ADDIS ABABA UNIVERSITY
COLLEGE OF EDUCATION
SCHOOL OF GRADUATE STUDIES

THE PSYCHOSOCIAL EFFECTS OF SEXUAL ABUSE ON CHILDREN

A Thesis Submitted to the Graduate School of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Education in Counseling Psychology

BY

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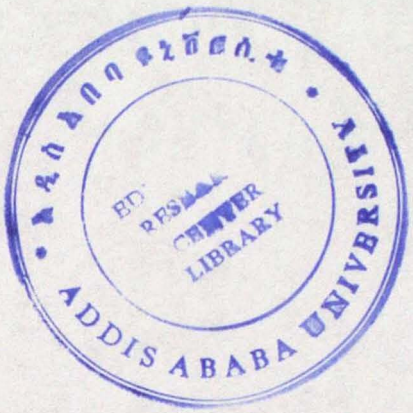
The Psychosocial Effect of Sexual Abuse on Children



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Acronyms

AIDS- Acquired Immuno Deficiency Syndrome
CSA-Child Sexual Abuse
HIV-Human Immunodeficiency Virus
NGO-Non Governmental Organizations
PTSD-Post Traumatic Stress disorder
S.A.-Sexual Abuse
S.A.C.-Sexually Abused Children

Abstract

This study attempts to assess the psychosocial effects of sexual abuse on children, sampled from Addis Ababa. The study is cross-sectional, non-experimental. Samples were selected using purposive sampling technique and data were gathered using both qualitative and quantitative methods: in-depth interview guide, Scales (PTSD, Anxiety and Emotional Distress).

The gathered quantitative data were analyzed by using descriptive statistics (percentage) and the conducted case studies were qualitatively analyzed by using the journal entitled: ***Long term and Immediate Impacts of CSA.*** *The results indicated that sexually abused victims suffer a lot of psychological and social consequences of the violence. These problems include increased anxiety, high emotional distress, more symptoms of PTSD, lowered self-esteem, guilt, shame, depression, lack of trust, betrayal, aggressive behaviors, hatred, anger, social withdrawal or isolation, helplessness, hopelessness, self-humiliation, sexual dysfunction, addiction, suicide, passivity, dissociation, less or no intimate relationship, fear, etc. The majority of their non-offending parents also developed sense of fear, guilt, shame, anxiety, betrayal, shock, isolation, social interaction problems, etc. The severity of the effects of CSA depends on who is doing the abuse-the context, the manner of the abuse-the nature, and how long the abuse goes on-the duration.*

Finally, based on the observed problems of the victims and the findings of the study, recommendations were forwarded focusing on disclosure/reporting, prevention and treatment strategies, and legal aspects.

CHAPTER ONE

Introduction

1.1 Background of the Study

It is a common knowledge that Ethiopia is suffering from complex socioeconomic problems. Some of the core causes are high population pressure, drought, and spread of communicable diseases like HIV/AIDS, and child sexual abuse. The effect has resulted in one of the biggest social, economic, developmental, and psychological crisis including food insecurity, orphanage, destitution of children, and deterioration of child health (IFSO, 2005).

As children are placed in the lowest social strata and family hierarchy, they are the ones who suffer most. Luthar (1999) stated that poor children are affected by an array of powerful risk and problematic influences, many of which are unique to the life circumstances of socio economically deprived people. The psychosocial adjustment profile of poor youth shows that younger children are more susceptible than older ones in several respects. They are especially the most vulnerable victims, among other types of exploitation and abuse, of sexual abuse.

According to Kornblum et al, (1995:124) social problems related to sex arise largely from changes and conflicts in attitudes toward human sexuality. Such problems, called *asocial sex variation*, are basically deviation from widely held norms of a particular society. According to Kornblum(1995), these asocial sex variances include incest, child molestation or sexual abuse, rape, exhibitionism, nd voyeurism. Child sexual abuse, one among the asocial sex variances, is a significant public health problem across the world. Thus, it is one form of sexual behavior that is common, but surprisingly little understood. Moreover, Feldman

(1999) said that although reported cases are low in number and firm data are hard to come by, its frequency was thought to be relatively high.

It is rare for a child to speak about sexual abuse. A child who is the victim of prolonged sexual abuse usually exhibits emotional or behavioral characteristics that may indicate distress. Further, according to McClendon (1993), approximately forty percent of all victims or survivors suffer social and psychological after effects serious enough to require therapy in adulthood. Unfortunately, according to Julia Whealin (2006), there are often no obvious signs that a child has been sexually abused. Because, sexual abuse often occurs in private and it often does not result in physical evidence, thus, it can be difficult to detect.

There are a significant number of negative short-term effects of sexual abuse that impacts a child's functioning. The most commonly experienced effect of sexual abuse is Post Traumatic Stress Disorder or PTSD (American Journal of Health Studies, 2000). The article estimated that approximately one third of child sexual abuse victims experience PTSD as adult survivors.

The reaction of the adult to whom a child discloses sexual abuse can significantly impact the child's subsequent social adjustment. It is important for the adult to be respectful, caring, and believing. A response involving panic, shock, disbelief, or an overly emotional response on the part of the adult can negatively impact the child. Children often feel badly and blame themselves for the sexual abuse.

When we consider sexually abused children of our country in general and Addis Ababa in particular, it could be said that the issue is not addressed very well despite of the fact that they should be looked at as a priority case. There are very few governmental and non-governmental organizations dealing with this

problem. Thus, the prevalence of such ailment suggests that there is a very high need for consideration of the psychosocial problems and consequences of sexually abused children.

1.2 Statement of the Problem

When sex - an activity that should be joyful, pleasurable and intimate- is forced on someone, it becomes one of the ultimate acts of aggression and brutality that people are capable of inflicting on one another, and few crimes produce such profound and long lasting consequences, (Feldman, 1999). Accordingly, when we see the major problems related to sex, we find child sexual abuse to be one among the most frequently occurring sexual difficulties leading to different psychosocial consequences.

Although child sexual abuse is one of the deep-rooted problems of Addis Ababa in particular and our country Ethiopia in general, the attention given to it was minimal. Whenever child sexual abuse or rape occurs, the victims prefer to keep silent fearing the blame of peer groups and society despite its psychosocial effects. In fact, it was considered a taboo to discuss about the issue in the open until very recently, when cases of sexual abuse or rape violence started to be broadcast by the media. However, it is a known phenomenon that victim's fall into a psychological crisis, which is characterized by psychosocial equilibrium disorder. That is, their entire thinking capacity is overwhelmed by emotion. The victims are unable to function in a normal way during social interaction unless they are treated timely. It is very likely that at some time or other, sexually abused children and even their parents will need professional help.

A child who is victim of sexual abuse obviously suffers from prolonged physical, psychological or social consequences. A common theme underlying most forms

of sexual abuse is that of emotional hurt resulted from the psychosocial and physical aftereffects. The child suffers from lack of affection and supervision, which leaves him/ her vulnerable to the subtle advances of the perpetrator (E. J. McFadden, 1990).

The physical harm of sexual abuse may cause infections such as HIV/AIDS resulting in death or physical damage such as Fistula. Beyond this, victims suffer from serious psychological and social problems.

The psychological impacts create PTSD, low self-esteem, depression, withdrawal from others, unusual interest of all things of a sexual nature, suicidal behaviors, etc. They are not able to speak directly about their problems. As a result, they develop isolation, secretiveness, and lack of trust on others, and generate statements in their mind that their bodies are dirty. Supporting this, Nana Luther (2004) noted that about fifty percent of victims of child sexual abuse experience depression, and suffered form emotional trauma, risky sexual behaviors, increased risky gynecological disorders, which left them with long term medical and emotional consequences.

The physical and psychological impacts of the violence put a negative effect on children's social adjustments. Since sexual abuse is associated with stigma, the victims are usually discriminated and neglected both in the family circles and in the community at large. The problem becomes even more acute when the offender happens to be one of the family members, as both are stigmatized. Sometimes, the breadwinner of the family is accused of raping or sexually abusing a child under his/her custody and gets imprisoned. Then, the family income drains and the children suffer. The victim is, thus, targeted as a cause for the family's socio economic disruption. But, children are never responsible for their sexual abuse, adults are the responsible ones.

These psychosocial consequences affect *almost* all victims of sexual abuse. Generally, all women and children are vulnerable unless they avoid uncertain situations and keep friendship at distance. However, poverty-stricken families are the most exposed to such dangers due to lack of protection and caretakers. In addition, children and girls with disability are highly vulnerable since their physical condition cannot permit them to resist their offenders. Therefore, the need to more effectively address the issue has become paramount because as we saw above, significant physical, emotional, social and psychological problems are related to child sexual abuse (or childhood trauma).

For all these compounded reasons, the victims of sexual abuse need a comprehensive support of psychological counseling, physical treatment and normal social adjustment. In order to be effective in identifying and treating victims of sexual abuse, helpers need to be knowledgeable about the characteristics, aftereffects and treatment strategies relevant to the issue.

Taking into consideration the issues involved in child sexual abuse, the following *research questions* were formulated to be answered by the researcher:

- what kinds of psychosocial problems do the sexually abused children experience?
- do all sexually abused children suffer at the same level from the psychosocial effects of sexual abuse?
- how was the way the survivor child disclosed the case?
- what are the coping strategies adapted or developed by the sexually abused children?
- which coping mechanisms are adapted or preferred more by sexually abused children?

1.3 Purpose of the Study

General Objective:

The main objective of the study is to assess or examine the psychological and social effects and coping styles of CSA in Addis Ababa.

Specific Objectives:

- to investigate the psychological and social problems or effects of CSA.
- to see whether all victims of sexual abuse equally suffer from the problem.
- to see how the child disclosed the problem or abuse?
- to investigate the coping strategies that are adapted by sexually abused children.
- to find out the coping strategies that are preferred more and utilized by the survivor children.
- to try to see an intervention program-Music & Drama Therapy- to ameliorate the PTSD symptoms.
- to forward possible prevention mechanisms and intervention strategies of child sexual abuse for survivor children and their families.

1.4 Significance of the Study

This study is significant in that

- it helps to become aware of the psychosocial problems of child sexual abuse.
- it also helps to become aware of the way the survivor child copes up with the abuse?
- it gives insight for Government and Non Government organizations so that they will design possible intervention strategies for the survivor children and their families

•despite the seriousness of the problem, there has not been a deep research undertaken on the psychosocial effects of child sexual abuse. In this context, the study can pave a way and give clue for those interested in the area to conduct further study in depth.

1.6 Operational Definition of Terms

Child –The African Charter on the Rights and Welfare of Child defined a child as every human being who has not attained the full age of 18.

Offender/perpetrator – is a person who committed sexual abuse on a child that he/she be at least five years older than the victim.

Survivor/Victim – a child who has been through an experience of S.A.

Psychosocial Effects – internalized (e.g. anxiety, emotional disturbances, PTSD...) and/or externalized (e.g. difficulties in parental relations, interpersonal difficulties...) patterns of unacceptable behaviors experienced by survivor children and their families as a result of the abuse.

Child sexual abuse – is any forced or tricked sexual contact by an adult or older person with a child.

1.5 Delimitation of the study

The prevalence of sexual abuse and its different aftereffects, especially on children, has become one of the most serious problems of our country among others. In different times, more and more abhorrent cases are appearing in various courts and Media, different governmental and NGOs are demonstrating their disgust, intervening on the problem and they are even participating to handle the issue as a priory case. But, when we see the conducted researches on the psychosocial problems of sexual abuse, they are very miniscule as compared

to the prevalence of the problem. This study thus, intended to bridge the gap. However, this study delimits itself to the psychosocial effects of sexually abused children. It doesn't assess similar problems of rape, incestuous, and pedophilic children in-depth. Besides, the study is delimited to Addis Ababa because of lack of accessibility, time and financial constraints.

1.7 Limitation of the study

- The researcher tried to include both male and female children in the study. But, due to the very small number of male victims, it is very difficult to generalize the results of this thesis to male victims.
- It has been impossible to assert the validity of the independent variable Child Sexual Abuse in this study due to the very nature of the crime-it is being performed in secrecy…
- The only real source of information for what the victims are suffering is *self-reports* from victims. The underlying assumption is that reports are generally reliable in the sense that abuse did occur although the extent and nature of the abuse may be subject to memory distortion.
- Another assumption is that there may be *under-reporting* or *over-reporting* of the abuse events.
- This study, as all other studies done in the area in our country, is retrospective, cross-sectional. It was very difficult for the researcher to conduct longitudinal study in this area although this was found, by different researchers, to be more effective to see into *the unique* consequences of CSA.

CHAPTER TWO

Review of Related Literature

2.1 Defining Child Sexual Abuse

Defining child sexual abuse needs the consideration of a host of factors like the physical, social, emotional, and psychological harms that result from the violent sexual intercourse. This is because researchers in the area use somehow different criteria for sexual abuse on children. Thus, it is common to have diverse definitions of child sexual abuse.

Briere and Elliott (1994) tried to define child sexual abuse as a sexual contact prior to the age of 16 or 18 either (a) with someone five or more years older or (b) by the use of force. Legal definition of what constitutes CSA usually requires that the perpetrator be older than the victim. It is agreed that perpetrators must be at least five years older than their victims for the behavior to be considered sexual abuse. Whealin (2006) defined CSA as an act that includes a wide range of sexual behaviors that take place between a child and an older person. These sexual behaviors are intended to erotically arouse the older person, generally without consideration for the reactions, choices or the aftereffects of the behavior upon the child. Child sexual abuse is also defined as any sexual activity involving a child where consent is not or cannot be given. Depending upon the age at which a state deems a child capable of giving consent, sexual abuse between two minors can also occur. For example, the law in Texas dictates that there be greater than a three year age differential between children in order to be considered sexual abuse (Wrightsman, 1987).

The types of sexual abuse vary widely and include physical contact as well as non- physical contacts. Despite the choices made by laws and research criterion, the impact of a forced or coerced sexual activity can be devastating on a child

even if the action cannot be legally or academically described as sexual abuse (Dominguez, et.al, 2001)

Behaviors that are sexually abusive often involve bodily contacts such as in the case of sexual kissing, touching, fondling of genitals, and oral, anal or vaginal intercourse. However, behaviors may be sexually abusive even if they don't involve contacts, such as in the case of genital exposure ("flashing"), verbal pressure for sex and sexual exploitation for purposes of prostitution or pornography. Supporting this, The Incest Survivors Resource Network (2000) provided one of the most succinct definition as follows 'CSA is the erotic use of a child, whether physically or emotionally, is sexual exploitation in the fullest meaning of the term, even if no bodily contact is ever made.' This last point – *'no bodily contact'*- is crucial. A parent who exposes a child to intercourse or deviant sexual behaviors or pornographic materials is abusing that child.

Sexual abuse, thus, can be any thing that the child engaged in a sexual situation with an older person. Together with this, Svedin (1999 in Eva M.C. Jonzon) defines CSA as an act or situation with sexual meaning where an adult or younger person is using a child in purpose to satisfy his/her own sexual or other needs. Svedin's definition tells us that CSA to be contacts or interaction between a child and an adult when the child is being used for sexual stimulation of the perpetrator or another person; when the perpetrator or another person is in a position of power or control over the victim.'

A comprehensive definition of CSA is given by The Federal Child Abuse Prevention & Treatment Act (CAPTA) and it defines sexual abuse as

> *" The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in or assist any other person to engage in, any sexual explicit conduct or stimulation of such conduct for the purpose of producing a visual depiction of such conduct."*

Generally speaking, though there exist various definitions of CSA, the definitions do not contradict and have even much commonality. However, one thing we need to be careful in labeling an act as sexually abusive and illegal between the offender and the victim is their relationship: the relationship between the offender and the victim should be viewed against socially determined regulations (Rahel G., 2004). This is to mean that not all behaviors that are sexual or involve sexual organs would necessarily be defined as sexual abuse.
Regardless of the above rare cases, CSA being devastating and life-long in its effect is a very sensitive social problem affecting all races of human kind. But, it is still under reported especially in our country- Ethiopia.

2.2. Prevalence of CSA

The biggest obstacle that experts and people in the area mostly face in trying to reduce and handle CSA is that it is the most hidden and unreported form of violence against children (Rahel, 2004). This makes it difficult to state the accurate prevalence rate of child sexual abuse in any country including our country (Russell, 1988 in Rahel, 2004).

Until the early 1970's, CSA was thought to be rare and centered among the poor. Experts now agree that CSA has always occurred and still exists in all socio-economic groups. But, increased public awareness has led to greater reporting especially from 1970's to 1990's. To support this advancement, Lawrence S. Wrightsman (1987) found out more than 75,000 rape cases reported to law in USA in 1979; two years later, the figure has increased to 170,000.

Presently, CSA has been reported up to 80,000 times a year, but still unreported instances are far greater, because the child is afraid to tell anyone what has happened, and the legal procedure for validating an episode is difficult (AACAP,

2006).In recent years, even as overall crime rates have fallen, the incidence of CSA has risen. Accordingly, David H. Olson & J. DeFrain (2000) indicated that the statistics are truly alarming and they said 'There were about 125,000 allegations of CSA in the USA during 1995.By age 18, an estimated 27% of girls and 16% of boys will have been sexually abused. A report released by The National Institute of Justice in 1997 revealed that out of 22.3 million children between the ages of 12 and 17 years in USA, 1.8 million were victims of a serious sexual assault or abuse.

Reported incidents of CSA are markedly on the rise. What is especially shocking is the fact that these reports represent only a small portion of actual occurrence of sexual abuse. It is currently estimated that one-third of all children are sexually abused before the age of 18. This means one out of three girls and one out of seven boys are sexually abused by the time they reach the age of18(P. D.McClendon, 1991). The several view of CSA pointed out that, according to information available, some 10% of the population of the world is subjected to sexual abuse by the of 18 and that females tend to suffer the brunt of sexual abuse more than males (The Third African Conference on Child Abuse and Neglect, 2000).

2.3 Perpetrators of Child Sexual Abuse

Another important dimension of child Sexual Abuse is the relationship between the perpetrators and the victims. So, here, one may be forced to ask who the perpetrator of CSA is. Was the rapist a complete *stranger*, a *casual acquaintance*, a *nuclear family* or a friend of the victim? With this regard, the perpetrators of sexual abuse can be anybody. That is, the perpetrators can be employee, caregiver, attendant, a parent, husband, neighbor, co-worker, a doctor, a

therapist, health professional, a friend, a family member: father, brother, uncle, grandfather, cousin, step-family members (Meron, 2006).

According to Julia Whealin (2006) most often, sexual abusers know the child they abuse but are not relatives. In fact, about 60% of the perpetrators are non-relative acquaintances, such as a friend of the family babysitter, or neighbor. About 30% of those who sexually abuse children are relatives of the child, such as fathers, uncles, cousins. Strangers are perpetrators in only about 10% of CSA cases. Gobena (1998) also indicated that 68% of the children in our country were abused by someone they know, 29% by family members and only 3% by strangers. Besides, Finney (1992) noted that 80% of sexual abuse is committed by family members or someone known to the victims. Thus, most sexual abuse can be taken as incest. This fact also seems true in the Ethiopia context as was shown by Gobena (1998).

