerous psychological, social, and behavioral difficulties in adults, ranging from poor self-esteem and depression to sexual disorders and post-traumatic stress disorder (Canton, 2010). As to the Briere & Elliott (1994) Research conducted over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences. And they pointed out childhood sexual abuse is a major risk factor for a variety of problems, both in the short term and in later adult functioning. Even if they described CSA is associated with both initial and long-term alterations in social functioning and difficulties in interpersonal relationships, they stated the absence of universal impact of sexual abuse. In this regard there is no certainty that any given person will develop any negative psychological response to sexual abuse. Thus, the extent of manifesting psychological problems after being sexually abused is results of undetermined number of variables about the circumstances of the abuse, individual and environmental factors that existed prior to, or occurred subsequent to the incidence (Briere & Elliott, 1994). In the same

token the journal of future for children (1994) noted that its consequence can be varied based on the nature of abuse, type, intensity, frequency, and duration of the offense.

### 2.2.1. Post Traumatic Stress Disorder

As to the American psychiatric Association (2000), PSTD is defined as an anxiety disorder characterized by a traumatic stress or leaving one to continuously have negative thoughts about the experience. Symptoms often appear within three months after a traumatic event, but may be delayed months or even years. The severity, proximity, and duration of a person's exposure to the traumatic event are the best predictors for determining who is most likely to develop PTSD (American Psychiatric Association, 2000). In this regard PSTD is assessed based on the age at onset, variations in nature, and frequency of child sexual abuse. Common symptoms that can be exhibited by the victims are: 1) Re-experiencing the traumatic event in their minds, 2) Avoidance of situations that remind them of the traumatic experience and numbing of general feelings,3) Arousal of emotions resulting from exposure to situations that remind them of the traumatic experience. In line with this, Ruby (2010) under Mental Health Today Bulletin of Indian Journal of Health and Well-being, reported that PTSD may cause avoidance of situations or activities that remind victims of the original trauma which may interfere with interpersonal relationships, or lead to marital conflict, divorce, or loss of job. Besides, it may result in feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs, hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

Different researchers described short and long-term traumatic impacts of Child sexual abuse. For instance, Wolfe V., Gentile & Wolfe D. (1989) investigated that children who have

been abused exhibit more posttraumatic fear, anxiety, and concentration problems than do their non abused peers. Similarly by taking clinical and nonclinical groups of adult sexual abuse survivors, Runtz (1991) have found more intrusive, avoidant, and arousal symptoms of PTSD among them than those not abused as children. Even if the incidence may have occurred months or years ago, it may seem occurring in the present rather than as a memory of the past event. In his research, Healing the incest wound; Courtois (1988), stated that flashbacks can be triggered by sexual stimuli or interactions, abusive behaviors by other adults, disclosure of one's abusive experiences to others, and reading or seeing sexual or violent media depictions. Repetitive intrusive thoughts of childhood sexual victimization among survivors of sexual abuse are disruptive. As to Courtois, these thoughts and recollections lead to themes of danger, humiliation, spontaneous sexual contact, guilt, and badness. In this regard, survivors of child sexual abuse had severe symptomology of intrusive thoughts, avoidance, hyper arousal, and sexual anxiety (Wondie et al., 2010; Feiring et al., 1999; Crouch et al., 1999; Chaffin & Shultz, 2001)

### 2.2.2. Attributions about Abuse

Various scholars of behavioral science believe that people make significant assumptions about themselves, others, the environment, and the future based upon childhood learning. This is because, the experiences of children who are abused are often negative, these assumptions and self-perceptions typically reflect an overestimation of the amount of danger or adversity in the world and an underestimation of the abuse survivors' self-efficacy and self-worth. In this regard by reviewing variety of studies, Peacock (1989) revealed that chronic self-perceptions of helplessness and hopelessness, impaired trust, self-blame, and low self-esteem are reflected in abused children. As agents of socialization are various and children encounter such abusive

experiences anytime and anywhere, negative thoughts probably arise from multiple sources including psychological reactions to abuse specific events, stigmatization of the victim by the abuser and society, and the victim's attempt to make sense of his or her maltreatment (Finkelhor, & Browne, 1985). As it is briefly elaborated by Briere (1992) chronic perceptions of helplessness and danger are thought to result from the fact that the child abuse occurred when the victim was physically and psychologically unable to resist or defend against the abuser. The researcher stated the potential vulnerability of the survivor is results of expectation of injury that has a capacity to lead to overreaction to real, potential, or imagined threats. In this point of view, the victim's perception of the world as dangerous and developing disempowered feeling to oneself is determined by the growing negative assumptions; like, thinking that he or she is without recourse or options under a widening variety of circumstances. Because such experiences are often chronic and ongoing, feelings of hopelessness regarding the future are also likely. Evidently, Wondie et al., 2010; Feiring et al., 1999; Crouch et al., 1999; Chaffin & Shultz 2001), supported that sexual abuse survivors have more Symptomology of feelings of the world as dangerous and exposed to further danger. Similarly, the child may make assumptions about his or her inherent badness, based on misinterpretation of abuse as, in fact, punishment for unknown transgressions (Briere, 1992). Beyond the victim's dangerous view of the world, researchers stated that, the abuse leads to subsequent guilt, low self-esteem, self -blame and other dysfunctional attributions. Pellegrine (1991) found that women with the history of sexual abuse were likely to attribute the cause of negative events to internal and their behavior while tending attribute the cause of good events to external factors by thinking that "this negative event occurred because I am an inherently bad person and I will never change".

### 2.2.3. Sexual Anxiety

Child sexual abuse is, by its nature threatening and disruptive, and may interfere with the child's developing sense of security and belief in a safe, just world (Birere, 1992). Thus, victims of such abuse are prone to chronic feelings of fearfulness or anxiety. As anxiety frequency has conditioned component, by taking clinicians' suggestion, Berliner & Wheeler (1987) stated that a learned association may form between various social or stimuli and danger. In this sense, formerly abused individual may become anxious in the presence of intimate relationships. As Meiselman (1978) depicted in his findings on psychological study of causes and effects with treatment recommendations, *"conditioned abuse –related fear among adult survivors results to sexual dysfunction"*. Furthermore, it is elaborated that child sexual abuse is likely to create an association between sexual stimuli and invasion or pain which results fear or anxiety related difficulties during sexual contact. The finding presented statistical support to the above argument describing 87% of clinical sample of adults molested as children had "serious" sexual problems, as opposed to 20% of those clients without a sexual abuse history. Similarly, a study conducted by groups of researchers (Wondie et al., 2010; Feiring et al., 1999Crouch et al., 1999, Chaffin & Shultz, 2001) in different time period indicated that sexual abuse survivors had severe problems of sexual anxiety. Besides, Maltz et al., (1987) described that 60% of the incest survivors reported pain during sexual intercourse, and 48% were unable to experience orgasms during sex. Many studies also showed connection between childhood sexual abuse and sexual problems or dysfunction in childhood, adolescence, and adulthood.

### 2.2.4. Eroticism

Clinicians stated that adolescents and adults molested as children are prone to episodes of frequent, short-term sexual activity, often with a number of different sexual partners (Meiselman, 1978). Sexual arousal and positive sexual attention can temporarily mask or dispel chronic abuse-related emotional pain by providing more pleasurable or distress-incompatible experiences. For such individuals, frequent sexual activity may represent a consciously or unconsciously chosen coping mechanism, invoked specifically to control painful internal experience. Sexually abused children are consistently reported to have more sexual behavior problems than non abused children (Kolko et al., 1968). On the other hand, the findings of (Wondie et al., 2010; Feiring et al., 1999; Crouch et al., 1999; Chaffin & Shultz2001) showed slight sexual feelings among sexual abuse survivor children. Although some kinds of sexual behaviors are quite common among non abused children (for example, kissing, touching genitals manually), as to Gil & Johnson (1993) sexually abused children tend to engage in a greater number of sexual behaviors than their non abused peers, many of which are developmentally precocious and seemingly imitative of adult sexual activity.

### 2.2.5. Social Reactions

In his paper, *Child Abuse trauma: Theory and treatment of lasting effects,* Birere (1992) described as child sexual abuse is associated with both initial and long-term alterations in social functioning. Thus, immediate cognitive and conditioned responses to victimization lead to interpersonal difficulties. Ultimately, this may lead to distrust of others, anger and fear of those with greater power, concerns about abandonment, perceptions of justice (Birere, 1992). Besides, Survivors of sexual abuse develop negative reaction to others because of violation and betrayal

of boundaries in their former relationships (Birere, 1992). Even if survivors may commonly experience such feelings, Birere, (1992), pointed out that, negative reactions to others are more prominent when the victimization begins at an especially early age, lasts over an extended period of time, or occurs within the nuclear family. Likewise, (Wondie et al., 2010; Feiring et al., 1999; Crouch et al., 1999; Chaffin & Shultz, 2001) by employing the same instrument (CITES-R), described that perception of negative reactions by others is common problem among the sexual abuse survivor children. As a result of such negative reaction to others, as stated by Friedrich et al., (1986) sexually abused children tend to be less socially competent, more aggressive, and more socially withdrawn than non abused children. This is because they perceive themselves as different from others and tends to be less trusting of those who are in their immediate environment; they have fewer friends during childhood, less satisfaction in relationships, and less closer with their parents (Moore et al., 1991).

### 2.3 Relationship between Age at Onset of Abuse and Psychosocial Problems

The age of onset of childhood sexual abuse is reported with great consistency as occurring most frequently between 7 and 10 years of age (Elliott, 1995). Similarly, Finklelhor (1994) described 7 to 13 years of age as peak age of vulnerability though victimization can occur at any age and abuse under age of 6 is particularly undercounted because children do not disclose it. In relation to association between exposure to CSA and emergence of psychosocial problems among survivors, different studies have been conducted and didn't have the same generalizations. For instance, in his paper "The persisting negative effects of incest", Courtois (1983) put as determining temporal relationship between CSA and onset of psychological problems is difficult because; CSA usually occurs in individuals who have been, or will be, exposed to multiple other forms of trauma. Similarly, Teicher et al., (2008) described difficulty

of pointing out the exact length of time between exposure to CSA and Development of major psychological by listing several possibilities for the emergence of such problems at any time. 1) Psychological problems including, PTSD follow rapidly, on the heels of exposure to CSA; 2) it emerges after the exposure or risk of exposure to CSA has abated; 3) the third possibility is that CSA doesn't directly lead to depression but that it sensitizes the individual, enhancing risk of developing depression as one passes through adolescence in to middle age as part of a nueromaturational process; 4) and CSA could both sensitize and accelerate the process leading to earlier age at onset if the survivor with multiple forms of abuse. Thus, the above possibilities imply that episodes of major depression or PTSD didn't immediately occur following exposure to CSA; but takes several years to emerge. Furthermore, the onset of such problems didn't directly coincide with the abatement of CSA. Rather, Ticher et al., (2008) stated the existence of a long holdup between exposure to CSA and onset of depression or PTSD, which can occur between 12 and 15 years of age. On the other hand, it doesn't mean that a child who experienced CSA is out of danger if she didn't develop depression or PTSD during, or within months of, her period of exposure (Ticher et al, 2008).

Even if the emergence of specific types of psychological and social problems among survivors of sexual abuse are dependent up on duration and frequency, use of force, severity of abuse, the perpetrators relationship with victim, Teicher et al., (2008) pointed out that survivors develop depression, suicidal ideation, PTSD, Sexual anxiety, inappropriate sexual behavior, and internalizing and externalizing problems in 6-12 years of age. Besides, the researcher showed additional outcomes of CSA among survivor children in 13-17 years of age. Survivor adolescents, beyond children at middle childhood, can experience developing risky sexual behaviors, substance use, pregnancy and other undesirable behaviors. In fact, Cohen et al.,

(1999) described as traumatic effects of CSA decrease as children passes to higher developmental stages of life by noting "survivor children become less upset by sex related issues when they get older". Trimblay et al., (1999) also mentioned the supportive role of significant others in reducing traumatic effects of CSA among survivor children both at middle childhood and adolescence; thus, supportive parents and friends are associated with a more positive self-worth and fewer externalizing problems.

**2.4. Perpetrators Relation with the Victim and Psychosocial Problems**

Various research findings done across societies, in different time period, revealed that perpetrators profile can range from close family members to strangers. In this regard, some estimates revealed that out of the total reported child sexual abuse, 50% of them were abused by someone the children know, close and trusted while about 30-40% was committed by family members (incest) but the remaining 10-20% of the children were abused by strangers (Wolfe & Gentile, 1989). Similarly, Jibril et al, (2012) described that greater number of perpetrators are someone closely known by the victims. Accordingly, family members, relatives, neighbors, friends, teachers, employers, friends teachers in general constitute 73.4% of all abusers. But the remaining 26.6% of perpetrators were reported to be the strangers the children never met before (jibril et al., 2012). With clear and typical categorization of perpetrators as members from extra or intra family, Feirnig, Taska, and Lewis (2002), investigated that majority (60%) of respondents were abused by members from intra-family, but the remaining respondents were abused by members from extra family. As Freyd (1996) strengthened by stating that, *"Child Sexual Abuse (for most victims) involves a profound betrayal of trust by someone on whom the child must depend, and to whom they must entrust their physical care and safety"*,the perpetrator of child sexual abuse is most commonly known figure or other close relative.

For the sake observing psychosocial impacts of perpetrators relationship with the victim, in this paper, the abusers are classified in broader category of intra-familial and extra-familial. In this regard different researchers pointed out that being abused by someone member of family has profound psychosocial impact than being abused by strangers, in fact, both have their own negative consequences. For instance, Finkelhor, 1986, stated that the effect of sexual abuse is more severe when the perpetrator is the father or a close family member. Similarly, Bennett et al., 2000 found that abuse by a family member, contrarily to a stranger, leads to long-term negative consequences and high levels of distress. On the other hand, Feinauer (1989) come out with different results and described that victims abused by an extra familial perpetrator, compared to those abused by family members, reported higher levels of psychosocial problems. Regarding such discrepancy, Faust et al., (1995) explanation can be taken as alternative view for afro-mentioned arguments. They stated that child sexual abuse related symptoms cannot unequivocally be related to the perpetrator's relationship with the victim, but demographic family variables and the functioning of the family can further clarify the severity of symptoms. Similarly, Gregory (1989) added that later psychological adjustment is affected by such circumstances surrounding the sexual victimization as the types and severity of the sexual acts experienced, whether or not force or violence was involved, the age of onset of the abuse, its frequency and duration. For instance, specifically he tried to show; as feelings of betrayal can be greater when children are abused by a trusted neighbor than abused by a distant uncle or grandfather. Brown and Finkelhor (1986) have also provided that how closely related the victim is to the offender does not necessarily reflect how much betrayal is involved in the abuse. On the other side, still, many researchers showed greater severity of intra familial abuse over the extra familial. For instance, the National Child Traumatic Stress Network (2009) stated that being

abused by someone who are supposed to protect them from harm, destroys the ability to trust and relay on adults. And children are more likely to blame themselves for the abuse than those who are abused by someone outside the family unit. Additionally, in relation to development of guilty feeling, self blame and faulty attributions Pellegrin (1991) stressed the importance of Cognitive factors like, the victim child's perception of the abuse and attribution style. McLeer et al., (1989) also showed greater effects of intra -familial abuse as compared to extra familial abuse by stating *sexually abused children experience greater psychosocial problems when the abuse has been perpetrated by a father/stepfather and when the abuse involves physical force and/or invasive contact such as penile penetration.* In the same way Brown and Folkehor, (1986) described multifaceted effects of abusing children being member loved family member. As to them, the victim child losses good image of the offending parent or family member, trust, a sense of safety in the world, develop feelings of guilt and loneliness.

### 2.5. Severity, Frequency of Abuse and Psychosocial Problems

As described in the previous section of this paper, severity of abuse is generally taken to express the spectrum that ranges from non-contact forms of sexual abuse (e.g. verbal sexual invitations, showing pornography), to contact forms of abuse (touching), through to intercourse. In their study on 147 abuse survivor children who were taking treatment in Children protective services (CPS), Feiring and Taska (2002), described that intercourse, the most serious forms of sexual abuse is the most common forms of sexual abuse among the sexual abuse survivors. Conversely, it is reported as the least common forms of sexual abuse, instead, contact and non-contact forms of CSA are most common forms of CSA (Fergusson and Mullen, 1999). Regardless of their prevalence, these forms of sexual abuse didn't have the same psychosocial effect on the victim children, when the form of abuse gets severe; it has long lasting

psychological consequences. In this regard, McLeer et al., (1989) described that sexually abused children experience greater psychosocial problems when the abuse involves physical force and/or invasive contact such as penile penetration. Kendler et al., (2000) further described that being exposed to more forms of sexual abuse increases risk of developing psychosocial problems and pointed out as CSA involving contact or intercourse is associated with more negative psychological outcomes than non-contact form of CSA. Besides, Fergusson and Mullen (1999) added that psychosocial outcomes vary with the level of exposure; the risk is highest for those who have experienced abuse involving intercourse. Saunders et al., (1999) also put that risk of PTSD was significantly higher for penetrative abuse than contact abuse.

