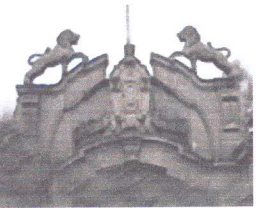


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**THE EFFECTIVENESS OF SOLUTION-FOCUSED BRIEF GROUP
COUNSELING FOR PSYCHOLOGICAL PROBLEMS OF SEXUALLY
ABUSED CHILDREN:**

THE CASE OF GODANAW REHABILITATION INTEGRATED PROJECT

BY MARKOS KANKO

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF PSYCHOLOGY**

**JUNE, 2010
ADDIS ABABA**



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**A THESIS
SUBMITTED IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF ART IN COUNSELING PSYCHOLOGY**

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
INSTITUTE OF PSYCHOLOGY**

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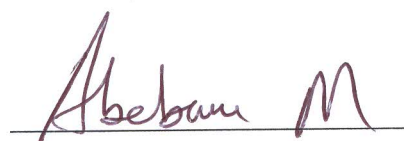
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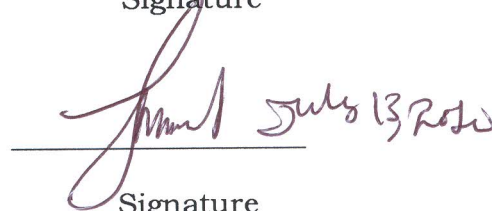
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ABSTRACT

This study examined whether Solution-Focused Brief Group Counseling (SFBGC) is effective in addressing psychological problems of sexually abused children in Godanaw Rehabilitation Integrated Project. Fifty participants aged 12-18 year old selected purposefully based on inclusion criteria who randomly assigned into the control and treatment group, each with 25 participants. The research design was a non-equivalent control group pretest and posttest of a quasi-experimental design. Three standardized scales, namely, the Children Depression Inventory, the Child Posttraumatic Stress Symptoms Scale and Rosenberg Self-Esteem Scale were used to measure the dependent variables at two occasions: pretest and posttest. Participants in the treatment group received SFBGC for three weeks, three days per week, 1:00-1:20 hours per session for a total of 8 sessions. Results of dependent t-test indicated that, after treatment, participants engaged in treatment group showed statistically significant reduction in the level of depression ($df=24$, $t=2.186$, $p<0.05$) and significant improvement in self-esteem ($df=24$, $t=-2.623$, $p<0.05$) compared to the control group. Independent t-test indicated that there was no statistically significant difference between the treatment and control group in posttraumatic stress symptoms during the pre-test ($df=48$, $t=0.183$, $p<0.05$) and during the post-test ($df=48$, $t=0.199$, $p<0.05$) respectively. From these results it was suggested that the application of SFBGC has to be expanded to address psychological problems of sexually abused children in more other organizations or settings.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	i
ABSTRACT	ii
TABLE OF CONTENTS	iii
ACRONYMS	v
LIST OF FIGURE AND TABLES	vi
 CHAPTER ONE	 1
INTRODUCTION	1
1.1 Background of the Study	1
1.2 Statement of the Problem	6
1.3 Objectives	6
1.4 Significance of the Study	7
1.5 Delimitation of the Study	8
1.6 Operational Definition of Terms	8
 CHAPTER TWO	 10
LITERATURE REVIEW	10
2.1 Definition and Concept of Child Sexual Abuse	10
2.2 Prevalence of Child Sexual Abuse in the World	11
2.3 Sexual Abuse against Children in Ethiopia	13
2.4 Effects of Child Sexual Abuse	14
2.2 Solution-Focused Brief Counseling	18
 CHAPTER THREE	 33
METHODS	33
3.1 The Research Design and Methods	33
3.2 Research Site	34
3.3 Population and Sampling	34
3.4 Randomization	34
3.5 Variables	35
3.6 Research Instrument	36
3.7 Pilot Testing	41
3.8 Ethical Issues Considered	41

3.9 Data Collection Procedures.....	42
3.10 Method of Data Analysis.....	43
CHAPTER FOUR	44
RESULTS.....	44
4.1 Demographic Characteristics of Participants	44
4.2 Psychological Problems of Sexually Abused Children.....	46
4.3 Analysis of Dependent and Independent t-test.....	50
CHAPTER FIVE	57
DISCUSSION	57
CHAPTER SIX	60
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS	60
6.1 Summary	60
6.2 Conclusions.....	62
6.3 Recommendations	63
REFERENCES	65
 APPENDICES	
Appendix-A Demographic Data Questionnaire (English Version)	
Appendix-B Children Depression Inventory (English Version)	
Appendix-C Child Posttraumatic Stress Symptoms Scale (English Version)	
Appendix-D Rosenberg Self-Esteem Scale (English Version)	
Appendix-E Demographic Data Questionnaire (Amharic Version)	
Appendix-F Children Depression Inventory (Amharic Version)	
Appendix-G Child Posttraumatic Stress Symptoms Scale (Amharic Version)	
Appendix-H Rosenberg Self-Esteem Scale (Amharic Version)	
Appendix-I Informed Consent Form	
Appendix-J Treatment Plans	

ACRONYMS

ACPF	African Child Policy Forum
BC	Brief Counseling
CDI	Children's Depression Inventory
CPSS	Child PTSD Symptom Scale
CPTSD-RI	Child Post-traumatic Stress Disorder Reaction Index
CSA	Child Sexual Abuse
FSCE	Forum on Street Children Ethiopia
GRIP	Godanaw Rehabilitation Integrated Project
PTDS	Posttraumatic Diagnostic Scale
PTSD	Post-traumatic Stress Disorder
RSES	Rosenberg Self-esteem Scale
SCS	Save the Children Sweden
SD	Standard Deviation
SFBC	Solution-focused Brief Counseling
SFBGC	Solution-focused Brief Group Counseling
SISE	Single-item Self-esteem Scale
WHO	World Health Organization

LIST OF FIGURE AND TABLES

Figure 1: Design of a Quasi-Experimental Design	33
Table 1: Demographic Characteristics of Treatment and Control Group	45
Table 2: Depression Level of Treatment Group before and after Treatment (N=25)	46
Table 3: Depression Level of Control Group before and after Treatment (N=25)	47
Table 4: Posttraumatic Stress Symptoms Level of Treatment Group before and after Treatment	47
Table 5: Posttraumatic Stress Symptoms Level of Control Group before and after Treatment	48
Table 6: Self-Esteem Level of Treatment Group before and after Treatment	49
Table 7: Self-Esteem Level of Control Group before and after Treatment	49
Table 8: Dependent T-Test of the Mean Depression Scores of the Treatment Group before and after the Treatment (N=25)	50
Table 9: Dependent T-Test of the Mean Depression Scores of the Control Group before and after the Treatment (N=25)	50
Table 10: Independent T-Test of the Mean Depression Scores of the Treatment and Control Group	51
Table 11: Dependent T-Test of the Mean Posttraumatic Stress Symptoms Scores of the Treatment Group before and after the Treatment (N=25)	52
Table 12: Dependent T-Test of the Mean Posttraumatic Stress Symptoms Scores of the Control Group before and after the Treatment (N=25)	53
Table 13: Independent T-Test of the Mean Posttraumatic Stress Symptoms Scores of the Control and Treatment Group before and after the Treatment	53
Table 14: Dependent T-Test of the Mean Self-Esteem Scores of the Treatment Group before and after the Treatment (N=25)	54
Table 15: Dependent T-Test of the Mean Self-Esteem Scores of the Control Group before and after the Treatment (N=25)	55
Table 16: Independent T-Test of the Mean Self-Esteem Scores of the Treatment Group and Control Group	55

CHAPTER ONE

INTRODUCTION

1.1. Background

The issue of child sexual abuse, exploitation and neglect, especially the plight of the girl child, has recently become a major area of concern in Ethiopia. Traditional Ethiopia value and belief systems coupled with poverty and ignorance, in most case, have facilitated the violations of the rights of children. Early marriages and the associated sexual abuse are not considered as abuse in most traditional communities of Ethiopia (Belay, 2001). The efforts of governmental and non-governmental bodies in rising the awareness of the public and preventing the abuse and neglect of children in Ethiopia is a good start although a lot remains to be done to protect children from all forms of abuse and neglect and promote their well being (Belay, 2001).

There is no universally accepted definition of what constitutes childhood sexual abuse because of the historical time, between cultures and among professional disciplines (Baker, 2002). Sanderson (2006) defined 'childhood sexual abuse' as the involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, where there is a difference in age, size or power, in which the child is used as a sexual object for the gratification of the older person's needs or desires. It is also considered sexual abuse when a child cannot give informed consent given the unequal power in the relationship. Activities can range from simple culturally unacceptable touching and fondling to forceful, penetrative sexual intercourse. This definition excludes consensual activity between peers (Sanderson, 2006).

According to the World Health Organization, (WHO, 2002), fewer than 1% of parents admit to have their children sexually abused. In expansively reviewing the international literature, the WHO determined a mean rate of 20% for females and 5-10% for males having reported child sexual abuse (WHO, 2002). Globally, 40 million children aged 0-14 years suffer from some form of abuse and neglect requiring health and social care among which the most devastating is child sexual abuse (WHO, 2004).

There are three primary forms of abuse: sexual, physical, and emotional. Sexual abuse includes sexual contact or attempted sexual contact with a child under the age of 18 by an adult for the purposes of the adult's sexual gratification or financial gain (Cicchetti & Toth, 2005). Physical abuse describes physical injuries to a child caused by punches or kicks, shakes or smacks, burns or scalds, drowning or suffocating, bites or poisons. Bruises may appear. Bones may be broken. Cuts are caused and illnesses arise. Even before they are born, some children are exposed to damaging levels of alcohol or drugs (Howe, 2005). Iwaniec (1995) defines emotional abuse as the 'hostile or indifferent behavior which damages a child's self-esteem, degrades a sense of achievement, diminishes a sense of belonging, prevents healthy and vigorous development, and takes away a child's well being.'

Females can and do sexually abuse children, however most abuse is carried out by males, including fathers, stepfathers, mothers' partners, brothers, grand fathers, uncles, as well as friends of the family including neighbors. Care-givers who are emotionally detached, violent or who abuse alcohol or drugs increase the risk of leaving their children prey to sexual abuse (Berliner and Elliot, 1996).

In relation to the impact of sexual abuse Howe (2005) found that many children who suffer sexual abuse experience pain, shame, fear, guilty, depression, low-self esteem and confusion. A national report produced by

Kilpatrick, Saunders, & Smith (2003, as cited in Cromer, 2006) for the U.S. Department of Justice that children aged 12 to 17 years who reported experiencing child sexual abuse (CSA), and who were still living at home (although not necessarily the home of an offender), were at increased risk for experiencing posttraumatic stress symptoms, for abusing substances, and for engaging in delinquent behavior compared to children who were not sexually abused.

Similarly, sexual abuse impairs children's ability to understand emotions and regulate their arousal. Severe physical and sexual abuse can traumatize children. Victims are, therefore, at increased risk of posttraumatic stress symptoms which include intrusive thoughts, sleep problems, nightmares, and feelings of helplessness, avoidance, numbing, and flashbacks of the abuse experience (Kendall-Tackett, 2002, as cited in Howe, 2005). Some sexually abused children become so deregulated and suffer from depression, internalizing and externalizing behavioral problems, and peer relationship difficulties. They tend to deny feeling emotionally needy, and yet they display high-level of emotional lability, inappropriate emotional outbursts, low levels of emotional awareness, and little emotional empathy. In challenging social situations they often seem to be psychologically disengaged and emotionally switched off (Berliner and Elliott, 1996; Widom and Kuhns, 1996; Jones, 2002).

In a further refinement, sexually abused children are at risk of experiencing a range of psychopathologies and problem behaviors including low self-esteem, major depression, anxiety, substance abuse, self-harming behavior, suicide, sudden feelings of anger and fear, obsessive-compulsive disorders, and eating disorders (Berliner and Elliott, 1996; Widom and Kuhns, 1996; Jones, 2002).

Johnson (2004) found that some long-term effects of CSA to include (mental and physical effects) emotional problems such as depression, anxiety, sexual

disturbances, eating disorder and substance abuse. Johnson (2004) also noted that victims of CSA have reported guilt, feelings of worthlessness and powerlessness, inability to distinguish sexual from affectionate behavior, difficulty in maintaining appropriate personal boundaries and the inability to refuse unwanted sexual advances. Similarly, Davis & Petretic-Jackson (2000) reported that experiencing problems with intimacy and feelings of guilt and shame are also long-term effects of CSA. Generally, several studies have found that the more physical force and violence used by the perpetrator, the more likely survivors will experience negative outcomes and the more intense the effects would be (Finkelhor, 1979; Friedrich, Beilke and Urquiza, 1986; Fromuth, 1983; Russell, 1986; Tufts New England Medical Center, 1984, as cited in Sanderson, 2006).

It is also found that sexually abused children were stigmatized and discriminated against by their family and community at large (Kelly, 2001). This stigmatization and discrimination have a long lasting effect on the lives of abused children. Stigmatization refers to the negative connotations like badness, shame, social isolation and guilt that communicated to the child by the experiences. Such negative connotations may come directly from perpetrator, who may want the victim to take the blame for the activity, or be reinforced by others in the family or community who hear of the abuse (Kelly, 2001).

Childhood sexual abuse (CSA) is often a significant trauma that may have a lifelong impact on survivors. When survivors of childhood sexual abuse seek counseling for any reason, counselors must be prepared to explore with them the impact the abuse had played in their development and the effect it might be having on their present concerns. Due to the prevalence of childhood sexual abuse in the histories of individuals who seek counseling, and its possible pervasive and long-term effects, it is important that all counselors become practiced at addressing the unique and complex needs of survivors.

Brief counseling is a descriptor of time-limited counseling which utilizes strengths, sees problems in context, and concentrates on the future (McLeod, 2003, as cited in Lines, 2006). It is an intervention provided for sexually abused children that emphasis the client's resources and strengths. Solution-focused brief Group Counseling (SFBGC) is one part of brief counseling. It is a non pathological approach that emphasizes competencies rather than deficits, and strengths rather than weakness (Metcalf, 2001). This approach differs from traditional counseling by focusing on the present and the future instead of evaluating and exploring past problems (Corey, 2009).

Reviews of SFBC generally have found an average number of sessions ranging between three and five (McKeel, 1996; Miller, 1994). Dewan, Steenbarger & Greenberg (2004) also asserted that Solution-focused counseling was able to address the concerns of clients in a brief fashion, generally in fewer than 10 sessions.

Therefore, the researcher has an interest in studying the effects of Solution-focused brief Group Counseling for sexually abused children problems; to help abused children realize their own potential, solve their own problems, and develop the psychological resilience and behavioral buoyancy to protect their lives in the future. The result also will be a guide for counseling service providers, especially counselors and social workers that work with sexually abused children with regard to the use and effectiveness of need-based Solution-focused brief Group Counseling services.

1.2 Statement of the Problem

Based on the above discussion, an attempt was made to answer the following research questions:

1. Is there a significant statistical difference in Depression from pre-to-post treatment measures between a treatment (child survivors who were treated with Solution-focused Brief Group Counseling) and control groups?
2. Is there a significant statistical difference in Posttraumatic Stress Symptoms from pre-to-post treatment measures between a treatment (child survivors who were treated with Solution-focused Brief Group Counseling) and control groups?
3. Is there a significant statistical difference in Self-esteem from pre-to-post treatment measures between a treatment (child survivors who were treated with Solution-focused Brief Group Counseling) and control groups?

1.3 Objectives

1.3.1 General Objective

The general objective of this research is to examine the effectiveness of Solution-focused Brief Group Counseling in addressing psychological problems of sexually abused children in Godanaw Rehabilitation Integrated Project.

1.3.2 Specific Objectives

1. To examine whether there is or not a significant statistical difference in Depression from pre-to post-treatment measures between treatment and control groups.
2. To explore whether there is or not a significant statistical difference in Posttraumatic Stress Symptoms from pre-to post-treatment measures between treatment and control groups.
3. To investigate whether there is or not a significant statistical difference in Self-esteem from pre-to post-treatment measures between treatment and control groups.
4. Forward recommendations based on the study findings that minimize sexually abused children's problems (depression, posttraumatic stress symptoms and low self-esteem).

1. 4 Significance of the Study

The researcher hopes that the results of the study will be helpful in the following major ways:

- The sexually abused children who shall be treated through Solution-focused Brief Group Counseling will be able to see their own potential, solve their own problems, and develop the psychological resilience and behavioral buoyancy to protect their lives in the future.
- The findings of the present study provide information for counseling service providers, especially counselors and social workers that work with sexually abused children with regards to the use and effectiveness of need-based Solution-focused Brief Group Counseling services.

- The findings of the present study are a base for organizations that need to develop specific counseling services for sexually abused children.
- The findings of the present study indicate what sort of problems sexually abused children suffer from and the role of Solution-focused Brief Group Counseling on the problems of sexually abused children.

1.5 Delimitation of the Study

The research was a quasi-experimental research design aiming at studying the effectiveness of Solution-focused Brief Group Counseling for sexually abused children. Participants were sexually abused children who are found in Godanaw Rehabilitation Integrated Project (GRIP).

Thus, this study was limited only to examining the most common psychological problems of sexually abused children, namely, posttraumatic stress symptoms, depression and low self-esteem. It also conducted on a sample of 50 only.

1.6 Operational Definition of Terms

Solution-Focused Brief Group Counseling (SFBGC): is defined as a practical, step-by-step group approach which promotes the utility of the clients' own strengths and resources in collaborative process of goal setting to work toward the desired change.

A Child: means every human being below the age of 18 years unless under the law applicable to the child, majority is attained otherwise, (United Nations Convention on the Rights of the Child, 1989: Article 1). For the purpose of this study a child defined as a human being with the age of 18 years and below.

Child Abuse: is defined as causing or permitting any harmful or offensive contact on a child's body; and, any communication or transaction of any kind

which humiliates shame or frightens the child maltreatment including physical, sexual, psychological/emotional abuse.