Finney (1992) noted that 80% of sexual abuse is committed by a family member or someone known to the victim. Thus, most sexual abuse can be taken as incest. This fact also seems true in the Ethiopian context. A study conducted by Gobena (1998) indicated that prevalence of CSA in the general society of Ethiopia is 38.5%. Among these, 68% of the children are found to be abused by someone they know and about 29% by family members. Strangers abused only 3% of the children. This implies that in Ethiopia, sexual abuse by strangers is not as common as sexual abuse by family members. Therefore; young people are at high risk mostly of those living with them, related to them or acquainted with them (Rahel, 2004).

On the other side, men are found to be perpetrators in most cases, regardless of whether the victim is a boy or a girl. However, women are found to be perpetrators in about 14% of cases reported against boys and about 6% of cases reported against girls.(A National Center for PTSD,2006) According to Diane

Russell and D. Finkehlore, 95% of the perpetrators of girls are men and 80% of the perpetrators of boys are men. Perpetrators are also from different social groups as mentioned earlier.

Sex offenders generally live in and come from family types that are unbalanced on the Couple and Family Map, families that lack genuine emotional closeness, have poor communication skills and have limited skills in dealing successfully with everyday stresses and major crisis. Patrick Carves(1989) as cited in D. Olson et al. found that 66% of sex offenders were living in unbalanced types of families and that 49% had grown up in unbalanced families (D. Olson & J. DeFrain,2000).

2.4 The Psychosocial Effects of CSA on survivors

Child Sexual Abuse is a secret crime-one in which participants are often motivated, albeit for different reasons, to keep their activities from being discovered. It is a violation of Human Right leading to different levels of behavioral, psychological, social, physical, and other consequences/effects. Research conducted over the past decades indicate that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused than among individuals with no such experiences (J. Briere & D. Elliott, 1994). Thus, childhood sexual abuse is a major risk factor for a variety of problems, both in the short-term and in later adulthood functioning as survivors are affected in so many ways that cannot be measured.

The effects of CSA seem to depend on who is doing the abusing, the manner of the abuse and how long the abuse goes on (Gelles, 1997 as cited in D. Olson & DeFrain, 2000). This is to mean that *the context, nature,* and *duration* of the attack influence the shape of the damage. The effects of a forceful, hurtful, exploitive sexual relationships last for a long time. The abused person may carry a burden

of guilt, shame, fear, bitterness, anger, lowered self-esteem, and depression for years and may suffer from sleep disturbance and or eating disorders (Gelles, 1997).

Despite the duration and manner of abuse, different research findings revealed three contradictory outcomes/aftereffects of CSA. This group argues that although CSA is generally unpleasant, the majority of sexual offences against children are innocuous affairs and the hazards they may cause is transient and the pain passes quickly (Landies, 1956 in Finkhelore, 1979). The most extremes are those that hold CSA is not real but constitutes 'Oedipal' wishes on the part of the child. Hence, it is not considered necessarily harmful to the daughter, since she is the seductive party who gains pleasure, gratification and power (Bender & Blau, as cited in Wolf et al., 1988) The last group, in fact, the majority of researchers believe that survivor children usually suffer many of the same severe consequences as do adult women who have been raped (Finkhlore, 1979).

Browne & Finkeihore (1986) in their review article on the initial and long-term effects of CSA warned against *exaggerating the effects of CSA*. Despite this research, M. Seligman (1994) has described Child Sexual Abuse as a "special destroyer of adult mental health". According to Berliner & Elliott (1996) this notion, that CSA is a 'destroyer' of mental health has been based largely on studies involving clinical samples. But, even these, if objectively considered, indicated that CSA neither necessarily nor usually psychologically harmful. That is, for the most majority CSA is not a 'destroyer' of mental health at any age. Similarly, Brown & Finkehlor (1986) found that among adults who had experienced CSA, less than 20% evidenced serious psychopathology. They observed that severe long-term harm was not inevitable. Further, they expressed concern over the efforts of child advocates to exaggerate the harmful effects for political purposes because of its potential to harm the victims and their families:

advocates (should) not exaggerate or overstate the intensity or inevitability of (negative) consequences (because) victims and families ... may be further victimized by exaggerated claims about the effects of sexual abuse(p. 178).

Thus, CSA is not necessarily associated with pervasive harm and that harm, when it occurs, is not typically intense. Then, psychological harm is neither inevitable nor typical (Tromovich, 1997).

There are a significant number of negative short-term and long-term effects of CSA that impacts a child's functioning. Wendy Moelker (2006) divided consequences of Child Sexual Abuse as psychological problem, social problem, and sexual problem, physical complains denial and depression. These problems may include sleeping problems, nightmares, fear, lack of trust on others, sexual relation problems, abdominal pain, headache, don't want to talk about it, avoid certain situations.

D. Olson & J. DeFrain (2000), on the other hand, generalized the effects of CSA to be linked to those of Post Traumatic Stress Disorder. Individuals regularly reexperience the trauma through recurrent invasive thoughts and uncontrollable emotions. They often feel detached from external world and avoid situations that reminded them of the original trauma (Edwards, 1989 cited in D. Olson & J.DeFrain, 2000). Besides, D.Olson et al. said that sexually abused children may have difficulties in school including low grades and truancy. Sexually Abused Children may develop avoidance of sexual interest, sleeping problem(nightmares), withdrawal from friends/family, seductiveness, refusal to go school, secretiveness, suicidal behaviors, PTSD, anxiety, depression, poor self image, and low self-esteem (AACAP,2004; J.Whealin, 2006). Approximately, 40%

of all survivors/victims of CSA suffer aftereffects serious enough to require therapy in adulthood (Brown & Finkehlor as cited in P.D.McClendon, 1991).

2.4.1 The Consequences of CSA

Therefore, as different researchers tried to assess, the harmful consequences of Sexual Abuse can be seen as physical, social, psychological, behavioral, health, economic, educational and others.

A. Physical Signs

Sexual Abuse obviously results in physical injuries; this may become more serious if the abuse is accompanied by force. These physical injuries include scratches, bruises, itching, cuts or injuries, especially in the genital areas, bleeding, illness, suicide, and death ... (Child Welfare Information Gateway, 1990)

B. Social Effects

The social problem that victims face may even begin from home especially if the abuse is incest. In this case, the victim's problem is put to be hidden as disclosing the abuser may result in the family's separation. However, the most serious social problem faced is stigma and discrimination against the victim and being blamed by others. According to Cohen (1993) as cited in Meron (2006), it is stated that the negative responses from others, revictimization, stigma are some of the problems victims face. All these lead towards isolation, lack of trust on others, poor relationship with friends or families, etc.

C. Psychological Effects

The psychological aftereffects faced by survivors are immeasurable. If child sexual abuse is not treated effectively, long-term symptoms may persist into

adulthood. These may include: PTSD, anxiety, depression, low self-esteem, sleep problems, nightmares, secretiveness, unusual aggressiveness, etc (J. Whealin, 2006). Besides, Ticoll (1994); Davies(2000) as cited in Meron (2006) indicated that those who experience sexual assault or long-term sexual abuse may exhibit difficulties with eating, sleeping and concentrating, feeling of being unclean, mood swings with no apparent cause, intrusive thought of the assault, flashbacks, responding aggressively, or have social withdrawal from others.

D. Behavioral Signs

Those who are sexually abused may express some new behaviors as a result of the abuse. These may include aggressive behaviors towards younger children, advanced sexual knowledge, seductive or 'sexy' behaviors, pseudo-mature behaviors(for example, a 16 year old wears makeup and generally acts "too old for her age"), regressive behavior, excessive masturbation, sudden or extreme changes in behavior, using drugs or alcohol, lying/stealing, prostitution, etc (Child Welfare Gateway,1990)

E. Health Problems

Victims of sexual abuse represent a substantial portion of health care clients. It is assumed that the health consequences are worse if the abuse has been considered severe or if the child has been exposed to cumulative trauma, e.g. physical abuse or other stressful life events(Eva M C Jonzon,2006) Thus, it is well understood that CSA results into different health problems. Some of the most seriously and frequently observed health problems of sexually abused children include:

. Self-mutilation

. Unwanted pregnancy

. HIV/AIDS & other sexually transmitted diseases

. Gynecological problems like Fistula

In general, there is no single universal or uniform impacts of Child Sexual Abuse, and no certainty that any given person will develop any post traumatic responses to sexual abuse. However, many researchers agree that children who have been sexually abused can suffer a range of psychological, social, or behavioral problems which in turn affect their personal life as well as social relation. In relation to this, different researchers have come up with different models to explain the effects of CSA, both in short-term and long-term.

2.4.2 *Models Explaining Long-term Effects of CSA*

2.4.2.1 *Post-traumatic Stress Model*

The relationship between child sexual abuse and adult psychopathology tended initially to be conceptualized in terms of a chronic form of post traumatic stress disorder (Bryer et al., 1987; Craine et al., 1988 as cited in P.E. Mullen & J. Fleming). This model focused on trauma-induced symptoms, most particularly dissociative disorders such as desensitization, amnesia, fugues and even multiple personality. The idea was that the stress induced symptoms engendered in the process of the abuse and have reverberated down the years to produce a post-abuse symptom in adult life.

In its more sophisticated formulation, this model attempts to integrate the damage inflicted at the time to the victim's psychological integrity, by the CSA and the need to repress the trauma, with resultant psychological fragmentation. The later manifests itself in adult life in mental health problems, and in problems of interpersonal and sexual adjustment (Rieker & Carmen, 1986). This model found its strongest support in the observation of clinicians dealing with individuals with histories of severe and repeated abuse. It was also often linked to notions of a highly specific post-abuse syndrome in which dissociative disorders were prominent (Paul E Mullen & Jillian Fleming, 1998).

2.4.2.2 Traumagenic Model

one of the most dominant models explaining about how sexual abuse survivors see the world, self and others and its effects on their psychosocial functioning is the Traumagenic Model. Finkeihor & Browne (1988), the developers of this model, have developed a list of areas that are affected by the sexual interaction of adults with children. This model is a fairly Comprehensive framework and shows to be gaining wide acceptance in the professional community. The model explained the possible short-term/immediate and long-term effects of sexual abuse based on four common characteristics of the nature of CSA. All the effects are listed in terms of the molested child, but they are feelings, misconceptions and thought patterns the molested child may carry into adulthood.

A. Traumatic Sexualization-

The child's sexuality is distorted by age-inappropriate sexualization. The child gets a sexuality shaped by the abuse, which may result in promiscuity or aversion, prostitution or confusion about sexual identity, norms and standards, etc (Finkehlor & Brown, 1988; Eva MC Jonzon,2006). Traumatic sexuality (also) refers to a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. This can occur in different ways. It can occur when the perpetrator rewards inappropriate sexual behavior, by trading gifts, affection, privileges or attention for sex.

B. Betrayal-

The child's expectations of how or what others will provide care and protection can be severely wrapped. Here, the child has been exploited by a trusted individual through sexual acts or non-protection from non-abusing others resulting in depression (loss of a trusted figure), a tendency to seek other abusive relationship, anger (Finkehlore & Browne, 1988; Eva M C Jonzon, 2006). Betray

may occur when children realized that a trusted person has manipulated them through lies or someone whom they loved, whose affection was important to them treated them with callous disregard(Finkehlore & Brown, 1988 as cited in Rahel, 2004).

C. Powerlessness-

The child's will, desire, and sense of efficacy is continually contravened. Ineffective attempts to avoid or stop the abuse causes fear, anxiety, impaired coping skills and possibly a need to control or dominate others (Eva M C Jonzon, 2006). Continued invasion gives rise to feelings of vulnerability and many damaged self-efficacy if the child cannot convince others of the abuse or sees no one stopping the abuse. The child may become fearful and anxious, suffer nightmares, become depressed, run away or show truancy, or may express a strong desire to control events and people. The child may try to gain control of conflicting emotions by recapitulating the experiences by trying to abuse others (Finkehlore & Browne, 1988)

D. Stigmatization-

The child's sense of being denigrated and the child is violated from a larger society. Stigmatization refers to the negative connotation like badness, shame and guilt that are communicated to the child by the experiences, and then becomes incorporated into the child's self-image. The perpetrator may explicitly blame the victims or the child may blame him/herself for the abuse, therefore feel sense of shame and responsibility (Finkehlore & Browne, 1988).

In general, the '*traumagenic model*' predicts a disparate range of psychological impairments and behavioral disturbances in adult life which contrasts with the post traumatic syndrome model with its specific range of symptoms (P. E. Mullen & J. Fleming, 1998).

2.5 *Disclosure*

2.5.1 Disclosure dilemmas

Despite CSA victims being a high risk group for adverse health development, victims often fail to get acknowledged. The main characteristics of sexual abuse are that it is performed in secrecy and perpetrators seldom confess spontaneously. Disclosure from the victim's crucial in order to stop the abuse or to receive help in childhood or later in life. Lack of disclosure is due to an inner ***resistance***. Inner resistance to tell may stem from loyalty to the family, feelings of shame and guilt, fear of disbelief/non-acceptance or inability to feel intimacy or trust. The awareness of social norms and fear of negative reactions may also cause victims to withdraw from disclosing abuse. Negative reactions from others may have roots in negative attitudes or lack of knowledge about CSA (Eva M C Jonzon, 2006).

The other side of the coin is the ***need*** of telling. Beside the prominent health effects of received social support there is a therapeutic effect in putting words to and describe one's life history(Pennebaker & Susman, 1988 as cited in Jonzon, 2006). Emotional relief lies in telling the truth, to let go of the stress inducing secrecy. It may enhance self-esteem to be believed and get one's reality confirmed. These two opposite urges puts the victim into a dilemma in which they must either forgo possible social support and emotional relief in order to avoid negative reactions in hope of receiving acceptance, respect and support from others.

Empirical Research on disclosure

Many therapists believe that children usually pass through a sequence of stages while disclosing sexual abuse that they have experienced. The stages are; secrecy, hopelessness, entrapment, disclosure, and retraction. Others use a different

sequence: denial, reluctance, gradual disclosure, recantation and reaffirmation. This theory assumes that it is very difficult for children to discuss having been sexually abused.

One study said that over 40% of children disclosed their abuse within 48 hours (Caren A. et al., 1992).There is no evidence that telling someone about the abuse is a sufficient act of coping. Instead, the reaction from a person told seems to be crucial. A positive and supportive response is often characterized by showing concern, empathy, and believing the victim, while a negative and unhelpful response is characterized by blaming the victim, denial or minimization of the event or even abandonment (Schatzow & Herman, 1989 as cited in Eva Jonzon, 2006).

2.6 Coping Strategies

Humans are continually faced with demands and stresses to which they must adapt. Effects of CSA like PTSD, anxiety, and emotional distress are one such factor we must learn to deal with. Because no one can tolerate high levels of anxiety over long period of time, people learn certain ways of behaving that reduce their level of anxiety (V. J. Derlega & L. H. Janda, 1986). Thus, the question to be raised here is that how could these victims possibly manage such stressful situations in their lifetime? Actually, people respond to stressful situations like CSA in different ways. How one girl deals with it will vary from another girl. Some may be hurt seriously when something is wrong in their life. Others may have motivation to work hard and seek solution to the problems they faced and to successfully adjust to even extremely taxing circumstances. Kelly (1988) as cited in Meron (2006) stated that some girls forgetting/ burry the memory of victimization or attempt to suppress the feelings it evokes. Talking to supporting friends, remembering and working through the past are also an

essential aspects of coping. In other words, the situation calls the person's coping capacity or behavior.

According to Barry D. Smith (1998), coping is an active effort to reduce stress by solving the problems that elicit it. Coping involves both cognitive and behavioral efforts to manage environmental and internal demands and stressors. On the other hand, coping is defined as a process of managing taxing circumstances, expanding efforts to solve personal and interpersonal problems and seeking to master, minimize or tolerate stress and conflict (Santrock, 1997 as cited in Rahel, 2004). In a broader sense, coping behaviors are defined as a cognitive and motoric activities that a victim uses to master, reduce or recover from the characteristic symptoms of emotional distress that may develop after rape (Lazarus & Lavnier, 1978; Lipowski, 1970 in B. Meyer & S.E. Taylor, 1986).Generally, coping styles are ecosystems that involve active interaction between an individual and environment influences within framework of available resources, potential, needs and vulnerabilities (Coombe, 2000 in Nemme N., 2006).

Richard Lazarus (1991) argues that individual difference in the responses to stress is a function of the person's *Cognitive appraisal* of a potentially stressful event or situation. Accordingly, it is this process that determines how positive or negative his/her stress reaction will be, what emotions he/she will experience, and what adaptive responses they will make (R. Lazarus, 1991 cited in B. D. Smith, 1998). On the contrary, research specifically related to children has revealed that coping mechanisms depend upon a combination of factors: learned responses, ability to integrate knowledge, self-image, and emotional environment (Wolman, 1977). Despite this, children who are physically adequate, loved, respected, and granted dependent life cope up better with stressful situations than others (Wolman, 1977 cited in Nemme, 2006).

Basic Coping Strategies:

In order to break the chain of events that can cause a stress-related consequence, it is necessary for a person either to alter his/her awareness of the problem and of the potential consequences or, if stress is unavoidable, to modify its physical and psychological effects. For this, there are many coping strategies developed by different researchers and psychologists. As V. J. Derlega (1986) stated some strategies for controlling anxiety, such as confronting cognitions and defense mechanisms are acquired as part of our psychological development. That is, we make no conscious efforts to learn a particular defense mechanism, but based upon our experiences the model we are exposed to; we do learn certain cognitive strategies for coping with anxiety. Thus, the intention of many survivors of CSA to utilize a certain coping strategy is to reduce the possible aftereffects. To support this, Denney & Quadagno (1992) explained their belief that the effect of the abuse directly related with the child's coping skill among other factors. Let us now look at some specific coping strategies that people (like S.A.C.) use.

Burgee & Holmstrom, 1979 cited in B. Meyer & S. E. Taylor, 1986 described the following coping strategies as successful:

.***Explanation***- identifying a person why the sexual abuse occurred.

.***Minimization***- telling oneself that the S.A. was not really so terrifying.

.*Suppression*- making a conscious effort to avoid thinking about the rape (the sexual abuse).

.***Action***- keeping busy, changing jobs, or moving.

.***Stress reduction***- using specific techniques such as mediation.

Among the above coping techniques, explanation is the coping technique stated by the authors that has received the most attention in the social psychological literature (B. Meyer & S. E Taylor, 1986).

In general, the coping potential, according to the model, is viewed as a result of one's cognitive, affective and instrumental appraisals; that is, the clarity or

structure of the perceived situation, the extent or quality of emotional involvement, and the perceived control over the situation (Eva M C Jonzon, 2006). To this effect, Rossman (1992) in Varma (1996) suggested that children should be helped to develop their own coping strategies that include self-calming, ignoring some situations, showing anger in controlled ways, and talking to friends, parents. Parents do have the access and potential skills to adapt coping styles in a calm and empathetic approach that may assist children to defend anxiety-inducing situations (Nemme, 2000).

2.7 Prevention and Intervention of CSA

2.7.1 Prevention of CSA

Most people who consider problems of CSA for any lengthy of time conclude that prevention of abuse is an essential priority. Hence, the imperative way to stop sexual abuse is to prevent it from happening in the first place. That is why L. S. Wrightsman (1987) stated the ultimate goal of concerned citizens, law enforcement officials and social scientists to be the prevention of rape or sexual abuse. For this, two methods are reviewed here:

1. action by potential victims
2. punishments of and interventions with rapists

The development of universal CSA prevention programs reflected, in part, a value statement: all children, not just some children, needed to be made free from sexual mistreatment (Deborah A. Dabo, 2002).For survivors of sexual abuse, there is no one formula for recovery, but every path to healing ultimately requires that we *speak out* about the ways in which we have been violated (R. D. Stone, 2002). The rationale behind this is that in order to stop repeated victimization, sexual abuse must be *reported* because without reporting, there can be no trial of prevention or treatment for victims. Concerning this, Yoder(2003) as in Meron(2006) stated that not just reporting the abuse is enough but also

working to help people in understanding when they are being abused are also crucial, even though both are more easily said than done.