Since Child Sexual Abuse is kept in great secrecy following the victim's fear of the implied or explicit consequences of disclosing the secret, the possibility for facing more than one time abuse is high. In relation to frequency of sexual abuse, Feiring Taska, and Lewis (2012), found that 31% of respondents were abused once in a year, 38% once in a month, and 31% once in a week. Several studies have reported that not only is re-abused common, it is also associated with poorer outcome. In relation to this; Kendler et al., (2000) described that poor psychological and behavioral outcomes in children were related to a variety of abuse-related variables, including greater abuse frequency. Furthermore, Bagley et al. (1995), clearly showed as increasing rates in frequency of abuse have significant association with greater severity of psychological disorder, such as making more numerous suicide attempts. This is consistent with the notion that cumulative trauma has a more substantial effect than a single or less frequent abusive event. On the other study of school girls, Sadowski et al., (2003) found that abuse characteristics (i.e., severity of abuse, frequency of abuse, and age at onset) are associated with separation anxiety disorder, major depressive disorder, and PTSD symptoms. Besides, they

showed that children who experienced a more severe form of abuse (e.g., penetration), scored significantly higher on scales of internalizing and externalizing behavior problems than children who experienced a less severe form of abuse (e.g., fondling), even, this pattern remained consistent from pre-to post treatment. This implies that children who experience more severe forms of sexual abuse remain at higher risk for behavior problems following treatment than those who experience less severe forms of sexual abuse. On the other side, even if it is generally acknowledged as frequency of abuse is associated with more negative outcome, very few studies reported that outcomes vary depending on the nature of sexual abuse itself.

# CHAPTER THREE

# RESEARCH METHODS

## 3.1. Research Design

The study employed quantitative approach and cross sectional research design with the function of description, explanation and prediction. The selected independent variables are demographic variables (age, age at onset of sexual abuse, and educational level), length of stay in the rehabilitation center, forms and frequency of sexual abuse, and the nature of perpetrators affiliation with the victim. The dependent variables are psychosocial consequences of child sexual abuse (PTSD, social reactions, attributions about abuse and eroticism). Quantitative method is preferred to qualitative method because it objectively measures variables under the study, tests the research hypothesis, and properly addresses the objectives of the study.

## 3.2. Participant Selection Criteria

In this study participants who are living in safe homes of each rehabilitation centers and who are victim of any forms of sexual abuse were selected. Only children who disclosed sexual abuse for the professional caretaker are participated in the study. In fact, they are actually taking counseling and their general profile was known by the counselors of the respective rehabilitation center, and they met the criteria. The children who have also stayed at least 4 weeks in the rehabilitation center are included in the study. A minimum of 4 weeks are set by American Psychiatric Association, (2000) to diagnose PTSD. After obtaining potential participants who meet the inclusion criteria, those who voluntarily agreed and gave consent are taken as the participants of the study.

### 3.3. Participants of the Study

The participants of this study are sexual abuse survivor female children in three child rehabilitation Centers; namely OPRIFS, IFSO and Kechene Child Rehabilitation Center. The total numbers of sexual abuse survivors who reside in OPRIFS are 81. Out of these children 69 met inclusion criteria and they voluntarily agreed to participate in the study. On the IFSO's side, among 30 children who are living in the safe home, 21 met inclusion criteria and agreed to participate in the study. On the other hand, 22 children were identified as sexual abuse survivor by the counselors of Kechenie Children rehabilitation center, but only 15 children met the inclusion criteria and voluntarily agreed to take part in the study. Therefore, the study participants are limited to 105 female sexual abuse survivor children living in the afore-mentioned safe homes of rehabilitation centers and who are taking regular psychosocial counseling services.

### 3.4. Data Collection Methods and Procedures

This study employed a survey questionnaire adopted from the African Child Policy Forum (ACPF), and *International Society for the Prevention of Child Abuse and Neglect (ISPCAN)*. The items are devised to know, type and frequency of Child sexual abuse, and perpetrators affiliation with the victim. Additionally the study used standardized instrument of '*The Children's Impact of Traumatic Events Scale-Revised (CITES-R)*'. The CITES-R is a 78-item standardized instrument specifically designed for sexually abused children. It measures such comprehensive dimensions as PTSD symptoms (i.e. intrusive thoughts, avoidance, hyper arousal and sexual anxiety), eroticism, and social reactions (i.e., social support and negative reactions by others) and abuse attributions (personal vulnerability, self-blame/guilt, a perception of the world

as dangerous, and empowerment). The respondents were asked to rate their experiences, on a scale of 1 to 3, feelings or opinions as 1 = *not true*, 2 = *somewhat true*, or 3 = *very true*.

The questionnaire adopted from the African Child Policy Forum (ACPF), and *International Society for the Prevention of Child Abuse and Neglect (ISPCAN)* has Amharic version and I directly used it; but the English versions of CITES-R was first translated into Amharic. This translation was then given to an Amharic-language expert to do back translation and ensure the accuracy of the first translation. The Amharic version was then given to an English-language expert who translated them back into English. Finally, the discrepancies between the two translations were resolved.

Two female counselors from OPRIFS, a male counselor from IFSO, and two female counselors from Kechenie child rehabilitation center collected the data from the participants. Since exposing sexual abuse survivor children to external person is unethical, counselors of each rehabilitation center assisted the children to fill the questionnaire. I clearly elaborated and oriented about the content of each items in the data collection instruments to the counselors and kept frequent contact with them. In this manner, the data collection procedure has been completed.

**3.5 Validity and Rreliability Test**

The validity of findings or data is traditionally understood as the correctness or precision of the data collection instrument (Ritchie &Lewis, 2003). In relation to the validity of the quantitative data, the instrument content wise was checked with thesis research advisor. Each item of the questionnaire was commented by the advisor and some items (from a survey questionnaire adopted from the African Child Policy Forum (ACPF), and *International Society for the Prevention of Child Abuse and Neglect (ISPCAN)* were discarded since the items were

unrelated with what was intended to measure. Besides, its validity is assured by other experts to ensure the clarity and absence of vague and confusing words.

**Table: 1 Summary of Cronbach's Alpha Reliability**

| | CITES-R | No. of items | Reliability* |
|---|---|---|---|
| Main scales | Sub-scales | | |
| Attributions about abuse | | 33 | .887 |
| | Dangerous world | 5 | .915 |
| | Empowerment | 7 | .891 |
| | Personal Vulnerability | 9 | .873 |
| | Self-blame/Guilt | 12 | .871 |
| PSTD | | 26 | .878 |
| | Sexual Anxiety | 5 | .886 |
| | Hyper arousal | 6 | .880 |
| | Avoidance | 8 | .874 |
| | Intrusive thoughts | 7 | .874 |
| Social Reactions | | 15 | .883 |
| | Social support | 6 | .892 |
| | Negative reactions by others | 9 | .875 |
| Eroticism | | 4 | .881 |
| Total | | 78 | .894 |

**Chronbach Alpha*

The reliability coefficient r is expressed as a number ranging between 0 and 1.00, with r = 0 indicating no reliability, r = 1.00 indicating perfect reliability, r=0.90 and above indicating excellent reliability, r=0.80 - 0.89 very good reliability, r=0.7-0.79 adequate reliability, and below 0.7 may have limited applicability (Robert, 1997). Studies employing this instrument

reported internal consistencies ranging from .60 to .93 for the CITES_R scales and subscales (Wondie et al., 2010). For this study, cumulative reliability of 78 items was tested using SPSS and indicated almost excellent reliability with Cronbach's alpha= .894; which implies that items included in the scale have almost strong internal consistency in measuring psychosocial outcomes of child sexual abuse on abuse survivor children in the study area. Thus, the instrument, which included four main scales and 11 sub-scales with three point likert scale, is suitable and used to measure psychosocial consequences of child sexual abuse. Detail description of each main scales and subscales' reliability is listed in table 1.

### 3.6. Data Analysis

The quantitative data collected from 105 abuse survivor children of the three rehabilitation centers were analyzed using univarate, bivariate and multivariate data analysis. Firstly, all independent variables (demographic data, length of stay in the rehabilitation center, forms and frequency of sexual abuse, the nature of perpetrators relation with the victim), and dependent variable (psychosocial consequences of child sexual abuse i.e. PSTD, attributions about abuse, social reactions, and eroticism) were analyzed and reported in percentages, measures of central tendency (mean), and measures of dispersion (standard deviation and range) as univarate analysis. Secondly, so as to study bivariate and multivariate analysis correlation and multiple regressions, as well as One-way analysis of variance (ANOVA) were used to measure the relative predication of the independent variables over the dependent variable, and to measure the contribution of independent variables in explaining the variation in the dependent variable. Besides, hierarchical multiple regressions are used to test combined effect of independent variables on outcomes of dependent variable. Before performing data analysis using, correlation, regression models and One-way analysis of Variance (ANOVA), a test was conducted to

determine if the assumptions for regression models and One-way Analysis of variance were met. Data was entered and analyzed using Statistical Package for Social Sciences (SPSS) version 20 computer application program.

### 3.7. Ethical Considerations

In the progress of research, researchers need to respect the participants and the sites for research (Creswell, 2007). Initially, after the approval of the proposal, received a support letter from the school of Social Work which indicates who am I and what I was doing. Primarily, I contacted with the head of each rehabilitation centers and asked permission from them by describing the purpose of the research. Even if they were happy by the purpose of the research, they described that the center do not want to expose clients to external person, and do not let them be part of the study since it may aggravate traumatic events that happened earlier. So, to harmonize such ethical issues of the center and the researchers desire to conduct research in this kind of sensitive research area, the researcher decided the data collection process has to be done by the counselors of each rehabilitation centers. Because when data is collected by counselors of the center, the clients are not exposed to external researcher and, as the same time counselors can handle problems related to exacerbating of trauma during data collection among clients. In this manner then, the purpose of the research was clearly communicated to participants and let them know to withdraw if they get discomfort in the progress of their participation. In doing so, the necessary information that enables the respondents to participate or withdraw is given and informed consent was obtained from them. Confidentiality and anonymity was ensure because it was impossible to know who said what without their consent by the external person. By and large, the interest of participants was given due place in the process and nothing was made that

hurts the participants physically and socially. Their dignity and privacy was also highly maintained.

# CHAPTER FOUR

# FINDINGS

This chapter presents quantitative findings obtained from children survey collected from sexual abuse survivor female children in three rehabilitation centers (OPRIFS, IFSO, and Kechene children rehabilitation centers). The demographic variables (age, age at onset of sexual abuse, and school level), and length of stay in the rehabilitation centers are presented and used as input for further simple and multiple regression analysis. Besides, results of descriptive and inferential statistics on forms of sexual abuse and the nature of perpetrators affiliation to the victim children, and their various level of influence on dependent variable are presented. Therefore, the following sections provided findings supported by descriptive and inferential statistics on variables mentioned above.

## 4.1. Demographic Characteristics of Respondents

Data from 105 victim children was examined to see the demographic variables of victim children, their relationship with the perpetrators, nature and frequency of abuse, length of stay in the rehabilitation center, and the psychosocial outcomes of sexual abuse on respondents. As it is indicated in table 2, the age of respondents ranged from 11-17 years. The average age was 14.38 years. The primary source of information about age at onset of abuse was the victim. During the course of this study, victims were asked to describe the first time the offender sexually abused them. Accordingly, minimum and maximum age at onset of sexual abuse were found to be 7 and 15 year, respectively; with 12.09 mean year of age at onset. Grade 8 is the highest educational level of respondents. Regarding the length of stay in the rehabilitation center, 6 and 25 are minimum and maximum months, respectively with mean (M=12.95, SD=4.025) month of stay.

**Table 2: Description of demographic variables and program factor (N=105)**

| Variables | N | Minimum | Maximum | Mean | SD |
|---|---|---|---|---|---|
| Age | 105 | 11 | 17 | 14.38 | 1.689 |
| Age at onset of abuse | 105 | 7 | 15 | 12.09 | 1.878 |
| Educational level | 105 | 0 | 8 | 3.85 | 2.421 |
| Length of stay in the rehabilitation center | 105 | 6 | 25 | 12.95 | 4.25 |

### 4.2. Descriptive Statistics on Forms of Sexual Abuse and the Nature of Perpetrators Relation with Victim

Even if CSA can vary along a number of dimensions, including frequency, duration, age at onset and relationship of victim with the perpetrator, forms of abuse also plays significant role in determining the victim's psychosocial status

**Table 3: Descriptive statistics of forms of sexual abuse and perpetrators relation with the victim (N=105).**

| Forms of sexual abuse | Members of intra-family | | Members of extra-family | | Members from both intra and extra family | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Frq | % | Frq | % | Frq | % | Frq | % |
| Contact only | 5 | 4.8 | 9 | 8.6 | 0 | 0 | 14 | 13.3 |
| Non-contact only | 5 | 4.8 | 7 | 6.7 | 1 | 1.0 | 13 | 12.4 |
| Intercourse only | 6 | 5.7 | 44 | 41.9 | 5 | 4.8 | 55 | 52.4 |
| Multiple forms | 4 | 3.8 | 11 | 10.5 | 8 | 7.6 | 23 | 21.9 |
| Total | 20 | 19.0 | 71 | 67.6 | 14 | 13.4 | 105 | 100 |

. With respect to forms of sexual abuse the respondents faced, this study revealed that, 52.4% of the respondents faced sexual intercourse in their childhood age, 21.9% of them had experienced multiple forms of abuse, and the rest 13.3%, and 12.4% had faced contact and non-contact forms of sexual abuse, respectively.

For each forms of sexual abuse, there are people out there who are involved in such immoral acts. The natures of perpetrator's are presented in table 5, classified into members of intra family, extra family, and members of both intra and extra family. In relation to non-contact forms of sexual abuse, 67% of respondents reported that the perpetrators are from the members of extra-family, and 4.8% of them reported that they are abused by members from intra-family. The remaining 1.0% of the respondents reported that they are abused by both members of intra and extra family. Regarding the contact forms of sexual abuse, 8.6% of respondents reported that they were touched or pinched on their breasts, buttocks, or genitals, by the members of extra-family, while 4.8% of respondents reported that such forms of sexual abuse are done by members from intra-family. Sexual intercourse is the other, perhaps the severe, forms of CSA. Based on the self reports of respondents 41.9% of respondents reported that the perpetrators of this form of abuse are members of extra-family, 5.7% of respondents reported as they had sexual intercourse with members of inter-family, and 4.8% of the respondents reported that the perpetrators are from both intra and extra family members. But, the rest 47.6% of respondents reported that they had no sexual intercourse with any of them. Nevertheless, this doesn't imply they didn't face CSA because they can be victims of other forms of sexual abuse. On the other hand, 10.5% of respondents reported that they faced multiple or more than one forms of sexual abuse by members from extra family, 7.6% of respondents also reported that perpetrators of such

abuse were both members of intra and extra family, and 3.8% of respondents reported that they are abused by members from intra-familial unit.

Thus, based on the above report, from all forms of sexual abuse, relatively the largest portion of victims (8.6% for contact, 6.7% for non-contact form, 41.9% for sexual intercourse, and 10.5% for multiple forms of sexual abuse) are abused by perpetrators from members of extra-family. On the contrary, 1% of respondents (for non-contact), 4.8% of them (intercourse), and 7.6% of respondents (for multiple forms), were abused by members from both intra and extra family. Overall, for all forms of sexual abuse, 67.6% of respondents reported that they were abused by members from extra family. Whereas, 19% and 13.3% of respondents reported that they were abused by members from intra family, and members from both intra and extra family, respectively.

### 4.3. Frequency of Child Sexual Abuse

Based on the data obtained from respondents of this study, the victims have experienced different forms of sexual abuse with various rates of occurrences. In line with this, for the contact form of CSA, 3.8% of respondents reported that they experienced sexual abuse once in a month, 4.8% once in 3 months, 1.9 % once in a week and 2.9% of them are abused once in six months. For the non-contact form of CSA, 2.9% of respondents reported that they experienced sexual abuse once in six months, and 3.8% of respondents experienced sexual abuse once in 3 months. Besides, 4.8% and 1.0% of the respondents reported that they experienced sexual abuse once in a month and week, respectively. With regard to the third forms of CSA, intercourse, 10.5% once in a year, 20.0% of the respondents reported that they experienced sexual abuse once in six months, 13.1% once in 3 months, 7.6% once in a month, , and 1.9% in a week. On the other hand, 2.9% of the respondents reported that they faced multiple forms of sexual abuse once in six

months, 4.8% of respondents reported that they experienced multiple forms of sexual abuse once in 3 months, and 10.5% and 3.8% of respondents had faced multiple abuse once a month and weekly base, respectively. Entirely, for all forms of abuse, 10.5% of the respondents reported that they were abused once a year, 28.5% of them were abused in six months, and proportionally equal number of (N=28) respondents reported that they were abused once in a month and once in three months. The rest 8.6% of them were abused once in a week.

**Table 4: Descriptive statistics on forms and Frequency of CSA (N=105)**

| Forms of CSA | Once in a week | | Once in a month | | Once in 3 months | | Once in 6 months | | Once in a year | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Frq | % | Frq | % | Frq | % | Frq | % | Frq | % |
| Contact | 2 | 1.9 | 4 | 3.8 | 5 | 4.8 | 3 | 2.9 | 0 | 0.0 |
| Non-contact | 1 | 1.0 | 5 | 4.8 | 4 | 3.8 | 3 | 2.9 | 0 | 0.0 |
| Intercourse | 2 | 1.9 | 8 | 7.6 | 13 | 13.1 | 21 | 20.0 | 11 | 10.5 |
| Multiple forms | 4 | 3.8 | 11 | 10.5 | 5 | 4.8 | 3 | 2.9 | 0 | 0.0 |
| Total | 9 | 8.6 | 28 | 26.6 | 28 | 26.6 | 30 | 28.5 | 11 | 10.5 |

### 4. 4. Descriptive Statistics on Psychosocial Outcomes of Child Sexual Abuse

The findings obtained from the self-report survey of survivor children on dimensions of Children's Impact of Traumatic Event Scale-Revised (PTSD, Abuse Attributions, Social Reactions, and Eroticism) are described in sequence of their mean scores. As it is described in table 5 of next page, PSTD score 54.74 (M=2.10, SD=.50) is highest, followed by attributions about abuse score 64.51 (M=1.95, SD=.40), social reactions score 27.62 (M=1.84, SD=.46), and eroticism score 5.92 (M=1.48, SD=.61). For this instrument the minimum possible score is 78

and the maximum possible score is 234 which indicate the lowest and highest psychosocial problems among the survivor children of sexual abuse, respectively. This means, children who score 78 didn't show symptoms of social and psychological problems at all, while children who score 234 experienced highest symptoms of social and psychological problems. The total score (M=152.6) therefore, indicates that, the study participants' response on three point likert scale, for items that intended to measure PSTD, attributions about abuse, social reactions, and eroticism are almost somewhat true.

