Child Sexual Abuse

Psychosocial Impact, Coping Mechanisms and Implications for Social Work Practice at Bale-Goba Hospital, South-eastern Ethiopia

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Declaration

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

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TABLE OF CONTENT

LIST OF TABLE

ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome

TF-CBT – Trauma Focused Cognitive Behavioral Therapy

CSA – Child Sexual Abuse

HIV –Human Immune Virus

PTSD- Post Trauma Stress Disorder

UN – United Nation

WHO-World Health Organization

Abstract

This study investigates the psychosocial impact, coping mechanism, the way of discloser of sexually abused children and its implication for social work intervention. The sample consists of 29 sexually abused children, six of non-offending parents and their counselors. The participants were recruited from Goba hospital through purposive sampling technique of the non-probability sampling method. The characteristics and the psychosocial effect of child sexual abuse were assessed with the standard questionnaires of post trauma distress scale, anxiety scale, and emotional distress scale. Depth interview were conducted with victim children and their parents in order to assess the psychological and social impact of the abuse, coping mechanism, how victims disclose the problem and the impact of the intervention service. In addition, focused group discussion and observation used to supplement the data obtained through aforementioned methods. The data collected by questionnaires and rating scale analyzed quantitatively by compiling in tables summary of frequency and percentage. The qualitative data analyzed using thematic and content analysis techniques to triangulate with quantitative data. The result of the study indict that the major psychosocial problems sexually abuse children face are post stress disorder, depression, emotional distress, anxiety, social withdraw, antisocial behavior etc. the extent of the problem differ from children to children based on age of the child, relationship with perpetrator, duration of the abuse, nature of abuse and the nature of help victim get from his parents and community. Despite difference on the extent of its psychosocial impact all sexually abused children use their own coping mechanism like seeking solution, self-improvement action, keeping busy and avoidance in order to cope up the problem. generally , this research funding conclude that child sexual abuse result short and long term psychosocial problem which affect social functioning of the children. Thus, social workers should have to have compressive knowledge about psychosocial impact of child sexual abuse for effective social work interventions.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Child abuse, now more commonly called child maltreatment, was "discovered" as a social problem and became a matter of intense public concern in Western industrialized countries in the 1870s, although children had been hurt, killed, injured and exploited by others well before this date (NSPCC, 2006).

The World Health Organization has defined child maltreatment as being: "All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (Butchart , 2006, p.59).

Abuse and neglect of children is not unique to the Ethiopian society. It is a global problem that has significant consequences for public health (Krug et al, 2002). Human rights provisions, particularly the United Nations Convention on the Rights of the Child, set out children's rights to physical integrity and governments' responsibilities to ensure children are protected from violence and that all reasonable steps are taken to help them overcome adverse consequences. The persistence of child maltreatment indicates societal and global failure to make our expressed commitment to children's rights a reality (Pinheiro, 2006, p.3).

It is a general fact that Ethiopia is a country trapped by many socio-economic problems. Some of these problems are high population growth, famine and spread of communicable diseases like HIV and sexual abuse of women and girls. The effects have resulted in a number of psychological, social, economic and political crises, including food insecurity, orphanage, and destitution of children deterioration of their health (IFSC, 2009).

As children are placed in the lowest social status in family hierarchy, they are the one who suffers most. Luther (2009) states that those poor youth show that are affected by an array of powerful risk and problematic influence, many of which are unique to the life circumstance of socio-economically deprived people. The psychological adjustment profile of poor youth show that younger children are more susceptible than other's in several respects. They are especially the most vulnerable victims among other types of exploitation in sexual abuse.

Social problems related to sex arise largely from change and conflict in attitude towards human sexuality. Such problems called asocial-sex variation which is basically deviations from widely held norms of particular society (Komblum, 2007). According to him, asocial sex variation includes incest, sexual abuse, rape and exploitation. Sexual abuse, as one of asocial sexual variations is a significant public health problem across the world (Luther, 2009). It is one form of behaviors that is common but surprisingly little understood. Feldman (2008) states that although sexual abuse cases are low in number and firm data are hard to come by its frequency has been thought to be relatively high.

It is rare for a child to speak about sexual abuse. A child who is a victim of sexual abuse may exhibit emotional and behavioural characteristics that may indicate distress (Feldman, 2008). According to McClendon (2006), approximately forty percent of all victims suffer psychological and social aftermath effects which have been serious enough to require a therapy in adulthood. Unfortunately, according to Whealin (2010), there is no obvious sign that a child has been sexually abused since sexual abuse often occurs in private and it does not result in physical evidence, and thus it is difficult to detect.

There are a number of negative short-term effects of sexual abuse that have impaired a child's normal functioning in its daily routines of life. The most commonly experienced effect of sexual abuse is post traumatic stress disorder (PSTD). Approximately, one-third of those who is victims of child sexual abuse have experienced PSTD as those of adult victims.

When we consider child sexual abuse of our country in general and Bale Zone in particular, it could be said that the issue is not well-addressed despite of the fact that it should be looked as a priority issues over others. There are only few governmental and non-governmental organizations dealing with this multi-dimensional problem. The prevalence of such a problem with victimized children suggests that there is a high need of consideration of their psychological and social impact and consequences of sexual abuse.

There has been a lot of research on child maltreatment in the last 30 years, but this is mostly generated in the West and the Asian countries which may not be directly

relevant to the Ethiopian cases in general and the dwellers of Bale-Goba town in particular (Gilbert et al, 2008a; 2008b). As social work and child protection has been subject to the long history of media interest in “failures” of the social work profession, positive findings from research conducted on successful child protection activities are rarely sought or promoted (MoWCD, 2007, p. 117).

Despite such high rates of sexual abuse and exploitation among victimized girls in Ethiopia and elsewhere, little is known about prevalence rate, psycho-social impact, coping mechanism parts of the world through social work perspective at different levels. It, therefore, appears to be imperative to conduct study on what the sexually abused children from both sexes have been suffering from psycho-social problems, their coping mechanisms and the implications of these issues for social work practice in various socio-cultural and economic contexts at different levels.

1.2 Statement of the Problem

Sex is an activity that should be joyful, pleasurable and intimate. However, when it is forced on someone, it becomes one of the ultimate acts of aggression and brutality that people capable of influencing one another and few crimes produce such profound and long lasting consequence (Feldman, 2008). Accordingly, when we see the major problem related to such forced act of appearing, we find child sexual abuse to be one among the most frequently occurring sexual difficulties leading to different types of psychosocial problems.

The subject of child sexual abuse is still a taboo in Ethiopia, including its regions. There is a conspiracy of silence around the subject and a very large percentage of

people feel that this is a largely western problem, but that child sexual abuse does happen in Ethiopia. Part of the reason, of course, lies in a traditional conservative family and community structure that does not talk about sex and sexuality at all. Parents do not speak to children about sexuality as well as physical and emotional changes that take place during their growing years. Consequently, all forms of sexual abuse that a child faces do not get reported to anyone. The girl, whose mother has not spoken to her even about a basic issue like menstruation, is unable to tell her mother about the uncle or neighbor who has made sexual advances towards her. This silence encourages the abuser so that he is emboldened to continue the abuse and to press his advantage to subject the child to more severe forms of sexual abuse. Very often children do not even realize that they are being abused.

Some deep seated fear has always moved Ethiopian families to keep their girls and their 'virginity' safe and many kinds of social and cultural practices have been built around ensuring this. This shows that there is knowledge of the fact that a girl child is unsafe though nobody talks about it. However, this fear is only around girls and the safety net is generally not extended to boys. There is evidence from this as well as other studies that boys are equally at risk.

As defined by the World Health Organization (1999), 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 that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may

include but is not limited to the inducement or coercion of a child to engage in any unlawful activity; the exploitative use of a child in prostitution or other unlawful sexual practices; and the exploitative use of children in pornographic performances and materials.

Sexual abuse is inappropriate sexual behaviour with a child. It includes fondling a child's genitals, making the child fondle the adult's genitals, intercourse, incest, rape, sodomy, exhibitionism and sexual exploitation. To be considered 'child abuse', these acts have to be committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a day care provider), or related to the child. If a stranger commits these acts, it would be considered sexual assault and handled solely by the police and criminal courts.

However, sexual abuse is also defined as severe forms of sexual abuse and other forms of sexual abuse. The severe forms of sexual abuse include: assault, including rape and sodomy; touching or fondling a child; exhibitionism, i.e. forcing a child to exhibit his/her private body parts; photographing a child in nude. There are similarly other forms of sexual abuse which include: forcible kissing, sexual advances towards a child during travel, sexual advances towards a child during marriage situations, exhibitionism (i.e. exhibiting before a child) and exposing a child to pornographic materials (MoWCD, 2007, pp. 71-77).

Although child sexual abuse is one of the deep-rooted problems of Bale-Goba children in particular and our country in general, the attention given to it is minimal. Whenever child sexual abuse or rape occurs, the victims prefer to silence fearing the blame of the society to appeal to legal institution despite its psychosocial effects. In

fact, it is considered a taboo to discuss about the issues in open until recently. However; it is a known fact the victims fall into different type's psychosocial crisis like sleep problems, depression, withdrawal, seductiveness, delinquency, secretiveness, etc. They are unable to function in normal way of social functioning unless they are treated timely. It is very likely that, sexual abused children and even their parents need professional help.

A child who is victims of sexual abuse obviously suffers from prolonged physical, psychological and social consequences. A common theme underlying most forms of sexual abuse is that of emotional hurt resulted from the physical, psychological and social after effects. The child suffers from lack of affection and supervision which leaves him vulnerable to the subtle advance of the perpetrator (McFadden, 2006).

The psychosocial effects of sexual abuse affect almost all victims irrespective to their age, sex, and socio-economic status. Generally, all women and children are vulnerable to sexual abuse unless they avoid uncertain situation. However, children from poverty stricken families are the most exposed to such dangers due to lack of protection and care takers. In addition, children with disability are highly vulnerable since their physical condition can't permit them to resist their offenders (McFadden, 2006). Therefore, there is a need for making positive interventions more effectively to address these negative consequences has become paramount importance because as we have discussed above, significant and multi-dimensional physical, emotional and social problem occur in relation to child sexual abuse.