Child Sexual Abuse: for the purpose of this study child sexual abuse is defined as sexual activity involving persons, 18 years of age or younger. Most often perpetrated by an adult, such activities include rape and molestation, sexual harassment, and exposure of children to the sexual acts of others.

Depression: is defined as acute, but time-limited, episodes of depressive symptoms including diminished interest or pleasure in all or most daily activities, significant unintentional weight loss or appetite decrease or increase, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or energy loss, feelings of worthlessness or inappropriate guilt, concentration difficulty or indecisiveness and recurrent thought of death or suicidality.

Posttraumatic stress symptoms: is a debilitating psychological condition caused by a major traumatic event, such as rape, war, a terrorist act, death of a loved one, a natural disaster, or a catastrophic accident. Symptoms include, but are not limited to: nightmares, flashbacks about the incident, low startle threshold, difficulty sleeping, thoughts or obsessions about death and dying, difficulty concentrating, loss of desire to do things the individual formerly enjoyed, isolating, and avoidance of reminders of the trauma. In the present study, Posttraumatic stress symptoms are a debilitating psychological condition caused by sexual abuse.

Self-esteem: is defined as an individual's set of thoughts and feelings about his or her own worth and importance, that is, a global positive or negative attitude toward oneself.

CHAPTER TWO

LITERATURE REVIEW

To build a context for the study and treatment of sexually abused children, the study will examine child abuse from a broad perspective and it will narrow the focus to issues pertaining to sexually abused children. To begin, definition and concept of child sexual abuse will be presented followed by an examination of the prevalence and consequences. Next, the effects of child sexual abuse will be discussed with particular attention paid to self-esteem, depression and post-traumatic stress symptoms. Finally, Solution-focused brief counseling will be presented in detail.

2.1 Definition and Concept of Child Sexual Abuse

There is no universally accepted definition of what constitutes childhood sexual abuse because of the historical time and cultures in which it occurs and professional disciplines (Sanderson, 2006). Definitions in the literature vary according to the types of activities considered to be 'sexual' and the circumstances considered to constitute abuse (Claire and Donna, 2006).

The Child Protection Statutes' legal definition defines child sexual abuse as: "the employment, use, persuasion, inducement, force of any child to engage in, or assist any other person to engage in any sexually explicit conduct or stimulation of such conduct for the purpose of producing a visual depiction"(Procare, 2003). Clinical definition of abuse is related to these legal statutes. However, it must be determined whether or not the encounter had a traumatic impact on the child. The intensity of the impact must also be determined. The meaning that a child gives to the act (the child's lived-experience) generally determines the impact of the trauma. The child's lived-experience might change and reoccur as the child progresses through the

different developmental stages. It might even happen that sexual abuse is not experienced as traumatic but that a child then develops cognitive distortions and/or problematic belief system (Porcare, 2003)

Finkelhor (1997, as cited in Claire and Donna, 2006) suggested that the following definition, formulated by the National Center on Child Abuse and Neglect, is consistent with most legal and research definitions of child sexual abuse:

Contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18 when that person is significantly older than the victim or when the perpetrator is in position of power or control over another child (NCCAN, 1978:2).

Sanderson (2006) defined childhood sexual abuse as the involvement of dependent children and adolescents in sexual activities with an adult, or any person older or bigger, where there is a difference in age, size or power, in which the child is used as a sexual object for the gratification of the older person's needs or desires. It is also considered sexual abuse when a child cannot give informed consent given the unequal power in the relationship. Activities can range from just touching and groping to forceful, penetrative sexual intercourse. This definition excludes consensual activity between peers (Sanderson, 2006).

2.2 Prevalence of Child Sexual Abuse in the World

Due to differences in CSA definitions, sampling procedures (e.g., clinical vs. community samples), sample size, method of obtaining information (e.g., telephone survey vs. clinical interview), and age of respondent, the prevalence rates of CSA differ in studies. A meta-analysis studies by Paolucci and colleagues (2001) indicated that definition of CSA (e.g., fondling versus penetration) did not statistically mediate the relationship between CSA and

negative health and psychological outcomes. Therefore, it would seem appropriate to include a broader definition in outcome studies.

According to the World Health Organization, (WHO, 2002), fewer than 1% of parents admit to have their children sexually abused. In expansively reviewing the international literature, the WHO determined a mean rate of 20% for females and 5-10% for males having reported child sexual abuse (WHO, 2002). Similarly, World Health Organization (2004) reported that globally 40 million children aged 0-14 years suffer from some form of abuse and neglect requiring health and social care among which the most devastating is child sexual abuse.

Varies studies in the United States have consistently found comparable prevalence rates of CSA. For instance, Felitti (1991) found a rate of 24% for adults reporting CSA. Similarly, Bolen and Scannapieco (1999) reported CSA rates of 30-40% for females and 13% for males. In addition, as cited in Cromer, (2006) 50% of imprisoned girls have been sexually abused (Fletcher, 2005) and 60% report being raped or being in danger of being raped (Cauffman et al., 1998).

Svedin et al. (2002) indicated that 10-20% of women and 3-10% of men had experienced sexual abuse before 18 years of age in Europe. Russell (1983) also found 54% reported being sexually abused before 18 years of age in San Francisco.

In a nationally representative sample telephone survey reported by Finkelhor and colleagues (2005) indicated that 8.33% of 2- to 17-year-olds children sexually abused living at home in the past year (sample excluded youth in prison or those receiving inpatient treatment). These findings may be underreporting actual abuse rates as there was no way to control whether a current perpetrator was present during the telephone interview, or in the case

of young children, if the parent failed to disclose abuse on behalf of the child (WHO, 2002).

In many parts of Africa, child sexual abuse is a major unrecognized problem, with shocking consequences and long lasting effects that negatively impact the health and social development of children (WHO, 2004). In the Northern Province of South Africa, Madu and Peltzer (2006) reported that an overall prevalence rate of child sexual abuse was 16.4%; 8.8% for males, 15.7% for females. 9.9% were kissed sexually by force, 6.8% were touched sexually by force and 6.1% were victims' oral/anal/vaginal intercourse using force.

2.3 Sexual Abuse against Children in Ethiopia

Several researches suggested that the sexual abuse of children is very common in Ethiopia. For instance, African Child Policy Forum (ACPF, 2006) found that nearly seven out of ten girls are sexually abused and three out of ten girls raped at least once before reaching the age of eighteen while slightly less than half (46%) of the girls in the study reported that they were raped three to ten times. It also found in the city of Adama that 161 cases, out of which the majority of victims were young girls between the ages of 7-12 but in some cases, as young as two years old, experienced sexual abuse (ACPF, 2006).

A study conducted in Addis Ababa high schools by Gobena (1998) indicated that penile/vaginal coitus is the most common form of child sexual abuse (64.10%) followed by touching, fondling or kissing children's genitals (61.50%) and kissing children in a socially unacceptable manner (61.50%). Getnet and Desta (2008) also reported 6 out of 10 girls aged below 18 years faced sexual abuse in one or another form in everyday life in Addis Ababa.

Regarding the prevalence of sexual abuse across sub cities, Getnet and Desta (2008) reported that in Kolfe Keranio sub city (14.7%) followed by Addis Ketema

sub city (13.0%) and Yeka sub city (12.4%). With regard to forced sexual intercourse (rape), the problem was more prevalent in Addis Ketema and Arada sub cities followed by Yeka, Gulele, and Kirkos sub cities.

Another study conducted in Bahir Dar found that 80% of the female students interviewed reported incidences of sexual harassment or abuse in schools mainly by male students (but at times teachers as well) with students forcing or threatening and appealing through gifts and the like (FSCE, 2005).

ACPF and SC-Sweden (2006) found that children participated in the study reported that they know of cases of abduction (60.8 percent), rape (52.2 percent), seduction (42.5 percent), sexual harassment (33.2 percent) and unwanted sexual advance (33.2 percent), experienced by other children.

2.4 Effects of Child Sexual Abuse

The negative effects of child sexual abuse are well-known. The impact varies from survivor to survivor, depending upon the other risks and difficulties children have experienced and the resources those children and their families are able to access once abuse is disclosed (Gilgun & Sharma, 2008).

Gold, Swingle, Hill and Elfant (1998, as cited in Smith, 2008) noted that childhood sexual abuse has been observed to go beyond the peripheral characteristics of abuse such as frequency, duration, age at onset, number of perpetrator and type of abuse. While all factors are considered important, many studies reduce childhood sexual abuse to absence or presence of penetration, which over-simplifies the abusive experience and implies that penetration constitutes the single most severe aspect of it.

The effects of child sexual abuse can be long-term, short-term or both, and can affect children socially, physically and/or psychologically. Sexual abuse can

cause physical injuries and sexually transmitted diseases. Some of the more common psychological effects are post traumatic stress, depression, anxiety, drug and alcohol abuse, and negative self concept. Survivors may be so traumatized that they develop dissociative disorders (Gilgun & Sharma, 2008).

According to the studies of Cole and Putnam (1992, as cited in Schreider & Lyddon, 1998) the often serious and damaging psychological effects associated with childhood sexual abuse, includes depression, anxiety, relationship difficulties, low self-esteem, suicidal behavior, substance abuse, sexual dysfunction and personality disorders. The personality disorders included in the list of effects of childhood sexual abuse are antisocial, histrionic, narcissistic dependant, avoidant and especially borderline behaviors (Sullins, 1998, as cited in Smith, 2008).

For the purpose of this study, some common psychological effects of child sexual abuse more discussed in detail on three specific areas: (i) depression; (ii) post-traumatic stress; and (iii) self-esteem. As previously noted, these three categories were the dependent variables analyzed in this study.

2.4.1 Depression and CSA

It is likely that one of the most common psychological effects of children being sexually abused, aside from poor self-esteem and posttraumatic stress symptoms, is depression (Gilgun and Sharma, 2008). Gilgun and Sharma also found that children who have often been traumatized develop persistent depression. Their inability to rid themselves of fear, their sense of themselves as defective and bad, and hopelessness that anything will change contribute to their depression. In fact, Welldon (2004) stated it is the primary mental health problems of sexually abused children. Depression indicates a pattern of feelings of hopelessness and worthlessness; a sense of inadequacy; diminished self-esteem; many somatic complaints; a loss of interest or pleasure in activities that were once enjoyed; as well as an altered belief system that

encompasses negative thoughts about oneself, one's world and one's future (Sanderson, 2006).

Studies reported that children sexually abused show significantly higher levels of depressive symptoms than non-abused children (Braver, Bumbery, Green, & Rawson, 1992; Jackson, Calhoun, Amick, Maddever, & Habif, 1990; Yama, Tovey, & Fogas, 1993, as cited in Polusny and Follette, 1995). Other researchers have also reported that CSA survivors experience significantly higher depression than non-abused participants (Hunter, 1991; Roland et al., 1989), suggesting symptoms of hopelessness about the future, and general dissatisfaction with life (Graham, 1990). However, Nash et al. (1993) suggested that family pathology may account for the higher levels of depression reported by sexually abused children. Increased levels of depression have also been associated with both the frequency and duration of sexual abuse experiences as well as whether the sexual abuse experience was perpetrated by a father figure (Wind & Silvern, 1992).

Polusny and Follette (1995) found significantly higher rates of major depression in sexually abused children compared to non-abused, the prevalence rates ranged from 13% to 88% for CSA survivors and 4% to 66% for non-abused. Pribor and Dinwiddie (1992) also reported the highest rates of depression for sexually abused female survivors. Burnam et al. (1988) reported that participants who were first sexually assaulted during childhood, compared with participants sexually assaulted during adulthood only, were more likely to develop major depression.

2.4.2 Posttraumatic Stress Symptoms and CSA

A research noted that the concept of posttraumatic stress symptom is a popular way of conceptualizing some of the negative effects of child sexual abuse and other forms of abuse trauma (Warner, 2009). Trauma and CSA

included within a posttraumatic stress symptoms framework and the related symptomatology, especially symptoms such as sleep disturbances, nightmares and flashbacks (Sanderson, 2006). A long-term consequence of childhood sexual abuse is the development of post-traumatic stress symptoms (Briere & Runtz, 1993; Rowan & Foy, 1993). For example, Ashcroft et al. (2003, as cited in Warner, 2009) reported that in their study of 12- to 17-year-old abuse victims in the USA about 10 per cent of girls had posttraumatic stress symptoms and that over 1 million girls had met the criteria for posttraumatic stress symptoms. According to Polusny and Follette (1995) the prevalence of posttraumatic stress symptoms among sexually abused children ranges between 33% and 86 %. Saunders et al. (1992) found significantly higher rates of lifetime posttraumatic stress symptoms in participants reporting contact sexual abuse and child rape compared to participants reporting non-contact sexual abuse experiences. Similarly, Rodriguez et al. (1992) found that 72% of children from a clinical sample of sexual abuse survivors met criteria for current posttraumatic stress symptoms diagnosis.

2.4.3 Self-Esteem and CSA

Sexually abused children frequently have extremely low self-esteem (Wickham & West, 2004). This statement is supported by numerous studies which repeatedly noted poor self-esteem in children as a result of being sexually abused (Kuyken and Brewin, 1999; Briere and Runtz, 1990; Russell, 1997). They may feel worthless, valued only as sexual objects because of their experience. Some children describe themselves as feeling 'invisible' because they have gone unnoticed and unprotected from the sexual abuse, particularly if the abuse was lengthy and ongoing. The child with low self-esteem frequently feels unworthy and undeserving of positive attention and affection (Wickham & West, 2004).

Being the victim of sexual abuse seriously impairs the child's developing sense of self and identity. In order to cope with and survive the trauma, children often suppress or repress their emotions, their affective range becoming strongly limited. This serves to protect the child from painful affect, but makes the child numb, removed, and distant from past experiences which interfere both with the child's capacity to function and the child's development of a sense of self (Wickham & West, 2004).

In clinical experience, adult survivors often describe themselves as feeling empty, going through the motions of life, of feeling nothing, of being unable to connect with reality in a meaningful way, and of being unable to experience their emotions. They have defended themselves from the abuse and the aftermath of the abuse, and paid a large price for it. As adults, they often find it difficult to reconnect with their feelings and experiences, and need help in developing a cohesive and stable sense of identity and positive self-esteem (Wickham & West, 2004).

2.2 Solution-Focused Brief Counseling

2.2.1 History and Definition of Solution-Focused Brief Counseling

Solution-focused Brief Counseling(SFBC) was pioneered through the work of Steve de Shazer, Insoo Kim Berg and their colleagues at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin (Burns, 2005), the term first being coined in 1982. Drawing on the tradition of family counseling and the work of Milton Erickson (Cade and O'Hanlon, 1993) the approach has evolved over time, and includes a number of theoretical approaches; cognitive, behavioral, narrative, experiential and systemic.

In SFBC, there is the assumption that change is always present in life. From this perspective, clients are not so focused on their complaints that they are unable to see that they already possess the resources to create solutions (Miller et al., 1996). It does not therefore focus on diagnosis, categorization of the problem or past events. The counseling was in direct contrast to other 'problem orientated' therapies and opened up a fresh and evolutionary way of working with clients (George et al., 2007). It has been used in a wide variety of contexts and has become popular amongst a diverse range of professionals, including social workers, educational psychologists and counselors (Kim, 2008).

SFBC utilizes a variety of techniques in an attempt to bring about positive change, including the 'miracle question', scaling activities, exception finding and establishing a detailed vision of a 'preferred future' (George et al. 2007). Iveson (2002) proposes that the average length of SFBC is five sessions with 45 minute per session and that it rarely continues for longer than 8 sessions, although in some cases one session is sufficient for the client. Iveson (2002) explains that if the counseling is going to be effective, this is usually apparent in the first three sessions and that, as sessions continue, the time between each is extended. This appears to be in order to reduce the risk of dependence and to prepare the client for the end of the therapeutic relationship.

2.2.2 Major Concepts of SFBC

2.2.2.1 SFBC is Strengths Based

SFBC is an approach that suggests that clients have strengths and those strengths are active in helping them manage their situation. The issue is not that clients can't solve their problem without additional training or somehow submitting to the counselors or social workers' view of the problem, rather, it is their own inherent strengths that will ultimately be what they use to resolve their problems (Kelly, Kim & Franklin, 2008).

2.2.2.2 SFBC is Time-Limited

The length of SFBC averages from 5 to 7 sessions (de Shazer, 1988). Reviews of SFBC generally have also found an average number of sessions ranging between 3 and 5 (McKeel, 1996; Miller, 1994). Counselors need counseling approaches that are specifically time-limited and thus appropriate for the reality of the severe time constraints they encounter daily. Garfield's (1994) research showed the clues indicating why SFBC works. First, most people seek help to resolve a specific, current problem rather than to gain insight, overall their personalities, or explore the past. Second, the majority of people prefer few sessions counseling. It provides a source of hope and encouragement for counselors who may have only one or two opportunities to meet with people concerning psychological problems (Murphy, 1997).

2.2.2.3 SFBC is Solution-Focused

In SFBC, counselors focus on what is possible, and they have little or no interest in gaining an understanding of the problem (Corey, 2009). Counselors believe that solutions are more likely to be found and created when the focus is on what works in clients' lives, rather than on what does not work. In SFBC, clients were assisted by focusing on three areas: (1) exceptions to the problem, (2) available resources, and (3) goals (Littrell, 1997). Further, De Shazer (1988, 1991) suggests that it is not necessary to know the cause of the problem to solve it and that there is no necessary relationship between the cause of the problems and their solutions.

2.2.2.4 SFBC is Action-Based

Brief counselors force their clients into new experiences as quickly as possible. These new experiences let clients know that new patterns of behavior are possible and hope comes into sight. Remarkable and empowering psychological transformations follow shifts in physiology. Brief counselors direct

physiological changes to speed up the counseling process (Littrell, 1997). The instant effect drives a small change in the counseling process can lead to larger changes in the behavior of all involved in an interaction (de Shazer, et. al, 1986).

2.2.2.5 SFBC is based on Positive-Orientation

An underlying assumption of SFBC is that people are competent and have the ability to resolve the challenges life bring us and construct solutions that can enhance their lives, yet at times we might lose our sense of direction or awareness of our competencies (Corey, 2009). The solution focused model requires a philosophical stance of accepting people where they are and assisting them in creating solutions. O'Hanlon(1994) describes this positive orientation: "grow the solution-life enhancing part of people's lives rather than focus on the pathology-problem parts and amazing changes can happen pretty rapidly" (p.23).