**Table 5: Results of overall sexual abuse measured by CITES-R (N=105).**

| Variables | N | Items | Min | Max | Mean | Std |
|---|---|---|---|---|---|---|
| PTSD | 105 | 26 | 30 | 78 | 54.74(2.10) | 13.00(.50) |
| Attributions about abuse | 105 | 33 | 44 | 95 | 64.51(1.95) | 13.27(.40) |
| Social reactions | 105 | 15 | 15 | 42 | 27.62 (1.84) | 7.02(.46) |
| Eroticism | 105 | 4 | 4 | 12 | 5.92(1.48) | 2.44(.61) |
| Total | 105 | 78 | 105 | 209 | 152.79(1.84) | 35.73(.49) |

With regard to the highest and lowest endorsement about consequences of child sexual abuse, 78 items are ranked based on the average ratings by respondents on three point likert scale, by which rating of 1 means "Not true" and 3 implies "Very true" . Accordingly, the mean score ranges from M=1.32 to M=2.81. Based on this, the item with the highest mean score (M=2.81, SD=.495) is "Perpetrator was to blame for what happened", whereas, the item with lowest mean score (M= 1.18, SD=.495) is "Social workers, police and/or doctors have helped me since I told about the sexual abuse". The item with the highest mean score indicates that most children blamed perpetrators for what happened. On the other hand, the item with the lowest

mean score implied that most sexual abuse survivor children negatively perceived social supports from social workers, police, and/or doctors after the disclosure of sexual abuse.

**Table 6: A highest and lowest item endorsements on Consequences of CSA on survivor children (N=105).**

| Rank | Top five items | N | Mean | SD |
|---|---|---|---|---|
| 1st | Perpetrator was to blame for what happened(AA) | 105 | 2.81 | .520 |
| 2nd | I feel I have to know people for a long time before I can trust them(AA) | 105 | 2.70 | .634 |
| 3rd | I have tried to forget about what happened(PSTD) | 105 | 2.59 | .566 |
| 4th | I try to stay away from things that remind me of what happened (PSTD) | 105 | 2.58 | .647 |
| 5th | Children shouldn't trust adults because they might sexually abuse them(AA) | 105 | 2.50 | .722 |
| **Rank** | **Bottom five items** | **N** | **Mean** | **SD** |
| 74th | I know enough about sexual abuse now that I can protect myself in the future (AA) | 105 | 1.45 | .650 |
| 75th | Things in my life will get better(AA) | 105 | 1.41 | .661 |
| 76th | Since people found out about the sexual abuse they have tried to protect me from it happening again(SR) | 105 | 1.38 | .594 |
| 77th | I have more sexual feelings than my friends (Ero) | 105 | 1.32 | .672 |
| 78th | Social workers, police and/or doctors have helped me since I told about the sexual abuse(SR) | 105 | 1.18 | .495 |

***AA=Attributions about abuse, PSTD= post traumatic stress disorder, SR= Social Reactions, Ero= Eroticism***

In relation to items belongingness, among the top five items, the 1st, 2nd and 5th item belong to attributions about abuse domains; specifically, to self-blame, personal vulnerability and dangerous world respectively. Whereas, the 3rd and the 4th item belongs to avoidance

component of post traumatic stress disorder. On the other hand, from the bottom five items, two of them (74th and 75th) are from Empowerment sub-scale, where as the 75th & 76th items are under social reactions domain, and 77th item is from eroticism.

### 4.4.1. Descriptive Statistics of Symptoms of PSTD among Sexual Abuse Survivor Children

Post traumatic stress disorder is one of the long-term psychological consequences of child sexual abuse. And its symptoms are manifested in terms of intrusive thoughts, avoidance, hyper arousal, and sexual anxiety. As it was described in the table 5 its total mean score is 54.74(2.10). Since it is 26-item scale, possible minimum and maximum score is 26(26*1) and 78(26*3) respectively. This indicates that children who scored 26 didn't show symptoms of PSTD, but those who scored 78 had highest symptoms of long-term psychological problems. Not that much far from possibly expected scores, 30 and 78 are reported as the actual minimum and maximum scores, respectively. The average score (M=2.10, SD= .5) for each item also indicated that on the three point likert-scale, respondents answer is "somewhat true"; which entails that the victim children are somewhat experiencing post- traumatic stress disorder due to their prior exposure to sexual abuse. It is further elaborated in its four components i.e. intrusive thoughts, avoidance, hyper arousal, and sexual anxiety, which have 7, 8, 6, and 5 items respectively.

As it is described in table 7 of page 56, avoidance is found to be with the highest mean scores M=17.57 (2.19) among the components of the PTSD. Both the possible and achieved maximum score (24) are found similar. Based on the mean score for each item, it is possible to infer that the respondents on three point likert-scale responded as "somewhat true"; which indicates using avoidance as defense mechanism to forget tragedy of the past or preferring not to

remember about the event and something related to it, is somewhat common among the victim children of the study area.

Hyper arousal and sexual anxiety are important components of PTSD, measured by 6 and 5 items, respectively. As it is depicted in table 7, the possible and actual minimum, as well as, maximum score for hyper arousal is 6(6*1) and 18(6*3), respectively. In the same token, 5(5*1) and 15(5*1) are actual minimum and maximum scores for sexual anxiety. The mean score for hyper arousal is found to be 12.39 with mean score for each item of 2.06, while the mean score for sexual anxiety is 10.60 with mean score for each item of 2.12. Even if there is slight difference among the mean score of each item, it is possible to infer that respondents' response on three point liket- scale, for both hyper arousal and sexual anxiety items, is "somewhat true". Thus, the mean score (M=2.06, SD= .59) indicated that survivor children of child sexual abuse in the study area are somewhat experiencing difficulty of concentration, irritable feelings, feelings of restlessness, or jumpy, and other symptoms of hyper arousal. Similarly, the mean score (M=2.12, SD=.46) implied that, to some extent, the abuse led them to develop fear and anxiety when they think of sex.

Moreover, re-experiencing traumatic events in the minds of victim children are common symptoms of Post-traumatic Stress Disorder. To measure such long-term symptoms among the victim children, 7 items are employed under intrusive thoughts category. As it is indicated in table7 of next page, the minimum and maximum scores are 7 and 21 respectively, which is almost similar with the actual 8 and 21 respective scores. Besides, the respondents' report showed that the mean score is 14.18 with mean score (M=2.02, SD=.48) of each items, which is the lowest score when compared with the other components of PTSD. Even though it is ranked

lastly in its mean score (M=2.02) for each items, statistically it showed that, on average, respondents' response on three point liker-scale falls under the option "somewhat true". Thus, the finding of this study signified that the victim children are somewhat troubled with intrusive thoughts like, flash backs, memories, bad dreams and images related to traumatic events. In general, the finding on the symptoms of Post Traumatic Stress Disorder(PSTD) among the child sexual abuse survivor children in the study showed that, to some extent, victim children have developed symptoms of avoidance, intrusive thoughts, hyper arousal, and sexual anxiety.

**Table 7: Descriptive results of symptoms of PSTD among abuse survivor children (N=105).**

| Post Traumatic Stress Disorder | N | Item | Min | Max | Mean | Std |
|---|---|---|---|---|---|---|
| Avoidance | 105 | 8 | 11 | 24 | 17.57(2.19) | 3.72(.46) |
| Sexual Anxiety | 105 | 5 | 5 | 15 | 10.60(2.12) | 2.33(.46) |
| Hyper Arousal | 105 | 6 | 6 | 18 | 12.39(2.06) | 3.54(.59) |
| Intrusive Thoughts | 105 | 7 | 8 | 21 | 14.18(2.02) | 3.41(.48) |
| Total | 105 | 26 | 30 | 78 | 54.74(2.10) | 13(.50) |

### 4.4.2. Descriptive Statistics on Attributions of Survivor children about Abuse

Attributions about abuse are one of the main scales in CITES-R with 33 items, and it is composed of four components (self-blame/guilt, personal vulnerability, dangerous world, and empowerment). As it was described in the table 5 (page 52), it is the second highest score with possible minimum score 33 and maximum possible score 99. In fact, the actual minimum score found is 44 and the maximum score is 95. Thus, children who scored 44 have developed less distorted perception due to abuse than those who scored 95. As the self reports' of the respondents showed, the mean score (M=64.51) with mean item score of (M=1.95, SD=.40), implies children's response option on three point likert-type scale is almost "somewhat true".

Thus, the finding with regard to attributions about abuse indicated that, on average, abuse survivor children's feeling of self-blame/guilt, personal vulnerability, perception of the world as dangerous is almost somewhat true; and children have developed distorted perception following sexual abuse. Detail description of the components that measured self blame/guilt, personal vulnerability, perception of world as dangerous, and empowerment among survivor children is illustrated in table 8 of page 58.

The five-item component constructed to measure respondent children's perception about the world showed that, on average, children perceives the world as "dangerous" and as there are many people out there who do bad things to children. As it is depicted in 8, the maximum score is 15 while the minimum score is found to be 8, with mean score of (M=2.38, SD=.46) for each item.

Self-blame/guilt is also one of the components, in attributions about abuse scale, where 12 items are designed to investigate children's attribution to the abuse. The possible minimum and maximum score is 12(12*1) and 36(12*3), respectively. Accordingly, the respondents' report showed that the actual maximum score is similar with possible maximum score with the average score of 2.01 for each item. Thus, for the three point likert scale, the mean value (M=2.01) implies that the response option of "somewhat true". By implication the finding showed that, on average the respondents' internal attribution about abuse, or self- blaming/guilty feeling is somewhat reflected.

Furthermore, Personal vulnerability is another component with 9 items designed to measure attributions about abuse in which the mean score is M=1.92, SD= .39. For 9 items that measured personal vulnerability of the respondents, the actual maximum score was 27(9*3),

which is the same with the possible maximum score. The self-reports of the respondents also indicated that the 1.92 is the average score for each item, which signifies that on average, the respondents' response on three point likert scale is almost somewhat true. Thus, the respondents somewhat feel that they are not safe and don't trust others, they rather feel vulnerable and worry that they will be sexually abused again.

Empowerment, the forth component employed to measure victim children's attribution about abuse, indicated that the mean score for each item is (M=1.59, SD=.35). The mean score for each item is lower than mean score of perceiving of the world as dangerous and personal vulnerability, which shows that, they believe other people don't stop trying to abuse them/other children since they want to take advantage of children. In this regard, victim children may know about the sexual abuse and the ways how others trick them, which enables them, not to be easily re-victimized, but it is hard to conclude that they feel safer around adults or other potential perpetrators.

**Table 8: Descriptive results of attributions survivor children about abuse (N=105)**

| Attributions about abuse | N | Item | Min | Max | Mean | Std |
|---|---|---|---|---|---|---|
| Dangerous world | 105 | 5 | 8 | 15 | 11.90(2.38) | 2.33(.46) |
| Self-blame/guilt | 105 | 12 | 16 | 36 | 24.13(2.01) | 4.93(.41) |
| Personal vulnerability | 105 | 9 | 13 | 27 | 17.31(1.92) | 3.51(.39) |
| Empowerment | 105 | 7 | 7 | 17 | 11.17(1.59) | 2.50(.35) |
| Total | 105 | 33 | 44 | 95 | 64.51(1.95) | 13.27(.40) |

In general, the finding on attributions about abuse among the survivor children of sexual abuse in the study area showed that, averagely, even if they hoped their life will get better, they

blamed themselves for what happened, and they perceived that the world is not safe for them in a way to avert further abuse possibilities.

### 4.4.3. Descriptive Statistics on Social Reactions among the Sexual Abuse Survivor Children

Social reactions are among the attributes considered to be studied among the child sexual abuse survivors by the developer of CITES-R. This scale is designed to compose two sub-scales i.e. negative reaction by others and social support which have 9 and 6 items, respectively. High scores on negative reaction sub-scale reflect problematic reactions by others, but high score on social supports indicate a perception of positive support. In view of that, it is found that the achieved minimum and maximum score is 9 and 27 respectively for negative reaction by others. This showed that respondents who scored 9 didn't have problematic reactions by others but those who scored 27 indicated that they have problematic reactions by others. Besides, 17.55 is the mean score with mean item score of 1.95. Depending on the mean item score (M=1.95, SD=.55), it is possible to infer that, on average, on the three point likert-scale, the respondents' response is almost "somewhat true". And this showed that sexual abuse survivor children in the study area are somewhat experiencing negative reactions by others. On the other hand, the reports of social support sub-scale indicated, the actual minimum and maximum score is 6 and 15 respectively with mean score of 10.07. Thus, respondents who scored 6 confirmed that they have negative perception of social support; but respondents who scored 15 gives an idea that they have positive perception about social support. Likewise, the mean item score (M=1.67, SD=.33) implied that, on average, respondents' response on three point likert scale approached to "somewhat true". Therefore, sexual abuse survivor children in the study area, to some extent, have positive perception about the social support. In general, results of mean score for each item both for

experience of negative reaction by others and perception of social support showed that, to some extent, sexual abuse survivor children in the study area are simultaneously, experiencing both negative reaction by others and perception of positive social support

**Table 9: Descriptive results of social reactions among abuse survivor children(N=105).**

| Social Reactions | N | Item | Min | Max | Mean | Std |
|---|---|---|---|---|---|---|
| Negative Reaction by others | 105 | 9 | 9 | 27 | 17.55(1.95) | 5.00(.55) |
| Social support | 105 | 6 | 6 | 15 | 10.07(1.67) | 2.02(.33) |
| Total | 105 | 15 | 15 | 42 | 27.62 (1.84) | 7.02(.46) |

### 4.4.4. Descriptive Statistics of Eroticism among the Sexual Abuse Survivor Children

Within the realm of broader psychosocial consequences of child sexual abuse, Eroticism is one of the main scales having least number (4) of items. The actual minimum and maximum score is 4 and 12 respectively. And its mean score is found to be 5.92 with 1.48 mean score of each item, which is put at the last place in the hierarchy of main scales. As the mean item score (M=1.48, SD=.61) showed that respondents' response on three point likert scale is almost in between "not true" and "somewhat true". By implication, assuming other things remain constant, the finding on Eroticism of sexually abused survivor children in the study area indicated that they are hardly reflecting frequent sexual feelings.

## 4.5. Bivariate Analysis

To check whether significant association exists between demographic variables (age, age at onset of sexual abuse, school level), program factor (length of stay in the rehabilitation center) and psychosocial consequences of child sexual abuse, bivariate correlation is employed. Based

on the preliminary analysis done, there are no violations in the assumptions of normality, linearity, or outliers and both independent and dependent variables are measured at continuous level. The results of bivariate analysis indicated that there was a strong negative association between age of respondents (M=14.38, SD=1.68) and psychosocial outcomes of child sexual abuse (M=152.8, SD=35.73), r=-.741, p<.01. Lower levels of age are associated with higher levels of psychosocial outcomes of sexual abuse and it explained 54.9% of the variance in the scores of psychosocial outcomes of sexual abuse. In the same way, it was found that age at onset of sexual abuse (M=12.09, SD=1.87) had a strong negative association with the psychosocial outcomes of sexual abuse (M=152.8, SD=35.73), r=-.768, p<.01. Showing that 58.9.0% of the variance in psychosocial outcomes of sexual abuse was explained by age at onset of sexual abuse indicating lower levels of age at onset are associated with higher levels of psychosocial outcome. Besides, respondents' school level (M=3.85, SD=2.42) was indicated as it has moderate negative association with psychosocial outcomes of child sexual abuse (M=152.8, SD=35.73), r=-.476, p<.01. It explained 22.6% of the variance of psychosocial outcomes of child sexual abuse in the opposite direction.

**Table 10: Results of bivariate analysis of demographic variables, length of stay and psychosocial outcomes of child sexual abuse (N=105).**

| Variables | N | Min | Max | Mean | SD | $R^2$ | R |
|---|---|---|---|---|---|---|---|
| Age | 105 | 11 | 17 | 14.38 | 1.689 | .549 | -.741** |
| Age at onset of sexual abuse | 105 | 7 | 15 | 12.09 | 1.878 | .589 | -.768** |
| School level | 105 | 0 | 8 | 3.85 | 2.421 | .226 | -.476** |
| Length of stay in center | 105 | 6 | 25 | 12.95 | 4.25 | .266 | -.516** |

** Correlation is significant at the 0.01 level (2-tailed).
Dependent variable: Psychosocial consequences of child sexual abuse

The results of bivariate correlation also showed that length of stay in the rehabilitation center (M=12.95, SD=4.02) had a moderate negative association with psychosocial outcomes of sexual abuse (M=152.8, SD=35.73), r=-.516, p<.01. This result signifies that 26.6% of the variance in the outcomes of the dependent variable is explained by length of stay in the rehabilitation center with lower levels in length of stay being associated with higher psychosocial outcomes of child sexual abuse.

**Hypothesis One**: Psychosocial outcomes of Child Sexual Abuse differ by the forms of Child sexual abuse

One-way analysis of variance (ANOVA) was employed to test whether psychosocial outcomes of sexual abuse differ by forms of sexual abuse, the nature of perpetrators affiliation with the victim, and frequency of sexual abuse. Accordingly, the results using ANOVA indicated that psychosocial consequences of child sexual abuse differ by the forms of sexual abuse ($F$ (3,101) =10.385, $p$<.01).

