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Exploring Symptoms of Post-Traumatic Stress Disorder among Sexually Abused Children at Safe House

Sonan Daniel

A Thesis Submitted to the School of Social Work Addis Ababa University

In Partial Fulfillment of the Requirements for the

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Approval Form

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Approved By Examining Board

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Examiners

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2. _____Signature _____ Date_____

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Acknowledgement

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Abstract

The main objective of this study was to assess the symptoms of post-traumatic stress disorder among sexually abused children and to assess factors that aggravate the onset of the symptoms. The study employed cross-sectional descriptive design with quantitative method of data collection. The participants of the study were 41children who are between the age of 12-18 and who are temporarily residing at Safe House for psychosocial rehabilitation for being sexually abused. To assess symptoms of PTSD two scales namely the Child's Reactions to Traumatic Events Scale (CRTES-R) and Child Posttraumatic Stress Disorder Symptom Scale (CPSS) were utilized. The findings revealed that, all the studied sexually abused children at Safe House have shown full diagnostic criteria of PTSD. However, based on the participants' scores in the two scales, participants were categorized under moderate and sever level of PTSD. Accordingly, when 95% participants categorized under moderate level of PTSD, 5% participants were categorized under sever level of PTSD in the PTSD diagnose scale. On the other hand, the result found in the revised PTSD reaction index categorized 39% participants under low and 61% participants under mild level of distress. Nature of abusive acts such as, frequent abuse, giving birth due to rape, the closeness of offenders' relation with the victims and the response the victims got when they first disclose the abuse were significantly correlated with the occurrence of symptoms of PTSD. The type of counseling given to traumatized sexually abused children was also found to be different from what was supposed to be given to these children. Based on the study findings, to optimize the outcome of the treatment given to these children, professional social workers engagement in developing indigenous manuals and guidelines that help organizations provide these children with appropriate psychosocial service which is based on the specific sequelas of abuse and age category was recommended.

Keywords: Post-Traumatic Stress Disorder; Child sexual abuse, Trauma Focused-Cognitive Behavioral Therapy, Distress Levels for the Child's Reactions to Traumatic Events Scale(CRTESR), Child PTSD Symptom Scale (CPSS), Safe House

Chapter one

Background

Child sexual abuse is an unfortunate reality for many children in the world. Studies on child sexual abuse show child sexual abuse is an international problem affecting children across nations. A cross-sectional study conducted in Addis Ababa shows the pervasiveness of sexual abuse of children in Ethiopia as it is in other parts of the world this study identified child sexual abuse prevalence rate of 38.5 % among the general public Jibril (2012, p.60)

The growing awareness of its high prevalence rate has led scholars study the significant immediate and long-term psychological distress of the abused children. Briere & Elliott (1994) in their study indicated sexually abused children are at higher risk of developing a wide range of psychological problems than their non-abused counterparts.

On the other hand, although sexually abused children may face a wide range of difficulties, according to studies conducted by Deblinger et al, (1989); Goodwin (1988); McLeer et al (1988) many of the impacts fall within the diagnostic criteria of posttraumatic stress disorder. Ombok et al (2013) in his study denoted posttraumatic stress disorder as a major psychological impact millions of sexually abused children worldwide experience.

Understanding the type of impact the abuse lingered on the abused is the determinant factor in choosing the kind of intervention that best solve the problem. Thus this study was meant to assess the onset of post-traumatic stresses disorder and factors that aggravate the development of Post-traumatic stress disorder among sexually abused female children at safe house.

Statement of the problem

Child Sexual abuse is one of the common problems worldwide. As a result, a range of studies have been conducted internationally and locally in different dimensions. Internationally, Lalor & Rosaleen, (2012); Douglas & Finkclhor, (2005); Kisanga, (2012); Lalor, (2005) studied the prevalence of child sexual abuse, in Europe, America and Tanzania, their finding show high rate of prevalence in the studied area. In addition, Cox et al, (2007) have studied the prevalence of child sexual abuse in Africa. Accordingly, in South Africa, there was 527333 sexual abuse reports in 2003/2004 almost half of them involving children. This study also indicates that the number and severity of injuries have increased yearly.

This is fact also holds true in Ethiopia. Gebre et al, (2009); Jibril (2012); Getnet, (2000) Ethiopian Ministry of Health [MOH], (2007); Worku & Addisie, (2002) their study findings show that child sexual abuse is a very prevalent problem Ethiopian children often face. According to Jibril (2012) in Ethiopia, out of the total reported crime cases committed against children, 23% of them were child sexual victimization.

Risk factor for child sexual abuse also has got much emphasis and has been studied by various researchers. Gebre et al (2009); Alemayehu (2013); Finkelhor & Douglas (2000) studied risk factor for child sexual abuse and indicate family breakdown, street vending, children with physical and developmental impairment and having step father as major risk factors for child victimization. Alemayehu (2013) also shows children working as maidservants and children who are destined to street life as exceedingly exposed to sexual violence. On the other hand, Finkelhor & Douglas (2000) found females, teens, children from low income family, and family problems such as parental alcoholism, parental rejection, and parental marital conflict to be the major risk factors for victimization.

The relationship of the perpetrators with the victims has been studied by different researchers, Bolen & Scannapieco (1999); Wonderlich et al, (1996); Finkelhor et al (2005) in their studies the majority of perpetrators were found to be acquaintances and family members. Similarly, in a study conducted by Lakew (2001) 50% of the participants were abused by someone the children know and 30-40% participants were abused by family members (incest).

Researchers also have found different reasons for why most victims of sexual abuse remain silent. Mary et al (2000); London et al (2005); Leander (2007) in their study, intimidation by the perpetrator was the major reason that holds back the study participants from disclosing the abuse early. In contrary, in a study conducted in urban Tanzania by Kisanga (2012) Problems such as fear of not being believed, lake of evidence, difficulties in confirming evidence and providing support, procedures and institutions for handling cases of child lack of working tools and financial support were perceived as major problems for not suing the rapist.

Studies also have shown the context in which most sexual abuses take place. Mark (2008) in his study identified family; schools and educational settings; institutions (care and judicial); the work place and the community as potential settings most sexual abuses take place. Similarly, Getenet & Desta, (2008) showed high prevalence of sexual abuse in the neighborhood, school, street and home environment.

The experience of having been sexually abused is associated with a wide range of long and short term sequelas. Ramchandani & David (2003); Kendall-Tackett et al (1993); Berliner & Elliott (2002); Putnam (2003) studied the long and short-term impacts of child sexual abuse; the result shows children who have been sexually abused face different kinds of psychological, physical, emotional, social and health problems either immediately after the abuse or later in adulthood. Alemayehu (2013) conducted a study on Psychopathological correlates of sexual

abuse in female students in Jimma zone, depression, panic anxiety and post-traumatic stress disorders were found to be the major difficulty the studied children faced. Girgira et al (2014) on the other hand, studied the health impact of child sexual abuse at two tertiary hospitals in Addis Ababa the study identified lost virginity, STI, Sustained perennial laceration, developed chronic rectal pain, unwanted pregnancy, became incontinent to urine and faces and Sustained soft tissue injury as the immediate health impact of sexual abuse.

The idea that PTSD is the major psychological sequela sexually abused children often face as a result of their experiences, has gained wide acceptance. King et al (2003); Dyb, (2005); Bruce & Perry (2007); Neuropsychiatric Disease and Treatment (2011) studied the prevalence of PTSD among sexually abused children the finding shows high rate of PTSD prevalence among the studied population. As it is stated in the work of Briere & Elliott, (1994); Bruce, Perry& Ishnella, (1999), PTSD was at first alleged to the reaction of adults to disasters, accidents, and combat experiences. However, more recent research such as Ombok et al, (2013); Widom, (2013); kaminer et al, (2008) has linked short- and long-term posttraumatic symptoms to childhood sexual abuse.

Studies on PTSD discovered common symptoms of PTSD on victimized children National Center for PTSD (2008); Chris & Emily (2002); Deblinger, Steer &Lippmann (1999) Alter-Reidet al (1986); Kendall-Tackett, Williams, & Finkelhor (1993); Wolfe & Birt (1995) indicated elevated anxiety, depressive symptomatology, inappropriate sexual behavior, nightmares, social withdrawal, sleep difficulties, anger, and shame/guilt and school problems as major symptom of PTSD. However, a diagnosis of DSM-IV PTSD by American Psychiatric Association (2012) classified the symptom of PTSD indicators into 7 categories for diagnosis criteria of PTSD.

Studies also have showed the different factors exacerbating the development of post-traumatic stress disorder among sexually abused children. According to a study conducted by Kaminer et al (2005) post-traumatic stress disorder is associated with the degree of physical or verbal abuse during sexual abuse, injuries during assault, absence of social support, duration of the abuse and familial abuse. Likewise, in a study conducted by Ombok et al (2013) highest PTSD symptoms were found in children who have encountered enduring abuse, who refrained from disclosing the abuse and who had parental or family problems. Others on the other hand, in addition to the aforementioned factors, have found home care as a major aggravating factor for the development of PTSD in sexually abused children. Dunn,Culhane, & Tassig (2010) conduct a study on abused children who are in a group care regarding their experiences and feelings to the system of care they receive, the results showed that children felt less loved and less safe and they were generally dissatisfied with their experience. In contrary, (Friedman, 2010) argues that though out of home care has its own drawbacks, it is a best option in certain situation.

Studies on the treatment of children suffering from PTSD also have been conducted. Findings across many studies suggest TF-CBT as the most effective therapy for sexually abused children suffering from PTSD for instance, (Cully& Teten (2008); National Child Traumatic Stress Network; (2004); Macdonald et al, (2012); Neuropsychiatric Disease and Treatment (2011) studied the effectiveness of a range of treatments to sexually abused children the result found TF-CBT as being one of the most effective interventions for children who have significant psychological symptoms related to trauma exposures.

In summary, despite differences in how it is explained, there is a general consensus amongst researchers that the sexual abuse of children when accompanied by various

aggravating factors, pave the way for the development of PTSD. The available researches done in Ethiopia on the one hand are limited in answering prevalence of child sexual abuse, impact of sexual abuse such as health, physical, emotional, social and risk factors for child sexual abuse on the other hand, the studies were done in sub cities, high schools, universities and hospitals. On such settings even though the impact of sexual abuse on the children can be identified, the victim children cannot be provided with appropriate treatment for the impact of the abuse following the studies finding.

In Ethiopia studies on posttraumatic stress disorder in sexually abused children who are in rehabilitation center is inadequate. Since the awareness of the impact of abuse on victim children is the determinant factor in the efficacy of the support the agency provides, studying the presence of symptoms of PTSD among this population is vital. Thus by assessing symptoms of PTSD and factors aggravating the onset of PTSD in sexually abused children at safe house, this study has addressed this gap.

Significance of the study

Safeguarding young girls from any kind of sexual abuse is an unequaled way to brighten a child's future. However, since encountering such cases is inevitable, providing sexually abused children with proper and effective psychosocial therapy is imperative. Providing sexually abused children with a proper and effective counseling requires awareness about the impact the abuse results. As various empirical findings indicated, it is vital that children who have been affected by childhood sexual abuse receive the best therapeutic help that they can get; this will benefit them throughout their childhood and adulthood.

Very few Non-governmental organizations in Ethiopia provide psychosocial services to victimized children. Safe house is one of them. However this agency doesn't only serve

sexually abused children, but children and adults who faced physical abuse are also the target group of the agency. As researchers indicate since the case of sexually abused children and children's experiences of physical or other maltreatment are quite varied, a thorough assessment of the impact of the abusive act should be done before the initiation of treatment.

Since research is one way of solving a certain problem, I believe that the prevalence of Post-traumatic stress disorder among sexually abused children should be supported by a research to determine the type of psychosocial provision that best solve the children's problem. Thus the finding of this study will help the organization understand the prevalence of Post-traumatic stress disorder among the abused children in the agency so that, the counselors will either be able to continue with the current intervention techniques or can use the finding to plan different interventions. In addition to this, since this is one concern of social worker, it is essential to have an awareness of the most prevailing psychological consequences of sexual abuse to optimize the outcome of the treatment given to these children. Hence, the study will have some contribution for the social work education and practice.

Objectives of the study

General objective

The general objective of this study was to assess symptoms of post-traumatic stress disorders among sexually abused children residing at safe house and to assess factors aggravating the development of post-traumatic stress disorder among the study population.

Specific objectives

- To assess symptoms of post-traumatic stress disorder in sexually abused children at safe house.

- ❖ To identify factors that are most strongly related to the development of posttraumatic stress disorder.
- ❖ To assess the type of counseling given to sexually abused children at safe house.

Research questions and hypothesis

1. What are the most common PTSD symptoms in sexually abused children at safe house?
2. What factors are associated with the development of PTSD?
3. What kind of counseling is given to sexually abused children at safe house?

Hypothesis 1; the nature of sexual abuse (i.e. duration, and closeness of the victim's relationship to the offender, having a child due to rape and response of the person whom the victim disclosed the abuse) exacerbate the occurrence of PTSD symptoms.

Hypothesis 2; if TF-CBT for sexually abused children suffering from PTSD is available in the organization, the symptomatology of PTSD in the abused children decreases.

Conceptual definition

The dependent and independent variables of this study are conceptually defined below.

Child sexual abuse ; National Sexual Violence Resource Center (2010) defines child sexual abuse as an act of violence that occurs whenever a person who is below the age of 18 forced, coerced, and/ or manipulated into any unwanted sexual activity, including, but not limited to rape, molestation and fondling.

Sexually abused child; a female child who is below the age of 18 whom for this particular research has encountered sexual penetrative act by someone who is related to the child or stranger to the child.

Social support: defined as "the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us" (Sarason, Levine, Basham, &

Sarason, 1993, p. 127). In this study social support is the existence and supportive responses of people (family, parent, and friends) to the child's disclosure of abuse.

Post-traumatic stress disorder: refers to certain enduring psychological symptoms that occur in reaction to a highly distressing, psychically disruptive event (Briere & Elliott, 1994).