For all these compounded reasons, the victims of sexual abuse need a comprehensive support of psychological counseling, physical treatments and normal social adjustment (Feldman, 2008). In order to be effective in identifying and treating victims of sexual abuse, social workers need to be knowledgeable about the characteristics, aftereffect and treatment strategies which are relevant to the issues.

This study attempts to answer such research questions as: (1) what are the socio-demographic, cultural and economic characteristics of sexually abused children? (2) Do all sexually abused children suffer from the psychosocial effects of sexual abuse at the same level? (3) In which way(S), do the abused children disclose the case? (4) What types of coping mechanisms used by sexual abused children? And (5) what type(s) of social work intervention should be designed and implemented to prevent and treat the specific problem at hand in various socio-cultural and economic contexts and at different levels?

1.3 Objectives of the Study

The general objective of this study is to asses and identifies psychosocial impact of child sexual abuse on the part of female victims in 'Bale-Goba' town, south-eastern Ethiopia. The specific objective of the study is:

- ✍ To investigate the psychosocial effects of child sexual abuse;
- ✍ To assess whether or not all sexually abused children equally suffer from the problem;
- ✍ .To identify their coping mechanisms that have been employed by sexually abused children;

- ✍ To investigate how sexually abused children discloses the abuse; and
- ✍ To explore social work interventions in place in order to effectively prevent child sexual abuse and to treat the victims.

1.4 Operational Definitions of Terms

Child – every human being who has been attained the full age of 18. .(Africa child Form)

Child sexual abuse- is any forced sexual contact by an adult or older person with a child.(Encyclopedia of child abuse)

Survivor – a child who has been through an experience of S.A. (Dictionary of Social work)

Offender- is a person who committed sexual abuse on a child with five years age difference. (Dictionary of Social work)

Perpetrator- is a person who committed sexual abuse on a child with five years age difference. (Dictionary of Social work)

1.5 Limitation of the Study

Despite the vigorous efforts made in carrying out this research, the researcher faced different challenges at different times and places. These were:

- Concerned officials in the hospital care and support center were not easily available, hence the researcher found it difficult to get their consent.
- Children sexual abuse related statistical data were hardly available in the social affairs department of city and
- Most of abused children parents were reluctant to provide information

1.6 Organization of the Report

This thesis report is organized in to five chapters. Chapter one deals with general description of the issue under study, statement of the problem, objectives of the study, operational definitions of terms and limitations of the study. Chapter two discusses review of related literature. Chapter three describes the study design and methods of study. It describes the study area; discusses about the study design and method, universe of the study, sampling methods, data collection tools and procedures, data processing and methods and ethical considerations. Chapter four present data presentation, analysis, interpretation and discussion. The last chapter puts those major findings and arguments, as well as counter arguments which have been running throughout the theses to draw as conclusions and suggestions.

CHAPTER Two

LITERATURE REVIEW

2.1 Definition of Child Sexual Abuse

There are many forms of childhood sexual abuse. The sexual abuse can involve seduction by a beloved relative or it can be a violent act committed by a stranger. Sexual abuse can be hard to define because of the many different forms it can take on, the different levels of frequency, the variation of circumstances it can occur within, and the different relationships that it may be associated with. Maltz (2002) gives the following definition: “sexual abuse occurs whenever one person dominates and exploits another by means of sexual activity or suggestion” (Maltz, 2001a, cited in Maltz, 2002, p. 321). Child sexual abuse is any forced or tricked sexual contact by an adult or older child with a child. Usually the adult or older child is in a position of power or authority over the child. Physical force is generally not used, since there is usually a trusting relationship between the adult or older child and the child who is abused (McClendon, 2009).

Child sexual abuse is any interaction between a child and an adult (or another older child) in which the child is used for the sexual stimulation of the perpetrator. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina, penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include trying to look at a child’s naked body, exhibitionism, or exposing the child to pornography. (Hanson , 2009).

The definition of child sexual abuse formulated by WHO Consultation on Child Abuse Prevention which stated that: “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. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the exploitative use of a child in prostitution or other unlawful sexual practices; the inducement or coercion of a child to engage in any unlawful sexual activity; and the exploitative use of children in pornographic performance and materials” (WHO 2007).

Child sexual abuse is defined as maltreatment that involves the child in sexual activity to provide sexual gratification or financial benefit to the perpetrator (Hanson , 2009) . Whealin (2006) tried to defined child sexual abuse as an act that includes a wide range of sexual behaviors that take place between a child and old person. These sexual behaviors include open mouth kissing, touching, fondling, manipulation of the genitals, anus or breasts with fingers, lips, tongue or with an object. It may include intercourse. Children may not have been touched themselves but may have been forced to perform sexual acts on an adult or older child.

Sexual abuse is also defined as any sexual activity involving a child where consent is not or cannot be given. Depending upon the age at which a state deems a child capable of giving consent (Wightman, 2002). Jonzon (2006) defined sexual abuse as act or situation with sexual meaning where an adult or younger person is using a child in purpose to satisfy his /her sexual need. Jonzon definition tell us that CSA to be contact the child and an adult when a child is being used for sexual stimulation of the perpetrator or another person; when the perpetrator or another person is in position of power.

Generally speaking, although the existing various definition of CSA, the definitions does not contradict and have even much community.

2.2 **Prevalence of Child Sexual Abuse**

Prevalence refers to the proportion of a population that has experienced a particular event or behavior. The estimation of any form of deviance behaviors in the general population is a very difficult task. It is impossible to assess the extent of sexual abuse, either in general or with children as targets. Most estimates of the distribution of sexual offenders in the general population are derived from executive or judiciary sources, that is, samples of those who are arrested or convicted for sex offenses (Lawson & Chaffin, 2009) .All researchers acknowledge that those who are reported to legal body represent only a fraction of all sexual abused.

Before the late 1970s, CSA was regarded as rare. In the following decades, the incidence based on official statistics in different countries show that the situation increased dramatically. (U.S.D.H.H.S, 2008). Presently, CSA has been reported up

to 80,000 times a years in US, but still unreported instances are far greater, because the child is afraid to tell anyone what has happened and the legal procedure for validating an episode is difficult (AACAP,2010). According to report released by The National Institution of Justice in 2009 out of 22.3million children between age of 12 and 17 years in UAS, 1.8million were victims of a serious sexual assault. Twenty-eight to 33% of women and 12 to 18% of men were victims of childhood or adolescent sexual abuse (Long, Burnett, & Thomas, 2009).

Reported incident of CSA are markedly on the rise. What is especially shocking is that these reports represent only a small proportion of the actual occurrence of the incident. It is currently estimated that one-third of all children abused before the age of 18.This mean one out of three girls are sexually abused by the time they reach age of 18 (McClendon, 2009).

2.3. **Models of Explaining the Short and Long Term Impact of CSA**

The most popular models which explain about psychosocial impact of child sexual abuse are:

A. **Post Traumatic Stress Model**

The relationship between child sexual abuse and adult psychosocial impact tended initially to be conceptualized in terms of posttraumatic stress disorder (Mullen & Fleming, 2005). This model focused on trauma-induced symptoms most particularly dissociates disorder such as desensitization, amnesia, fugues and even multiple personality.

In its more sophisticated formulation, this model attempts to integrate the damage inflicted at the time to victim's psychological integrity by the CSA and the need to repress the trauma with resultant psychological fragmentation. The later manifests itself in adult life in the mental problems, and in problem of interpersonal and sexual adjustment (Carmen, 2006). This model found its strongest support in the observation of clinicians dealing with individuals with severe and repeated abuse. It was often linked to notions of a highly specific post-syndrome in which dissociative disorder were prominent (Mullen & Fleming, 2005).

B. Traumagenic Model

One of the most dominates model explaining about how sexual abuse survivors see the world, self and others and its effects on their psychosocial functioning are the Traumagenic model. The model explained the possible short-term and long-term effects of child sexual abuse on four common characteristic of the nature of CSA. All the effects are listed in terms of the sexual abused child, but they are feelings, misconceptions and thought patterns the sexually abused child may carry into adulthood.

a) Traumatic Sexualization

The child's sexuality is distorted by age- inappropriate sexualization. The child gets a sexuality shaped by the abuse, which may result in aversion, prostitution or confusion about sexual identity, norms and standards, etc (Jonzon, 2006). Traumatic sexuality refers to a process in which a child's sexuality is shaped in a developmentally inappropriate and interpersonal dysfunctional fashion as the

result of sexual abuse. It can occur when the perpetrator rewords inappropriate sexual behavior, by trading gifts, affection, privileges or attention to sex.

b) Betrayal

The child expectation of how or what others will provide care and protection can be severely wrapped. Here, the child has been exploited by a trusted individual through sexual acts or non-protection from non-abusing others resulting in depression, a tendency to seek other abusive relationship, anger (Jonzon, 2006). Betray may occur when children realized that a trusted person has manipulated them through lies or someone whom they loved, whose affection was important to them treated them callous disregard(Finkehlore & Brown,2004).

C) **Powerlessnes**s

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

D**. Stigmatization**

The child's sense of being denigrated and the child is isolated from a large society. Stigmatization refers to the negative connotation like badness, shames and guilt that communicate to the child by the experience, and becomes incorporate in to the child self-image. The perpetrator may explicitly blame the victims or the child may blame himself for the abuse, therefore feel sense of shame and responsibility (Finkehlore & Browne, 2006).