**Table11: Results One-way ANOVA for psychosocial consequences of CSA and forms of abuse (N=105).**

| Psychosocial consequences of CSA vs. Forms of sexual abuse | | | | |
|---|---|---|---|---|
| Source of Variation | D.F | Mean Square | *F* | Sig. |
| Between groups | 3 | 6220.028 | 10.385 | .000 |
| Within groups | 101 | 598.920 | | |
| Total | 104 | | | |

Even if the above table showed the existence of significant difference, it didn't indicate which groups have greater contribution to such variation. Thus, checking Post Hoc test was needed. As it is clearly put in table 12 below, it is found that psychosocial consequences of child

sexual abuse differ by forms of sexual abuse. Because, the mean difference between non-contact forms of abuse and intercourse, non-contact and multiple forms, contact forms of sexual abuse and intercourse, contact forms of sexual abuse and multiple forms of sexual abuse are statistically significant. And multiple forms of sexual abuse is to be found highest in contributing significant difference to psychosocial consequences of child sexual abuse. Therefore hypothesis one is supported by the findings of this study.

**Table12: Results of Post Hoc test for ANOVA between psychosocial consequences and Forms of CSA (N=105).**

| LSD (I) Type | (J) Type | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower Bound | Upper Bound |
| Non-contact | Contact | .48352 | 9.42607 | .959 | -18.2153 | 19.1823 |
| | Intercourse | -19.48531* | 7.54720 | .011 | -34.4569 | -4.5137 |
| | Multiple | -38.40468* | 8.49180 | .000 | -55.2501 | -21.5592 |
| Contact | Intercourse | -19.96883* | 7.32594 | .008 | -34.5015 | -5.4361 |
| | Multiple | -38.88820* | 8.29578 | .000 | -55.3448 | -22.4316 |
| Intercourse | Multiple | -18.91937* | 6.07696 | .002 | -30.9744 | -6.8643 |

*the mean difference is significant at the 0.05 level.
Dependent variable: psychosocial consequences of child sexual abuse

**Hypothesis Two:** Psychosocial outcomes of Child Sexual Abuse differ by nature of perpetrators' relation with the victim.

The One-Way Analysis of Variance (ANOVA) employed to see whether there is difference in outcomes of dependent variable exist or not, showed that psychosocial

consequences of child sexual abuse differs by the nature of perpetrators affiliation to the victim ($F$ (2,102) =20.757, $p$<.01).

**Table13: Results of One-way ANOVA of psychosocial consequences of CSA and nature of perpetrators affiliation to the victim (N=105).**

| Psychosocial consequences of CSA vs. nature of perpetrators' relation to the victim children | | | | |
|---|---|---|---|---|
| Source of Variation | D.F | Mean Square | $F$ | Sig. |
| Between groups | 2 | 11448.033 | 20.757.000 | .000 |
| Within groups | 102 | 551.519 | | |
| Total | 104 | | | |

Regarding the mean differences of each groups included in this analysis, Post Hoc test was checked. As a result, the mean difference between members of intra family and members from both intra and extra family, as well as the mean difference between members of extra family and members from both intra and extra family were found significant. The mean difference between members of intra and extra family were not found significant at $p$<.05.

**Table14: Results of Post Hoc test for ANOVA between psychosocial consequences and nature of perpetrators affiliation to the victim children (N=105).**

| (I) Type | (J) Type | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower Bound | Upper Bound |
| Members of intra family | members of extra family | -10.85493 | 5.94507 | .071 | -22.6469 | .9371 |
| | members from both intra and extra | -50.12857* | 8.18353 | .000 | -66.3606 | -33.8966 |
| members of extra family | members from both intra and extra | -39.27364* | 6.86747 | .000 | -52.8952 | -25.6521 |

* The mean difference is significant at the 0.05 level.
Dependent variable: psychosocial consequences of child sexual abuse

Based on the above data it is possible to conclude that being abused by members from both intra and extra familial unit has highest contribution to bring statistically significant difference in psychosocial outcomes of child sexual abuse. Thus, hypothesis two is partially supported by the data.

**Hypothesis Three**: Psychosocial outcomes of Child Sexual Abuse differ by the frequency of sexual abuse.

As it is indicated in the univarate analysis section, sexual abuse survivor children are exposed to different forms of sexual abuse in different time period. Taking this in to account, further investigation on outcomes of child sexual abuse on survivor children as a result of various degree of exposure to the event is needed. To this end, One-way Analysis of variance is used to test whether psychosocial consequences of child sexual abuse differ due to variation of exposure to different forms of sexual abuse. Accordingly, results of the ANOVA showed that psychosocial consequences of child sexual abuse differ by the frequency of abuse ($F$ (4,100) =4.327, $p$<.05).

**Table 15: Results of One-way ANOVA for psychosocial consequences of CSA differ by Frequency of sexual abuse (N=105).**

| | Psychosocial consequences of CSA vs. Frequency of sexual abuse | | | |
|---|---|---|---|---|
| Source of Variation | D.F | Mean Square | $F$ | Sig. |
| Between groups | 4 | 2919.587 | 4.327 | .000 |
| Within groups | 100 | 674.726 | | |
| Total | 104 | | | |

Besides, Post Hoc test is checked to see the mean variation of each groups included in this analysis, and found that the mean difference between once in a year and once in 3 months,

once in a year and once in a week, once in six months and once in a week, once in three months and once in a year, and once in a month and once in a week were significant. The Post Hoc test result indicated that the mean difference between once in a week and other types of frequencies were statistically significant, which implies that children who were frequently abused on weekly bases have varied psychosocial consequences than children who were abused less than once in a week. Since there is no significant difference among all categories of frequencies of sexual abuse, hypothesis four is partially supported by the data.

**Table16: Results of Post Hoc test for ANOVA between psychosocial consequences and frequency of sexual abuse (N=105).**

| | | | | | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| LSD (I) Type | (J) Type | Mean Difference (I-J) | Std. Error | Sig. | Lower Bound | Upper Bound |
| Once in a year | Once in a 6 months | -9.09659 | 9.07876 | .319 | -27.1086 | 8.9154 |
| | Once in 3 months | -21.90909* | 9.24317 | .020 | -40.2473 | -3.5709 |
| | Once in a month | -10.24242 | 9.29132 | .273 | -28.6761 | 8.1913 |
| | Once in a week | -44.76623* | 12.55899 | .001 | -69.6829 | -19.8496 |
| Once in a 6 months | Once in 3 months | -12.81250 | 6.72180 | .060 | -26.1484 | .5234 |
| | Once in a month | -1.14583 | 6.78786 | .866 | -14.6128 | 12.3211 |
| | Once in a week | -35.66964* | 10.83857 | .001 | -57.1731 | -14.1662 |
| Once in 3 months | Once in a month | 11.66667 | 7.00623 | .099 | -2.2335 | 25.5668 |
| | Once in a week | -22.85714* | 10.97665 | .040 | -44.6345 | -1.0798 |
| Once in a month | Once in a week | -34.52381* | 11.01723 | .002 | -56.3817 | -12.6659 |

* The mean difference is significant at the 0.05 level.
Dependent variable: Psychosocial consequences of child sexual abuse

Comparative analysis of psychosocial dimensions of sexual abuse by forms of sexual abuse was done using One-way ANOVA. The results revealed the comparison to be statistically significant in all PSTD, social reactions, attributions about abuse (except dangerous

world), and eroticism dimensions of the CITES-R. Specifically, the effect was significant for symptoms of PTSD, including intrusive thoughts, $F(3,101) = 5.81, p < .005$; avoidance, $F(3,101) = 8.43, p < .001$; hyper arousal, $F(3, 101) = 3.61, p < .005$; and sexual anxiety, $F(3, 101) = 9.21, p < .001$.

**Table 17: Comparative analysis of psychosocial dimensions of sexual abuse in relation to forms of abuse (N=105)**

| | Forms of sexual abuse | | | | | |
|---|---|---|---|---|---|---|
| | Non-contact | Contact | Intercourse | Multiple | | |
| Outcomes | M(SD) | M(SD) | M(SD) | M(SD) | $F^a$ | Sig |
| Intrusive Thoughts | 11.92(1.81) | 12.14(3.13) | 14.67(3.34) | 14.41(3.47) | 5.81 | .001 |
| Avoidance | 15.46(3.68) | 14.50(3.73) | 18.03(3.07) | 19.52(3.67) | 8.43 | .000 |
| Hyper Arousal | 12.00(3.71) | 10.35(3.47) | 12.29(3.34) | 14.08(3.38) | 3.61 | .016 |
| Sexual Anxiety | 9.53(1.980 | 8.71(2.23) | 10.69(2.05) | 12.17(2.18) | 9.21 | .000 |
| Negative Reactions | 14.76(5.32) | 15.14(4.60) | 17.50(4.40) | 20.69(4.48) | 6.28 | .001 |
| Social Support | 11.53(1.85) | 11.35(1.78) | 9.74(1.72) | 9.26 (2.24) | 6.86 | .000 |
| Self-blame/Guilt* | 21.61(2.72) | 21.85(3.08) | 23.92(4.61) | 27(5.89) | 6.46 | .000 |
| Personal Vulnerability* | 15.61(1.66) | 16.07(2.49) | 16.98(3.19) | 19.82(4.32) | 6.57 | .000 |
| Dangerous World * | 13.07(1.60) | 12.50(2.02) | 11.41(2.15) | 12.00(2.15) | 2.28 | .84 |
| Empowerment | 12.38(1.98) | 12.14(2.41) | 10.96(2.59) | 10.39(2.31) | 2.71 | .049 |
| Eroticism* | 5.23(1.92) | 5.14(1.87) | 5.30(1.78) | 8.26(2.98) | 11.84 | .000 |

[a] df =3,101.
*Levene's test for homogeneity of variance is assumed
Dependent variable: Psychosocial consequences of child sexual abuse

It was also significant on negative reactions by others, $F(3,101) = 6.28, p < .005$, and social

support, $F$ (3,101) =6.86, $p$ <.001, of the social reactions dimension. Yet such a comparison had significant effects on self-blame/Guilt, $F$ (3,101) =6.46, $p$ <.001; personal vulnerability, $F$ (3,101) =6.57, $p$ <.001 of the abuse attribution variables, and $F$ (3,101) =11.84, $p$<.001 for Eroticism..

**Table 18: Comparative analysis psychosocial dimensions of sexual abuse in relation to nature perpetrators' affiliation to the victim**

| | Perpetrators affiliation to the victim | | | | |
|---|---|---|---|---|---|
| Outcomes | Members of intra family M(SD) | Members of extra family M(SD) | Both intra & extra family M(SD) | F[a] | Sig |
| Intrusive Thoughts | 12.65(3.24) | 14.11(3.13) | 16.71(3.81) | 6.48 | .002 |
| Avoidance | 15.25(3.87) | 17.46(3.29) | 21.42(2.50) | 14.34 | .000 |
| Hyper Arousal | 11.10(3.97) | 12.12(3.20) | 15.57(2.87) | 8.14 | .001 |
| Sexual Anxiety | 10.35(2.32) | 10.29(2.07) | 12.57(2.76) | 6.28 | .003 |
| Negative Reactions | 15.25(4.85) | 17.30(4.54) | 22.07(4.90) | 9.15 | .000 |
| Social Support | 9.60(2.41) | 10.25(1.76) | 9.85(2.14) | 4.72 | .011 |
| Self-blame/Guilt* | 21.45(3.88) | 23.45(2.66) | 31.42(4.81) | 29.17 | .000 |
| Personal Vulnerability* | 16.70(2.97) | 16.53(2.66) | 22.14(4.32) | 21.14 | .000 |
| Dangerous World * | 13.00(1.89) | 11.64(2.36) | 11.57(2.47) | 2.86 | .061 |
| Empowerment | 11.20(2.66) | 11.26(2.29) | 10.64(2.79) | 4.10 | .019 |
| Eroticism* | 5.05(2.01) | 5.57(2.01) | 8.92(2.86) | 16.32 | .000 |

[a] df =2,102.
Dependent variable: Psychosocial consequences of child sexual abuse

Similarly, based on the comparative analysis made using One-way ANOVA to investigate variations among respondents who were abused by different perpetrators, the results revealed the comparison to be statistically significant in all PSTD, social reactions, attributions about abuse, and eroticism dimensions of the CITES-R. Specifically, the effect was significant for symptoms of PTSD, including intrusive thoughts, $F$ (2, 102) = 6.48, $p$ < .005; avoidance, $F$ (2, 102) = 4.34, $p$ < .001; hyper arousal, $F$ (2,102) =8.14, $p$ < .005; and sexual anxiety, $F$ (2, 10) =6.28, $p$ <.005. It was also significant on negative reactions by others, $F$ (2,102) =9.15, p <.001, and social support, $F$ (2,102) =4.72, $p$ <.005, of the social reactions dimension. Such a comparison had also significant effects on self-blame/guilt, $F$ (2,102) =29.17, $p$ <.001; personal vulnerability, $F$ (2,102) =21.14, $p$ <.001; empowerment, $F$ (2,102) =4.10, $p$<.005 of the abuse attribution variables, and $F$ (2,102) =16.32, $p$<.001 for Eroticism.

### 4.6. Multivariate Analysis

In the preceding sections I presented univarate analysis of both dependent and independent variables as well as tested each hypothesis by employing appropriate models for bivariate analysis of dependent and independent variables. Based on findings of both univarate and bivariate analysis, in the following sections I presented the findings of multivariate analysis using multiple and hierarchical regression.

**Hypothesis Four**: There is significant relationship between the demographic factors (age, age at onset and school level), and length of stay in rehabilitation center, and psychosocial consequences of CSA.

Multiple regression was run using demographic factors, (except age), and length of stay in the rehabilitation center as independent variable and Psychosocial consequences of CSA as

dependent variable to know whether independent variables predict the outcomes in the dependent variables. Age of the respondents is excluded from this model since it was highly correlated with the other predicting variable (age at onset).

This means that it didn't met multicollinearity assumption as a result of their correlation factor (R=.94) is higher and tolerance[1] value (.09) is very small, which in turn, indicates variation inflation factor (VIF[2]) is greater than 10. On the other hand, the rest independent variables (age at onset, school level and length of stay in the rehabilitation center) met multicollinearity.

With regard to the assumptions of normality and linearity, both normal probability plot and Scatter plot are checked. Accordingly, the points are drawn in reasonably straight line with little deviation from the perfect line. So, the points have good fit on the Normal P-P plot since there is no major deviation from normality. Similarly, scatter plots produced by the variables showed roughly rectangular distribution of dots with absence of clear or systematic pattern to the dots higher to the one side versus on the other. In this regard, the assumption of linearity is met. Furthermore, outliers are checked by the mahalanobis distance. To identify which cases are outliers, I determined critical values, which is 16.27 for three independent variables, by using the number of independent variables included in this analysis and the degree of freedom, Based on the residual statistics, the maximum Mahalanobis distance (Mahal. distance=13.70) is found less than critical value of 16.27, which assured the absence of outliers.

Thus, having met the basic assumptions, the model as a whole predicted 65.1% ($R^2$= .651) of variation in the dependent variable is a result of change in the independent variables included in this analysis. But school level is not found to be significant predictor of the

[1] Tolerance is ( $1-R_i^2$ ) indicating the proportion of variance in the" i"th independent variable that is not related to the other independent variables in the model

[2]The Variance Inflation Factor is $1/(1-R_i^2)$.

dependent variable at 95% confidence interval. As a result, to know the combined effect of the rest variables, I deducted the square $(.151)^2$ of partial[3] correlation. Which is 2.2% of variation in the psychosocial outcomes CSA is explained by school level alone, which needed to be reduced since such variation is not supported by $p<.05$. Therefore, the combined predicting power of age at onset and length of stay in the rehabilitation center on the psychosocial effects of child sexual abuse on survivor children are 62.8% (.651-.023=.628=$R^2$).

**Table 19: Multiple regression analysis for demographic factors and length of stay in the rehabilitation center predicting psychosocial outcomes of CSA (N=105).**

| Predicting variables | Unstandardized Coefficients | | Standardized coefficients |
|---|---|---|---|
| | B | Std.Error | Beta |
| Age at onset of abuse | -9.123 | 1.041 | -.621*** |
| School level | -1.189 | .777 | -.104 |
| Length of stay in the rehabilitation center | -1.642 | .442 | -.240*** |
| $R^2$ | | .628 | |
| F | | 62.698 | |

Dependent variable: psychosocial consequences of CSA,

***P< .001

This means that together the two variables (age at onset, and length of stay in the rehabilitation center) significantly predicted psychosocial outcomes of CSA (p<.01). Thus, hypothesis one is partially supported with greater contribution of age at onset of sexual abuse for the variation in psychosocial outcomes of CSA.

[3] It indicates how much of the dependent variable's variance is explained by independent variable alone after all other independent variables included in the analysis model are statically controlled.

When unique contribution of each predicting variables are looked; 43.1% of the dependent variables' variance is explained by age at onset of abuse, whereas, 12.1% of the dependent variables' variance is explained by length of stay at the rehabilitation center, which is measured in terms of months. Since the nature of relationship is negative, the slope indicates that for each one added year of age at onset of abuse, there are 0.621 reductions in the outcomes of sexual abuse. Similarly, for an additional month of stay in the rehabilitation center, there are 0.24 reductions in the outcomes of CSA on sexual abuse survivor children.

**Hypothesis Five**: Each independent variable can uniquely predict change on psychosocial outcomes of child sexual abuse when their effects are examined in sequential combination.