According to the National Institute of Mental Health (n.d) "PTSD is an anxiety disorder that may develop following an individual's experiencing or witnessing of a traumatic event, where the natural "fight or flight" response is damaged or altered". Similarly, NICE clinical guideline (2005) described PTSD as a stress disorder that developed following a stressful event or situation of an exceptionally threatening or catastrophic nature which doesn't include incidents people usually face in their everyday life. The common symptoms of PTSD are defined below.

Re-experiencing; the characteristic symptoms resulting from exposure to traumatic stressors include persistent re-experiencing reflecting the traumatic events. Distressing, repeated and intrusive recollections of traumatic events include images, thoughts or perceptions as a cluster whilst awake or in dreams (Brier & Lanktree, 2008).

Avoidance and numbing; Avoidance of stimuli associated with the traumatic experience includes willful avoidance; Efforts to avoid feelings, places, activities and people that remind the person of what happened. (King et al, 2008)

Hyper arousal includes sleep disturbances, irritability, difficulties concentrating and hyper vigilance that were not present before the trauma (Dyb, 2005)

Nature of abusive acts; In this study, frequency of abuse, giving birth due to rape, response of a person who heard the abuse and offenders relation with the victims are independent variable and they are assumed to be factors that acerbate the occurrence of the independent variable which is PTSD.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms, depression, behavior problems, and other difficulties related to traumatic life experiences Macdonald, et al(2012).

Safe house; women's shelter often alternatively called woman's refuge or is a place of temporary refuge and support for women escaping violent or abusive situation, such as rape and domestic violence it also deal with related issues such as housing victimized children both male and female, fleeing abuse as well as providing legal aid for domestic violence victims, among many other services (Kathleen & Tierney, 1982, p.207)

The assumption here is when the occurrence of sexual abuse is accompanied by all the aforementioned independent variables, the chance of developing (the dependent variable) post - traumatic stress disorder will be folded and if traumatized sexually abused children are provided with TF-CBT the symptomatology of PTSD decreases and victimized children will be resilient.

Limitation of the study

While this study does add new information to the research literature on the onset of PTSD symptoms among sexually abused children, the reported results should be interpreted while considering the possible limitations of this study.

1, Inability to involve parents or guardians in the study. 2, In spite of the orientation given to the participants prior to data collection, there was low response rate from four participants and this was due to the sensitive nature of the questions. 3, by the time I went to the organization to conduct the research 9 children have been discharged from the Safe House, thus I was obliged to involve the newly arrived respondents who do not have any counseling.

This made evaluating the counseling which was one of the study's objectives impossible. 4, validity of the scale for Ethiopian context this has challenged the children's capacities to understand and respond accurately to items. These limitations questioned the generalizability of the study finding in other settings.

Chapter two

Literature review

Historical back ground

As Lalor (2010) stated literature on child sexual abuse existed for almost one and half century. However, as Becker (2008) indicates public awareness did not occur until the late 20th century. McElvaney& Lalor (2010) argue that 1960 following the battered child syndrome child sexual abuse came in to the picture. The feminist's anti-rape movement in the early 1970s also had a significant role in making the problem public (as cited by Klein, 2010). Later on following the argument proposed by psychologists, people instigated to tell the truth about sexual abuse so as to heal the impact of abuse and take concerted action against it (Hunter, 2010). Gradually, when the problem begun to knock everyone's door it became a public concern and today it's a well-known evil for a society. As cited by Hall & Hall (2011) Childhood sexual abuse is a subject that has received much attention in recent years. As a result, (as cited in Ulrich, 2007) laws has been quickly enacted in several states to address an array of sex crimes involving both adults and children.

In Ethiopia, as Getenet and Desta (2008) stated a number of studies regarding child sexual abuse started to carry out in the early 90's yet, the studies have not gone beyond providing a sketchy detail of the problem. However, following these studies, various

international and national legal instruments have adopted and came in to force in the country to protect children from all forms of abuse and exploitation.

Child sexual abuse definition

Due to the different acts and behavior it encompasses, child sexual abuse lack common definition (Ulrich, 2004). However, various international organization and individual researchers have defined child sexual abuse differently." Childhood sexual abuse may be defined loosely as any act against a minor that is sexual in nature including voyeurism, fondling, and sexual intercourse" (Viviani, 2010.P 2).

> Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (As cited in WHO department of women & health, 2003.p 13).

World Health Organization (2002) referred child sexual abuse as a major public health issue. According to national clearing house on child abuse and neglect, sexual abuse is sexual activity involving persons younger than 18 years of age most often perpetrated by an adult, such activities include rape and molestation, sexual harassment and exposure of children to the sexual act of others (as cited in Getnet & Desta, 2008).

In this study the definition proposed by National Sexual Violence Resource Center (2010) which sees child sexual abuse as an act of violence that occurs whenever a person who is below the age of 18 forced, coerced, and/ or manipulated into any unwanted sexual activity, including, but not limited to rape, molestation and fondling will be used.

Prevalence of child sexual abuse

Viviani (2011,Pp.3) stated that Childhood sexual abuse is prevalent, but taboo topic in society Conservatively 80,000 new cases are reported each year with many more either unreported or unsubstantiated within the legal system. A study by the U.S. Department of Health and Human Services (2010) shows over 70,000e sexually abused children under the age of 18 in 2008.

A 2004 WHO review of research estimated the global prevalence of childhood sexual victimization to be about 27% among girls. More specifically, that review found the average prevalence of reported childhood sexual abuse among females to be around 7–8%. In studies from South and Central America and the Caribbean, as well as from Indonesia, Sri Lanka and Thailand, estimated prevalence was as high as 28% in parts of Eastern Europe, the Commonwealth of Independent States, the Asia–Pacific region and North Africa (as cited in WHO & Pan American Health Organization, 2014).

According to a study conducted by Cox et al (2007) over the past decade, reported sexual violence against children in Africa has increased by 400%. One U.S governmental source counts 78,188 child victims of sexual abuse in 2003 that's a rate of 1.2 per 1,000 American children (as cited by Douglas and Finkelhor, 2003). The 2001 National Crime Victimization Survey (2005), which only covers youth 12-17, estimates that 1.9 per 1,000 children are raped or sexually assaulted. Similarly, as quoted by National Sexual violence research center (2012) in the U.S. studies shows that, one in four girls are sexually abused before their 18th birthdays. As cited in the work of Liya (2011) the meta-analysis done by analyzing sixty-five articles from twenty-two countries also revealed that 19.7% of women

are exposed to sexual abuse before the age of eighteen. A study conducted by Lalor & McElvaney (2010) also revealed occurrence of sexual abuse of children throughout Europe.

Research evidence on child sexual abuse incidence in Ethiopia is relatively scarce however, the available researches confirms the global fact also holds true in Ethiopia. Gebre et al, (2009); Jibril (2012); Getnet, (2000) Ethiopian Ministry of Health [MOH], (2007); Worku & Addisie, (2002) their study findings show that child sexual abuse is a very prevalent problem Ethiopian children often face. According to a study conducted by Getnet & Desta in (2008) a significant proportion of girls (66.6%) reported to have encountered different forms of sexual abuse in other words 6 out of 10 girls in the city face sexual violence in one or another form in everyday life. Alemayehu also showed that estimates of the incidence of sexual abuse ranges from 15% to 22% or higher. In 2012 study Jibril indicated that, of the total reported crime cases committed against children (between July 2005 and December 2006), 23% of them were child sexual victimization. A cross-sectional study conducted in Addis Ababa identified child sexual abuse prevalence rate of 38.5 % among the general public (Jibril, 2012, p.60).

As cited in the work of Girma (2006) statistically, in Ethiopia over 5.5 million children live under extremely difficult circumstance which as a matter of fact most of these children are exposed to different forms of abuse and exploitation accordingly, the problem of child sexual abuse and exploitation has become one of the major concerns of the country. A recent study conducted in five regional states (Amhara, Oromia, SNNPR, Tigray,and Addis Ababa) by African Child Policy Forum on violence against children including sexual violence generally indicated the prevalence of all type of sexual violence including rape, sexual harassment, and abduction in all the study sites (As cited by Girma, 2006). Another study

conducted in some selected sub cities of Addis Ababa (Addis ketema, Cherkos, yeka and Nifas silik) , "estimated number of 3 girls are raped each day in each of the sub cities in Addis Ababa resulting in a total of 30, 660 rape cases every year" (as cited in Getnet & Desta, 2008,pp. 17). According to African child policy forum on the state of violence against girls including sexual violence, in Ethiopia nearly 7/10 girls are sexually abused and 3/10girls will be sexually abused at least once before reaching the age of eighteen while slightly than half (46%) of the girls in the study reported that they were sexually abused three to ten times (Getnet & Desta, 2008). A data obtained from FSCE information booklet indicates, in three years period (2000-2002) a total of 3099 abused children (1707 females) were reported to the child protection units in the four cities(Addis Ababa, Dessie, Diredawa, and Nazareth) (Girma, 2006).

Risk factor for victimization

A number of factors that make individual children vulnerable to sexual abuse have been identified. According to the experience in North American countries, the key determinants are believed to be female sex, unaccompanied children; children in foster care, stepchildren physically or mentally disabled children, history of past abuse; poverty; war, psychological or cognitive vulnerability; single parent homes; social isolation; parent (s) with mental illness or drug dependency (guidelines for medico-legal care for victims of sexual violence, 2003, pp. 76)

In addition, Finkelhor (2009) found a strong association between not living with both parents, residing in families characterized by parental discord, divorce, violence, impaired supervisory capacities and histories of sexual abuse.

In a study conducted in by Gebre et al (2009) in Ethiopia and the capital of Addis Ababa, Children's exposure to sexual abuse is found to be exacerbated by poverty, family

breakdown, and child migration and trafficking. Children who migrated from countryside to live with kin or to work as a domestic servant are also at high risk of victimization. According to a survey done by form on street children Ethiopia (FSCE) in 2005 of 84 child domestic servants in Addis Ababa, 60.0% of these children experienced sexual harassment by the male household heads or their sons. Similarly, a study of Child sexual abuse conducted in urban Tanzania, Kisanga (2012) showed an increased rural urban migration with people seeking employment opportunities and better living conditions predisposed girls aged 10-19 years to have sex with adults.

In a study conducted in 10 North African countries, insufficient food at home; being over 13 years of age, low knowledge of children's rights, a high proportion of students experiencing or perpetrating abuse, alcohol abuse, high rates of intimate partner violence, and adults involved in transactional sex were found to be at higher risk of being sexually abused factors that expose children to sexual abuse (as cited by Kisanga, 2012).

Offender's relation with the victim

The relationship of the perpetrator to the victim has been studied by different researchers. According to Lakew (2001) out of the total reported child sexual abuse cases, 50% of them were committed by someone the children know, close and trust while about 30-40% was committed by family members (incest). On the other hand, (Bolen & Scannapieco, 1999; Wonderlich, et al, 1996; Finkelhor, et al, 2005) argued the majority of perpetrators to be acquaintances and family members. The finding of investigation by Hall & Hall, (2011) in contrary argues, most victims are abused by their family. In another study conducted by Kisanga (2012) in urban Tanzania most often Perpetrators were neighbors, teachers and peers. while a study finding in Ethiopia indicates 36% strangers, 31.5% school mates, 16.7% family

members (comprising 1.4% father, 9.3% step father, 2.3% elder brother, 0.9% uncle, 5% other family members) and 15.8% neighbors (as cited by Lalor & McElvaney, 2010). As cited in Lalor & McElvaney (2010). Victims are far less likely to report child sexual abuse when it is perpetrated by somebody close to them for reasons of fear of perpetrator, fear of consequences, embarrassment, and shame.

Barriers to discloser

Numerous factors are mentioned as barriers that prevent the abused child or her family from disclosing the case. A child's self-disclosure of sexual abuse is a critical component in initiating intervention to halt the abuse, address its immediate effects, and decrease the likelihood of negative long-term Outcome (Mary et al, 2000). However, the empirical basis for the child sexual abuse accommodation syndrome (CSAAS), a theoretical model posits that most abuses remain secret. London et al (2005) have conducted a study on children who didn't disclose the abuse at the onset according to their finding 67% of the studied sexually abused children refrain from disclosing the abuse because they were intimidated by the perpetrator. A study conducted by Leander (2007) also showed that the majority N=340 of the studied sexual abuse survivors did not disclose the abuse at childhood because of intimidations.

In a study done by Kisanga (2012) Problems such as not being believed, lake of evidence, difficulties in confirming evidence and providing support, procedures and institutions for handling cases of child lack of working tools and financial support were perceived as major problems among the key professionals. Community passivity and lack of knowledge about laws regulating sexual offences were identified as additional challenges for conducting fair investigation for child abuse reports

The context of sexual abuse

Regarding the setting where sexual abuse of young girls often occur, mark(2008) in his study identified five potential settings such as family; schools and educational settings; institutions (care and judicial); the work place and the community. Getenet & Desta (2008) on the other hand argue, In every setting be it family (home), neighborhoods, schools, streets and work places seem to be unpredictably unsafe for young girls however, the home setting is the major hidden, but emerging environment where young girls face sexual abuse. Their finding further indicates child sexual abuse in the neighborhood environment is reported by 32.3%, school20% street19.3% home environment (13.8%) and bars/cafes (9.6%) work place and friend's house were reported by 4.5% and 3.3% respectively.

Post-traumatic stress disorder as a major sequela of CSA

Van der kolk (1997, p.279) defined trauma as the result of exposure to an inescapably stressful event that overwhelms peoples coping mechanism. Posttraumatic stress refers to certain enduring psychological symptoms that occur in reaction to a highly distressing, psychically disruptive event (Briere & Elliott, 1994). According to the National Institute of Mental Health (N.d) "PTSD is an anxiety disorder that may develop following an individual's experiencing or witnessing of a traumatic event, where the natural "fight or flight" response is damaged or altered". Similarly, NICE clinical guideline (2005) described PTSD as a stress disorder that developed following a stressful event or situation of an exceptionally threatening or catastrophic nature which doesn't include incidents people usually face in their everyday life. Thus according to this definition problems such as divorce, loss of job or failing an exam doesn't lead one develop PTSD.

