UNIVERSITY OF GHANA

IMPACT OF SEXUAL ABUSE ON PSYCHOLOGICAL WELL-BEING AMONG SENIOR HIGH SCHOOL STUDENTS IN NORTHERN GHANA

BY

SALMA MOHAMMED

(10203381)

THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPHIL PSYCHOLOGY DEGREE.

JUNE, 2014

DECLARATION

I hereby assert that this thesis is the result of my own research and has not been presented by anyone for any academic award in this university or any other university. All references used in this work have been duly acknowledged. I bear sole and full responsibility for any shortcomings of this research work.

…….. ……..

Salma Mohammed Date

(10203381)

We hereby certify that this thesis was supervised in accordance with the procedures laid down by the University of Ghana.

…… ……

Dr. S. Atindanbila Date

Principal Supervisor

…… ……..

Dr. Afrifa Date

Co-Supervisor

DEDICATION

I dedicate this whole project work to my family.

To my handsome husband Abu-Zaid, my Mother, and all of my family and friends, thank you for all of the support you have given me.

ACKNOWLEDGMENTS

The highest gratitude goes to Allah almighty for my life and the life of those who contributed in several ways towards this project. I would like to thank my supervisors for their patience, constructive criticisms and assistance throughout the cause of my work.

I am also grateful to all the lecturers at the Department of Psychology, University of Ghana, for all the wonderful suggestions and comments given during the course of study.

I also, thank my respondents and the Heads of the schools from all the institutions I visited during my data collection for volunteering their time and sharing their stories with me. This project work was indeed made possible because of all you.

I am also appreciative of the encouragement from my family especially my husband and my sisters. You guys are simply the best.

Finally, thank you to everyone who supported me, listened to me, and encouraged me to keep going on. Dzifa, Emmanuel, Abdul-Fatahi, Eric and Stella, thank you for all your help from the very beginning. Without you keeping me motivated and encouraged, this would not have happened. I am so thankful for each and every one of you!

ABSTRACT

Child sexual abuse occurs throughout the world, although in most sub- Saharan countries there has been little research conducted on the problem and its psychological effects. Current research has established that a childhood history of sexual abuse is usually associated with a range of problem behaviors in childhood, adolescence and adulthood. Firstly, this study seeks to document the relationship between childhood sexual abuse and psychological wellbeing. Secondly, this study seeks to investigate the relationship between the forms of childhood sexual abuse and the types of perpetrators on psychological well-being. It further seeks to explore the moderating role of family relationships in the ensuing psychological sequelae following the experience of CSA. 380 Senior High School students from the Northern region of Ghana were used for the study. Results from the analyses indicated that there was no difference between males and females experience of CSA on psychological wellbeing. Results showed those students who experienced both forms of CSA (contact and non-contact) reported significantly less psychological wellbeing than students who experienced no CSA or only one form of CSA. Results further indicated that students who have experienced actual sex perpetrated by family members experienced less psychological well-being than students who experienced actual sex perpetrated by others. This means that sex perpetuated by family members have serious negative impact on victims. Finally it was observed that physical abuse and family relationships accounted for 24% and 13% of the variance in psychological distress respectively, indicating a significant impact of both on psychological distress. Implications for clinical practice and recommendations for future research are discussed.

TABLE OF CONTENTS

Content **Page**

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS:	Acquired Immune Deficiency Syndrome
ANNPCAN:	African Network for the Prevention and Protection against Child Abuse and Neglect
BSI:	Brief Symptom Inventory
CEVQ:	Childhood Experience of Violence Questionnaire
CSA:	Child Sexual Abuse
DOVVSU:	Domestic Violence and victim Support Unit
FRI:	Family Relationship Index
HIV:	`Hunan Immune Virus
PEP:	Post Exposure Prophylaxis
PTSD:	Post-Traumatic Stress Disorder
RPWB:	The Ryff Scales of Psychological Well-Being Inventory
STIs:	Sexually Transmitted Infections
SWB:	Subjective Well-Being
SWLS:	Satisfaction with Life Scale
UESE:	Unwanted Early Sexual Experiences
WAJU:	Women and Juvenile Unit of the Ghana Police Service
WHO:	World Health Organization

CHAPTER ONE

INTRODUCTION

Background to the Study

Over the last decade, it has become apparent that child sexual abuse (CSA) is more prevalent than previously estimated (Hornor, 2010; Finkelhor, 1994). It is now identified and recognized as a global health problem with resounding health implications (WHO, 2006). Child sexual abuse has been documented to have both immediate and long term adverse psychological effects that might be carried over into adolescence and adulthood (Hornor, 2010; Finkelhor, 1994).

Child sexual abuse is defined as when an older child, a youth or an adult uses a child for their own sexual gratification or pleasure (Ark Foundation, 2010). According to the Domestic Violence and Victim Support Unit DOVVSU sexual abuse, is "namely the forceful engagement of another person in a sexual contact which includes sexual conduct that abuses, humiliates or degrades the other person or otherwise violates sexual integrity …"). Child sexual abuse can be categorized as including physical contact forms of being touched and fondled in sexual areas and kissing; and non-contact forms, such as exposure, voyeurism, and child pornography (Fleming, 1997; Finkelhor, 1994). Some researchers (Jones & McQuiston, 1988; Wyatt, 1985) have included peers in child sexual abuse, provided that the sexual activities are unwanted, exploitative, or can otherwise be distinguished from normal sexual exploration and curiosity.

During the past decade, researchers have found that a history of sexual abuse is usually associated with a range of the problem behaviors in childhood, adolescence, and adulthood

(Hornor, 2010; Briere & Elliott, 1994; Kendall-Tackett, Williams, & Finkelhor, 1993). Some studies concluded that children who have been sexually abused are more likely than others to experience various emotional problems, including posttraumatic stress disorder, sexualized behavior, depression, anxiety, high levels of anger and aggression, interpersonal difficulties and low moral (e.g. Luster, 1997).

Despite the increased academic and political discourse that has attended to this societal problem, there are still gaps in research in many parts of the world, most noticeably in Sub-Saharan Africa. With the exception of South Africa, most countries on the continent lack in peer reviewed research on CSA (Lalor, 2004), with the media dominating reportage and often capturing the most shocking cases. Explanations given for this oversight include the belief that CSA is only a recent incident in Sub-Saharan Africa. It is also thought that it is so culturally engrained so that it is considered the norm (Lalor, 2004). The dearth of research on child sexual abuse can also be attributed to lack of resources due to the overshadowing of child care by political and economic problems, and lack of a research culture and history (Lachman, 1996).

To address this issue of lack of research data on the African continent the African Network for the Prevention and Protection of Children against Neglect (ANPPCAN) organized conferences for stake holders (ANPPCAN, 2007; 2012). These conferences were designed among others to highlight other research areas as most researches are still geared towards perceptions of the problem, estimating the prevalence of CSA, the connection to HIV and AIDS and other STI's, sexual violence legislation and other legal and medical reasons (Madu & Peltzer, 2000, 2001; Armstrong, 1998; Lema, 1997; Meursing et al. 1995; Kisekka & Otesanya, 1988). It was noted

that most research done in Africa fail to record the psychological impacts as a product or contributing factor of child sexual abuse. This makes it necessary for researches such as the current one to investigate the psychological impact of sexual abuse.

In Ghana, sexual abuse is not uncommon, currently there are not enough, accurate and reliable statistical data on sexual abuse in general and CSA abuse in particular. Data from the Domestic Violence and Victims Support Unit (DOVVSU) show an upward trend in reported cases of rape, assault, incest, early marriage and attempted rape from 181 in 2000 to 1,578 in 2007. This rising trend in sexual abuse is consistent in school records and on the streets of Accra (Ampofo et al., 2007; Brown, 2003). According to a Non-Governmental Organizations (NGO) report 53% of sexual abuse cases occurred in the school environment while 47% happened at home while 67% of the victims of child sexual abuse are in senior high school, 28% in Junior high school and 5% in primary school (Plan Ghana, 2009).

Similarly, in Ghana as in other countries CSA poses a challenge to the survival, development and participation of children in homes, schools, communities, sacred places and even on the streets (Ampofo et al., 2007; Brown, 2003). This impedes their right to health, education, dignity and well-being and serves as a hindrance to the implementation and realization of other rights entitled them. However, sexual abuse remains under reported due the fact that victims of sexual abuse are stigmatized and ostracized by their families and others as a consequence of the abuse. Also, the perceived shame and secrecy associated with it as well as the perceived negative outcomes it has on the family and individual further hinders reportage (Ampofo, et al., 2007).

Despite the worrying statistics, in Ghana today there is still a dearth of research on the impact of CSA on the psychological well-being of survivors. The present study aims to examine the impact of CSA among males and females adolescents in the northern region of Ghana and document possible psychological effects on student survivors of CSA and their satisfaction with life. It further seeks to explore the possible significance of family relationships in the ensuing psychological squeal following experience of CSA.

Epidemiology

The World Health Organization (WHO) 2006 report on violence and health estimated that globally, about 223 million children (150 million girls and 73 million boys) have experienced forced sexual intercourse or other forms of sexual violence; 1.8 million children were involved in prostitution and pornography and 1.2 million are victims of trafficking. Other researchers estimate that between 7-36% of female and 5-10% of male children suffer from sexual violence (Jewkes, Penn-Kekana & Rose-Junius, 2005; Jewkes, Sen, & García-Moreno, 2002; Finkelhor, 1994).

According to the Centers for Disease Control and Prevention (2005, 2007), sexual violence is a pervasive problem in the United States. An estimated 8% reported having been forced to have sex among a population of high school students surveyed nationwide. Females (11%) were more likely to report having been forced to have sex than males (4%). Likewise an estimated 20% to 25% of college women in the United States experience attempted or complete rape during their college career (Centers for Disease Control and Prevention, 2005, 2007).

The prevalence of CSA in Africa is similar (if no higher instances than on other continents). Geographical review of global prevalence rates estimates the highest prevalence rate of child sexual abuse to be in Africa (34.4%), while Europe reported the lowest prevalence rate of 9.2% (Stoltenborgh, Van IJzendoorn, Euser & Bakermans-Kranenburg, 2011). Globally South Africa showed the highest prevalence rates for both women (60.9%) and men (43.7%) (Stoltenborgh, Van IJzendoorn, et.al, 2011).

In other African countries such as Kenya, an estimated 10 girls or women were raped every month from a population of 12 million (Kakhongwe & Mkandawire, 1999). Results from another survey of 501 children in both rural and urban centers revealed that 7.6% of children were reported as having been sexually abused (ANPPCAN, 2000). Likewise, percentages of adolescent females who was "not willing at all" to have sex in their first sexual debut were highest for Malawi 38%, followed by 30 % for Ghana, 23% for Uganda and the lowest figure for Burkina Faso was at 15% (Moore, Awusabo-Asare, Madise, John-Langba, & Kumi-Kyereme, 2007). They further stated that between 20 to 30 percent of this population reported to be "somewhat willing" at their first sexual debut.

In Ghana, the (DOVVSU) formerly known as Women and Juvenile Unit of the Ghana Police Service (WAJU) recorded annual cases of violence against women to have risen steadily from 360 in 1999 to 3622 in 2002 (WAJU, 2003). In 2002, between January 1999 and December 2002, the same unit reported 1072 of defilement and 249 of rape (Amoakohene, 2004). DOVVSU further recorded rising figures on cases of defilement and rape 755 to 1207 and 150 to 422, from 2003 to 2009 respectively.

In another article which sampled 3,047 Ghanaians six percent (6%) of the female respondents stated that they had been defiled (Ardayfio, 2005). Of the percentage defiled 78% reported close relations, acquaintances or family friends as the perpetrators. Eight percent (8%) of the female's respondents said they have had sex forced on them before, while 5% of the men said they had forced sex on their wives and girlfriends (Ardayfio, 2005).