So as to know the combined effects of two or more independent variables over the dependent variable hierarchical regression using psychosocial consequences of child sexual abuse as dependent variable is employed. Sequentially, demographic factors (excluding age[4]) as control variable, and forms of abuse as independent variable was done to test if forms of child sexual abuse predicts psychosocial consequences of child sexual abuse. The results indicated that model two (forms of child sexual abuse) explained 5.8% of variance ($R^2$=.058, $F$=38.437, $p$ <.001). It was found that forms of child sexual abuse significantly predicts psychosocial outcomes of child sexual abuse together with demographic factors (age at onset and school level). And there is significant difference between the each forms of child sexual abuse in predicting power of psychosocial consequences of child sexual abuse. Thus, being abused by non-contact forms of CSA alone decreases psychosocial consequences of child sexual abuse by 0 .257 points ($\beta$ =-.257 $p$<.01), being abused by contact forms of CSA alone also decreases psychosocial consequences of child sexual abuse by 0.237 points ($\beta$ =-.237,$p$<.01), and being

[4] Age is excluded from the model since it has higher multicollinearity with age at onset of sexual abuse

abused by intercourse forms of CSA brings reduction in 0.208 points($\beta$ =-.208,$p$<.01) of psychosocial consequences of child sexual abuse in reference to multiple forms of child sexual abuse.

Similarly, to test the unique contribution of frequency of sexual abuse on the psychosocial outcomes of child sexual abuse, I employed hierarchical multiple regression by controlling both demographic variables and forms of child sexual abuse. Accordingly, the results revealed that frequency of child sexual abuse explained 3.3% of variance ($R^2$=.033, $F$=23.799, $p$ <.001), which, indicated that frequency of child sexual abuse significantly predicts psychosocial outcomes of child sexual abuse together with demographic factors (age at onset and school level), and forms of child sexual abuse. However, only being abused by at least once a week showed significant difference from the means of being abused by at least once in a six months in psychosocial outcomes of child sexual abuse. Being abused at least once in a week increases psychosocial consequences of child sexual abuse by 0.161 points ($\beta$ =.161, $p$<.05).

Furthermore, the nature of perpetrators affiliation with victim is tested to know how changes occurred in psychosocial outcomes of child sexual abuse by controlling other variables. The results indicated that model four (the nature of perpetrators affiliation with victim) explained 7.2% of variance ($R^2$ =.072, $F$=27.416, $p$<.01). It indicated that the nature of perpetrators affiliation to the victim significantly predicts psychosocial consequences of child sexual abuse together with demographic variables, forms of child sexual abuse, and frequency of child sexual abuse. The results also showed that there is significant difference between the means of being abused by both members from intra-family and extra-family, and members from intra-family in psychosocial outcomes of child sexual abuse. Thus, children abused by both members of intra-

family and extra family increases psychosocial outcomes of child sexual abuse by 0.338 points ($\beta$ =.338, $p$<.01) from those who are abused by members of intra-family only.

**Table 20: Results of Hierarchical Regression Analysis for all Independent Variables and Psychosocial Consequences of Child Sexual Abuse (N=105).**

| Variables | | Model1 | Model 2 | Model 3 | Model 4 | Model 5 |
|---|---|---|---|---|---|---|
| Demographic variables | Age at onset | -.703*** | -.617*** | -.573*** | -.552*** | -.514*** |
| | School level | -.132 | .135* | -.133* | -.119* | -.105 |
| Forms of child sexual abuse | Non contact alone | | -.257*** | -.258*** | -.188*** | -.199*** |
| | Contact alone | | -.237*** | -.231*** | -.143* | -.142* |
| | Intercourse alone | | -.208*** | -.187* | -.102 | -.117 |
| | Multiple forms CSA[@] | | | | | |
| Frequency of sexual abuse | At least Once in a year | | | .000 | .023 | .026 |
| | At least Once in 6 months[@] | | | | | |
| | At least once in 3 months | | | .102 | .103 | .077 |
| | At least once in a month | | | -.027 | .011 | -.005 |
| | At least in a week | | | .161* | .086 | .085 |
| The nature of perpetrators relation with the victim | Members of Intra-family[@] | | | | | |
| | Members of Extra-family | | | | .069 | .026 |
| | Both from intra-and extra family | | | | .338*** | .277*** |
| Program factor | Length of stay in the rehab.center | | | | | -.154** |
| $R^2$ | | .602 | .660 | .693 | .764 | .781 |
| F | | 77.301 | 38.437 | 23.799 | 27.416 | 27.374 |

Dependent variable: psychosocial consequences of child sexual abuse
*p<.05, **p<.01, ***P<.001
[@]reference variable

Finally, the unique contribution of length of stay in the rehabilitation in predicting the psychosocial outcomes of child sexual abuse is tested by keeping previously included variables constant in hierarchical regression model. The results indicated that model five (length of stay in the rehabilitation center) explained 1.7% of the variance ($R^2$=.17, $F$=27.374, $p$<.01). This implied that length of stay in the rehabilitation center significantly predicated psychosocial consequences of child sexual abuse together with demographic variables, forms of child sexual abuse, frequency of abuse, and the nature of perpetrators affiliation with the victim. The results indicated that staying for additional one month in the rehabilitation center decreases psychosocial consequences of child sexual abuse by .154 points ($\beta$ =-.154, $p$<.01).

Generally, the results of hierarchical multiple regression containing five models in which each independent variables are sequentially included showed that each model significantly predicted outcomes on the dependent variable with 95% of confidence level. Since model five contains all independent variables that predicted outcomes of dependent variable in better way than other models with highest predicting power of 78.1% ($R^2$=.781, $F$=27.374, $p$<.01), it is possible to conclude that each independent variables have significant combined contribution to the changes in the outcomes of the dependent variable. Therefore, hypothesis five is supported by the data.

# CHAPTER FIVE

# DISCUSSION

The main purpose of this study was to examine psychosocial consequences of Child sexual abuse on sexual abuse survivor children. Particularly, it sought to explore the relationship between psychosocial consequences of sexual abuse with the demographic factors (age, age at onset of sexual abuse, and school level), length of stay in the rehabilitation center, with different forms and frequency of sexual abuse, and the nature of perpetrators relationship with the victim. Thus, this section provides discussion of major findings of the study in the context of previous literature.

## 5.1. Discussion of Descriptive Findings

The participants of this study are from three rehabilitation centers; namely Organization for Prevention, Rehabilitation, and Integration of Female Streets (OPRIFS), Integrated Family Service Organization (IFSO), and Kechenie Children Rehabilitation Center. A total of 105 sexual abuse survivor children aged 11-17 participated in the study. The average age of the respondents was 14.38, and age at onset of sexual abuse was 12.06 with 7 and 15 minimum and maximum years at onset of sexual abuse, respectively, which is somehow different from the findings of the previous studies. In their study, Elliott, and Kilcoyne (1995) reported that age at onset of sexual abuse mostly occur between 7 and 10 years of age. On the other hand, Finklelor (1994) described 7 to 13 years of age as peak age of vulnerability to sexual abuse, whose figure is relatively consistent to the current study.

When prevalence of CSA based on its forms are examined, Penetration or intercourse was reported by more than half (52.4%) of the respondents, followed by multiple or more than one forms of CSA (21.9). This result is consistent with studies done by Feiring and Taska

(2002), on 147 abuse survivor children who were taking treatment in Children Protective Services (CPS). On the other hand, it is found inconsistent with the findings of Fergusson and Mullen (1999). The possible explanation for the consistency of current study with the findings of Feiring and Taska can be, the respondents in both cases were abuse survivors and were being taking psychological treatments.

With regard to the nature of perpetrators relationship with victim children, in this study perpetrators are categorized as members of intra-family, extra-family and both members of intra- and extra-family. Accordingly, the results showed that for all forms of CSA, majority of respondents were abused by members from the extra-family where as 19% and 13.4% of respondents were abused by members of intra-family, and members from both intra and extra family. Regardless of the exact nature of perpetrators relationship to the victim, (Freyd, 1996, Wolfe, & Gentile, 1989, Jibril et al, 2012) described that majority of children were abused by someone who is commonly known and close to the victim. In reference to the findings of Feiring, Taska and Lewis (2002), the current study is inconsistent. Because their findings showed that majority of respondents were abused by members from intra-family, and this contrasts to the findings of the current study. The possible reason for the inconsistencies can be due to the living condition of participants, most of them have been living with non-relatives, before they join respective rehabilitation centers.

The result of this study showed that very small numbers of respondents (9 and 11) were abused once in a week and a year respectively. Relatively the largest number of respondents (30) were abused once in six months, whereas, proportionally equal number of respondents (28) were abused once in a month and six months. In previous study of sexual abuse survivors, Feiring, Taska and Lewis (2002), described that 31% of respondents were abused once in six month, 38%

once a month, and 31% once in a week, which, is slightly inconsistent with the results of the current study. Measuring Psychosocial consequences of CSA in this study was also further extended to comparisons with previous studies that employed the CITES-R for examining CSA impact severity (Wondie et al, 2002), examining psychological distress at the time of discovery (Feiring, Taska & Lewis, 1999), measuring reactions of sexual trauma (Crouch et al., 1999) and assessing the internal consistency and construct validity of the CITES-R (Chaffin & Shultz, 2001). The result showed that mean scores for most of the CITES-R variables in the present study were found to be significantly different from those studies done on CSA survivors. While the average mean score of all CITES-R variables in present study was found to be 152.8 (SD=35.73), the previous studies that employed CITES-R reported the mean score of 155.81/SD=46.44 (Wondie et al., 2002), 137.09/SD=21.9 (Chaffin & Shultz, 2001), 139/SD=45.4(Feiring, Taska, &Lewis, 1999), and 140/SD=33.54, Crouch, Smith, Ezzell, & Sounders, 1999).

The findings of this study showed that the respondents were more symptomatic; perceived a lower degree of social support (except Wondie et al., 2002) and a higher degree of negative reactions by others upon disclosure of the abuse, felt more vulnerable to further abuse (except Wondie et al., 2002), experience a higher degree of self guilt/blame and dangerous world (except Wondie et al., 2002, Feiring et al., 1999), and had less sense of empowerment to defend themselves from similar abuse than did the CSA survivors in the previous studies ( see table below). Thus, it is possible to conclude that the CSA survivor respondents of this study were found to be significantly more symptomatic, perceived a lower degree of social support upon abuse disclosure, and experienced a higher degree of guilt and dangerous world, a higher degree

of personal vulnerability, experienced sexual anxiety, intrusive thoughts, hyper arousal, and developed avoidance mechanisms.

**Table 21: Comparison of the present study with other studies that employed the CITES-R.**

| | The present study (N=105) | | Wondie et al, 2002 (N=318) | | Chaffin & Shultz 2001 (N=158) | | Feiring et al, 1999 (N=169) | | Crouch et al ,1999 (N=97) | |
|---|---|---|---|---|---|---|---|---|---|---|
| Variables | M | SD | M | SD | M | SD | M | SD | M | SD |
| Intrusive thoughts | 2.02 | .48 | 2.41 | .55 | 1.69 | .24 | 2.00 | .60 | 1.89 | .57 |
| Avoidance | 2.19 | .46 | 2.54 | .50 | 2.29 | .29 | 2.30 | .40 | 2.21 | .40 |
| Hyper arousal | 2.06 | .59 | 2.38 | .57 | 1.79 | .30 | 2.10 | .50 | 2.05 | .50 |
| Sexual anxiety | 2.12 | .46 | 2.10 | .70 | 2.41 | .48 | 2.10 | .70 | 1.81 | .68 |
| Eroticism | 1.48 | .61 | 1.30 | .42 | 1.50 | .37 | 1.40 | .50 | 1.33 | .48 |
| Negative reactions by others | 1.95 | .55 | 1.75 | .69 | 1.40 | .15 | 1.40 | .40 | 1.40 | .43 |
| Social support | 1.67 | .33 | 1.57 | .61 | 2.29 | .38 | 2.70 | .40 | 2.46 | .42 |
| Personal vulnerability | 1.92 | .39 | 1.95 | .60 | 1.48 | .16 | 1.80 | .30 | 1.69 | .42 |
| Self-blame/Guilt | 2.01 | .41 | 1.75 | .56 | 1.54 | .13 | - | - | 1.51 | .40 |
| Dangerous world | 2.38 | .46 | 2.60 | .50 | 2.29 | .46 | 2.40 | .40 | 2.27 | .42 |
| Empowerment | 1.59 | .35 | 2.03 | .69 | 2.23 | .32 | 2.60 | .40 | 2.43 | .43 |

Psychosocial consequences of Child Sexual abuse in relation to forms and frequency of sexual abuse, the nature of perpetrators relation with the victim, demographic variables (age, age at onset of sexual abuse, and school level) and length of stay in the rehabilitation center are discussed in the following sections.

**5.2. Discussion of Bivariate and Multivariate Findings**

The hypothesis test was done to see if any of the demographic variables (age, age at onset of sexual abuse, and school level), and length of stay in the rehabilitation center is associated with psychosocial consequences of CSA. Findings from multiple regression analysis (age at onset of sexual abuse, school level and length of stay in the rehabilitation center) were included, and age at onset of sexual abuse ($\beta$=-.621, $P$<.01) and length of stay in the rehabilitation center ($\beta$=.-24, $p$<.05) significantly predicted the dependent variable, psychosocial consequences of CSA but School level didn't significantly predicted variation in outcomes of the dependent variable at 95% significance level. Even if it is difficult to determine the exact temporal relationship between child sexual abuse and onset of psychosocial problems (Courtois, 1983), the results of regression analysis of age at onset of sexual abuse ($\beta$=-.621) showed that it has negative relationship with psychosocial consequences of child Sexual abuse.

These findings are consistent with the findings that showed as traumatic effects of Child sexual abuse decreases when children passes to higher development of life, and when abuse occurs in their later stage of development (Cohen et al., 1999). As possible reason, children's lower degree of being upset by sex related issues when they get older is considered. On the other hand, this finding is found to be inconsistent with the findings of Ticher et al (2008) that showed that survivors of child sexual abuse in 13-17 years of age develop additional risky behaviors than children found in 6-12 years of age. Besides, results of regression analysis of length of stay in the rehabilitation center ($\beta$=-.24) indicates that it has negative relation with the outcomes of the psychosocial consequences of Child sexual abuse, which is consistent with the findings that emphasized the supportive role of significant others in reducing traumatic effects of child sexual abuse (Trimblay et al., 1999).

The other hypothesis was done to see whether outcomes of sexual abuse differ by the forms of sexual abuse. The results of One-way Analysis of variance (ANOVA) indicated that traumatic effects of sexual abuse differ by forms of sexual abuse ($F$ (3,101) =10.385, $p$<.01). Specifically, Post hoc test of the model showed that the multiple forms of sexual abuse has greater traumatic impacts of CSA than, intercourse ($M^5$=18.91), Contact ($M^6$= 38.88), and Non-contact ($M^7$=38.40) at 95% of significance level. Similarly, results of Post Hoc test indicated that abuse survivors who had experienced sexual intercourse in their childhood had developed greater symptomology of traumatic events of sexual abuse than those who had faced contact form of sexual abuse only ($M^8$= 19.96), and Non-contacts only($M^9$=19.48). When such comparisons are made by splitting the Child sexual abuse survivors in to their respective abuse contexts, it is possible to conclude that children who experienced penile penetration had higher degree of intrusive thoughts, hyper arousal, sexual anxiety, negative reactions by others, guilty feeling, personal vulnerability, perception of the world as dangerous, and higher erotic feelings than children experienced non-contact and contact forms of sexual abuse. The results of Post Hoc test also indicated that for majority of variables, by which traumatic effects of child sexual abuse are manifested, increase when severity of abuse increases from non-contact to multiple forms of sexual abuse.

The finding of this study in this regard was found to be significantly consistent with findings that dictated that when the forms of abuse gets sever, it has long lasting psychosocial consequences (Feiring and Taska, 2002), and when the abuse involves physical force or invasive

---

[5] Mean difference between Multiple forms of sexual abuse and intercourse
[6] Mean difference between Multiple forms of sexual abuse and Contact forms of sexual abuse
[7] Mean difference between Multiple forms of sexual abuse and Non Contact forms of sexual abuse
[8] Mean difference between intercourse and contact forms of sexual abuse
[9] Mean difference between intercourse and Non-contact forms of sexual abuse.

contacts like penile penetration (Mcleer et al, 1989). Similarly, kindler et al (2000), described that being exposed to more forms of sexual abuse increases risk of developing psychosocial problems and particularly, CSA involving contact or intercourse is associated with more negative psychosocial problems than non contact forms of sexual abuse, and risks of Post Traumatic Stress Disorder is higher for penetrative abuse than contact forms of abuse (Saunders et al., 1999), which is significantly consistent with the current study. Furthermore the current finding is found to be consistent with the finding that stated children who experienced a more severe form of abuse (e.g., penetration), scored significantly higher on scales of internalizing and externalizing behavior problems than children who experienced a less severe form of abuse (e.g., fondling) even after post treatment (Sadowski et al, 2003).

The other hypothesis was also done to see whether traumatic effects of Child sexual abuse differ by the nature of perpetrators affiliation with the victim or not. The results indicated that psychosocial consequences of child sexual abuse differ by the nature perpetrators affiliation frequency of abuse ($F$ (2,102) =20.757, $p$<.01). The results of Post Hoc test indicated that children abused by members from both intra-and extra-familial situation had significantly greater traumatic symptomology of child sexual abuse than by members from intra-familial situation only ($M^{10}$=50.12), and by members from extra-familial context ($M^{11}$=39.27). On the other hand, even if majority (67.6%) of respondents reported that they were abused by members from extra-family, significant difference in traumatic effects of child sexual abuse is not recorded when compared with few children (19%) abused by members of intra-familial context. With specific reference to some variables in CITES-R, the results of comparative analysis showed that children abused by intra-familial context experienced significantly greater symptomology of sexual

[10] The mean difference between members from both intra-and extra-family and members from extra-family
[11] The mean difference between members from both intra-and extra-family and members from intra-family

anxiety, personal vulnerability, lower social support, less empowered to defend further abuses, and perception of the world as dangerous than children abused by extra-familial context. But for other variables greater symptomology of traumatic effects child sexual is found among children who faced extra-familial context.