Child sexual abuse and PTSD

Child sexual abuse is reported in various studies as highly prevalent problem that frequently occasions the onset of posttraumatic stress disorder in the victimized children or youngster. (Widom, 1999; Terri, Messman & Patricia, 2000; Kendler et al, 2000) studied a range of events that are believed to cause PTSD their finding designated child sexual abuse as a major traumatic event. Kaffman (2009) found Childhood sexual abuse as the major traumatic stressors which is extremely common and described it as a silent epidemic.

PTSD has been studied primarily in adult population most commonly combat veterans and victims of sexual assault (Bruce, Perry &Azad, 1999, pp. 312). However as Ombok et al, (2013) stated, there has been increasing recognition that children who have been exposed to traumatic events like child sexual abuse can develop post-traumatic stress disorder just like adults.

Prevalence of post-traumatic stress disorder in sexually abused children

Many PTSD studies suggest that PTSD is one of the psychological sequela of child sexual abuse. It is estimated that approximately one third of child sexual abuse victims experience PTSD as adult (Widomd, 1999). According to two review articles Terri, Messman & Patricia, 2000; Kendler et al, 2000) over 50% of sexually abused children meet at least partial criteria of PTSD and suggested that a third of all sexually abused children develop full diagnostic criteria of PTSD.

Common Symptoms of posttraumatic stress disorder

Various researchers have identified major symptoms of PTSD. (Alter-Reidet al, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993; Wolfe & Birt, 1995) in their study it was indicated that traumatized sexually abused children often exhibit elevated anxiety, depressive

symptomatology, inappropriate sexual behavior, nightmares, social withdrawal, sleep difficulties, anger, shame/guilt and school problems. The above mentioned common symptoms, sexually abused children demonstrate were summarized for a diagnosis of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) PTSD by American Psychiatric Association (2012). Accordingly, the DSM-IV-TM specifies the following criteria for a diagnosis of PTSD

> (1) the person has experienced or witnessed a traumatic event(s) that elicited intense fear, helplessness or horror; (2) persistent re-experiencing of the traumatic event, such as distressing memories or dreams about the event; (3) persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness; and (4) persistent symptoms of increased arousal, such as sleep disturbance, irritability or difficulties in concentration (American Psychiatric Association, 2000,p.7).

Factors aggravating the development of posttraumatic stress disorder

The development of PTSD in sexually abused children is found to be exacerbated by different factors. In various Studies familial abuse, penetrative acts absence of social support; sever abuse and prolonged abuse, has been mentioned as factors exacerbating the occurrence of PTSD in the victimized child. A study cited by Hall & Hall (2011) has correlated variables such as familial abuse, higher number of sexual abuse experiences, a younger age during the first sexual abuse experience and closeness with the abuser as factors for developing PTSD among the abused children. Likewise, in a study conducted by Sahin & McVicke (2009) duration of the abuse and the relationship to the abuser were found to influence the occurrence of PTSD outcome and recovery of the victim, with longer duration and abuse having occurred by a close family member exacerbates symptoms of PTSD for sexually abused children. Similarly, Browne and Finkelhor (1986) denoted incestuous experiences with a father or

stepfather as more detrimental to the victim than other types of intra-familial or extra-familial abuse.

Social support as a mediating factor

Social support has been found to be a "key variable in resiliency of child sexual abuse victims. Various researchers Spacarelli and Fuchs, (1997); Sarason et al, (1993); Ulrich, (2004) studied the importance of social support for the effective outcome of treatment. In a study conducted by (Sarason et al., 1993) survivors of childhood sexual abuse who report satisfactory social Support appear to have higher self-esteem and a more optimistic view of life compared to those who report low social support. In addition, individuals with low social support appear to have an external locus of control (i.e., feeling that things are beyond their control), have considerable dissatisfaction with their life, and difficulty persisting through difficult tasks. The social support model was found to explain 14% of the variance in impaired self-reference ($R2=.14$, $p<.05$), and added 10% of explained variance over the abuse characteristics alone ($R2=.10$, $p< .05$). Only participants' satisfaction with their social support was found to be significantly related to impaired self-reference ($R2= .29$, $p< .01$), and it uniquely accounted for 7% of the variance in outcome, indicating that college students who are less satisfied with their social support report more symptoms of impaired self-reference

Out of home care

There is evidence that shows children who are in out of home care for being abused are at higher risk of developing of PTSD. Dunn,Culhane & Tassig (2010) conduct a study on abused children who are in a group care regarding their experiences and feelings to the system of care they receive, the results showed that children felt less loved and less safe and they were generally dissatisfied with their experience. Furthermore, Edmond et al, (2006) argued that, for

those sexual abuse survivors who are placed in the foster care system, there is the hope of the abuse ending, but it comes at the cost of separation from their families. Both events constitute significant stressors that can disrupt normal development. Youths who have had these experiences are psychologically at risk for developing mental health and behavioral problems that can negatively affect their life trajectories. In contrary, Friedman (2010) argues that though out of home care has its own drawbacks; it is a best option in certain situation.

Absence of social support

Absence of social support after the disclosure of the abuse also has been associated with the development of PTSD. In a study conducted by (Sarason et al,1993) survivors of childhood sexual abuse who report satisfactory social Support appear to have higher self-esteem and a more optimistic view of life compared to those who report low social support. In addition, individuals with low social support appear to be more traumatized and have an external locus of control (i.e., feeling that things are beyond their control), have considerable dissatisfaction with their life, and difficulty persisting through difficult tasks. Various researchers (Spacarelli and Fuchs, (1997); Sarason et al, (1993); Ulrich, (2004) studied the importance of social support for the effectiveness of treatment given to traumatized sexually abused children. Ulrich (2004) also indicated that abuse in family environment and absence of social support after the disclosure of the abuse were found to have a stronger correlation with the development of PTSD.

The need for Therapeutic intervention

After sexual abuse got public attention different therapeutic approach such as TF-CBT, Art Therapy, Mode Deactivation Therapy and the like have begun to develop to help the victim child cop up with the effects of abuse. As cited by (Priebe, 2008) during recent years, efforts

have been made to identify "first choice" approaches that have empirical support for their efficacy and to develop guidelines for the clinical assessment and treatment of sexually and physically abused children and their families.

Survivors of childhood sexual abuse often times seek counseling assistance to manage the variety of short- and long-term emotional issues that may arise as a result of their abuse (Viviane, 2011). Because the negative correlates of child sexual abuse are often long-term, early intervention with children is important to reduce the prevalence of adulthood problems (Trask, Walsh, & DiLillo, 2011). However, many centers around the globe don't have the luxury of professionally trained counselors or therapists among their staff besides many centers find themselves employing new staffs without having the resource or opportunity to provide training (Cotterill & Delaney, 2005, p. 13). According to Cochrane database of systematic reviews (2013) it is vital that children who have been affected by childhood sexual abuse receive the best therapeutic help that they can get this will benefit them throughout their childhood and adolescence and into adulthood. In a study conducted by Lalor & McElvaney (2010) to understand the outcome of counseling, it was indicated that those children who have been sexually abused and get therapeutic intervention were far better than those who never got.

What constitute effective treatment?

Although no specific treatment modality is used for counseling sexually abused children, researchers have provided suggestions to the most effective treatment modality that help victim of sexual abuse decrease the symptom of PTSD. Effective treatments refer to treatments that have been tested and have proven to be effective in reducing the symptomatology of female adolescent survivors (Underwood, Stewart& Castellanos, 2007). Accordingly, different researchers such as Cohen & Mannarino (1997); Avinger & Jones,

(2007); Lanktree & Brier (1995); Gospodarevskaya1 & Segal (2012);Cyr et al (2012); Esch, (2013); Lyons-Ruth (2006); Alaggia (2009); Saraw, (2009); Underwood, Stewart & Castellanos (2007); Cohen et al (2004); Cronch, Viljoen, & Hansen (2006); Trask, Walsh & DiLillo (2011). Have provided relevant knowledge to the process through which sexually abused children should be intervened and the best suited approach for this population. For instance Cyr et al (2012) have presented attachment theory as a useful framework for assessing and promoting parental competency in child protection cases. In a study done by Alaggia an ecological analysis is offered as a better approach to understand this issue. However most of the researchers have suggested cognitive behavioral therapy as an effective way of helping a child cope up with the effect of child sexual abuse.

Legal framework

Internationally, various instruments like the UN Convention on the Rights of the Child (CRC), The African Charter on the Rights and Welfare of the Child, and the ILO Convention on the Worst Forms of Labor have been issued for the protection of children from any kind of abuse. The Ethiopian Government also has welcomed the thereof global conventions on violence against children. In the national setting, the issue of violence against children is addressed by various laws, policies and programs. First and foremost, the supreme law of the land, which is the Federal Constitution, provides a sound framework for the protection and promotion of the rights of children (The Federal Ministry of Labor and Social Affairs).sexual abuse is one area where the amended penal law has incorporated elaborated provisions. Accordingly Article 626 states about.- Sexual Outrages on Minors between the ages of Thirteen and Eighteen, whoever performs sexual intercourse with a minor of the opposite sex, who is between the ages of thirteen and eighteen years, or causes her to, Perform such an act

with her, is punishable with rigorous imprisonment from three years to fifteen years. The punishment will be aggravated to 20 years in the cases where the victim is the pupil, apprentice or servant of the offender, or is in any other way directly dependent upon or subordinate to the Offender. Sexual offence on a female child below the age of 13 is punishable with rigorous imprisonment of 15 to 25 years (Criminal code, 1997).

Conceptual framework

Ecological perspective

The study was guided by ecological perspective developed by Bronfenbrenner in 1979. This perspective sees a child at the center of various systems that maximize a child's chance of being victimized or factors that maximize the victim child resiliency. This perspective was used to show the influence other factors such as; family problem, living with relatives and being maidservant have on exposing children to sexual abuse. In addition, it was used to show the association between the identity of the abuser, the presence of social support, the impact of abusive act and the response of a person who heard the abuse on the development of symptoms of PTSD on individual child who experienced sexual abuse. According to this model, it is the accumulation of different risk factors across a wide range of settings, rather than a single factor that is important in determining the risk of adverse outcome. Similarly in this study this perspective was utilized to illumine the determinant factors such as nature of the abusive act, supportive response from the person who heard the abuse and the availability of effective treatment for the victim child resiliency or development of more PTSD symptoms.

Trauma-focused cognitive-behavioral therapy for sexually abused children

"Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based model of psychotherapy that addresses the unique needs of children with PTSD symptoms,

depression, behavior problems, and other difficulties related to traumatic life experiences" Macdonald, et al(2012). The basic premise of TF-CBT as Cully & Teten (2008, p.3) stated, is that emotions are difficult to change directly, so TF-CBT targets emotions by changing thoughts and behaviors that are contributing to the distressing emotions

The effectiveness of this therapy in decreasing symptomatology of traumatic stress has been proven in a range of studies for instance (Foa, Zoellner & Feeny, (2008); Nishith et al, (2003); NICE clinical guideline (2005) Suggested the successfulness of TF-CBT in reducing the Symptoms of PTSD following assault on females, rape and childhood sexual abuse. The reason for its effectiveness as stated in the work of Cully & Teten (2008) is, unlike other treatments, TF-CBT focuses on teaching skills instead of simply discussing the issue with the patient or offer advice and encourage victims talk about the traumatic experiences. Trauma-Focused Cognitive Behavioral Therapy has nine components.

1, Psychoeducation, this is given to the victim to make them watchful to the impact of trauma and common reaction to it 2, Parenting skills to enhance behavioral ejectment 3,Relaxation and stress management skills 4, Affective expression and modulation 5,Cognitive coping and processing 6, Trauma narration7, In vivo mastery of trauma reminders this is to help children dare experience which is no longer dangerous 8,Conjoint child-parent sessions9, The final phase of the treatment this is to help the children have optimistic view of the future.(National Child Traumatic Stress Network, 2004,p.8)

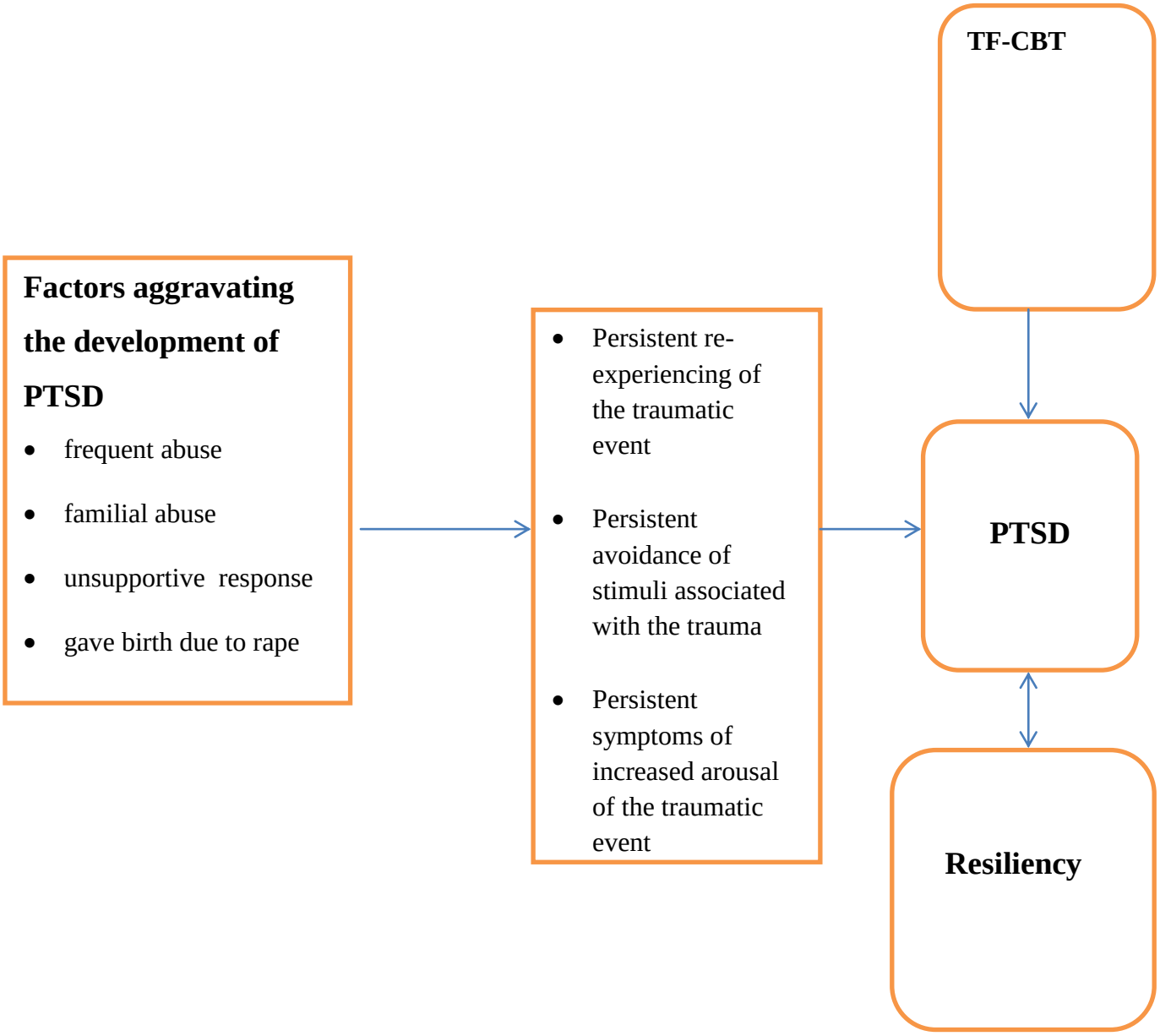

Figure: Conceptual framework of ecological perspective and cognitive behavioral therapy for traumatized sexually abused children.