Effects of Child Sexual Abuse

Child Sexual abuse has been associated with negative impacts on the mental, psychological and physical well-being of individuals particularly if the sexual abuse involved actual intercourse (Jonas et al., 2010; Cheasty, Clare & Collins, 1998). Victims of child sexual abuse are more likely to suffer from a range of psychological effects, both in the immediate period after the assault or over the longer term (Jonas et al., 2010; Hornor, 2010; Finkelhor, 1994). These include guilt, anger, anxiety, depression, post-traumatic stress disorder, sexual dysfunctions, somatic complaints, sleep disturbances, withdrawal from relationships and attempted suicide (Hornor, 2010; Finkelhor, 1994). CSA has also been associated with regression in academic studies, learning difficulties and or slower development, as well as negative behavioral patterns in later life (Maniglio, 2009).

Adolescent survivors of sexual abuse reportedly exhibit more behavioral and emotional problems than their counterparts who have not experienced any abuse (Auslander et al., 2002; Jonson-Reid & Way, 2001; Lipschitz, Rasmusson, Anyan, Cromwell, & Southwick, 2000). Similarly adolescents with a history of sexual abuse scored higher on measures of anxiety and depression and lower on interpersonal sensitivity and self-esteem than did those without such a

history (Lanz, 1995). According to other studies, victims of sexual assault often experience psychological difficulties like heightened fear, anger, anxiety, depression, guilt, self blame, loss of trust, flash backs, withdrawal and post traumatic stress disorder (Jewkes, Sen & Garcia-Morena, 2002; Smith & Kelly, 2001; Resick, 1993). Although the overwhelming focus, in both research and intervention programs, is on research and amelioration of the impact of sexual violence on women, sexual violence against men and boys also poses a significant problem.

In a few population-based studies conducted with adolescents in developing countries, the percentage of males reported ever having been the victim of sexual assault ranges from 3.6% in Namibia, 13.4% in the United Republic of Tanzania, 20% in Peru, 11% in South Africa and 29.9% in Cameroon (Krug, 2002). Furthermore, evidence available suggests that males may be even less likely than female victims to report an assault to the authorities (Jewkes, Penn-Kekana & Rose-Junius, 2005). This is due to a variety of reasons, including shame, guilt and fear of not being believed or of being denounced for what has occurred. Myths and strong prejudices surrounding male sexuality prevent men from coming forward (Jewkes, Penn-Kekana & Rose-Junius, 2005). Though experience of CSA for both genders is generally associated with negative psychological outcomes other notable researchers hold a different viewpoint.

Rind, Tromovitch, and Bauserman, (1998) suggested that the negative effects of CSA could be either small or in some instances even positive emphasizing that the relationship between psychopathology and CSA is usually low when other factors have been accounted for. They argued that causality of effects were often wrongly attributed to CSA, and that other

confounding variables, such as a dysfunctional home environment, were usually not taken into consideration in estimating the effects of CSA on psychological variables. A dysfunctional home environment may contribute to the child developing negative symptoms, such as adjustment problems, anxiety, depression and disruptive behaviors, which are often attributed to CSA (Bhandari, Winter, Messer & Metcalfe, 2011; Rind, Tromovitch, & Bauserman, 1998).

Similarly the type and quality of family relationships have also been shown to influence the development of psychological outcomes to child sexual abuse (Deblinger, Steer, & Lippman, 1999; Mannarino & Cohen, 1996; Kendall-Tackett, Williams, and Finkelhor 1993). A positive family or social environment may be linked with a reduced risk for negative psychological outcomes (Kinnally et al., 2009). Likewise, parental belief in the sexual abuse allegation and support can safeguard against the development of negative consequences for sexual abuse victims (Tremblay, Hebert & Piche, 1999). Other factors that help account for the myriad of behaviors associated with CSA include differences in age and gender of the child victim, the nature of the relationship between the child and the perpetrator, and the frequency and duration of the sexual abuse, (Horner, 2010).

In line with the above this study aimed to look at the psychological impact of child sexual abuse among an adolescent population in the Northern region of Ghana. It seeks to document possible psychological correlates on student survivors of sexual abuse and their satisfaction with life. It further seeks to explore the probable implications of family relationships in mitigating the impact of CSA on psychological well-being and distress.

Statement of the problem

Child sexual abuse impacts on the psychological well-being of the persons involved and thus might affect the student performance in school as well as psychosocial development. Sometimes victims of sexual abuse are stigmatized and ostracized by their families and others as a consequence of the abuse.

In Ghana, currently there is a recognized child sexual abuse problem in some Ghanaian schools (Leach et al., 2003; Brown, 2003; Coker-Appiah & Cusack, 1999). A study of public school children (Brown, 2003) found out that 11 percent of the children studied had been victims of either rape or defilement. Another study by Plan Ghana, (2009) stated that 53% of sexual abuse cases occurred in the school environment while 47% happened at home (Plan Ghana, 2009). It has also been noted that 67% of the victims of child sexual abuse are in senior high school, 28% in Junior high school and 5% in primary school (Plan Ghana, 2009).

Despite these alarming statistics chronicling the prevalence of sexual abuse in the country it appears little has been done to document its detrimental or otherwise effects on survivors. To the best of the knowledge of the current researcher, most researches in Ghana concentrated on violence against women and girls and were concentrated in the central, eastern and southern sectors of the country (Ardayfio, 2005; Aryeetey, 2004; Amoakohene, 2004; Abbey et al., 1996). Moreover, these researches did not investigate the psychological impact of child sexual abuse has on survivors, (Ardayfio, 2005; Aryeetey, 2004; Amoakohene, 2004).

The former Vice President John Dramani Mahama and current president of Ghana called for more studies and research to document cases of child sexual abuse so as to get accurate data on

the nuisance (ANPPCAN, 2012). This was a speech read on his behalf at a conference for stakeholders of CSA in Ghana. The organizers of the conference noted among other things that, "…the impact of sexual abuse on children is devastating and requires skilled manpower to respond appropriately so as to yield results to the victim…'' This is a huge omission in Africa where children who have been extremely violated end up with unskilled service, providers who have no knowledge of sexual abuse and its impact. This is a double tragedy to sexually abused children in the continent" (ANPPCAN, 2007; 2012).

In line with the above this study seeks to understand the psychological impact of sexual abuse among a senior high school population in the Northern region of Ghana, their overall adjustment and satisfaction with life. Additionally it further seeks to examine the relationship between gender, forms of child sexual abuse and type of perpetrator on psychological well-being as well as taking into account victim's family relationship. Currently most studies examining effects of child sexual abuse on psychologically health concentrate on a measure of psychological distress and ignore or fail to consider it impact on measures of positive psychological well-being.

Rationale of the study

This study adopts the Ghanaian constitution, article 28 section 5, definition of the child being any person below the age of 18 years of age. This is because the study is being conducted in the Ghanaian context. As such, the use of the constitutional delineation will support all the national information and data. The United Nation Convention (1989) on the rights of a child similarly defined the child as one who is vulnerable needs exceptional care and protection and is below 18 years of age.

Child sexual abuse impacts on the psychological well-being of the persons involved and thus might affect the student experience and performance in school. Thus, strategies must be put in place to stop or at least help curb the menace. Sometimes victims of sexual abuse are stigmatized and ostracized by their families and others as a consequence of the abuse rather than being provided with the medical and psychological services that are essential to their well-being.

It would therefore, be useful to assess the extent of CSA and how the experience affects students psychologically. This would enable schools to be alert and be able to promptly identify sexually abused students who might need psychological and counseling services and provide such services. Additionally the early management of CSA victims among these students is crucial as this influences the degree and rate of recovery of victims from both psychological and physical effects. The physical injuries may require immediate or long term attention (for example, in the case of sexually transmitted infections (STIs) and HIV, unwanted and unintended pregnancy and unsafe abortion (Kilonzo & Taegtmeyer, 2005). Furthermore, early interventions geared towards helping victims of CSA as been found to prevent and or reduce psychological correlates as a product or function of CSA (Resnick, Acierno & Waldrop, 2007; Foa et al., 1999).

The study is also geared towards helping to create awareness of the possible similar effects of CSA on adolescent males in the country as some research documents that male suffer from similar psychological symptoms as their female counterparts and have to deal with the same, or potentially greater, negative reaction from their societies (Jewkes, et al., 2002). These reactions

might be more evident in a patriarchal and male dominated society as the Northern region where reportage of male CSA might further be discouraged.

Furthermore, studies from other continents and countries have demonstrated that the presence and quality of social and family environment serves as a buffer to the experience of CSA (Rind & Tromovitch, 1998; Kendal-Tackett, William and Finkelhor, 1993). In this vein, the researcher thought it relevant to assess the contribution of this variable on ameliorating the effects of CSA in the Ghanaian student population.

Relevance of the study

The study would contribute to the understanding of the CSA and its psychological impact among the Ghanaian sample. Findings from this study will serve as good information first of all to the Government agencies in Ghana especially the Ministry of Education. The results documenting the impact of CSA on psychological well-being will inform preventive and treatment strategies aimed at protecting young students in Ghana especially in the Northern Region. Likewise, it would help inform the need for the Ministry to employ qualified educational psychologist and/or trained school counselors to be stationed in schools and professionally handle cases of such nature.

In creating awareness of possible effects of CSA on males in the country (especially in the Northern region), results from this study will also go a long way to help inform the design of interventions which are gender sensitive. The Northern region of Ghana is mainly dominated by patriarchal attitudes which further hinders, male reportage of any form of abuse especially

sexual abuse thus information on effects of male CSA is crucial to modify current societal beliefs.

This study should also be a good reference for the Ministry of Health in the country as well. Findings from this research will help in the designing of programs that are meant to help victims of CSA so that, hospitals and clinics will be equipped not only with drugs and medical personnel, but also qualified psychological experts who can help victims deal with the trauma they might be experiencing. Victims experiencing psychological distresses are not able to seek such services maybe for the simple reason that the services are neither offered nor available to them.

Non-Governmental organizations would also benefit from the finding of this study. These bodies make tremendous efforts to complement government efforts in educational awareness and in providing services to victims of CSA. The question however, is whether they think of providing psychological services to these victims. In most cases, the answer is perhaps a no because some might have little idea as to the impact of CSA on psychological well-being or the level of some of the negative psychological outcomes experienced by victims. They may also fail to appreciate the need to do so. As such, a data base for such issues in the country through empirical research such as this will be a good point of call.

Finally, this study seeks to address the role of family environment especially family relationships in the reduction and management of negative psychological symptoms among a Ghanaian population and as such garner parental involvement in the fight against CSA.

Aims

The aims of conducting this study include the following;

1. To examine the possible effect of child sexual abuse on psychological functioning.
2. To explore the contributory role of family relationships on psychological effects of CSA.

Objectives

1. To examine the effects of the gender of child and impact of child sexual abuse on psychological well-being.
2. To explore how forms of child sexual abuse impact the psychological well-being of students.
3. To investigate the relationship between type of perpetrator and symptom severity on psychological measures.
4. To investigate the role of family relationship variables on effects of child sexual abuse.

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter presents information on the theory and review of literature on the problem under investigation. The chapter begins with the citation of the relevant theory that forms the background to this study. This is followed by the review of related studies that were done on the subject area. The review examined forms of CSA, gender of the victim, perpetrators' relationship with victim, victim's experience of physical abuse and victim family relationship in relation to psychological well-being among individuals who have been sexually abused. Implications and critique of such studies are given in the review.