The finding is found to be significantly consistent with the findings that showed greater traumatic effects of child sexual abuse among survivors of extra-familial abuse (Feinauer, 1989). Thus, the results of this finding showed greater traumatic effects of child sexual abuse in some outcome variables among the abuse survivors of intra- familial abuse than extra-familial abuse; but for other variables children who were abused by perpetrators from extra-familial context have higher symptomology of traumatic impacts of child sexual abuse.

The possible explanation for such inconsistency can be influence of circumstances surrounding the sexual victimization, types and severity of sexual abuse, age at onset of the abuse, frequency and duration (Gregory et al., 1989), and the nature of family functioning can further clarify the severity of tramatic effects of child sexual abuse regardless of perpetrators affiliation to the victim (Faust et al., 1995). In this regard, it is possible to argue that child sexual abuse related symptoms may not unequivocally be related to the perpetrator's relationship with the victim; because a feeling of betrayal can be greater when a child is abused by a trusted neighbor than by distant uncle or relative. In general, this finding showed that a traumatic effect of child sexual abuse is significantly greatest among victims who were abused by both members of intra-and extra family.

The other hypothesis of the study was to test whether psychosocial consequences of Child sexual abuse differ due to various degree of exposure to different forms of sexual abuse or

not. The results of One-way analysis of variance (ANOVA) showed that Psychosocial consequences of child sexual abuse differ by the frequency of abuse ($F$ (4,100) =4.327, $p$<.05). The results of Post Hoc test indicated that Children who were abused once in a week showed significantly greater traumatic impacts of Child Sexual Abuse than once in a year ($M^{12}$=44.76), once in six months ($M^{13}$=35.66), once in three months ($M^{14}$= 22.85), and once in a month ($M^{15}$=34. 52). And similarly being abused by once in three months was brought significantly greater traumatic outcomes of sexual abuse than being abused by once in a year ($M^{16}$=21.90). Thus, the finding showed that when the frequency of sexual abuse increases, the traumatic outcomes Child sexual abuse get greater though there are various factors can have vital influence in its overall outcome. With regard to this, Kendler et al (2000) mentioned that poorer psychological and behavioral outcomes in children are related to greater abuse frequency, and higher rates in frequency of abuse have significant association with greater severity of psychosocial problems (Bagley et al., 1995). Therefore the current finding is found to be significantly consistent with the previous studies described above. Even if cumulative trauma is expected to have a more substantial effect than single or less frequent abusive events, the nature of sexual abuse itself should be noted, since it can have a vital role in determining the outcomes of dependent variable.

---

[12] The mean difference between once in a week and once in a year
[13] The mean difference between once a week and once in six months
[14] The mean difference between once in a week and once in three months
[15] The mean difference between once in a week and once in a month
[16] The mean difference between once in three months and once in a year

# CHAPTER SIX

## SUMMARY AND CONCLUSION, AND IMPLICATIONS

The study has examined psychosocial consequences of child sexual abuse on 105 sexual abuse survivor children who inhabited in three children rehabilitation centers; (IFSO, OPRIFS, and Kechenie children rehabilitation center). The study and its findings are delimited to these children rehabilitation centers and 105 abuse survivor children only since the study was conducted with no intention of representing a larger population due to lack of sufficient abuse survivor children in those centers to take representative sample.

To examine the basic questions of the study, standardized instruments were used. Data pertaining to psychosocial consequences of child sexual abuse on abuse survivor children were collected through children's impact of traumatic event-revised. Data collected from 105 abuse survivor children of three children rehabilitation centers were analyzed using a series of statistical models, mainly simple, multiple regression analysis, and One-way analysis of variance (ANOVA).

Based on this finding, on average, the abuse survivor children were abused at 12.06 years of age. Penetration or intercourse was reported by more than half of the respondents, followed by multiple or more than one forms of CSA. The findings indicated that, relatively the largest number of respondents were abused once in six months, whereas, proportionally equal number of respondents were abused once in a month and six months. With regard to the perpetrators' profile, the finding also showed that majority of the respondents were abused by members from extra-family and the least of them were abused by perpetrators from both intra- and extra-familial situation.

Significant relationship between demographic variables (age, age at onset of sexual abuse) and length of stay in the rehabilitation centers, and psychosocial consequences of child

sexual abuse has been found. Though school level didn't have significant relationship with the psychosocial consequences of child sexual abuse, as school level increases traumatic impacts of child sexual abuse decreases.

Psychosocial outcomes of child sexual abuse significantly differed by forms of child sexual abuse. Multiple forms of sexual abuse has greater traumatic impacts of CSA than, intercourse, contact, and non-contact at 95% of significance level. Similarly, abuse survivors who had experienced sexual intercourse in their childhood had developed greater symptomology of traumatic events of sexual abuse than those who had faced contact form of sexual abuse only, and non-contacts only. In general, traumatic effects of child sexual abuse increases when severity of abuse increases from non-contact to multiple forms of sexual abuse.

Psychosocial outcomes of child sexual abuse significantly differed based on nature of perpetrators relation with the victim. Children abused by members from both intra-and extra-familial situation had significantly greater traumatic symptomology of child sexual abuse than by members from intra-familial situation only and by members from extra-familial context. On the other hand, even if majority of respondents reported that they were abused by members from extra-family, significant difference in traumatic effects of child sexual abuse is not recorded when compared with few children abused by members of intra-familial context. Thus, traumatic effect of child sexual abuse is significantly greatest among victims who were abused by both members of intra-and extra family.

Psychosocial consequences of child sexual abuse significantly differed due to various degree of exposure to sexual abuse. Thus, the finding showed that when the frequency of sexual abuse increases, the traumatic outcomes of child sexual abuse gets greater, though, there are various factors that can have vital influence in its overall rate of outcome.

As this study employed standardized instrument specifically designed for sexual abuse survivor children to examine such comprehensive dimensions of post traumatic stress disorder, social attributions, social reactions and eroticism, it has important contribution in using the instrument for further research on both male and female abuse survivor children in Ethiopian context. Besides, the study can serve as a reference material for further studies on issues of child sexual abuse and its pervasive effects on victim children. Therefore, from the research point of view, the study implies that psychosocial consequences of child sexual abuse have to be given due emphasis and studies have to be done across Ethiopia on abuse survivor children.

To this end, School of Social Work in collaboration with different stake holders has to play a great role by designing different projects on issues of sexual abuse, by encouraging students and other researchers to conduct scientific researches on pervasive impacts of CSA to victims, their families and to the society at large. The study also signifies that School of Social Work can play great importance by letting students take field placements on different organizations that work on rehabilitation of sexually abused children, and the findings can be additional input for devising effective treatment approaches to victim children which enables to reduce existing psychological and social problems The results showed that abuse survivor female children are largely developed distorted perceptions due to abuse, and experiencing symptoms of post traumatic stress disorder which demands provision of effective intervention techniques and therapeutic models to the victim children in respective rehabilitation centers. This implies that protecting children from further episodes of abuse by letting them join the center alone is not sufficient to reduce pervasive problems reflected due to their earlier exposure to sexual abuse; but the respective rehabilitation centers should work in better way to reduce such problem. Therefore, the study showed that, practically, a lot need to be done to avert such

pervasive problem through joint collaboration of all concerned bodies with the organizations working on rehabilitation of abuse survivor children.

It is obvious that for the brighter tomorrow, the healthy socialization of today's children is inevitable reality. In spite of this, in our society children are not given attention due to long rooted traditions and cultural practices, even sexual abuse of children, which is the other version of early marriage, is common. Therefore, to tackle such problems, a lot has to be done in awareness raising programs about openly discussing issues of sexuality, multifaceted effects of child sexual abuse, grasping importance of immediately disclosing if abuse happens, and working in collaboration with the teachers, social workers, psychologists, lawyers and other concerned bodies by formulating policies at national level.

**References**

American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental Disorders (4th edn). Washington DC.

Babiker, G., & Herbert, M. (1998). Critical issues in the assessment of child sexual abuse *Clinical Child and Family Review, 1, 231–251.*

Bagley C. (1991). The prevalence and mental health sequels of child sexual abuse in a community sample of women aged 18 to 27. *Canadian Journal of Community Mental Health, 10,103–116*

Bennett, S. E., Hughes, H. M., & Luke, D. (2000). Heterogeneity in patterns of child sexual abuse, family functioning, and long term adjustment. *Journal of Interpersonal Violence, 15, 134-157.*

Berliner, L., and Wheeler, J.R. (1987). Treating the effects of sexual abuse on children. *Journal of Interpersonal Violence, 2, 415-434.*

Briere, J. (1992). *Child abuse trauma: Theory and treatment of the lasting* effects. Newbury Park, Sage publications.

Briere, j., & Elliott, D.M. (1994). Prevalence and psychological sequel of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Journal of Child Abuse & Neglect 27,1205-1222.*

Briere, j., & Elliott, D.M. (1993). Sexual abuse, family environment, and psychological symptoms: On the validity of statistical control. *Journal of Counseling and Clinical Psychology, 61, 284-288.*

Browne A, Finkelhor D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99, 66–77*

Candice, F., Valerie, A., & Charles, M. (2009). Childhood sexual abuse, stigmatization, internalizing symptoms, and the development of sexual difficulties and dating aggression. *Journal of Counseling and Clinical Psychology, 77, 127-137.*

Caring for kids-what parents need to know about sexual abuse (2009). *National Child Stress Network*

Chaffin, M., Shultz, S. K. (2001). *Psychometric evaluation of the Children's Impact of Traumatic Events Scale-Revised.*

Community treatment of child sexual abuse: A survey of practitioners in the National Child Traumatic Stress Network. *Journal of Mental Health (2009) 36, 37-49.*

Crouch, J. L., Smith, D. W., Ezzell, C. L., & Sounders, B. E. (1999). Measuring reaction to sexual trauma among children: Comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. *Journal of interpersonal violence, 6, 494-511*

CSA-Ethiopia & ORC USA. (2005). *Ethiopia demographic and health survey. Addis Ababa.*

Conton J. (2010). *Coping with child sexual abuse among college students and post-traumatic stress disorder: The role of continuity of abuse and relationship with the perpetrator.*

Courtois, C.A. (1988). *Healing the incest wound: Adult survivors in therapy.* New York: W.W. Norton

Dereje W., Abebe G. & Jayalakshmi.(2005). *Child Sexual Abuse and its Outcomes among High School Students in South West Ethiopia.*

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

Faust, J., Runyon, M. K., & Kenny, M. C. (1995). Family variables associated with the onset and impact of intrafamilial childhood sexual abuse. *Clinical Psychology Review, 15, 443-456.*

Feinauer, L. L. (1989). Comparison of long-term effects of child abuse by type of abuse and by relationship of the offender to the victim. *American Journal of Family Therapy, 17, 48-56.*

Feiring, C., Taska, L., & Chen, K. (2002). Trying to understand why horrible things happen: Attribution, shame, and symptom development following sexual abuse. *Journal of Child Maltreatment, 7(1), 26–41*

Feiring, C., Taska, L., & Lewis, M. (1999). Age and gender differences in children's and adolescents' adaptation to sexual abuse. *Journal of interpersonal violence, 13, 279-399.*

Finkelhore D.(1994). Current Information on the Scope and Nature of Child Sexual Abuse. *Future of Children*, 1994; 4(2): 31-36.

Finkelhoer. D. (1984). *Child sexual abuse: New theory and research.* New York: Free Press.

Finkelhore, D., Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55,530-41.*

Finkelhore, D., Ormrod, R.K., and Turner, H.A. (2009). Lifetime assessment of poly victimization in a national sample of children and youth. *Child Abuse & Neglect, 33:403–411.*

Fergusson DM, Mullen P. (1999*). Childhood sexual abuse: an evidence based perspective*. Sage Publications.

Freyd, J. J. (1996). Betrayal *trauma: The logic of forgetting childhood abuse*. Cambridge, MA: Harvard University Press.

Friedrich, W.N., Urquiza, A., & Beilke, R.L. (1986). Behavior problems in sexually abused young children. *Journal of Pediatric Psychology,* 11:47-57.

Gavin Andrews et al. (2000). *Comparative Quantification of health risks among sexual abuse survivor children.*

Gelinas, D.J. (1983). The persisting negative effects of incest. *Journal of interpersonal violence 46:312-32.*

Gil, E., Johnson, T.C. (1993). *Sexualized child: Assessment and treatment of sexualized children.* Rockville, MD.

Gligan, J. & Sharma, A. (2008). *Child sexual abuse: Child survivors, mothers, and perpetrators tell their stories*. Lulu Enterprise 860 Aviation Parkway USA.

Gregory-Bills, T., & Rhodeback, M. (1995). Comparative psychopathology of women who experienced intra-familial versus extra-familial sexual abuse. *Child Abuse and Neglect, 19, 177-189.*

Haugaard, J. J. (2000). The challenge of defining child sexual abuse. *Journal of American Psychologist, 55, 1036-1039.*

Jane R., Jane L. (2003). *Quantitative Research practice: A Guide for Social Science Students and Researchers*. Sage publications, London.

Jibril j et al. (2012). The child sexual abuse epidemics in Addis Ababa: Some Reflections on Reported incidents, Psychosocial consequences and Implications. *Journal of Ethiopian health science 22(1) 59-66.*

Jones, L., and Finkelhor, D. (2003). *The Decline in Child Sexual Abuse Cases.* Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Kathleen A. kendall-tackett, Linda Meyer Williyams, & Finkelhor. D. (1993). Impact of sexual abuse on children : A review and synthesis of recent empirical studies. *Psychological Bullitin, 113(1), 164-180.*

Kathleen .F. (1989). Characteristics of a clinical sample of sexually abused children : How boy and girl victims differ. *Child abuse and Neglect, 13, 281-291.*

Kendler KS, Kessler RC, Walters E (2000). Stressful life events, genetic liability and onset of an episode of major depression. *American psychiatric journal, 152:833–842.*

Killian,B.,& Brakarsh,J.(2004). *Therapeutic approaches to sexually abused children.* Cape Town: HSRC Press.

Kolko, D.J., Moser, J.T., and Weldy, S.R. (1988). Behavioral/emotional indications of sexual abuse in child psychiatric inpatients: A controlled comparison with physical abuse. *Child Abuse & Neglect. 12,529-542.*

Lakew, Z. (2001). Alleged Cases of Sexual Assault Reported to Two Addis Ababa Hospitals. *East African Medical Journal,* 78(2), 80-83.

Lipovsky, J.A., Saunders, B.E., and Murphy, S.M. (1989 Depression, anxiety, and behavior problems among victims of father-child sexual assault and non-abused siblings. Journal of interpersonal violence,4, 452-468.

Makoae, M., Warria, A., Bower, C., Ward, C., Loffel, J., & Dawes, A. (2009). *South Africa country report on the situation on prevention of child maltreatment study.* Cape Town.

Maltz, W. & Holman, B. (1987). *Incest and sexuality: A guide to understanding and healing.* Lexington Books.

Maniglio, R. (2009). Severe mental illness and criminal victimization. *A systematic review Psychiatric bulletin 119(3), 180-191.*

Martin H. T (2008). *Windows of vulnerability: neurobiology of child sexual abuse*. Harvard medical school Developmental Bio-psychiatry Research program.

Mannarino, A.P., Cohen, J.A., Smith, JA., & Moore-Motley, S. (1991). Six-and twelve-month follow-up of sexually abused girls. *Journal of Interpersonal Violence* 6:494-511.

Mathews, S. (2009). *Exploring the mental health needs of children post sexual assault in South Africa*. Misty Hills, Johannesburg.

McLeer SV, Dixon JF, Henry D, Ruggiero K, Escovitz K, Niedda T, Scholle.R. (1998). Psychopathology in non-clinically referred sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry, 40, 875-879.*

Meiselman, KC. (1978). *Incest: A psychological study of causes and effects with treatment Recommendations.* San Francisco: Jossey-Bass.

Ministry of Labor and Social Affairs. (2005). *National action plan on sexual abuse and exploitation of children 2006-2010.*Addis Ababa, Ethiopia.

Peacock, A.(1989). Self-esteem of abused children. *Journal of Child Abuse and Neglect, 9, 159-163.*

Pereda,N., Guilera, G., Forns, M., &Gómez-Benito, J.(2009). The prevalence of child sexual abuse in Community and student samples: A meta-analysis. *Clinical Psychology Review, 29, 328-341.*

Perry, D.G., Hodges, E.V.E., and Egan, S.K. (2001). *Determinants of chronic victimization by peers: A review and new model of family influence*. New York, NY: Guilford Press.

Pinheiro, P.S. (2006). *World report on violence against children: Report of the independent expert for the United Nations study on violence against children. Geneva:* United Nations.

Ruby, C. (2010). Childhood under threat: Effect of child sexual abuse on mental health in India. *Indian Journal of Health and Well-being 2(2), 334-337.*

Runtz, M.(1991). *The influence of coping strategies and social support on recovery from physical and sexual maltreatment during childhood.* Doctoral dissertation. University of Manitoba, Canada

Sadowski, C.M., &Friedrich, W.N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment, 5, 364-372.*

Smith, S.G.,(2002*). Chronic disease and health behaviors linked to experiences of nonconsensual sex among women and men.*

Tracy K. (2002). *Sexual Abuse of Children and Adolescents: National Association of School psychologists*. Western Illinois University.