CHAPTER THREE

RESEARCH METHODOLOGY

Research design

The study employed institution based cross-sectional descriptive design. Sexually abused children residing at safe house for psychosocial therapy were the unit of analysis in this study. Quantitative Method of data collection was used to collect primary data from the study participants. Standardized and structured questionnaire were the primary data collection tools. The study employed census survey and utilized the data collected from the entire sexually abused children who are residing at safe house for psychosocial rehabilitation. Census was chosen as a technique because the study population was 45 and it can be managed with the available finance and time. On top of that, as Richard & Jacobs (2009) stated, for smaller samples (N ‹100), there is little point in sampling survey the entire population.

Study area

Association for Women's Sanctuary and Development or safe house /former Tsotawi Tekat Tekelakay Mahiber (TTTM) is an Ethiopian resident charity association (non-governmental organization) established to advance women's social and economic development and provide support for women and girls who faced physical and sexual violence. The organization is located at Yeka sub city worda 9 around Civil Service College.

Association for Women's Sanctuary and Development /AWSAD/ was first legally registered with the Ministry of Justice of Ethiopia in 2003. Currently the safe house is involved in provision of rehabilitation and reintegration services and skill trainings for survivors. Services like, vocational skill trainings, clothing, food, dormitory, health services, psychosocial

support, counseling and non-formal education for women and girls who faced physical and sexual violence.

Safe house works to improve survivor handling mechanisms of organizations and institutions that provide services for survivors of Gender based violence. To this effect, safe house implements capacity development programs on quality service provision for survivors, survivor handling procedures and referral linkages for police, women's affairs officials and psycho-social support providers.

The organization provides services such as temporary safe home, food, counseling, medication, legal aid, rights awareness, non-formal education and skill development trainings. The target groups of the safe house are girls and women's who are victims of physical and psychological harm and declared by referral organizations. Women / girl survivors with low income, who don't have identifiable support from family or friends and who have been survivors of repeated and severe violence are the addmition criteria of safe house.

Currently the hosting capacity of the organization is 150, to date the organization is serving 72 survivors out of the total 72surviovers, 45 are under the age of 18 and 14 of them have a child due to rape these children will stay at the organization until the offender is convicted and until the children can stand by their own. Regarding the human resource of the organization, currently there are 52 employees in the organization including staffs at Adama branch (AWSAD, 20014).

Study population

The target population of the study was the entire sexually abused children who are between the ages of 12-18 admitted to safe house for psychosocial treatment for being sexually abused. The manageability of the number of sexually abused children at the organization

obliged the researcher involve the whole 45 children in the study. Sexually abused children were purposively selected from the organization's record of abused children who are between the age of 12 and 18.

Data collection instrument

Data was collected using two scales and three questionnaires.

1, Socio demographic questionnaires designed by the researcher which included information on age, place of birth, participants' level of education, and parent marital status was filled by the study participant.

2, to get the children sexual abuse profile a questionnaire designed by the researcher based on Ombok et al, 2013 sexual abuse profile questionnaire was used. The questionnaire incorporates, age of onset, identity of perpetrator, participants opinion toward out of home care, frequency of the abusive incidents, abuse impact severity, how the abuse was disclosed, and the reaction of the parent or the care taker to the incidence and the presence or the absence of social support after disclosure of the abuse.

3, to determine the availability of TF-CBT for victimized children, a questionnaire designed by the researcher based on the 9 component of TF-CBT was employed.

4, Child Version of Post-traumatic Diagnostic Scale (PTSD) developed by Foa, Johnson, Feeney & Treadwell in 1997

5, Revision of Distress Levels for the Child's Reaction to Traumatic Events Scale developed by Jones, Fletcher & Ribbe in 2002.

Description of Study variables

Independent variables; factors aggravating the development of post- traumatic stress disorder such as unsupportive response to sexual abuse disclosure, frequency of sexual abuse, intra familial abuse and having child due to rape.

Dependent variable; post- traumatic stress disorder

Operational definition of terms

Post -traumatic stress disorder; the presence or absence of symptoms of PTSD which is the dependent variable of the study was determined using two measurement scales. Posttraumatic Diagnostic Scale (PTSD) developed by Foa, Johnson, Feeney & Treadwell in 1997 and the Revision of distress levels for the Child's Reactions to Traumatic Events Scale CRTES-R developed by, Fletcher & Ribbe in (2002).

The PTSD scale assesses the frequency of all PTSD symptoms within the last two weeks for a child who has experienced a traumatic event. There is one question for each of the DMS-IV PTSD symptoms in the three criteria clusters (re-experiencing, avoidance, and arousal). The response format is a 4-point Likert scale participants respond to the 24 items according to the frequency of occurrence during the past two weeks. Not at all/ only at one time= 0, "once a week or less once in a while= 1, "2 to 4 times a week/ half the time" = 2 and "5 or more times a week almost always" = 3. The severity score results in the following guidelines: a total score of 12-24 indicates a mild level of PTSD reaction; 25-39 a moderate level; 40-59 a severe level; > 60 a very severe reaction Strand, Pasquale & Sarmiento (n.d). The scale was administered by interviewing each child individually.

On the other hand revision of distress levels for the Child's Reactions to Traumatic Events Scale, measures the distress level after one has encountered traumatic event. This scale

is also a 4-point Likert scale (0) not at all, (1) rarely, sometimes and (3). In the new version the cut off scores used to summate scale scores of intrusion and avoidance are included these are, 0-14 "low distresses" for all 23 items, 15-27 "mild distress" for all 23 items, 28+ "high distress" for all 23 items. Thus, to say PTSD is present the score should be 28 and above in the distress level for a child Jones (2002).

The availability of TF-CBT at Safe House for victimized children was determined by the questionnaire developed by the researcher based on the nine components of TF-CBT (National Child Traumatic Stress Network, 2004) according to this therapy, there are nine components that should be present in counseling to refer the counseling as TF-CBT this components are 1, Psychoeducation, 2, Parenting skills to enhance behavioral ejectment 3, Relaxation and stress management skills 4, Affective expression and modulation 5, Cognitive coping and processing 6, Trauma narration 7, In vivo mastery of trauma reminders 8, Conjoint child-parent sessions 9, The final phase of the treatment this is to help the children have optimistic view of the future. If the counselors answered yes to the question "are these (the nine components) activities incorporated in the counseling you give to the abused children? The counseling they give was considered as TF-CBT.

Reliability of measurement

Reliability is the extent to which a measure yields the same scores across different times, groups of people, or versions of the instrument. Reliability is about consistency (Scott & Deirdre, 2009) The PTSD measure has been used in various researches such as Ombok et al (2013); Bruce & Perry (2007); NICE clinical guideline (2005) and it has produced similar results across different nations and several languages. For instance as cited in the work of Strand, Pasquale & Sarmiento (n.d) in five studies by Greenwald, Rubin, Jurkovic,

Wiedemann, Russell, O'Connor, Sarac, Morrell & Weishaar, (2002) the psychometric properties of the test have been explored and excellent internal consistency was found for the measures in the United States, Bosnia, Germany, and Scotland.

In another studies conducted by Foa, Johnson, Feeny & Treadwell, (2001) Preliminary psychometric properties were established with seventy-five school-aged children in California who experienced sexual abuse. These findings demonstrated good internal consistence and test-retest reliability (as cited in Wolfe, Sas & Wekerleas p.34). Similarly, Jaycox (2002) used the measure with Spanish, Korean, Russian, and Armenian Speaking immigrant children and found a strong correlation between exposure to sexual violence and PTSD symptoms.

Data collection Procedure

After I got permission to conduct my research in the agency, pretest of the questionnaire was carried out at the same organization on 4 children. Based on the result, modification was done on the Amharic version of the scale. The questionnaire was also amended based on the feedback from the organization's counselors. After preparing the modified data collection tools, training was given for two female social work students. On the first day, all participants were gathered with the help of the counselor in the organization hall then orientations that include a briefing on the general objective and usefulness of the study, discussing the contents of the questionnaire, how confidentiality will be kept and their right to quit the participation at any time or to jump questions they don't want to answer was given for 15 seconds. Then for those participants who could read, written consent form was given and they were left alone to read the consent form and decide to participate or not. Those participants who cannot read were helped by the researcher and the counselors. Fortunately, all

45 students agreed to participate. Then the questionnaires were administered by interviewing each child individually in a separate room.

Data analysis

The data gained through the two measurement tools along with the questionnaires was first checked for completeness. After validation the items were summed up to generate a PTSD symptom total score then the data was coded. Analysis was conducted using SPSS version 22.0 statistical package for social science. Descriptive statistical techniques such as frequencies, percentages and mean were calculated and results were presented using tables. In addition, since the objective of the study was to describe how many children show PTSD symptoms, correlation between variables was computed using Pearson's correlation coefficient.

Ethical consideration

As the question provided to victim children might have sensitive topics, there was a chance that the participants may feel vulnerable or anxious after answering questions thus to avoid potential risks of reentering in to emotional trauma, in addition to ethical requirements related to research on human beings, additional safety precaution was considered.

According to a research conducted on Ethical Issues in Surveys about Children's Exposure to Violence and Sexual Abuse, there are two ways the participant childe might get harmed due to her/his participation in the study. The first potential harm relates to the survey content. The survey content can harm a child in two ways, on the one hand it could remind of a traumatic incident the child faced, on the other hand, raising troubling questions particularly concerning sex or sexual violence, to developmentally unprepared and sensitive child could put the participants' psychological wellbeing in jeopardy. The second potential harm is "informational" harm or risk. This harm is usually forwarded by either the perpetrators

themselves or others who might be endangered by disclosure of the abuse. (Finkelhor et al, n.d, Pp.3-8)

The first safety precaution that I used to reduce the risks of psychological distress that might arise as a result of participating in this study was to make sure the availability of supervision for the children after their participation, so that the organization's counselors will provide those participants who seem to be distressed or changed after their participation. To do this, prior to data collection, I talked to the counselors to check the children up and make counseling available for the participant children I also have planned to visit the children after data collection to make sure the availability of counseling. The participant children were also told to seek counseling in case they are troubled after their participation.

In addition to this, prior to data collection, I arranged orientation session that took 15 seconds this was done to aware respondents about the sensitivity of the questions they are going to be asked. Along with this, I also have told them that their participation is only out of their free will, how they were chosen, their right to skip questions they don't want to answer and their right to quit anytime they want without any harm. After the orientation the children were given time to read the consent form. Those who cannot read were helped by the researcher and the counselors. This was done to give them a room to think and decide to participate or encourage them not to participate out of fear of punishment.

The second safety precaution I had to use to work with victimized children was minimizing informational risks. Preventing retaliation and informational risk is closely related to the ethical practice of maintaining confidentiality (Finkelhor et al, n.d). Confidentiality was maintained by interviewing each respondent in Separate rooms.

CHAPTER FOUR

FINDINGS

In this part, the findings of the study are presented and interpreted. The analysis has four parts the first section deals with background information including age, place of origin and grade completed by the participants. The second part comprises information that is assumed to be factor exposing participants to sexual abuse; these include participants' sexual assault profiles. The third section will focus on the counselling the children attain and their attitude toward the usefulness of the safe house. The fourth part focuses on factors associated with the development of PTSD that includes frequency of victimization, other person's response to the victimization, having a child due to the rape and relationship of the offender with the victim. At the end of the analysis part, the correlation of PTSD and these aggravating factors along with the hypothesis testing are presented.

The study involved 45 children who fulfil the first criteria of PTSD that is sexual victimization. 4 participants were not used in the analyses due to having an incomplete outcome measure in the two scales. Symptoms of PTSD among participants were differed by the level of severity based on this; when 95% of the participants categorized under moderate level of PTSD, the rest 5% were categorized under severe level of PTSD in the PTSD diagnose scale. On the other hand, the result found in the revised PTSD reaction index categorized the participants under low and mild level of distress 39% participants and 61% participants consecutively.