Theoretical Framework

The Post-Traumatic Stress Disorder (PTSD) Model and the Traumagenic Dynamics Model of Childhood Sexual Abuse which offer various perspectives on the impact of sexual abuse victims have been used as the bases for this study.

The Post Traumatic Stress Disorder Model

According to Mullen, King and Tonge (2000), the relationship between child abuse and adult psychopathology was initially conceptualized in terms of Post-traumatic stress disorder (PTSD), and focused on trauma-induced symptoms, particularly dissociative disorders, amnesias and even multiple personality. This theory proposed that the stress-induced symptoms created during the abuse (including sexual abuse) produce a post-abuse syndrome in adult life. PSTD theory postulates that traumatic experiences profoundly impact the ways in which people

deal with their emotions and their environments (Van der Kolk, McFarlane, & Weisaeth, 1996). Subsuming childhood sexual abuse within the PTSD framework has been an important step forward in understanding its impact. In addition, PTSD enables these effects to be viewed as a syndrome with core etiology rather than just a list of symptoms. This places childhood sexual abuse into a broader context by highlighting similarities with other trauma experiences and dynamics.

Research has consistently documented the relationship between PTSD and child abuse (Lindberg & Distad, 1985; Spila, Makara, Kozak, & Urbanska, 2008). For instance, comparing the effects of different types of traumatic events suggests that the experience of child sexual abuse and sexual abuse (male and female) may be more likely to lead to PTSD than other types of traumatic events. This percentage at 54% was significantly higher than the 38.8% diagnosed in men who had experienced combat (Kessler, Sonnega, Bromet, Hughes & Nelson, 1995).

On the negative side, although PTSD accounts for many of the observed impacts of childhood sexual abuse it does not account for the full range of survivors experience, such as depression, self-blame, guilt and sexual problems as well as self-destructive behaviours, suicide, and victimization. In focusing almost entirely on emotion as the location of trauma the PTSD model is in danger of minimizing or ignoring other vital impacts, especially impacts on cognition. Distortions of cognitive processes are common in childhood sexual abuse survivors and it is these distortions that are related to mood disturbances and low self-esteem in adulthood.

Another problem with the PTSD framework is that many of the diagnostic criteria are not met in many survivors. Childhood sexual abuse is not always, necessarily accompanied by danger, threat or violence and much of childhood sexual abuse is a process rather than a discreet event.

Children often only realize in retrospect that they have in fact been abused. This awareness develops in light of increasing awareness and cognitive understanding of appropriate and inappropriate touching and sexual behaviour. So the trauma of childhood sexual abuse stems not solely from potential physical danger or threat, or from an overwhelming event but may be lodged in the dynamics of a relationship involving the betrayal of trust, the meaning allocated to the behaviour and feelings of guilt.

The Traumagenic Dynamics Model of Childhood Sexual Abuse

Finkelhor and Browne (1985, 1986) developed a comprehensive model for understanding the trauma of sexual abuse and its short and long-term effects. They postulated that the experience of sexual abuse can be analyzed in terms of four trauma-causing factors, or what they referred to as 'traumagenic dynamics' which explains the impacts of CSA on victims. The four trauma causing factors are traumatic sexualization, powerlessness, stigmatization and betrayal. According to this theory, any experience that alters a child's cognitive or emotional orientation to the world can cause trauma by distorting the child's self-concept, worldview or emotional capacities. In turn, coping with these distortions can give rise to the observed psychological and behavioral effects of childhood sexual abuse (Finkelhor, 1987). The Traumagenic Model is process-oriented conceptualizing sexual abuse as an ongoing, dynamic process in the child's life (Finkelhor & Browne 1985, 1986; Finkelhor, 1987).

The first dynamic explains how sexuality is shaped, often in an inappropriate and dysfunctional manner. Finkelhor and Browne (1985) stated that the traumatic sexualization refers to a process in which a child's sexuality which includes both sexual feelings and attitudes has been shaped in a developmentally inappropriate and interpersonally dysfunctional way. It also occurs when

the child's mind regarding sexual activity is associated with very frightening memories and events. Children who have been traumatically sexualized emerge from their experiences with improper repertoires of sexual behavior, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities (Finkelhor & Browne 1985, 1986).

The stigmatization aspect of traumagenic dynamics of sexual abuse focuses on the negative nuances (such as shame, guilt and depravity) that are communicated to the child around the experiences and that then become incorporated into the child's self-image (Finkelhor & Browne 1985, 1986). These messages may be overtly communicated during the abuse by the abuser as a way of blaming, or communicated covertly through the furtiveness and secrecy of the abuse. In some cases messages are received later, especially during disclosure, when moral judgments about the deviancy of their experiences may be communicated by others such as the mother, family members, relatives or even professionals. Stigmatization may thus grow out of the child's prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria, or blame the child for what has transpired (Finkelhor & Browne 1985, 1986).

In the next dynamic, betrayal occurs when the victim discovers that someone they trust and depend upon, wishes or causes them harm (Finkelhor & Browne, 1985). This may happen the first time the abuse takes place, or may not occur until much later. The authors also suggest that betrayal might be dependent on how much the victim feels s/he has been betrayed, not just as a result of the closeness of the relationship. Finkelhor and Browne (1985, 1986) maintain that

betrayal may be much worse in the case of an abusive relationship which started off in an affectionate and nurturing way than in one in which there was suspicious behavior from the outset. Furthermore, they pointed out that sexual abuse experiences that are perpetrated by family members or other trusted persons obviously involve more potential for betrayal than those involving strangers. Thus this could manifest in greater impact on the child's psychological well- being. However, the degree of betrayal may also be affected by how taken in the child feels by the offender, whomever the offender may be. The authors also noted that children can also experience betrayal not only at the hands of offenders, but also with family members who were not abusing them. A family member whom they trusted but who was unable or unwilling to protect or believe them or who has a changed attitude toward them after disclosure of the abuse may also contribute to the dynamics of betrayal Finkelhor and Browne (1985, 1986). Obviously, the degree of betrayal is also related to a family's response to disclosure. Children who are disbelieved, blamed, or ostracized undoubtedly experience a greater sense of betrayal than those who are supported.

The dynamic of powerlessness mainly consists of repeated overruling and frustration of desires and wishes, along with a reduced sense of productivity; and the threat of injury and annihilation leading to disempowerment (Finkelhor & Browne, 1985, 1986). Many aspects of the sexual abuse experience contribute to this dynamic. In this dynamic the child's will, desires, and sense of efficacy are continually contravened. According to the authors a basic kind of powerlessness occurs in sexual abuse when a child's territory and body space are repeatedly invaded against the child's will. This is exacerbated by whatever coercion and manipulation the offender may impose as part of the abuse process. Powerlessness is then reinforced when a child sees his or her attempts to halt the abuse frustrated. It is increased when the child feels fear, when he or

she is unable to make adults understand or believe what is happening, or when he or she realizes how conditions of dependency have him or her trapped in the situation (Finkelhor & Browne, 1985, 1986).

As noted earlier coping with the traumagenic dynamics and their interaction in various ways result in the ensuing psychological and behavioral attributes associated with a history of CSA situation (Finkelhor & Browne, 1985, 1986). The authors further acknowledge that most of the psychological correlates as a result of CSA can be conveniently categorized according to one or two of these dynamics; however each dynamic may be more likely to be associated with specific impacts on psychological distress and well-being. For example stigmatization may be more related to guilt, shame, depression and low self esteem while betrayal might be connected with grief, depression, extreme dependency, mistrust, anger, hostility among others. Powerlessness might also be associated with somatic complaints, eating and sleeping disorders, depression, and inability to cope with their environment, dissociation, running away, school problems and truancy (Finkelhor & Browne, 1985). Furthermore there is no specific one on one connection with some psychological effects being associated with several dynamics (e.g. depression and/or anxiety may be as a result of traumatic sexualization, betrayal, powerlessness and stigma among) (Finkelhor & Browne, 1985).

According to Finkelhor and Browne, (1985) the four trauma causing factors can be conceptualized as an ongoing process with elements of them existing before the abuse, are present during the abuse and afterwards. Thus a child who has already been exposed to adverse conditions is more likely to have a more negative impact on their psychological well-being. For example a previous history of physical abuse or a hostile family environment already

predisposed that child to feelings of powerlessness, betrayal and stigma, thus experiencing child sexual abuse might definitely lead to poorer psychological outcomes. Furthermore, how significant others (especially the parents) and society react during the abuse and disclosure also has an impact on psychological well-being. Thus in a family with healthy relationships, there is a greater chance of support; reassurance and relief for the victim (De Witt, 2009; Bass & Davis, 1988), translating to better outcomes on psychological well-being and distress.

This theory has numerous advantages (over what) firstly; it offers a much broader explanation of the range of reported impacts of childhood sexual abuse and proposes that the impact of trauma is related to the extent to which any of the four dynamics are present and how they might work in conjunction (Finkelhor, 1987). This enables the explicitation of similar effects with different behavioral manifestations which has major implications for treatment (Finkelhor, 1987). For example, symptoms of depression may be related to stigma or powerlessness. Finally, this model allows for variation and individual differences in the manifestation of the effects of childhood sexual abuse and explains why some survivors manifest certain impacts while others do not (Finkelhor, 1987). This has important implications for treatment in that it allows targeting of specific traumagenic dynamics rather than a general, rigid treatment plan for all childhood sexual abuse survivors (Finkelhor, 1987).

To summarize the researcher suggest that following from the four trauma causing dynamics, children who have experienced CSA will be more likely to exhibit lower psychological well-being and higher distresses especially those who have experienced both contact and non-contact forms of sexual abuse and CSA by family members. Similarly the researcher expects

that that both males and females will have similar impacts on their psychological well-being due to the presence of the traumagenic dynamics. It is also anticipated that family relations will help mitigate the impact of CSA on psychological well-being and distress among victims

Review of Related Studies

This aspect of the study reviewed various previous studies that have been conducted in the study area with regards to childhood sexual abuse and psychopathology, gender differences in experience of CSA, forms of abuse and symptom severity, family relationship as well as relationship of victim and abuser and its impact of severity of psychological symptoms. Critique of such studies is also provided.

Childhood Sexual Abuse and Psychopathology

Stoltenborgh, Van IJzendoorn, Euser and Bakermans-Kranenburg (2011) examined the influence of geographical and sample characteristics and procedural factors on the estimated prevalence rates. The review found a prevalence of 18% for girls and 7.6% for boys respectively. This may be due to a higher occurrence of CSA among females or the lower levels of non-disclosure among male victims or both reasons. Additional males might be afraid of being labeled as the initiators rather than victims of abuse or as homo-sexual as most perpetuators are after males, furthermore they might not consider the experiences as abuse in the light of sex stereotype especially if it involved older women.

Trickett, Noll and Putnam (2011) conducted a multi-generational and longitudinal study into the impact of sexual abuse on female development. The study covered a 23-year period

involving the impact of intra-familial sexual abuse and included 6- to 16-year-old females with substantiated sexual abuse histories. Results of many analyses, both within circumscribed developmental stages and across development, indicated that sexually abused females (on average) showed deleterious sequel across a host of bio-psychosocial domains including: earlier onsets of puberty, cognitive deficits, depression, dissociative symptoms, maladaptive sexual development, hypothalamic–pituitary–adrenal attenuation, asymmetrical stress responses, high rates of obesity, more major illnesses and healthcare utilization, dropping out of high school, persistent posttraumatic stress disorder, self-mutilation, *Diagnostic and Statistical Manual of Mental Disorders* diagnoses, physical and sexual victimization, premature deliveries, teen motherhood, drug and alcohol abuse, and domestic violence. It was also observed that offspring born to abused mothers were at increased risk for child maltreatment and overall problematic development.