2.2.3 Theory and Basic Assumption of SFBC

The theoretical underpinnings of SFBC come from several sources including social constructionism, Wittgenstein's philosophy of language, and Milton Erickson's ideas on therapy. Constructivism: the notion that the problems experienced by clients are not intrinsic to them but the result of the ways in which they construe themselves and their world (Dewan, Steenbarger, & Greenberg, 2004). Constructivism is a philosophical tradition that emphasizes perception as the result of active, interpretive processes mediated by individual's experience, values, beliefs and created through the process of social interaction and the use of language. A problem only becomes a problem when it is so construed by an individual (Dewan et al., 2004).

SFBC asserts that problems occur in interactions between individuals and do not rest within any one individual. People define and create their sense of what

is real through interaction and conversation with others, a form of negotiation carried out within the context of language (Franklin, 1998). SFBC helps clients do something different by changing their interactive behaviors or the interpretations of behaviors (Berg & De Jong, 1996). This approach makes no assumptions about the "true" nature of problems. It has a strong orientation toward the present and future and further believes that everyone's future is negotiated and created. How clients are currently living their lives and their future goals are emphasized, thus orienting the client away from the past problem toward the future solution (Dewan et al., 2004).

Language is a resource that is vital to all therapists' practices and relationships with their clients. The importance of language in SFBC is crucial. Miller and de Shazer (1998) wrote about how meanings of words are inseparable from the ways in which people use them within concrete social contexts. Problem-focused language emphasizes what is wrong with people's lives, and frequently describes the sources of our problems as powerful forces that are largely beyond our control or understanding. In contrast, solution-focused language focuses on finding ways of managing one's problems. Solution-focused therapists ask, "Since we talk ourselves into problems and solutions anyway, why not emphasize solutions." This is not to deny the deprivations and injustices in clients' lives, but to help get through and beyond them. This model uses postmodern assumptions that problems and solutions are talked into being, and meaning is changeable based on our use of language.

Solution-focused brief counseling is different from many other traditional therapies in a number of ways. Rather than assessing problems, signs, and symptoms, SFBC assesses for solutions, exceptions to problems, and strengths within an individual and his or her social context. It further focuses on past successes, coping strategies, and resources and collaboratively co-constructs a solution with the client (Corey, 2009; Berg & De Jong, 1996).

There are several assumptions made in SFBC that are very important to this counseling that stem from the influences of brief therapy and social constructionism. Walter and Peller (1992, 2000, as cited in Corey, 2009) described fundamental assumptions and principles of solution-focused brief counseling as a model that explains how clients change and how they can reach their goals: (1) clients naturally have the ability, strength and resources to behave effectively in the counseling process, even though this effectiveness may be temporarily blocked by negative cognitions; (2) counselors focus on solutions, on the present and future; (3) every problem has exceptions. Clients can get control over what had seemed to be an unsolvable problem by talking about these exceptions. This process facilitates the possibility of creating solutions; (4) clients often present only one side of themselves. Solution focused counseling invites clients examine another side of the story they are presenting; (5) a Small change paves the way for large changes. Oftentimes, small changes are all that are needed to resolve problems that clients bring to counseling; (6) clients have the capacity and want to change, and they are doing their best to make change happen. Counselors should employ a cooperative stance with clients than planning strategies to control resistive patterns; and (7) each client is unique. This implies that there are no "right" solutions to specific problems that can be applied to all clients.

2.2.4 The Therapeutic Process of SFBC

The process of counseling is collaborative and exploratory rather than being counselor-lead and aims to empower the individual to assess their existing strategies, knowledge and resources and therefore envisage a preferred future (George et al, 2007; Kim, 2008.) Bertolino and O'Hanlon (2002) also stressed the importance of creating collaborative and cooperative therapeutic relationships as necessary for successful counseling. Burns (2005) believed that the clients are the expert in all aspects of their lives challenges the role of the counselors as the expert. They may have considerable expertise in dealing

with certain situations but that does not necessarily mean they know all the 'right' or 'wrong' ways for the clients to move forward. The role of counselors is in creating a context for change.

Walter and Peller (1992) described four steps that characterize the process of SFBC: (1) find out what clients want rather than searching for what they do not want; (2) Do not look for pathology, and do not attempt to reduce clients by giving them a diagnostic level. Instead, look for what clients are doing that is already working and encouraging them to continue in that direction. (3) If clients are doing is not working, encourage them to experiment with doing something different. (4) Keep counseling brief by approaching each session as if it were the last and the only session.

2.2.5 Therapeutic Goals of SFBC

The central assumption is that the goals for counseling will be chosen by the client and that the clients themselves have resources required to make changes. Counselors promote descriptions of goals in specific, small, positive steps and in interactional terms. Their descriptions favor the presence of solutions rather than the absence of problems; the start of something new rather than stopping something that is happening already. Counselors adopt a respectful, non-blaming and cooperative stance, working towards their clients' goals from within their clients' frame of reference (Macdonald, 2007).

Walter and Peller (1992, as cited in Dewan et al., 2004) indicated characteristics of well-defined goals that are (1) stated in the language of the client and reflect the desired ends of the clients, (2) stated in positive and active form—The goals of therapy should be stated in the active terms of what the client would like to be doing rather than as some future end state, (3) formulated in here-and-now terms— When client states goals as a future state

of affairs, the counselor is appropriate to solicit a reframing of the goal statement and (4) stated in specific, attainable terms.

Solution-focused counseling offers several forms of goals: changing the viewing of a situation or a frame of reference, changing the doing of the problematic situation, and tapping client strengths and resources (O'Hanlon & Weiner-Davis, 2003). Clients are encouraged to engage in change- or solution- talk, rather than problem talk, on the assumption that what we talk about most will be what we produce. Talking about problems can produce ongoing problems. Talk about change can produce change. As soon as individuals learn to speak in terms of what they are able to do competently, what resources and strengths they have, and what they have already done that has worked, they have accomplished the aim of the counseling (Nicholas, 2006, 2007).

2.2.6 Major Therapeutic Techniques and Procedures of SFBC

2.2.6.1 Pre-Session Change

One distinctive facet of the SFBC approach is the attention that the solution focused counselor pays to changes that are already in motion from the moment the first session was scheduled and the actual first meeting (Kelly et al., 2008). This is called "pre-session change" and allows the solution-focused counselor to model the SFBC concept that change is a natural and constant occurrence, and that this notion can become a source of hope and empowerment for clients as they struggle to change what initially seems to be overwhelming problems that they fear will take years of treatment to address (Berg, 1994; De Jong & Berg, 2001; Murphy, 1996; Selekman, 2005, as cited in Kelly et al., 2008). To do this, solution-focused counselors at the first meeting ask questions such as, "since we talked on the phone and scheduled this first meeting, have there been any changes in the way that you and your son are getting along at home?" (Kelly et al., 2008). On the basis of any changes that the client identifies, the

solution-focused counselor moves on to amplify that change and see what ideas the client might have about maintaining that change into the future.

2.2.6.2 The Exception Question

The search for exception is the technique perhaps most commonly associated with SFBC. The search for exception emphasizes client strengths by soliciting those times when clients have not been enacting their problem patterns (Dewan et al., 2004). These times are called exceptions (Burns, 2005). The focus on exception question helps the client use the past practically. By identifying times in the past when the problem wasn't affecting the client, or times when the client was more able to handle a similar situation successfully, the solution-focused counselor invites the client to view his or her current reality as being less stuck and hopeless (Kelly et al., 2008).

2.2.6.3 The Miracle Questions

The miracle question is a central and main intervention in the solution-focused counseling (O'Connell and Palmer, 2003). de shazer (1988) noted that one of the most common ways of developing goals in SFBC is through the miracle question. It is used to assist clients in the establishment of concrete and specific behaviors which will indicate to them that the problem is solved (Stilts, Rambo, & Hernandez, 1997). The miracle question has a future focus and is a tool that helps clients identifies what changes they want to see in their lives. For that reason, many practitioners use it towards the beginning of a session, so that they can follow with exceptions and scaled questions (Burns, 2005).

It can be stated, according to Tohn and Oshlag (1996), as "Suppose that tonight, after our session, you go home and fall asleep, and while you are sleeping a miracle happens. The miracle is that the problems that brought you here today are solved, but you don't know that the miracle has happened because you are asleep. When you wake up in the morning what will be some

of the first things you will notice that will be different that will tell you this miracle has happened?" this process of considering hypothetical solutions reflects O'Hanlon and Weiner-Davis's (2003) belief that changing the doing and viewing of the perceived problem changes the problem.

2.2.6.4 The Scaling Questions

When changes in human experiences are not easily observed, such as feelings, moods, or communication, solution-focused counselors use scaling questions (de Shazer & Berg, 1988, as cited in Corey, 2009). It helps the client to maintain a true sense of objectivity and a means of measuring improvement that does not rely on inaccurate recall (Lines, 2006). It also can be an effective tool in eliciting clients' goals and strength (Dewan et al., 2004; Burns, 2005). For example, a client reporting feelings of depression might be asked: "On a scale from 0 to 10 with 0 being the worst that you felt (for example, when you came into counseling?), and 10 being how you feel the day after your miracle occurs and your problem is gone, where would you say you are now? Even if the client has only moved away from zero to one, she/he has improved. How did she/he do that? What does she/he needs to do to move another number up the scale? Scaling questions clients to pay closer attention to what they are doing and how they can take steps that will lead the changes they desire (Burns, 2005; Corey, 2009).

The scaling question can be asked to introduce the notion of variability into the definition of problems and solutions. By asking about the "average" rating, the counselor can then naturally inquire about those occasions that are above average and what makes these different. Such scaling may be conducted throughout counseling, both as a way of tracking progress and as a way of focusing on the specific actions that can account for improvements over time. The latter forms the basis for between sessions tasks in counseling (Dewan et al., 2004).

2.2.6.5 The Therapist Feedback to Clients

In SFBC the end of a session is just as important as the beginning. Each session ends with feedback to the clients. A structured feedback is useful to both clients and therapists (Burns, 2005; Macdonald, 2007). The counselors want it to end with a positive note and a feeling of having accomplished something, as well as some concrete plans for what is going to happen next. Difficulties will be acknowledged again, skills and strengths highlighted, and attention will be paid to any signs of change in the direction of the preferred future (Burns, 2005). On the other hand, clients take that feedback and are motivated to make more changes, either for the same problem or for a different problem that the solution-focused counselors may not even be aware of yet (De Jong & Berg, 2002; Metcalf, 1995; Selekman, 2005).

Some practitioners in SFBC take a break of 5–10 minutes before giving clients feedback. This is particularly advantageous if the session has been monitored from behind a one-way direction, when others are able to add to the list of compliments or any clients' solutions that you may have missed. Usually the break is for quiet reflection alone (Burns, 2005; Corey, 2009). A structured feedback consists of three key elements; namely, acknowledge the problem briefly, compliments and a bridge (Macdonald, 2007).

2.2.7 Effectiveness of Solution-Focused Brief Counseling

A growing list of research is proving the effectiveness of Solutions-focused brief counseling approaches in a wide variety of settings, including mental health, school behavior problems, anger management, family and marital therapy, occupational health and rehabilitation, problem drinking and prison (Jackson & McKergow, 2007). Research also recommended that SFBC is an effective treatment for a wide range of client problems (McKeel, 1999). De Jong and Berg (1998, as cited in McKeel, 1999) reported that SFBC accomplished 70% or

better success rates for many clinical problems, including depression, suicidal thoughts, sleep problems, eating disorders, parent-child conflict, marital/relationship problems, sexual problems, sexual abuse, family violence, and self-esteem problems. Moreover, De Jong and Hopwood (1996, as cited in Dewan et al., 2004) summarized outcome research at the Brief Therapy Family Center in Milwaukee, Wisconsin, and found that approximately 80% of the clients reported satisfaction with their therapy 7–9 months after their counseling.

Other research studies have examined the effectiveness of SFBC with internalizing behavior problems such as depression, anxiety, self-concept and self-esteem. SFBC doesn't appear to be as effective with externalizing behavior problem such as hyperactivity, conduct problems, and aggression or with family and relationship problems, though each of these two areas do have studies showing small effect sizes (Cockburn, Thomas, & Cockburn, 1997; Franklin et al., 2007; Franklin et al., 2008).

Cloitre and Koenen (2001) recruited participants with posttraumatic stress symptoms related to child sexual abuse to participate in a study of a 12-week interpersonal process group. Participants in the groups in which there were no members diagnosed with borderline personality disorder showed significant improvement on measures of anger and posttraumatic stress symptoms.

Smock et al. (2008) compared Solution-focused Group Counseling (SFGC) with a traditional problem-focused treatment for level-one substance abusers. To determine therapeutic effectiveness, clients were measured before and after treatment. The clients who engaged in the solution-focused group counseling significantly improved on depression, while clients in the comparison group did not improve significantly.

Kim (2008) synthesized Solution-focused brief Counseling outcome studies using meta-analytic procedures to find out how effective is SFBC for externalizing behavior problems (e.g., aggression and conduct problems), internalizing behavior problems (e.g., depression and self-esteem), and family or relationship problems. Kim found that SFBC demonstrated small, but positive, treatment effects favoring the treatment group on the outcome measures. The overall weighted mean effect size estimates were .13 for externalizing behavior problems, .26 for internalizing problem behaviors, and .26 for family and relationship problems. Only the magnitude of the effect for internalizing behavior problems was statistically significant, thereby indicating that the treatment outcome for the treatment group is different from the treatment outcome for the control group.

Froeschle et al. (2007, as cited in Kim and Franklin, 2009) investigated SFBC group sessions, mentorship, and action learning techniques to examine the program's effectiveness on 65 adolescent girls' knowledge, attitudes, and use of drugs, as well as their self-esteem and academic success. Statistically significant differences were found favoring SFBC group on drug use, attitudes towards drugs, knowledge of physical symptoms of drug use, and competent behavior scores as observed by both parents and teachers. No group differences were found on self-esteem, negative behaviors as measured by office referrals, and grade point averages

Franklin et al. (2008) examined a quasi-experimental design study with two middle schools to improve student internalizing and externalizing behaviors. Thirty students were in the treatment group and twenty-nine were in the control group and outcomes were measured at pretest, posttest, and follow-up. Students received five to seven sessions of SFBC. The Internalizing score of treatment group decreased below the clinical level by posttest and remained there at follow-up while the control group changed little between pre, post, and follow-up. A large effect size ($d=1.40$) was reported for the Internalizing score.

Results of the Internalizing score for the Youth Self-Report showed no difference between the treatment and control groups and a small effect size ($d=.08$) was reported.

Springer et al. (2000, as cited in Kim and Franklin, 2009) examined six-session of specific solution-focused brief group counseling techniques such as scaling questions and the miracle questions, including mutual aid and interactional approaches for children whose parents or other family members have been imprisoned. Using a quasi-experimental design, ten elementary students participated in the groups with five in the treatment group and five in the control group (wait list). Students in the treatment group make significant pre-post improvements on self-esteem, whereas the control group's scores were unchanged.

Summary and Implications

To build a context for the study and treatment of sexually abused children, the study examined child abuse from a broad perspective and narrowed the focus to issues pertaining to sexually abused children. The treatment approach called Solution-focused Brief Counseling that provided for the participants of the study also discussed in the study in detail.

It is revised in the literature part of the study that child sexual abuse (CSA) has an impact on the child and can lead to a number of long-term effects. It is crucial for counselors to remember that CSA and its impact will vary enormously from individual to individual, and each experience is unique. Survivors of CSA are not an identical group. Thus, clients must be seen as individuals within their own experiences.

It is also found that there are a number of long-term effects of CSA, some of which seem contrast to each other. Counselors need to ensure that they do not apply any approach to identifying problems, diagnosis and treatment. It is not the existence of any one symptom that indicates a history of CSA, but the collection of symptoms within the context of the survivor's experience. Therefore, diagnosis and treatment need to be handled sensitively and professionally in order that the counselor does not make early assumptions or conclusions.

It is also important for counselors to recognize that working with survivors of CSA will impact on them in raising worries and anxieties. Counselors must be aware of the impact such work has on them, so that they are able to work in the best way with these clients group. In order to work with sexual abuse survivors, counselors need to understand the impact and long-term effects of sexual abuse on survivors.

The Solution-focused Brief Counseling was a treatment which provided for the participant was also another revised in the literature part of the study. SFBC is an approach that started in the American Midwest and has now extended all over the world, heavily influencing the different practitioners. Its main ideas that client has resources, competency and strengths, client change is constant, and that clients can be trusted to develop solutions to their own problems, are an alternative to many of the traditional and problem-based diagnostic and treatment approaches prevalent in different setting today. Thus, counselors can apply Solution-focused Brief Counseling together with its counseling techniques like the miracle question, coping questions, and scaling questions to identify clients' goals and strengths to help make changes in their lives.

CHAPTER THREE

METHODS

3.1 The Research Design and Methods

The study was a non-equivalent control group pretest-post-test a quasi-experimental designed (Cohen et al., 2000):

	Pre-test		Post-test
Treatment group	O_1	X	O_2
Control group	O_3		O_4

Figure 1: Design of a Quasi-Experimental Design

Where:

1. The **Treatment group** was sexually abused children who received both usual care provided by the institution and Solution focused Brief Group Counseling delivered by the researcher.
2. The **Control group** was sexually abused children who only received usual care provided by the institution.
3. O_1 and O_3 refer to mean scores of dependent variables (Depression, Posttraumatic stress symptoms and Self-esteem) **before** the treatment for both the treatment group and control group.
4. **X** refers to Solution-focused Brief Group Counseling delivered by the researcher.
5. O_2 and O_4 refer to mean scores of dependent variables (Depression, Posttraumatic stress symptoms and Self-esteem) **after** the treatment for both the treatment group and control group.