The descriptive analysis of the demographic characteristic that incorporates age and educational level of the study participants are present in the following section

Age grade level and place of origin

The age range of participants was 12-18 years of age with a mean age of 15.51(SD1.832) years and the modal age at which sexual abuse occurred was 16 years of age with 22.0 % children reporting they were 16 years old. Sexual abuse was more prevalent in children aged between 15 and 18 years who represented 65.9% of all children at the organization. This age group was followed by that of children who are between the age of 11 and 14 who accounted 34.9% out of the 41 children.

Table1; Frequency and percentage distribution of participants by Age

Age category		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	11-14	14	34.1	34.1	34.1
	15-18	27	65.9	65.9	100.0
	Total	41	100.0	100.0	

Regarding the participant's educational status the majority of respondents did not complete elementary level education. The data collected from the respondents indicated that 22.0 % of the participants were illiterate. 39.0% had completed between 1-3 grades of education, 31.7% of the respondents had completed between 4-8 grades of education and the rest 7.3% of the respondents had completed 9-10 grades of education. In general, 92.7% of the respondents had not yet completed elementary education.

Table.2 Frequency and percentage distribution of the respondents by grade level

Grade level		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-3	16	39.0	39.0	39.0
	4-8	13	31.7	31.7	70.7
	9-10	3	7.3	7.3	78.0
	Illiterate	9	22.0	22.0	100.0
	Total	41	100.0	100.0	

Concerning participants place of origin, when only 4.8% of participants were born and grew up in Addis Ababa the remainder 95.1% participants were migrant from other provinces of Ethiopia.

Table.3 Frequency and percentage distribution of respondents by place of origin

Place of origin	Frequency	percent	Valid percent	Cumulative Percent
Amhara regional state	17	42.1	42.1	42.1
Oromia regional state	11	26.5	26.5	68.6
Southern nation and nationality	9	21.8	21.8	90.4
Addis Ababa	2	4.8	4.8	95.2
Tigiray Regional stats	2	4.8	4.8	100.0
Total	41	100.0	100.0	

Participants living condition and alleged perpetrator

Respondents were asked to indicate with whom they were living at the time of the abuse and to indicate the alleged perpetrator. As it is shown in table.3, N=39 participants came from different provinces. The most frequent reason to come to Addis for the study participants (N = 33) was to live with relatives and to attain education. However, 92.7% of the study participant didn't even complete elementary level education and 23 of them end up maid. Only 6 participants came to Addis in search of job. Of the total study population N=41, 10 respondents were living with close relatives. Two respondents who were born in Addis Ababa have been living with their biological parents (one respondents with both parents the other with mother only) at the time of the abuse. The sexual experiences participants faced classified as extra-familial abuse, meaning that the perpetrator was a known person, but not a family member, or a friend and intra-familial abuse meaning that the perpetrator was a family member. In this study 12.2 % of the alleged perpetrators were close and extended family members. The remainder 87.8% were non family members, i.e. employers N= 16(39.0 %) followed by strangers =5 (12.2 %) and persons known to the child, but not a friend N= 15 (36.6%).

Of 41 respondents 29 (67.2%) of them were maidservants and 16 of them were raped by their employers while 4 participants were raped by person known to them the rest 9 were raped by stranger. Out of the total participants (N=10) who were living with relatives, 5 of them were sexually abused by close and extended family members such as half-brother, cousin and uncle. The rest were raped by stranger and persons known to the child 3 and 2 consecutively. Two participants who were living with their biological parents, when 1 participant who was living with both parents raped by a stranger the other who was living with mother only was raped by a person known to the child.

Table.4participants living condition and alleged perpetrator

Living Condition And Perpetrator		Frequency	Percent
Live With Both Parents		1	2.4
Perpetrator	stranger	1	2.4
Live With Mother Only		1	2.4
Perpetrator	known to the child	1	2.4
Live With Relatives		10	24.3
Perpetrator	Known to the child	3	7.3
	Stranger	2	4.8
	Relatives	5	12.2
Worked as maid servant		29	70.7
Perpetrator	Known to the child	4	9.7
	Stranger	9	
	Employer	16	39.0
	Total	41	100

Nature of the abusive act

The study participants were asked questions including whether the abuse happened once or frequently, whether the abuse accompanies physical injury, whether they gave birth due to rape, how the abuse was disclosed whether the victim themselves disclosed it or the offender caught red-handed and the presence or the absence of social support after disclosure. Social support was considered as supportive response of a person who heard about the sexual abuse. It ranges from standing with the victim up to suing the offender and unsupportive response ranges from doing or saying noting up to blaming the victim.

Age of onset, way of abuse and place the abuse occurred

The youngest age of victimization reported in the current study was 5 (2.4%) years old, and the oldest age of victimization reported was 18 (4.8%) years. Regarding the way the participant exposed to sexual abuse, 12.2% of the participants were exposed to sexual abuse by trickery the remainder 87.8 was abused by use of force. Attach

The context of sexual abuse

Concerning the place the abuse occurred, 29 (67.2%) of respondents said they were abused in the house. all respondents except one respondent who was abused by her employer in the jangle the rest were abused in the house where they were hired to work. One the other hand of those participants who were exposed to sexual abuse by trickery, only one respondent who were abused by a police man was abused in a hotel room the remainder was abused at the offender house.

Duration and impact of abuse

Concerning the frequency of abuse 31(75.6%) of respondents said they were abused more than 2 times the remainder 10 (24.3%) were abused once. Respondents also have been asked if there were any physical injuries as a result of the abuse. Of the total respondents (N=41) majority of the participants 55.8% didn't encounter sever injuries other than the abuse itself. 2 participants were severely beaten and they still have scars. 11respondents were severely battered, but they don't have any scar or other reminder. 4 respondents said they had had health problems as a result of the abuse especially at the time the abuse happened. Out of the total participants N=41, 34.1% of the study participants gave birth due to the rape. Out of the total N=16 respondents who gave birth due to rape 8 of them were participants who were sexually abused by their employer. Two participants gave birth to a person known to them, but not a friend. 1of the 4

respondents who were abused by family member had given birth to her relative on the other hand, Out of 12 respondents who were raped by a stranger 3 of them had given birth.

Table.5 frequency and percentage of respondents by duration and impact of abuse

Gave birth due to rape	Frequency	Percent	Cumulative percent
Yes	14	34.1	34.1
No	27	65.9	100.0
Total	41	100.0	
Frequency of assault	Frequency	Percent	Cumulative percent
Repeatedly	31	75.7	76
Once	10	24.3	100.0
Total	41	100.0	
Physical injury during assault	Frequency	Percent	Cumulative percent
Scar	2	4.9	2.9
Battering	11	26.8	31.7
No abuse	24	58.5	90.2
Health problem	4	9.8	100.0
Total	41	100.0	

Way of disclosure

Regarding the way the abuse disclosed 8 participants which are18.6% of the total participants didn't disclose the abuse purposely. Their being abused was rather known by other people due to their pregnancy and sickness. According to the respondents who got pregnant due to the rape they didn't disclose the abuse, because they were intimidated by the offender the only one respondent kept silent because they had no one close to them to tell. 25 respondents said they were the one who disclosed the abuse out of these respondents 3 of them got unsupportive response from the person who heard the abuse. 14 respondents got supportive response from the person who heard the abuse. On the other hand 8 respondents said they got no replay when they first tell they were abused. However, they were believed and got somehow encouraging reaction as they frequently tell they are abused. 4 participants said the abuse was known to others

because the offender was caught red-handed. 3 participants said that they disclosed the abuse because they were asked by a person who noticed symptoms. According to these children, they would have remained silent if the persons hadn't asked them. Similar to this, 1 respondent's being abuse was disclosed because she was very sick and went hospital.

Table; 6 frequency and percentage distribution of respondents by the way they disclosed the abuse

Way of disclosure	Frequency	Percent	Cumulative Percent
Due to my pregnancy	8	19.5	19.5
Because I was sick due to the assault	1	2.4	21.9
I my self-disclosed Eventually	24	58.5	80.4
I was asked by a close person	4	10	90.4
He caught Red-handed	4	10	100.0
Total	41	100.0	

When we compare the injury the victim children faced with the frequency of abuse, the respondents age and their living condition, those children who are under the age category of 15-18 are the highest age group some form of physical injury registered. Regarding the frequency of abuse, among the children who were abused frequently those respondents who were abused by their employer take the lions share (N=23). Of the total respondents N=10 who were living with relatives more than half (N=7) have been abused frequently the remainder 3 abused only once. In contrary, those respondents who were living with their parents were abused only once. 2 participants who were living with relatives were abused only once and 6 of the 29 respondents who were working as a maidservant abused only once.

Reason for not disclosing the abuse fast

All 31 participants who were abused frequently didn't disclose the abuse at the onset. The reason for delaying to disclose the abuse as it is shown in the table below is when 2 participants say that was because they had no one to tell, the rest 29 participants were intimidated and had nowhere to go thus, stayed under the same roof with their rapist facing farther abuse. As the study participants reported, they eventually decide to disclose the abuse when their condition forced them and when they got the chance to be with someone they trust.

Table.7 Percent and frequency distribution of respondents for not disclosing the abuse at the on set

Reason for not disclosing the abuse	Frequency	Valid Percent	Cumulative Percent
I had no one to tell	2	4.9	4.9
I was intimidated	29	70.7	75.6
Total	41	100.0	

The type of Counseling and children's attitude toward the center

Out of the total N=41 participants only 32 participants have gotten the counseling giving in the center the remainder 9 participants did not get any counseling. This was because these 9 participants were new to the organization. The counseling given to these children doesn't differ on the bases of the abuse the children have faced. Participants of the study said they have group counseling once a week and the counseling focuses on personal hygiene, how they can develop self-confidence, how to settle disagreements, how to change their life situation and so on.

The data gained from the counselor also revealed all the children who have been sexually and physically abused are given similar counseling. Regarding participants' attitude towards the center, more than half of the total N=41 participants N= 21(51.2 %) said being in the center is not helping in any way the rest said its helping and they are feeling better since they got in this organization.

Table.8 Availability of each components of TF-CBT in the counseling given to the children

	Components of trauma focused cognitive behavioral therapy								
Have you got these activities in the counseling you attain so far?	1,Psych oeducat ion	2,Parentings kills to enhance behavioral ejectment	3,Relaxation and stress management skills	4,Affective expression and modulation	5,Cognitive coping and processing	6,Trauma narration	7, In vivo mastery of trauma reminders	8,Conjoi nt child-parent sessions	9,optimis tic view of the future
NO	X	X	X	X	X	X	X	X	
YES									X

As the table above indicates, the counseling given to these children doesn't fully incorporate all components of the therapy however, the counselors have reported that they do give counseling that encourage the children to have positive view of the future and this can be taken as only one component of the therapy is fulfilled by the counseling the organization gives to the victim children the.

Factors aggravating the onset of PTSD symptoms

Giving birth due to rape

Symptoms of PTSD were present in all N=41 participants in different levels. When (5%) of participants show sever level of PTSD symptoms the rest (95%) respondents were categorized under moderate level of PTSD based on their score in the PTSD symptom scale.

Compering PTSD symptom with respondents who gave birth due to birth and who did not, of the total 14 participants who did give birth due to the abuse 2 were categorized under sever level of PTSD symptom. In the rest 12 participants moderate level of PTSD symptoms were found.

Frequency of abuse

Of all respondents who were abused repeatedly N=31, 2 (6.4%) respondents showed sever level of PTSD symptom the rest 29 (93.5%) showed moderate level of PTSD symptom. On the other hand those respondents, who were abused only once N=10 which is 24.3% of the total participants, were found to be under moderate level of PTSD symptom category.

Offenders' relation to the victim

Regarding offenders' relation to the victims, the PTSD symptom scale results in 2 participants who showed sever PTSD symptom these participants were abused by family members. The other 3 participants abused by family member showed moderate level of PTSD. 36 participants who were victimized by extra family members conveyed moderate level of PTSD symptoms.

Response of the person who heard the abuse

Presences of PTSD symptoms also differ between participants who got supportive response and unsupportive response when they first disclosed the abuse. Accordingly, out of the total number of participants N=16 who got supportive response when they first disclosed the abuse, 2(5%) showed sever PTSD symptoms in the remainder 14 participants moderate level of PTSD symptom were found. On the other hand, 25(60.9%) participants showed moderate level of PTSD symptoms.

The child reaction to traumatic event scale based on frequency of abuse, response of the other person, giving birth due rape and offenders' relation to the victim.

Giving birth due to rape

A number of 41 participants were found to be distressed due to the frequent PTSD symptoms they faced during the past week prior to the data collection. The level of distress in 12(29.2%) participants was low level. The remainder 29(71 %) were mildly distressed. of all the total participants N=27(66%) who did not give birth due to the sexual abuse they encountered, 12(29.2%) of them were categorize under low level distress. The rest 15(36.5%) participants were mildly distress.

Frequency of abuse

Regarding the frequency of abuse, of all the 10 participants who were abused only once, all of them were found to be mildly distressed in the reaction to traumatic distress scale. On the other hand, of those participants who were raped repeatedly N=31, 12 of them were under low level of distress the rest 19 (46.3%) were mildly distressed.

Offenders' relation to the victim

Concerning offender relation to the victim participant, out of the total participants N=41, 5 participants who reported familial abuse were placed under mild level of distress in the children reaction to traumatic event scale. The distress level also differed for participants who were reaped by extra-family members when 16(39.0%) participants who were raped by non-family member found to be under low level distress, 20(4.8%) participants who were also raped by non-family member on the other hand were mildly distress.

Response of the person who heard the abuse

The children reaction to traumatic events measure also categorized participants who got supportive answer when they first disclose the abuse and those who did not get under law and mild level distress. Of all the total participants N=12 who were found in the low level distress category, 3 were participants who were supported when they first disclosed the abuse. 9 participants, who did not get supportive response, were also found under this distress category. Regarding participants who were placed under mild level of distress, 18 were unsupported children while the rest 11 were found to be those participants who have got supportive response when they first disclose the abuse. The following table summarized this finding.