Preventing abuse can be seen as a process of altering the potential perpetrator, the potential victim, and the environment in which both exists (Deborah A Dabo, 2002).Thus, prevention requires the participation of parents and significant others. Abrahamson & Masteroleo (2002) as cited in Meron (2006) proposed that parents or other family members can assist with educating their children on abuse prevention. They should be aware of what will be taught in the classrooms and have access to copies of the curriculum in order to teach their child and to convey their concerns or fears about the vulnerabilities that their child faces (Meron, 2006).

Prevention of Child Sexual Abuse can occur in one of the three levels: Primary, secondary and tertiary prevention.

Primary prevention- targets services to the general population in order to decrease the frequency and occurrence of CSA. Recently, public awareness campaigns have emerged to address the issue. There is some indication that the incidence of sexual abuse may be decreasing and some experts have attributed this to an increase in public awareness at the primary prevention level as a possible explanation.

Secondary prevention- targets services to specific groups considered as high risk groups in order to avoid CSA from occurring. This includes child assault prevention programs and safety education taught to children in schools. These programs may increase a child's knowledge of sexual abuse and how to respond, and may even facilitate subsequent disclosure, which ultimately may reduce CSA from occurring.

Tertiary prevention- targets services to known perpetrators and victims of CSA with the goal of minimizing its negative effects and avoiding reoccurrences (Deborah A Dabo, 2002; P.E. Mullen & J. Fleming, 1998; & Dominguez et al., 2002).

There are two major deterrents to prevention efforts in areas of CSA: lack of efficacy for prevention services and lack adequate resources. It is imperative that prevention services document they do indeed prevent Child Sexual Abuse. Adequate resources are needed, both for treatment of victims of CSA and for prevention strategies that reach the broader population. Once effective primary prevention techniques are established, adequate funding for tertiary programs may be more easily attainable and this problem may be more appropriately addressed (P. E. Mullen & J. Fleming, 1998).

2.7.2 *Intervention of CSA: Counseling CSA*

When we think of preventing or treating sexually abused children, we should bear in our mind the following statement: 'Sexual molestation or abuse of children is a *treatable*, but not *curable* behavior problem.' Child Sexual Abuse, as we know, is a pervasive problem affecting individuals of all racial and socio economic backgrounds. The short and long-term effects of sexual abuse have been well documented and highlight the need for effective psychological *intervention/treatment*. CSA contributes for developmental disruption that laid the basis for interpersonal and social problems in the victim's future life; hence, the need to provide rehabilitation services is very essential. The impact of sexual abuse is a family problem, not only a child's problem. Hence, the components of the treatment program should include the survivor child, their parents and the offenders or perpetrators (Rahel, 2004).

Researchers have come up with different techniques to rehabilitate children. Some of these may include Cognitive-Behavioral techniques, psychological educations, anxiety management, gradual exposure, etc. Their common task in anyways is to address responsibility for the abuse, with absolving the child off blame as one of the components (Swenson & Hanson, 1998, cited in Rahel, 2004). There are, actually, several modalities of psychological treatment that have demonstrated positive benefits for child victims of sexual abuse. These include individual psychotherapy, group-based prevention, and treatments that involved the entire family (Dominguez et al., 2002). Treatment is also available to the offenders of sexual abuse. The primary goal of the treatment of sexual offenders is to minimize the likelihood that the individual will re-offend. This is best achieved by modifying emotional, cognitive, behavioral, environmental, and psychological factors which support the desire, capacity and opportunity to offend (P.E. Mullen & J. Fleming, 1998). On the other hand, according to Cooney (1987) cited in Meron(2006), the following treatment are important to follow regardless of the nature of abuse, how recently or how long the abuse took place:

Medical services

A complete medical examination by the physician who understands the nature of sexual abuse can eliminate the fear someone holds, can figure out pregnancy or venereal diseases including HIV/AIDS, etc and can give solution for it. This is because the body of a sexually victim child is used without the consent of the victim.

Sex Education

Reeducating the confused victims in individual or small group meetings with a nurse or health educator must be the first step towards reeducating. The victims should have the opportunities to ask questions that are unclear, and to correct their distorted information about sex.

Counseling Sexually Abused Children

It is very likely that at some time or other, parents of a child who was sexually abused will need professional help and support for their child basically and for themselves. For this, there are varieties of Counseling services available to victims of sexually abused. It provides the support system necessary to deal with the abuse and to put into an end. However, counseling abused children is a challenging task for practitioners.

Counselor's Awareness

Currently, practitioners have become aware of the widespread of sexual abuse of girls and are developing increasing awareness of the sexual abuse of boys. Counselors need to keep abreast of the indicators of maltreatment, the laws for reporting suspected abuse, and the ways in which children can best be served to overcome effects of a negative family experience (McFadden, 1990).

Identifying Maltreatment

Children who have been maltreated (sexually abused) are usually unwilling or unable to reveal their situation to a counselor because of parental treats, or a feeling of loyalty to the family. While sensitive interviewing may help to unearth details of maltreatment, counselors used to be aware of non-verbal ways in which the massage of abuse may be communicated. The presence of one indicator alone doesn't necessarily mean that maltreatment has occurred. The counselor looks rather for configurations of indicators.

The Team Approach

Counseling, in and of itself, cannot ensure the safety of a maltreated child. It is important to remember that counseling alone can't protect children, and that any effective long-term intervention will require a concrete team approach and a community which cares enough to offer adequate resource for families. Families,

medical personnel, educators and school personnel, lawyers are important parts of the team.

Counseling the Child

One of the primary purposes of counseling sexually abused children is to provide a safe place and a safe relationship within which the child may experiment with new adaptations to a safer world. Counselors cannot literally replace the requisite parental bonding, but have an opportunity to help the child develop a trusting relationship with an adult. The counselor will be able to identify adaptations which the child made to the maltreatment and teach the child more appropriate ways of interacting.

In the counseling relationship, working with abused children requires many techniques other than talking and listening. Using structured and unstructured play situations, music or clay provides a safe way for children to release tension and express themselves. In doing so, counselors can use individual or group-based counseling as appropriate as possible (McFadden, 1990). Individual counseling helps to get past the painful experience and will help the client to get well eventually. In group counseling, members can learn from one another and from the counselor who leads the group. They learn how to express themselves in a positive way, how to stand up for themselves and how to cope with potential abusers (Cooney, 1987 as cited in Meron, 2006).

2.8 Legal Aspects of CSA in Ethiopia

Child Sexual Abuse and/or rape is a humiliating and devastating crime; for its victims, it is the 'ultimate violation of the self'. L.S. Wrightsman, 1987 indicated that "Yet until recently, society has denied rape victims their legitimate rights; through out history, rape has had a rather uncertain status within whatever

moral and legal system was in effect." Thus, it was only very recently that extensive research on rape and/or Sexual Abuse, rapists and their survivors began to influence public consciousness and legal reform. In the last decades, added Wrightsman(1987), state legislatives and the court have began to rewrite, modify, or reinterpret long-standing laws about rape; as a result, most states now have rape-shield laws that restrict the defense attorney's questioning of the victim about her/his previous sexual contact. When we see our country's stand, similar and agreeable modifications are being made since the prevalence of the issue is requiring a notable attention.

The one common factor in the varieties of sexual offences is that each breaks the law. The law can be seen to have three functions in this respect:

First- to protect the individual

Second- to avoid social disruption

Third- the 'declarative' function, or the discouragement of certain forms of behaviors considered to be undesirable (J. Bancroft, 1983).

Here, protection of the individual is concerned not only with assault, the use of physical force or the threat of it to achieve sexual ends, but also with exploitation. With this regard, J. Bancroft (1983) stated that protection against exploitation raises more disputes. It is accepted in principle, but the definition of exploitation poses many problems, most notably in relation to "*Age of consent*".

It is a well known fact that crimes against children are crime against humanity. But what makes it different is that the victim child is not able to use his/her rights in justice for the crimes committed against as adults do. That is why P. Newell (1998) stated "Children- and especially young children- have particular difficulty in finding and using legal remedies when their rights are breached."

In general terms, though the existence of evidence, violation of laws, violation of consent/use of force, etc in CSA are essential to the courthouse, the legal categories are found to be unhelpful to assess the reasons why people commit this crime. That is why J. Bancroft (1983) said that:

'In attempting to understand why people commit sexual offences and the effects that they have on their victims, we find the precise legal categories relatively unhelpful.'

The most important requirement for the legal system to be involved but one that become the biggest headache to the law with regard to CSA is the existence of *reporting* the incident. Mostly, (until recently), CSA was considered to be taboo; as a result, families become reluctant and ashamed to report to the law. But, now, there has been a steady rise in the incidence of reported cases. But, the extent to which rape/sexual abuse occurs without being reported to the police remains uncertain. Though a study conducted by Peters (1979) as cited in J. Bancroft (1987) found that 60% of the incidents of rape uncovered in the survey had not been reported.

When we see the case of our country, the Ethiopia Criminal Code under Art. 623 states that:

> *Whoever, knowing of his victim's incapacity, but without using Violence or intimidation, performs sexual intercourse, or commits A like or any other indecent act, with an idiot, with a feeble-minded or retarded, insane or unconscious person, or with a person who is for any other incapable of understanding the nature or consequence of the act, is punishable, according to the circumstances of the case, with simple imprisonment for not less than one year, or with rigorous, imprisonment not exceeding fifteen years (2005:363)*

When we see the above code, it could be possible to say that the maximum penalty taken on the offenders is not as such satisfactory. It is quite rarely do

rapists get life imprisonment as in case when only if rape results in grave injury or death. This is stated in Art 620 sub art.3:

> *Where the rape has caused grave physical or mental injury or death, the punishment shall be life imprisonment (2005:362).*

Besides, those perpetrators who are under custody are not given any rehabilitation counseling or service. Another biggest headache is the problem related with reporting the case. As we can see and hear, the number of sexual abuse committed and the number of reported cases is not proportional. That is, only a few cases are reported to the court house. Thus, there is much to be done but still left open by the court house, the police officers, and the families to increase the awareness of the people, the victim and their families to come to the court house.

Surprisingly, the Criminal Code of Ethiopia, it is possible to say, doesn't give guarantee to boy/male victims of sexual abuse as compared to female victims. Because, the maximum penalty against female offenders is only five years according to Art 621:

> *A woman who compels a man to sexual intercourse with herself, is punishable with rigorous imprisonment not exceeding five years (2005:362).*

To conclude, the good news on the legal aspect for any violence against children in our country is the existence of some voluntary and free service counseling, legal court proceeding and social support providing organizations for these children. Thus, besides the revision of the law in the problem area, the society as well as the government should help the existing voluntary organizations to strengthen the services given.

CHAPTER THREE

Methods of the Study

3.1 Design

This part deals with the methods to be followed and the tools to be used in gathering the relevant and necessary data and supplementary information. The main objective of the study is to assess the psychosocial effects of child sexual abuse. Hence, in order to investigate deeply how the aftereffects of the trauma could affect their psychosocial functioning of the sample subjects, qualitative research approach is considered to be appropriate together with quantitative approach.

The study was based on non-experimental cross-sectional design about the characteristics of abused and perpetrator, psychosocial effects as well as current data about coping strategies used by the abused and parents and families of the abused children. An effective assessment of all these was considered to be possible if a combination of both qualitative and quantitative approaches were applied.

3.2 Participants of the study

The sample participants were 26 sexually abused children between the ages of 6-18. They were selected from an indigenous NGO governed by Ethiopians as this organization was found to be most appropriate because it consists of sexually abused children whose cases were *reported* and who are getting *counseling services*. Besides, some of their parents (12), their counselor and related others were included to triangulate the study and supplement the data.

3.3 Sampling Technique

Though the researcher utilized both qualitative and quantitative approach, the weight was on the former one. Thus, qualitative research naturally recommends purposive sampling technique and even the nature of the problem by itself forces to use the same technique. As a result, the same procedure was applied in this study to select the participants of the study. Later, because of lack of access to all the samples, available children were included in the study.

When selecting the sample subjects, some factors were taken into consideration. These were:

. The age of the survivor child should be between 6&18.

. The age gap between the perpetrator and the survivor child should not be less than 5 years because if the age gap is less than 5 years, this age gap will make them '*peers*' and sex among peers is considered as '*sex play*' rather than sexual abuse.

. The abuse relationship must involve physical contact (since the definition of child sexual abuse also included non-physical contacts.)

3.4 Tools/ Instruments

Interview guide, PTSD Symptom Scale[1], Anxiety Scale[2] and Emotional Distress Scale[3] were used to gather data from the respondents, their parents and their counselor. Besides, FGDs were held to supplement the data gathered. The rationale behind using or mixing the different scales is because of the need, adequacy and appropriateness of the variables: PTSD, Anxiety, Emotional distress and Interpersonal difficulties as these variables are the basis for the analysis.

For 1, 2 & 3, see last part of this chapter.

3.5 Procedures of Data Collection

The researcher decided to use standardized instruments because such a step will enable comparison with other studies conducted elsewhere using the same instruments. However, in order to make the instruments readable and understandable for the sample they were transacted into Amharic and later retranslated into English and checked with the originals. However, minor adjustments and clarifications were made after having experts' opinion and academic advisor's comment on the change of certain words in all the instruments to acclimatize the instrument to the local population and culture. The academic advisor, six experts, some colleague went through the changes and gave their opinions. For more information about the instruments, please see the Appendix part.

For the purpose of conducting interview, interview guides were self-made or developed by the researcher in view of the difficulties in finding standardized interview guides with appropriate size, depth or content. The interview guide was examined by the academic advisor and tried out in a pilot study.

Before meeting with the victims and conducting the main study, the researcher faced a very great challenge in securing permission from the NGO(in which the sample subjects are easily available) for fear by the rehabilitating organization that asking their psychosocial problems may even aggravate or repress their problems. The researcher discussed with the NGO managers and counselors and even made modifications on some words (from the questionnaire and interviews) that might hurt the feelings of the survivor children. But, finally, the NGO personnel decided not to allow the researcher to contact the survivors inside the premises of the organization. However, the researcher was free to

contact them outside the organization. The researcher collected the data from the S.A.C. in different places outside the compound of the organization.

The interviews were initially adopted in English and translated into Amharic. The translated copies were given to language experts to check its consistency. Subsequently, slight corrections were made and then applied.

During the personal meetings with the survivors, they were asked to rate the degree to which they had experienced each symptom in the scales and take part in an about a 40 minutes interview. The interview had semi-structured and open-ended questions about offenders, disclosure, reactions, psychosocial effects, and coping styles. If the participants agreed (almost all did), the interview was *taped*, otherwise, *notes* were taken during the interview. Actually, the first interview guide was a little bit modified after listening to it.

Administration of Instruments

The instruments were administered for the sample subjects in two ways: For the very young sample that were unable to easily read and understand, the researcher was reading the instruments and scored their answers for them. But for those who are able to read the instruments, the instruments were handed over to them and they were requested to read the instructions and follow the directions.

3.5.1 Pilot study

The pilot study was done on four survivor children and one mother of the survivor. The pilot study enabled the researcher to ensure:

- Whether or not the prepared instruments (questions) are relevant, appropriate and helpful to gather the intended data.
- The appropriateness of the data collection procedure or plan.

. The selected model (Immediate and Long-Term Impacts of Child Sexual Abuse, J.N. Briere & D.M. Elliott, 1994) to analyze the psychosocial aftereffects of CSA is applicable and relevant to the purpose of the study.

3.5.2 *The Main Study*

After going through all the above procedures, the following steps were taken turn by turn in conducting the main study:

. The researcher contacted the available survivor children individually to ask their *willingness to participate in the study.*

. After receiving their willingness, the researcher *briefed* the participants about the purposes of the study and the *confidentiality* of their information to make them feel free and relaxed in giving genuine information and in expressing their feelings freely.

. The researcher told them how he wanted to meet and ask them (by showing and explaining the questionnaires and interviews)

. Then, the researcher fixed comfortable time and place to meet them based on their own interests. Together with this, the researcher met some available parents of the victims (Not all parents were available as some were orphans, some living away from their parents and some parents were unwilling to participate). They were briefed about the purposes of the study and encouraged to feel free and relaxed to discuss the issue.

. Besides, two victims were especially selected for *small scale 'case study'* as these victims were found to have more depression, anxiety and isolation than the others. This would help to deeply look into the problem.

. Finally, after receiving their oral and written informed consent, the necessary data collection with all available respondents was conducted in places and time they preferred.

The nature of the study forces to establish *rapport* with samples. But, establishing rapport was not difficult to the researcher as the researcher knew the survivor children for about a year (already established rapport).

To extract data from the interview, the tapes were listened to several times and relevant information was coded. A selection of the interview was transcribed word by word.

3.5.3 Focus Group Discussion (FGD)

Conducting FGDs were found to be necessary to understand the overall nature of CSA, its aftereffects, and coping styles. Thus, semi structured FGD guide was used as a supplementary source with groups of experts that are believed to have relevance with the issue and relation with the victims. After informing the purpose of the study and securing their consent, all the FGDs were held in centers where it had much convenience for the respondents.

3.6 Ethical considerations

As the study dealt with the most sensitive and taboo issues, major ethical concerns were taken into account to handle the delicate situation of asking about severe trauma without causing emotional turmoil. According to Eva MC Jonzon (2006) "it was more common that respondents reported positive effects of talking about these matters with a neutral person as they feel being important, needed and paid attention to by participating in the study." Thus, it is worth mentioning the ethical consideration considered while gathering data from respondents:

. In the first place, the full *consent* of all participants of the study was orally requested and *informed consent* was given.

. Tape recording was made by the willingness of each participant. While recording, the child's interest and disinterest was respected.

. All the gathered data were showed and read to them to identify anything that could reveal their identity.

. The *confidentiality* of the gathered data was informed stressfully.

. The name of the organization in which the victims were selected from is kept confidential to avoid any risk that serves the revelation of their identity.

3.7 Methods of Data Analysis

The data were gathered using both qualitative and quantitative methods together with a small scale 'case study'. Thus, both qualitative and quantitative analysis was made using appropriate models.

Descriptive Statistics (percentage) was used to present the data obtained through the questionnaires or scales. That is, the collected data thought the questionnaires are presented and analyzed using tables with percentages. Together with this, computer software entitled "*Spss 12.0 for Windows*" was applied to quantify the results.

The data collected through interview and an in-depth interview (as in the case study) were tape-recorded and transcribed accurately after listening time and again. Short note was also taken during the interview where tape-recording could not be possible. Then, full account of the story was written for the two cases just after the interview. The collected data were categorized in a meaningful link with the research questions.