2.4 **Discloser of Child Sexual Abuse**

Every published empirical study on the disclosure of child sexual abuse indicates that a high percentage of those child sexual abuse victims who report their abuse to authorities delay disclosure of their abuse, and that a significant number of children do not disclose the abuse at all. The delay between the initial occurrence and the subsequent disclosure of the abuse varies, depending on a number of factors such as the abuse's age at the time of the events, the relationship between the perpetrator and the abused, the gender of the abused, the severity of the abuse, developmental and cognitive variables related to the abused, and the likely consequences of the disclosure. Consequently, child sexual abuse is significantly under reported. When victims do report that they were abused, they often do so years after the abuse occurred. Adult retrospective studies of childhood sexual abuse underline the delay in disclosure. In a study of 228 adult female victims of childhood incest who were predominantly abused by males, Roesler and Weissmann-Wind (2007) found that the average age of first abuse was 6 years, and the abuse lasted on average 7.6 years. Only one-third of the subjects in this sample disclosed the abuse before the age of 18, and the average age of disclosure was 25years. Arata (2008) found that only 41% of the 204

female participants in her study, whose average age at the time of victimization was 8.5, disclosed the abuse at the time it occurred. Lawson and Chaffin (2009) found that only 43% of their child subjects disclosed their abuse when they were initially interviewed. Lamb and Edgar-Smith (2004) conducted a study with 45 adult female and 12 adult male victims of childhood sexual abuse, and they found that although the average age at the time of victimization was 10, 64% of the victims disclosed their abuse in adulthood. In a study of childhood rape of girls, Smith, Letourneau, and Saunders (2009) found that approximately half of the women waited more than eight years to disclose the abuse.

The process of disclosing childhood sexual abuse varies, though it is often described within two axes: as purposeful or accidental; and as spontaneous or prompted. DeVoe and Coulborn-Faller (2007) found that child subjects in their study required assistance with disclosure. Sorenson and Snow (2008) noted that accidental disclosure was more common in preschool children, whereas purposeful disclosure was more common in adolescents. They also found four stages of disclosure in their retrospective study of 630 subjects who were aged 3 to 17 at the time of abuse: denial, disclosure (tentative and active), recantation and reaffirmation. These researchers also found that 72% of their subjects originally denied the abuse; 78% of the subjects who tentatively revealed their abuse progressed to active disclosure; 22% recanted their reports, and of those who recanted 93% later reaffirmed the original report.

One of the factors that affect discloser of the abuse is care taker ability to help the child to disclose the abuse. Bradley and Wood's (2009) research supported

the notion that the role of the caretaker is essential in the discloser of child sexual abuse. Although recantations of disclosure were rare in their sample, they found that 50% of children who recanted did so under pressure from a caretaker. Summit's (2003) model of child sexual abuse, the Child Sexual Abuse Accommodation Syndrome, explains the hindrance to disclosure. This syndrome consists of five components:

- Secrecy: the abuse occurs when the victim and perpetrator are alone, and the perpetrator encourages the victim to maintain secrecy;
- Helplessness: children are obedient to adults and will usually obey the perpetrator, who encourages secrecy,
- Entrapment and accommodation: once the child is helplessly entrenched in the abusive situation, he or she assumes responsibility for the abuse and begins to dissociate from it;
- Delayed disclosure: because the victims who report child sexual abuse often wait long periods of time to disclose, their disclosures are subsequently questioned; and
- Retraction: the victims may retract their disclosures of abuse after facing disbelief and lack of support after their disclosure.

Generally, there are numbers of factors that hinder the discloser of child sexual abuse. Some of the majors are the following:

a) Victims Relationship to the Perpetrator

If the perpetrator is a relative or acquaintance, victims of child sexual abuse are less likely to report the offense, or they are likely to disclose the abuse after a delay (Arata, 2008).

In Arata's study, 73% of the victims did not disclose the abuse when the perpetrator was a relative or stepparent, and 70% did not disclose when the perpetrator was an acquaintance. According to Edelstein study those children who felt responsible for the abuse, often because the abuse occurred within the family, took longer to report the abuse. Wyatt and Newcomb (2009) study found that the women who did not disclose their abuse to anyone were likely to have been closely related to the perpetrator and abused in close proximity to their home.

b) Severity of Sexual Abuse

Research results vary in regard to disclosure of abuse in relation to the severity of that abuse. Arata (2008) found that child victims who experienced more severe levels of sexual abuse were less likely to disclose their abuse. This is consistent with the findings of Cavanaugh (2006), who reported that fondling was reported by 80% of their subjects who disclosed. In contrast , Hanson (2009) found that of their 341 adult females who were victims of childhood rape, the more severe assaults were likely to be reported. DiPietro (2008) also found that contact sexual offenses were those most commonly reported in his sample of 76 children.

c) Development and Cognitive Variables

Lamb and Edgar-Smith (2004) speculate that "more astute" children may not disclose because they may "anticipate unsupportive reactions." They also maintain that such children may wait until adulthood to disclose when they can choose appropriate people to tell. White (2006) found that older victims of child sexual abuse were less likely to disclose than their younger counterparts and noted that the knowledge of social consequences was a significant hindrance to disclosure. Keary and Fitzpatrick (2004) concluded that children over the age of five, who had previously disclosed sexual abuse, were more likely to disclose this information during formal assessment, but the converse was true for children under five. Similarly, DiPietro (2008) found that developmental maturation clearly facilitates disclosure.

d. Fear of Negative Consequences

Sorenson and Snow (2008) found that fear of further harm had an impact on a child's motivation to disclose abuse and that the child victims often only felt safe enough to disclose after the departure of the perpetrator. Berliner and Conte (2005) also noted that the fear about perceived reactions of others prevents some children from disclosing sexual abuse. Roesler and Weissmann-Wind (2007) found that 33.3% of their subjects did not disclose their abuse during childhood because they feared for their safety. They also found that 32.9% of their subjects did not report their abuse during childhood because they felt guilt or shame as a result of the abuse.

e. Gender Differences

Lamb and Edgar-Smith; and Holden in their study found that girls are more likely to report abuse than boys. Reinhart found that sexual abuse of males was more likely to be disclosed by a third party. There are no methodologically sound empirical studies that indicate that males disclose at a higher rate than females. Gender does not appear to be as important, however, as victim perpetrator relationship in disclosure of abuse (Paine and Hanson, 2007).

2.5 **Risk factors for Child Sexual Abuse**

CSA occurs across all socioeconomic and ethnic groups (Finkelhor, 2006). A number of factors, however, have been identified that increase risk for CSA. Some of them are:

Gender

Girls are at about 2.5 to 3 times higher risk than boys, although approximately 22% to 29% of all CSA victims are male (U.S. Department of Health and Human Services, 2008). Boys are underrepresented in psychiatric samples, especially older boys who may be reluctant to disclose or who may be shunted into the criminal justice or substance abuse treatment systems.

Age

Risk for CSA rises with age (U.S. Department of Health and Human Services, 2008). Data from 2006 indicate that approximately 10% of victims are between ages 0 and 3 years. Between ages 4 and 7 years, the percentage almost triples (28.4%). Ages 8 to 11 years account for a quarter (25.5%) of cases, with children 12 years

and older accounting for the remaining third (35.9%) of cases (U.S. D.H.H.S, 2008). Some authorities believe that, as a risk factor, age operates differentially for girls and boys, with high risk starting earlier and lasting longer for girls.

Disabilities

Physical disabilities, especially those that impair a child are perceived credibility such as blindness, deafness, and mental retardation, are associated with increased risk (Westcott and Jones, 2009). Three factors seem to contribute to this increased vulnerability: dependency, institutional care, and communication difficulties.

Socioeconomic Status

Although low socioeconomic status is a powerful risk factor for physical abuse and neglect, it has much less impact on CSA. Community survey studies find almost no socioeconomic effects, but a disproportionate number of CSA cases reported to Child Protective Services come from lower socioeconomic classes (Finkelhor, 2006).

Race and Ethnicity

Race and ethnicity do not seem to be risk factors for CSA, although preliminary research suggests that they may influence symptom expression. Two studies found that Latina girls have worse emotional and behavioral problems than African-American or white girls (Mullen, 2005).

Family Constellation

Family constellation, particularly the absence of one or both parents, is a significant risk factor (Finkelhor, 2006). The presence of a stepfather in the home doubles the risk for girls, not only for being abused by the stepfather but also for being abused by other men prior to the arrival of the stepfather in the home

(Mullen, 2005). Parental impairments, particularly maternal illness, maternal alcoholism, extended maternal absences, serious marital conflicts, parental substance abuse, social isolation, and punitive parenting, have all been associated with increased risk in some studies (Nelson, 2008)

2.6 **Psychosocial Effect CSA**

The impact of childhood sexual abuse varies from person to person and from case to case. A study compared the experiences of women who experienced familial sexual abuse with women who experienced non-familial abuse. They found that women who experienced familial abuse reported higher current levels of depression and anxiety when thinking about the abuse. Other variables they found to increase the levels of reported distress were abuse experiences that involved more extensive sexual abuse, a higher number of sexual abuse experiences, and a younger age during the first sexual abuse experience (Hartman, Finn, & Leon, 1987).

Childhood sexual abuse infringes on the basic rights of human beings. Children should be able to have sexual experiences at the appropriate developmental time and within their control and choice. The nature and dynamics of sexual abuse and sexually abusive relationships are often traumatic. When sexual abuse occurs in childhood it can hinder normal social growth and be a cause of many different psychosocial problems (Maltz, 2002). To support this (Cole and Putnam 2002), stated that child sexual abuse has negatives impact on overall psychological, social and interpersonal development of children. These problems typically include depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, and acting out. Depending on the severity of the incident, victims of sexual abuse may also

develop fear and anxiety regarding the opposite sex or sexual issues and may display inappropriate sexual behavior. However, the strongest indication is that sexual abused child develops inappropriate sexual knowledge, sexual interest, and sexual acting (Sorenson & Snow, 2008).

The initial or short-term effects of abuse usually occur within 2 years of the termination of the abuse. These effects vary depending upon the circumstances of the abuse and the child's developmental stage but may include regressive behaviors (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, behavior and/or performance problems at school, and nonparticipation in school and social activities (Fergusson, 2006).