3.2 Research Site

The study was conducted at Godanaw Rehabilitation Integrated Project Center (GRIP). The aim of GRIP is to provide protection and assistance to the girls (age 20 and below) who suffer from various type of social problems, such as domestic violence, abuse, victims of trafficking, etc. GRIP can accommodate up to 120 girls enrolling for rehabilitation services. The length of stay of the girls in this organization is approximately 8 to 14 months. GRIP, as a local non governmental organization, provides social services free of charge. The girls receive accommodation, medical care, and education, vocational training (e.g. beauty treatment, hair-dress, dress-sewing, candle and soap-making, hand crafts, etc), recreational services and social activities, such as entertainment programs and religious activities.

3.3 Population and Sampling

The population in this study was sexually abused female children who live in Godanaw Rehabilitation Integrated Project. The inclusion criteria were children who:

1. are between 12-18 years of age.
2. have been sexually abused prior to the study; will stay in the institution at least for six months.;
3. were willing to participate in the study.

Accordingly, 50 sexually abused children who met the above criteria were selected and included as the samples of the study.

3.4 Randomization

The main purpose of the study is to examine the effectiveness of Solution-focused Brief Counseling in addressing psychological problems of sexually abused children who are found in GRIP. Based on the stated criteria 50 eligible participants were selected purposefully. The participants ranged in age from 12

to 18. All participants were sexually abused female children. Before the administration of the pre-test, the researcher assigned code numbers to the questionnaire from 01 to 050. Then after, during the completion of pre-test, the researcher requested the participants to write and use their first name and assigned code numbers on the front of the questionnaire which remained strictly confidential between the participants and the researcher. After the participants completed the questionnaire, the researcher changed all first names into code numbers. These code numbers were also erased immediately after all the data gathered. The main reason behind assigning code numbers was just to allocate participants randomly in to the treatment or the control group. Accordingly, using coin toss (head means even and tail means odd number) beginning from 01 as starting point, the researcher selected downward the first 25 unlike odd numbers from the list of 50 participants. The participants who previously had been assigned these numbers were allocated to the control group. Thus, the remaining 25 participants who were assigned even numbers were allocated to the treatment group.

3.5 Variables

3.5.1 Independent Variables

The two independent variables for the research design were treatment and time. The treatment variable included Solution-focused Brief Group Counseling for treatment group and no Solution-focused Brief Group Counseling for control group. The time variable was before (pre) and after (post), and included those that received treatment and those that did not receive treatment programs.

3.5.2 Dependent Variables

The dependent variables were: (i) depression; (ii) posttraumatic stress symptoms, and (iii) self-esteem. The dependent variables were measured by pre

and post-test self-report measures: Children's Depression Inventory (Kovacs, 1981); Child Posttraumatic Stress Symptom Scale (Foa et al., 2001); and Rosenberg Self-Esteem Scale (Rosenberg, 1965). Detail psychometric properties of each self-report measure is reviewed below.

3.6 Research Instrument

In this study, the questionnaire was comprised of two parts: demographic data sheet and standardized scales to measure pre- and post-treatment effects of Solution-focused Brief Group Counseling on sexually abused children's problems.

3.6.1 Standardized Scales

3.6.1.1 Children's Depression Inventory (CDI)

The Children's Depression Inventory (CDI; Kovacs, 1981) is a 27-item scale designed to quantify a wide range of depression symptoms, including disturbances in mood, pleasure capacity, self-evaluation, interpersonal behavior, eating and sleeping behaviors. It is designed for children 7 through 18 years of age.

The CDI is a downward extension of the Beck Depression Inventory (Beck, 1967), one of the most widely used adult measures of depression. Some items were removed and reworded to decrease the reading level of the scale, and a few items were rewritten. Berndt, Schwartz, and Kaiser (1983) evaluated the reading level of the CDI and nine other depression scales. They found that the CDI was written at a third-grade reading level and had the lowest reading level of all the measures assessed.

Each item of the CDI consists of three statements from which the respondent chooses the one that describes his or her feelings best. Half the items are

reversed so that the choice indicating more depression comes first; this helps control for the acquiescent response set. About 15 minutes is required to administer and 5 minutes to score the questionnaire.

Cronbach's alphas ranged from 0.59 to 0.68 for the subscales of the CDI and the alpha was 0.86 for the Total score in the normative sample. Test-retest correlations ranged from 0.66 to 0.83 across 2- to 4-week intervals, and ranged from 0.54 to 0.56 across 4- to 6-month intervals (Kovacs, 1985). The Total score of the CDI has a sensitivity of 80% and a specificity of 84% in distinguishing children with depression from children without depression (Kovacs, 2003).

Items are scored on a 0(absence of symptom) through to 2(definite symptom), in the direction of severity of symptoms. A total score ranges 0-54 where higher scores indicate greater depression severity is calculated by summing all items. Kovacs (1981) suggested a cutoff score of 11 if the CDI is used as a screening device and false negatives are to be kept to a minimum (children who score below 11 but are later found to be depressed). If the CDI is to be used to assess the presence of depression in a sample of problem behavior children, a cutoff 13 is suggested. Thus, taking 11 as a cutoff score of CDI, the following ranges were adapted for the purpose of this study:

- Scores between 0 and 10 are indicative of minimum levels of depression symptoms
- Scores between 11 and 25 are indicative of mild levels of depression symptoms
- Scores between 26 and 40 are indicative of moderate levels of depression symptoms
- Scores between 41 and 54 are indicative of severe levels of depression symptoms

3.6.1.2 The Child Posttraumatic Stress Symptoms Scale

The Child Posttraumatic Stress Symptom Scale (CPSS) is a new instrument that was developed to assess the severity of Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994) posttraumatic stress symptoms in children exposed to trauma. The CPSS is a child version of the Posttraumatic Diagnostic Scale (PTDS; Foa et al., 1997), a well-validated measure for assessment of Posttraumatic Stress Symptoms severity and diagnosis in adult victims of a variety of traumas. The language of the PTDS was modified to incorporate developmentally appropriate language to maximize children's understanding of the items. The CPSS was designed to assess Posttraumatic Stress Symptoms diagnosis and symptoms severity in children ages 8 to 18 who had experienced a traumatic event. It contains one question for each of the 17 *DSM-IV* PTSD symptoms to ascertain their frequency in the past month.

The psychometric properties of the CPSS show high internal consistency and test-retest reliability for both the total score and the three subscales. The Coefficient alpha was 0.89 for the total score. Item analysis did not reveal any item whose exclusion would increase the internal consistency. The test-retest reliability coefficients of the total scale score was 0.84 (Foa, Johnson, Feeny & Treadwellet, 2001).

The convergent validity of the total scale score was assessed by comparing it with the severity rating obtained from the Child Post-Traumatic Stress Disorder Reaction Index (CPTSD-RI). The Pearson Product-moment correlation coefficient was 0.80 (Foa et al., 2001). As expected, the correlations of the CPSS with depression and anxiety measures were lower than those with the CPTSD-RI, providing some support for discriminant validity of the CPSS (Foa et al., 2001). These results suggest that the CPSS is a useful tool for the

assessment of posttraumatic stress disorder (PTSD) severity and for the screening of PTSD diagnosis among traumatized children.

The instructions for answering the questions are as follows: "Circle the number that describes how often that problem has bothered you in the past two weeks." Answers are on a 4-point Likert type scale, ranging from 0 (not at all), 1 (once a week or less), 2 (2 to 4 times a week), to 3 (5 or more times a week). Seven additional items that inquire about daily functioning (e.g., relationships with friends, schoolwork) were inserted after the 17 posttraumatic stress symptoms. The 17 symptom items yield a total symptom severity scale score ranging from 0 to 51. Sum the scores for the 24 items, scores range from 0-58. Scores for children who have been diagnosed with posttraumatic stress symptoms are interpreted as follows:

- Scores between 0 and 15 are indicative of minimum levels of posttraumatic stress symptoms.
- Scores between 16 and 24 are indicative of mild levels of posttraumatic stress symptoms.
- Scores between 25 and 39 are indicative of moderate levels of posttraumatic stress symptoms.
- Scores between 40 and 58 are indicative of severe levels of posttraumatic stress symptoms.

3.6.1.3 The Rosenberg Self-Esteem Scale

The Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965) was originally designed to measure children and adolescents' global feelings of self-acceptance and self-worth. It consists of 10 items with Likert scaling represented by four points (ranging from strongly agree to strongly disagree) used to assess global self-esteem. Respondents are requested to read the statements and rate the degree to which each one can be self-applied. The 10 statements are related to overall feelings of self-acceptance and self-worth. Five

statements worded positively and five statements worded negatively. The original sample for which the scale was developed consisted of 5024 juniors and seniors from 10 randomly selected schools in New York State (Rosenberg, 1965).

The reliability of this scale has been extensively reported in the literature. McCarthy and Hoge (1982) reported internal consistency coefficients (Cronbach's alpha) of between 0.74 and 0.77. McCarthy and Hoge also found test-retest reliability of 0.63 (with a 7-month interval) and of 0.85 (2-week interval). Silbre & Tippet (1965) reported a test-retest correlation of 0.85 for 28 subjects after a 2-week interval. Rosenberg (1989) found test-retest correlations typically in the range of 0.77 to 0.88.

The RSES is associated with self-esteem related constructs. For example, Reynolds (1988) found a correlation of 0.38 between RSES scores and overall academic self-concept with correlations between RSES scores and specific facets of academic self-concept ranging from 0.18 to 0.40. The Rosenberg measure correlated 0.60 with Coopersmith Self-Esteem Inventory (Coopersmith, 1967). The correlation between the Single-Item Self-Esteem scale (SISE) and RSE scale ranged from 0.74 to 0.80 (Robins et al., 2001).

Respondents express their degree of agreement on a 4-point Likert-type Scale of Strongly Agree=4, Agree=3, Disagree=2, and Strongly Disagree=1. Items worded negatively are reverse scored, that is, Strongly Agree=1, Agree=2, Disagree=3, and Strongly Disagree=4. Sum the scores for the 10 items, Scores range from 10-40 with lower scores representing lower reported levels of self-esteem, feelings of rejection, and self-dissatisfaction. Some researchers (Strange et al., 2005) considered scores of 17-25 to be average and the same ranges were adapted for the purpose of this study as follows:

- Scores between 0 and 16 are indicative of low levels of self-esteem.

- Scores between 17 and 25 are indicative of average levels of self-esteem.
- Scores between 26 and 40 are indicative of high levels of self-esteem.

3.6.1.4 Translation of the Scales

The English version of Children Depression Inventory, The Child Posttraumatic Stress Symptoms Scale and Rosenberg Self-Esteem Scale were first translated in to Amharic by the researcher in this study. Then, its accuracy and readability were revised by two graduate students of literature department. And, finally it also was verified again by two former graduates of counseling psychology.

3.7 Pilot Testing

Pilot testing was made on 20 participants for the main purpose of determining the reliability of the Children's Depression Inventory, Child Posttraumatic Stress Symptoms Scale and Rosenberg Self-Esteem Scale. Accordingly, after administering the instrument for the pilot samples, the responses were scored and assessed for its reliability by using Cronbach Alpha. The computation yielded reliability coefficient of 0.883, 0.754, 0.80 and 0.728 for Children Depression Inventory, Child Posttraumatic Stress Symptoms scale part one and part two, and self-esteem scale respectively. The above coefficients of reliability clearly show that the instruments seem to be highly reliable. Moreover, following pilot testing, minor modifications were done on the scales like changing formats, adding some words in the sentences (e.g., after you have been sexually abused.....) and so on.

3.8 Ethical Issues Considered

Success of any study counts upon unconditional and enthusiastic cooperation from the participants. If the participants are not willing to participate in the study voluntarily, they might provide careless response which could mislead

the overall findings of the study. In order to ensure the quality of data and also for ethical purpose the following ethical issues were taken into account while contacting and obtaining data from children:

- Objective of the study were briefed to all the study participants and their informed consent was obtained.
- Date and time of the data collection and group counseling were decided as per the convenience of the study participants.
- Participants were assured about the confidentiality of the communicated information.
- Participants were informed of their choice to withdraw at any point during the study period, if they wished so.

3.9 Data Collection Procedures

To conduct and accomplish the research, the following steps were followed in the study:

1. The researcher requested a letter of introduction from the Department of Psychology, Addis Ababa University, to the Director of Godanaw Rehabilitation Integrated Project to ask for permission to collect the data.
2. After receiving the permission to collect data at Godanaw Rehabilitation Integrated Project, the researcher met with 'home mothers' at Godanaw Rehabilitation Integrated Project to ask for their collaboration by presenting the objectives of the study and the research process.
3. The 'home mothers' at Godanaw Rehabilitation Integrated Project selected the samples according to inclusion criteria of the study. A total of 50 participants were selected. The participants were approached by the researcher, to inform them of the research objectives, the research process, and confidentiality of the information. The confidentiality of participants was maintained through the assignment of a code which was used throughout the data collection, analysis, and reporting process to reduce the anxiety of participants.

4. Then, the participants were asked to complete pre-test questionnaire. They were encouraged to answer the questions honestly and ask if they had any problems in understanding the questions. After completing the questionnaire, all selected participants were randomly assigned to treatment and control group, with 25 participants per group.
5. The participants in the treatment group were asked to participate in the program of Solution-focused Brief Group Counseling for a total of 8 sessions, three sessions per week. Each session took approximately 1:00-1:20 hours. (See Appendix-J, Treatment Plans). These sessions are the maximum average sessions in SFBC. Generally, several researchers have found an average number of SFBC sessions ranging between three and 8 (Dewan et al., 2004; de Shazer, 1988; Iveson, 2002; McKeel, 1996; Miller, 1994).
6. The control group didn't receive Solution-focused Brief Counseling; they received the usual care that is provided by the institution.
7. The post-test was conducted after 8 sessions of Solution-focused Brief Group Counseling for the treatment group to check whether there had been any significant change on the scores compared with the pre-test. The control group also completed the post-test and it was compared with treatment group to detect any difference in the counseling effectiveness.

3.10 Method of Data Analysis

Data collected was analyzed using the statistical Package for Social Science (SPSS) version 17.0. Descriptive statistics, frequency distributions and percentage were used to describe participants' demographic characteristics and prevalence of problems. Dependent and independent t-test was used to compare the mean difference between the treatment and control group existed that on pre-test and post-test measures. In this study, to determine whether the mean difference was statistically significance or not, 0.05 levels of significance was used.

CHAPTER FOUR

RESULTS

The major purpose of the present study was to examine the effectiveness of Solution-focused Brief Group Counseling for sexually abused children problems (depression, posttraumatic stress symptoms and self-esteem) in Godanaw Rehabilitation Integrated Project.

In order to properly meet the above objectives, the collected data on both pre-test and post-test were presented based on the specific research questions raised in chapter one.

4.1 Demographic Characteristics of Participants

Demographic characteristics of the participants in the control and treatment group are provided in Table 1. All of the participants 50 (100%) were female both in control and treatment group. The average age for the control group was 16.80 years (SD=1.32; range=13-18) and 16.40 years (SD=1.60; range=12-18) for the treatment group. In terms of educational background, it was found that in the control group 68% had elementary school level and 32% had secondary school level, while 76% of treatment group had the elementary school level and 24% had the secondary school level. As to the period the participants stayed in the institution, data show that all of the participants 50 (100%) of control and treatment groups have stayed for less than a month in the institution.

TABLE 1: DEMOGRAPHIC CHARACTERISTICS OF TREATMENT AND CONTROL GROUP

Characteristics		Control group (N=25)		Treatment group (N=25)	
		Mean	SD	Mean	SD
Age	12-18	16.80	1.32	16.40	1.60
		Frequency	Percentage	Frequency	Percentage
Sex	Female	25	100	25	100
	Male	-	-	-	-
	Total	25	100	25	100
Educational level	Elementary	17	68	19	76
	Secondary	8	32	6	24
	Total	25	100	25	100
Time stayed in the institution	One week	3	12	5	20
	Two weeks	6	24	7	28
	Three weeks	5	20	4	16
	Four weeks	11	44	9	36
	Total	25	100	25	100
Time since abused	Less than 1 year ago	25	25	25	25
	1-2 years ago	-	-	-	-
	Total	25	100	25	100
Counseling received	Yes	-	-	-	-
	No	25	100	25	100
	Total	25	100	25	100
Received SFBGC before	Yes	-	-	-	-
	No	25	100	25	100
	Total	25	100	25	100

As far as the time since they sexually abused is concerned, all of the participants 50 (100%) in the control and treatment groups were abused less than a year ago. When participants were asked if they had ever received counseling from the institution, all of the participants 50 (100%) in the control and treatment groups responded "No". Similarly, When subjects were asked they had ever received solution focused brief counseling before, all of the participants 50 (100%) in the control and treatment groups responded "No". In addition to the above findings, the researcher also observed that all social

workers called 'home mothers', who are found in GRIP, are working with sexually abused children without any training on how to recognize, understand, , identify physical and psychological needs and rights of abused children and then how care for and handle them properly. Therefore, in general, the descriptive and percentage analyses of participants both in the treatment and control groups indicated that the groups were fairly equal in terms of demographic characteristics. This implies that the participants were comparatively and equally distributed between the treatment and the control group with little to no discrepancies.

4.2 Psychological Problems of Sexually Abused Children

4.2.1 Depression

TABLE 2: DEPRESSION LEVEL OF TREATMENT GROUP BEFORE AND AFTER TREATMENT (N=25)

Level of Depression	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-10 (Minimum)	-	-	1	4
11-25 (Mild)	8	32	13	52
26-40 (Moderate)	12	48	9	36
41-54 (Severe)	5	20	2	8
Total	25	100	25	100

As shown in table 2, before the treatment the participants in the treatment group showed moderate (48%), mild (32%) and severe (20%) level of depression. Whereas, after the treatment majority of the participants showed mild or minimum(56%) and relatively fewer number of participants displayed moderate(36%) and severe (8%) levels of depression.

TABLE 3: DEPRESSION LEVEL OF CONTROL GROUP BEFORE AND AFTER TREATMENT (N=25)

Level of Depression	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-10 (Minimum)	2	8	1	4
11-25 (Mild)	9	36	7	28
26-40 (Moderate)	12	48	15	60
41-54 (Severe)	2	8	2	8
Total	25	100	25	100

Table 3 indicates that, before the treatment, 48% of the control group participants showed moderate, while 36%, 8%, and 8% of participants respectively experienced mild, minimum, and severe levels of depression. Whereas, after the treatment, 60% of the participants showed moderate while 28%, 8%, and 4% of the participants showed mild, severe and minimum level of depression, respectively.