Table.8 level of PTSD symptoms and frequency of abuse, response of other person, offender's relation to the victim and giving birth due to rape

	Ptsd symptom				
Gave birth due to rape	Moderate		Sever		
Yes	N	%	N	%	total
	12	29.2%	2	5%	41
No	27	66%	0	0	
Frequency of abuse Once	10	24.3%	0	0	41
Repeatedly	29	70.7%	2	5%	
Relation to offender Family	3	7.3%	2	5%	41
Non-family	36	87.8	0	0	
Response of a person who heard the abuse Supportive	14	34.1%	0	0	41
Unsupportive	25	60.9%	2	5%	

Table.10 level of Distress and frequency of abuse, response of other person, offender's relation to the victim and giving birth due to rape

	Distress level				
Gave birth due to rape	Low level		Mild level		
Yes	N	(%)	N	%	Total
	0	0	14	34.1%	
No	12	29.2%	15	36.5%	41
Frequency of abuse Once	0	0	10	24.3%	
Repeatedly	12	29.2%	19	46.3%	41
Relation to offender Family	0	0	5	12.1%	
Non-family	16	39.0%	20	48.7%	41
Response of a person who heard the abuse Supportive	3	7.3%	11	26.8%	
Unsupportive	9	21.9%	18	43.9%	41

Generally, all participants who showed sever PTSD symptoms in the PTSD diagnostic scale, were those participants who gave birth due to rape, who have encountered repeated sexual abuses, who got unsupportive response and who were abused by family member. On the other hand, in the child reaction to traumatic event scale, when only 9 participants who got unsupportive response placed under low level distress category the rest participants who gave birth due to rape, who were abused repeatedly, who were abused by family member were placed in mild level of distress category.

The above table indicates relationship among the hypothesized factors, severity of PTSD symptom and mild level of distress, however, the table does not show the correlation among them. Hence, in order to examine their correlation, a correlation analysis was conducted.

Table.11 Correlation between PTSD and gave birth due to rape, frequency of abuse, relation to offender and Response of a person who heard the abuse

		Factors associated with PTSD			
		Gave birth due to rape	Frequency of abuse	Relation to offender	Response of a person who heard the abuse
Symptoms of PTSD	Pearson correlation	.318 *	.374*	.314*	.572*
	Sig.	.043	.016	.046	.000
	N	41	41	41	41

Correlation is significant at the 0.05 level (2-tailed).* for relation to offender, frequency of abuse and gave birth due to rap.
Correlation is significant at the 0.01 level (2-tailed).* for response of a person who heard the abuse

From the table above it is possible to observe that there has been significant correlation among offenders relation to the victim, frequency of abuse, response of other person and symptoms of PTSD. The correlation between giving birth due to rape and the incidence of PTSD was significant at 0.05 (p= -.318, sig .043); the correlation between frequency of abuse and incidence of PTSD was significant at 0.05 (p=-.374, sig .016); the correlation between relation to offender and incidence of PTSD was also significant at 0.05(p=-.314, sig .046); the correlation between response of a person who heard the abuse and incidence of PTSD was significant at 0.01(p=-.572, sig .000).

Table.12 Correlation between distress level and gave birth due to rape, frequency of abuse, relation to offender and Response of a person who heard the abuse

		Factors associated with PTSD			
		Gave birth due to rape	Frequency of abuse	Relation to offender	Response of a person who heard the abuse
Distress level	Pearson correlation	.340*	.322*	.438*	.581*
	Sig	.030	.040	.003	.000
	N	41	41	41	41

Correlation is significant at the 0.05 level (2-tailed).* for gave birth due to rape and frequency of abuse.
Correlation is significant at the 001 for response of a person who hear the abuse.

The result gained through the children's reaction to traumatic event scale also found significant positive correlation between distress levels due to frequency of PTSD symptoms and frequency of abuse, giving birth due to rape, response of other person, and offenders' relation to the victim. The correlation between giving birth due to abuse and distress level is significant at 0.05(p=-340, .030); the correlation between frequency of abuse and distress level is significant at 0.05(p= 322, sig 040); the correlation between offenders relation and distress level is significant at 0.05(p=438, sig.003) and the correlation between reaction of other person is significant at.001 (p=.581, sig.000).

Tests of hypothesis

The study hypothesised the nature of the abusive acts (i.e. closeness of the victim's relationship to the offender, having a child due to rape, frequency of abuse and absence of supportive response from adults) as exacerbating factor for the occurrence of PTSD symptoms. The assumption here is that, if children are abused frequently, if the abuser is family member, if they gave birth due to the sexual abuse and if they did not get supportive response when they disclose the abuse, the chance of conveying most of PTSD symptoms will be higher and this in return will place the children under sever level of PTSD category. To test this hypothesis Person correlation was under taken. The correlation shows significant relationship between frequency (more than two times) of sexual abuse, having a child due to rape, absence of supportive response from the person who heard the abuse and the offenders' relationship to the victim. Therefore, the findings of the study accept the alternative hypothesis and reject the null hypothesis.

Hypothesis 2; the study hypothesised that; if TF-CBT is available for traumatized sexually abused children, it decreases the symptomatology of PTSD. The finding of the study shows

unavailability of the therapy for these children. Therefore, this finding along with the findings in the PTSD and Distress level scale supports the alternative hypothesis that says if traumatized sexually abused children are not provided with TF-CBT they will have more PTSD symptoms.

Discussion

The purpose of this study was to describe the prevalence of PTSD among sexually abused children. The previous chapter shows the presence of PTSD in the studied participants in different level. In this chapter, the findings of this study along with previous findings will be discussed.

Age of report

The age range of participants in this study was 12-18 with a mean age of 15.51(SD1.832) years and the modal age at which sexual abuse occurred was 16 years of age with 22.0 % children reporting they were 16 years old. Sexual abuse was most prevalent in children aged between 15 and 18 years who represented 65.9% of all children at the organization. This finding is consistent with what is reported in the Global School-based Student Health Survey on13-18year old children in Namibia, Swaziland, Uganda, Zambia and Zimbabwe the study estimated high prevalence rate of sexual violence in children aged 16 Brown et al (2009). A study finding by Finkelhor, Hammer, and Sedlak (2009) also indicated over half of the children who were sexually victimized were between 15-17 years old.

Risk factor for victimization;

In this study 95.1% of sexually abused child participants were migrants from other provinces these children came to Addis in search of job and to live with their relatives however, this children were exposed to sexual abuse either by their employers (39.0%) or by their own relatives (12.2%). of the total number of the abused participants, 70.7% were maidservants.

Similar to these findings, a study conducted in2009 by (Gebre et al) found in Ethiopia and the capital of Addis Ababa, Children's exposure to sexual abuse is found to be exacerbated by poverty, family breakdown, and child migration and trafficking. Children who migrated from countryside to live with kin or to work as a domestic servant are also at high risk of victimization. According to a survey done by form on street children Ethiopia (FSCE) in 2005 of 84 child domestic servants in Addis Ababa, 60.0% of these children experienced sexual harassment by the male household heads or their sons. This fact holds true in Tanzania in a study done by Kisanga (2012) an increased rural urban migration with people seeking employment predispose girls aged 10-19 years to sexual abuse.

Nature of the abusive act

The youngest age of victimization reported in the current study was five (2.4%) years old, and the oldest age of victimization reported was 18 (4.8%) years. Regarding the way the participant exposed to sexual abuse, 12.2% of the participants were exposed to sexual abuse by trickery the remainder 87.8 was abused by use of force. My findings also match with what was reported on studies conducted In Ethiopia

Frequency of abuse

in this study 31(75.6%) participants were abused more than 2 times. this finding is consistent with the study result conducted by Becker (2007) in this study 47 children (36.1%) of the total 130 participants had reported repeatedly sexually victimization. Additionally, in a study conducted by Douglas & Finkelhor (2000) out of the total N= 148 participants (24.3%) had more than one report of sexual abuse, indicating that their risk was not reduced following the first report.

The Context of abuse

Concerning the place the abuse occurred, 29 (67.2%) of respondents said they were abused in the house. all respondents except one respondent who was abused by her employer in the jangle the rest were abused in the house where they were hired to work. One the other hand of those participants who were exposed to sexual abuse by trickery, only one respondent who were abused by a police in a hotel room, the remainder was abused at the offender house. This finding is inconsistent with previous research that indicates Child sexual abuse in the neighbourhood environment is reported by 32.3%, school20% street19.3% home environment (13.8%) and bars/cafes (9.6%) work place and friend's house were reported by 4.5% and 3.3% respectively (Getnet & Desta, 2008).

Impact of abuse

Of the total respondents (N=41) majority of the participants 55.8% did not encounter sever injuries other than the abuse itself. Two participants were severely beaten and they still have scars. 11respondents were severely battered, but they do not have any scar or other reminder. This finding contradicts previous research by Dereje et al (2005) in their study half of the study participants have indicated other health consequences of sexual abuse the finding includes difficulty in walking or sitting, bruises, bleeding or itching in genital area or the mouth, pregnancy or sexually transmitted disease, especially among preteens and repeated urinary infections.

PTSD and sexual abuse

Many PTSD studies suggest that PTSD is one of the psychological sequela of child sexual abuse. It is estimated that approximately one third of child sexual abuse victims experience PTSD as adult (Widomd, 1999). According to two review of articles Terri,

Messman & Patricia, 2000; Kendler et al, 2000) over 50% of sexually abused children meet at least partial criteria of PTSD and suggested that a third of all sexually abused children develop full diagnostic criteria of PTSD this literature is consistent with the finding of this study which suggests 95.1% of the study participant shows moderate level of PTSD symptoms.

Social support

This study indicates different level of f PTSD symptoms between participants who got supportive response and unsupportive response when they first disclosed the abuse. Accordingly, out of the total number of participants N=16 who got supportive response when they first disclosed the abuse, 2(5%) showed sever PTSD symptoms in the remainder 14 participants moderate level of PTSD symptom were found. the correlation between response of a person who heard the abuse and incidence of PTSD in this study was significant at 0.01(p=-.572, sig .000). My findings also match with a study conducted by (Sarason et al., 1993) in this study survivors of childhood sexual abuse who report satisfactory social Support appear to have higher self-esteem and a more optimistic view of life compared to those who report low social support. In addition, individuals with low social support appear to have an external locus of control (i.e., feeling that things are beyond their control), have considerable dissatisfaction with their life, and difficulty persisting through difficult tasks.

Child sexual abuse and PTSD

PTSD and sexual abuse; This study shows high prevalence of PTSD affecting each participant in different levels 39 of the study participants were categorized under moderate level of PTSD symptoms the rest2 participants were categorized under moderate level of PTSD symptoms. This finding is consistent with a previous study on trauma exposure including sexual assault among school age children in Jimma zone the study finding shows the presence

of a significant difference between mean values of the abused and non-abused children groups in their depression, panic episode, and PTSD test scores. In other words, respondents with childhood sexual abuse experiences demonstrated a significantly higher mean score of PTSD (X=42) than did those without the history of childhood sexual abuse, who exhibited mean scores of18 reported that sexual assault is the trauma type most likely to be associated with PTSD among children attending urban schools in Nairobi.

Frequency of abuse and PTSD

In this study the prevalence of PTSD among repeatedly sexually abused participants N=31 has correlated significantly at 0.05 (p=-.374, sig .016); similar to this finding in a study conducted by Ombok, et al,(2013) the frequency of sexual abuse has shown statistically significantly associated with PTSD. Eighty five% of children who reported that they had been sexually abused for years had PTSD compared to lower PTSD prevalence among children abused for days (52%), weeks (11%) or months (57%).

Offenders' relationship with the victim

This study finds 12.1% participants abused by family member. The correlation between offenders relationship to the victim and incidence of PTSD was also statistically significant at 0.05(p=-.314, sig .046). This study finding is consistent with the study done by Hall & Hall, (2011) according to their findings, children who experienced familial abuse and higher numbers of sexual abuse experiences were very prone to higher levels of PTSD, depression and anxiety when they think about the abuse. Browne and Finkelhor (1986) similarly found high prevalence of PTSD and other psychological problems in participants who encountered incestuous experiences, with a father, stepfather or with other types of intra-familial. Sahin & McVicke (2009) stated that duration of the abuse and the relationship to the abuser influence

the outcome and recovery of the victim, with longer duration and abuse having occurred by a close family member exacerbates symptoms for survivors of sexual abuse. Ulrich also indicated that abuse in family environment was found to have a stronger correlation with PTSD and later psychological maladjustment (2004)

Counselling and participants Attitude toward Safe house

In this study out of the total participants N=41 only 32 participants have gotten counselling giving in the centre the remainder 9 participants did not get any counselling. The counselling given to these children was not based on the abuse they have faced. Regarding the type of counselling the children are getting, participants of the study said they have group counselling once a week which focuses on personal hygiene, self-confidence, dispute settling and so on however, the counselling doesn't involve none of the components of TF-CBT. This study finding contradicts the finds of other studies. The importance of counselling to sexually abused children was indicated by different researchers. Viviane (2011,pp.32) argues that "Survivors of childhood sexual abuse often times seek counselling assistance to manage the variety of short- and long-term emotional issues that may arise as a result of their abuse." However, as indicated in the study of Cotterill & Delaney (2005, pp. 13) many centres around the globe don't have the luxury of professionally trained counsellors or therapists among their staff besides many centres find themselves employing new staffs without having the resource or opportunity to provide training. Studies on the treatment of children suffering from PTSD also have been conducted. Findings across many studies suggest TF-CBT as the most effective therapy for sexually abused children suffering from PTSD for instance, (Cully& Teten, 2008; National Child Traumatic Stress Network; 2004; Macdonald et al, 2012; Neuropsychiatric Disease and Treatment 2011) studied the effectiveness of a range of treatments to sexually

abused children the result found TF-CBT as being one of the most effective interventions for children who have significant psychological symptoms related to trauma exposures.