McPherson (2002) stated that sexual abuse has long-lasting negative effects on children. Different forms of psychiatric problems or disorders are observed to be high among sexually abused children. In a meta-analytic review the author observed that sexually abused children have sleep disruption. They had higher levels and percentages of nocturnal activity, were twice as active at night and they emitted a higher percentage of their total daily activity during the night than the control groups. They took three times longer to fall asleep and had significantly poorer sleep efficiency (Glod, Teicher, Hartman & Harakal, 1997). This experience for instant would definitely affect the normal functioning of these children in all areas, as a good night sleep is very important. In that regards it is clear that sexual abuse has detrimental effects on children and leaves scars that might last a lifetime. This has been exemplified in several studies

(Zlotnick, Mattia & Zimmerman, 2001; McLeer, Dixon, Henry, Ruggiero, Escovitz, Niedda & Scholle, 1998).

From the foregoing, it is evident that having a history of childhood sexual abuse puts the individual at a risk for a broad range of psychological disorders and a higher rate of multiple Axis 1 disorders. In addition to this, McLeer et al. (1998) have indicated that there is a strong presence of Posttraumatic Stress Disorder (PTSD) and posttraumatic stress symptoms in sexually abused children. Depression is also found in sexually abused children (Briere & Elliott, 2003; Zlotnick, Mattia & Zimmerman, 2001; Roosa, Reinholtz &Angelini, 1999).

Another effect noted in victims of childhood sexual abuse is anxiety. Research has shown that anxiety levels in victims of childhood sexual abuse were significantly higher than the non-abused group (McLeer et.al, 1998) which investigated Psychopathology in non-clinically referred sexually abused children observed that sexually abused children are at high risk for PTSD and symptoms of posttraumatic stress, anxiety, and depression. Eighty non-clinically referred sexually abused children were compared with clinical and nonclinical groups of non-abused children matched by age, race, and socioeconomic status. McLeer et al (1998) concluded that sexually abused children are at high risk for PTSD and symptoms of posttraumatic stress, anxiety, and depression in the immediate period after disclosure and termination of abuse. McLeer and colleagues suggested that their findings indicate the need for routine and systematic evaluation for these symptoms and PTSD for treatment planning.

In their review of forty five (45) clinical and non clinical studies Kendal-Tackett, William and Finkelhor (1993) observed that childhood sexual abuse victims exhibited symptoms such as

anxiety, depression, withdrawn behavior, somatic complaint, aggression, and school problems. Moreover, CSA victims showed more symptoms than their non-abused counterparts with regards to scary nightmares, general PTSD, withdrawn behavior, neurotic mental illness, cruelty, delinquency and aggressive behavior such as tantrums and whining. Other conditions include enuresis, encropresis, running away, general behavior problems, internalizing and externalizing, suicidal ideation and poor self esteem. The review also highlighted specific outcome which seems to be present in the different age groups, hinting at a possible developmental pattern. For preschoolers (0-6) symptoms such as anxiety, general PTSD, internalizing, externalizing and inappropriate sexual behavior were observed. Among school age children, symptoms included fear, neurotic and general mental illness, aggression, nightmares, school problem, hyperactivity and aggressive behavior. For adolescents, common behavior exhibited were depression, withdrawal, suicidal, or self injurious, somatic complaint, illegal act, running away and substance abuse. Symptoms include nightmares, depression, withdrawn behavior, neurotic mental illness, aggression; a regressive behavior seems to feature in all age groups (Kendal-Tackett et al., 1993).

Holmes and Slap (1998) reviewed 166 clinical and non-clinical studies of CSA among boys. They asserted that male CSA is more common than was previously indicated. The review stated that the full extent of male CSA was previously not known because male victims might have been afraid of what other people's reactions to their disclosure may be and that they fear being stigmatized or that they may want to protect the perpetrator. The review noted that sexual abuse in boys occurred mainly before puberty and the most common duration is once-off experiences. The types of sexual incidents that were reported by males ranged from exhibitionism to anal penetration. They reported that the consequences of male CSA included

poor school performance, running away from home, aggression, anxiety disorders, PTSD, gender role confusion and depression. The review also reported that males who were sexually abused were up to five times more likely than their non-abused counterparts to report sexual problems as a result of the abuse. Sexually abused boys were found to be at a higher risk of engaging in risky sexual behaviors such as unprotected anal intercourse. It was concluded by the authors that not all victims responded negatively to the abuse, and that some victims had positive responses to the CSA.

It has been argued that previous researches mostly drew their samples from clinical and community populations which may not be true reflections of normal population as these samples especially those from clinical samples are more likely to report more negative psychological symptoms than other populations (Hyde, 2003). A famously cited meta-analysis is that of Rind, Tromovitch, and Bauserman (1998) using non-clinical samples. The review consisted of 59 studies that examined the long-term effect of child sexual abuse on college populations between the years of 1965 and 1995. The meta-analysis was geared towards answering whether the four basic assumption of child (1) child sexual abuse causes harm to the individual, (2) the harm is pervasive for individuals who have a history of child sexual abuse, (3) the harm experienced is likely to be intense, (4) the experience of child sexual abuse is equivalent for both genders were true. Their results indicated that the magnitudes of CSA and later psychological functioning were small (effect size was less than 1%). Other variables such as family environment accounted for a larger effect size (9%) than experience of CSA to later psychopathology. Rind, Tromovitch, and Bauserman (1998) concluded that the effects of CSA were not particularly damaging or intense for at least that population. They further found that

females generally experience more negative symptoms than males, thus their initial assumptions of CSA was not supported.

These findings lend support to theorized causal links between child sexual abuse and some aspects of later psychological well- being and distress.

Gender and Childhood Sexual Abuse

The three basic assumptions regarding gender difference of experience of CSA and psychological correlates are namely that there is no gender difference in the experience of CSA (Rind, et al., 1998). Secondly, that female victim of CSA generally experience more negative symptoms than males (Rind, et al., 1998). Finally other researchers assert male victims tend to display more externalizing outcomes while female victims tend to display more internalizing outcomes (Stern, Lynch, Oates, O'Toole, & Cooney, 1995; Kendall- Tackett et al., 1993).

As noted above, one of the basic assumptions about the effects of child sexual abuse reviewed earlier stated that it would result in equal harm for both males and females (Rind, et al., 1998). A meta-analysis review of 26 studies investigating the associating between CSA and later psychological correlates found that males and females did not differ in terms of later psychological outcomes (Jumper, 1995). Rind and Tromovitch (1997) in their meta-analysis examined the long-term impact of sexual abuse and found there was no significant difference between the genders on outcomes measured. They used 7 each of females and males based on national probability samples and noted that the effect size was generally small for both genders. The two meta-analyses above provide evidence to support the concept that CSA is experienced equally for males and females.

This conception has been challenged by other research work which is suggestive of an existing gender difference in the outcomes following CSA experience, with females generally experiencing more negative symptoms than males (Rind, et al., 1998; Haj-Yahia & Tamish, 2001). A study conducted by Haj-Yahia and Tamish (2001) among 652 Palestinians undergraduate students revealed that female victims of childhood sexual abuse showed significantly higher levels of somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism than their male abused counterparts.

The assertion that females more often report more negative symptoms than males could be due to the fact that generally statistics for male victims appear to be lower than those for females (Jewkes, Penn-Kekana & Rose-Junius, 2005). This does not mean that boys are not abused (Jewkes, Penn-Kekana & Rose-Junius, 2005). According to Spies (2007), boys who are sodomised and sexually abused do not generally disclose their experiences as often as girls do. They do, however, "experience the same feelings of anger, sadness, poor self-esteem, confusion and loss of power as sexually abused girls" (Spies, 2007: 52).

De Witt (2009) indicated that in South Africa and other African countries, children are raised in societies where boys are taught to be physically and emotionally strong while females are thought to physically and emotionally soft. As a result, boys less seldom show emotions such as crying and sadness. Male lack of display of emotions does not however mean that they are less affected than their female counterparts. Furthermore perpetrators of CSA can be male or female and where a man (as a young boy) was abused by a woman, the abuse is more traumatic

and impacts greatly on his decision not to disclose his experiences, generally as a result of being embarrassed and ashamed (De Witt, 2009; Guma & Henda, 2007).

In their research, Sherman and Sigfusdottir (2009) examined the impairments associated with childhood sexual abuse for both genders. Their sample consisted of 8618 Icelandic youth between the ages of 16 and 20. The authors access the participants on psychological factors such as general anxiety, eating anxiety, depressed mood, theft, and violent behavior. The results suggested that gender differences in impairment may depend on the particular psychological outcome measured. Sherman and Sigfusdottir (2009) concluded that females were approximately three times more likely than males to experience childhood sexual abuse; the association between childhood sexual abuse and subsequent depressed mood and general anxiety varied significantly by gender, with females more likely to experience these impairments; and the associations between childhood sexual abuse and subsequent eating anxiety, theft, and violent behavior did not vary by gender.

Lastly difference observed in research between the genders concerning experience of CSA is that male victims tend to display more externalizing outcomes while female victims tend to display more internalizing outcomes (Stern, Lynch, Oates, O'Toole, & Cooney, 1995; Kendall-Tackett et al., 1993).

Feiring, Taska and Lewis (1999) examined how age at the time of the sexual abuse discovery and gender of victim are related to psychological distress. One hundred and sixty-nine participants (96 children and 73 adolescents) were interviewed within 8 weeks of discovery of the abuse. Multivariate analyses were used to examine how age at discovery, and gender, with

abuse characteristics as covariates, were related to shame, attribution style, depression, self-esteem, and traumatic events sequel. Adolescents compared to children reported a higher level of depressive symptoms, negative reactions by others, and lower levels of self-esteem, social support, and sexual anxiety. Girls compared to boys report higher levels of intrusive thoughts, hyper arousal, sexual anxiety, personal vulnerability, and perceiving the world as a dangerous place and lower levels of eroticism.

Chandy (1996) investigated gender differences in the outcomes of sexually abused adolescents in relation to school performance, suicidal involvement, disordered eating behaviors, sexual risk taking, substance abuse, and delinquent behaviors of 370 males and 2,681 females. The participants completed self- reported questionnaires which measured history of sexual abuse. Chandy (1996) observed from the results that female adolescents engaged in more internalizing behaviors and males in externalizing behaviors. Male adolescents were found to be at higher risk than females in poor school performance, delinquent activities and sexual risk taking. Female's adolescents on the other hand showed higher risk for suicidal ideation and behavior as well as disordered eating.

To summarize the interest of this current study is to explore whether there are gender differences in psychological functioning after the experience of CSA.

Forms of Childhood Sexual Abuse and Psychopathology

Researches have shown different results for the influence of noncontact versus contact on psychological outcomes following CSA abuse experience (Kendal-Tackett et al., 1993; Beitchman et al., 1992; Beitchman, Zucker, Hood, Da-Costa, & Akman, 1991). Though the

results are non-conclusive over which form of abuse is associated with more severe outcomes, previous researches seem to suggest sexual abuse involving contact forms (i.e., intercourse or oral-genital contact) is generally linked to more negative outcomes (Li, Saifuddin & Zabin 2012). Other researches however show no relationships and later psychological outcomes (Beitchman et al., 1992).