4.2.2 Posttraumatic Stress Symptoms

TABLE 4: POSTTRAUMATIC STRESS SYMPTOMS LEVEL OF TREATMENT GROUP BEFORE AND AFTER TREATMENT

level of posttraumatic stress symptoms	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-15 (Minimum)	-	-	-	-
16-24 (Mild)	7	28	5	20
25-39 (Moderate)	15	60	18	72
40-58 (Severe)	3	12	2	8
Total	25	100	25	100

As shown in table 4, before the treatment, of the participants in treatment group they showed moderate (60%), mild (28%) and severe (12%) level of posttraumatic stress symptoms. Whereas, after the treatment, of the participants in the treatment group they experienced moderate (72%), mild

(20%) and 8% participants showed severe level of posttraumatic stress symptoms.

TABLE 5: POSTTRAUMATIC STRESS SYMPTOMS LEVEL OF CONTROL GROUP BEFORE AND AFTER TREATMENT

level of posttraumatic stress symptoms	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-15 (Minimum)	-	-	1	4
16-24 (Mild)	9	36	7	28
25-39 (Moderate)	13	52	14	56
40-58 (Severe)	4	16	3	12
Total	25	100	25	100

Table 5 indicates that, before the treatment, 52% of the control group participants showed moderate, while 36% and 16% of participants respectively showed mild and severe level of posttraumatic stress symptoms. Whereas, after the treatment, 56% of participants showed moderate while 28%, 12%, and 4% participants showed mild, severe and minimum level of posttraumatic stress symptoms respectively.

4.2.3 Self-Esteem

TABLE 6: SELF-ESTEEM LEVEL OF TREATMENT GROUP BEFORE AND AFTER TREATMENT

Level of Self-esteem	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-16 (Low)	7	28	2	8
17-25 (Average)	15	60	13	52
26-40 (High)	3	12	10	40
Total	25	100	25	100

Table 6 indicates that, before the treatment, of the participants in the treatment group had low (28%), average (60%) and high (12%) level of self-esteem. Whereas, after the treatment, majority of participants in the treatment group had average or high (92%), while only 8% participants had low level of self-esteem.

TABLE 7: SELF-ESTEEM LEVEL OF CONTROL GROUP BEFORE AND AFTER TREATMENT

Level of Self-esteem	Before Treatment (Pre-test)		After Treatment (Post-test)	
	Frequency	Percentage	Frequency	Percentage
0-16 (Low)	9	36	6	24
17-25 (Average)	15	60	17	68
26-40 (High)	1	4	2	8
Total	25	100	25	100

As can be seen in table 7, before the treatment, 60% of the control group participants had average while 36% and 4% of participants had low and high level of self-esteem respectively. Whereas, after the treatment, 68% of participants had average, 24 % had low and 8% had high level of self-esteem.

4.3 Analysis of Dependent and Independent t-test

TABLE 8: DEPENDENT T-TEST OF THE MEAN DEPRESSION SCORES OF THE TREATMENT GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Treatment Group	Depression Score			
	Mean	SD	t	Significance
Before treatment(pre-test)	28.36	9.16	2.186	.039
After treatment(post-test)	23.56	7.62		
Paired Differences	4.80	10.98		

*Statistically significant at $P \leq .05$

As table 8 indicates, in the treatment group, it was found that the pre-test mean depression scores was 28.36 (SD=9.16), whereas the post-test mean depression score decreases to 23.56 (SD=7.62). The mean difference in depression scores was 4.80. A 2-tailed t-test for statistically significant difference between the means indicated that the difference between the pre-test and post-test scores was highly significant at 0.05 level of significance ($df=24$, $t=2.186$). The implication of this finding is that Solution-focused Brief Group Counseling had impact on the improvement of treatment group depression from pre-test to post-test.

TABLE 9: DEPENDENT T-TEST OF THE MEAN DEPRESSION SCORES OF THE CONTROL GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Control Group	Depression Score			
	Mean	SD	t	Significance
Before treatment(pre-test)	26.64	8.73	-.913	.371 ^{ns}
After treatment(post-test)	28.92	7.93		
Paired Differences	-2.28	12.49		

ns=not statistically significant

Table 9 indicates that the mean depression scores in the pre-test was 26.64 with the standard deviation of 8.73 while in the post-test the mean depression scores was 28.92 with standard deviation of 7.93. The mean difference in depression scores was -2.28. The dependent t-test was used for a comparison of the mean depression scores of the control group before and after the treatment. The result revealed that there was no statistically significant difference between pre-test and post-test mean of depression scores ($df=24$, $t=-.913$). This implies that though there is a seemingly worsening situation in the control group, the variation from pretest to post-test is ascribable to probability.

TABLE 10: INDEPENDENT T-TEST OF THE MEAN DEPRESSION SCORES OF THE TREATMENT AND CONTROL GROUP

Depression Scores	Groups		Mean Difference	t	Sig.
	Control	Treatment			
Pre-test	26.64	28.36	1.72	.679	.500 ^{ns}
Post-test	28.92	23.56	-5.36	-2.437	.019
Mean Difference	-2.28	4.80			

ns= not statistically significant

As can be seen in table 10, the provision of Solution-focused Brief Group Counseling for treatment group has brought a significance improvement in depression scores over the control group. That is, treatment group decreased by a mean of 4.80 against -2.28 in control group after eight sessions of group counseling. The mean difference in depression scores for pre-test between groups was 1.72 whereas for post-test was -5.36. A 2-tailed significance test for the equality of means indicated that there was statistically significant difference between control group and treatment group during the post-test at 0.05 level of significance ($df=48$, $t=-2.437$) and no statistically significant difference during the pre-test at 0.05 level of significance (sig.2-tail=.421, $t=.679$, $df=48$). This finding indicated that participants in the treatment group

had a high advantage of improving depression level as measured by Children Depression Inventory from pre-test to post-test.

TABLE 11: DEPENDENT T-TEST OF THE MEAN POSTTRAUMATIC STRESS SYMPTOMS SCORES OF THE TREATMENT GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Treatment Group	Posttraumatic Stress Symptoms Scores			
	Mean	SD	t	Significance
Before treatment(pre-test)	29.44	7.64	.628	.536 ^{ns}
After treatment(post-test)	28.24	5.39		
Paired Differences	1.20	9.56		

ns= not statistically significant

Table 11 indicates that the mean posttraumatic stress symptoms scores in the pre-test was 29.44 with the standard deviation of 7.64 while in the post-test the mean posttraumatic stress symptoms scores was 28.24 with standard deviation of 5.39. The mean difference in posttraumatic stress symptoms scores was 1.20. The dependent t-test was used for a comparison of the mean posttraumatic stress symptoms scores of the treatment group before and after the treatment. The result revealed that there was no statistically significant difference between pre-test and post-test mean of posttraumatic stress symptoms Scores ($df=24$, $t=.628$). This implies that the treatment group was not improved in posttraumatic stress symptoms from pre-test to post-test.

TABLE 12: DEPENDENT T-TEST OF THE MEAN POSTTRAUMATIC STRESS SYMPTOMS SCORES OF THE CONTROL GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Control Group	Posttraumatic Stress Symptoms Scores			
	Mean	SD	t	Significance
Before treatment(pre-test)	29.08	7.35	.527	.603 ^{ns}
After treatment(post-test)	27.88	7.24		
Paired Differences	1.20	11.39		

ns= not statistically significant

It was found in Table 12 that the mean posttraumatic stress symptoms scores for the pre-test was 29.08 (SD=7.35) while for the post-test the mean posttraumatic stress symptoms scores was 27.88(SD=7.24). The mean difference in posttraumatic stress symptoms scores was 1.20. A 2-tailed significance test for the equality of means indicated that there was no statistically significant difference between post-test and pre-test scores at 0.05 level of significance ($df=24$, $t=.527$).

TABLE 13: INDEPENDENT T-TEST OF THE MEAN POSTTRAUMATIC STRESS SYMPTOMS SCORES OF THE CONTROL AND TREATMENT GROUP BEFORE AND AFTER THE TREATMENT

posttraumatic stress symptoms scores	Groups		Mean Difference	t	Sig.
	Control	Treatment			
Pre-test	29.08	29.44	.36	.170	.866 ^{ns}
Post-test	27.88	28.24	.36	.199	.843 ^{ns}
Mean Difference	1.20	1.20			

ns= not statistically significant

As can be seen in table 13, before the treatment, the mean posttraumatic stress symptoms scores of control group for the pre-test was 29.08 while the mean posttraumatic stress symptoms scores of treatment group was 29.44.

The mean difference in posttraumatic stress symptoms scores between groups for pre-test was .36. A 2-tailed significance test for the equality of means indicated that there was no statistically significant difference between control and treatment group during the pre-test at 0.05 level of significance ($df=48$, $t=.170$).

After the treatment, the mean posttraumatic stress symptoms scores of control group for the post-test was 27.88 while the mean posttraumatic stress symptoms scores of treatment group was 28.24. The mean difference in posttraumatic stress symptoms scores between groups for post-test was .36. A 2-tailed significance test for the equality of means indicated that there was no statistically significant difference between control and treatment group during the post-test at 0.05 level of significance ($df=48$, $t=.199$). These results indicated that both the control and treatment group were not improved in posttraumatic stress symptoms as measured by the Child Posttraumatic Stress Symptoms Scale from pre-test to post-test.

TABLE 14: DEPENDENT T-TEST OF THE MEAN SELF-ESTEEM SCORES OF THE TREATMENT GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Treatment Group	Self-esteem Scores			
	Mean	SD	t	Significance
Before treatment(pre-test)	20.64	5.49	-2.623	.015
After treatment(post-test)	25.32	5.86		
Paired Differences	-4.68	8.92		

*Statistically significant at $P<.05$

The result in table 14 indicates that the pre-test mean self-esteem scores in the treatment group was 20.64 (SD=5.49), whereas the post-test mean self-esteem scores became 25.32 (SD=5.86). The mean difference in self-esteem scores was -4.68. Comparison by using dependent t-test revealed that the mean scores of

self-esteem in the treatment group were higher after the treatment with a statistically significant level ($df=24$, $t=-2.623$, $P<.05$).

TABLE 15: DEPENDENT T-TEST OF THE MEAN SELF-ESTEEM SCORES OF THE CONTROL GROUP BEFORE AND AFTER THE TREATMENT (N=25).

Control Group	Self-esteem Score			
	Mean	SD	t	Significance
Before treatment(pre-test)	19.16	5.13	-.715	.481 ^{ns}
After treatment(post-test)	20.28	5.91		
Paired Differences	-1.12	7.83		

ns= not statistically significant

As table 15 indicates, in the control group, it was found that the pre-test mean self-esteem scores in the control group was 19.16 (SD=5.13), whereas the post-test mean self-esteem scores was 20.28 (SD=5.91). The dependent t-test was used for a comparison of the mean self-esteem scores of the control group before and after the treatment. The result as presented in Table 15 shows that there was no statistically significant difference between pre-test and post-test mean of self-esteem scores ($df=24$, $t=-.715$).

TABLE 16: INDEPENDENT T-TEST OF THE MEAN SELF-ESTEEM SCORES OF THE TREATMENT GROUP AND CONTROL GROUP.

Self-esteem scores	Groups		Mean Difference	t	Sig.
	Control	Treatment			
Pre-test	19.16	20.64	1.48	.984	.330 ^{ns}
Post-test	20.28	25.32	5.04	3.030	.004
Mean Difference	-1.12	-4.68			

ns= not statistically significant

As can be seen in table 16 above, before the treatment, the control group had the mean self-esteem scores of 19.16 while the treatment group had the mean self-esteem scores of 20.64. The mean difference in self-esteem scores for pre-test was 1.48. A 2-tailed significance test for the equality of means indicated that the mean self-esteem scores between control group and treatment group during pre-test was not statistically significant at 0.05 level significance ($df=48$, $t=.984$).

After the treatment, the control group had the mean self-esteem scores of 20.28 while the treatment group had the mean self-esteem scores of 25.32. The mean difference in self-esteem scores for post-test was 5.04. When the dependent t-test was used to test the mean self-esteem scores between the control and treatment group, the mean self-esteem scores of the treatment group was higher than the control group with statistically significant at 0.05 level ($df=48$, $t=3.030$). The result indicates that the provision of solution focused brief group counseling for treatment group has brought a significance improvement in self-esteem scores over the control groups as measured by Rosenberg Self-Esteem Scale from pre-test to post-test.

CHAPTER FIVE

DISCUSSION

This study was designed to examine the effectiveness of Solution-focused Brief Counseling in addressing psychological problems of sexually abused children. Thus, the results mentioned in the previous chapter are discussed in relation with the available related researches.

5.1 Psychological Problems of Sexually Abused Children

5.1.1 Depression

The present study found that, before treatment, 48% of the treatment group participants showed moderate, 32% mild and 20% severe level of depression. Whereas 48% of the control group participants showed moderate, 36% mild, 8% severe and 8% of participants experienced minimum level of depression. It means that 68% of sexually abused children from treatment group and 56% of sexually abused children from control group show higher levels of depression and these findings is consistent with many previous researches. For instance, Pribor and Dinwiddie (1992) reported highest rates of depression for sexually abused female survivors. Other researchers have also found that CSA survivors experience significantly higher depression than non-abused participants (Hunter, 1991; Roland et al., 1989), suggesting symptoms of hopelessness about the future, and general dissatisfaction with life (Graham, 1990). Polusny and Follette (1995) reported significantly higher rates of major depression in sexually abused children compared to non-abused ones, the prevalence rates ranged from 13% to 88% for CSA survivors and 4% to 66% for non-abused.

Following the provision of solution focused brief group counseling, the findings of the study revealed that the treatment group had low levels of the mean depression scores with statistical significance at $p < 0.05$. In addition, the

treatment group was compared to the control group and showed improvement on measures of depression. This finding was congruent with the study by Smock et al. (2008), who compared solution-focused group counseling (SFGC) with a traditional problem-focused treatment for level-one substance abusers. The clients who engaged in the solution-focused group counseling significantly improved on depression while clients in the comparison group did not improve significantly on either measure.

5.1.2 Posttraumatic Stress Symptoms

As shown in the result section, before treatment, 60% of the treatment group participants showed moderate, 28% mild and 12% severe level of posttraumatic stress symptoms. Whereas 52% of the control group participants showed moderate, 36% mild, 16% of participants experienced severe level of posttraumatic stress symptoms. The findings indicated that majority of participants (72 %) from the treatment group and 68% of participants from control group experienced high level of posttraumatic stress symptoms.

These findings are similar with previous findings. For example, Saunders et al. (1992) found significantly higher rates of lifetime posttraumatic stress symptoms in participants reporting contact sexual abuse and child rape compared to participants reporting non-contact sexual abuse experiences. Rodriguez et al. (1992) found that 72% of children from a clinical sample of sexual abuse survivors met criteria for current posttraumatic stress symptoms diagnosis.

After the Solution-focused brief group treatment, it was found that there were no differences between the treatment and control groups in posttraumatic stress symptoms as measured by the Child posttraumatic stress symptoms Scale from pre-to posttest. The finding was inconsistent with Cloitre and Koenen (2001) who recruited participants with posttraumatic stress symptoms

related to child sexual abuse to participate in a study of a 12-week interpersonal process group. Participants in the groups in which there were no members diagnosed with borderline personality disorder showed significant improvement on measures of anger and posttraumatic stress symptoms.

5.1.3 Self-Esteem

It was found that, before the treatment, of the participants in the treatment group had low (28%), average (60%) and high (12%) level of self-esteem while 60% of the control group participants had average, low (36%) and high (4%) level of self-esteem. The result implied that more number of participants (88%) from the treatment group and 96% of participants from the control group had low or average level of self-esteem.

The result was congruent with previous research. Sexually abused children frequently have extremely low self-esteem (Wickham & West, 2004). Moreover, this statement was supported by numerous studies which repeatedly noted poor self-esteem in children as a result of being sexually abused (Kuyken and Brewin, 1999; Briere and Runtz, 1990; Russell, 1997).

After solution-focused brief group treatment, the participants engaged in the treatment group showed significant improvement in levels of self-esteem. The result is the same with the finding of Springer et al. (2000, cited in Kim and Franklin, 2009), who examined six-session of specific solution-focused brief group therapy techniques such as scaling questions and the miracle questions, including mutual aid and interactional approaches for children whose parents or other family members have been imprisoned. Children in the treatment group make significant pre-post improvements on self-esteem, whereas the control group's scores were unchanged.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

This quasi-experimental study was conducted to examine the effectiveness of solution focused brief group counseling in addressing psychological problems of sexually abused children. Specifically, it aimed at examining whether there is or not a significant difference in depression, posttraumatic stress symptoms and self-esteem from pre-to post treatment measures between treatment and control group. The study was conducted on sexually abused children who are found in Godanaw Rehabilitation Integrated Project.

A total of 50 sexually abused children were purposefully selected based on the inclusion criteria. They were randomly assigned into two groups: the control and the treatment group, with 25 participants in each group. The participants in the control group received usual care provided by the center, while the participants in the treatment group received usual care provided by the center plus followed by 8 sessions of Solution-focused Brief Group Counseling.

The research questionnaire was comprised of two parts: demographic data and three standardized scales (depression, posttraumatic stress symptoms and self-esteem) to measure pre- and post-treatment effects.

Data collections were started with the participants of both treatment and control groups by their completion of the demographic data questionnaire and pre-tests. Thereafter, the treatment group was given three sessions per week of Solution-focused Brief Group Counseling, a total of 8 sessions; whereas the control group did not receive solution focused brief group counseling. In the final sessions, the participants in the treatment group were asked to complete

post-test questionnaire as was the control group. Then, after the data were collected and tabulated, percentage analysis, descriptive statistics, dependent and independent t-test were applied as analysis methods

The findings regarding the level of psychological problems of sexually abused children found that before the treatment, participants (68%) in the treatment group and 56% in the control group showed high level of depression. After the treatment, majority of participants showed mild or minimum (56%) in the treatment group and 88% of participants in the control group showed moderate or mild level of depression.