But the negative effects of child sexual abuse can affect the victim for many years and into adulthood. Adults who were sexually abused as children commonly experience depression. Additionally, high levels of anxiety in these adults can result in self-destructive behaviors, such as alcoholism or drug abuse, anxiety attacks, situation-specific anxiety disorders, and insomnia. Many victims also encounter problems in their adult relationships and in their adult sexual functioning. (Cole & Putnam 2002).

Olson and DeFrain (2008) generalized the effects of CSA to be linked to from disclosing their childhood sexual abuse. Relationship building techniques such as using encouragement, validation, self-disclosure, and boundary setting are encouraged to help build the therapeutic alliance. Accepting the survivor’s version of their sexual abuse experience is often therapeutic and helps strengthen the alliance (Pearson, 1994). It is important for the counselor to allow the client

time to build feelings of trust, safety, and openness. Because sexual abuse is abusive in power by nature egalitarianism is stressed as an important factor. Allowing the client to have control in both the pace and direction of the therapeutic process is important (Ratican, 1992) those of Post Traumatic Stress Disorder. Individual regularly re-experience the trauma through recurrent invasive thoughts and uncontrollable emotions. They often feel detached from external world and avoid situations that reminded them of the original trauma (Olson&DeFrain, 2008). Besides, Olson& DeFrain stated that Sexual abused children develop commonly sleeping problem, withdrawal from friends/family, seductiveness, refusal to go schools, secretiveness, suicidal behaviors, PTSD, depression, anxiety, depression, poor self-image and low self-esteem (Whealin, 2006).

2.7 **The Consequence of CSA**

According to researches Child sexual abuse damages children physically, emotionally and behaviorally. Both its initial effects and long-term consequences impact on the individual, on their family and on the community. Some of the major consequence CSA stated below:

a) Physical Consequence

Child sexual abuse obviously results in physical injuries; this may become serious if the abuse is accomplished by force. these physical injuries includes scratches ,itching, cuts or injuries in genital area, bleeding, illness, suicide ,etc (child welfare information Gateway,2007).All the above consequence increase children vulnerability to HIV, fistula, and unwanted pregnancy.

b) Social Consequence

The most serious social problem faced is stigma and discrimination against the victims and being blamed by others. According to Cohen (2003) the negative responses from others, re-victimization, stigma are some of the problems victims face. All these lead towards isolation, lack of trust on the others, poor relation with families and friends, etc.

C) Psychological Consequence

The psychological effect of child sexual abuse is immeasurable. If child sexual abuse is not treated effectively, long-term symptoms may persist into adulthood. These may includes PTSD, anxiety, depression, low self-esteem, sleep problems, nightmares, secretiveness, unusual aggressiveness, etc. (whealin, 2006).

d) Behavioral Consequence

Sexual abused children express some new behaviors as a result of the abuse. These may includes aggressive behaviors towards younger children, advanced sexual knowledge, seductive behaviors, pseudo-mature behaviors, regressive behavior, and excessive masturbation. Sudden changes in behavior, using drugs or alcohol, lying, prostitution, etc. (Child welfare Gateway, 2007)

2.8 **Coping**

Coping is an active effort to reduce stress by solving the problem that elicits it. (Smith, 2008).Coping involves both cognitive and behavioral efforts to manage

environmental and internal demands and stressors. On the other hand, Coping defined as process of managing taxing circumstances, expanding effort to solve personal and interpersonal problems and seeking to master, minimize or tolerate stress and conflict (shamrock, 2007). In broadest sense, coping behavior defined as a cognitive and meteoric activities that a victims uses to master, reduce or recover from the characteristic symptom of emotional distress that may develop after sexual abuse (Mayer and Taylor, 1986). Generally, coping styles are ecosystems that involve active interaction between an individual and environment influences within framework of available resources, potential, needs and vulnerabilities (Nemme, 2006).

Lazarus (2001) argues that individual difference in the responses to stress is a function of the person's cognitive appraisal of the potential stressful situation. Accordingly, it is the process that determines how positive or negative his/her stress reaction will be, what emotions he/she will experience, and what adoptive responses they will make (smith, 2008). On the contrary, research specifically related to children has revealed that coping mechanisms depend upon a combination of factors, learned responses, ability to integrate knowledge, self-image, and emotional environment (Wolman, 1997).despite this ,children who are physically adequate, loved, respected, granted dependent life cope up better with stressful situations than others (Nemme, 2006).

Coping Strategies

In order to break the chain of the event that cause a stress related consequence ,it is necessary for the person either to alter his/her awareness of the problem

and of the potential consequences or if stress is unavoidable, to modify its physical and psychological efforts. For this, there are many coping strategies developed by different researchers and psychologists. As Derlega (2006) stated some strategies for controlling anxiety, such as confronting and defense mechanisms are acquired as part of our psychological development. That is, we make no conscious effort to learn a particular defense mechanism, but based upon our experiences the model we are exposed to; we do learn certain cognitive strategies for coping with anxiety. Thus, the intention of many survivors of CSA to utilize a certain coping strategy is to reduce the possible aftereffects.

Meyer and Taylor (2006) described the following coping strategies as successful: **explanation**- identifying a person why the sexual abuse occurred, **minimization**-telling oneself that the sexual abuse was not really so terrifying, **suppression**-making conscious effort to avoid thinking about the sexual abuse, **action** -keeping busy, changing jobs, or moving; and **stress reduction** -using specific stress reduction techniques like meditation.

2. 9 **Social Work Intervention**

The short and long term effects of sexual abuse have been well documented and highlight the need for the effective social work intervention. CSA contribute for development disruption that laid the basis for psychological and social problems in the victim's future life, hence, the need to provide rehabilitation services is essential. The impact of sexual abuse is not only a victim child problem but also it is also family problem. Hence, the components of the treatment program should include the survivor child, their parents and the offenders (Whealin, 2006).

There are several modalities of psychosocial treatment that have demonstrated positive benefits for child victims of sexual abuse. These include individual psychotherapy, group-based therapy and treatments that involve the entire family (Dominguez 2002). According to Cooney (2003), the following treatment should be followed by social worker in their intervention with abused child regardless of the nature of the abuse:

Medical Intervention

Social worker should facilitate medical service facilities for the victims. A complete medical examination by the physician who understands the nature of sexual abuse can eliminate the fear someone holds, can figure out pregnancy or venereal diseases including HIV/AIDS, etc can give solution for it.

Sex Education

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

Counseling Sexually Abused Children and their Family

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

Worker should become aware of the widespread of sexual abuse of girls. the social worker need to keep abreast of the indicators of maltreatment, the law for reporting suspected abuse, and the ways in which children can be served to overcome effects of a negative family experience (McFadden, 1990).

Counseling the Child

One of the primary purposes of counseling sexual abused children is to provide a safe place and a safe relationship within which the child may experiment with new adoptions to a safer world. The counselor should help the child to develop trusting relation with an adult. The counselor will be able to identify adaptations with the child made to the abuse and teach the child more appropriate ways of interacting.

In the counseling relationship, working with abused children requires many techniques other than talking and listening. Using structured and unstructured play situations, music or clay provides a safe way for children to release tension and express themselves. In doing so, the worker can be use individual or group-based counseling as appropriate as possible (McFadden, 1990). Individual counseling helps to get past the painful experience and will help the client to get well eventually. In group counseling, members can learn from one another and from the counselor who leads the group. They learn how to express themselves in appositive way, how to stand up for themselves and how to cope with potential abuser (Cooney, 2003).

CHAPTER THREE
STUDY DESIGN AND METHODS

3.1 Description of the Study Area

Geographically, Oromia region is located between 30 401 to 100 461 North and 340 081 to 420 551 East. The region borders with Amhara region to the North, Afar region to the north east, Kenya and Southern Nations, Nationalities and Peoples (SNNPR) region to the south, Somali region to the East and Sudan to southwest and Benishangul Gumuz to the North West . Administratively, the region is divided into 14 zones, 2 special zones, 198 'woredas', 16 special 'woredas', 6500 'kebeles' and 375 urban centers (OEB, 2005:2,3).

Goba is a town and separate woreda in south-central Ethiopia. Located in the Bale Zone of the Oromia Region approximately 446 km southeast of Addis Ababa, this city has a latitude and longitude of 7°0N 39°59E and an elevation of 2,743 meters above sea level.

The 2007 national census reported a total population for Goba of 32,025, of whom 15,182 were men and 16,843 were women; 4,797 or 6.13% of its population were urban dwellers. The majority of the inhabitants said they practiced Ethiopian Orthodox Christianity, with 69.84% of the population reporting they observed this belief, while 23.12% of the populations were Muslim and 5.84% were Protestant

3.2 The Study Design and Methods

This part deals with the methods followed and tools used in gathering the necessary information. The main objective of the study is to assess the psychosocial impact of child sexual abuse .Hence, in order to investigate deeply

how aftereffects of the trauma could affect their psychosocial functioning of the sample subjects, qualitative research approach considered to be appropriate together with quantitative approach. The study was based on non-experimental design about the characteristics of the abused and perpetrator and families of abused children. An effective assessment of all these was considered to be possible if a combination of both qualitative and quantitative approach applied.

3.3 Universe of the Study

The sample participant were 29 sexually abused children between the age of 5-17.they were selected from Goba-hospital sexually abused children care and support center which established by indigenous NGO. This center found to be most appropriate because it consists of sexually abused children whose cases were reported and who are getting counseling services. Besides, six of their parents, two counselors and one police officer were included in the study to supplement the data.

3.4 Sampling Technique

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

When selecting the sample subject, some factors were taken into consideration. some of them are the age of victim children should be between 5 and 17; the age

gap of the victim child and perpetrator should be 5years; and the abuse should have physical contact.