The meta-analysis of Kendal-Tackett et al. (1993) provides an account for the variation in the symptomatology, sex of victims, identity of perpetrator, type of abuse (whether contact or not contact), among others. They asserted that all influence child sexual abuse symptomatology. They found severity of symptoms was positively correlated with number of times abused, relation to the perpetrator, duration of abuse, the use of physical force and sexual acts that involves penetration (oral, anal, and vaginal). Among those who experienced CSA 21% to 49% showed no symptoms at all and symptoms were found to abate overtime and 55 to 65 % of the children showed improvement in their level of symptoms over time. Conversely one third or 10% to 24% of the children in the review appeared to have gotten worse. In addition they found some symptoms such as anxiety were most likely to abate or disappear while symptoms like aggression, sexual preoccupation (12 years and below) may increase over time. It was also observed by Kendal-Tackett et al (1993) that another reason why some children show no symptoms at all might be because they have experience less damaging forms of sexual abuse (non-contact forms of sexual abuse) and they had more resilient, social and psychological support and access to treatment. From these findings it may be suggested that even though CSA victims experience some psychological symptoms, it is difficult to state both shorter and long term effects of sexual abuse as and its subsequent effects should be conceptualize within a multi faceted model of traumatization. Additionally it was observed that in 6 out of 10

researches there was a significant relationship between contact forms of abuse involving penetration and negative psychological correlates. They conclude that contact forms of CSA involving oral, anal and vaginal penetration was associated with a greater number of symptoms in children.

Miller and colleagues coined the term, 'unwanted early sexual experiences' (UESE), as they felt this term was more sensitive and would not require respondents' self-nomination of sexual abuse (Miller, Johnson & Johnson, 1991). In a survey of 345 college men and women they conceptualized the different types of unwanted early sexual experiences into two main categories: less severe and more severe. The less severe group included experiences such as exhibitionism and touching or fondling of sexual organs. The more severe group included anal and vaginal intercourse and oral-genital contact. They found that 44% of their respondents reported experiencing some form of UESE before the age of 16 years, 49% of these were females and 38% were males. The results of the study indicated that both males and females were more bothered by the more severe types of UESE than they were by the less severe types. In the majority of cases which included both less and more severe forms of UESE the victim knew the perpetrator. In these cases they found that the child was reluctant to report the sexual offence to anyone. These cases were found to cause chronic stress, as the child was more likely to have continuing contact with the perpetrator in their familial interactions.

Defferary, (2008) conducted a study using 213 first year psychology students to assess the occurrence and psychological distress or what was referred to as "bothersomeness" of unwanted early sexual experience (UESE) among males and females. The study reported that 31% had been exposed to unwanted early sexual experiences when they were less than 16.

Friends or acquaintance were the most commonly reported perpetrator especially among females. Females were more bothered by the being exposed to UESE than males. The results indicated that there was no significant relationship between the degree of unwanted early sexual experiences and the extent of psychological distress experienced by respondents. It was also realized that of those who experienced unwanted early sexual experiences , males were more likely to experience low self esteem, flashback and confusion about sexual orientation and girls were more likely to experience anxiety, sexual guilt, flash backs, confusion of sexual orientation and behavioral problems.

Priebe and Svedin (2008) conducted a survey of 4339 high school seniors with a focus on disclosure rate and patterns of sexual abuse (contact and non – contact and peer abuse. Out of the sample, 65% of girls and 23% at boys among them 2324 females and 2015 males reported some form of abuse, 10% of the females reported non-contact forms of abuse while 69.2% and 20.8% reported contact abuse without penetration and penetrative abuse respectively of the males 18.46%, 57.3% and 24.3% reported non-contact, contact and penetrating abuse respectively. It was revealed that conditions which influenced females non-disclosure includes, experience of contact sexual abuse with or without penetration abuse by a family member, abuse involving a single event or if they had perceive their parent as none caring. Among males, reasons contributing to non-disclosure were if they studied in a vocational program lived with both parent or perceive their parents as either caring or non-caring and not over protective.

In a study by Li, Saifuddin and Zabin (2012) in Taipei on CSA comprising 4,084 participants aged 15–24 years, an overall prevalence rate of 5.2% of CSA was found. The objective of this

study was to examine the relationship between a history of childhood sexual abuse (CSA) and negative psychological consequences in adulthood, controlling for family environments and Confucian values. Young people who experienced CSA had significantly higher rates of depression, anxiety, and suicidal ideation than young adults who had not experienced CSA. Bivariate analysis between different forms of CSA and negative psychological outcomes shows that a history of CSA is associated with more than a twofold increase in the risk of depression, anxiety, and suicidal ideation. The prevalence of these negative psychological outcomes is highest among those who reported penetrative sexual abuse. Even noncontact sexual abuse is significantly associated with increased odds of all three psychological outcomes. Their findings confirmed that CSA is an independent predictor of negative psychological consequences in adulthood.

In conclusion current researches have fairly established that the experience of contact forms of CSA as leading to more negative psychological sequel than noncontact forms of CSA but most researches have failed to examined the combined effects of both forms of CSA on psychological well-being. In this vein the current research seeks to explore the potentially effects of both forms of CSA on survivors.

Victims' Relationship with Perpetrator and Psychological Well-being

Some studies have directly or indirectly attempted to investigate victims' relationship with the CSA perpetrator and its impact of psychological functioning of victims. For instance, a study conducted by Sanders-Phillips, Moisan, Wadlington, Morgan and English (1995) assessed psychological symptoms of Black and Latino sexually abused girls aged 8 to 13 years. Among

other findings, it was observed that girls who have been abused by a relative received significantly higher scores for depression than those abused by non-relatives or strangers. Furthermore, higher more severe symptoms have been reported among individuals who have been abused at younger age.

De Witt (2009) indicated that if the perpetrator is a person who is familiar to the child, the abuse has a far greater impact. Most often, a perpetrator that is known to the child is a significant person in the child's life and is someone who exerts great influence over the child. In that sense, the child becomes confused by the mixed feelings experienced and the messages received from the abuser. As a result of the sexual abuse, the relationship of trust is destroyed and the child's privacy is violated and this makes the sexual abuse worse if it has been committed by a family member or by a close friend (De Witt, 2009; Barker & Hodes, 2007; Spies, 2006; DeFrain, & Oslon, 2000).

As mentioned above, Haj-Yahia and Tamish (2001) cross sectional survey of 652 Palestinians undergraduate students revealed that perpetrators of sexual abuse include family members (18.6%), relatives (36.2%) and strangers (45.6%). Haj-Yahia and Tamish noted that sexual abuse was not related to the socio-demographic characteristic examined such as are family size, income parent age and levels of education, place of residence and religion. Female victims showed significant higher levels on somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism than their male abused counterparts. In addition results also revealed those respondents who were sexually abused by a family member showed significantly higher levels on somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety,

paranoid ideation and psychoticism as compared to those who were sexually abused by someone other than a family member (relative or stranger). Likewise those who had experienced sexual abuse by a relative or known person reported significantly higher levels of symptomatology than other sexually abused counterparts who have been abused by non-relatives or strangers.

Finally Kendall- Tackett et al. (1993) study also affirmed that victims of CSA who have a close relationship with their perpetrator experience more negative outcomes (although the definition of close was not provided) in their review of 45 studies examining the short-term effects of child sexual abuse. Likewise Rind et al., 1998 in their meta-analysis review of 59 studies examining the long-term effect of child sexual abuse on college populations analyses of effect sizes revealed that larger effect sizes were significantly linked to intrafamilial abuse and definition of abuse including both willing and unwanted sex (only for women). Additionally according to Barker-Collo and Read, (2003) many theoretical models explaining the effects of child sexual abuse differentiate the harmful effects that intrafamilial abuse has on victims as compared with extrafamilial CSA abuse. This gives further evidence of the potentially negative impact of CSA on psychological well-being when the perpetrator happens to be a family member.

Family Relationship and effects of CSA

Recent study gives support to the potentially more significant contributions of family variables to psychological outcomes of victims of CSA (Mannarino & Cohen, 1996; Deblinger, Steer, & Lippman, 1999; Kendall-Tackett et al., 1993). Some researchers further argue that characteristics of family variables for example parent's response to the disclosure of CSA and the support given to the victim following CSA can be influenced as opposed to the static

characteristic of the abuse itself thus making them plausible areas of intervention for victims of CSA (Deblinger et al., 1999). Due to the obvious important influence of family environment the current researcher deems it plausible to include it in the present study. The content and quality of family relationships (family cohesion, conflict and expressiveness) was used as a moderator variable in this study.

Family variables such as family level of cohesion, conflict and expressiveness have been found to be associated with later adjustment of victims of CSA (Mannarino & Cohen, 1996; Deblinger et al., 1999; Kendall-Tackett et al., 1993). In a study by Mannarino and Cohen (1996) mothers whose children have experienced CSA generally reported low family cohesion than mothers whose children had not experienced CSA irrespective of whether the perpetrator was a family member or not. In addition, children reported to come from families who were low in cohesion also lack social competence skills suggesting that these children find it difficult to find the much needed support they deserve for better outcomes.

Deblinger et al. (1999) reported that higher family conflict scores were related to increased behavioral symptoms in victims of CSA and their non offending parents. In their sample of hundred victims mothers who reported greater distress and used pejorative parenting reported greater depression and PTSD symptoms. Stern et al. (1995) did not find family functioning to be significant after controlling for abuse severity.

Ulrich, (2008) examined both moderator variables and abuse characteristics on the effects of CSA within a college population. The moderator variables included family environment, and social support among others. The study sought to prove among others that, family environment,

and social support would moderate the long-term outcome of child sexual abuse victims, beyond the variance accounted for by the abuse characteristics. The research revealed that both social support satisfaction and family environment were both significant and accounted for 6% and 8% of the variance in sexual concern outcome, respectively. Family environment and the outcome variable defensive avoidance were also found to be significant. They however noted that family environment (which defines a healthy family as having balanced levels of cohesion and adaptability) did not significantly explain any more variance in the presence of trauma symptoms than abuse characteristics alone.

Family variables have also been found to account for variations in adult psychological outcomes independent of previous experience of CSA. In their study Bhandari, Winter, Messer, and Metcalfe, (2011) examined the influence of family variables on the development of psychological problems among people with an experience of CSA. Sixty-four participants drawn from university and clinical populations (32 matched abuse and non-abused pairs) participated in the study. The researchers sought to verify whether family variables and experience of CSA would have a significant effect on psychological correlates and whether the two variables are independent of each other. The results of their study demonstrated that the relationship between CSA and adult adjustment was weak and was largely not independent of the family variables. Furthermore their results found a strong association between family variables and psychological distress, sexual adjustment, self-esteem, body image, and sexual attitude independent of the effects of sexual abuse on these variables. These highlight the significant importance of the family environment and have serious implications for future research and practical implications.

A study was conducted by Fromuth, (2002) to explore the relationship of childhood sexual abuse with later psychological and sexual adjustment. The participants consisted of 383 female college students. Results indicated significant relationships between a history of CSA and measures of later psychological and sexual adjustment. In light of the relationship between family background and sexual abuse, however, it was questioned whether these associations were due to the sexual abuse per se, or were due to the confounding of sexual abuse with family background. Indeed, once parental supportiveness was controlled, very few significant relationships emerged.

A growing body of research indicates the centrality of the parent-child relationship in the adjustment of sexually abused children. Benedict & Zautra (1993) in a study of 76 college students found that parental absence in the family home places children at an increased risk for experiencing CSA. The study indicates this may be because of a lack of parental supervision and not meeting their child's emotional needs, which may increase the risk of the child responding to other adults who provide these emotional needs and attention. The quality of the parent-child relationship, more than any other variable, defines the child's ability to change and rebound from victimization (Deblinger et al. 1999). In a family with healthy relationships, there is a greater chance of support; reassurance and relief for the victim (De Witt, 2009; Bass & Davis, 1988), thus effects of CSA on psychological well-being and distress is are often mitigated.