According to the results, before the treatment, the posttraumatic stress symptoms level of participants (72%) in the treatment group and 68% in the control group were moderate or severe. After the treatment, 79% of participants in the treatment group and 60% in the control group experienced moderate or sever level of posttraumatic stress symptoms.

It was found that majority of participants (88%) from the treatment group and 96% of participants from the control group had low or average level of self-esteem before the treatment while 92% of participants from the treatment group and 76% of participants from the control group had average or high level of self-esteem after the treatment.

Results from the analysis of dependent t-test indicated that there were statistically significance difference in mean depression and self-esteem scores of the treatment group, implying that participants engaged in the treatment group had improvement in depression and self-esteem compared to the control group. In contrary, independent t-test indicated that there was no statistically significant difference in mean posttraumatic stress symptoms scores between the treatment and control group.

6.2 Conclusions

The following are major findings of the study.

- Most of the participants (68%) from the treatment group and 56% from the control group experienced high levels of depression before the treatment.
- Majority of participants (72 %) from the treatment group and 68% of participants from control group showed high level of posttraumatic stress symptoms before the treatment.
- Majority of participants (88%) from the treatment group and 96% of participants from the control group had low or average level of self-esteem before the treatment.
- The treatment group showed a statistically significant reduction in the level of depression from pretest to posttest mean of depression scores after the completion of solution-focused Brief Group Counseling.
- The control group didn't show statistically significant reduction in the level of depression from pretest to posttest mean of depression scores.
- Following the completion of Solution-focused Brief Group Counseling, both the control and treatment group didn't show statistically significant difference between pretest and posttest mean of posttraumatic stress symptoms scores.
- The treatment group had a statistically significant improvement in the level of self-esteem from pretest to posttest mean of self-esteem scores after the completion of solution-focused Brief Group Counseling.
- The control group didn't show a statistically significant improvement in the level of self-esteem from pretest to posttest mean of self-esteem scores.

6.3 Recommendations

Based on the findings of the study, the following recommendations are forwarded.

1. The results indicated that all of the participants responded that they didn't receive any psychological counseling services from the organization and the researcher also observed that there was no counseling service center and a counselor who could provide psychological counseling to sexually abused children who are found in the organization. Consequently, it is suggested that the organization should hire counselors and establish and organize counseling service center to render psychological counseling service for the victims.
2. It was also found that majority of sexually abused children experienced depression, posttraumatic stress symptoms and poor self-esteem, so it is recommended that counselors along with social workers should assess sexually abused children problems and determine their physical and psychological needs to plan the appropriate intervention strategies to support their development, optimum growth, and function as capable individuals, family members and citizens of the nation.
3. The researcher found that all social workers called 'home mothers', who are found in GRIP, are working with sexually abused children with out any training on how to recognize, understand, , identify physical and psychological needs and rights of abused children and then how care for and handle them properly. So, it is recommended that the organization should provide training on the capacity building of these home mothers on how to treat and handle sexually abused children properly.
4. The results of the study indicate that Solution-focused Brief Counseling is as effective for treating sexually abused children experiencing

depression and poor self-esteem as measured by Children Depression Inventory and Rosenberg Self-esteem Scale. This is a good beginning in helping sexually abused children. Thus, counselors or social workers in developing psychological treatment plan for sexually abused children problems should use the findings of this study and theory of SFBC as a guide.

5. While the results of this study were encouraging and positive, more research is still needed that counselor educators should encourage and promote continued research in various areas regarding the application of solution-focused Brief Counseling in different settings or with other groups of children, such as imprisoned children, children with disabilities or drug addicts, because these children are at risk of suffering from psychological problems.

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APPENDICES

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

INSTITUTE OF PSYCHOLOGY

Date _____

Place _____

Data Collector Sign. _____

Questionnaires for sexually abused children

Data Collector: Please follow the following instructions before using the questionnaire.

1. This instrument can be used to collect data from selected participants who are sexually abused children.
2. Prior to the administration of the questionnaire introduce yourself formally and remind the selected participants that they have been selected as eligible respondents for the study.
3. Explain the objectives of the study using the information below:

The General Objective of the Study

The general objective of this research is to examine the effectiveness of Solution-focused Brief Group Counseling in addressing psychological problems of sexually abused children.

The Specific Objectives of the Study

1. To examine whether there is a significant difference in Depression from pre-to post-treatment measures between treatment and control group.
2. To explore whether there is a significant difference in Posttraumatic Stress Symptoms from pre-to- post-treatment measures between treatment and control group.
3. To investigate whether there is a significant difference in Self-esteem from pre-to post-treatment measures between treatment and control group.

Some Ethical Considerations of the Study

1. Give enough information and explanation to all study participants about the study (who it is for; what it is about; its objectives and methodology; actual and potential impact to various bodies, including the institutions where the study is conducted, study participants and their related populations).
2. Since the respondents could be sensitive to some of the items included in the instrument present the items with caution;
3. Make sure that you interview all respondents in complete privacy and no participants are seated close by allow interruption;
4. Secure the informed consent of all respondents who participate in the study and before the administration of the questionnaire express your thankfulness to them for their willingness to participate in the study.
5. Protect research participants' mystery and confidentiality

Appendix-A

1. Sex: _____

2. Age: _____

3. Educational level: _____

4. For how long times have you lived in this institution? _____(week, months, years)

5. What was the time since you abused?

1. Still occurring
2. Less than 1 year ago
3. 1- 2 years ago

6. Are you receiveing counseling at this time from the institution?

1. Yes
2. No

7. Have you ever received solution focused brief counseling before?

2. Yes
2. No(The questionnaire is completed. Thank you)

8. If "yes", what type of counseling did you receive?

1. Individual
2. Group
3. Other

9. How many counseling sessions did you receive?

1. 1 to 4 sessions
2. 5 to 8 sessions
3. 9 or more sessions

Appendix-B

INSTRUCTIONS: This scale lists the feelings and ideas in groups of three statements. From each group pick one sentence that describes you best for the **past two weeks**. There is no right or wrong answer. Just pick the sentence that best describes the way you have been feeling recently.

1. 0. I am sad once in a while.
1. I am sad many times.
2. I am sad all the time.
2. 0. Nothing will ever work out for me.
1. I am not sure if things will work out for me.
2. Things will work out for me O.K.
3. 0. I do most things O.K.
1. I do many things wrong.
2. I do everything wrong.
4. 0. I have fun in many things.
1. I have fun in some things.
2. Nothing is fun at all.
5. 0. I am bad all the time.
1. I am bad many times.
2. I am bad once in a while.
6. 0. I think about bad things happening to me once in a while.
1. I worry that bad things will happen to me.
2. I am sure that terrible things will happen to me.
7. 0. I hate myself.
1. I do not like myself.
2. I like myself.
8. 0. All bad things are my fault.
1. Many bad things are my fault.
2. Bad things are not usually my fault.
9. 0. I do not think about killing myself.
1. I think about killing myself but would not do it.
2. I want to kill myself.
10. 0. I feel like crying everyday.
1. I feel like crying many days.
2. I feel like crying once in a while.
11. 0. Things bother me all the time.
1. Things bother me many times.
2. Things bother me once in a while.
12. 0. I like being with people.
1. I do not like being with people many times.
2. I do not want to be with people at all.

- 13. 0. I can not make up my mind about things.
 - 1. It is hard to make up my mind about things.
 - 2. I make my mind about things easily.
- 14. 0. I look O.K.
 - 1. There are some bad things about my looks.
 - 2. I look ugly.
- 15. 0. I have to push myself all the time to do my schoolwork.
 - 1. I have to push myself many times to do my schoolwork.
 - 2. Doing schoolwork is not a big problem.
- 16. 0. I have trouble sleeping every night.
 - 1. I have trouble sleeping many nights.
 - 2. I sleep pretty well.
- 17. 0. I am tired once in a while.
 - 1. I am tired many days.
 - 2. I am tired all the time.
- 18. 0. Most days I do not feel like eating.
 - 1. Many days I do not feel like eating.
 - 2. I eat pretty well.
- 19. 0. I do not worry about aches and pains.
 - 1. I worry about aches and pains many times.
 - 2. I worry about aches and pains all the time.
- 20. 0. I do not feel alone.
 - 1. I feel alone many times.
 - 2. I feel alone all the time.
- 21. 0. I never have fun at school.
 - 1. I have fun at school only once in a while.
 - 2. I have fun at school many times.
- 22. 0. I have plenty of friends.
 - 1. I have some friends but I wish I had more.
 - 2. I do not have any friends.
- 23. 0. My school work is alright.
 - 1. My school work is not as good as before.
 - 2. I do very poorly in subjects I used to be good in.
- 24. 0. I can never be as good as other kids.
 - 1. I can be as good as other kids if I want to.
 - 2. I am just as good as other kids.
- 25. 0. Nobody really loves me.
 - 1. I am not sure if anybody loves me.
 - 2. I am sure that somebody loves me.
- 26. 0. I usually do what I am told.
 - 1. I do not do what I am told most times.
 - 2. I never do what I am told.
- 27. 0. I get along with people.
 - 1. I get into fights many times.
 - 2. I get into fights all the time.

Appendix-C

Instruction: Below is a list of problems that children sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you in the last 2 weeks. All the responses will be kept confidential. Thank you for your corporation!!!

Part-1					
S.N	List of Problems	Responses			
		Not at all (0)	Once a week (1)	2 to 4 times a week (2)	5 Or more times a week (3)
1	Having upsetting thoughts or images about the event that came into your head when you did not want them to				
2	Having bad dreams or nightmares				
3	Acting or feeling as the event was happening again (hearing something or seeing a picture about it and feeling as if I am there again)				
4	Feeling upset when you think about it or hear about the event (for example, feeling scared, angry, sad, guilty, etc)				
5	Having feelings in your body when you think about or hear about the event (for example, breaking out in a sweat, heart beating fast)				
6	Trying not to think about, talk about, or have feelings about the event				
7	Trying to avoid activities, people, or places that remind you of the traumatic event				
8	Not being able to remember an important part of the upsetting event				
9	Having much less interest or doing things you used to do				
10	Not feeling close to people around you				
11	Not being able to have strong feelings(foe example, being unable to cry or unable to feel happy)				
12	Feeling as if your future plans or hopes will not come true (for example, you will not have a job or getting married or having kids)				
13	Having trouble falling or staying asleep				
14	Feeling irritable or having fits of anger				
15	Having trouble concentrating(for example, losing track of a story on the television, forgetting what you read, not paying attention in class)				
16	Being overly careful(for example, checking to see who is around you and what is around you)				
17	Being jumpy or easily startled(for example, when someone walks up behind you)				
Part -2					
Indicate below if the problems you rated in Part-1 have gotten in the way with any of the following areas of your life DURING THE PAST 2 WEEKS					
18	Doing your prayers				
19	Chores and duties at home				

20	Relationship with friends		
21	Fun and hobby activities		
22	Schoolwork		
23	Relationships with your family		
24	General happiness with your life		

Appendix-D

Instruction: For each item below, circle the choice which indicates how you feel about yourself.

1. I feel that I'm a person of worth, at least on an equal basis with others.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
2. I feel that I have a number of good qualities.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
3. All in all, I am inclined to feel that I am a failure.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
4. I am able to do things as well as most other people.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
5. I feel I do not have much to be proud of.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
6. I take a positive attitude toward myself.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
7. On the whole, I am satisfied with myself.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
8. I wish I could have more respect for myself.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
9. I certainly feel useless at times.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree
10. At times I think I am no good at all.
1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree

በአዲስ አበባ የኒቨርስ-ቴ በድህረ ምረቃ ትምህርት ቤት ኢንሰይትዩት እና ሳይኮሎጂ

ቀን _____
ቦታ _____
የመረጃ ሰብሳቢው ፊርማ _____

ወሲባዊ ጥቃት ለደረሰባቸው ልጆች የተዘጋጀ መጠይቅ

የመረጃ ሰብሳቢ፡ መጠይቁን ከመጠቀምዎ በፊት ቀጥሎ የቀረቡትን መመሪያዎች በመከተል ተግባራዊ ያድርጉ።

- ይህ መጠይቅ ወሲባዊ ጥቃት የደርሶባቸውን ተሳታፊዎች በመምረጥ መረጃ ለማሰባሰብ ይውላል።
- መረጃውን ከመሰብሰብዎ በፊት ራስዎን ካስተዋወቁ በኋላ ለሚካሄደው ጥናት አስፈላጊውን መረጃ ለመሰብሰብ መጠይቁን እንዲሞሉ የተመረጡ ተሳታፊዎች እንደሆኑ ይግለጹላቸው።
- የሚከተለውን መረጃ በመጠቀም የጥናቱን አላማዎች ይግለጹላቸው።

የጥናቱ አጠቃላይ አላማ

የጥናቱ አጠቃላይ አላማ መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ወሲባዊ ጥቃት የደረሰባቸው ልጆች የስነ-ልቦና ችግሮችን በመፍታት ረገድ ያለውን ወጤታማነት ለመፈተሽ ነው።

የጥናቱ ዝርዝር አላማዎች

- የምክክር አገልግሎት ከመሰጠቱ በፊት እና ከተሰጠ በኋላ የምክክር አገልግሎት በተሰጣቸው እና ባልተሰጣቸው ልጆች መካከል የድብርት ስሜት(Depression) ላይ የጎላ ለውጥ እንዳለ ለመመርመር፤
- የምክክር አገልግሎት ከመሰጠቱ በፊት እና ከተሰጠ በኋላ የምክክር አገልግሎት በተሰጣቸው እና ባልተሰጣቸው ልጆች መካከል አስቃቂ ወሲባዊ ጥቃትን ተከትለው የሚከሰቱ የስሜትና የመንፈስ መረበሽ ችግሮች (Posttraumatic Stress Symptoms) ላይ የጎላ ለውጥ እንዳለ ለመፈተሽ፤
- የምክክር አገልግሎት ከመሰጠቱ በፊት እና ከተሰጠ በኋላ የምክክር አገልግሎት በተሰጣቸው እና ባልተሰጣቸው ልጆች መካከል ስለራሳቸው ያላቸው ግምት ወይም ዋጋ(Self-Esteem) ላይ የጎላ ለውጥ እንዳለ ለመፈተሽ፤

የጥናቱ ስነ ምግባር መርሆች

- ስለጥናቱ በቂ መረጃ ይስጡ፤ ይኸውም የሚከተሉትን ያካትታል ጥናቱ ምን እንደሆነ፤ ዓላማውን እና አሰራሩን፤ ጥናቱ የሚሰራባቸውን ተቋሞች እና ለተለያዩ አካላት ያለውን ጥቅም በተጨማሪም ለተሳታፊ ግለሰቦች እና ለተቀረው ህዝብ ያለውን አንድምታ።
- በመጠይቁ ውስጥ የተካተቱ አንዳንድ ነጥቦች የተሳታፊዎችን ስሜት ሊረብሹ ስለሚችሉ በጥንቃቄ እና አግባባዊ ባለው ሁኔታ ያቅርቡላቸው።
- ተሳታፊዎች በሂደቱ ውስጥ ብቻቸውን መሆናቸው እና ከማንኛውም ጣልቃ ገብነት ነፃ መሆናቸውን ማረጋገጥ።
- የተሳታፊዎችን ፍቃድ ማግኘትና መፈራረም እንዲሁም መጠይቁን ከማቅርብ በፊት ለፍቃደኝነታቸው ምስጋና ማቅርብ።
- የተሳታፊዎችን መረጃ ሚስጥራዊነት መጠበቅ።

Appendix-E

1. ፆታ: _____

2. ዕድሜ: _____

3. የትምህርት ደረጃ: _____

4. በዚህ ድርጅት ውስጥ ለምን ያህል ጊዜ ኖረሃል? _____ (ሳምንት፣ ወር፣ ዓመት)

5. ጥቃቱ ከደረሰብሽ በኋላ ምን ያህል ጊዜ ሆኗል?

1. አሁንም እየደረሰብኝ ነው፡፡

2. አንድ ዓመት አልሞላውም፡፡

3. 1-2 ዓመት በፊት

6. በአሁን ሰዓት ከድርጅቱ የምክክር አገልግሎት እየተጠቀምሽ ነው?

1. አዎ

2. አይደለም

7. ከዚህ በፊት መፍትሔ ተኮር አጭር ጊዜ የቡድን የምክክር አገልግሎት ተጠቅመሽ ታውቂያለሽ?

1. አዎ

2. አላውቅም / መጠይቁ ተጠናቋል፡፡ አመለግናለሁ/

8. ለጥያቄ “5” መልስሽ “አዎ” ከሆነ፣ ምን ዓይነት የምክክር አገልግሎት?

1. የግል የምክክር አገልግሎት

2. የቡድን የምክክር አገልግሎት

3. ሌላ

9. ምን ያህል የምክክር አገልግሎት ክፍለ ጊዜ ነው የተጠቀምሽው?