3.5 Data Collection Tools and Procedure

The following tools used to collected data: depth interview, observation, structured questionnaire and focused group discussion. An in depth interview was made with 8 abused children; 3 children abused by family members, 3 of the children are abused by someone who is not stranger and 2 of them abused by stranger. These children were selected for in depth interview because they were cooperative during the questionnaire. This method helped to enhance the profundity of information about victim children psychosocial impact, extent of the problems, coping mechanism and discloser. In addition to this, in depth interviews were conducted with 3 parents of victim children, one counselor and one policy officer. Two different structured questionnaires used to collect data concerning sexually abused children general features and psychosocial problems mainly-anxiety, PTSD and depression. The questionnaire was filled by 29 sexually abused children and ten parents of them. This method helped the researcher to make wider the size of data. The researcher conducted focus group discussions; with two counselors and with six available and willing parents who are believed to have relevance with the issues and relation with the victims to understand the overall nature of CSA, its aftereffect, and coping styles. Thus, semi structured FGDs guide used as supplementary source information.

The researcher decided to use standardized instruments because such a step will enable comparison with studies conducted elsewhere using the same instruments. However, in order to make the instrument readable and understandable for the sample they were translated in to Amharic and checked with the originals. However, minor adjustments and clarifications were made in all instruments to acclimatize to the local population and culture. For the purpose of conducting interview, interview guides were developed by the researcher in the view of difficulties in finding standard interview guides with appropriate size, depth and content. The interview guide was examined and approved by the academic advisor.

Before meeting the victims and conducting the main study, the researcher faced a very great challenge in securing permission from the hospital sexual abused children care and support center officials because of their fear of asking victim children psychosocial problems may aggravate or repress their problem. The researcher discussed with the center official and counselor made some modification on both questionnaires and interviews especially on words that might hurt the feeling of the survival children. Finally, the center official decided to allow the researcher to contact the survivals inside the promise of the center. The researcher collected the data from victim children inside the compound of the center.

During the personal meeting with the survivals, they were asked to rate the degree to which they had experienced each symptom in the scales and open ended questions about offenders, disclosure ,reaction, psychosocial effect and

coping styles. If the participant agreed the interview was taped; otherwise note are taken during interview.

3.6 Administration of Instrument

The instrument were administrated for the sample subjects in two ways; for the very young sample that were unable to easily read and understand the researcher was reading the instruments and scored their answer for them. For those who are able to read the instruments, the instruments were handed over to them and they were requested to read the instructions and followed the directions.

Pilot study

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

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

The main study

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

- The researcher contacted the available survivor children individually to ask their willingness to participate in the study.
- After receiving their willingness, the researcher briefed the participant about the purpose of the study and the confidentiality of their information to make them feel free and relaxed in giving genuine information and in expressing their feeling freely.

- The researcher asked how he meets them and fixed comfortable time to meet in the organization. Together with this, the researcher met some available parents and guardian who are agreed to participate in the study. They were briefed about the purpose of the study and encouraged to feel free and relaxed to the discussion the issues.
- Finally, after receiving their oral and written consent, the necessary data collected with available respondents.

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

3.7 Ethical Consideration

As the study deals with the most sensitive issues, major ethical consideration were taken in to account to handle the delicate situation of asking about several trauma without causing emotional turmoil. The ethical consideration considered while the data collected are:

- In the first place, the full consent of all participants of the study was orally requested and informed consent was signed.
- Tape recording was made by the willingness of the participant.
- All the gathered data were showed and read to them to identify any thing that could be revel their identity.
- The confidentially of the gathered data was informed stressfully.
- The name of the center and organization in which the victims were selected from is kept confidential to avoid any risk that serves the revelation of their identity.

3.8 Methods of Data Analysis

The data were gathered using both qualitative and quantitative methods. Thus, both qualitative and quantitative analysis was made using appropriate models.

Quantitative data analysis applied for analyzing the data collected by using scales. The responses given in a numerical rating scale was complied in tables summarizing the frequency of each variable. The results of the schedule or the questionnaire were presented in percentage as a principle method of presenting the reports.

The data collected trough interview was tape-recorded and transcribed accurately after listening time and again. Short note was also taken during the interview where tape-recording could not be possible. The collected data were categorized in meaningful link with the researcher questions and analyzed using thematic and content analysis techniques in order to triangulate with the quantitative data generated through the aforementioned tools.

CHAPTER FOUR
Data Presentation, Analysis, Interpretation and Discussion

This part deals with presentation, analysis and interpretation of both qualitative and quantitative data. The item collected by using quantitative approach are tabulated and presented in Percentages and the analyses follow after the table. The data collected by interview guide are analysis in detail qualitatively together with the quantitative ones.

4.1. Characteristic of Sexually Abused Children

Table 1.characteristic of sexually abused children

VARIABLE		f	%
Number of perpetrators	1	27	93.1%
	2	2	6.68%
	3 or more	0	0%
Relation to the perpetrators	Nuclear family	15	51.72%
	Close person	11	37.93%
	Stranger	3	10.34%
Age at onset of abuse	0-7 years	8	27.58%
	8-17 years	21	72.42%
Duration of abuse	o-5 year	3	10.34
	6-10 years	22	75.86
	>10years	4	13.79
Type of the abuse	Non-contact	0	0%
	Contact	17	58.62%
	Penetration	12	41.37%
Frequency	once	9	31.01%
	A few time a year	11	37.93%
	Few time a month	7	24.14%
	Every week	2	6.89%
Use of forces	Psychological violence	7	24.14%
	Physical violence	22	75.86%

Table 1 presents the demographic feature of abuse characteristic of the samples. The demographic character of the sample subjects includes children from age five to seventy. Their educational background ranges from grade one to twelve. All of them are female. When we see their place of residence, the survival children come from all six kabeles of the city.

As Table 1 shows only one offenders has sexually abused the majority children; that is, 93.1% of the survivors were abused by only one offender and a considerable number of the survivors children 6.68% were abused by two persons. But no abused occurred by more than two offenders. Many of the survivors had been numerously sexually abused for a long period of time by someone closer in the nuclear family(about 51.72%).the sexual abuse often started before and after the age of 8.The majority (72.42%)0f the abuse started between the age of 8-17;and the duration rage between a single episode to numerous times spanning seven years. that is, in the case the abuse intra familial like incest, the sexual relationship stayed from single incident to about seven years being its maximum. the statics on the duration of the sexual abuse tell us that most of the sexual abuses do not last long except as in case of incest where the relationship proceeds in a hidden manner. Besides, the type of abuse indicated that there was no sexual abuse taking place without contact.non contact sexual abuse was inexistent (0%).whereas ,more than half of the sample subjects (about 58.62%) were sexually abused with contacts that involved pressure or force, etc and about 41.37%of the sexually abuse involved penetration.

Based on the frequency of the incidence, about 31.01%of the respondents were sexually abused only once.24.14% of the sample respondents were sexually abused in a few times a month. However, the highest marked frequency of the sexual abused that was taking place a few times a years was in only 37.93% of the total survivors. This tells us those survivors' children who were involved in the sexual relationship for a long time with a marked frequency were those who were abused or victimized by someone in the nuclear family. Therefore, it is possible to conclude that there in a significant relationship between relationships to the perpetrators, duration and frequency of the sexual abused .last, but not least, and almost all perpetrators used violence against their victims either by threatening or by utilizing physical violence.

Discloser and Reaction

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

Accordingly, most of the respondents in the study stated that in the beginning, the abuse was accomplished by "silence" the reason for all of the sample subjects to prefer silence is because of fear of the reaction on how receptive their families may be to acknowledge their sexual abuse and the community culture of perception about sexual abuse which considered the act as normal that the perpetrator only force to marry the victim. Thus, this study may help to make sense why survivors of the sexual abuse remain silent.

From the respondents of this study, despite the delay in reporting, all of the sample subjects disclosed their cases in one or another way. For all of these survivors the most common person first told was the Mather. But about 49% of the mothers responded negatively. The study found that it is in the cases where the sexual abuse was incest that all of these mothers responded negatively.

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

On the other hand, family support was found to be less available to the victim child following disclosure in case where the offender was within the family member or in intra familiar abuse .in the support of this idea, a study by Russel (1986) found that those who disclose their sexual abused by their father or brother were only supported in 31% of the cases whereas those who were abused by a more distant male relative were supported in 80% of the cases.

The disclosure of the victim child in this study was believed more when the offender is a stranger or someone not from family member. otherwise, the closer the perpetrator to the family, the less likely was the child believed in reporting the sexual abuse .most of the incestuous survivors(87%) were targeted as a cause for the family s socioeconomic disruption. This is because after disclosure, the

father (the breadwinner) of the family accused of sexually abusing the child under his custody, the father imprisoned. Then, the family income drained and the family suffers. Thus, this study discovered that children abused by family members were at high risk and faced greater psychological and social consequences.

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

4.2- Post Trauma Stress Disorder

Table-2 PTSD symptoms scale

	Scale Items	**1**		**2**		**3**		**4**	
		f	%	f	%	f	%	f	%
1	Do You have repeated disturbing memories, thought, or image of the event?	1	3.44	3	10.35	21	72.41	4	13.80
2	Do you have repeated disturbing dream of the event?	1	3.44	6	20.68	19	65.51	3	10.35
3	Do you suddenly act or feel as if the abuse were happening again?	1	3.44	12	41.38	14	48.28	2	6.90
4	Do you feel very upset when something reminded you of the event?	0	0	4	13.79	23	79.31	2	6.90
5	Do you have physical reactions when something remind you of the event?	2	6.90	11	37.93	12	41.38	4	13.79
6	Do you avoid thinking about or talking about the abuse or avoid having feeling related to it?	1	3.44	3	10.35	23	79.38	2	6.90
7	Do you avoid people, activities, or situations because they reminded you of the event?	0	0	3	10.35	22	75.86	4	13.79
8	Have you lost interest in activities that you used to enjoy?	2	6.90	15	51.72	11	37.93	1	3.44
9	Do you feel any distance from other people?	2	6.90	4	13.79	13	44.83	10	34.48
10	Do you feel as if your future plan or hope would not come true?	8	27.59	5	17.24	14	48.83	2	6.90
11	Do you have trouble in feeling or staying asleep?	2	6.90	4	13.79	18	62.07	5	17.24
12	Do you feel angry outburst?	4	13.79	2	6.90	14	48.28	9	31.03
13	Do you have difficulty in concentrating on your study Or other things?	9	31.03	5	17.24	14	48.28	1	3.44
14	Are you not able to have strong feeling (not very happy or sad on things)?	2	6.90	11	37.93	13	44.83	3	10.35

1-Almost never 2-Sometime 3-Often 4-Very often

One of the psychosocial effects of CSA is the experience of PTSD symptoms related to the abuse. Thus, the 14 standardized items on the PTSD symptom scale that are intended to measure whether the children experience these symptoms as a result of the sexual abuse or not were distributed to and scored by the survivor children according to their most distressing events on the scale. As a result, from all the respondents, it was found that an overwhelming majority (91.38%) of the victims had experienced the PTSD symptoms after the abuse .from these respondents, about 69.73% of them had highly experienced the consequences or the trauma . that is ,for these respondents(69.73%),the PTSD symptoms were observed to be at least ' often'. whereas ,about 8.62% of the respondents either did not experience the symptoms at all or they experienced the symptoms very rarely after the abuse.