As reviewed above Kendall-Tackett, et al. (1993) specifically looked at the impact that family environment and functioning on the outcome of child sexual abuse victims. They examined

properties of families that contributed to quicker recovery and better outcomes among CSA survivors. Maternal support defined as belief in the disclosure after abuse experience and protectiveness was found to be crucial. Additionally children who reported the least symptoms had supportive mothers and families who had less strain, less enmeshment, and less expressions of anger.

In conclusion and as reviewed earlier Rind and Tromovitch (1997) stated that a dysfunctional family environment is confounded with CSA and that often the victim's dysfunctional family environment is more likely to be a predictor of long-term adjustment problems than CSA is. They also state that researchers in general should take into account these causal factors. Further, they argue that studies using clinical samples and generalize from these findings to the general public are problematic, as these clinical samples are not representative of the general population.

The current study seeks to investigate the possible contributory role of family relationships on psychological well-being and distress among senior high school students in the Northern Region of Ghana.

Sexual Abuse and Psychological Well-being/Distress

The concepts of psychological well-being and psychological distress have been an issue of debate with various researchers arguing about the independent nature of both concepts (Larsen, McGraw & Cacioppo, 2001). Other researchers have further argued that although these two concepts are independent, they are also interrelated aspects of an individual's existence

(Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes 2011; Keyes, 2005) with variables positively associated with psychological distress being negatively associated with psychological well-being and vice versa.

Psychological distress is largely defined as the presence of negative emotional states with some researchers linking it specifically to the presence of a stressor and or inability to cope with that stressor (Ridner, 2004) for example experience of CSA. Other researchers have argued against this transient view of the nature of psychological distress postulating that it is moderately more stable (Wheaton, 2007). Additionally, presence or absence of psychological distress is associated with clinical diagnoses of some psychiatric and/or psychological problems and further severs as an indicator of the severity of those disorders (Phillips, 2009; Watson, 2009).

On the other hand well-being refers to how people evaluate their lives and is usually conceptualizes as including a balance of negative affect as well as a cognitive appraisal of one's life as satisfactory (Deci & Ryan 2008). Ryff and Keyes (1995) propounded six dimensions of psychological well-being. These include self-acceptance (possessing a positive attitude towards oneself), positive relationships with others (having warm, satisfying, trusting relationships with others), autonomy (self-determination and independence) and environmental mastery (a sense of mastery and competence in handling one's environment). The rest are purpose in life (having goals for one's life and a sense of direction), and personal growth (a feeling of continued development). According to Ryff (2009) the personal experiences of individuals significantly impacts on the various aspects of well-being.

It has been postulated that the potential impacts of attributes of psychological well-being and psychological distress on individuals depends on interpersonal and environmental contexts and thus should be studied with these factors in mind (McNulty & Fincham, 2012). They further stated that "Just as studying dysfunction cannot tell researchers how to promote flourishing ..... Studying flourishing cannot tell us how to prevent suffering" (McNulty & Fincham, 2012) thus it becomes necessary for researchers to study both concepts and its contribution to psychological health. Additionally in contrast to focusing on only distress and dysfunction Seligman (2000) argues the need to research into positive aspects of psychological functioning in a bid to help individuals attain their maximum potential.

In line with the above and to achieve greater specificity, the current researcher thought it wise to measure both concepts and find out their impact on the individual after experience of CSA among the current student population.

Child Sexual Abuse and Satisfaction with Life

Satisfaction with life is a concept that is defined as one of the components of subjective well-being. Although there are varying definitions of subjective well being (Jovanovic, 2011) according to Diener, 1985 subjective well-being is defined as the presence of life satisfaction, the presence of positive affect, and a lack of negative affect. Keyes (2005) also conceptualized subjective well-being (SWB) as a person's observation of the personal experience of life satisfaction.

Thus satisfaction with life is usually captured as the cognitive aspects of subjective well-being and involves a person subjective and cognitive appraisal of any given situation and how it currently or continually affects their lives. In this sense individuals are continually engaged in

the process of self appraisal by their own set standards and their current situation in a bid to find out if they are in harmony.

In a study Callahan, Tolman, and Saunders, (2003) examined among others the effects of adolescent's dating violence (including sexual coercion) on psychological well-being. Their sample consists of 190 high school students comprised of 100 boys and 90 girls from the ages of 13 to 19. Over all the results indicated that for both boys and girls there was a positive correlation between victimization and psychological well-being measures with more severity forms of victimization being significantly related to lower levels of life satisfaction.

In another study by Fassler, Amodeo, Griffin, Clay, & Ellis, (2005) examined the long-term adult outcomes of three factors namely multidimensional CSA Severity Scale, the presence or absence of CSA, and family environment. They sampled 290 community-dwelling women raised in intact families. The study found out among others that the Severity Scale and the dichotomous measure significantly predicted most of the adult outcomes with women with more severe CSA scored worse on social adjustment, self-esteem, and life satisfaction. They concluded that experience of sexual abuse and family variables may be more important than the abuse characteristics in predicting long term psychological out comes.

Furthermore Himelein and McElrath (1996) examined the cognitive coping strategies associated with resilience in a non-clinical sample of child sexual abuse (CSA) survivors. The first study involved 1,180 college women who completed surveys assessing self-enhancing cognitive distortions of reality, known as positive illusions, and CSA history. CSA survivors and non-victimized women were found to be equally likely to engage in illusion, and for both

groups, measures of illusion were strongly associated with psychological well-being. In Study 2, a qualitative study, a sample of 20 CSA survivors from Study 1 was interviewed regarding their efforts to cope with CSA. Analysis was focused on comparisons between well-adjusted and poorly-adjusted women. The high adjustment group revealed a greater tendency to engage in four types of cognitive strategies: disclosing and discussing CSA, minimization, positive reframing, and refusing to dwell on the experience. The results of both studies highlight the importance of cognitive reappraisal in CSA recovery.

Though current research seems to lean towards the idea that experience of CSA leads to adverse outcomes it would be worthy to find out whether the experience of CSA would be judged as detrimental by this population.

Critique of Literature

Studies have established the impact of (child) sexual abuse on the psychological well being among various groups of individuals including adolescents (e.g., McLeer, et al., 1998; McPherson, 2002; Zlotnick, Mattia & Zimmerman, 2001). However, there are certain loopholes in some of the previous studies and these calls for new researches that would attempt to address such weaknesses. Because of the myth that only males can perpetuate sexual abuse against females, many previous researches have concentrated on girls where a wide variety of emotional and behavioral problems, including depression, anxiety, social withdrawal and somatic complaints, have been described among victims of sexual abuse (e.g., Mian, Marton & LeBaron, 1996; Sherman & Sigfusdottir, 2009). According to Ah-Hing (2010) it is completely mythical to conclude that sexual abuse can only be perpetuated by males against females. This limits the extent to which the phenomenon is investigated among male victims. Given the

damage that child sexual abuse can cause to a child's self-concept, sense of trust and perception of the world as a relatively safe place, irrespective of gender, it is logical to assume that male victims will also experience childhood adjustment difficulties. In that regard, the current study involved both males and females in order to investigated possible differences in psychopathology as well as psychological well-being among those who are victims of CSA.

In addition, despite clinical impressions, related empirical findings, and various theoretical formulations implicating CSA as a contributor to psychopathology and development later interpersonal difficulties, systematic investigation of this relationship has been slow to evolve. When considered at all, interpersonal variables have most often been included within the context of larger studies of the long-term individual correlates of CSA. Nevertheless, these scattered findings have gradually accrued, and together provided a glimpse of the interpersonal functioning among women reporting a history of CSA. Although some previous studies (e.g., Kendal-Tackett, William & Finkelhor, 1993; Miller, Johnson & Johnson, 1991) have included forms of CSA as well as the victims' relationship with the perpetrator and their impact on psychopathology, but this is diffuse especially in Sub-Saharan Africa. Important body of research such as the current study which combines gender, relationship with perpetrator and forms of sexual abuse on well-being of victims has yet to be considered in its entirety especially in Sub-Saharan Africa. Furthermore, study conducted by Coohey (2010) was done among children between 11 and 14 years of age. This age limitation constrains the ability to generalize the findings by Coohey (2010) populations that are outside this age bracket.

Taking a critical look at all these studies that attempted to trace the impact of sexual abuse on the psychological well-being among adolescents, it can be observed that most of them have

been conducted outside the African continent. Many of the studies reviewed were done in American, European and Asian countries. As a result of significant cultural differences, it might be doubtful whether these findings could be applicable to African countries such as Ghana. Methodologically, the most compelling evidence to date for an association between a history of child sexual abuse and adverse psychological and social outcomes comes from random community samples, birth cohorts and twin studies (Dinwiddie, Heath & Dunne, 2000; Kendler, Bulik & Silberg, 2000; Fergusson, Lynskey & Horwood, 1996). Such studies depend, however, on the adult retrospective ascertainment of child sexual abuse, which creates difficulties, including forgotten or non-disclosed abuse and the reconstruction of abusive experiences to make sense of current distress. Thus the current study sought to address this issue by looking at immediate impact of CSA on psychological well-being by using a sample of students below the age of eighteen (The Ghanaian constitution, article 28 section 5).

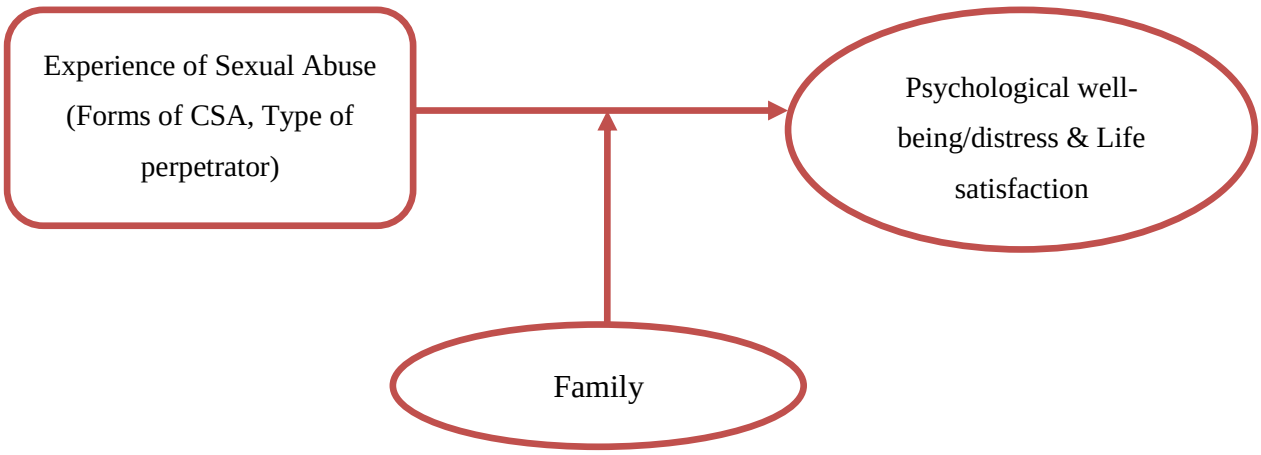
Hypotheses

Based on the aims/objectives of the study and the review of the relevant literature, the following hypotheses were formulated and tested.

1. Male victims of CSA will experience less psychological well-being than female victims.
2. There will be a significant relationship between psychological well-being and psychological distress among victims of CSA.
3. Students who have experienced both forms of abuse (contact and non-contact) will have lower psychological well-being than students who experienced no CSA or only one form (contact or non-contact) of sexual abuse.

4. Students who experienced actual sex perpetrated by family members will experience higher levels of psychological distress than students who experienced actual sex perpetrated by others.
5. There will be a significant relationship between experience of CSA and general satisfaction with life.
6. Family relationships will significantly moderate the relationship between CSA experience and psychological distress.