The finding of this study designates, more than half of the total participants (51.2%) have reported dissatisfaction towards the centre they are residing at (safe house). This study is consistent with the finding of a study done by Dunn,Culhane, & Tassig (2010) their study was conducted to assess the experiences and feelings of sexually abused children who are in a group care centre toward the system of care they received, the results showed out of 170 participants 120 children felt less loved and less safe and they were generally dissatisfied with their experience in the centre.

Implications of the study findings for social work practice and Research

Findings of this study have necessitated the intervention of social worker in different levels. One of the intervention level professional social workers usually engage in is group work. This is a very effective way of intervention with people who have common problems or concerns. (Coady & Lehmann, 2007). This study was done in a group care centre in which sexually abused children between the ages of 12-18 along with other children and adults who are victims of physical abuse live in. As it is described in the findings these children and adults are attaining similar counselling service for the different sequelas of abusive act they are dealing with. Studies on the impact of child sexual abuse suggest that since the impact of physical abuse and sexual abuse differ, victims of both abuses need special treatments. Thus to optimize the outcome of the treatment given to these children, professional social workers should work together with such agencies to develop manuals and guidelines that help organizations provide these children with appropriate psychosocial service which is based on the specific sequelas of abuse and age category. To do this, Social workers should strive to

update themselves to the newly emerging counselling techniques and appropriate therapies such as TF-CBT to help traumatized sexually abused children.

Moreover, in order to enhance the effectiveness and understandability of the therapy by both the counsellors and the counselees, social workers should involve in conducting researches on the effectiveness of the therapy given to sexually abused children so that they can develop indigenous and culturally competent counselling techniques and therapies that take the culture in which the children grow up in to consideration. Generally, Published research on the effectiveness of therapy outcome for sexually abused children, the effect of out of home care on victimized children, giving birth due to rape and coping from impact of abuse and consequences of PTSD on the victimized children are in adequate in Ethiopia thus, farther research can be done to look answers for these problems.

Implication of the study finding for policy

In Ethiopia, the issue of violence against children is addressed by various laws, policies and programs. First and foremost, the supreme law of the land, which is the Federal Constitution, provides a sound framework for the protection and promotion of the rights of children .sexual abuse is one area where the amended penal law has incorporated elaborated provisions. Accordingly Article 626 states about.- sexual abuse of children between the ages of Thirteen and Eighteen, whoever performs sexual intercourse with a minor of the opposite sex, who is between the ages of thirteen and eighteen years, or causes her to, perform such an act with her, is punishable with rigorous imprisonment from three years to fifteen years. The punishment will be aggravated to 20 years in the cases where the victim is the pupil, apprentice or servant of the offender, or is in any other way directly dependent upon or subordinate to the

Offender. Sexual offence on a female child below the age of 13 is punishable with rigorous imprisonment of 15 to 25 years (Criminal code, 1997, p.364).

Even though, the sexual abuse of minors as it is discussed above is a penalized act, studies shows high level of increment in the number of sexually victimized children yearly. If penalizing the abuser cannot deter potential abusers and minimize the problem, the government should also think of other options that can directly lead to a reduction of the problem. As it is shown in the findings of this study, 95.2% of the total participants were migrants from rural area and 67.2 % of them were maidservants this connotes a need to look at the problem from other angles thus to dry the problem from its sources, instead of concentrating only on punishing the guilt a policy focusing on prevention should also be drafted.

Conclusion

The study involved 41 children aged 12-18 residing in Association for Women Development and Sanctuary (safe house) for psychosocial rehabilitation for being sexually abused. The main objective of the study was to assess the prevalence of PTSD among sexually abused children and to assess factors associated with the development of PTSD. The study employed cross section quantitative design. Data was collected using Revised version of distress levels for the Child's Reactions to Traumatic Events Scale (CRTES-R), the child PTSD symptom scale (CPSS) and questionnaires designed by the researcher. The findings of the study show the presence of PTSD among the studied population in moderate and severe levels. The data gained through CPSS indicates 5% participants showing sever level of PTSD symptoms and 95% showed moderate levels of PTSD symptoms. This categorization was done based on participant's score in the CPSS scale the scale assesses the frequency of all PTSD symptoms within the last two weeks for a child who has experienced a traumatic event. On the other hand, the data gained through CRTES-R categorized the study participants in low level and mild level distress. The distress level was measured based on how the children get troubled because of the thought of the traumatic event during the week prior to data collection. According to this scale, when 39% of the participant categorized under low-level distress the rest 61% were mildly distressed.

To assess the correlation among PTSD symptoms and the independent variables Pearson correlation was used. The result shows statistically significant correlation between PTSD symptoms and giving birth due to rape, frequency of abuse, response of other person and offenders' relationship with the victim. Finally, it was hypothesized that the nature of the abusive acts i.e., giving birth due to sexual abuse, repeated sexual abuse, closeness of the victim's relationship to the offender and negative response would predict the presence of PTSD symptoms and the absence of TF-CBT for traumatized sexually abused children have worsened their situation.

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Annex. A, consent form

My name is Sonan Daniel I am a prospect graduate student at Addis Ababa university school of social work. I am conducting this research for the partial fulfillment of the Master degree of Social Works (MSW) at Addis Ababa University.

Purpose:

The purpose of this study as I have mentioned it above is for academic purpose however, the finding of the study can be used to deliver the appropriate counseling and rehabilitation service to sexually abused children according to the effect the abuse lingered on the children. The study is all about the sexual abuse you encountered and the psychological impact the abuse accompanied mainly posttraumatic stress disorder. In addition, this study hopes to identify the factors that are most strongly related to the development of posttraumatic stress disorder, so that treatment and interventions can begin to target those specific areas.

Procedures:

If you agree to take part in this research study, you will be given a packet of questionnaires to fill out. These questionnaires should take approximately 30 minutes to fill out. The questionnaires will ask you about the history of your sexual abuse experiences (focusing on those experiences when, where, for how long time and whom), questions concerning your current adjustment, what kind of counseling your currently receiving, your thoughts about the causes of events, your social support, and questions about your family of origin and finally there are questions that are prepared to measure state of traumatic disorder. All the questions will be asked to measure 1, re-experiencing of the traumatic event 2, loss of interest or general removal 3, psychological hyperactivities. All information that you will give will remain anonymous and confidential. Moreover, Your participation in this study is 100% based on your willingness. If you agree, we will continue. If not, I will stop. You can also change your mind at any time, even if we started the interview. If you have any questions about the study, you can ask me or call the School of Social Work at (telephone number 0913234919). Before we finish this one and start the interview, do you have any questions?

If you do not have any questions, would you be willing to participate in this interview?

Thank you.

Participant agrees _____ Participant refuses _____

Code of participant _____

Signature of the researcher_____

Annex. A, Consent form Amharic version

ስሜ ሶናን ዳንኤል ሲሆን የአዲስ አበባ University የ ሁለተኛ አመት የ Social Work ተመራቂ ተማሪ ነኝ፡ ይህንን ጥናት የማደርገው በ Social Work ሁለተኛ ዲግሪየን ለማግኘት ነው፡፡

አላማ

ከላይ እንደጠቀስኩት የዚህ ጥናት ዋና አላማ የመመረቂያ ፅሁፍ ለማዘጋጀት ነው፡፡ ይሁን እነጂ የጥናቱ ግኝት የወሲብ ጥቃት ለደረሰባቸው ህፃናት ጥቃቱን ተከትሎ ከሚገጥማቸው የአዕምሮ መታወክ እና ስነልቦናዊ ቀውስ እንዲያገግሙ የሚሰጣቸው የምክር እና የማገገሚያ ግልጋሎት ውጤታማ እንዲሆን ይረዳል፡፡ ጥናቱ ስለ ገጠመሽ የወሲብ ጥቃት እና ጥቃቱ ስላስከተለው አዕምሮአዊ እና ስነልቦናዊ ቀወስ በተለይም ሰቆቃዊ ኢጋጣሚዎችን ተከትሎ ስለሚመጣው የጭንቀት መዛባት ላይ የጠነጥናል፡፡ በተጨማሪም ይህ ጥናት ሰቆቃዊ ኢጋጣሚዎችን ተከትሎ የሚመጣውን የጭንቀት መዛባት የሚያባብሱ እና ከ ችግሩጋር ጥብቅ ቁርኝት ያላቸውን ነገሮች ይዳስሰሳል፡፡ ስለሆነም የጥናቱ ግኝት የጥቃቱ ሰለባ ለሆኑት ልጆች የሚሰጣቸው አገልግሎት እነዚህን ችግሮች መፍታት ላይ ምሰረት ያደረገ እንዲሆን ይረዳል፡፡

የጥናቱ ሂደት

እዚህ ጥናት ውስጥ ለመካተት ከተስማማሽ 30 -45 ደቂቃ ሊወስዱ የሚችሉ ጥያቄዎችን የያዘመጠይቅ እንድትሞዪ ይሰጥሻል፡ መጠይቆቹ የሚያተኩሩት ከገጠመሽ የወሲብ ጥቃት ጋር ቁርኝት ስላላቸው ማለትም (መቼ ነው የገጠመሽ፣ የት ነበር፤ ማን ነበር) አሁን ያለሽበትን ሁኔታ፤ ኢያገኝሽው ስላለው የምክር እነዲሁም የተለያዩ አገልግሎቶች፤ ተከስቶ ስለነበረው ጥቃት አሁን ያለሽን ሃሳብ፤ አሁን እና ጥቃቱ በደረሰብሽ ጊዜ ስለነበረሽ ማህበራዊ ድጋፍ እና ስለቤተሰብሽ ነው፡፡

የምትሰጪኝ መረጃ በሙሉ ስምሽ የማይጠቀስባት እና ሚስጥራዊ ነው፡፡በተጨማሪም እዚህ ጥናት ላይ የሚኖርሽ ተሳትፎ ሙሉበሙሉ ባንቺ ፍላጎት ላይ የተመረኮዘ ነው፡፡ ከተስማማሽ እንቀጥላለን ካልተስማማሽ አሁንም ሆነ ጥያቄዎቹ መሀል ላይ እናቆማለን፡፡

ጥናቱን በተመለከተ ምንም አይነት ጥያቄ ካለሽ ልጠይቂኝ ወይም ለ Social Work ትምህርት ቤት በዚህ ስልክ( ) ደውለሽ መጠየቅ ትችያለሽ፡፡ ወደ ጥየቄዎቹ ከማለፋችን በፊት ጥያቄ አለሽ? ከሌለሽ ጥናቱ ውስጥ ለመሳተፍ ፍቃደኛ ነሽ?

አመስግናለሁ

ተሳታፊዋ ተስማምቷለች _____ ተሳታፊዋ አልተስማማችም _____

የተሳታፊዋ ሚስጥራዊ መለያ_____

ፊርማ_____

Annex. B, Questionnaire

Addis Ababa University

Graduate School of Social work

Questionnaire for sexually abused children

Background information

1. Age: ____

2. Educational levels: _____

3. Place of origin (Birth Place): _____

4. Your parents' marital states

A, divorced B, widowed C, still married

5. With whom were you living when the sexual abuse happened?

A, Father &mother B, stepfather and mother C, other specify

6. Have you ever worked as a maid servant?

A, Yes B, No

7. When did you come to this organization?

8. Do you believe being in this organization is helpful?

A, Yes B, No

9What services have you got so far?

10. How do you rate the counseling and other services you got so fare?

A, Helping B, somewhat helping C, not at all

11. Were there times that your parents frequently quarreled with each other?

Annex. B, Questionnaire for sexually abused children

Background information Amharic version

Addis Ababa University

Graduate School of Social work

ı. እድሜ___

2.የትምህርት ደረጃ: _____

3. የትውልድ ቦታ_____

4. የቤተሰብ የጋብቻ ሁኔታ

ı, ተፋተዋል 2, በሞት ተለያይተዋል 3, አብረው ናቸው

5. የወሲብ ጥቃቱ ባጋጠመሽ ግዜ ከማጋር ነበር የምትኖሪው?

ı, ከ ሁለቱም ወላጆቼ ጋር 2, ከ እንጅራ አባቴ ጋር እና ከ ወላጅ እናቴ ጋር 3, ከ ዘመድ ጋር

4.ሌላ ካለ ጥቀሽ----------

6. ሰው ቤት በሰራተኛነት ሰርተሰሽ ታውቂያለሽ?

ı, አዎ 2, አይ

7. ወደዚህ ድርጅት ከመጣሽ ምን ያህል ግዜ ሆነሽ?

8. እዚህ ድርጅት ውስጥ መሆንሽ ከደረሰብሽ ችግር ለማገገም ጠቅሞሻል?

9እስከዛሪ ከድረጅቱ ምን ምን አገልገሎቶችን አግኝተሻል

ı, አዎ 2, አይ

ıo. እስካሁን ከድርጅቱ ያገኝሽው የምክርም ሆነ ሊላ አገልግሎቶች ምንያህል ከደረሰብሽ ችግር እነድታገግሚ ጠቅሞሻል?

ı.በጣም ጠቃሚ 2. የሆነ ያህል ጠቅሞኛል 3. ምንም አልጠቀመኝም

ıı. ወላጆችሽ መሀከል ተደጋጋሚ ግጭት ይፈጠር ነበር?

Annex. C, Questionnaire for counselor at Safe House

TF-CBT related questions

Addis Ababa University

Graduate School of Social work

Which of the following activates is present in the counseling you give to traumatized sexually abused children? If you do have them as a way of counseling these children, say YES if not say NO

1. Psychoeducation is provided to children and their caregivers about the impact of trauma and common childhood reactions.

1, YES 2, NO

2. Parenting skills are provided to optimize children's emotional and behavioral adjustment.

1, YES 2, NO

3. Relaxation and stress management skills are individualized for each child and parent.

1, YES 2, NO

4. Affective expression and modulation are given to help children and Parents identify and cope with a range of emotions.

1, YES 2, NO

5. Cognitive coping to help children and parents modify inaccurate or unhelpful thoughts about the trauma.

1, YES 2, NO

6. Trauma narration, in which children describe their personal traumatic experiences

7, in vivo mastery of trauma reminders

1, YES 2, NO

8, conjoint child-parent sessions

1, YES 2, NO

9 help the children have optimistic view of the future.