The occurrence of these PTSD symptoms caused by the sexual abuse scored as 'almost never 'was very small number of the respondents 8.62%.this implies that about 91.38%of the respondents were experiencing and experienced the PTSD symptoms or its psychosocial effects because of the sexual abuse. From these, the response or the scoring of these some four respondents was somehow exceptional. That is, the scoring of these respondents was observed to have very few of the symptoms. Otherwise, they were either experiencing the symptoms rarely in case something reminded them o the sexual abuse or they were experiencing the symptoms at all most of the times. When the researcher was conducting observation, these samples were found or observed to be relatively relaxed, anxiety-free and depression free. What is common to these respondents were they were about the same in age and they were somehow older than the

survivors. Therefore, it is possible to conduct that the occurrence of PTSD symptoms as psychosocial effects of sexual abuse may be less as age increases or if the age of the

On the other hand, from the 14 items intended to measure the PTSD symptoms resulting from sexual abuse, some of the items were occurring highly or mostly in the high majority of the respondents. That is, items numbers 1, 2, 3, 4, 6, 7, 9, 11, and 12 were faced often and very often by a very high proportion of the respondents 77.04%. The most frequently and seriously observed PTSD symptoms of the sexual abuse by the survivors children among others from table 2 were (item numbers 1,2,4,6,7,11 and 12) having repeated ,disturbing dreams, memories or thought of sexual abuse ,feeling very upset when something reminded them of the sexual abuse, avoiding to think or to talk about sexual abuse or feeling related to it, and even avoid people ,activities or situations that are reminders of the sexual abuse ,having trouble in feeling or staying asleep, and finally increased arousal of irritation or out breast of anger.

To summarize the above result high numbers of the respondents (68.36) are found to have almost all symptoms of PTSD. Thus, the presentence of PTSD symptoms by sexually abused children can be said very common.

4.3. Emotional Distress

Table 3.Emotional distress scale

NB- **1**-Never **2**- Sometime **3**-Often **4**-Very often

	Scale Items	1		2		3		4	
		F	%	f	%	f	%	f	%
1	I want things right away.	3	10.35	19	65.51	6	20.68	1	3.44
2	I refuse to sleep alone	4	13.80	3	10.35	19	65.51	3	10.35
3	I feel fearful without reason	2	6.90	4	13.80	20	68.97	3	10.35
4	I cry without good reason (s)	11	37.93	13	44.83	3	10.35	3	10.35
5	I feel sad and withdrawn	1	3.44	1	3.44	22	75.86	5	17.24
6	I feel worried	0	o	4	13.80	23	79.38	2	6.90
7	I do not want to be left alone	2	6.90	3	10.35	16	55.17	8	27.59
8	I become hyperactive	1	3.44	7	24.14	19	65.51	2	6.90
9	I have temper tantrums	1	3.44	3	10.35	21	72.41	4	13.80
10	I easily become worried	1	3.44	3	10.35	18	62.07	7	24.14
11	I become aggressive person	4	13.80	2	6.90	17	24.14	6	20.68
12	I created games, stories or pictures about the traumatic events	3	10.35	1	3.44	18	62.07	7	24.14
13	I bring up the traumatic event on conversation	22	75.86	4	13.80	2	6.90	1	3.44
14	I avoid taking about the trauma even when asked	0	0	1	3.44	23	79.38	5	17.24
15	I become fearful of things that are reminders of the traumatic event	1	3.44	1	3.44	22	75.86	5	17.24

Being emotionally distressed is anther serious psychological effects faced by survivors of the sexual abuse frequently .The emotional distress is a result of both psychological and social problems.

Based on the score of survivor children, a very high majority of the respondents (86.85%) indicated that they were experiencing the emotional distress symptoms

as the result of the sexual abuse. From this survivors, about 70.65% of the survivors were highly suffering from emotional distress was observed frequently. On the contrary, a small respondents (13.15%) were become 'almost never' emotionally distressed. what is special here is that those survivors who were not severely suffering the psychosocial effects of the sexual abuse in the case of the PTSD symptoms were not suffering high emotional distress too.

From the items on the emotional distress scale, there were items that had been faced by the survivors of the sexual abuse more than the others. Item numbers 2, 3,5 ,6, 8,9,10,12,14 and 15 from the table 3 were faced 'often' or 'very often' by a very high numbers of respondents. That mean, these item were among the most frequently observed symptoms or problem of emotional distress by the majority of the survivors children. Thus, the most frequently experienced emotional distress effects of the sexual abuse of the survivors children were, among others ,refusal and free of sleep, feeling fearful without reason , feeling sad, withdraw and worried ,having temper tantrum, becoming easily started and highly aggressive ,creating games, stories and pictures about the traumatic events ,refusing to bring out the traumatic event into conversation, becoming unwilling to talk about the abuse, and being fearful of things that are reminders of the sexual abuse.

In general the numbers of victims free from the depression in this category is found to be relatively small; that is 13.15%. However, depression, being faced by a very majority of the respondents, is seen to be a symptom of most frequently observed by CSA survivors than the other symptoms.

4.4 Anxiety

Table -4 anxiety symptoms scale

	Scale items	1		2		3		4	
		f	%	f	%	f	%	f	%
1	I get nerves when things do not go right.	6	3.44	12	6.90	10	75.86	1	13.80
2	Others seem to do things easier than I do.	2	6.90	3	10,35	17	58.62	7	24.14
3	I worry a lot of time	1	3.44	1	3.44	23	79.38	4	13.80
4	I get made easily	2	6.90	4	13.80	18	62.07	5	17.24
5	I feel that other people do not like the way I do things	1	3.44	2	6.90	24	82.76	2	6.90
6	it is hard for me to get to sleep at night	1	3.44	3	10.35	23	79.38	2	6.90
7	I feel alone when there are people with me	2	6.90	4	13.80	19	65.51	4	13.80
8	My feeling get hurt easily	1	3.44	5	17.24	17	58.62	6	20.68
9	I am afraid a lot of time	7	24.14	9	31.03	11	37.93	2	6.90
10	Other children are happier than I am	0	0	3	10.35	24	82.76	2	6.90
11	I have bad dream	1	3.44	2	6.90	22	75.86	4	13.80
12	My feelings get hurt easily when I am fussed at.	2	6.90	3	10.35	19	65.51	5	17.24
13	I feel someone will tell me I do things in wrong way	5	3.44	13	27.59	9	62.07	2	6.90
14	I wake up scared some of the time	2	6.90	3	10.35	20	20.68	4	13.80
15	I worry when I usually go to bed at night	1	3.44	3	10.35	22	75.86	3	10.35
16	it is hard for me to keep my mind on my school	0	0	3	10.35	20	68.97	6	20.68
17	I squirm in my seat a lot	4	13.80	12	41.38	11	37.93	2	6.90
18	people are against me	3	10.35	8	27.59	13	44.83	5	17.24
19	I often worry about something bad happening to me	0	0	3	10.35	24	82.76	2	6.90
20	My hands feel sweaty	7	24.14	9	31.03	10	34.48	3	10.35

NB- **1**-Never **2**- sometime **3-**often **4**-very often

The 20 standardized items used to assess the anxiety symptoms of victim children. Anxiety is among the most repeatedly observed consequences of CSA. As a result, from the total samples of child victims, about 91.67% of the survivor's children were obtained to have high anxiety symptoms as the result of the sexual abuse. That is, the majority of the respondents were feeling anxious and irritable because of the abusive trauma. whereas, very small survivors (8.33%) were not experiencing the anxiety symptoms at all after being sexually abused. when we look on the demographic characteristic of these respondents who were relatively free from anxiety symptoms they were older than the other victims; they were at least 14 years old and above. Besides, all of the victims were abused by strangers not by a family.

From the items used as anxiety scales, some items (item numbers 1, 9, 13, 17 and 20) were less observed or scored by the majority of the survivor children. That is, the survivors were not suffering from being tired easily; from a feeling that someone will tell them they do things the wrong way, wriggling in their seat, or hand-seating. whereas ,the rest items(item numbers 2,3,5.6.7.8,11,12,14,16,18 and 19) from the table 4 were experienced frequently by most survivors of the sexual abuse. That is, the anxiety symptoms most frequently faced by the survivors children were inability to do things easily than others, a lot of worry, getting mad easily, feeling of loneliness, gutting easily hurt, being unhappy, having bad dream, waking up scared because of the trauma, phobia with sleep and bed, and Worrying about bad things had happen to them.

A general summary of the results of the respondents' from the above table 21.01% of the survivors children showed mild anxiety experience (they experience the symptoms sometime); the majority of the respondents (70.66%) showed from moderate to severe anxiety experience. This indicates that a grater majority of the survivors showed profoundly significant anxiety symptoms. On contrary, those who experience very low or no anxiety symptoms are only 8.33% from all the total respondents.