Tremblay, R. E., Japel, C., Pérusse, D., McDuff, P., Boivin, M., Zoccolillo. (1999). The search for the age of 'onset' of physical aggression. Journal of *Criminal Behavior and Mental Health, 9(1), 8-23.*

UNICEF. (2001). Early marriage, child spouses. *UNICEF Digest No. 7, 1-28.*

Whitaker, D.J., Le, B., Hanson, R.K., Baker, C.K., Mcmahons, P.M., Ryan. (2008). Child abuse & neglect risk factors for the perpetration of child sexual abuse: A review and meta-analysis. *Journal of Child Abuse Neglect, 32(5), 529-548.*

Wolfe (1989). Factors associated with the development of posttraumatic stress disorder among child victims of sexual abuse. *Journal of Behavioral Therapy 20, 215-228.*

Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). *The Children's Impact of Traumatic Events Scale: A measure of post-sexual-abuse PTSD symptoms.*

Wolfe, V.V., Gentile, C., & Wolfe, D.A. (1989). The impact of sexual abuse on children: A PTSD formulation. *Behavioral Therapy.*

Wondie Y, Zemene W, Tafesse B, Reschke K, & Schoroder H., and Harry(2010). The Psychosocial Consequences of Child Sexual Abuse in Ethiopia: A Case-Control Comparative Analysis. *Journal of interpersonal Violence 26:2026-2040.*

WHO (2010). *Report on violence and health in Africa.* Brazzaville, World Health Organization, Regional Office for Africa.

WHO (2001). *WHO multi-country study on women's health and domestic violence*. World Health Organization, Geneva.

Wurtele, S. K., & Miller-Perrin, C. L. (1992). *Preventing child sexual abuse: Sharing the responsibility.* Lincoln, NE: University of Nebraska Press.

Wurtele, S. K., Miller (2009). Preventing sexual abuse of children in the twenty-first century: Preparing for challenges and opportunities. *Journal of Child Sexual Abuse, 18, 1–18.*

Yemataw W. The Psychosocial Consequences of Child Sexual Abuse in Ethiopia: A Case-Control Comparative Analysis. *Journal of Family & Community Health, 2008; 31(1), 24-31.*

**Appendix A**

**ADDIS ABABA UNIVERSITY**

**GRADUATE STUDIES**

**SCHOOL OF SOCIAL WORK**

**Questionnaire to Children**

My name is Endeshaw Aynetu. I am a second year post graduate student in the school of social work, Addis Ababa University. The purpose of this study is to examine psychosocial consequences of child sexual abuse among survivor female children. The questionnaire is designed to assess forms of sexual abuse you faced, the nature of perpetrators, frequency of abuse, and the psychological and social consequences that follow sexual abuse.

The information that you provide will be kept anonymous, highly confidential and not be utilized for any other purpose. There is no right and wrong responses but you are highly encouraged to provide honest response about sexual events you faced before, and current state of your feeling to keep the quality of the study.

Are you willing to participate in this study? Yes ☐ No ☐

**Background Information of Respondents**

***Instruction**: Please encircle your choice*

1. How old are you? _____
2. How old were you when sexual abuse occurred for the first time?_____
3. Religion
   A. Orthodox C. Catholic E. Others (specify)
   B. Protestant D. Muslim F. No religion
4. Place of origin
   A. Tigray B. Afar C. Amhara

D. Oromiya
E. SNNPR
F. Binshangul Gumuz
G. Harari
H. Somali
I. Gambella
J. Dire Dawa
K. Addis Ababa

5. Educational background (maximum grade completed)_____
6. When did you come to this center? _____
7. With whom you were living before you came to the center(mark all that applies)
   A. Step-mother
   B. Step-father
   C. Biological mother
   D. Biological father
   E. Grand mother
   F. Grand father
   G. Brother(s)
   H. Sister(s)
   I. Uncle
   J. Aunt
   K. Other relative
   L. People who were not relatives

**Guiding Questions on Sexual violence within the home and family situation, and community**

The questions are adopted from the African Child Policy Forum (ACPF), and *International Society for the Prevention of Child Abuse and Neglect (ISPCAN)*. The questionnaire is developed for children in the targeted areas. Mainly these questions are developed for survey. Accordingly, the questions on Sexual abuse try to answer issues related to prevalence, type and frequency of child sexual abuse in the family, community, and elsewhere.

***Instruction 1**: Read the items carefully and circle the numbers that closely reflect what have been experienced in your life.*

| No | Questions | | | Frequency | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Yes(1) | No (0) | once in a year(1) | Once in 6 month(2) | Once in 3 month(3) | Once in a month(4) | Once in a week(5) | Every day(6) |
| 1. | Did someone in your family or community touched or pinched your breasts, buttocks or genitals? | 1 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | Have you been forced to look at private parts, sexual acts or pornographic materials by any member of your family or community? | 1 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | Did you have experienced a forced sex with any member of your family or community? | 1 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | Did you have been forced to have more than one forms of sexual abuse by any members of your family, or community? | 1 | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | For the afore-listed forms of sexual, totally for how long you were abused | | | | | | | | |

***Instruction 2**: For this part you are requested to choose the people who sexually abused you within family or community level. (Mark "X" for all that applies*)

| **No** | Questions | Members of intrafamily | Members of extra family | Members of both intra and extra family |
|---|---|---|---|---|
| 1. | In your family or community who touched or pinched your breasts, buttocks or genitals? | 1 | 2 | 3 |
| 2. | In your family or community who forced you to look at private parts, sexual acts or pornographic materials? | 1 | 2 | 3 |
| 3. | With whom did you have forced sex or unwanted sex in your family or community | 1 | 2 | 3 |
| 4. | Who touched or pinched your breasts, buttocks or genitals, forced to look at sexual acts, forced to have sex? | 1 | 2 | 3 |

The following standardized instrument will be employed to measure psycho-social impacts of child sexual abuse on survivor children;

**Children's Impact of Traumatic Event Scale-Revised (CITES-R)**

**SCALES:**

**PTSD**

IT- Intrusive Thoughts

AV- Avoidance

HYP-AR= Hyper arousal

SX-A= Sexual Anxiety

**Social Reactions**

NRO- Negative Reactions by others

SS- Social Support

**Attributions about abuse**

SB-GU= Self blame/Guilt

PV- Personal Vulnerability

DW- Dangerous World

EMP- Empowerment

**Eroticism**

ERO-Eroticism

| | Very true | Some what true | Not true | |
|---|---|---|---|---|
| 1. Things like this WILL NOT happen again | 3 | 2 | 1 | EMP |
| 2. Some people believe that I did a very bad thing | 3 | 2 | 1 | NRO |
| 3. I try to stay away from things that remind me of what happened. | 3 | 2 | 1 | AV |
| 4. People who know about what happened think bad thoughts about me | 3 | 2 | 1 | NRO |
| 5. Some people blame me for what happened. | 3 | 2 | 1 | NRO |
| 6. I often feel irritable for no reason at all. | 3 | 2 | 1 | Hyp-AR |
| 7. I have trouble falling asleep because pictures or thoughts of what happened keep popping into my head. | 3 | 2 | 1 | IT |
| 8. I dislike or feel uncomfortable spending time alone with older boys or men. | 3 | 2 | 1 | PV |
| 9. If adults bother me, I can stop them. | 3 | 2 | 1 | EMP |
| 10. These kinds of things happen often | 3 | 2 | 1 | PV |
| 11. I have dreams or nightmares about what happened. | 3 | 2 | 1 | IT |
| 12. I have difficulty concentrating because I often think about what happened. | 3 | 2 | 1 | Hyp-AR |
| 13. This happened to me because I was too young to do anything about it. | 3 | 2 | 1 | SB-GU |
| 14. This happened to me because I was too young to do anything about it. | 3 | 2 | 1 | NRO |
| 15. Something like this might happen to me again. | 3 | 2 | 1 | PV |
| 16. I was to blame for what happened | 3 | 2 | 1 | SB-GU |
| 17. People often take advantage of children | 3 | 2 | 1 | DW |
| 18. I am easily startled or surprised. | 3 | 2 | 1 | Hyp-AR |
| 19. These kinds of things happen to a lot of children. | 3 | 2 | 1 | DW |
| 20. I think about what happened to me even when I don't want to. | 3 | 2 | 1 | IT |
| 21. I was not to blame for what happened. | 3 | 2 | 1 | SB-GU |
| 22. This happened to me because I acted in a way that caused it to happen. | 3 | 2 | 1 | SB-GU |
| 23. Pictures of what happened often pop into my mind. | 3 | 2 | 1 | IT |

| | | | | |
|---|---|---|---|---|
| 24. I often feel restless or jumpy | 3 | 2 | 1 | Hyp-AR |
| 25. Things in my life will get better. | 3 | 2 | 1 | EMP |
| 26. Some kids at school make fun of me because of what happened | 3 | 2 | 1 | NRO |
| 27. Most people who know about what happened are nice and understanding. | 3 | 2 | 1 | SS |
| 28. I feel I have caused trouble to my family | 3 | 2 | 1 | SB-GU |
| 29. Some people think I am lying about what happened. | 3 | 2 | 1 | NRO |
| 30. I am easily annoyed by others. | 3 | 2 | 1 | Hyp-AR |
| 31. This happened to me because I was not smart enough to stop it from happening. | 3 | 2 | 1 | SB-GU |
| 32. I try not to think about what happened. | 3 | 2 | 1 | AV |
| 33. Most people believe me when I talk about what happened. | 3 | 2 | 1 | SS |
| 34. I think about sex even when I don't want to. | 3 | 2 | 1 | ERO |
| 35. This happened to me because I was bad and needed to be punished. | 3 | 2 | 1 | SB-GU |
| 36. I sometimes have trouble remembering what happened during the sexual abuse. | 3 | 2 | 1 | AV |
| 37. I am embarrassed when I see people who know what happened | 3 | 2 | 1 | SB-GU |
| 38. There are many people who do bad things to children. | 3 | 2 | 1 | DW |
| 39. I feel I have caused problems for many people. | 3 | 2 | 1 | SB-GU |
| 40. I feel guilty about what happened | 3 | 2 | 1 | SB-GU |
| 41. Thinking about sex upsets me. | 3 | 2 | 1 | SX-A |
| 42. Sometimes when playing, I act out what happened during the sexual abuse. | 3 | 2 | 1 | IT |
| 43. This happened to me because I always have bad luck. | 3 | 2 | 1 | PV |
| 44. I get frightened when I think about sex. | 3 | 2 | 1 | SX-A |
| 45. As a result of what happened, people who used to care about me no longer do. | 3 | 2 | 1 | NRO |
| 46. I have more sexual feelings than my friends. | 3 | 2 | 1 | ERO |
| 47. (PERPETRATOR) was to blame for what happened. | 3 | 2 | 1 | SB-GU |

| | | | | |
|---|---|---|---|---|
| 48. When I am reminded of what happened, I sometimes feel very scared. | 3 | 2 | 1 | Hyp-AR |
| 49. If something like this happens again, I CAN stop it. | 3 | 2 | 1 | EMP |
| 50. I sometimes want to cry when I think of what happened | 3 | 2 | 1 | IT |
| 51. Some people think that I was to blame for what happened. | 3 | 2 | 1 | NRO |
| 52. No matter what I do, I can't stop sexual abuse. | 3 | 2 | 1 | PV |
| 53. If something like this happens again, I think I KNOW what to do to stop it. | 3 | 2 | 1 | EMP |
| 54. I am not as interested in some things I used to like before the sexual abuse happened. | 3 | 2 | 1 | AV |
| 55. People who I trusted let me down. | 3 | 2 | 1 | NRO |
| 56. Many things remind me of what happened. | 3 | 2 | 1 | IT |
| 57. I feel I should be punished for what I did. | 3 | 2 | 1 | SB-GU |
| 58. When I'm reminded of what happened, I try to think of something else. | 3 | 2 | 1 | AV |
| 59. I worry that other children will also be sexually abused. | 3 | 2 | 1 | DW |
| 60. Things like this happen to only a few children. | 3 | 2 | 1 | PV |
| 61. I know enough about sexual abuse now that I can protect myself in the future. | 3 | 2 | 1 | EMP |
| 62. I often worry that I will be sexually abused again. | 3 | 2 | 1 | PV |
| 63. I have someone with whom I feel comfortable talking about the sexual abuse. | 3 | 2 | 1 | SS |
| 64. Sex is dirty. | 3 | 2 | 1 | SX-A |
| 65. I like to look at naked people in books or on tv. | 3 | 2 | 1 | ERO |
| 66. I have tried to forget about what happened. | 3 | 2 | 1 | AV |
| 67. Children should not trust adults because they might sexually abuse them. | 3 | 2 | 1 | DW |
| 68. My family will protect me from being sexually abused again. | 3 | 2 | 1 | EMP |
| 69. I hope I never have to think about sex again. | 3 | 2 | 1 | SX-A |
| 70. I feel good about how my family treated me after I told about the sexual abuse. | 3 | 2 | 1 | SS |
| 71. I feel I have to know people for a long time before I can trust them. | 3 | 2 | 1 | PV |

| | | | | |
|---|---|---|---|---|
| 72. I sometimes have sexual feelings when I see people kiss on TV | 3 | 2 | 1 | ERO |
| 73. I sometimes pretend this never happened or that it was a bad dream. | 3 | 2 | 1 | AV |
| 74. Since people found out about the sexual abuse, they have tried to protect me from it happening again. | 3 | 2 | 1 | SS |
| 75. I wish there was no such thing as sex. | 3 | 2 | 1 | SA-A |
| 76. Social workers, police, and/or doctors have helped me since I told about the sexual abuse. | 3 | 2 | 1 | SS |
| 77. It is more difficult for me to love people than it was before the sexual abuse. | 3 | 2 | 1 | AV |
| 78. Bad things happen to be all the time. | 3 | 2 | 1 | PV |

Thank you!!!

## Appendix B

**አዲስ አበባ ዩኒቨርስቲ**

**ሶሻል ወርክ ትምህርት ቤት**

ለህፃናት የተዘጋጀ መጠይቅ

**አጠቃላይ መመሪያ**

ስሜ እንደሻዉ አይነቱ ይባላል፡፡ በአዲስ አባባ ዩኒቨርስቲ የሶሻል ወርክ ት/ት ክፍል የሁለተኛ ዲግሪ ተማሪ ስሆን በአሁኑ ሰዓት በህጻናት ላይ እየደረሰ ያለዉ የወሲብ ጥቃት ሊያደርስ ስለሚችለዉ ማህበራዊና ስነ-ልቦናዊ ችግር በተመለከተ ጥናት በማድረግ ላይ እገኛለሁ፡፡ጥናቱ በዋናነት የሚያካልለዉ በአዲስ አባባ ከተማ አስተዳደር በሚገኙ የወሲብ ጥቃት ሰለባ የሆኑ ህጻናትን በሚንከባከቡ ማዕከላት ላይ ብቻ ነዉ፡፡

ስለሆነም ወደ ማዕከሉ ከመምጣትሽ በፊት ባንቺ ላይ ስለተከሰተብሽ ነገሮች እና አሁን ላይ ስለሚሰማሽ ስሜት ልጠይቅሽ እፈልጋለሁ፡፡ እባክህሽን የተፈፀሙብህሽን ነገሮች በማሰብ በተቻለ መጠን ጥያቄዎቹን በትክክል እንድትመልስልሽልኝ እጠይቃለሁ፡፡ ትክክል ወይም ስህተት የሚባል መልስ ስለሌለ በአንቺ ላይ የተፈጸመና የምታስታውሰውሽውን እና አሁን ላይ ስለሚሰማሽ ስሜት ብቻ እንድትመልስልሽልኝ ነው የሚጠበቀው፡፡ ማንኛውም የምትሰጠዉ ምላሽ በሙሉ በሚስጢር የሚጠበቅ ነው፡፡ በዚህ መጠይቅ ላይ ስምሽን ማስፈር አይጠበቅብህሽም፡፡ማንም በቤተሰብሽ ውስጥ ያለ ሰው፣ ጎረቤትሽ፤ ወይም ባለስልጣናት ለእኔ ስለመለስክልሽልን ነገር ሊያውቁ አይችሉም፡፡መጠይቁን ለመመላት እንደማትችይ ከተሰማሽ በማንኛውም ወቅት እንድታቋርጪ ትችላለሽ፡፡

በዚህ ጥናት እንድትሳተፊ የማዕከሉ ኃላፊ/ዎችን ወይንም አሳዳጊዎችሽን ጠይቄ ተስማምተዋል፡፡

በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ነሽ? በሳጥኑ ውስጥየ «√» ምልክት አድርጊ::

☐ አዎ ☐ አይደለሁም

**ክፍል አንድ፡ አጠቃላይ ግላዊ መረጃ**

1. እድሜሽ ስንት ነዉ?_____
2. የወሲብ ጥቃት ሲደርስብሽ እድሜሽ ስንት ነበር?_____
3. ኃይማኖትሽ ምንድን ነዉ?