1. 1-4 ክፍለ ጊዜ

2. 5-8 ክፍለ ጊዜ

3. 9 ወይም ከዚያ በላይ ክፍለ ጊዜ

Appendix-F

መመሪያ: ይህ መጠይቅ ስሜቶችን እና ሀሳቦችን በሶስት ዐ.ነገሮች መድቦ 27 ጥያቄዎችን ይዟል። በእያንዳንዱ ምድብ ውስጥ ያሉትን ሶስት ዐ.ነገሮች በጥሞና በማንበብ / በማዳመጥ ላለፉት ሁለት ሳምንታት የአንቺን ስሜት በትክክል የሚገልፀውን አንድ ዐ.ነገር ምረጭ። እባክዎን ለእያንዳንዱ ጥያቄ አንድ ምርጫ መምረጥዎን እርግጠኛ ይሁኑ። ትክክል ወይም ስህተት የሚባል መልስ የለም።

1. 0. አንዳንዴ የህዘን ስሜት ይሰማኛል።
 1. ብዙውን ጊዜ የህዘን ስሜት ይሰማኛል።
 2. ሁል ጊዜ የህዘን ስሜት ይሰማኛል።
2. 0. ለእኔ ምንም ነገር አይሳካልኝም።
 1. ነገሮች እንደሚሳኩልኝ እርግጠኛ አይደለሁም።
 2. ነገሮች በጥሩ ሁኔታ ይሳኩልኛል።
3. 0. አብዛኛውን ነገሮች ጥሩ አድርጌ እሠራለሁ።
 1. ብዙውን ነገሮች በተሳሳተ ሁኔታ እሠራለሁ።
 2. ሁሉንም ነገር በተሳሳተ መንገድ እሠራለሁ።
4. 0. በብዙ ነገሮች እደሰታለሁ።
 1. በጥቂት ነገሮች እደሰታለሁ።
 2. በአጠቃላይ ምንም ነገር አያስደስትም።
5. 0. ሁል ጊዜ መጥፎ ነኝ።
 1. ብዙውን ጊዜ መጥፎ ነኝ።
 2. አንዳንዴ መጥፎ ነኝ።
6. 0. አንዳንዴ መጥፎ ነገር በእኔ ላይ ይከሰታል ብዬ አስባለሁ።
 1. መጥፎ ነገር ይከሰታል ብዬ እጨነቃለሁ።
 2. መጥፎ ነገር በእኔ ላይ እንደሚከሰት እርግጠኛ ነኝ።
7. 0. እራሴን እጠላለሁ።
 1. እራሴን አልወድም።
 2. እራሴን እወዳለሁ።
8. 0. ሁሉም መጥፎ ነገሮች የእኔ ስህተቶች ናቸው።
 1. ብዙውን መጥፎ ነገሮች የእኔ ስህተቶች ናቸው።
 2. መጥፎ ነገሮች ሁል ጊዜ የእኔ ስህተቶች አይደሉም።
9. 0. እራሴን ስለመግደል አላስብም።
 1. እራሴን ስለመግደል አስቢያለሁ ነገር ግን አላደርገውም።
 2. እራሴን መግደል እፈልጋለሁ።
10. 0. ሁል ጊዜ የማልቀስ ስሜት ይሰማኛል።
 1. ብዙውን ጊዜ የማልቀስ ስሜት ይሰማኛል።
 2. አንዳንዴ የማልቀስ ስሜት ይሰማኛል።
11. 0. ሁል ጊዜ ነገሮች ያስጨንቁኛል።
 1. ብዙውን ጊዜ ነገሮች ያስጨንቁኛል።
 2. አንዳንዴ ነገሮች ያስጨንቁኛል።
12. 0. ከሰዎች ጋር መሆን እወዳለሁ።
 1. ብዙውን ጊዜ ከሰዎች ጋር መሆን አልወድም።
 2. በአጠቃላይ ከሰዎች ጋር መሆን አልፈልግም።

ካውንስለንግ ሳይኮሎጂ

13. 0. አዕምሮዬን ለነገሮች ዝግጁ እንዲሆን ማድረግ አልችልም።
 1. አዕምሮዬን ለነገሮች ዝግጁ ማድረግ ያስቸግረኛል።
 2. አዕምሮዬን ለነገሮች በቀላሉ እንዲዘጋጅ አደርጋለሁ።
14. 0. አምራለሁ።
 1. ስለ እኔ ገዕታ ጥቂት መጥፎ ነገሮች አሉ።
 2. ብዙም አልሰብም ወይም አላምርም።
15. 0. የትምህርት ቤት ሥራዎች ለመሥራት ሁል ጊዜ እራሴን መገፋፋት አለብኝ።
 1. የትምህርት ቤት ሥራዎች ለመሥራት ብዙውን ጊዜ እራሴን መገፋፋት አለብኝ።
 2. የትምህርት ቤት ሥራ መሥራት ትልቁ ችግር አይደለም።
16. 0. ዘወትር ማታ የእንቅልፍ ችግር አለብኝ።
 1. ብዙውን ጊዜ ማታ የእንቅልፍ ችግር አለብኝ።
 2. እንቅልፌን በአግባቡ አተኛለሁ።
17. 0. አንዳንዴ ይደክመኛል።
 1. ብዙውን ጊዜ ይደክመኛል።
 2. ሁል ጊዜ ይደክመኛል።
18. 0. አብዛኛውን ቀናት ምግብ የመብላት ስሜቱ የለኝም።
 1. ብዙውን ቀናት ምግብ የመብላት ስሜቱ የለኝም።
 2. ምግብ በአግባቡ አበላለሁ።
19. 0. ስለ ህመሞች እና ሥቃዬች አልጨነቅም።
 1. ብዙውን ጊዜ ስለ ህመሞች እና ሥቃዬች አልጨነቃለሁ።
 2. ሁል ጊዜ ስለ ህመሞች እና ሥቃዬች አልጨነቃለሁ።
20. 0. ብቸኝነት አይሰማኝም።
 1. ብዙውን ጊዜ ብቸኝነት ይሰማኛል።
 2. ሁል ጊዜ ብቸኝነት ይሰማኛል።
21. 0. ትምህርት ቤት በፍፁም ተደሰኜ አላውቅም።
 1. እንዳንዴ ትምህርት ቤት አደሰታለሁ።
 2. ብዙውን ጊዜ ትምህርት ቤት አደሰታለሁ።
22. 0. ብዙ ጓደኞች አለኝ።
 1. ጥቂት ጓደኞች አሉኝ ነገር ግን ተጨማሪ ጓደኞች እንዲኖሩኝ አመኛለሁ።
 2. ምንም ጓደኛ የለኝም።
23. 0. የትምህርት ቤት ውጤቴ ጥሩ ነው።
 1. የትምህርት ቤት ውጤቴ እንደበፊቱ ጥሩ አይደለም።
 2. ከዚህ በፊት ጥሩ ውጤት የነበረኝ የትምህርት ዓይነቶች ላይ አሁን ዝቅተኛ ነው።
24. 0. እንደ ሌሎች ልጆች በፍፁም ጥሩ መሆን አልችልም።
 1. ከፈለኩኝ እንደ ሌሎች ልጆች ጥሩ መሆን አችላለሁ።
 2. እኔ ልክ እንደ ሌሎች ልጆች ጥሩ ነኝ።
25. 0. ማንም ሰው የእውነት አይወደኝም።
 1. ማንም ሰው እንደሚወደኝ እርግጠኛ አይደለሁም።
 2. የሆነ ሰው እንደሚወደኝ እርግጠኛ ነኝ።
26. 0. ሁል ጊዜ የተነገረኝን ሥራ አሰራለሁ።
 1. አብዛኛውን ጊዜ የተነገረኝን ሥራ አልሠራም።
 2. የተነገረኝን ሥራ በፍፁም አልሠራም።
27. 0. ከሰዎች ጋር አብሬ ሆናለሁ።
 1. ብዙውን ጊዜ አጣላለሁ።
 2. ሁል ጊዜ አጣላለሁ።

Appendix-G

መመሪያ:- ቀጠሎ የተዘረዘሩት ጥያቄዎች ልጆች የደረሰባቸውን አስቃቂ ጥቃትን ተከትለው የሚከሰቱ የስሜትና የመንፈስ መረበሽ ችግሮች የሚለኩ ሲሆኑ እያንዳንዱን ጥያቄ በጥሞና በማንበብ ወይም በማዳመጥ ችግሩ ላለፉት ሁለት/2/ ሣምንታት ከተሰጡት አራት/4/ አማራጮች (0-3) የአንቺን ስሜት በትክክል ይገልጻል ባልሸው ምርጫ ሥር “✓” ምልክት በማድረግ መልሽ፡፡ የመረጥሽው ምላሽ ሁሉ በሚስጥር ይቀመጣል፡፡ ለትብብርሽ በጣም አመለካከት!!!

ክፍል 1

ተ.ቁ	ጥያቄዎች	አማራጮች			
		ምንም የለም (0)	በሳምንት አንድ ጊዜ (1)	በሳምንት ክ2 እስከ 4 ጊዜ (2)	በሳምንት 5 ጊዜ እና ከዚያ በላይ (3)
1	ስለደረሰብኝ ጥቃት የሚያስፈሩና የሚያስጨንቁ ሀሳቦች ሳልፈልጋቸው በአዕምሮዬ እየተመለሰሁ ያስቸግሩኛል				
2	ማታ ማታ መጥፎ ህልሞች እመለከታለሁ ወይም ያቃዝኛል				
3	የደረሰብኝ ጥቃት በድጋሚ የሚከሰት ዓይነት ስሜት ይሰማኛል፤ ማለትም ስለ ጥቃቱ የሆነ ነገር መስማት ወይም ማየት እና እዚያ ቦታ ላይ እንደገና የመገኘት ስሜት ይሰማኛል				
4	ስለደረሰብኝ ጥቃት ሳስብ ወይም ስለማ የሚያስፈራ እና የሚያስጨንቅ ስሜት ይሰማኛል /ለምሳሌ፡- የመደንገጥ፣ የመፍራት፣ የመናደድ፣ የማዘን፣ የወጀለኝነት ስሜት ይሰማኛል/				
5	ስለደረሰብኝ ጥቃት ሳስብ ወይም በሰማው ጊዜ በሰውነቴ ላይ የተለያዩ ለውጦች ይከሰታሉ /ለምሳሌ፡- ማላብ፣ የልብ ምት መጨመር/				
6	ስለደረሰብኝ ጥቃት ማሰብና መናገር ወይም ስለጥቃቱ ምንም ዓይነት ስሜት እንዲሰማኝ አልፈልግም				
7	የደረሰብኝን አስቃቂ ጥቃት ሊያስታውሱኝ የሚችሉ ድርጊቶች፣ ሰዎች እና ቦታዎች ለማስወገድ እሞክራለሁ				
8	ስለሚረብሽኝና ስለሚያስጨንቀኝ ሁኔታ አስፈገላጊውን ወይም ዋነኛውን ጉዳይ ለማስተዋስ አለመቻል				
9	ከዚህ በፊት የምሠራቸውን ሥራዎች የመሥራት ፍላጎቴ በጣም ቀንሷል				
10	በአካባቢዬ የሚገኙ ሰዎችን የመቅረብ ስሜቴ የለኝም				
11	ስሜቴን በአግባቡ መግለፅ አልችልም /ለምሳሌ፡- የደስታ ስሜት ማጣት፣ ለማልቀስ መቸገር/				
12	የወደ ፊት ዕቅዶቼ ወይም ተስፋዎቼ የማይሳኩ መስሎ ይሰማኛል /ለምሳሌ፡- ሥራ አለማግኘት፣ አለማግባት፣ ወይም ልጄ አለመውለድ/				
13	እንቅልፌ የተቆራረጠ እና የተረበሽ ወይም እንቅልፍ				

ካውንስሊንግ ሳይኮሎጂ

	ላይ ለረዥም ጊዜ እቆያለሁ				
14	የመነጫነጭና የመናደድ ስሜት ይሰማኛል				
15	አዕምሮዬን በአንድ ሥራ ላይ እንዲያተኩር ማድረግ ያስቸግረኛል /ለምሳሌ፡- ቴሌቪዥን መከታተል አለመቻል፣ ያነበብኩትን መርሳት፣ ክፍል ውስጥ ትኩረት ማድረግ አለመቻል/				
16	ለእያንዳንዱ ነገር ከመጠን በላይ ጥንቃቄ እደርጋለሁ /ለምሳሌ፡- በዙሪያዬ ማን እና ምን እንዳለ ደጋግሞ ማረጋገጥ/				
17	በቀላሉ መደንገጥ፣ መፍራት ወይም መንቀጥቀጥ /ለምሳሌ፡ ከኃላ የሆነ ሰው ሲመጣ/				
	ክፍል-2				
በክፍል-1 ሥር የመረጥኸቸው ችግሮች በሚከተሉት እንቅስቃሴዎች ላይ ላለፉት ሁለት ሳምንታት በአንቺ ላይ ችግር አስከትለው ከሆነ “አዎ” ካልሆነ ደግሞ “አይደለም” በማለት መልስ ሰጪ፡፡					
18	ሀይማኖታዊ ግዴታዎች/ለምሳሌ ጸሎት/ በበቂ ሁኔታ በመወጣት ረገድ			አዎ	አይደለም
19	በዕለት ዕለት የቤት ሥራዎችን በበቂ ሁኔታ በመወጣት ረገድ			አዎ	አይደለም
20	ከጓደኞችሽ ጋር ባለሽ መልካም ግንኙነት ላይ			አዎ	አይደለም
21	የሚያዝናኑ እና የሚያስደስቱ እንቅስቃሴዎችን በማከናወን ረገድ			አዎ	አይደለም
22	የትምህርት ቤት ሥራዎችን በማከናወኑ ረገድ			አዎ	አይደለም
23	ከቤተሰቦችሽ ጋር ባለሽ መልካም ግንኙነት ላይ			አዎ	አይደለም
24	በአጠቃላይ በደስተኛ ህይወትሽ ላይ			አዎ	አይደለም

Appendix-H

መመሪያ፡ ከታች ከተዘረዘሩት ጥያቄዎች ስለራስሽ ያለሽን ስሜት ይገልጻል የምትይውን ምርጫ በጥሞና በማዳመጥ ወይም በማንበብ አክብቧል፡፡

1. ቢያንስ ከሌሎች ሠዎች ጋር ተመጣጣኝ በሆኑ መልኩ ዋጋ ያለኝ ሠው እንደሆንኩ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

2. እኔ መልካም የሆኑ ባህሪያቶች እንዳሉኝ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

3. በአጠቃላይ እኔ የማይሳካልኝ ሠው እንደሆንኩኝ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

4. ሌሎች ብዝሃዎች ሠዎች የሚሠሩትን ያህል መሥራት እችላለሁ፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

5. እኔ ያህን ያህል የምኮራበት ነገር እንደሌለኝ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

6. እኔ ስለራሴ ያለኝ አመለካከት አዎንታዊ ነው፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

7. በአጠቃላይ እኔ በራሴ ሁኔታ በጣም ደስተኛ ነኝ፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

8. እኔ ስለራሴ የበለጠ ክብር እንዲኖረኝ እመኛለሁ፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

9. እኔ በእርግጠኝነት የማረባ ሰው እንደሆንኩ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

10. አንዳንዴ ስለራሴ ሳስብ በሁሉም ነገር ጥሩ እንዳልሆንኩ ይሰማኛል፡፡

ሀ. በጣም እስማማለሁ ለ. እስማማለሁ ሐ. አልስማማም መ. በጭራሽ አልስማማም

ካውንስሊንግ ሳይኮሎጂ

Appendix-I

ለተጠኝ ቡድን (Experimental Group)

ቀን: _____

በፈቃድ ላይ የተመሠረተ ስምምነት

(Informed Consent)

እኔ _____ (የኮድ ስም) የተባልኩ በጎዳናው ሪከብሊቴሽን ኢንትግሬትድ ፕሮጀክት ተጠቃሚ ስሆን በአዲስ አበባ ዩኒቨርሲቲ በካውንስሊንግ ሳይኮሎጂ የድረህ ምረቃ ተማሪ ከሆነው ከአቶ ማርቆስ ካንኮ ጋር “መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ወሲባዊ ጥቃት በደረሰባቸው ልጆች ችግር ላይ ያለውን ውጤታማነት” ለመፈተሽ በሚያደርገው ጥናታዊ ምርምር ላይ ተሳታፊ ለመሆን ፈቃደኝነቴን በመግለጽ ጥናቱ የሚጠይቃቸውን ሁኔታዎች ማለትም፤

- በጥናቱ ላይ በፈቃደኝነት ተሳታፊ ለመሆን፤
- የሚቀርቡልኝን ቅድመ እና ድህረ-መጠይቆች በአግባቡ ለመመላት፤
- መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ላይ ከባለሙያው ጋር በተስማማነው ሰዓትና ቀን ያለማቋረጥ የአገልግሎቱ ተጠቃሚ ለመሆን፤

እና ሌሎች ለጥናቱ አስፈላጊ የሆኑ ሁኔታዎችን ለማሟላት በፊርማዬ አረጋግጣለሁ፡፡

እኔም ማርቆስ ካንኮ ከተጠቃሚ _____ (የኮድ ስም) ጋር ከላይ በተጠቀሰው ጥናታዊ ምርምር ዙሪያ በጎዳናው ሪከብሊቴሽን ኢንትግሬትድ ፕሮጀክት በመገኘት ለጥናቱ ስኬታማነት የሚያስፈልጉትን ከዚህ በታች የተዘረዘሩትን የጥናቱን ስነ-ምግባራዊ ደንቦች ማለትም፡-

- ተሳታፊዎች በጥናቱ ለመሳተፍ ፍቃደኛ በመሆናቸው ልባዊ ምሥጋና በማቅረብ፤
- ለጥናቱ ተሳታፊዎች ስለጥናቱ በቂ ገለጻ እና መረጃ በመስጠት፤
- አንዳንድ የጥናቱ ጥያቄዎች የተሳታፊዎችን ስሜት ሊረብሹ ስለሚችሉ በጥንቃቄ እና በአግባቡ በማቅረብ፤
- መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ሂደቱ በተገቢው እና በጥንቃቄ እንዲካሄድ በማድረግ፤
- በጥናቱ እና በቡድን የምክክር አገልግሎት ሂደት የሚነሱ ሃሳቦችና መረጃዎች በሙሉ በሚስጥር በመያዝ፤

በአጠቃላይ ጥናታዊ ምርምሩን በአግባቡ ለማካሄድ መስማማቴን በፊርማዬ አረጋግጣለሁ፡፡

የጥናቱ ተሳታፊ ስም: _____ ፊርማ: _____
(ወይም የቤቱ እመቤት ስም)

የጥናቱ ባለቤት ስም: _____ ፊርማ: _____

ለማንጻጸሪያ ቡድን (Control Group)

ቀን: _____

በፈቃድ ላይ የተመሠረተ ስምምነት
(Informed Consent)