As a result, a comprehensive analysis of the interview and the cases narrated was made in a series of the topics or themes. The qualitative analysis of the two 'case studies' was made based on the framework in the "*Immediate & Long-term Impacts of Child Sexual Abuse, J. Briere & D. Elliott, 1994.*" This journal is selected as basis for analysis as it is found to have high similarity. The framework consists of PTSD, Cognitive Distortion, Emotional Distress, Impaired sense of self,

Avoidance, and Interpersonal Difficulties. The quantitative (statistical) data and analysis is used as a supplementary approach for the qualitative ones. This is because the samples of this study are selected non-probability sampling; and for non-random samples, it is not advisable to use statistical model (as a basic analysis model but as a supplementary one.)

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1. Wheathers, Litz, Huska, & Keane; National Center for PTSD- Behavioral Science Division; 1999.
2. "A Personality Scale of Manifest Anxiety." Journal of Abnormal & Social Psychology, 1953, Vol.48, 285-290. Cited in V. J. Derlega & L. H. Janda. PERSONAL ADJUSTMENT: The psychology of Everyday Life, Third Edition, 1986.
3. Mary Cooper, Ph.D. LMFT, Director, the Trauma Resolution Center of La Veta, Colorado, 1999.

CHAPTER FOUR

Data Presentation, Analysis and Interpretation

This part deals with the presentation, analysis and interpretation of both the qualitative and quantitative data.The items collected by using quantitative approach are tabulated and presented in percentages and the analysis follows after the table. The data collected by the interview guide are analyzed in detail qualitatively together with the quantitative ones. The small scale *'case studies'* analysis is presented at the end by using the journal article entitled *"Immediate & Long-term Impacts of CSA"* as a basis for the analysis.

4.1 Descriptive Data

4.1.1 Abuse Characteristics

Table 1. Child abuse characteristics.

Variables		Girls % (n=24)		Boys% (n=2)		Total % (n=26)	
		%	N	%	n	%	N
Number of perpetrators	1	73.03	19	7.69	2	80.72	21
	2	19.2	5	0	0	19.2	5
	3 or more	0	0	0	0	0	0
Relation to the perpetrators [a]	Nuclear family	57.69	15	0	0	57.69	15
	Close person	26.92	7	0	0	26.92	7
	Stranger	7.69	2	7.69	2	15.38	4
Age at onset of abuse	0-6 years	30.7	8	0	0	30.7	8
	7-14 years	61.53	16	7.69	2	69.03	16
Duration (range 0-18 years)	0-4 years	7.69	2	0	0	7.69	2
	5-10 years	61.53	16	7.69	2	69.23	18
	> 10 years	23.07	6	0	0	23.07	6
Type of abuse	Non-contact	0	0	0	0	0	0
	Contact	57.69	15	0	0	57.69	15
	Penetration	34.61	9	7.69	2	42.21	11
Frequency [b]	Once	23.37	6	7.69	2	30.76	8
	A few times a year	34.61	9	0	0	34.61	9
	Few times a month	26.92	7	0	0	26.92	7
	Every week	7.69	2	0	0	7.69	2
Use of violence	Threat of violence	30.7	8	3.84	1	34.54	9
	Physical violence	61.53	16	3.84	1	65.37	17

[a]- The perpetrator most closely related [b]- The highest marked frequency

Table 1. Presents the demographic feature or abuse characteristic of the samples. The demographic characteristics of the sample subjects includes children from age six to eighteen(though the majority of the victims are from age seven to fourteen).Their educational background ranges from grades two to twelve. From the total samples, almost 93% of the respondents are female victims and male victims cover only 7% of the total samples. But, this percentage or proportion can not be taken as a general statistics for the whole sexually abused children throughout the country as the number of the samples is too small to generalize. When we see their place of residence, the survivor children came from almost all parts of Addis Ababa; that is, almost all sub-cities of Addis Ababa are represented by some victims.

As Table 1 shows, the majority of the survivor children had been sexually abused by only one offender; that is, 80.72% of the survivors were abused by only one offender and a considerable number of the survivor children (19.2%) were abused by two persons. But, no sexual abuse was occurred by more than two offenders. Many of the survivors had been numerously sexually abused for a longer period of time by someone close in the nuclear family (about 57.69%). The sexual abuse often started before and after the age of 7. The majority (69.23%) of the abuse started between the ages of 7-14; and the duration ranged between a single episode to numerous times spanning seven years. That is, in cases where the abuse was intra familial like *incest,* the sexual relationship stayed from a single incident to about seven years being its maximum. The statistics on the duration of the sexual abuse tells us that most of the sexual abuses do not last long except as in case of incest where the relationship proceeds in a hidden manner. Besides, the type of abuse indicated that there was no sexual abuse taking place without contact. Non-contact sexual abuse was inexistent (0%). where as, more than half of the sample subjects (about 58%) were sexually

abused with contacts that involved pressure or force, etc and about 35% of the sexual abuse involved penetration.

Based on the frequency of the incidence, about 30.76% of the respondents were sexually abused only once. 26.92% of the sample respondents were sexually abused in a few times a month. However, the highest marked frequency of the sexual abuse that was taking place a few times a year was in only 34% of the total survivors. This tells us that survivor children who were involved in the sexual relationship for a longer time with a marked frequency were those who were abused or victimized by someone in the nuclear family. Therefore, it is possible to conclude that there is a significant relationship between relation to the perpetrators, duration and frequency of the sexual abuse. Last, but not least, almost all perpetrators used violence against their victims either by threatening or by utilizing physical violence.

To summarize as is shown in table 1, there are no male victims who were abused by nuclear family or by a closer person, who were abused before the age of 7. Moreover, the sexual violence on males did not last long and did not take place more than once as compared to female victims. Thus, as the duration, frequency and assault by family members was more observed on female victims than their male compatriots; and as these factors were seen to aggravate the effects of the problem, it is possible to conclude that more female victims suffer the psychosocial effects of sexual abuse than male victims.

4.1.2 Disclosure dilemmas and reactions

In disclosing the sexual abuse to someone trusted, the dilemma is due to the *survivor's relationship to the perpetrator;* that is, the survivors' relation to the perpetrator is a complicating factor in the process of disclosure.

Accordingly, most of the respondents in this study stated that in the beginning, the abuse was accompanied by *'silence'*. The reason for almost all of the sample subjects to prefer silence is because of fear of the reaction on how receptive their families may be to acknowledge their sexual abuse. Thus, this study may help to make sense why survivors of sexual abuse remain silent.

From the respondents of this study, despite the delay in reporting, all of the sample subjects disclosed their cases in one way or another. For all of these survivors, the most common person first told was the mother. But, about 46% of the mothers responded negatively. The study also found that it is in cases where the sexual abuse was incest that all of these mothers responded negatively. In line with this, Wyatt & Newcomb (1990:765) as cited in Kim McGregor (1999) said the following:

> *Women who consistently disclose their abuse to no-one were likely to have been victimized by a family member in close proximity to home.*

It is also found that those who disclose and receive a negative reaction to their disclosure of the sexual abuse have worse psychological and social problems than those who receive a better reaction. Moreover, the likelihood of telling again after receiving a first negative reaction did not significantly decrease. About 80% of those who receive the first negative reaction searched out another trusted relative or person and told their abuse.

On the other hand, family support was found to be less available to the victim child following disclosure in cases where the offender was within the family member or in intra familial abuse. In support of this idea, a study by Russell (1986) cited in Kim McGregor (1999) found that those who disclose their sexual abuse abused by their father or brother were only supported in 31% of the cases

whereas those who were abused by a more distant male relative were supported in 80% of the cases.

The disclosure of the victim child in this study was believed more when the offender is a stranger or someone not from family member. Otherwise, the closer the perpetrator to the family, the less likely was the child believed in reporting the sexual abuse. Most of the incestuous survivors (87%) were targeted as a cause for the family's socioeconomic disruption. This is because after disclosure, the father (the breadwinner) of the family accused of sexually abusing the child under his custody; consequently, the father imprisoned. Then, the family income drained and the family suffers. Thus, this study discovered that children abused by family members were at high risk and faced greater psychological and social consequences.

In short, the disclosure characteristics of the respondents indicate that positive reaction to disclosure was given to those victimized by strangers or to those with non-familial abuse. As a result, these survivors of sexual abuse believed better, received greater support from family, and faced relatively lesser psychological and social consequences. Where as, negative reaction to disclosure resulting in greater psychosocial consequences or effects was given to those sexually abused by family members.

Generally, Berliner & Elliott (1996) as cited in Kim McGregor (1999) stated a comprehensive statement about disclosure dilemma and its reaction as follows:

> *In general, the closer the relationship of the offender to the mother, the more likely that support will be compromised. the highest risk of failure to support is found when the offender is a stepfather or the mother's live-in boyfriend.*

4.2 The Psychosocial Effects of the Sexual Abuse

Table 2. PTSD symptoms scale

Scale Items	1 (%)	2 (%)	3 (%)	4 (%)
1. Do you have repeated, disturbing memories, thoughts, or images of the sexual abuse?	3.8	15.38	69.3	11.53
2. Do you have repeated, disturbing dreams of the sexual abuse?	0	26.92	61.5	11.53
3. Do you suddenly act or feel as if the sexual abuse were happening again (as if you were reliving it)?	7.69	38.5	42.3	11.53
4. Do you feel very upset when something reminded you of the sexual abuse?	0	19.3	73	7.69
5. Do you have physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the sexual abuse?	11.53	42.3	46.15	0
6. Do you avoid thinking about or talking about the sexual abuse or avoid having feelings related to it?	0	11.53	80.7	7.69
7. Do you avoid peoples, activities or situations because they reminded you of the sexual abuse?	0	7.69	76.9	15.38
8. Have you lost interest in activities that you used to enjoy?	7.69	53.8	34.6	3.84
9. Do you feel distant or cut off from other people?	7.69	15.38	42.3	30.7
10. Are you not being able to have strong feelings (for example, being unable to cry or unable to feel happy)?	26.92	19.3	30.7	23.07
11. Do you feel as if your future plans or hopes will not come true?	30.7	15.38	46.15	7.69
12. Do you have trouble in falling or staying asleep?	7.69	19.3	57.69	15.38
13. Do you feel irritable or having angry outbursts?	15.38	7.69	50	26.92
14. Do you have difficulty in concentrating?	34.6	15.38	46.15	3.84
15. Are you in a state of being overly careful, "super-alert" or watchful?	7.69	26.92	34.6	30.8

1. Almost Never 2. Sometimes 3. Often 4. Very Often

One of the psychosocial effects of CSA is the experience of PTSD symptoms related to the abuse. Thus, the 15 standardized items on the PTSD symptom scale that are intended to measure whether the children experience these symptoms as a result of the sexual abuse or not were distributed to and scored by the survivor children according to their most distressing events on the scale. These 15 items were analyzed using spss 12.0 for windows and their reliability is found to be 0.851, which is highly acceptable reliability. As a result, from all the respondents, it was found that an overwhelming majority (86.88%) of the victims had

experienced the PTSD symptoms after the abuse. From these respondents, about 68.36% of them had *highly experienced* the consequences or the trauma. That is, for these respondents (68.36%), the PTSD symptoms were observed to be *'very often'*. Where as, about 13.12% of the respondents either did not experience the symptoms at all- *'almost never'* or they experienced the symptoms very rarely- *'sometimes'* after the abuse.

The occurrence of these PTSD symptoms caused by the sexual abuse scored as *'almost never'* was by very small number of respondents- 7.12%. This implies that about 92% of the respondents were experiencing and experienced the PTSD symptoms or its psychosocial effects because of the sexual abuse. From these, the response or scoring of some four respondents was somehow exceptional. That is, the scoring of these respondents was observed to have very few of the symptoms. Otherwise, they were either experiencing the symptoms rarely in cases where something reminded them of the sexual abuse or they were not experiencing the symptoms at all most of the times. When the researcher was conducting observation, these samples were found or observed to be relatively relaxed, anxiety-free and depression-free. What was common about these respondents were they were about the same in age and they were somehow older than the other survivors. Therefore, it is possible to conclude that the occurrence of PTSD symptoms as psychosocial effects of sexual abuse may be less as age increases or if the age of the victim child is older.

On the other hand, from the 15 items intended to measure the PTSD symptoms resulting from sexual abuse, some of the items were occurring highly or mostly in the high majority of the respondents. That is, from table 2, item numbers 1,2,3,4,6,7,9,12,13,14 and 15 were faced often and very often by a very high proportion of the respondents- 80.32%. The most frequently and seriously observed PTSD symptoms of the sexual abuse by the survivor children among

others from table 2 were (item numbers 1,2,4,6,7,12 and 13) having repeated, disturbing dreams, memories or thoughts of the sexual abuse, feeling very upset when something reminded them of the sexual abuse, avoiding to think or to talk about the sexual abuse and feelings related to it, and even avoiding people, activities or situations that are reminders of the sexual abuse, having trouble in falling or staying asleep, and finally increased arousal of irritability or outbursts of anger.

Table 3. A Summary of PTSD scores of the Victim Children (N=26)

	Mean	% above the mean	% below the mean
PTSD Symptoms Score	25.24	68.36	31.64

As can be seen from the table above, based on the mean score of the respondents (25.24), very high numbers of respondents (68.36%) are found to have almost all symptoms of PTSD. Thus, the presence of PTSD symptoms by sexually abused children can be said very high. On the other hand, 31.64% of the respondents were obtained below the mean score; thus, these respondents are believed to have very less or sometimes no symptoms of PTSD.

Table 4. Emotional Distress Scale

Scale Items	1(%)	2(%)	3(%)	4(%)
1. I want things right away.	11.53	69.23	19.3	0
2. I refuse to sleep alone	15.38	7.69	63.38	11.53
3. I feel fearful without reason	11.53	11.53	69.23	7.69
4. I cry without good reason	34.6	42.3	11.53	11.53
5. I feel sad and withdrawn	0	3.84	80.7	15.38
6. I feel worried	0	15.38	73	11.53
7. I do not want to be left alone	15.3	11.53	50	23.07

8. I become hyperactive	3.84	23.07	65.38	7.69
9. I have temper tantrums	3.84	15.38	69.23	11.53
10. I easily become startled	3.84	11.53	61.53	23.07
11. I become aggressive	15.38	7.69	57.69	19.3
12. I create games, stories or pictures about the traumatic event	11.53	3.84	61.5	23.07
13. I bring up the traumatic event in conversation	73	11.53	11.53	3.84
14. I avoid talking about the trauma even when asked	0	3.84	80.7	15.38
15. I become fearful of things that are reminders of the traumatic event	0	7.69	73	19.3

1. Almost Never 2. Sometimes 3. Often 4. Very Often

Being emotionally distressed is another serious psychosocial effects faced by survivors of the sexual abuse frequently. The emotional distress is a result of both psychological and social problems. The 15 items adopted for measuring emotional distress were analyzed using spss 12.0 for windows. And the reliability of the 15 items was found to be 0.852- which is highly acceptable reliability.

Based on the results of the scoring by the survivor children, a very high majority of the respondents (90.96%) indicated that they were experiencing the emotional distress symptoms as a result of the sexual abuse. From these survivors, about 74.16% of the survivors were highly suffering from the emotional distress resulted from the sexual abuse. For these respondents, the emotional distress was observed very frequently- *'very often'*. On the contrary, a very small respondents (8.97%) were either *'sometimes'* became emotionally distressed or *'almost never'* emotionally distressed. What is special here is that those survivors who were not severely suffering the psychosocial effects of the sexual abuse in the case of the PTSD symptoms were not suffering high emotional distress either.

From the 15 items on the emotional distress scale, there were items that had been faced by the survivors of the sexual abuse more than the others. Item numbers 2,3,5,6,9,10,11,12,14 and 15 from table 4 were faced 'often; or 'very often' by a very high number of the respondents. That means, these items were among the most frequently observed symptoms or problems of emotional distress by the majority of the survivor children. Thus, the most frequently experienced emotional distress effects of the sexual abuse by the survivor children were, among others, refusal and fear of sleep, feeling fearful without reason, feeling sad, withdrawn and worried, having temper tantrum, becoming easily startled and highly aggressive, creating games, stories and pictures about the traumatic event, refusing to bring up the traumatic event in conversation, becoming unwilling to talk about the abuse, and being fearful of things that are reminders of the sexual abuse.

Table 5. Summary of Emotional Distress Score of the victims (N=26)

Depression Score	Frequency	%
0-15 (Normal mood)	3	11.53
16-21 (Probable depression)	7	26.94
Above 21 (syndromal depression)	16	61.53

Table 5 gives a summary of the scores of respondents' depression level. Accordingly, the analysis tells us that 11.53% of the respondents showed relatively normal mood or very less depression; 26.94% of the respondents are victims of a probable depression and a very high sample respondents (61.53%) are suffering from very high or severe depression as a result of the sexual abuse. The number of victims free from depression in this category is found to be

relatively insignificant; that is 11.53%. However, depression, being faced by a very high majority of the respondents, is seen to be a symptom most frequently observed by CSA survivors than the other symptoms.

Table 6. Anxiety Scale

Scale Items	1 (%)	2 (%)	3 (%)
1. I get nervous when things do not go right for me	73	19.2	7.6
2. Others seem to do things easier than I can.	65.38	26.9	7.69
3. I worry a lot of my time.	80.7	19.2	0
4. I get mad easily.	69.3	26.9	3.84
5. I feel that others do not like the way I do things.	42.3	46.2	34.6
6. It is hard for me to get to sleep at night.	65.38	34.6	0
7. I feel alone when there are people with me.	80.7	19.2	0
8. My feelings get hurt easily.	61.5	23	15.38
9. I am tired a lot.	69.3	19.2	11.53
10. Other children are happier than I am.	80.7	15.38	3.84
11. I have bad dreams.	76.9	23	0
12. My feelings get hurt easily when I am fussed at.	65.38	7.69	26.9
13. I feel someone will tell me I do things wrong way.	61.5	23	15.38
14. I wake up scared some of the time.	80.7	19.2	0
15. I worry when I go to bed at night.	73	23	3.84
16. It is hard for me to keep my mind on my school	69.3	19.2	11.53
17. I wriggle in my seat a lot.	50	38.4	11.53
18. A lot of people are against me.	46.2	53.8	0
19. I often worry about something bad happening to me.	84.6	7.69	7.69
20. My hands feel sweaty	61.5	38.4	0

1. Yes 2. No 3. I don't mind

The 20 standardized items used as anxiety scales were found to have reliability of 0.657- reasonably acceptable reliability. Anxiety is one among the most repeatedly observed consequences of CSA. As a result, from the total samples of child victims, about 87.44% of the survivor children were obtained to have high

anxiety symptoms as a result of the sexual abuse. That is, the majority of the respondents were feeling anxious and irritable because of the abusive trauma. Where as, a very small survivors (12.56%) were not severely experiencing or were not experiencing the anxiety symptoms at all after being sexually abused. When we look into the demographic characteristics of those respondents who were relatively free from anxiety symptoms, they were older than the other victims; they were at least 13 years old and above. Besides, all of these victims were abused by strangers not by a family.

From the 20 items used as anxiety scales, some items (item numbers 1, 9, 13, 17 and 20) were less observed or scored by the majority of the survivor children. That is, the survivors were not suffering from being tired easily, form a feeling that someone will tell them they do things the wrong way, wriggling in their seat, or hand-sweating. Whereas, the rest items (item numbers 1,3,4,5,6,7,8,10,11,12,14,15,16,18 and 19) from table 6 were experienced frequently by most survivors of the sexual abuse. That is, the anxiety symptoms most frequently faced by the survivor children were inability to do things easier than others, a lot of worry, getting mad easily, feeling of loneliness, getting easily hurt, being unhappy, having bad dreams, waking up scared because of the trauma, phobias with sleep and bed, worrying about bad things had happened to them.