4.5 Symptoms of the CSA Observed by Non-offending Parents

Table 5.signs and symptoms of child sexual abuse from parents

Have you observed your child exhibit any of the following?	No		Some times		often		Very often	
	F	%	f	%	f	%	F	%
Does she have abnormal interest in sex and sexual activity?	1	16.67	2	33.33	4	66.67	0	0
Does she fear to be alone with a give person	0	0	1	16.33	4	66.67	1	16.67
Does she show sudden emotional changes?	1	16.67	1	16.67	3	50	1	16.67
Does she show less trust of those in the immediate environment or those with greater Power?	0	0	1	16.67	4	66.67	1	16.67
Does she show isolation from friends and others?	0	0	2	33.33	4	66.67	0	0

NB- **1**-No **2**- Sometime **3-**Often **4**-Very often

Tables 5 show some symptoms of the psychosocial effects or consequences of the sexually abused children as observed by their nuclear family (especially by their mothers since almost all of the respondents were mothers of the victim children). The symptoms of CSA mentioned above in the table indicate both psychological and social problems of the survivor children.

The response of some of these parents showed that almost these entire survivor children exhibit the after mentioned symptoms of CSA as were observed by their parents. As it is shown in the table5, about 70.97%of the survivor children exhibited the above signs of CSA in a more frequently manner; that is 70.97% of the respondents observed their victim child frequently –'often' or 'very often'- to be socially isolated, to have less trust on others and even on those with greater power; sudden emotional or behavioral change, fear of left alone with a given person because of lack of trust and abnormal curiosity about sex.

The observation of these signs of CSA, as it was reported by parents of these victim children, replicates the previous findings and literatures on CSA. For example, the development of abnormal interest or curiosity about sex' after the abuse goes with one of Browne & Finkehlores (1986) model explaining long term effects of CSA called 'traumatic sexualization'- in which the victim's child sexuality is shaped by the abuse which may result in confusion about sexual identity, norms or standards. 'fear of left alone with any person may also correlate with 'powerlessness'- in which a child being incapable to protect herself left alone with someone that can dominate; as a result, the child will have ineffective attempts to stop the abuse .'Lack of trust on others and on those with greater power' can be seen 'betrayal'- in which the child has been exploited by a trusted individual through sexual. and lastly, "social isolation' may correlate with Browne & Finkehlore's (19860) "stigmaziationthe"- feeling of shame and guilt may develop because of the abuse and victim child preferred to be isolated in order to escape from the possible bad social reaction.

Discussion

Based on the above three standard scales, the researcher tries to see the problems these survivors faced, and the intensity of the problems. The result of the study supported the idea that sexually abused children, despite the difference in the severity of the problems, suffer both psychologically and social consequences as a result of the sexual abuse.

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

The result of the study found that when compared with the time before the sexual abuse (as it was reported by the non-offending parents of the victims); those children who had been sexually abused showed more symptoms of PTSD, Emotional distress, anxiety and interpersonal difficulties. More specifically, these victims children showed more fear, nightmares, withdraw behaviors, psychological unwellness , delinquency, sexualized behaviors, running way ,general behavioral problems, poor self-esteem, self-injurious behaviors, internalizing behaviors(like depression, inhibition, overt control) and externalized behaviors(such as aggression, antisocial and under controlled behaviors.)

Victims of CSA are at risk of exposure to high stress level during their life time. That is, the sexual abuse is not over when the molestation is over- its effect is an ongoing process over time as we can see from the responses of the victims.

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

In conclusion, there are factors such as age of the child, duration of the abuse, the degree of closeness of the offender, and other factors that contribute to severe effects of the sexual abuse. The effects of the CSA and incest may relate to variables in the dynamics of the abuse.

4.6 Coping Strategies Used by Victim Children

Table 6.coping strategies used by victim children

Coping strategies	Victims	
	f	%
Self-improvement action -considering several alternatives to handle it, thinking on things which create good feeling, etc.)	26	89.66
Seeking solution- (talking with professionals and others who can help you)	19	65.51
Keeping busy- (keeping the mind off the problem and participating in different activities	6	20.68
Avoidance- social withdraw, less interested in group activities	5	17.24

As it is shown in table 6, the overwhelming majority of the sample children (about 89.66%) identified 'self-improvement' efforts as their primary means of coping with the sexual abused. They indicated that they would continue to work on considering several alternatives to handle the after effects of the abuse by having thoughts that create better feelings. In doing so, some sample indicated that they would prefer to escape from or telling a lie about the situation so that they will not re-victimized by remembering the abuse. By using self-improvement as coping strategy ,more than half of the respondents (about 65.51%) were using seeking solution' for the problems they faced as their coping strategies. These samples reported that they could improve their situation by talking to relatives especially to their mother and to someone whom they rely on; or by talking to professionals-counselors.

A majority of these samples applying “seeking solutions” as their coping mechanism stated than taking to professionals (their counselors) and obtaining counseling services enabled them to get some sort of relief from their previous trauma. In this case, thus, the counseling service served them both as a therapy and as a coping strategy. Besides, the respondents reported that when they came to the center for the intervention service and when they met their friends who are sexually abused, they feel relatively better. Because of their consideration of they are not the only person in this world who faced such type of problem.

A smaller proportion of the respondents (20.68%) were obtained to cope with their situation by “keeping themselves busy “. These children were keeping their mind off the abuse and participating in different activities that will enable them to forget the reality they live in. These groups of survivors were less interested in active resistance, and preferred to participate in activities such as play, sports, routine work, etc as means to keep busy.

The last group of sample subjects were somehow coping their problem in a different ways by preferring “avoidance or isolation” – 17.24%. These groups reported to be socially withdrawn, less interested in group activities, etc because of the lack of trust on the others. They also reported that they accepted what happened to them as they could do nothing about it. Though these respondents were small in number, almost all of them were found to be very young in age and abused by someone in the family or very trusted person. Overall, the above analysis indicated that almost all survivors of the sexual abuse applied some sort of the coping strategy in order to mitigate their problem.

4.7 **The Intervention Services for Victim Children**

Since these sexually abused victims were selected from the hospital sexual abused children care and support center, which has been providing professional intervention services, they were, asked about the nature of service they get “what type of help did you get from the center?”. They respond shows that they got medical, psychosocial and legal service. In order to treat the physical effects of the abuse, the center provide free general medical examination and treatment especially in focusing HIV and unwanted pregnancy. For those victims children who came to the center immediately to the incident the center offered emergency drug to reduce their risk of infecting with HIV and unwanted pregnancy. According to the information from observation and focused group discussion, to address the psychosocial impacts of the victim children the center primary used Truman Focused –cognitive behavioral therapy and group therapy. Information from depth interview with counselor TB-CBT is important and effective intervention to solve all psychological and social impact of victim children. The other service the center organized for victim children is free legal aid for victim child and parents.

The victim asked the impact of intervention on their life ‘does the intervention services, you have received helped you to feel better or to deal more effectively with the problem that led you to seek professional help or therapy’, 52 % answered ‘yes- a great deal’, 29.92%replied’yes-to some extent, 8.60%answered ‘uncertain’, 6.06% replied ‘no it didn’t really help’ and 3.42%answered ‘no made things even worse’. Thus, the above finding indicated that the majority of the

survivor children reported as the intervention service helped them to reduce their abuse-related problem. The intervention service in the organization helped many of the survivors to overcome substantial problems and to ameliorate the effects of the remaining problems.

The last but not the list is the center prevention strategies to protect those children who are at risk of sexual violence. It is possible to say that there is no any kind of preventive approach applied by center to protect 'risk group children' from any kind of sexual violence. The center only emphasized on treating victim children. That is why almost all the samples of this study did not have any awareness regarding the occurrence of sexual violence or how to keep them from 'bad touché' before the abuse.

CHAPTER FIVE

CONCLUSION AND SUGGESTION

5.1 CONCLUSION

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

From the results of the study PTSD, Anxiety, emotional distress, depression, cognitive distortion, avoidance and interpersonal difficulties are the most frequently observed psychosocial consequences of the CSA.

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

All sexually abused children do not suffer equally from the problem. The magnitudes of the psychosocial impact determine by factors such as the victim's age, relationship to the offender, duration and frequency of the abuse, family and community support. The result of the study indicated that victim children who were abused at early age, or abused by a family member, and abused frequently for a long time are found to have severe psychological consequences than those who were not.

Almost all sexually abused children used their own coping strategies to make their situation better or to handle it. Their coping strategies include self-improvement techniques, keeping themselves busy, avoidance and seeking solution. These coping strategies are positive but also include negative strategies like avoidance, etc.

Children always want to tell about their abuse so that it can be stopped; but they are often afraid that will not be believed or protected or they are afraid of what might happen if they do tell. Especially in the case of incest, when the abuser is a close family member, children may not reveal their sexual victimization. Age of the victims, relation to the perpetrator, feeling of powerless, fear, dependency, conflicting emotions are found to be some of the basic factors why victims may or may not disclose their sexual abuse. There is a greater possibility of serious distress to the child if the abuser is a family member, or if the child doesn't receive support from her non-abusive parent.

All of the sample victims have been receiving medical, psychosocial and legal services from the center. Thus, the majority of these victims indicated that the intervention service which they got from the center helped them to reduced abused related problems. But there is no any kind of preventive approach designed by the care and support center or other organization in the city to protect 'risk group children' from any kind of sexual violence. All the samples of this study did not have any awareness regarding the occurrence of sexual violence or how to keep themselves from 'bad touché' before the abuse.

5.2 **Suggestions**

The following social work intervention is suggested for effective prevention and treatments of victims and risk groups of child sexual abuse:

- Launching of compressive child protection program in the society and creating awareness in the society is very essential to protect every child from sexual abuse.
- Prevention education is important for sexual abused children as they are at higher risk of revictimization .
- Prevention education is very much important for non-abused risk group children. Such educations help children in order to able to protect themselves.
- Parents are responsible more than anyone in educating their children from any kind of harm, in preventing, if the abuse occurs in immediately reporting the case to the concerned officials. Thus, parents should have good relation with their children, and should be equipped with the necessary information.
- Only a small portion of child sexual abuse is ever identified easily; therefore, social workers must consider the possibility of sexual abuse when a child with a behavioral or psychiatric disorder that can develop as a result of sexual abuse. When a child presents with depression, anxiety, emotional distress, or PTSD, the possibility of sexual abuse should be explored. These children should be asked a few screening questions regarding sexual abuse.