እኔ _____ (የኮድ ስም) የተባልኩ በጎዳናው ሪከብሊቴሽን ኢንትግሬትድ ፕሮጀክት ተጠቃሚ ስሆን በአዲስ አበባ ዩኒቨርሲቲ በካውንስሊንግ ሳይኮሎጂ የድረህ ምረቃ ተማሪ ከሆነው ከአቶ ማርቆስ ካንኮ ጋር “መፍትሔ ተኮር የአጭር ጊዜ የቡድን የምክክር አገልግሎት ወሲባዊ ጥቃት በደረሰባቸው ልጆች ችግር ላይ ያለውን ውጤታማነት” ለመፈተሽ በሚያደርገው ጥናታዊ ምርምር ላይ ተሳታፊ ለመሆን ፈቃደኝነቴን በመግለጽ ጥናቱ የሚጠይቃቸውን ሁኔታዎች ማለትም፤

- በጥናቱ ላይ በፈቃደኝነት ተሳታፊ ለመሆን፤
- የሚቀርቡልኝን ቅድመ እና ድህረ-መጠይቆች በአግባቡ ለመመላት፤

እና ሌሎች ለጥናቱ አስፈላጊ የሆኑ ሁኔታዎችን ለማሟላት በፊርማዬ አረጋግጣለሁ፡፡

እኔም ማርቆስ ካንኮ ከተጠቃሚ _____ (የኮድ ስም) ጋር ከላይ በተጠቀሰው ጥናታዊ ምርምር ዙሪያ በጎዳናው ሪከብሊቴሽን ኢንትግሬትድ ፕሮጀክት በመገኘት ለጥናቱ ስኬታማነት የሚያስፈልጉትን ከዚህ በታች የተዘረዘሩትን የጥናቱን ስነ-ምግባራዊ ደንቦች ማለትም፡-

- ተሳታፊዎች በጥናቱ ለመሳተፍ ፍቃደኛ በመሆናቸው ልባዊ ምሥጋና በማቅረብ፤
- ለጥናቱ ተሳታፊዎች ስለጥናቱ በቂ ገለጻ እና መረጃ በመስጠት፤
- አንዳንድ የጥናቱ ጥያቄዎች የተሳታፊዎችን ስሜት ሊረብሹ ሰለሚችሉ በጥንቃቄ እና በአግባቡ በማቅረብ፤
- በጥናቱ ሂደት የሚነሱ ሃሳቦችና መረጃዎች በሚስጥር በመያዝ፤

በአጠቃላይ ጥናታዊ ምርምሩን በአግባቡ ለማካሄድ መስማማቴን በፊርማዬ አረጋግጣለሁ፡፡

የጥናቱ ተሳታፊ ስም: _____
(ወይም የቤቱ አመቤት ስም)

ፊርማ: _____

የጥናቱ ባለቤት ስም: _____

ፊርማ: _____

Appendix-J

Solution Focused Brief Group Counseling Treatment Plans for Treatments of Depression, Stress and Self-Esteem

GROUND RULES FOR GROUP COUNSELING

1. COME ON TIME

- Do not keep others waiting

2. COME EVERY SCHEDULED DAY

- Make a commitment to the group

3. BE SUPPORTIVE TO EACH OTHER

4. BE CONSTRUCTIVE

- Avoid criticism, give constructive feedback.
- Help each other find the good side of things.
- Be caring, thoughtful.
- Don't put pressure on each other (no "shoulds").

5. EQUAL TIME FOR ALL

- Give everyone a chance to talk.
- One person at a time talks, no side conversations.

6. KEEP IT PRACTICAL

- Focus on solutions, not on how bad things are.

7. DO THE HOME WORK!!

- Practice what you learn.
- These methods can help you control your depression, stress and self-esteem only if you practice.

8. CONFIDENTIALITY

- Don't discuss personal things with people outside of the group.
- You can discuss what you are learning about depression with others.
- Do not talk about other people who are in group with you.

9. TELL US IF YOU ARE UNHAPPY!!

- Bring concerns up in the group.
- We want to work with you.
- Don't stay mad at the group without letting us know.

10. COME BACK TO THE GROUP.

- Don't drop out.
- Let us know if you feel upset or have concerns, we can work things out.

2. Depression

Sessions: 1-3

Time: 6hrs

Setting: GRIP

Date: _____

2.1 Behavioral Definitions

- Feels depressed or down nearly every day.
- Is less productive on the job and in general.
- Experiences little pleasure in formerly pleasurable activities.
- Experiences withdrawal from social relationships.
- Reports negative, dysfunctional cognitions.
- Verbalizes feelings of low self-esteem.
- Feels hopeless and helpless, possibly accompanied by suicidal thoughts.
- Is not actively suicidal.
- Reports low levels of activity accompanied by feeling tired all the time.
- Reports changes in sleep patterns.
- Reports changes in appetite and eating habits.
- Has difficulty concentrating.

2.2 Long-Term Goals

- Eliminate significant depressive symptoms and practice relapse prevention.
- Replace negative, dysfunctional cognitions that precipitate depression with positive, health-enhancing cognitions that minimize depression.
- Increase the number of pleasant activities engaged in.
- Improve feelings of self-esteem.
- Increase productivity.
- Reinvest in social relationships.

2.3 Short-Term Objectives

- State reason for attending group.
- Verbalize both acceptance of the rules of the group and understanding of the potential impact of being in the group.
- Articulate identifying information about self apart from being depressed.
- Identify own symptoms of depression.
- Monitor and keep a chart of mood changes.
- Verbalize an understanding of the distinction between thoughts and feelings.
- Verbalize an understanding of the ability of thoughts to influence feelings.
- Identify thoughts that cause and maintain depressed feelings.
- Categorize thoughts that lead to depression.
- Demonstrate success at reducing negative thoughts that foster feelings of depression.
- Report success in the use of thoughts that improve mood.
- Verbalize understanding of the relationship between depressed thinking and low levels of pleasurable activity.
- Identify activities that might be pleasurable.
- Increase number of pleasurable activities engaged in daily.
- Verbalize an understanding of the relationship between depressed thinking and social isolation.
- Initiate more pleasurable social activities.
- Express feelings, thoughts, and needs assertively and openly in group and later with significant others.

2.4 Therapeutic Interventions

- Describe the ground rules for the group (e.g., confidentiality, no substance use, preferably no missed sessions, the ability to take an interactive time-out if overwhelming feelings arise in the session) and ask for the members' commitment to those ground rules.
- Have the members make a statement of purpose for participating in the group.
- Have the members introduce themselves to the rest of the group without reference to their depression.
- Elicit the members' symptoms of their depression including feelings, behaviors, and thoughts; brainstorm and facilitate group counseling on a list of common symptoms.
- Assign the members to monitor their moods to facilitate identification of factors that improve or worsen these moods. Use a 10 point scale where 9 represents the best mood they can imagine, 0 the worst mood they can imagine, and 5 a typical mood when they are not depressed. Have members rate their mood each night before bed and keep a chart. If mood varies during the day, have members assigned a best and worst score each day.
- Confront the members' assertions that they feel terrible all the time; encourage them monitoring of the time of day and specific circumstances that might contribute to mood differences.
- Clarify for the group the distinction between thoughts (e.g., things people say to themselves about what goes on around them) and feelings (e.g., physiological response in the body or a mood state).
- Facilitate group counseling about the influence on thoughts of family, culture, and individual personality traits.
- Elicit the members' descriptions of their thoughts influencing their feelings and encourage members to relate their own experiences to those of the speaker.
- Encourage the members to pay attention to their thoughts on a regular basis, with particular focus on the recurring ones.
- Brainstorm and facilitate group counseling with the group to identify the thoughts that cause and maintain depression by working backward from feelings to thoughts (e.g., ask members to notice when they are feeling

- particularly bad, and then notice what they are saying to themselves at those times [thoughts]); assign them to monitor this during the week.
- Assign the members to categorize their thoughts as they monitor them throughout the week and report back to the group the following week.
 - Encourage the members to try to decrease the incidence of unnecessary, distorted thinking using thought-stopping techniques (e.g., mentally shouting “stop” or snapping a rubber band worn around the wrist) to interrupt negative thoughts.
 - Assign the members who identify themselves as “worriers” to set aside 15 to 30 minutes a day to worry, and to postpone until then worry thoughts that come up at other times.
 - Facilitate a group discussion about the cycle wherein depression leads to decreased activity which in turn increases depression; ask the members to share their own experiences of this cycle with the rest of the group.
 - Brainstorm and elicit from the members a list of activities (preferably ordinary, simple things like taking a walk, taking a boil bath, listening to music, read book, watching TV) that they find—or used to find—pleasurable. Have members select several activities from the list and agree to engage in at least one each day.
 - Explain group members to monitor daily participation in the pleasant events on their personal lists.
 - Assign the members to participate in a new activity from their pleasant activity list in the next week; ask them to predict ahead of time how much pleasure they will derive from the activity and to assess afterward how pleasurable the activity actually was.
 - Facilitate a group discussion about how negative anticipatory thoughts can interfere with motivation to participate in activities that can bring pleasure.
 - Have the members commit to rewarding themselves (e.g., eating a favorite meal, going to/watching a movie, calling a friend, watching TV) for engaging in a new activity regardless of the outcome of the activity.
 - Help the members generate a list of suggestions for meeting people, and a list of the activities they could invite someone to join them in doing.
 - Have the members share with the rest of the group their success in assertive communication, reinforcing success and redirecting for failures.

3. Posttraumatic Stress Symptoms

Sessions: 1-3

Time: 6hrs

Setting: GRIP

Date: _____

3.1 Behavioral Definitions

- Has experienced a traumatic event or series of events that incurred a risk of bodily harm and/or a threat to life.
- Reports having felt and continuing to feel fear, helplessness, and/or horror about that experience and of future potential traumas.
- Reports experiencing nightmares, flashbacks, and/or intrusive thoughts about the trauma.
- Demonstrates symptoms of physiological arousal including hyper-vigilance, insomnia, difficulty concentrating, startle response, anxiety, and/or irritability.
- Expresses a loss of interest in work or leisure activities.
- Describes a tendency to avoid places and activities that evoke memories of the traumatic event.
- Expresses feelings of alienation resulting in social isolation or emotional distance from others.
- Reports problems with relationships, intimate and/or informal.

3.2 Long-Term Goals

- Increase feelings of control and safety in all areas of life.
- Reduce behaviors aimed at avoiding situations evocative of the trauma.
- Eliminate feelings of shame associated with the trauma.
- Develop and maintain a sense of meaning in life.
- Increase the ability to sustain meaningful relationships.

2.3 Short-Term Objectives

- Verbalize both acceptance of the rules of the group and understanding of the potential impact of being in the group.
- Introduce self and describe the symptoms that precipitated joining the group as well as the trauma that triggered those symptoms.
- Verbalize an understanding of the typical symptoms of posttraumatic stress symptoms.
- Verbalize the erroneous beliefs that have resulted from the trauma experience.
- Practice safe place visualization and other stress-reduction techniques at least once a day.
- Acknowledge strengths demonstrated during the trauma.
- Identify internal and external triggers of flashbacks and reactions to those triggers.
- Implement at least five strategies for improving sleep.
- Identify inappropriate expressions of anger and alternate modes of expression.
- Practice at least three self-nurturing behaviors daily in the service of reducing shame.

3.3 Therapeutic Interventions

- Describe the ground rules for the group (e.g., confidentiality, no substance use, preferably no missed sessions, the ability to take an interactive time-out if overwhelming feelings arise in the session) and ask for the members' commitment to those ground rules.
- Ensure that the members understand that participating in the group may elicit a temporary increase in posttraumatic stress symptoms.
- Ask the members to introduce themselves, describing their symptoms.
- Explain the typical range of posttraumatic stress symptoms and frame the members' problems in terms of their trauma.
- Describe to the group the most common cognitive distortions that can result from trauma exposure (e.g., an inability to tolerate mistakes in oneself or others; a denial of any personal problems resulting from the trauma; all-or-nothing, or black-and-white, thinking; the need to continue survival tactics to avoid further disaster).
- Facilitate group counseling with the members identify how their cognitive distortions have led to erroneous personal beliefs about themselves and others.
- Demonstrate for the group one of stress- management a technique which is easy to practice (e.g., safe place visualization, deep breathing, and progressive muscle relaxation); elicit a commitment from each member to practice at least once a day.
- Facilitate a group brainstorming with the members in identifying the triggers that elicit emotional and physiological arousal evocative of the trauma (e.g., sights, sounds, smells, physical sensations, tastes, places, persons, weather, thoughts), and the reactions they have to their triggers.
- Describe good sleep hygiene, and behavioral techniques for improving sleep (e.g., keep regular sleep habits; avoid going to bed after midnight; avoid

vigorous exercise shortly before retiring; avoid late afternoon or evening sleeps; reserve bed for sleep; avoid large meals or excessive fluid intake shortly before retiring; avoid caffeine and nicotine shortly before retiring; take a warm bath before retiring; play relaxing music before retiring; ensure a quiet, warm, and dark environment; deep breathing, and positive imagery relaxation exercises upon retiring; get out of bed if sleep has not been attained in 30 minutes). Ask them to implement at least five of the techniques aimed at improving their sleep.

- Explain to the group the role of anger as a healthy response to trauma, as well as the healthy and unhealthy ways of expressing anger; elicit from the members the ways that anger expression has helped as well as hurt them.
- Brainstorm with the group alternate means of responding to feelings of anger (e.g., implementing relaxation and deep breathing, identifying and avoiding thoughts that trigger anger); encourage the members to practice at shelter and report at least one successful anger-coping experience without an outburst.
- Facilitate a group brainstorming of self-nurturing behaviors (e.g., listen to favorite music, read a book, take a warm bath, get a massage, take a walk in the woods, lay in the sun, call a friend, watch a favorite video); have the members commit to practicing at least three every day between sessions.

4. Self-esteem

Sessions: 1-2

Time: 4hrs

Setting: GRIP

Date: _____

4.1 Behavioral Definition

- Self-esteem is feeling good about us. We love and respect ourselves. We expect others to do the same and treat us well. We are strong enough to say what we feel and think clearly.
- People with high self-esteem do not feel that they are better than other people. But they are able to accept their disappointments and frustrations and get on with their lives.
- Parents, guardians, caregivers and teachers can help us to have high self-esteem by loving, respecting and praising us and giving us challenges.
- Our culture can lower, for example, women's self-esteem by training them to believe that they are inferior to men and should accept everything that men say. The same is true for children. This makes girls and women accept practices that are bad for them and the community. For example, women may not be involved in making decisions, children are also not allowed to discuss with their parents, even though they have good ideas.
- Low self-esteem is an important reason why some young girls are not able to say no to early sex.

4.2 Short-term Objectives

1. Define the term self-esteem.
2. Describe the link between self-esteem, assertive behavior, and good decision making.
3. Identify the strengths of others in the group.
4. List and discuss qualities others admire in them.
5. List and discuss qualities that they most admire about themselves.
6. List and discuss areas in which they would like to improve.

4.3 Interventions to give each other high self esteem

In the group counseling process, **We**, group members: (which were also applied in previous sessions)

- Praise each other when we do well and say what we like about each other.
- Help and encourage each other when we do badly.
- If our counseling group members do something that we don't like, we tell them how we want them to change in a helpful way.
- Don't tease or laugh at group members in ways that make them feel sad.
- Listen to each other and accept each other as special group members.

4.4 Activities

1. Praising group members, changing group members

1. We all have things that people like about us, our behavior and the things we do well: for example, our smile, our kindness or our skill in communicating others. In pairs, tell each other three things that you like about each other – one each about:
 - Your looks
 - Your behavior
 - Things you do well.

2. Now tell each other something you like about your own looks, behavior and skills.
3. We all have things that we would like to improve. This helps us to do better. But sometimes we worry too much and make ourselves feel bad. No one is 100 per cent good! Tell your group members one thing that you would like to improve about:
 - Your own looks
 - Your own behavior
 - Your own skills.

For each point, facilitate group counseling using scaling questions:

Please look at this scale from 0–10 with 10 being the best. Zero is how you felt when things were at their worst. Ten is as good as things can be in relation to this problem.

- Where are you now on this scale right now? [pause] Give it a number (for example, '2 or 3?')
- If not precise, 'nearer 2 or nearer 3?'
- How long will it take to get to 10? [Prompt if necessary to get a time – a month? More? Less?]
- May be 10 is too big a goal?
- Is something lower more realistic?
- What number will be acceptable for you?
- How will you recognize when you are one point further up the scale?
- What else will be different when you are one point further up?
- Who will notice?
- How long will it take to get one point up the scale?

Explain to the group help their group members to accept the way they are, or encourage them to change if they can.

2. Making a shield

Make a shield that shows good things about you. Stick all the shields on the wall for a week and praise each other. (If time and place allows you to do this)

Put on your shield:

I am good at ...

I like my ...

My friends like me because ...

I have achieved ...

Home Activities

Activity 1: Helping our guardians and caregivers

1. In pairs talk about the things guardians or caregivers does that make you feel good about yourself and the things they do that make you feel bad about yourself.
2. Share this with your counseling group members and agree on one request to make to your caregivers or guardians to act in a way that raises your self-esteem. You could do this as a song.

ጥሩ የሆኑባቸው ነገሮች---	ስለራሴ የምወዳቸው ነገሮች---
ጓደኞቼ ይወዱኛል ምክንያቱም---	ስኬቶቼ---
ስሜ-----	

DAILY MOOD SCALE

Week Number _____

Name _____ Week Starting: _____

Day		_____	_____	_____	_____	_____	_____	_____
D	BEST	9	9	9	9	9	9	9
A								
I		8	8	8	8	8	8	8
L								
Y		7	7	7	7	7	7	7
M								
O		6	6	6	6	6	6	6
O								
D		5	5	5	5	5	5	5
	AVERAGE	4	4	4	4	4	4	4
S								
C		3	3	3	3	3	3	3
O								
R		2	2	2	2	2	2	2
E								
	WORST	1	1	1	1	1	1	1

Number of
thoughts

Positive: _____

Negative: _____

DECLARATION

I declare that this thesis is my own work. It has not been presented for a degree in any other University and that all sources of material used for the thesis have been duly acknowledged.

Name: MARKOS KANKO

Signature: 

Date: July 01/2010

This thesis has been submitted for examination with my approval as a University advisor.

Name: Sentayehu Tadesse

Signature: 

Date of approval: July 01/2010