Table 7. A Summary of Anxiety Score of the Victim children (N=26)

Anxiety Score	Frequency	%
8-21 (Mild Anxiety)	5	19.2
22-36 (Moderate Anxiety)	7	26.94
Above 36 (Severe Anxiety)	14	53.76

Table 7 gives a summary of the results of respondents' Anxiety level based on Beck Anxiety Inventory (BAI). As a result, 19.2% of the survivor children showed mild anxiety experience; more than a quarter of the respondents (26.94%) showed moderate anxiety symptoms and the majority of the respondents (53.76%) showed severe anxiety experience or clinically significant anxiety symptom. This indicates that a great majority of the survivors showed profoundly significant anxiety symptoms. On contrary, those who experience very low or no anxiety symptom are less than one fifth of the total respondents.

Symptoms of the CSA Observed by Non-offending parents

Table 8. Signs and symptoms of child sexual abuse (from parents)

Instructions: Have you observed your child exhibit any of the following?	No (1)	Sometimes (2)	Often (3)	Very often (4)
1. Abnormal interest in or curiosity about sex	16.66	25	58.33	0
2. Fear of left alone being With a given person	8.33	8.33	75	8.33
3. Sudden emotional or behavioral changes	8.33	25	50	16.66
4. Less trust of those in the immediate environment or those with greater power	8.33	0	83.33	8.33
5. Social isolation	8.33	33.33	58.33	0
Total	9.98	18.33	64.99	6.66

Table 8 shows some symptoms of the psychosocial effects or consequences of the sexually abused children as observed by their nuclear family (especially by their mothers since almost all of the respondents were mothers of the victim children). The symptoms or signs of CSA mentioned above in the table indicate both psychological (item numbers 1, 2,3and 4) and social (item numbers 4 and 5) problems of the survivor children.

The responses of some of these parents showed that almost these entire survivor children exhibit the aforementioned symptoms or signs of CSA as were observed by their parents. As it is shown in table 8, about 71.65% of the survivor children exhibited the above signs of CSA in a more frequent manner; that is these 71.65% of the respondents observed their victim child frequently- *'often'* or *'very often'* - to be socially isolated, to have less trust on others and even on those with greater power, sudden emotional or behavioral change, fear of left alone with a given person because of lack of trust and abnormal curiosity about sex.

The observation of these signs of CSA, as it was reported by parents of these victim children, replicates the previous findings and literatures on CSA. For example, the development of 'abnormal interest or curiosity about sex' after the abuse goes with one of Browne & Finkehlore's (1986) model explaining long-term effects of CSA called *'traumatic sexualization'*- in which the victim's child sexuality is shaped by the abuse which may result in confusion about sexual identity, norms or standards. 'Fear of left alone with any person may also correlate with Browne & Finkehlore's (1986) *'powerlessness'*- in which a child being incapable to protect him/herself left alone with someone that can dominate; as a result, the child will have ineffective attempts to stop the abuse. 'Lack of trust on others and on those with greater power' can be seen as *'betrayal'*- in which the child has been exploited by a trusted individual through sexual. And lastly, 'social isolation' may correlate with Browne & Finkehlore's (1986) *'stigmatization'*- feelings of shame and guilt may develop because of the abuse and the victim child preferred to be isolated in order to escape from the possible bad social reactions.

Discussion

Based on the above three standardized scales (PTSD symptoms Scale, Emotional Distress Scale and Anxiety Scale), the researcher tried to see the problems these survivors faced and the intensity of the problems. Results of the study support the idea that sexually abused children, despite the difference in the severity of the problems, suffer both psychological and social consequences as a result of the sexual abuse.

One of the primary aims of the study was to investigate the psychological and social effects of sexual abuse of the survivor children and to see whether all victims of sexual abuse equally suffer from the violence. Thus, the result of this study addresses evidences to these purposes.

The results of the study found that when compared with the time before the sexual abuse (as it was reported by the non-offending parents of the victims); these children who had been sexually abused showed more symptoms of PTSD, Emotional Distress, Anxiety and Interpersonal Difficulties. More specifically, these victim children showed more fear, nightmares, withdrawn behaviors, psychological unwellness, delinquency, sexualized behaviors, running away, general behavior problems, poor self-esteem, self-injurious behaviors, internalizing behaviors (such as depression, inhibition and overcontrol) and externalized behaviors (such as aggression, antisocial and undercontrolled behaviors).

Victims of CSA are at risk of exposure to high stress levels during life. That is, the sexual abuse is not over when the molestation is over- its effect is an ongoing process over time as we can see from the responses of the victims. As Rathsman (2001) cited in Eva M C Jonzon (2006) informed:

"... CSA may result in prolonged stress, or chronic stress, due to

maintenance of secrecy, continuing interpersonal dysfunctional relations, and further events during life directly or indirectly associated to the abuse."

What we can understand from the results of the study is that though almost all sexually abused children suffer the psychosocial effects of CSA, the intensity or severity of the trauma differs inline with age of the survivor and the relation of the survivor with the offender. That means, more serious psychosocial effects of the sexual abuse were evident in very young victims of the sexual abuse than in older ones. And, more depression, anxiety and social isolation were evident in those abused by someone closer to the nuclear family than those abused by strangers and not by family members. Together with this, it can be said not all victims of the sexual abuse suffer the psychosocial effects equally. The younger the age and the more closer the offender, the more serious the trauma will be.

In conclusion, there are factors that contribute to severe effects of the sexual abuse. The effects of CSA and incest may relate to variables in the dynamics of the abuse. According to Kim McGregor (1999), severe adaptations are likely to result if any of the following were involved:

. the child was either very young or in early puberty
. the abuse was of longer rather than of shorter duration
. force or violence were also involved
. the abuse involved misrepresentation or coercion
. the child was 'groomed' to be an active participant
. the abuse was blamed on the child or the child was disbelieved about
. there was an escalation of sexual abuse over time
. physical penetration occurred
. there was more than one perpetrator
. the offender was a (step-)parent or other member of the nuclear family
. the abuse was observed, acknowledged or disclosed but not stopped
. the intervention was traumatic or ineffective

. the abuse was embedded in other forms of family dysfunction or in other forms of child abuse or neglect

. the abuse was sadistic (such as the child witnessed the offender's pleasure from their pain) or ritualistic.

Of all in all, there are agreements between the present study and the conditions advocated by Kim McGregor in about 11 out of the fourteen quoted above.

4.3 Coping strategies

Table 9. Coping strategies: "to make the situation better."

Coping Strategies	Victims	
	n	%
Self-improvement:-*Consider several alternatives to handle it* *-Having thoughts that create better feeling* *-Escaping or telling a lie about the situation*	23	88.46
Seeking solution:- *Talked to relatives or professionals* - *Seeking solution to the problem* - *Prepared for the worst*	17	65.38
Keeping busy:- *Keeping the mind off the problem* *- participating in different activities*	5	19.2
Avoidance/Isolation:- *Social withdrawal* *- Less interested in group activities* - Accepted it, nothing could be done	4	15.38

As is shown in table 9, the overwhelming majority of the sample children (about 88%) identified *'self-improvement'* efforts as their primary means of coping with the sexual abuse. They indicated that they would continue to work on considering several alternatives to handle the after effects of the abuse by having thoughts that create better feelings. In doing so, some samples indicated that they would prefer to escape from or telling a lie about the situation so that they will not be revictimized by remembering the abuse. By using self-improvement as coping strategy, more than half of the respondents (about 66%) were using *'seeking solution'* for the problems they faced as their coping strategies. These

samples reported that they could improve their situation by talking to relatives especially to their mother and to someone whom they rely on; by talking to professionals-Counselors.

A majority of these samples applying 'seeking solution' as their coping mechanism stated that talking to professionals (their counselors) and obtaining counseling services enabled them to get some sort of relief from their previous trauma. In this case, thus, the counseling service served them both as a therapy and as a coping strategy. Besides, the respondents reported that when they come to the organization for the counseling service and when they meet their friends who are sexually abused, they feel relatively better relief. One of the respondents even implied the following:

> *I still had an idea that I am stupid, disgusting and a failure sort of. I think that; I don't think I had let that go unless I met them (the other sexually abused). You know what, what is good for me is to come to this organization, to be and to talk with such strong, and beautiful victims. This is the right time I feel as if I were not violated by somebody.*

Moreover, another survivor indicated that to be easily understood about someone's problem being as a source of relief from the possible trauma or from the psychosocial consequences as follows:

> *It was so incredibly strengthening and relieving to have someone who speaks the same issue. I need to use much words and actions to easily enable my listeners understand about my problem. But, I met friends who speak the same language, who immediately understood what I meant. Eh, I mean about the abuse without me using thousands of words or trying to find parallels. We easily understand each other about what we want to say.*

A smaller proportion of the sample subjects (19.2%) were obtained to cope with their situation by *'keeping themselves busy'*. These children were keeping their mind off the abuse and participating in different activities that will enable them to forget the reality they live in. These groups of survivors were less interested in active resistance, and preferred to participate in activities such as play, sports, etc as a means to keep busy. One of the respondents even said the following:

> *I prefer to wash even washed clothes, to do things at home without being ordered; if there is nothing to do at home, I would love to watch the most boring television program than seat doing as it keeps my mind from thinking of my cursed problem.*

The last groups of the sample subjects were somehow coping their problem in a different way by preferring *'avoidance or isolation'* -15.38%. These groups reported to be socially withdrawn, less interested in group activities, etc because of lack of trust on others. They also reported that they accepted what happened to them as they could do nothing about it. Though these respondents were very small in number, almost all of them were found to be very young in age and abused by someone in the family or very trusted person. Overall, the above analysis indicated that almost all survivors of the sexual abuse applied some sort of coping strategy in order to mitigate their problem.

4.4 Intervention or Treatment

Since these sexually abused victims were selected from an organization which has been providing Professional Counseling services, they were asked about the improvement they saw as a result of the counseling services. Thus, when asked "Does the Counseling services, and/or *Drama and Music Therapy*[1], you have

1- It is a therapy designed for CSA, specifically given to the selected samples and seen to be effective.

received helped you to feel better or to deal more effectively with the problem that led you to seek Counseling or Therapy?", 46.19% answered 'Yes- a great deal', 26.92% replied 'Yes- to some extent, 7.69% answered 'Uncertain', 7.69% replied 'No- it did not really help' and 11.53% answered 'No- made things even worse'.

Thus, the above finding indicated that the majority of the survivor children reported as the counseling service helped them to reduce their abuse-related problem. The Counseling service in the organization had helped many of the survivors to overcome substantial problems and to ameliorate the effect of remaining problems.

4.5 *Case Study Presentation*

Case Presentation-(A)

A-(Nini)

Background

This case was selected, as it was stated in the previous parts of the study, for its special features from among the other samples. The case was reported before 13 months of the interview with the researcher. The victim was sexually abused outside home when she was selling soft, cigarette and chewing gum on a street- one of her daily activities. The offender was confirmed to be a long time cigarette cstomer of the victim child. The offender faced no problem in order to take the child away from the place she used to sell to a 'safe' place for his mad sexual act.

The abusive relationship took place once but it was accompanied by ruthless violence and threatening for secrecy. Nini reported that she was extremely shocked when she realized that he was to abuse her. She got no chance to escape

as the offender had a sharp knife on his hand that if she tried to escape or to scream, he warned her he would have no mercy but to kill her.

The first move of the researcher was to debrief the purpose and secure permission. Hence, the researcher debriefed in detail the purpose of his study and why he wanted to contact her; and secured her consent to participate in the study. Once again, the researcher asked Nini about her mother's possible reaction in providing information related to her violence. After receiving a positive response from Nini, the researcher went to their home to contact her mother. Introducing himself, the researcher elaborated the purpose of being at their home. Primarily, Nini's mother, accompanied with tears, began talking the tragedy that had happened to her child by the day when Nini was sexually abused without being asked by the researcher to tell the story. Nini's mother blamed herself even more than anybody else in that it was their living condition (economic income) that forced to send her child by a street by the age when her age mates are being looked after at their home. Nini's mother cursed herself again and again by memorizing the sleepless nights she spent just after the abuse.

As a result of all this, full consent to participate and provide every necessary information was secured from both (Nini and her mother). Her mother was even motivating Nini to be free, relaxed and to tell all her story ever since the violence occurred; she even encouraged her that the more she would tell everything to the researcher, the better relief she would earn. Finally, the researcher fixed a comfortable time and place with Nini for their ongoing meeting based on her preferences.

The researcher felt that he was triumphant enough after being successful in getting Nini's mother full consent and especially after having a confirmation

from Nini that she is ready and even eager to tell her story without any discomfort. This was because she considered the researcher as her 'good' brother for she knew him for more than a year. Thus, to make her even more comfortable and relaxed, the researcher reassured her that everything will be kept confidential, whatever her responses will not hurt her life, and the interview session will start, proceed and be stopped any time based on her own interests.

After all this, they began to meet according to their scheduled time and place. Their approach and greeting tells something about their intimacy and close understanding. In their first meeting, the researcher did not want to get directly into interviewing Nini. Rather, he invited her for a 'warm up talk' that would lead them towards their core issue with ease.

In their third meeting, Nini came to the truck and she narrated all her story, accompanied with different emotions and tears, as follows:

The Abuse: What happened to Nini?

I think he was a street vagabond. But, what I knew about him was that he was my 'daily customer' of cigarette, and chewing gum for a long time. I know him much and he even used to call me as 'Mita, my best seller'. He used to ask me about my education; he even used to advise me to study hard, etc. He always used to say 'say hi to your mom.' as he knew my mother from distance.

It was one cursed, rainy night. I was standing on one dark corridor being wet and shivering by the rain. Later, I realized that I was not alone; my 'daily customer' was aside. Being considerate and brotherly, he gave me his jacket for the coldness. He was surprised to tell me that my mom was searching for me carrying umbrella for me together with him. He showed me the direction my mom went on looking for me. And I began to go that way; eventually, he followed me telling that he would take me to my mom.

However, after a long journey I began to fear the place we were in. It was too dark, no walk, no voice, only him and me. I gave his jacket back and asked to be back. Later, what I remember was a very big, old cloth on my mouth to silent my screaming, a knife at his hand in that if I refuse anything, I would be killed. After all my suffer, I went home with my fresh pain and blood.

The first disclosure

My mom, looking at my bare hands, immediately realized that something terrible had happened to me. She loudly screamed, hold me tightly and asked me what bad thing I faced or happened to me struggling with her cry. When she asked me to tell her everything, what came to my mind immediately was the sharp knife he showed me when he threatened me.

To be frank, I was afraid to tell to mom because I felt she might not believe me. But, I convinced myself that I had no choice except to tell and be prepared for the worst. But, my mom was such a nice and considerate mother that she believed me and told me she would do whatever was necessary to protect me.

Reporting the Case

My mom and I spent a sleepless night at home waiting until the dawn came. So soon, mom and I went to the nearby police station and reported the case to police. Based on the interrogation of the police officer, I explicitly narrated each and every bit of the abuse from the beginning to the end. It was really horrible to tell my entire story because every word I used to explain my abuse hurt me and reminded me that situation. It was really painful.

Others reaction upon me

It was just after reporting to the police that our relatives and our neighbors became aware of my abuse. Their reaction towards me was not uniform. Our neighbors went crazy for the action and they were encouraging my mom to go to the court house to seek justice. At the same time, they used to tell me that they were always on my side. Despite these, some of our relatives, especially the most elder ones, were blaming me and counted me responsible for it. They made me responsible for my victimization. I could not believe they had a negative reaction to me as a result of all what happened to me. They discredited or ignored my problem. Rather, they were concerned about my mother's suffering, not my abuse, because of me. As a result, my mind became confused and mixed up with sympathy and guilt. On the one hand, I began to blame myself because of their hatred towards me. On the other hand, I felt that I have at least my mom and our neighbors to stand for my justice.

Psychosocial Effects or Consequences of the abuse

I began to go to the police station together with my mom for my case was serious. I met different people especially from the Humanitarian Organization and from Women's Association. Their reaction, sympathy and advice were hurting me as it remembered me that event. Then, I decided not to meet people and to be alone. But, I started to feel different feelings on my body parts and in my mind. I had serious headache and bad pains around my genital especially when I urinate. Some people were staring at and laughing at me because I used to walk differently.

The more I tried to forget my abuse, the more worried I became because I woke up scared most of the time as I was experiencing dreadful nightmares about the abuse. I often saw my offender in my dreams threatening me. I sometimes screamed without reason. Thus, I preferred to be alone for fear that I might scream even being with someone else. Actually,

I was not like this before the abuse and I began to think that if this worry would continue in my future life. Hence, I realized that I worry, think, depress and became isolated much more than others. This made her to be careless and bored about my school and learning. I felt that other than my mom no one was good, helpful and trusted for me.

Another biggest headache for my instability was that my offender was not caught and might meet me unexpectedly. If so, I extremely afraid that he might hurt me once again because of reporting to the police and because of telling to other people. I became unprotected and restless. Besides, whatever people talk or see, I became overly careful because it seemed that it was all about me and I wanted to be aggressive in that others would not ask me anything about my abuse.

Though I was treated medically for my headache and for the pains around my genital, I could not become free of the bad flashbacks of the situation in my mind. My memories of the abuse are still fresh. Sometimes, I said to myself that I had not to be with that devil and I had to suspect something bad when he took me to the dark because that was where I was not supposed to be. This feeling of guilt was hurting me much as it involved my innocent mother. Until I was sexually abused, I heard no one facing the same problem just like me in my surrounding and I began to question "why only me?"- someone who is poor, who have no father or anyone else except her mother. Thus, I believed I was disgusting and worthless and especially an evil influence on the world to my poor mother. This was really shameful to me. I was forced to perceive the world as a deliberately hurtful place against me.

A New World

With the help of our 'kebele' officials confirmation of our poorness and my being sexually abused, I was admitted to a Humanitarian NGO where in I have been helped basically with Counseling services for my trauma and with monetary and other services. I came across other sexually abused victims just like me for the first time. Then, my misconception of being 'the only one in the world' was taken away. I began to have a

better environment and better friends who speak the same language though my instability about my offender still existed as he is not caught.

Coping Strategies

Before coming to this NGO, I used to be isolated so that I would not see others being sympathetic for me. I already accepted what happened to me. Later, together with the Counseling service, I used to make my mind off thinking about the abuse. I kept myself too busy at home. Sometimes, my mom used to take me to the rural areas thinking that I would forget what happened to me when I changed environment. In general, I wanted and struggled to forget everything and to make my situation better.

Discussion

1. Post-traumatic Stress

The Observed ***Post traumatic Symptoms*** *of Nini:*

- *Frequent re-experiencing of the event through nightmares*

Nini (the victim) often woke up scared because of the disturbing nightmares and dreams related to the abuse.

- *Avoidance of thinking or talking about the sexual abuse.*

She used to escape from anybody who might initiate a conversation about the sexual abuse.

- *Feelings of fear and even helplessness.*

Her offender has not been captured yet. As a result, she is unstable or restless for fear that one day he might attack her and she thought she had nobody to protect and help her form this except her mother.