- Social workers must facilitate compressive professional intervention services for sexually abused children.

- If a child discloses a history of sexual abuse or has a physical examination finding that is concerning for sexual abuse, the social worker must report concerns of suspected sexual abuse to the appropriate officials or law enforcement agency.

- Counseling and rehabilitation services for sexually abused children should be provided extensively since psychosocial consequences are evidenced to their most serious problems.

- For the effective social work intervention of CSA, there must be organized rehabilitation centers, and well trained social workers.

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Appendix-i

St. Marry University College in the Collaboration with Indira Gandhi National Open University School of Social Work Questionnaires for Abused Children

INSTRACTION

This **questionnaire** is designed to assess the psychosocial impact of child sexual abuse in Goba town of Bale Zone. Since the success of the research dependent on respondent's reliable response, you are kindly requested to respond each question accurately and frankly. I promise complete anonymity confidentiality concerning everything you have done as part of this research. In addition your name and address will not be included as part of the data and included in the final version of MSW thesis.

I cannot begin to tell you how much I appreciate your help with this study undertaking .project. If you have any doubt about the questions, please ask me at any time. Again, thank you so much for your help and cooperation.

Part-1 Please considers the following reactions and rates the degrees whether or not experienced any of the following issues:

1**. POST TRUMA STRESS DISORDER SCALE** NB 1. Never 2.sometimes 3.often 4.very often

	Scale Items	1	2	3	4
1	Do You have repeated disturbing memories, thought, or image of the event?				
2	Do you have repeated disturbing dream of the event?				
3	Do you suddenly act or feel as if the abuse were happening again?				
4	Do you feel very upset when something reminded you of the event?				
5	Do you have physical reactions when something remind you of the event?				
6	Do you avoid thinking about or talking about the abuse or avoid having feeling related to it?				
7	Do you avoid people, activities, or situations because they reminded you of the event?				
8	. Have you lost interest in activities that you used to enjoy?				
9	Do you feel any distance from other people?				
10	Do you feel as if your future plan or hope would not come true?				
11	Do you have trouble in feeling or staying asleep?				
12	Do you feel angry outburst?				
13	Do you have difficulty in concentrating on your study?				
14	Are you not able to have strong feeling (not very happy or sad on things)?				

2. Anxiety scale- NB- **1**-Never **2**- sometime **3**-often **4**-very

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

often

	Scale Items	1	2	3	4
1	I want things right away.				
2	I refuse to sleep alone				
3	I feel fearful without reason				
4	I cry without good reason (s)				
5	I feel sad and withdrawn				
6	I feel worried				

7	I do not want to be left alone				
8	I become hyperactive				
9	I have temper tantrums				
10	I easily become worried				
11	I become aggressive person				
12	I created games, stories or pictures about the traumatic events				
13	I bring up the traumatic event on conversation				
14	I avoid taking about the trauma even when asked				
15	I become fearful of things that are reminders of the traumatic event				

3. Emotional Distress scale- NB- 1-Never 2- sometime 3-often 4-very often

Part-2 Give Short Answers for the Following Summary Questions.

1. Will you please summaries the main psychosocial effect of child sexual abuse?_____
   _____
   _____
   _____
   _____
2. Do you think that all victim children suffer equally from the incident?_____
   _____

_____

_____

3. What would you say about the Copying mechanism you used to reduce aftereffect?____
   _____
   _____
   _____
4. What would you say about the disclosing the incident?_____
   _____

_____

5. How do you see intervention you got after the incident? _____
_____
_____
_____

6. In your opinion, what should be done to address comprehensively the psychosocial problem of sexually abused children in Goba town of Bale Zone? _____
_____
_____
_____
_____

Appendix -ii

Interview Guide for Victim Children

1. Respondents code name _____ 2.Age ____
2. How old are you at the onset of the abuse?
A. 5-10 YEAR OLD B.11-15 YEARS OLD C.>16 YEARS OLD
3. What type of relationship do you have with perpetrators?
A. Nuclear family B. closed person
C. stranger d. others (please specify)_____
4. How many does the numbers of perpetrators?
a. One b) TWO C) THREE OR MORE
5. How long does the incidents persist?
A. 0-4 YEARS B. 5-10 YEARS C. >10 YEARS
6. How many times have you face the incident?
A. once B . A few time a year C. Few time a month D. Every week
7. What type(s) of force perpetuator were used?
A. Physical violence B. Psychological violence
8. What is the nature of the abuse?
A. Non-contact B. Contact C. Penetration
9. Did you disclose the abuse to someone immediately the incident?
A. yes B. no
9.1 If your answer is no, why?
10. To who did you disclosed the case for the first time?
A. Mother B. Friends C. Teachers D. other family members (please specify)_____
12. What type of response did you get?
13. How do you feel about the response of the person you told first?

14. Did you get support from your family after they had heard about the incident?
15. What types of measure did you use to make the situation better?
    A. **Self-improvement action** -(considering several alternatives to handle it, thinking on things which create good feeling, etc.)
    B. **Seeking solution-** (talking with professionals and others who can help you)
    C. **Keeping busy-** (keeping the mind off the problem and participating in different activities)
    D**. Avoidance-** (social withdraw, less interested in group activities)
    E. **others** (please specify)_____
16. What type of intervention service you got from the social service agency?
17. Does the intervention service you have received from agency help you to feel better?
    A. Yes- a great deal B. Yes to some extent
    C. Uncertain D. No, it didn't not really help
    E. others (please specify)_____

Appendix -iii

FOCUS GROUP DISCUSSION ITEMS

1. What are the psychosocial problems of sexually abused children faced after the incident?
   _____
   _____
   _____
2. Do all victimized children suffer equally from the **psychosocial problem(s**)?
   _____
   _____
   _____
   _____
3. What type(s) of coping mechanism were used by victimized children to make the situation (s) better?
   _____
   _____
   _____
4. How do the victimized children disclose the problem(s)?
5. To whom do the victimized children disclose the problem(s)?_____
   _____
   _____
   _____
6. What types of action are expected from different stakeholders to prevent child sexual abuse and to treat victimized children?
   _____
   _____

_____
_____

7. What do you think are the major strengths of the Medawolabo Child Care and Empowerment of the Organization?

   _____
   _____
   _____
   _____

8. What do you think are the major constraints of the Medawolabo Child Care and Empowerment of the Organization?

   _____
   _____

9. What do you suggest regarding the overall situations of child sexually abuse in the town?

   _____

Thank you!

Appendix -iv

Observation checklist of victim's children

No	Observed character	yes	No
1	anxiety feeling		
2	Depressed feeling		
3	get frustered too easily or with out good reason		
4	cling to adults/doesnt want to be alone		
5	seems fearul of things that are reminds of the incident		
6	Sense of frustrated future		
7	seem sad and withdraw		
8	Gulit feeling over acts of commission orommistion		
9	seems hyperactive		
1o	short tempered		
11	acts aggressively		
12	acts younger than used to for age		
13	Avoidance of thought,feeling or conversation		
14	Avoidance of people and activity		
15	avoiding taking about the incident when asked		

Appendix –v

INTERVIEW GUIDE QUESTIONS FOR KEY INFORMATE IN THE CITY
1.HOW IS THE PREVALENCE OF CHILD SEXUAL ABUSED IN THE CITY
_____
_____
_____
2.FROM OBSERED CASE, IN THE CITY WHO ARE THE
OFFENDER?_____
_____
_____
3.WHAT IS THE RECACTION OF VICTIMS FAMILY AND OTHER MEMBERS OF THE SOCIETY IN DISCLOSER OF CHILD SEXUAL ABUSE TO RESPONSIBLE
ORGAN?_____
_____
_____
4. WHAT DO YOU THINK THE PSYCHOSOCIAL IMPACT OF CHILD SEXUAL
ABUSE?_____
_____
_____
5.WHAT SHOULD BE TAKEN TO PREVENT CHILD SEXUAL ABUSE AND TO TREAT WELL VICTIMS CHILDREN IN THE
CITY?_____
_____
_____

Appendix- vi

St. Marry University College in the Collaboration with Indira Gandhi National Open University School of Social Work Questionnaires for Abused Children parents

INSTRACTION

This **questionnaire** is designed to assess the psychosocial impact of child sexual abuse in Goba town of Bale Zone. Since the success of the research dependent on respondent's reliable response, you are kindly requested to respond each question accurately and frankly. I promise complete anonymity confidentiality concerning everything you have done as part of this research. In addition your name and address will not be included as part of the data and included in the final version of MSW thesis.

I cannot begin to tell you how much I appreciate your help with this study undertaking .project. If you have any doubt about the questions, please ask me at any time. Again, thank you so much for your help and cooperation.

Part-1

Have you observed your child exhibit any of the following?		**YES**	**NO**
1	Does she have abnormal interest in sex and sexual activity?		
2	Does she fear to be alone with a give person?		
	Does she show sudden behavioral changes		
3	Does she show sudden emotional changes?		
4	Does she show less trust of those in the immediate environment or those with greater Power?		
5	Does she show isolation from friends and others?		

Part- please gives short answer for the following questions

1. Will you please summaries the main psychosocial problems occurred in your child after the incident? _____
   _____
   _____
   _____
   _____
2. Do you think that all victim children suffer equally from the incident?_____
   _____

_____

_____

3. What would you say about the Copying mechanism your child used to reduce aftereffect?_____
   _____
   _____
   _____
4. What would you say about your child disclosure of the incident?
   _____
   _____
   _____
5. How do you see intervention your child got after the incident?
   _____
   _____
   _____
   _____