Figure 2. 1: Conceptual Framework



In this model, experience of CSA is hypothesized to be predicting level of psychological well-being, a relationship that would be moderated by family relationships. Experience of physical abuse will be held constant to observe if the experience of CSA is still significant.

Operational Definitions

Child sexual abuse: This study defines child sexual abuse as experience of contact and non-contact sexual acts or activities irrespective of force before age 18. This includes all sexual touching between an adult and a child or sexual touching between students or peers where the experience was unwanted, forced or coercive in order to distinguish them from sexual exploration with peers.

Contact forms of sexual abuse: This is defined as child sexual abuse involving physical contact with or without penetration. Contact forms includes touching or fondling, and actual sex or intercourse, (oral, anal or vaginal intercourse). Examples of contact CSA includes: Rubbing against the child's body in a sexual way; to have anal or vaginal penetration by penile or other body parts, or digital or non digital object; as well as complete anal or vaginal intercourse.

Non-contact forms of sexual abuse: This is defined as child sexual abuse involving no physical contact between victim and perpetrator. Non-contact sexual abuse includes a range of behaviors and includes improper sexual solicitation or indecent exposure. This includes the following: exposing oneself to a child or asking a child to expose him/her self for sexual pleasure; exposing a child to pornographic material; using vulgar language in the presence of a child.

Psychological Well-being: This includes the six dimensions measured by the Ryff psychological well-being (autonomy, environmental mastery, positive relations, personal growth, purpose in life and self acceptance)

Psychological Distress: This includes the nine dimensions measured by Brief Symptoms Inventory (BSI) namely somatization, obsessive–compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Satisfaction with Life: This refers to global evaluation of a person on how his/her life looks like.

Family Relationships: This refers to the degree of commitment, help, and support family members provide for one another (cohesion), the extent to which family members are encouraged to act openly and express their feelings (expressiveness), and the amount of openly expressed anger, aggression, and conflict among family members (conflict).

CHAPTER THREE

METHODOLOGY

This chapter presents the methodological approaches employed by this study. Information on the setting, population, sample, research design, sample technique, participants, measures and procedure used for the study are presented in this chapter.

Population

The primary population chosen for the study comprises of both male and female senior high students from selected public Senior High Schools in the Northern Region of Ghana below the age of eighteen. This population was chosen due to the fact that most studies conducted in the country concerning child sexual abuse was done in the Southern regions mainly involving girls and women.

Sample Size determination

Sample size of three hundred and eighty (380) students was randomly selected from the population of public senior high school students in the Northern Region of Ghana. This sample size is based on the rule of thumb suggested by Krejcie and Morgan (1970), that for a population of about 40000 a sample size of 380 will suffice.

Sampling Technique

The cluster sampling technique was used to select districts from the Northern Region. This is due to the large population and geographical nature of the region, and cost effectiveness due to traveling. The Northern region was divided into four clusters namely North East, North West, South East and South West. Using convenience sampling at least a school was selected from

each cluster depending on willingness to participate in the study. Furthermore two schools were selected from Tamale as it is the capital town of the Northern region and thus may hold a fair representation of all students found in this region. A total of eight schools, two in the capital and at least one per a cluster were selected from the pool of thirty public schools.

The schools selected for the study were Northern School of Business and Tamale Girls Secondary school from Tamale metropolis. Damango Secondary and Ndewura Jakpa Secondary Technical from West Gonja District in the South Western cluster. Savlugu Nanton Senior High school and Saboba E. P. from Savelugu-Nanton and Chereponi- Saboba districts respectively were selected from the North Eastern cluster. Yendi Senior High School from the Yendi district was selected from the South Eastern cluster. Kumbungu Secondary School was also selected from Tolon Kumbungu district in the Northern Western cluster.

The random sampling method was utilized to select senior high school students from each of the selected schools to participate in the study. This sampling method was used to ensure that the sampling was representative and also helped to eliminate subject and researcher bias.

Other characteristics of the participants as represented in table 3.1 shows that majority of the participants 311 (82.7%) have experienced some form of CSA and of this number 159 (51.1%) were males. From the total of 378 participants 276 reported some form of physical abuse with 253 of participants experiencing both physical and sexual abuse. Also, majority of the participants used for the study are 17years old. Majority were in form three.

Table 3.1: Demographic Characteristics of the participants

Characteristic	Victims *n/311 (*	Non-victims n/65
Experience of CSA	**311 (82.7)**	**65 (17.3)**
Forms of CSA		
Contact	**18**	----
Non-contact	**67**	----
Both	**226**	----
Gender		
Male	159 (83)	32 (16.8)
Female	152 (82.2)	33 (17.8)
Class		
Form One	127 (80.4)	31 (19.6)
Form Two	96 (82.8)	20 ()17.2
Form Three	88 (86.3)	14 (13.7)
Age		
15 & Below	23 (85.2)	4 (14.8)
16	46 (76.7)	14 (23.3)
17	242 (83.7)	47 (16.3)
Whom do they stay with		
Alone	4 (100)	0 (0)
Both parents	162 (83.1)	33 (16.9)
Father Alone	12 (92.3)	1 (7.7)
Mother Alone	43 (78.2)	12 (21.8)
Father &step mother	19 (90.5)	2 (9.5)
Mother &stepfather	7 (63.6)	4 (36.4)
Uncle	15 (68.2)	7 (31.8)
Auntie	23 (92)	2 (8)
Hostel	21 (95.5)	1 (4.5)
Other	5 (62.5)	3 (37.5)
Districts		
Tamale Metropolitan	90 (93.6)	6 (6.4)
West Gonja	81 (86.2)	13 (13.8)
Savlugu/ Nanton	35 (74.5)	12 (25.5)
Saboba E. P	39 (83)	8 (17)
Tolon/Kumbungu	36 (76.6)	11 (23.4)
Yendi	32 (68.1)	15 (3.9)
Experience of Physical Abuse		
Male	148 (77.5)	43 (22.5)
Female	128 (69.2)	57 (30.8)
Experience of CSA * Experience of Physical Abuse	252 (81.3)	----

From the total populations also 18 experienced contact form of CSA out of which 10 were females and 8 being males. Additionally 67 experienced non-contact forms of CSA 27 of which were female participants and 40 were male participants. Likewise 252 participants experienced both forms of abuse out of which 115 were females and 111 were males.

Research Design

The study used the quantitative correlational survey design as it mainly sought to establish a relationship between the variables (child sexual abuse, psychological well-being) as posited by Punch (2005). A quantitative correlational survey is a study design which basically describes or measures the degree of association between two or more variables or sets of scores and seeks to find the relationship between variables in that particular study. The variables under study in this research include a history of sexual abuse, forms of sexual abuse and family relationships and their relation to psychological variables (six factors of psychological well-being, life satisfaction, nine dimensions of psychological distress and a measure of life satisfaction and family relationships). This design will allow investigation of whether a positive or negative relationship exists between sexual abuse and symptom severity of psychological variables (psychological well-being, life satisfaction nine dimension of the symptoms checklist).

Measuring Instruments

The tests administered include a Demographic data, the Brief Symptoms Inventory (BSI), Satisfaction with Life Scale (SWLS), The Ryff Scales of Psychological Well-Being which measures aspects of psychological well-being, and an adapted version of the Childhood

Experience of Violence Questionnaire (CEVQ) measuring experience of CSA which are discussed in detail below.

The Brief Symptom Inventory (BSI)

The BSI is the short version of the SCL-R-90 (Derogatis, 1975, 1977). The BSI consists of nine symptom dimensions and was used as the measure of psychological distress. The dimensions include Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation and Psychoticism; and three global indices of distress: Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total. There are 5 additional items which contribute to the global scores of the questionnaire but are not scored collectively as a dimension. They primarily touch upon disturbances in appetite and sleep patterns. This scale demonstrates a strong internal reliability with Cronbach alpha of the nine subscales ranged from 0.71 to 0.85, and test–retest reliability from 0.68 to 0.91 (Derogatis, 1993).

The Ryff Scales of Psychological Well-Being Inventory

The Ryff scale of Psychological Well-Being consists of 54 questions (medium form) was developed by Carol Ryff (1995). It has six dimensions and was used as a measure of positive psychological states. It consists of a series of statements reflecting the six areas of psychological well-being: autonomy, environmental mastery, personal growth, positive relations with others, and purpose in life, and self-acceptance. Respondents rate statements on a scale of 1 to 6, with 1 indicating strong disagreement and 6 indicating strong agreement. Responses are totaled for each category (about half of the responses are reverse scored, which

is indicated on the master copy of the test). For each category, a high score indicates that the respondent has a mastery of that area in his or her life. Conversely, a low score shows that the respondent struggles to feel comfortable with that particular concept.

The autonomy subscale measures an individual's sense of self-determination, independence, and freedom from norms. The environmental mastery subscales measures the ability of an individual to manage one's life and surroundings. An individual's ability to being open to new experiences as well as having continued development is measured by the personal growth subscale. The positive relations subscale measures the quality and satisfaction derived from relationships with others. Purpose in life is measured as the rate at which one has life goals and his/her belief that life is meaningful and achievable. The self-acceptance subscale measures a positive attitude toward oneself and one's past history.

Satisfaction with Life Scale (SWLS)

The Satisfaction with Life Scale (SWLS) is a measure of life satisfaction developed by Ed Diener and colleagues (1985). Respondents are instructed to rate each item using a 7-point scale ranging from 1 (strongly disagree) to 7 (strongly agree). Item ratings are summed to provide a total score ranging from 5 – 35 where higher scores are indicative of greater life satisfaction.

Scores may be interpreted in absolute rather than relative terms. In this case, it has been suggested that a score of 20 is regarded as neutral, while scores in excess of 20 represent satisfaction (21-25=slightly satisfied; 26-30= satisfied), and scores of less than 20 represent dissatisfaction (15-19=slightly dissatisfied; 5-9=extremely dissatisfied) (Pavot & Diener 1993).

In their 1993 review, Pavot and Diener (1993) reported test retest reliabilities ranging 0.83 – 0.50 – intervals ranged from 2 weeks to 4 years and, in general, higher reliabilities were associated with shorter retest intervals.

Childhood Experience of Violence Questionnaire (CEVQ)

The Childhood Experience of Violence Questionnaire (CEVQ) is a measure of victimization among the youth. It was developed by Walsh, MacMillan, Harriet, Trocme, Jamieson, and Boyle (2008). It is an 18-item self-report inventory designed to measure five types of victimization namely emotional abuse physical abuse, sexual abuse, and emotional and physical neglect among adolescents of ages 12–18 years. It also collects information about the perpetrator, severity, onset, duration, and disclosure of abuse. The CEVQ was designed to assess multiple forms of victimization experienced by youth with special attention on exposure to physical abuse and sexual abuse. With the exception of peer violence, the test–retest reliability of the stem questions for victimization exceeds 0.75 (Walsh, et al., 2008).

For the purpose of this study an additional question was added to further asses the experience of sexual abuse (Have you ever experienced digital penetration (e.g. use of fingers) or object penetration). Additionally for the purpose of this study the results from only physical and sexual victimization (13- 18) will be used. This is to specifically assess physical and sexual abuse and also differentiate between the forms of CSA (contact and non-contact) experienced by respondents. Thus, a "yes" or 1 for a question indicates that at least one form of victimization was reported, whereas a "no" or zero indicates that no forms of sexual victimization were reported.

Family Relationship Index

The Family Relationship Index of the Family Environment Scale (FES) is a 27-item scale that rates the domains of cohesion, expressiveness, and conflict *(*Moos & Moos, 1981). This scale measures three aspects of family relation that is found in the FES, namely; cohesion, expressiveness and conflict. The FRI consists of 12 items (4 items per subscale). Responses of each statement was scored using a 4-point Likert scale (4 = strongly agree; 1 = strongly disagree).