Immediate and Long-term Psychosocial Impacts of CSA

Post traumatic stress refers to certain enduring psychological symptoms that occur in reaction to a highly distressing, psychically disruptive event
Like child sexual abuse (J. Briere & D. Elliott, 1994). This is actually verified after the sexual trauma Nini experienced. The victim told to the researcher that she was having repetitive, intrusive thoughts and memories of the sexual abuse through her dreams. She even preferred to call dreadful nightmares instead of dreams. For example, her mother informed the researcher in the interview that Nini woke up being scared very much most of the time with very loud screaming. Her consciousness was said to come after a long stay.

As the victim herself indicated, she did not want to think about the abusive event and she preferred to avoid talking about the situation with anyone especially at the beginning of her abuse. Kim McGregor (1999) explained these feelings as one of the symptoms of PTSD as a result of child sexual abuse as follows: "Persistence avoidance associated with the trauma and numbing of general responsiveness such as efforts to avoid thoughts, feelings or conversations associated with the trauma, efforts to avoid activities, places or people that arouse recollections of the trauma." Thus, her mother told the researcher, after her victimization, she hated to go out alone anywhere and she even totally hated the place we are in currently. Such behavioral manifestations are indicators that Nini developed fear and helplessness about their environment, with anybody. She also developed diminished interest or participation in her previous activities with anybody because of lack of trust on anyone. Nini even at one time tried to escape from her mother away to anywhere just to change the environment. This is because she had fear of her offender as he has not been caught yet.

2. *Cognitive Distortion*

The observed ***Cognitive Distortion symptoms*** *of Nini:*
- Perception of helplessness and danger

The victim had a feeling that she had no one to help her except her mother. This enforced her to think that she was always in danger.

- Sense of lowered self-esteem, self-blame and inaccurate attribution

The victim considered herself as she was cursed and someone who is disgusting.

- Her sense of vulnerability to be violated again increased

- Hopelessness

- Some others reacting negatively towards her

Though her abuse was acknowledged by her mother, some of her relatives and her neighbors were reacting negatively towards her instead of her victimization.

Immediate and Long-term Impacts of the CSA

J. Briere & D. Elliott (1994) explained this dynamic as follows: "People make significant assumption about themselves, others, their environment and the future based upon their childhood learning." Thus, the victim's assumption on others and the environment was that those with greater power give care and support to children. They didn't hurt them. However, she found her assumption to be the opposite one. Because of the experience of the abuse, the victim's assumption and self-perception reflected an overestimation of the amount of danger and underestimation of her own self-worth and self-efficacy. She thought that she was worthless after her abuse; she developed a feeling of hopelessness regarding her future.

Her attributions were all in all inaccurate and inappropriate because the victim was making an assumption about her inherent badness based on what happened to her. This feeling began to be intensified especially when some of her relatives and her neighbors blamed her, made her accountable for the abuse and

negatively reacted towards her instead of treating her as a victim. She began even to consider herself as guilty person. At this time, she started thinking that all her assumptions were wrong. She was abused. Some of her relatives and her neighbors reacted negatively and blamed her. Then, she believed that 'I was wrong to think that I could be protected. The environment and other people are all against me. So, I have nobody to trust and to rely on.' Such Cognitive Distortions, according to Briere & Elliott (1994), may contribute to or, alternatively, act as mediators of the emotional distress event among many adult survivors of child sexual abuse.

In her bed, she was often worried thinking that at anytime, she is exposed to or vulnerable for further abuse. The threat her offender used while he was sexually violating her frequently came in her memories and she felt as a result she was not even safe at her own home. She took long hours to get asleep for fear that someone might come, invade their house and abuse her again. She knew she had no power to prevent herself from anything that might happen to her- feeling of powerlessness. As Finkelhor & Browne (1988) explained, feeling of powerlessness is a common problem in situations where the child's body is invaded against her/his wish and when vulnerability to invasion continues for a long.

3. Emotional Distress

The observed ***Emotional Distress symptoms*** *of the victim:*

- *Became highly anxious about anything*
- *Fearfulness on bodily functioning*
- *Uncontrollable feelings of anger*
- *Aggression*
- *Being highly depressed*

The victim experienced high level of depression because of the fact that her mind was extremely overwhelmed by the unexpected thoughts she had about the trauma.

Immediate and Long-term Impacts of the CSA

According to J. Briere & D. Elliott (1994), this dynamic basically constitute depression, anxiety and anger. Browne & Finkelhor (1988) noted that "in the clinical literature, depression is the symptom most commonly reported among adult survivors molested as children." The researcher observed the victim, in the counseling center, to be highly depressed than others in the organization. She had become highly anxious when she reminded her nurturance and relationship she had with her offender because she felt she had been abandoned or betrayed by someone whom she didn't expect him to abuse her. As a result, she developed a sense of insecurity and disbelief even in a safe place.

She reported that she had bad pains around her genitals. Because of this, she afraid to have problem related to it in the future like in conception, delivery, etc. She hated to be asked about anything related to the abusive event. To escape from this, she preferred to be aggressive on others when they try to approach her and to have conversation with her. Sometimes, she had unexpected and uncontrollable feelings of anger even when she is with others. Nini reported about her uncertain feelings of anger was because of an uncontrollable bad memory or image about the abusive event. Rarely, she memorized the most horrible part of the abuse being alone or with other people. She had difficulties of controlling any of her emotions or anger. At this time, she used to express her aggressiveness towards others in a bad and harmful way. She reported, in the very beginning of the abuse, that she commonly used to fight and attack other children as a reaction to her feeling of anger. Research findings suggested that abused children's aggressiveness towards others- commonly expressed as

fighting, bullying or attacking other children- is a frequent short-term sequel of their sexual molestation (J. Briere & D. Elliott, 1994).

4. Impaired Sense of Self

The observed ***Impaired sense of Self*** *of the victim:*
- Lowered sense of self

The victim felt that she was disgusting and bad. That was, according to her perceptions, the reason to be sexually abused.

- Inability to comfort herself adequately

The victim lacked the ability to soothe or to make herself comfortable in any situation.

Immediate and Long-term Impacts of the CSA

Different psychological researches confirmed that severe childhood maltreatment- including early and sustained sexual abuse- may interfere with the child's development of a sense of self. This is found to be true in case of Nini because it has been observed in her after the sexual abuse she faced. The victim appeared to have overreactions to her stress and painful effects. She reported to be overly careful because the image she had about herself was very bad. She perceived herself to be disgusting, bad and unlucky; that was why she said she was sexually abused. Thus, her sense of self was, as it was read in her detailed narration, impaired and very much lowered.

She felt that she has no personal territory. In short, she was unable to define her own boundaries and reasonable rights. She had difficulties of being free and relaxed to meet people, to talk with them, and even without meeting and talking to anyone, she could not be free to go in her own way. These feelings hurt her much but she was not able to confront her painful feelings. This indicates that the

impaired feelings she had about herself inhibited her mind, trapped her, made her unable to free, relax and comfort herself.

5. *Avoidance*

*The observed **avoidance behaviors** of Nini:*
- Separating herself from others

The victim believed to earn her comfort of avoiding thinking and talking about her abuse by isolating herself from other people.

- Fear of others negative reaction towards her

The reaction and blaming she faced from some of her family members was much painful together with the abuse. However, she experienced some sort of negative reactions from others.

Immediate and Long-term Impacts of the CSA

As the victim reported, this avoidant behavior helped her much in the first weeks of her abuse to free her mind from others 'bad treatment' and from being blamed by some people. But, later, as a result of separating herself from others, she realized that her problems were aggravated. Her chance of being treated was denied at least for a while. Whatever stranger she met, she considers them as wild beasts and for that matter, she did not want to talk to or respond to anyone when asked about anything. She frequently preferred to be alone at home so that she would be able to escape from other people's opinions or reactions to her. This helped her in order not to meet and see anything that could remind her abuse. But, unfortunately, every important part of the abusive event came to her mind and disturbed her much.

When alone, she became hopeless about her future and began to think about suicide as a solution to her for the multiple consequences she faced and to free

her mother from the suffering she had and the social reaction she faced because of the sexual abuse. Thus, it should not be surprising that increased suicide ideation and behaviors related to it have been linked to sexual abuse in child victims.

6. Interpersonal Difficulty

The observed Interpersonal Difficulties of Nini:
- Fear of those with greater power

- Social avoidance or isolation

- Became less socially competent

The victim became more socially withdrawn for fear of different social reactions.

- Less satisfaction in relationship

The victim had good relationship with her peers and even with her offender before the abusive situation. However, after being abused by someone she knows before, she hated to have friends further.

Immediate and Long-term Impacts of the CSA

Research and clinical observations have long suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning. Actually, we can see the different 'social alterations' in the victim. It was reported by the victim's mother that the victim was very much active in different activities at home before being abused. But now, it has been observed that her active participation in different activities has been washed away and she became passive. She didn't want to involve in any activity and she even stopped playing games that she used to earlier with her friends. She had a very big problem related to any of her elders. Her offender was older than her. Thus, she generalized that those with greater power than her could at anytime hurt her and she used to fear them as a result.

According to J. Briere & D. Elliott (1994), 'sexual abuse usually occurs in the context of human relationship, with as many as 85% of cases perpetrated by individuals known to the victim.' This is true in the case of Nini. The violation and betrayal of her boundaries by someone she knew created a problem to the victim in developing intimacy or friendship with anyone and create interpersonal difficulties in her. This intimacy problem appeared to create fear regarding interpersonal vulnerability. That is why the victim preferred to be socially withdrawn and to be less socially competent in any activities. The victim reported that if her present feeling of 'developing intimacy' continues, she said she might remain single in her later life.

Case Presentation- (B)

B. (Kuku)

Background

Kuku is the last born in her family from three children. She can be said a beautiful, attractive baby with a wonderful predisposition. All of her elder brothers are currently soldiering in the Federal military service and they were not at home by the time their sister was sexually abused. Kuku is grown up by a step-father since her father died before her birth. She told the researcher that she did not even see her father in life.

The case was reported before 11 months of the interview with researcher. But, Kuku herself later reported to the interviewer that she was betrayed and sexually violated at an earlier age by other perpetrators- a relative and a neighbor before her step-father's severe sexual assault. Her memories of the abuse by all of them were not as such hurtful in Kuku's memory as her step-father. However, her memories of the abuse by her step-father was really painful, much vivid and as she emphasized unforgettable.

The abusive relationship took place at their home when her mother was away for the death of her grandfather. As kuku informed, her step-father was a decent and restricted person. He did not talk much. Kuku also said that her step-father spent much of his time outside home and came home being drunk but without disturbing us. The trauma Kuku experienced was accompanied by silence.
Kuku's violation by her 'father' came to the court house as a result of the disclosure to and the pressure by one of her brothers. Before that, she disclosed only to her mother and her mom was afraid to take any action against her *third husband*. As soon as her eldest brother came home, chaos and parental conflict existed in Kuku's family between her brother and their step-father. As a result, everything was revealed to her brother secretly until their step-father was sent to jail.

Kuku was 10 when she became aware that she was not 'the only one in the world'. This time, she got the chance to see other children who had also been sexually abused like her. It was after this and after a long Counseling services by the Humanitarian organization that she was first able to describe to the researcher the details of the abuse. But, before all this, the researcher had to go through a long step to secure Kuku's full willingness to participate in the study in the first place; and her mother's full consent for participating in the study as much as necessary. For this purpose, the researcher explicitly debriefed Kuku the purpose of the study and her role in the study. Finally, the researcher secured her full consent to participate in the study but after a long conversation to convince her. As her mother's involvement was vital, the researcher also contacted both her mother and her brother, debriefed them in detail the purpose and benefit of the study, discussed with them for a long time and secured their full consent to contact Kuku any time she is ready and even to contact them freely to provide every necessary information when necessary.

The researcher, then, met Kuku, discussed with her about how he wanted to conduct the interview, about when and where to meet. Based on the suggestion given by Kuku, the researcher fixed a comfortable time and place to meet for their discussion (Interview). The emphasis given by the researcher in their discussion was about the confidentiality of every pieces of her information, to make her free and relaxed in giving the necessary information as there is no judgment (there was no right or wrong answer) and there was no pressure when she wanted to stop or quit the interview. After all this, they began to meet based on their schedule. The researcher had to look whether she was ready or not to begin the issue. For that, he prepared a warm up talk that would lead to their point of discussion or to their main issue. Finally, Kuku narrated all her sexual abuse-related story as follows:

The Abuse: What happened to Kuku?

I did not believe still now that he did that nasty and cruel thing against me. It was in the afternoon. There was nobody at home. My step-father ordered me first not to go anywhere and then to boil water for he wanted to take shower. When it was ready, he asked me to wash his back while he was taking shower in my presence. I agreed; there was no evil idea in my mind as anybody could do it for his father. He told me take my clothes before they became wet. I was not afraid to do so considering it as a fatherly advice. But, later, he ordered me to wash all his body parts even his "genital" (Kuku became shy when she pointed towards her genitals). I was shy. I don't want to remember what he did against me after all this.... (Kuku was silent for a while being in tears. Then, she kept on narrating accompanied with cries). ... He picked me up, hugged me tightly; when I tried to wriggle in his hug, he threatened me not to shout and even to try anything as he might hurt me seriously. And, finally, he did things against me that were shameful, unexpected, painful and disgusting (by pointing to her genital area once again).

Silence or Secrecy

I had to wait until my mom came back to tell all my suffer because I had no one else other than her; my brothers as I told you were not around. As I had bad pains, I was in bed when my mom came back. Previously, he warned me to keep everything secret; but if I told to my mom, she would die immediately since, he said, she was suffering from blood pressure. If this happened, he told me that he would kill me. Hence, I afraid and kept it with me even when my mom asked me repeatedly.

Further Victimization

When mom was at home, he didn't want to seat for a long. Either he went out or he preferred to sleep. After I recovered, he advised me that I would be ok and asked me if I was feeling pain as a result. I was actually suffering new and serious pains. Then, he told me to overdo it so that it would not hurt me. After the first abuse, he met me three times. I saw no improvement and change in my health conditions; but I realized that I began to naturalize having sex. And, I decided to stop doing it. One night, he came to me; I told him to get back otherwise I said I would shout. For fear that my mom might be awakened, he silently got back.

The First Disclosure

The next morning, my mother asked me what was going on between me and 'her husband' last night. It was an unexpected question and I had no answer but too keep quite. My mom was intuitive enough to understand me when I felt sad. I knew she had tolerance for me whatever wrong I did. She treated me empathetically and told me that she didn't want any bad thing to happen against me by anybody. Then, I became courageous enough and I narrated everything my step-father did against me when she was away. … (Kuku once again began to cry. I waited her till she stopped her cry). …

My mom went crazy; she cried deeply putting her hands on her head. She cursed herself and her luck. She blamed herself much.

Kuku's Mother Reaction

Later, my mom told me to keep silent; not to tell anyone and to wait until my brother came. My mom stressed that let alone reporting to police, he would take any fatal measures against all of us if he knew I told her everything. I accepted her and I began to wait the day my brother arrived home. Side by side, I was curious enough to see whether my mom had been changed after being aware of the abuse. But, I could sense nothing.

Reporting the Case

Our elder brother was a Federal soldier. When he came back home, our step-father was not interested and he wanted him to go from the house. There began repeated chaos and parental conflicts; I began to fear that if he knew I told to mom in one way or another, he might kill us. My brother became aware about my abuse. He said he would kill him immediately. But, my mom convinced him that killing him didn't benefit me and it was not justice. Besides, she would suffer more by his imprisonment together with the existing problem. Finally, we reported to the nearby police station. The case even went to the court house.

Others Reaction towards Kuku

When he was sent to the prison, I became the topic of discussion in our surrounding by our neighbors and relatives. As a result, different things began to be heard. Our relatives especially those who were on the side of the offender were against the disclosure and reporting to the police. They said I was responsible for everything because he was not that kind of person; that was why my mom confidently left him with him when she went away. I became out of my mind when I was counted responsible for the abuse despite all

my miseries. I could see them to react negatively towards me especially when he was imprisoned. Some of our neighbors said I seduced him because of my 'wearing styles'. I could not become free to go out of home for fear that everyone might stare at and talked about me. I became unable to concentrate on one thing and to free my mind. I repressed back the reaction of one of our relatives: He said my mom should not have left me alone with him, someone who was not my father. Thus, I began to blame my mother because if I was not left alone with him, that devil would not have touched me.

Psychosocial Effects or Consequences of the Abuse

I knew I was suffering and still I am suffering from so many intolerable things as of the abuse. Since the first day of the abuse, I experienced serious pain around my genital. As a result, I couldn't freely urinate. I diagnosed so many times for fear that I might be victimized of Fistula. The doctor told me that I have to be careful for my uterus and genital areas were hurt and I might face problem in delivery if this went serious. I had bad headache; I think it might be because I had several things in my mind and I became easily disturbed.

We are poor and incapable. Had we been wealthy, I would have changed place or our home to other different place. Because when I was home, everything and every material reminded me that event. When I went out, I could not be free and relaxed like other children because everyone in our kebele knew me and knew what happened to me. Being sympathetic, some of our neighbors treat me just like their child but was hurting to me. Others murmur about me when they saw me. I could not play games I used to with my age mates as these kids, I don't know why; they did not want to play with me. When I went to school, I think it was for the good of me that some of my teachers and my friends used to ask me. But, that was really disturbing to me. Thus, I became differently aggressive so that they might not ask me anything. Consequently, I hated school, my learning (though it was my favorite place) and even my study and my result declined as a result.

I used to separate myself from others. I wanted to be alone; I withdrew myself from any group activities. However, my mind could not be free of the trauma. I felt I was anytime exposed to further victimization by others- that is, inadequate self-protectiveness. Thus, feeling of helplessness developed in me. I knew I was guilty because I didn't have to take off my clothes when he asked me to do so. My biggest problem even now is that I have no one to trust especially those with greater power except my mom and my brother. I repeatedly experienced bad nightmares of the sexual abuse. I think it was because I had disturbing memories or images about the event. I was less socially competent, more aggressive and more withdrawn just to avoid thinking or talking about the sexual abuse. At the beginning of the abuse, I faced difficulty in sleeping. I worried a lot because I used to see others being happy and relaxed than me. Then, I ask myself 'why only me?'. Sometimes, I had unexpected and uncontrollable feeling of anger and even I couldn't express my anger.

A New World

I always used to ask myself 'why only me? Why my 'father did this to me?'. Finally, I convinced myself that I was dirty and cursed; that was why it happened to me and I accepted it. But, thanks to 'one person' who advised my mom and convinced me to go to this Humanitarian Organization so that I could be helped in psychological treatment and other benefits. This was the time I saw victims of my own kind for the first time. Everything in that organization was much better than anywhere else. This had become the new world to me.

Coping Strategies

At the beginning of the abuse, I accepted what happened to me as I could change nothing. I prepared myself for the worst. Besides, I used to isolate myself from others so that I would not be asked and I would not remember it. I wanted nothing to remind me of that

situation even now. Thus, I preferred to change place (to stay in the organization for a very long time). I used to keep my mind off the event being busy in different activities.

Discussion

1. Post traumatic Stress

The observed ***Post traumatic Stress symptoms*** *of Kuku:*

- Sleep disturbances and the resultant poor concentration

The victim child had experienced frequent nightmares and developed a problem going to bed. She had also poor concentration on one thing

- Disturbing flashbacks related to the abuse

Most of the time, the victim had unexpected memory of the abuse that made her restless.