1, YES 2, NO

Annex. D, Sexual Abuse Profile Questionnaire

1. How old were you when this (the sexual abuse) happened?

2. Relationship to the abuser/s

1. Stranger 2. Person you knew, but not friend

3. Friend 4. Father

5. Brother 6. Nephew

7. Cousin 8. Grandfather

9. Other _____

3. Did you face any physical impairment as a result of the abuse?

A. YES B. NO

4. Over how long time did the sexual abuse go on? (Give number of days, months, years)_____

5. Who did you tell about this experience, at the time?

1. No one 3. Father 5. Brother/ Sister

2. Mother 4. Other adult 6. Friend

6. If you did tell anyone how did she/ he react?

1. Supportive 2, Angry 3, doubtful 4, yelled at me

7. Did you feel that her / his reaction was good enough to make you feel at ease?

1, yes it was 2, Somehow 3, Not at all

8. If you did not tell anyone, why was that?

1. Because nobody wouldn't believe me 2. Because nobody wouldn't support me

3. Because I had no one to tell to 4. Because I was intimidated by the abuser.

Annex. D, sexual abuse profile questionnaire Amharic version

1. ድረጊቱ ሲፈጸም ስነት አመትሽ ነበር?

2. ጥቃቱ ያደረሰብሽ ሰው ምንሽ ነው

1. እማላውቀው ሰው 2. እማውቀው ግን እማልቀርበው ሰው

3. ጓደኛዬ 4. አባቴ

5. ወንድሜ 6. እንጀራ አባቴ

7. የ አጎቴ/ የአክስቴ ልጅ 8. አያቴ

9. ሌላ _____

3.ወሲባዊ ጥቃቱን ተከትሎ የደረሰብሽ የ አካል መጉደል / ጉዳት አለ?

1.አዎ 2. አይ

4. ይህ ጥቃት ለምን ያህል ግዜ ሲፈጸምብሽ ነበር? ግዜውን ግለጭ_____

5. ስለ ደረሰብሽ ጥቃት ለማ ተናገርሽ?

1. ለማንም 3. ለ አባቴ 5. ለወንድሜ/ ለእህቴ

2. ለእናቴ 4. ለጓደኛዬ 6. ለ ሌላ ሰው

6. የነገርሽው ሰው ምን ይነት ምላሽ ሰጠሽ.

1.እኔን እሚያበረታ 3, ተጠራጥሮኝ ነበር 3. ተቆጡኝ

7. ምላሻቸው ቀለል እነዲልሽ አርጓል?

1, በጣም 2, የሆነያህል 3, በፍጹም

8. ለማንም ካልተናገረሽ ለምን ነበር ያልተናገርሽው?

1. ማንም ሊያምነኝ ስለማይችል 2. ምንም ሊጠቅሙኝ አይችሉም ብዬ ስላሰብኩ

3. የምነግረው ሰው ስላልነበር 4. ጥቃት ያደረሰብኝ ሰው ስላስፈራራኝ.

Annex. E, Questionnaire Revision of Distress Levels for the Child's Reactions to

Traumatic Events Scale (CRTES-R)

Jones, R.T., Fletcher, K., & Ribbe, D.R. (2002)

Child's Reaction to Traumatic Events Scales – Revised (CRTES-R)

Name: _____ Date: _____

Recently you experienced _____

Below is a list of comments made by people after stressful life events. Please Check each item, indicating how often these comments were true for you DURING THE PAST SEVEN DAYS. If they did not occur during that time, please mark the "Not At all" column.

	Not at all	Rarely	Sometimes	Often
1. I thought about it when I didn't mean to.				
2. I stopped letting myself get upset when I thought about it or was reminded of it.				
3. I tried not to remember.				
4. I had trouble falling asleep or staying asleep because pictures or thoughts about it came into my mind.				
5. I had strong feelings about it.				
6. I had dreams about it.				
7. I stayed away from things that reminded me of it.				
8. I felt that it did not happen or that is was make-believe.				
9. I tried not to talk about it.				

10. I kept seeing it over and over in my mind.				
11. Other things kept making me think about it.				
12. I had lots of feelings about it, but I didn't pay attention to them.				
13. I tried not to think about it.				
14. Any reminder brought back feelings about it.				
15. I don't have feelings about it anymore.				
16. It was easy to make me angry and upset.				
17. Loud noises made me jump in surprise.				
18. I would act like it was happening all over again.				
19. I had trouble keeping my mind on what I was doing.				
20. Thinking about it made my heart beat faster.				
21. Thinking about it made it hard for me to breathe.				
22. Thinking about it made me sweat.				
23. I kept checking to make sure nothing else bad would happen.				

Annex. E, Questionnaire

Revision of distress levels for the Child's Reactions to Traumatic Events Scale (CRTESR)

Amharic version

Jones, R.T., Fletcher, K., & Ribbe, D.R. (2002)

Child's Reaction to Traumatic Events Scales – Revised (CRTES-R)

ስም_____

ቀን_____

በቅርብ የደረሰው አሰቃቂ አጋጣሚ_____

ከዚህ በታች በአሰቃቂ የህይወት አጋጣሚ ወስጥ ባለፉ ሰዎች የተሰጡ አስተያየቶች ተዘርዝረዋል፡፡ ምን ያህሉ በትክክል ላለፉት ሰባት ቀናት በአንቺ ህይወት ውስጥ ተስተውለዋል፡፡

1, በፍጹም 2, አልፎአልፎ 3,አንዳንድ ጊዜ 4, በብዛት

1) ማሰብ ሳልፈልግ አስበዋለሁ፡፡

2) ባስታወስኩት ጊዜ ከመናደድ እቆጠባለሁ፡፡

3) ላለማስታወስ እሞክራለሁ፡፡

4) የአጋጣሚው ምስል በአይምሮዬ ስለሚመላለስ

ለመተኛትም ሆነ ተኝቼ ለመቆየት አልችልም፡፡

5) ስለአጋጣሚው ጠንካራ የውስጥ ስሜት ነበረኝ፡፡

6) መጥፎ ህልሞችን አልም ነበር፡፡

7) አጋጣሚውን ከሚያስታውሱ ነገሮች እራሴን

አሸሻለሁ፡፡

8) አሰቃቂው አጋጣሚው ንዳልተፈጠረ አርጌ እቆጥር ነበር፡፡

9) ስለ አጋጣሚው አለማውራት እሞክር ነበር፡፡

10) አጋጣሚውን በተደጋጋሚ በአይምሮዬ አየው ነበር፡፡

11) የተለያዩ ነገሮች ድርጊቱን እንዳስብ ያረጉኝ ነበር፡፡

12) ስለ አጋጣሚው ብዙ የሚሰሙኝ ስሜቶች ቢኖሩም

ትኩረት እነፍጋቸው ነበር፡፡

13) ስለ አጋጣሚው ላለማሰብ እሞክር ነበር፡፡

14) ማንኛውም ከጋጣሚው ጋር የተያያዘ ነገር መጥፎስሜትን

ያጭርብኝ ነበር፡፡

15) ከ አሁን በኋላ ስለ አጋጣሚው ምንም አይነት ስሜት አይኖረኝም

16) ድርጊቱ እኔን ለማበሳጨት እና ለማናደድ ቀላል ነበር፡፡

17) ከፍ ያሉ ድምጾች በድንጋጤ ያዘልሉኝ ነበር፡፡

18) ድርጊቱ በድጋሚ እየተፈጸመ እንዳለ እቆጥር ነበር፡፡

19) በስራዎቼ ትኩረት አጣ ነበር፡፡

20) ስለድርጊቱ ሳስብ የልብ ምቴ ይጨምር ነበር፡፡

21) ስለ ድረጊቱ ሳስብ ትንፋሽ ያጥረኝ ነበር፡፡

22) ስለድረጊቱ ሳስብ ላብ ያስምጠኝ ነበር፡፡

23) ሌላ ተመሳሳይ ድርጊት እንዳይፈጠር በተደጋጋሚ ዙሪያዬን እቃኝ ነበር፡፡

Annex. F, The Child PTSD Symptom cale (CPSS)

Below is a list of problems that kids sometimes have after experiencing an upsetting event. Read each one carefully and circle the number (0-3) that best describes how often that problem has bothered you in the last 2 weeks.

Please write down your most distressing event:

Length of time since the event

0	1	2	3
Not at all only at One time	once a week or less once in while	2 to 4 times a week/ half the time	5 or more times a week/ almost always

1.	0	1	2	3	having upsetting thought or images about the event that came into your mind when you did not want them to.
2.	0	1	2	3	having bad dreams or nightmares.
3.	0	1	2	3	acting or felling as if the event was happening again (Hearing something or seeing a picture about it and feeling as if I am there again)
4.	0	1	2	3	Feeling upset when you think about it or hear about the event(for example, feeling scared, angry, sad, guilty, etc.)
5.	0	1	2	3	having feeling in your body when you think about or hear about the event (for example, breaking out into a sweat, heart beating fast)
6.	0	1	2	3	trying not to think about, talk about or have feelings about the event.
7.	0	1	2	3	trying to avoid activities, people, or places that remind you of the traumatic event.
8.	0	1	2	3	Not being able to remember an important part of the upsetting event.
9.	0	1	2	3	Having much less interest or doing things you used to do.

10.	0	1	2	3	Not feeling close to people around you.
11.	0	1	2	3	Not being able to have strong feelings(for example, being unable to cry or unable to feel happy.
12.	0	1	2	3	Feeling as if your future plans or hopes will not come true(for example, you will not have a job or getting married or having kids)
13.	0	1	2	3	having trouble falling or staying asleep.
14.	0	1	2	3	feeling irritable or having fits of anger.
15.	0	1	2	3	having trouble concentrating (for example, losing track of a Story on the television, forgetting what you read, not paying attention in class).
16.	0	1	2	3	being overly careful (for example, checking to see who is around you and what is around you).
17.	0	1	2	3	being jumpy or easily startled (for example, when someone walks up behind you.

Annex. F, Child PTSD Symptom Scale (CPSS) Amharic Version.

Author(s): Foa, Johnson, Feeney, Treadwell Year: 2001 Population/Age Group: Children between the ages of 8 and 18. Purpose: To probe for DSM-IV PTSD symptoms in children.

ከዚህ በታች ህጻናት አሰቃቂ አጋጣሚዎችን ካሳለፉ በኋላ የሚገጥማቸው ችግሮች ተዘርዝሯል። በጥንቃቄ ካነበባችሁ በኋላ ካሉት ምርጫዎች ከሁለት ሳምንት ወዲህ በተደጋጋሚ የገጠመሽን ችግር በይበልጥ የሚገልጸውን መርጠሽ አክብቢ።

1) የገጠመሽን አሰቃቂ አጋጣሚ ጻፊ _____

2) አሰቃቂው አጋጣሚው ካለፈ ምን ያህል ጊዜ ሆነው_____

0	1	2	3
በፍጹም ወይም ከዛ በላይቀን።	በሳምንት አንዴ እንደ ብልጭታ።	በሳምንት ከ 2- 4 ለግማሽ ሰዓት ያህል።	በሳምንት ለ 5 እና አንድ ጊዜብቻ/ ሁልግዜ።

1.	0	1	2	3	ስለ አጋጣሚው ማሰብ ሳትፈልጊ በድንገት ድረጊቱን የሚያስታወስ ሀሳብና ምስል በ አይምሮሽ ውስጥ መፈጠር።
2.	0	1	2	3	ከ አሰቃቂው አጋጣሚ ጋር የተያያዘ ቅዠት እና ህልም ማለም።
3.	0	1	2	3	አጋጣሚው አሁን በድጋሚ እየሆነ እንደሆነ መሰማት(ካለፈው ድርጊት ጋር የሚመሳሰል ድምጽ ወይም ምስል መታየት)።
4.	0	1	2	3	ስለ አጋጣሚው በሰብሽ ወይም በሰማሽ ጊዜ መበሳጨት(ፍርሀት፣ ንዴት፣ ሀዘን እና ጥፋተኛነት መሰማት)።
5.	0	1	2	3	ሰለአጋጣሚው ስታስቢ ላብ ማስመጥ እና የልብ ምት መጨመር።
6.	0	1	2	3	ስለ አጋጣሚው ማሰብ፣ ማውራት እና መስማት አለመፈለግ።
7.	0	1	2	3	አጋጣሚውን ከሚያስታውሱ ተግባራት፣ ሰዎች እና ቦታዎች መራቅ።
8.	0	1	2	3	የአሰቃቂውን ድርጊት አፈጻጸም ሊያብራሩ የሚችሉ ወሳኝ ጉዳዮችን ማስታወስ አለመቻል።
9.	0	1	2	3	ከአጋጣሚው መፈጸም በፊት በትኩረት ለምትሰሪያቸው ስራዎች ፍላጎት መጣት።
10.	0	1	2	3	በዙሪያሽ ካሉ ሰዎች መሸሽ/ ሰውን የመቅረብ ፍላጎት ማጣት።
11.	0	1	2	3	የውስጥ ስሜትን (ደስታ ወይም ሀዘን) መግለጽ አለመቻል።
12.	0	1	2	3	የወደፊት ተስፋዎችሽ እና እቅዶችሽ እንደማይሳኩ ማሰብ(የመስራት፣ የማግባት እና ልጆች የማፍራት)።
13.	0	1	2	3	ለማረፍ ወይም ለመተኛት መቸገር።
14.	0	1	2	3	ደስተኛ ያልሆነ እና ቁጡ ፊት ማሳየት።
15.	0	1	2	3	ትኩረት ማጣት(ያነበብሽውን መርሳት የሀሳብ መበተን)።
16.	0	1	2	3	አጉል ስጋት የፈጠረው ጥንቃቄ(አካባቢን በተደጋጋሚ መቃኘት)።
17.	0	1	2	3	ድንጉጥ መሆን (አጠገብሽ ሰው ሲቆም ወይም ሲያልፍ)