☐ ኦርቶዶክስ ☐ ካቶሊክ ☐ ሌላ ካለ ጥቀስ----------

☐ ፕሮቴስታንት ☐ ሙስሊም ☐ ኃይማኖት የለኝም

4. የተወለድሽበት ክልል

☐ ትግራይ ☐ የደ/ብ/ብ/ሕ ☐ ጋምቤላ

☐ አፋር ☐ ቢነሻንጉል ጉሙዝ ☐ ድሬደዋ ከተማ

☐ አማራ ☐ ሃራሬ ☐ አዲስ አበባ ከተማ

☐ ኦሮምያ ☐ ሶማሌ

5. የምትከታተይው ስንተኛ ክፍል ነው?_____

6. አሁን ወዳለህበት/ሽበት ማዕከል መቼ መጣሽ?_____

7. ወደ ማዕከሉ ከመምጣትሽ በፊት የምትኖሪው ከማን ጋር ነበር?/ የሚመለከታቸዉን ሠዎች ሁሉ መጥቀስ ይቻላል /

☐ ወላጅ እናት ☐ የሴት አያት ☐ አክስት

☐ ወላጅ አባት ☐ የወንድ አያት ☐ አጎት

☐ የእንጀራ አባት ☐ እህት(ቶች) ☐ ሌላ ዘመድ

☐ የእንጀራ እናት ☐ ወንድም(ሞች) ☐ ዘመድ ያልሆኑ ሠዎች

**ክፍል ሁለት፡ በቤተሰብ ውስጥ፤ በአካባቢና በሌላ ቦታ የሚፈፀም ፆታዊ ጥቃትን በተመለከተ**

ከዚህ በታች የሚገኙ ጥያቄዎች የግል እና ሚስጢራዊ የሆኑ ጉዳዮችን ማለትም ከዚህ በታች ከተዘረዘሩት ማንኛውም ዓይነት ወሲባዊ ጥቃቶች በቤተሰብ ዉስጥ፤ በአካባቢሽ፤ በትምህርት ቤት ወይም ከቤት ውጭ ባሉ በሌሎች ቦታዎች በአንቺ ላይ የተፈፀመብሽ ስለመሆኑ ይመለከታሉ፡፡ ማንኛውም የምትነግሪኝ ነገር በጣም በሚስጢር የሚያዝ እና ማንም ሊያውቀው ስለማይችል ምንም አይነት ስጋት ሊገባሽ አይገባም፡፡

| ተ.ቁ | ጥያቄዎች | ይህ ጥቃት ደርሶብሻል | | ስንት ጊዜ ነበር እንደዚህ ያሉ አጋጣሚዎች የተከሰቱብህ/ሽ? | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | አዎ | አይደለም | በአመት አንዴ | በስድስት ወር አንዴ | በሶስት ወር አንዴ | በወር አንዴ | በሳምንት አንዴ | በየቀኑ |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. | በቤተሰብሽ ውስጥ ወይም በአከባቢሽ ወሲባዊ በሆነ ሁኔታ ጡቶችሽን፤ መቀመጫሽን ወይም ብልትሽን የነካሽ ወይም የነነተለሽ የቤተሰቡ አባል ወይም የአከባቢ ሰው ነበር? | | | | | | | | |
| 2. | ወሲባዊ ብልቱን ሆነ ብሎ በመግለጥ እንድታየው ፣የወሲብ ትዕይንቶችን ወይም ፊልሞች (መጽሔቶች) እንድታይ ያደረገ የቤተሰቡ አባል ወይም የአከባቢዉ ሰው ነበር? | | | | | | | | |
| 3 | ከቤተሰብሽ አባል ከሆነ ሰው ጋር ወይም ከሌላ የአከባቢ ሰዉ ወሲብ/የግዳጅ ወሲብ/ ፊጽመሽ ታዉቃለሽ? | | | | | | | | |
| 4 | በጠቅላላው ለምን ያህል ጊዜ ከላይ የተጠቀሱት ወሲባዊ ጥቃቶች ደርሰውብሻል? | | | | | | | | |

**ክፍል ሶስት፡** ከዚህ በታች የተዘረዘሩትን ማንኛውም ዓይነት ወሲባዊ ጥቃቶች በቤተሰብ ዉስጥ፣ በአካባቢሽ፣ በትምህርት ቤት ወይም ከቤት ውጭ ባሉ በሌሎች ቦታዎች በአንቺ ላይ የፈፀሙብሽ የቤተሰብ አባል፣ የአከባቢ እንዲሁም ሌላ ሰዉ እንድትነገሪኝ በትህትና እጠይቃለሁ( የወሲብ ጥቃት አድርሶብኛል የምትይዉን ሰዉ ሁሉ መምረጥ ይቻላል)፡፡ ከላይ እንደተገለፀው ማንኛውም የምትነግሪኝ ነገር በጣም በሚስጢር የሚያዝ እና ማንም ሊያውቀው የማይችል መሆኑን በድጋሚ አረጋግጥልሻለሁ፡፡

| ተ.ቁ | ጥያቄዎች | የወሲብ ጥቃት ያደረሰብሽ የቤተሰብ አባል፣ የአከባቢ ወይም ሌላ ሰዉ | | |
|---|---|---|---|---|
| | | የቤተሰብ አባል | ከቤተሰብ አባል ያልሆነ | ሁለቱም |
| 1. | በቤተሰብሽ ውስጥ ወይም በአከባቢሽ ወሲባዊ በሆነ ሁኔታ ጡቶችሽን ፤መቀመጫሽን ወይም ብልትሽን የነካሽ ወይም የነነተለሽ የቤተሰቡ አባል ወይም የአከባቢ ሰው ማን ነበር? | | | |
| 2. | ወሲባዊ ብልቱን ሆነ ብሎ በመግለጥ እንድታየው ፣ የወሲብ ትዕይንቶችን ወይም ፊልሞች (መጽሔቶች) እንድታይ ያደረገ የቤተሰቡ አባል ወይም የአከባቢዉ ሰው ማን ነበር? | | | |
| 3 | ከቤተሰብሽ አባል ከሆነ ሰው ጋር ወይም ከሌላ የአከባቢ ሰዉ ወሲብ/የግዳጅ ወሲብ/ ማን ጋር | | | |

| | | | | |
|---|---|---|---|---|
| | ፈጽመሽ ታውቃለሽ? | | | |
| 4 | ከላይ ከተጠቀሱት ወሲባዊ ጥቃቶች ሁለት እና ከዚያ በላይ ደርሰውብሻል? በነማን? | | | |

**ክፍል አራት** ከዚህ በታች የተዘረዘሩ ነጥቦች ጥቃቱ ከደረሰብሽ በኋላ የሚሰማሽን ስሜት እና አሁን ያለሽበትን ሁኔታ ለመረዳት የሚጠቅሙ ናቸዉ:: ስለሆነም የአንቺ ትክክለኛ ምላሽ የጥናቱን ውጤት የሚወስን በመሆኑ ትክክለኛውን ምላሽ ታሰፍሪ ዘንድ በአክብሮት እየጠየቅሁ የሚሰጠው ማንኛውም መረጃ አሁንም በሚስጥር የሚጠበቅ መሆኑን እገልፃለሁ::

| ተ.ቁ | | በጣም እዉነት ነዉ | በተወሰነ መልኩ እዉነት ነዉ | እዉነት አይደለም |
|---|---|---|---|---|
| 1 | በፊት የደረሱብኝ ነገሮች በድጋሜ አይከሰቱብኝም፤ | | | |
| 2 | ጥቂት ሰዎች በጣም መጥፎ ነገር እንደሰራሁ ያምናሉ፤ | | | |
| 3 | የተከሰተዉን ነገር ከሚያስተዉሱ ነገሮች ለመራቅ እሞክራለሁ፤ | | | |
| 4 | ስለተከሰተዉ ነገር የሚያዉቁ ሠዎች ስለእኔ መጥፎ ያስባሉ፤ | | | |
| 5 | ጥቂት ሠዎች ስለተከሰተዉ ነገር እኔን ይወቅሳሉ፤ | | | |
| 6 | ያለምንም ምክንያት የመነጫነጭ ስሜት ይሰማኛል፤ | | | |
| 7 | በፊት የተከሰቱት ነገሮች ምስል ወይም ሁኔታ በምናቤ አየታየኝ ለመተኛት እቸገራለሁ፤ | | | |
| 8 | ብቻየን በዕድሜ ከሚበልጡኝ ወንዶች እና ትልልቅ ሠዎች ጋር መሆን አልወድም /አይመቸኝም፤ | | | |
| 9 | በዕድሜ የሚበልጡኝ ሠዎች ቢያስጨንቁኝ ማስቆም እችላለሁ፤ | | | |
| 10 | እንዲህ አይነት ነገሮች በአብዛኛዉ ይከሰታሉ፤ | | | |
| 11 | በፊት ስለተከሰተዉ ነገር እቃጥለሁ ወይም በህልሜ ይመጣብኛል | | | |
| 12 | ስለደረሰብኝ ነገር አብዝቼ ስለማስብ ትኩረት የማድረግ ችግር አለብኝ | | | |
| 13 | ጥቃቱ የደረሰብኝ በጣም ትንሽ ስለሆነኩኝ እና ምንም ማድረግ ስለማልችል ነዉ፤ | | | |
| 14 | ሠዎች ስለደረሰብኝ ነገር ካወቁ በኋላ ብዙም ከኔ ጋር መቆየት አይፈልጉም፤ | | | |
| 15 | እንደዚህ አይነት ነገር በድጋሜ ሊከሰት ይችላል፤ | | | |
| 16 | ለደረሰብኝ ነገር ራሴን እወቅሳለሁ፤ | | | |

| | | | | |
|---|---|---|---|---|
| 17 | ሰዎች በአብዛኛዉ የህጻናትን ጥቅም ይጋፋሉ፤ | | | |
| 18 | እኔ በቀላሉ እጨነቃለሁ ወይም እገረማለሁ፤ | | | |
| 19 | እንደዚህ አይነት ነገሮች በብዙ ህጻናት ላይ ይከሰታሉ፤ | | | |
| 20 | ስለደረሰብኝ ነገር ማሰብ ባልፈልግ እንኳን አስባለሁ፤ | | | |
| 21 | ስለደረሰብኝ ነገር አልወቅስም፤ | | | |
| 22 | ነገሩ የተከሰተዉ እኔ እንዲከሰት ስላደረገሁኝ ነዉ፤ | | | |
| 23 | ብዙን ጊዜ ስለደረሰብኝ ነገር ምስሎች ብልጭ ይሉብኛል፤ | | | |
| 24 | ብዙን ጊዜ የመረበሽ ወይም የመደናገጥ ስሜት ይሰማኛል፤ | | | |
| 25 | ነገሮች በህይወቴ ላይ እየተሻሻሉ ይሄዳሉ፤ | | | |
| 26 | የተወሰኑ ልጆች ት/ት ቤት ይስቁብኛል/ይሳለቁብኛል፤ | | | |
| 27 | ስለደረሰብኝ ጥቃት የሚያዉቁ ብዙ ሰዎች ጥሩና የሚረዱ ናቸዉ፤ | | | |
| 28 | ቤተሰቦቼን እንደበጠበጥኩኝ ወይም ለችግር እንደዳረግሁኝ ይሰማኛል፤ | | | |
| 29 | ጥቂት ሰዎች ስለደረሰብኝ ነገር የዋሸሁ ይመስላቸዋል፤ | | | |
| 30 | ሰዎች በቀላሉ ያናድዱኛል፤ | | | |
| 31 | ጥቃቱ የደረሰበኝ ለመከላከል በቂ ስላልነበረኩኝ ነዉ፤ | | | |
| 32 | ስለደረሰብኝ ነገር ላለማሰብ እሞክራለሁ፤ | | | |
| 33 | ስለደረሰብኝ ነገር ስነግራቸዉ ብዙ ሰዎች ያምኑኛል፤ | | | |
| 34 | ባልፈልግ እንኳን ስለወሲብ አስባለሁ | | | |
| 35 | ጥቃቱ የደረሰብኝ እኔ መጥፎ እና መቀጣት ስለነረብኝ ነዉ፤ | | | |
| 36 | አልፎ አልፎ በጥቃቱ ጊዜ የደረሰብኝን ማስታወስ ያዳግታኛል፤ | | | |
| 37 | ስለደረሰብኝ ጥቃት የሚያዉቁ ሰዎችን ሳይ አፍራለሁ፤ | | | |
| 38 | ልጆች ላይ መጥፎ ነገሮችን የሚያድረጉ ብዙ ሠዎች አሉ | | | |
| 39 | ለብዙ ሠዎች ችግር እንደፈጠረኩ ይሰማኛል | | | |

| | | | | |
|---|---|---|---|---|
| 40 | ስለደረሰብኝ ነገር የጥፋተኝነት ስሜት ይሰማኛል፤ | | | |
| 41 | ስለወሲብ ማሰብ ያናድደኛል፤ | | | |
| 42 | አንዳንዴ እየተጫወትኩኝ ሳለ ጥቃቱ ሲደርስብኝ የሆንኩትን አንጸባርቃለሁ፤ | | | |
| 43 | ይህ የደረሰብኝ እኔ ሁሌም መጥፎ ዕድል ስላለኝ ነዉ፤ | | | |
| 44 | ስለወሲብ ሳስብ እፈራለሁ፤ | | | |
| 45 | ጥቃቱ ከደረሰብኝ በኃላ ይነከባከቡኝ የነበሩ ሰዎች ሁሉ ትተዉኛል፤ | | | |
| 46 | ከጓደኞቼ የበለጠ የወሲብ ስሜቶች አሉኝ፤ | | | |
| 47 | ጥቃቱን ያደረሰብኝ ሠዉ ሊወቀስ ይገባል፤ | | | |
| 48 | የደረሰብኝ ነገር ሲታወሰኝ አንዳንዴ በጣም ፍርሃት ይሰማኛል፤ | | | |
| 49 | አንደዚህ አይነት ነገር ድጋሜ ቢከሰት ማስቆም እችላላሁ፤ | | | |
| 50 | አንዳንዴ ስለተከሰተዉ ነገር ሳስብ ማልቀስ እወዳለሁ፤ | | | |
| 51 | አንዳንድ ሠዎች ለተከሰተዉ ነገር የምወቅስ ይመስላቸዋል፤ | | | |
| 52 | ምንም ባደርግ ምን የወሲብ ጥቃቱን ማስቆም አልችልም፤ | | | |
| 53 | እንደዚህ አይነት ነገር በድጋሜ ቢከሰት እንዴት ማስቆም እንዳለብኝ የማዉቅ ይመስለኛል፤ | | | |
| 54 | ከጥቃት በፊት የምወዳቸዉ የነበሩ ነገሮች ላይ አሁን ብዙም ፍላጎት የለኝም፤ | | | |
| 55 | ያመንኳቸዉ ሠዎች ጎዱኝ/ እንድጎዳ አደረጉኝ/፤ | | | |
| 56 | ስለተከሰተብኝ ጥቃት ብዙ ነገሮች ያስታዉሱኛል፤ | | | |
| 57 | ስላደረግሁት ነገር መቀጣት እንደነበረብኝ ይሰማኛል፤ | | | |
| 58 | የደረሰብኝ ጥቃት ሲታወሰኝ የማይሆን ነገር ለማሰብ እሞክራለሁ፤ | | | |
| 59 | እንደ እኔ ሁሉ ሌሎች ልጆችም የወሲብ ጥቃት ይደርስባቸዋል ብዬ እጨነቃለሁ፤ | | | |
| 60 | እንደዚህ አይነት ነገር የሚከሰተዉ ጥቂት ልጆች ላይ ብቻ ነዉ፤ | | | |
| 61 | ስለወሲብ ጥቃት በሚገባ ስላወቅሁኝ ወደፊት ሊደርስብኝ ከሚችል ጥቃት ራሴን መጠበቅ እችላለሁ | | | |

| | | | | |
|---|---|---|---|---|
| 62 | ብዙ ጊዜ በድጋሜ ጥቃቱ ይደረችብኛል ብዬ እጨነቃለሁ፤ | | | |
| 63 | ስለወሲብ ጥቃት ሳወራዉ ደስ የሚለኝ /ምቾት የሚሰማኝ ሠዉ አለኝ፤ | | | |
| 64 | ወሲብ ቆሻሻ ነዉ፤ | | | |
| 65 | እርቃናቸዉን የሆኑ ሠዎች መጽሐፍ ወይም ቴሌቨዥን ላይ መመልከት እወዳለሁ፤ | | | |
| 66 | የደረሰብኝን ነገር ለመርሳት ሞክሬያለሁ፤ | | | |
| 67 | ህጻናት ወጣቶችን ማመን የለባቸዉም ምክንያቱም ለወሲብ ጥቃት ሊዳርጓቸዉ ይችላሉና፤ | | | |
| 68 | የወሲብ ጥቃቱ በድጋሜ እንዳይከሰት ቤተሰቦቼ ሊጠብቁኝ ይችላሉ፤ | | | |
| 69 | ስለወሲብ በፍፁም በድጋሜ እንደማለስብ አምናለሁ፤ | | | |
| 70 | ስለወሲብ ጥቃት ከነገርኳቸዉ በኋላ ቤተሰቦቼ ላደረጉልኝ እንክብካቤ ጥሩ ስሜት ይሰማኛል፤ | | | |
| 71 | ሠዎችን ከማመኔ በፊት በደንብ ማወቅ እንዳለብኝ ይሰማኛል፤ | | | |
| 72 | አንዳንዴ ሠዎች ሲሳሳሙ ቴሌቭዥን ላይ ስመለከት የወሲብ ስሜት አለኝ፤ | | | |
| 73 | እንዳንዴ ምንም እንዳልተከሰተ እደናገራለሁ ወይም መጥፎ ህልም ይመስለኛል፤ | | | |
| 74 | ስለወሲብ ጥቃት ካወቅሁ ጀምሮ ሠዎች ጥቃቱ በድጋሜ እንዳይከሰትብኝ ለመጠበቅ ሞክራዋል | | | |
| 75 | ወሲብን ያህል ነገር ያለ አይመስለኝም፤ | | | |
| 76 | የማህበራዊ አገልግሎት ሠራተኞች፣ ፖሊስ፣ ዶክተሮች እንዲሁም ሌሎች ሰዎች ስለጥቃቱ ከነገርኳቸዉ በኋላ ረድተዉኛል፤ | | | |
| 77 | እንደበፊቱ/ከጥቃቱ በፊት/ ሠዉ መዉደድ በጣም አስቸጋሪ ሁኖብኛል፤ | | | |
| 78 | መጥፎ ነገሮች ሁሌም ይከሰቱብኛል፤ | | | |

ስለ ትብብርዎ እጅግ በጣም አመሰግናለሁ፡፡