- Avoidance of anything related to the sexual abuse

The victim child did not want to think about or to talk about the abuse as far as possible. She used to escape from it.

- *Feeling of fear-* the victim child had the feeling of being revictimized. As a result she had abnormal feeling of fear.

Immediate and Long-term Impacts of the CSA

According to J. Briere & D. Elliott (1994), 'a diagnosis of PTSD requires the occurrence of a traumatic event, as well as (1) frequent reexperiencing of the event through nightmares or intrusive thoughts (2) a numbing of general responsiveness to, or avoidance of, current events and (3) persistence symptoms of increased arousal, such as jumpiness, sleep disturbances, poor concentration.' Thus, all of the above symptoms for the diagnosis of PTSD were observed in the victim child after the sexual abuse. That is, the victim suffered a series and frequent experience of the traumatic event through dreadful nightmares. She had a big problem to go to sleep- sleep disturbances. The victim reported to the

researcher that the sudden flashbacks related to her abuse made her avoidant of so many previous habits that she used to.

When asked about the abusive event, she preferred to avoid any conversation related to it. She didn't even want to think about it as far as possible just to escape from its painful memories. When it came to her mind, she felt as if the traumatic event was occurring again. To escape this, she had a much decreased interest or participation in significant activities. She further developed a feeling of fear and helplessness. As a result, she became overly careful or watchful of things. She lost interest in activities that she used to before. She said she easily became angry or outburst when something reminded her of the abuse.

Sometimes, the victim felt humiliated by the traumatic event when something reminded her or when she had unexpected recall of the specific abusive events. The victim also told the researcher about the bad feeling she had towards her own home. That is, when she is at home, she used to feel that the event was occurring in the present right now rather than as a memory of a past event. Because of this, she hated their house, her surrounding all in all as she was victimized by her own step-father at that house.

2. Cognitive Distortion

The observed ***Cognitive Distortion symptoms*** *on Kuku:*

- A feeling of hopelessness

The victim felt that her future looks distorted and cloudy because of her sexual violence.

- Bad reaction of others towards her

The victim experienced a negative reaction from her own relatives despite the abuse she faced and its psychosocial consequences.

- *Feelings of lowered self-esteem and inaccurate attributions*

The image the victim child had about herself was very low. She also felt that all her previous assumptions were wrong.

- *Pressure for secrecy*

Her offender- her step-father- warned her not to disclose to anyone.

Immediate and Long-term Impacts of the CSA

It is obvious that the victim's assumption about herself, about others, about the environment and about her future became inaccurate as a result of the abuse. Her assumption that she would be protected and supported by her step-father was obtained to be out of her expectation. As a result, she developed a bad impression that nobody in the world could be trusted. The previous trust she had on her step-father had been eroded, she developed hatred as a result and this hatred has been extended into others. That is, whoever father she saw, she had hatred towards them. This lack of trust and hatred she had led her to hopelessness about her future. Because of the abuse, she had bad genital pains and she was abused by someone she relied on. Thus, she began to have a cloudy and hopeless image about her future.

In the ongoing interview with the researcher, the victim has been frequently heard to say bad things about herself. She used to say "I am bad, dirty and cursed. This bad thing happened to me because I am inherently bad person and I know I will never change it." As can be seen, the image she had is too low. The victim told that she was forced for secrecy- not to tell to anyone even her mother. Consequently, she was unable to tell her mother even when asked. Because of this, she was not able to get the necessary medical treatment on time. Her mother, in the conversation with the researcher, blamed herself for all what happened against her child. What made the victim's mother more regretful was that she was of no help for her child in the very beginning of the abuse.

Another headache that worsened the victim's problem was others reaction as a result of the abuse disclosure. It was surprising for her when her relatives blamed her when the case was disclosed and made her the reason for her father's imprisonment despite the sexual assault she suffered. She began to self-blame and to consider herself as a guilty person for everything. Her depressive feeling and restlessness aggravated as a result. The victim indicated about her extreme restlessness, depression, hopelessness and lack of trust especially before she began the counseling service that helped her much.

3. Emotional Distress

The observed ***Emotional Distress symptoms*** *of Kuku:*

- Hostility and angry feelings towards others
The victim developed hatred and hostility towards others and especially towards those who negatively reacted against her abuse.

- High level of Depression
The victim child became highly depressed than the other victim children in the counseling center. She preferred not to talk too much.

- Became anxious most of the time
The victim had repeated experience of fear and anxiety because of her offender- for being her step-father- and his relatives' reaction.

- Being highly worried even without a reason
The victim developed worry most of the time, sometimes even without any good reason.

- Being aggressive

Immediate and Long-term Impacts of the CSA

J. Briere & D. Elliott (1994) noted that 'depression to be a symptom most commonly reported among adults molested as children.' Consequently, the victim had been selected for this small scale 'case study' from others because of

the extreme level of depression she had than other victims. She was highly depressed most of the time. What worsened her feeling was because her offender was her own 'father'. To support this, Kim McGregor (1999) indicates that 'increased levels of depression seem to be associated with both the frequency and the duration of the CSA experiences as well as whether the offender was a father figure.' The victim had an image of herself as shameful and she perceived the world as deliberately hurtful place. Thus, she preferred to be quite.

Kuku used to be easily startled and angry outburst especially when she had unexpected and uncontrollable memory of the abuse. It reminded her worst thing that she faced; and when others negative reaction added to this, she developed hostility towards all others.

Mostly, the victim preferred to be aggressive, to aggressively react on other people so that they would not remind her what she had. This aggressive behavior later led her to be socially isolated from others. Thus, she began to worry most of the time about what happened to her, her mother's suffer because of her, about her future and sometimes without any good reason. Her worry was much dreadful especially in the first week of her abuse as her offender warned her not to disclose to anyone. At this time, she was much worried when she reminded what her 'father' told her about her mother 'blood pressure'; that is, she was fearful in that her mother might die if by any means she heard about the abuse.

Sometimes, she used to have pictures and stories about the traumatic event unexpectedly. This made her nervous. She was anxious most of the time and she easily became mad- her feelings get hurt easily. When she saw other children being free, relaxed and happily enjoy their childhood experience, she began to worry about something bad happened to her because of the feeling that a lot of

people are against her. She also concluded that other children are happier than her. Thus, these bad feelings of anxiety and worry had impacted the victim's school performance- she evidenced a decline in her school works.

4. Impaired Sense of Self

The observed ***Impaired sense of self*** *of the victim:*
- Feeling of guilt and self-blame

The victim felt guilt and began to blame herself after some of her relatives counted her responsible for what had happened.

- Feeling of being betrayed

The victim child was offended by somebody who was a trusted person on her eye. But, after the abuse, she felt that she was betrayed by her own step-father.

- Lowered sense of self

The victim used to curse herself thinking that it happened only on her. This wrong impression led her to think that she has low self-esteem.

Immediate and Long-term Impacts of the CSA

J. Briere & D. Elliott (1994) noted that 'how a child treated or maltreated early in life influences his/her growing self-awareness.' Thus, we can see that the growing self-awareness of the victim child being influenced by her early maltreatment by someone trusted. She was maltreated by her own step-father. Then, she felt that she was betrayed. This increased her feeling of inadequate self-protectiveness. The victim used to think that she is vulnerable anytime, anywhere. Besides, when some of her relatives despised her, she thought that she was highly exposed. Their reaction increased her guilty feeling and she frequently used to blame herself.

The image she had about herself was extremely impaired and distorted. She believed herself to be 'bad', 'dirty', 'defective', 'unlucky' and 'worthless' because

of the sexual abuse. The impaired perception she has as a 'bad seen' or as an evil influence on the world to her mother was reinforced by the discrediting and ignoring of her disclosure by some of her relatives. When she saw other children being happy and relaxed than her, she used to ask herself 'why only me...?'

5. *Avoidance*

The observed ***Avoidance behaviors*** *on kuku:*

- *Separating self from others*

The victim used to isolate herself as her coping strategy to escape from what she didn't want to think, hear and talk.

- *Lack of interest being with others*

The victim hated to have any communication or conversation. She even hated everything she used to before.

- *Social withdrawal and being less socially competent*

The victim afraid to do things in group for fear that others may tell her she did it the wrong way.

Immediate and Long-term Impacts of the CSA

According to J. Briere & D. Elliott (1994), 'avoidant behaviors among victims of sexual abuse may be understood as attempt to cope with the chronic trauma induced by childhood victimization.' Consequently, the victim was using avoidant behaviors as her coping strategy to hide herself. But, it was found that this avoidant behavior later developed with her and became one source to her aggravated psychosocial problems. Avoiding and separating herself from others, she began to evaluate herself and she found to have greater feelings of guilt and decreased self-image about herself. This is actually substantiated by Briere & Elliott as follows: 'avoidant and self-destructive methods of coping with child

abuse experiences may lead ultimately to higher levels of symptomatology, lower self-esteem and greater feelings of guilt and anger.'

The victim lacks interest of being and participating with other people. She feared that others may not like the way she does things; and even she felt that someone may tell her that she did things the wrong way. She realized that her feelings get hurt easily and she easily became nervous. Thus, she preferred this avoidant behavior or social withdrawal as a solution.

6. Interpersonal Difficulty

The observed ***Interpersonal Difficulties*** *of Kuku:*

- Distrust of others
The victim had bad attitude towards others and she concluded that she had nobody to trust as a result of the sexual abuse.

- Interpersonal rejection
The victim showed that she had no interest to communicate or talk with anybody. She rejected.

- Less closeness with her parents
The victim was abused by her own step-father. Thus, she hated to have any closer intimacy with her relatives.

- Very fewer friends
After the abuse, she had very fewer friends; they are even all in all other sexually abused children.

-Socially withdrawn

Immediate and Long-term Impacts of the CSA

It is a confirmed fact that CSA leads victims to 'alterations in the social functioning'. This also has an impact on their interpersonal functioning. As a

result, it was observed that the victim child developed alterations in different aspects of social functioning and faced interpersonal difficulties. The victim child preferred isolation and social withdrawal because she had nobody to trust as a result of her abuse. Her isolation and her profound lack of trust were reasons why she used to have less or no close intimacy with other people. Sh/e also feared those with greater power may attack her again. She had problem in creating intimacy with anybody. She saw herself as unworthy of relationships with people she consider healthy. When others try to get closer to her, as her mother indicated, she either rejected them or has poor form of involvement in the relationship.

Unlike her previous time before the abuse, she became less socially competent, more withdrawn. She had very few friends. Sometimes, she became more aggressive. Even with her existing friends, she had less satisfaction in the relationship she had. When others looked her, she felt that they had a different abnormal feeling to her, she felt stereotyped. J. Briere & D. Elliott (1994) indicated that sexual abuse survivors typically report having fewer friends, less interpersonal trust, less satisfaction in relationship, more maladaptive interpersonal patterns and greater discomfort, isolation and interpersonal sensitivity.

CHAPTER FIVE

Summary, Conclusion and Implications

5.1 Summary

The main objective of the study is to investigate the psychosocial effects and to see into the coping strategies of sexually abused children. The study tried to show, in a very small sample subjects, a detailed literature reviews about the different dimensions of CSA: its prevalence, perpetrators, disclosure, most importantly its psychosocial effects, coping styles and interventions.

In order to assess this, data was gathered from the selected respondents and then both qualitative and quantitative analysis was made to arrive at conclusions and findings and to forward possible suggestions. Results of the analyses and interpreted data indicate that survivor children of the sexual abuse suffer from multiple psychological, social, physical, or other effects. Besides, almost all non-offending parents S.A.C. also developed sense of fear, guilt, shame, anxiety, betrayal, shock, isolation, social interaction problems, etc.

At last, following the study results, the necessary recommendations are forwarded.

5.2 Findings and Conclusion

The only devils in the world are those running around in our
Own hearts, and that is where all our battles ought to be fought

Mahatma Gandhi

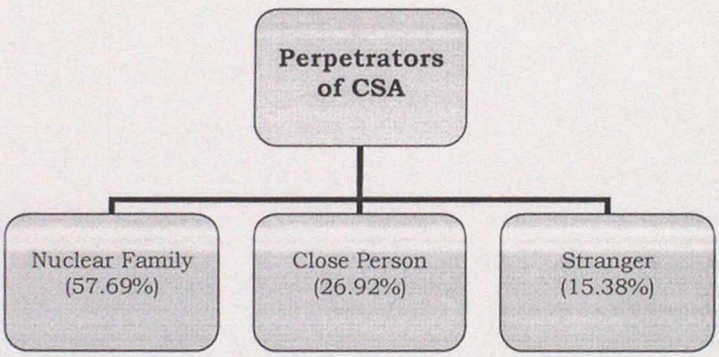
The major **findings** of the study are presented as follows:

Though it is not possible to support with current statistical data, the prevalence of CSA in our country has been found to be highly increasing despite the unreported cases. Nowadays, it has become common to repeatedly hear of CSA incident through Media in different parts of the country.

Almost all victim samples of this study are females and male victims of sexual abuse are found to be very small. Thus, most victims who suffer the psychosocial impacts of CSA are females.

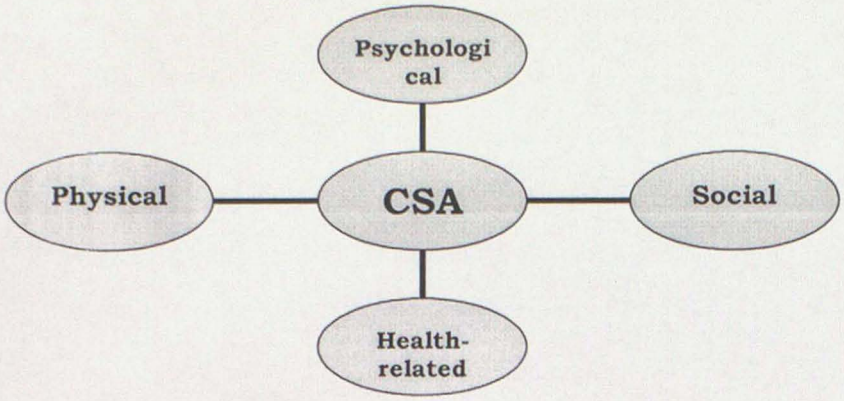
Most offenders are not strangers to their victims. In most cases, they are well known to their victims. The result of the study indicated that about 84.16% of the offenders are known by the victims.

Perpetrators or Offenders of CSA



It has been observed in the study that almost all, but very few, victims of CSA suffer psychological, social, physical, health-related, and other consequences. From these effects, results of the study indicated that psychological and social consequences are found to be worse for the victims than any other consequences.

Severe Effects or Consequences of CSA



PTSD (92%), Anxiety (87.44%), Emotional Distress (90.96%), Depression, Cognitive Distortion Avoidance and Interpersonal Difficulties are the most frequently observed psychological consequences of the CSA. Results of the study show that the high majority of the sample subjects suffer the above effects.

These sexually abused children are found to show different signs like physical signs (sleeping, eating, etc problems), behavioral problems (aggression, running away, suicidal behaviors, etc), emotional signs (becoming quite, depressed, anxious, etc), social problems (withdrawal, isolation, etc), and others.

Consequences of CSA and exploitation vary based on factors such as the victim's age, relationship to the offender, duration and frequency of the abuse, family and community support. The result of the study indicated that victim children who were abused at early age, or abused by a family member, and/or abused frequently for a long time are found to have severe or worse psychosocial consequences than those who were not.

Children vary in their responses to sexual abuse. That is, not all sexually abused children suffer the psychosocial effects of the abuse. Very few sample victims of the study are found to have less or almost no problems of the sexual abuse. These samples are relatively older in age as compared to other victims.

There is a greater possibility of serious distress to the child if the abuser is a family member, or if the child does not receive support from his or her non-abusive parent. The long-term consequences are also worse if force or the threat of force was used in the commission of the abuse, or if there were many incidents of abuse over a long period.

The analysis of the results of the study indicates that societal reaction after the abuse created a greater degree of victims' current difficulties and their psychosocial problems than their own subjective assessments of the impacts.

Non-offending family members also experience negative consequences when a child or sibling is sexually abused or exploited. These consequences may vary by factors such as the nature of their relationship with and dependency on the perpetrator. For example, they may feel shame, anger and guilt about their failure to protect the child.

Children always want to tell about their abuse so that it can be stopped; but they are often afraid that they will not be believed or protected, or they are afraid of what might happen if they do tell. Especially in cases of incest, when the abuser is a close family member, children may not reveal their sexual victimization. Thus, most cases of sexual abuse in our country are hidden

Most cases of CSA in our country, like most other cases, are kept hidden. Age of the victims, relation to the perpetrator, feeling of powerlessness, fear, dependency, conflicting emotions are found to be some of the basic factors why victims may not disclose their sexual abuse.

Almost all victims used their own coping strategies to make their situation better or to handle it. Their coping strategies include self-improvement techniques,

keeping themselves busy, avoidance and seeking solution. These coping strategies are positive but also include negative strategies like avoidance, suicidal, etc.

It is possible to say that there is no any kind of preventive approach applied to protect 'risk group children' from any kind of sexual violence. All of the samples of this study did not have any awareness regarding the occurrence of sexual violence or how to keep themselves from 'bad touches' before the abuse.

The information these victims had about sex and sexual orientation from their parents, from their schools or other sources was highly inappropriate and unhelpful. There is a very big problem about sex education with regard to these sample subjects in particular and in our country in general.

All of these sexually abused sample victims have been receiving professional counseling services. Thus, the majority of these victims (73.11%) indicated that the treatment procedure (the counseling services) helped them to reduce their abuse-related problems.

Some of the survivor children of the study suggest that participation in legal proceedings following sexual abuse can be further distressing for the child sexual abuse victim. When victims receive professional support prior to giving testimony in court, their statements are more likely to be clear and accurately reflect the time and details of the event. The experience is also less stressful for the child who has received such support.

Conclusion

Results of the analysis indicate that victims suffer from psychological, social, physical, or other effects. There is not one single pattern of sequel experienced by all survivors of CSA. In addition, not all those sexually abused as a child will develop psychological, social or physical symptoms. In short, sexually abused victims suffer a lot of psychological and social consequences of the violence. These problems include increased anxiety, high emotional distress, more symptoms of PTSD, lowered self-esteem, guilt, shame, depression, lack of trust, betrayal, aggressive behaviors, hatred, anger, social withdrawal or isolation, helplessness, hopelessness, self-humiliation, sexual dysfunction, addiction, suicide, passivity, dissociation, less or no intimate relationship, fear, etc. The majority of their non-offending parents also developed sense of fear, guilt, shame, anxiety, betrayal, shock, isolation, social interaction problems, etc. The severity of the effects of CSA depends on who is doing the abuse-*the context*, the manner of the abuse-*the nature*, and how long the abuse goes on-*the duration*.

5.3 Recommendations

The following recommendations are suggested for the possible prevention, reducing the prevalence and Therapy (rehabilitating or counseling) of the victims and risk groups of CSA:

Prevention

- A specialized training should be given to professionals (Lawyers, judges, psychologists, doctors, social workers, police and other) who provide assistance to victims of CSA.

- Launching a comprehensive child protection program throughout the country and creating an awareness in the society that they should do this protection not for their own children only but also for everyone's children.
- Prevention education is particularly important for sexually abused children as they are at higher risk of revictimization than children who have not been sexually assaulted.
- Prevention education is also very much important for non-abused risk group children. Thus, culture-based appropriate sex education with appropriate age should be provided so that children will be able to protect themselves.
- Educating the victim and non-victim children the necessary knowledge and skill for their safety and well-being. Children can best be protected by giving them the knowledge and skills necessary for their safety and well-being, and by creating in our families and communities an atmosphere in which they feel safe enough to come forward if they are being mistreated or abused
- Children should also be able to differentiate 'good touch' and 'bad touch'. Children who are well informed about inappropriate touching, who are taught to trust their feelings about situations and people are less likely to be victims of any type of assault.
- Parents are also responsible more than anyone else in educating their child from any kind of harm, in preventing, if the abuse occurs in immediately reporting the case to the concerned office. Thus, parents should have good relationship with their children, and should be equipped with all the necessary information.

Disclosure or Reporting

- If anyone believes that he/she has reasonable grounds to suspect that a child is being sexually abused or exploited or if a child is being sexually abused, anyone should report the case to the concerned body: police, court house, etc.

If the person to report is not from the family, the person should be protected by law- provided that the report is not falsely made and motivated by malice.

- Parental reporting is the most frequently observed problem in CSA- especially when the case is incest. So, parents should have deep understanding and be informed about the possible health, social and psychological problems children faced when they are sexually abused; consequences that come as a result of delay of reporting and the benefit that victim children may have after disclosure.
- Sexually abused children whose cases are not reported and who want help should have the chance to report their violence in a more secured and protected manner just like the HIV/AIDS *'Wegene AIDS talkline'*[1]. For example, most countries have a service for children called *the kid's Help Phone* like in Canada.

Treatment or Intervention

- After the case is reported, sexually abused children should, as far as possible, immediately get a complete medical examination so that they will not have any obstacles in looking into the statements of medical witnesses to pass heavy sentences against these criminal.
- Collaborative work should be done among Government, NGOs and the society at large to prevent and to intervene or rehabilitate the survivor children. They should also design possible intervention strategies for the victims and their families.
- Counseling and/or rehabilitation services for these victims of CSA should be provided extensively since psychological consequences are evidenced to be their most serious problems.

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1. A free phone call, designed to provide any information and counseling services related to HIV/AIDS; the number to make a call is 952.

- For the effective and fruitful counseling of CSA, there must be organized counseling or rehabilitation centers, experts or well trained counselors and even appropriate counseling environment.

Legal aspect

- Strengthening the criminal justice system's approach to the sexual abuse and exploitation of children. In doing so, the government should accelerate the court proceedings and should immediately respond to the victim's health-related, psychological, legal, economical and social needs.
- Supporting and providing legal education and community-based prevention and intervention training programs and services for the general public. For example, 'Drama and Music Therapy' training was given by Italian experts for very few professionals to psychologically treat victims of CSA and is found to be effective.

Future Research

The real psychosocial effects of CSA could be well known if research in the area is longitudinal ones. Thus, any concerned body should pave the way so that longitudinal researches will be conducted- as all the previous researches in the area in our country including this one are cross-sectional ones.

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Appendixes

Appendix A

Addis Ababa University
College of Graduate Studies
Department of Psychology

The Child PTSD Symptom Scale (CPSS) - for the Child

INSTRUCTIONS: Below is a list of problems and complaints that people sometimes have in response to stressful experiences (Like Sexual Abuse). Please, read each one carefully, put an X in the box to indicate how much you have been bothered by that problem/ how often that problem bothered you after the stressful experience(Sexual Abuse) has occurred in the past times. All the responses will be kept confidential. Thank you for your cooperation!
Please write down your most distressing event:

1. Almost Never 2. Sometimes 3. Often 4. Very Often

Scale Items	1	2	3	4
1. Do you have repeated, disturbing memories, thoughts, or images of the sexual abuse?				
2. Do you have repeated, disturbing dreams of the sexual abuse?				
3. Do you suddenly act or feel as if the sexual abuse were happening again (as if you were reliving it)?				
4. Do you feel very upset when something reminded you of the sexual abuse?				
5. Do you have physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the sexual abuse?				
6. Do you avoid thinking about or talking about the sexual abuse or avoid having feelings related to it?				
7. Do you avoid peoples, activities or situations because they reminded you of the sexual abuse?				
8. Have you lost interest in activities that you used to enjoy?				
9. Do you feel distant or cut off from other people?				
10. Are you not being able to have strong feelings (for example, being unable to cry or unable to feel happy)?				
11. Do you feel as if your future plans or hopes will not come true?				
12. Do you have trouble in falling or staying asleep?				
13. Do you feel irritable or having angry outbursts?				
14. Do you have difficulty in concentrating?				
15. Are you in a state of being overly careful, "super-alert" or watchful?				

Appendix B

Emotional Distress Scale for the Survivor Child

Instruction: The following items are intended to measure the level of Emotional Distress a child manifests after experiencing a traumatic event- like child sexual abuse. You are therefore expected to rate the items on a four point scale. All the responses will be kept confidential. Thank you for your cooperation! Each point refers:

1. Almost Never 2. Sometimes 3. Often 4. Very Often

Scale Items	1	2	3	4
1. I want things right away.				
2. I refuse to sleep alone				
3. I feel fearful without reason				
4. I cry without good reason				
5. I feel sad and withdrawn				
6. I feel worried				
7. I do not want to be left alone				
8. I become hyperactive				
9. I have temper tantrums				
10. I easily become startled				
11. I become aggressive				
12. I create games, stories or pictures about the traumatic event				
13. I bring up the traumatic event in conversation				
14. I avoid talking about the trauma even when asked				
15. I become fearful of things that are reminders of the traumatic event				

Appendix C

Anxiety Scale for the Survivor Child

Instructions: Read each question carefully. Put a circle around the word YES if you think it is true about you. Put a circle around the word NO if you think it is not true about you. All the responses will be kept confidential. Thank you for your cooperation!

1. Yes **2. No** **3. I don't mind**

Scale Items	1	2	3
1. I get nervous when things do not go the right way for me			
2. Others seem to do things easier than I can.			
3. I worry a lot of my time.			
4. I get mad easily.			
5. I feel that others do not like the way I do things.			
6. It is hard for me to get to sleep at night.			
7. I feel alone when there are people with me.			
8. My feelings get hurt easily.			
9. I am tired a lot.			
10. Other children are happier than I am.			
11. I have bad dreams.			
12. My feelings get hurt easily when I am fussed at.			
13. I feel someone will tell me I do things the wrong way.			
14. I wake up scared some of the time.			
15. I worry when I go to bed at night.			
16. It is hard for me to keep my mind on my schoolwork.			
17. I wriggle in my seat a lot.			
18. A lot of people are against me.			
19. I often worry about something bad happening to me.			
20. My hands feel sweaty			

Appendix D

Addis Ababa University
College of Graduate Studies
Psychology Department

Interview Guide for Sexually Abused Child

Background Information:

Age ----------
Sex ----------
Grade ----------
Educational performance ----------
Place of birth ----------
Place of residence ----------

The Interview:

1. Who was the offender? (Does he belong to the nuclear family, a close person or a stranger?)
2. How old was the offender when the abuse started?
3. Was the sexual abuse took place once or more than once?
4. When the abuse relationship started, how often did the abuse occur (the frequency, duration)?
5. What was the circumstance or situation in which the sexual abuse took place? (Were you playing together, cheated by the abuser, …)
6. How close did you feel to the offender at the time of the sexual abuse? (Whether you had a close relationship like kin relationship or friendship or neighborhood relationship?)
7. Has the offender used force and or pressurized you for secrecy after the offence? If so, what was your reaction?
8. What are the reactions to having been sexually abused?
9. Who disclosed the case? When? What was the reason for disclosing the case?
10. What was the reaction and attitude of significant others upon you when the case was disclosed?
11. What was the feeling, problems or effects you experienced after you have been sexually abused? (Problems you faced because of the abuse.)
12. Have you ever noticed any behavioral change after the case is disclosed and stopped?
13. Is the sexual abuse disturbing your or your families' everyday life?
14. At present, what serious problems are you facing after the abuse?
15. What are the measures taken by you and by those close to you after the case is disclosed? Are you feeling better by the measures?

Appendix E

Interview Guide for Parents of Sexually Abused Child

Background Information

Age (Mother/Father) ----------
Educational Background ----------
Occupation/Income ----------
Number of Children ----------
Sub-city ----------

The Interview:

1. Who is the perpetrator of the crime?
2. By whom is the case disclosed? What was the intention of the discloser?
3. How was the way survivor child explained the case?
4. What was the reaction of the parent? (How did the parent react on hearing the explanation about the sexual abuse narrated by the survivor child? Was it by listening attentively, by crying, by hiding what happened, by blaming the abused or other?)
5. What was the reaction and attitude of other family members and the society at large after the case is disclosed?
6. What are the problems you see your child faced after the abuse occurred?
7. How serious or severe was the effects of sexual abuse on the survivor child?
8. Have you seen any behavioral change on the child after the case is disclosed?
9. Is the abuse interfering the child's behavior with her/his abilities to function through everyday life?
10. What are the measures taken after the case is reported?
11. Have you seen any changes on the survivor child?

Appendix F

Interview Guide for the Counselor(s)

Instruction: This interview is designed to be conducted with counselors working with sexually abused children. The main objective of the interview is to assess the possible psychosocial effects (that) sexually abused children faced and their coping mechanisms. It is believed that your participation in giving full information, opinions, feelings and reactions on the issue is highly crucial and base for good outcomes in this study. This information will only be used for nothing else other than for research purpose.
For your cooperation and willingness, I thank you very much in advance.

Personal Information

Age ----------
Sex ----------
Educational background ----------
Experience as a counselor ----------

1. Who commits the child sexual abuse?
2. What are the reactions to having been sexually abused?
3. Why are people (victims, their families, others) so reluctant to talk about sexual abuse or violence?
4. How was the way the survivor child explained the case?
5. What are the most serious psychological and social consequences or effects you observed from the victim child?
6. Are all sexually abused victims equally suffering the consequences or effects of the sexual abuse?
7. What are the coping mechanisms most sexually abused children used?
8. How does one cope most effectively with stress?
9. How do victims of sexual abuse seek and receive social support?
10. As a counselor, what do you suggest in order to prevent or stop child sexual abuse?
11. Is there any change that you have seen on the victims? If so, what contributes to this change?
12. Last, but not least, how do you get the legal aspect of child sexual abuse in our country-Ethiopia?

PTSD Checklist Civilian version (PCL)

Name: _____

INSTRUCTIONS TO PATIENT: Below is a list of problems and complaints that people sometimes have in response to stressful experiences. Please read each one carefully, put an X in the box to indicate how much you have been bothered by that problem in the past month.

1. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience? *1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely*

2. Repeated, disturbing *dreams* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

3. Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

4. Feeling *very upset* when *something reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

6. Avoiding *thinking about* or *talking about* a stressful experience or avoiding *having feelings* related to it?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

7. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

8. Trouble *remembering important parts* of a stressful experience?

   1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

9. *Loss of interest* in activities that you used to enjoy?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

10. Feeling *distant* or *cut off* from other people?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

12. Feeling as if your *future* will somehow be *cut short*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

13. Trouble *falling* or *staying asleep*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

14. Feeling *irritable* or having *angry outbursts*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

15. Having *difficulty concentrating*?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

16. Being *"super-alert"* or watchful or on guard?

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

17. Feeling *jumpy* or easily startled?

Weathers, Litz, Huska, & Keane; National Center for PTSD - Behavioral Science Division

Both the Anxiety and Emotional Distress scales were taken as they are without any modifications.

Translated Versions

አዲስ አበባ ዩኒቨርስቲ

የድህረ ምርቃ ኮሌጅ

ሳይኮሎጂ ትምህርት ክፍል

መመሪያ- ቀጥሎ የተዘረዘሩትን ህፃናት ወሲባዊ ትንኮሳ አማካኝነት የደረባቸውን አሰቃቂ አደጋ ተከትለው የሚከሰቱ የመንፈስ መረበሾች ችግሮች ናቸው:: ጥያቄዎቹን በማንበብ አንተን አንቺን ምን ያህል እንዳስጨነከህ/እንዳስጨነቀሽ ሃሳቤን ይበልጥ ሊገልፅ ይችላል የምትለውን/የምትይውን ከተሰጡት አራት ምርጫዎች ውስጥ ምረጥ/ምረጭ:: መረጃዎች በሙሉ በሚሰጪር ይጠበቃሉ ስለትብብርህ/ሽ በቅንሚያ አመሰግናለሁ

0- ምንም ጊዜ ብቻ 1- በሳምንት አንድ ጊዜ

2- በሳምንት ከሁለት እስከ አራት ጊዜ 3- በሳምንት አምስት ጊዜና ከዛ በላይ

1	የሚያስጨንቁ ሀሳቦችና ምስሎች ባልፈለኳቸው ጊዜ ወደ ሃሳቤ ይመጣሉ	0	1	2	3
2	አስፈሪ ህልሞችና ቅዥቶተ አያለሁ	0	1	2	3
3	አሰቃቂው አደጋ በድጋሚ የሚከሰት ይመስለኛል	0	1	2	3
4	ስለ አሰቃቂው አደጋ ባሰብኩ ጊዜ በሰውነቴ ላይ የተለያዩ አካላዊ ለውጦት ይታያል	0	1	2	3
5	ስለ አሰቃቂው አደጋ ባሰብኩ ቁጥር እረበሻለሁ	0	1	2	3
6	ሰለ አሰከፊ አደጋ መናገርና ማሰብ አልፈልግም	0	1	2	3
7	አሰቃቂው አደጋ ሊያስታውሱ የሚችሉ ቦታዎች ሰዎችንና ድርጊቶችን አሶግዳለሁ	0	1	2	3
8	የአሰቃቂውን አደጋ ዋና ክፍል ማስታወስ አልፈልግም	0	1	2	3
9	አሰቃቂው አደጋ ከመድረሱ በፊት የማክናውናቸውን ድርጊቶች አሁን ለማድረግ ያለኝ ፍላጎት ዝቅተኛ ነው	0	1	2	3
10	ስሜቴን በአግባቡ መግለጽ እቸገራለሁ	0	1	2	3
11	የወደፊት እቅዶቼ ትግባራዊ ይሆናሉ የሚል ግምት የለኝም	0	1	2	3
12	እንቅልፍ የማጣት ችግር አለብኝ	0	1	2	3
13	የመነጫነጭና በቀላሉ የመናደድ ስሜቶች ይታይብኛል	0	1	2	3
14	ሀሳቤ በቀላሉ ይበታተናል	0	1	2	3
15	መጠራጠር አበዛለሁ	0	1	2	3

የስሜት መረበሽን መለኪያ ስኬል

ቀጥሎ የተዘረዘሩትን ጥያቄዎች ከአራት ነጥብ ስኬሎች ውስጥ አንተ/አንቺን ይበልጥ ጥ ሊገልጽ የሚችለውን ምረጥ/ምረጪ :: መልሱ በከፍተኛ ሚስጥር ይጠበቃል:: አመሰግናለሁ::

አራት ነጥብ ስኬሎችም

1. ምንም ጊዜ
2. እንዳንድ ጊዜ
3. ብዙ ጊዜ
4. በጣም ብዙ ጊዜ

1	የፈለኩትን ወዲያው እንዲፈጸምልኝ እፈልጋለሁ	1	2	3	4
2	ብቻዬን መተኛት አልፈልግም	1	2	3	4
3	ያለበቂ ምክንያት ፍርሃት ይሰማኛል	1	2	3	4
4	ጭንቀት ይሰማኛል	1	2	3	4
5	ያለበቂ ምክንያት አለቅሳለሁ	1	2	3	4
6	ማዘንና መገለል ይሰማኛል	1	2	3	4
7	ብቻዬን መሆን አልፈልግም	1	2	3	4
8	እቅበጠበጣለሁ	1	2	3	4
9	በቀላሉ እበሳጫለሁ	1	2	3	4
10	በቀላሉ እደነግጣለሁ	1	2	3	4
11	ሃይለኝነት ይታይብኛል	1	2	3	4
12	አሰቃቂውን አደጋ በተደጋጋሚ አስታውሳለሁ	1	2	3	4
13	በጨዋታ መሀል ስለአሰቃቂው አደጋ እናገራለሁ	1	2	3	4
14	የደረሰብኝን አሰቃቂ አደጋ ብጠየቅም መናገር አልፈልግም	1	2	3	4
15	አሰቃቂውን አደጋ ሊያስታውሱ የሚችሉ ነገሮችን እፈራለሁ	1	2	3	4

የጭንቀትን መጠን መለኪያ ስኬል

ቀጥሎ የተዘረዘሩተን ጥያቄዎች በማንበብ አዎ ወይም አይሰለም በማለት መልስ ስጥ/ስጭ ዓ.ነገሩ ለአንተ/ለአንቺ የሚሰራ ከሆነ አዎ የማይሰራ ከሆነ ደግሞ አይደለም በማለት መልስ/መልሽ:: ስለትብብርህ/ሽ በድጋሚ አመሰግናለሁ::

1	ያሰበኩት ሳይሳካ ሲቀር እረበሻለሁ	አዎ	አይደለም
2	ከኔ ይልቅ ሌሎች የሚፈልጉትን ሥራዎች በቀላሉ የሚሰሩ ይመስለኛል	አዎ	አይደለም
3	ሠዙ ጊዜ እጨነቃለሁ	አዎ	አይደለም
4	ሁል ጊዜ ብሩህ ነገር ይታየኛል	አዎ	አይደለም
5	በቀላሉ እበሳጫለሁ	አዎ	አይደለም
6	የምሰራውን ሁሉ ሌሎች የሚቀበሉት አይመስለኝም	አዎ	አይደለም
7	ምሽት እንቅልፍ በቀላሉ አይወስደኝም	አዎ	አይደለም
8	ከሰዎች ጋርም ሆኜ ብቸኝነት ይሰማኛል	አዎ	አይደለም
9	ስሜቴ በቀላሉ ይጎዳል	አዎ	አይደለም
10	እጆቼን ያልበኛል	አዎ	አይደለም
11	ምጣም ይደክመኛል	አዎ	አይደለም
12	ከኔ ይልቅ ሌሎች ደስተኞች ናቸው ብዬ አስባለሁ	አዎ	አይደለም
13	የማልመው ሁሉ አስፈሪ ነው	አዎ	አይደለም
14	ስጨነቅ ስሜቶቼ በቀላሉ ይጎዳሉ	አዎ	አይደለም
15	ስህተቴን ሰዎች ሁሉ የሚያርሙኝ ይመስለኛል	አዎ	አይደለም
16	አንዳንዴ ደንግጬ እነሳለሁ	አዎ	አይደለም
17	ምሽት ለመተኛት ስዘጋጅ ጭንቀት ይሰማኛል	አዎ	አይደለም
18	ሀሳቤን የማሰባሰብና በትምህርት ላይ ማተኮር እቸገራለሁ	አዎ	አይደለም
19	ስቀመጥ እቁነጠነጣለሁ	አዎ	አይደለም
20	በቀላሉ እረበሻለሁ	አዎ	አይደለም
21	ተቃዋሚዎቼ በርካታ ናቸው	አዎ	አይደለም
22	መጥፎ ነገር ደርሶብኛል ብዬ እበሳጫለሁ	አዎ	አይደለም

Declaration

I the undersigned, declare that this thesis is my work and that all sources of material used for this thesis have been duly acknowledged.

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Signature 29/08/07.

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

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Date: 05.07.07