The cohesion scale measures the degree of commitment, help, and support family members provide for one another, the higher the score, the better the family functioning. Distressed families score lower than non-distressed families. The expressiveness scale measures the extent to which family members are encouraged to act openly and express their feelings directly. The higher the score, the better the family communications are. Distressed families score lower than non-distressed families on expressiveness. The conflict scale measures the amount of openly expressed anger, aggression, and conflict among family members. The higher the score, the more common conflict is in the family. Distressed families score higher than non-distressed families on conflict. A total relationship score is obtained by adding the cohesion and expressiveness scores, and subtracting the conflict score.

The FRI has demonstrated good reliability and validity and provides standardized norms and scores. The internal consistency of the scale is 0.70. Test measured at 2 months interval and 4 months interval produced the following reliability; cohesion- 0.86 and 0.72 respectively, expressiveness- 0.73 and 0.70 and conflict was 0.85 and 0.66 respectively. Validity of the test

has also been predicted in various studies of families of substance abuse patients and psychiatric patients. (Moos & Moos, 1994).

Pilot Study

Before the main study was conducted, a pilot testing of the various scales used in the study was done using 25 students sampled from Business Senior High School in the Tamale Metropolis. This was intended to establish the suitability of the scales, among a student population in the Northern region of Ghana. The pilot study also provided the estimated duration of the test administrations. Reliabilities of the scales tested under the pilot are presented in table 3.1 below.

Reliabilities recorded for the Global Severity Index of the Brief Symptom Inventory is .91 whereas the subscales recorded reliabilities ranging from .63 to .83 for victims.

Table 3.2: Internal consistency (Cronbach's Alpha) of the various instruments or measures used

SCALE	Cronbach's Alpha (A)	Skewness	Kurtosis
Sexual Abuse	.73	.69	.85
Physical Abuse	.71	.23	.91
Brief Symptom Inventory (BSI)			
Somatization	.73	.64	.19
Obsessive Compulsive	.73	..08	.37
Interpersonal Sensitivity	.83	.28	-.69
Depression	.63	.51	-.02
Anxiety	.71	.47	.01
Hostility	.75	.59	-.29
Phobic anxiety	.71	.50	.05
Paranoid ideation	.70	.35	-58
Psychoticism	.65	.71	.88
Global Severity Index	.91	.55	.30
Ryff Psychological Well-Being			
Autonomy	.79	.66	.15
Environmental Mastery	.70	.05	.56
Personal Growth	.70	.45	.64
Positive Relations	.66	.57	.69
Purpose in Life	.68	-.10	.39
Self Acceptance	.69	.92	.62
RPWBS	.80	.36	.11
Satisfaction With Life Questionnaire	.71	.18	.35
Family Relations Index	.72	-.05	.74

The reliability for the Ryff scales of psychological well-being range from .66 to .80 various scales autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance. The Satisfaction with Life Scale (SWLS) reported a reliability of .71. The reliability for the sexual and physical abuse subscales of the Childhood Experience of Violence Questionnaire (CEVQ) was .71 and .71.

Ethical Clearance and Consideration

Ethical clearance was obtained from Noguchi Memorial Institute for Medical Research Ethics Review Board. The researcher also adhered fully to the American Psychologist Association Ethical codes by strictly ensuring that participants were duly informed about the research, possible risks etc in order to voluntarily decide whether to participate or not in the study. Furthermore, the researcher made sure no physical, mental or any harm would come to participants. In the selection and recruitment of research participants, no amount of coercion (subtle or otherwise) was involved and no inducements offered for participation. Participants were also allowed to withdraw from the study at any time if they wish to stop participating. Finally, due to the sensitivity of the research study and age of participants the identity of participants was protected and anonymity of participants was ensured.

Procedure

A letter of introduction was obtained from the Department of Psychology, University of Ghana Legon introducing the researcher to the heads of the senior high schools. The research project was introduced to the heads of schools to ascertain interest and seek permission for allowing students to participate in the study. After permission was obtained from school authorities a

date and time of convenience was agreed upon to inform and interact with the students. Convenient and comfortable settings were located within the various school environments for administering the questionnaires.

Prior to the date set Parental Informed consent forms were modified so that the school authorities (school counselors and administrative heads) would sign on behalf of their parents and guardians. This was due to time and resource constraints since majority of the student are boarders and do not live in the towns, thus getting their parents would prove difficult. With the assistance of the teachers, the researcher approached the students from form 1, 2 and 3 and introduced the research project to them. Students were randomly selected to participate in the study and then directed to the place of convenience set aside for data collection. The researcher then obtained informed consent individually which consisted of reviewing the entire protocol of the study, and subsequently obtaining signatures from the students authorizing consent for participation.

The participants were administered the assessment measures in this order: a Demographic Measure, an adapted version of the Childhood Experience of Violence Questionnaire (CEVQ), the Brief Symptoms Inventory (BSI), the Ryff Scales of Psychological Well-Being, Satisfaction with Life Scale (SWLS), the Family Relationship Index (FRI). During the administration of the test, the researcher took all necessary measures to ensure that participants understood the test instructions and knew what they were required to do. Afterwards, the completed questionnaires were collected for scoring and subsequent analysis.

Due to the knowledge that responding to questions on such sensitive and traumatic past experiences will elicit some emotional challenges for the participants, a special arrangement was made after the data collection where participants were met after a short break to discuss their concerns with regards to the topic at hand. Counseling was provided by the researcher, making sure that their concerns were addressed as best as possible.

CHAPTER FOUR

RESULTS

Introduction

This section of the study presents the analysis of the collected data. An alpha level of 0.05 was used for all the analysis in this study. Hypotheses were formulated and appropriate statistical tests were used to analyze them. Statistical Package for Social Sciences (SPSS) version 16 was used to analyze the various hypotheses. Four approaches were used to test the hypotheses stated; MANOVA, Independent t test, One way ANOVA, and Pearson Correlation coefficient. First, the formulated hypotheses were tested with the appropriate statistical test and the summary of the result presented. This was followed by the interpretation of the results. Additional findings were also presented.

Hypothesis One

The first hypothesis of this study stated that male victims of CSA will experience less psychological well-being than female victims, thus comparing the male victims and female victims on the Ryff's psychological well-being scale. Independent t-test was used to analyze the data because the hypotheses have an independent variable (gender) which has two levels and one dependent variable (psychological well-being). The results are presented in table 4.1.

Table 4.1: Summary of Means, SD and Independent-*t* test of Female and Male Victims on Psychological Well-Being.

Psychological wellbeing	**Male**	**Female**	**t**	**p-value**
	N=190	**N=186**		
	Mean(SD)	**Mean(SD)**		
Autonomy	19.96 (4.85)	20.63 (5.04)	1.31	.10
Environmental mastery	21.57 (5.61)	22.19 (5.73)	1.07	.14
Personal growth	22.31 (5.38)	22.92 (5.68)	1.08	.14
Positive relations	21.29 (5.13)	21.51 (4.96)	.40	.34
Purpose in life	23.15 (5.30)	23.55 (5.83)	.71	.24
Self-acceptance	20.89 (5.04)	20.70 (5.37)	.37	.36
Total wellbeing	126.18 (22.05)	128.46 (23.07)	.98	.17

As presented in table 4.1 the mean score of male victims of CSA measure (M = 126.18, SD = 22.05) is less on the psychological well-being as compared to their female counterparts (M = 128.46, SD = 23.07). However, the difference in the mean scores of the male and female victims of CSA is not statistically significant (t = .98, df = 374, p = .17, one tailed]. This therefore does not support the hypothesis, indicating that male victims of CSA and their female counterparts have about the same level of psychological well-being. It is also clear from the table that both males and females do not differ on any of the sub-domains of wellbeing.

Hypothesis Two

The second hypothesis states that there will be a significant relationship between psychological well-being and psychological distress among victims of CSA. The relationship between psychological well-being and psychological distress among victims of CSA was investigated using the Pearson Product Moment Correlation Coefficient and the result is presented in table 4.2 below.

Table 4.2: Correlation matrix showing the relationship between Psychological Well-Being and Psychological Distress among Scores of Students who have experienced CSA.

	Autonomy	Environmental Mastery	Personal Growth	Positive Relations	Purpose in Life	Self Acceptance	Total wellbeing
Somatization	.006	.126*	.081	.111*	-.035	.145**	.102*
Obsessive Compulsive	-.011	.189**	.119*	.124*	-.059	.076	.105*
Interpersonal Sensitivity	.049	.055	.067	-.002	-.004	.124*	.068
Depression	-.009	.056	.034	.006	.008	.072	.040
Anxiety	-.008	.093	.093	.077	-.020	.146**	.091
Hostility	.012	.117*	.073	.017	-.069	.070	.053
Phobic anxiety	-.001	.160**	.052	.112*	.135**	.150**	.146**
Paranoid ideation	.062	.205**	.115*	.095	.031	.060	.136**
Psychoticism	.027	.151**	.079	.055	.041	.134**	.117*
Global severity index	.025	.178**	.114*	.098	.003	.151**	.136**

**** significant at the 0.01 (2-tailed)**

***significant at 0.05 (2-tailed)**

From the result above, it is indicated that a significant positive correlation exists between psychological well-being and psychological distress (r = .136, $p<.01$). The correlation found is a positive one indicating that a higher level of psychological well-being is related with higher psychological distress. This confirms the hypothesis being tested.

Hypothesis Three

Hypothesis three states that that students who have experienced both forms of abuse (contact and non-contact) will have lower psychological well-being than students who experienced no CSA or only one form (contact or non-contact) of sexual abuse. The One- Way ANOVA was used to analyze the data because the hypothesis has an independent variable on four levels and one dependent variable. Summary of results are presented in table 4.3.

Table 4.3: Summary of the *F* test, Means, Standard Deviations for forms of CSA on psychological well-being

Form of abuse	**N**	**Mean**	**SD**	***df***	***F***	***P***	η^2
No abuse	67	119.27	25.56	3,372	3.67	0.01	.029
Contact	18	127.00	20.73				
Non-contact	65	127.92	27.48				
Both	226	129.54	19.62				

From table 4.3 it can be observed that there is a significant difference reported in the forms of CSA with regards to psychological well- being among respondents [F (3.372) = 3.67, p =

.01,one – tailed]. The post hoc analysis show that those who experienced both forms of abuse reported the highest mean score (*M* =1.29, *SD* = 19.6) whilst students who experienced no form of abuse the least mean score (*M* = 1.19. *SD* = 25). The effect size using eta squared was small η^2 = .029. Since those with both forms of CSA had the highest score and differed significantly from only those with no CSA but not the other groups, the hypothesis is not supported.

Hypothesis Four

The fourth hypothesis states that students who experienced actual sex perpetrated by family members will experience higher psychological distress than students who experienced actual sex perpetrated by others. This hypothesis was tested using the independent *t*-test because the hypotheses has an independent variable (perpetrator) which has two levels (others and family members) and one dependent variable (psychological distress) and the summary of results is presented in table 4.4 below.

Table 4.4: Independent *t*-test result comparing level of psychological distress resulting from actual sex perpetrated by family members and others

Psychological distress	**Others**	**Family members**	**t**	**p-value**
	N=61	**N=78**		
	Mean(SD)	**Mean(SD)**		
Somatization	1.10 (.67)	1.41 (.84)	-2.401	.01
Obsessive Compulsive	1.54 (1.08)	1.96 (.98)	-2.417	.01
Interpersonal Sensitivity	1.47 (.82)	1.63 (.96)	-.945	.17
Depression	1.12 (.77)	1.41 (.75)	-2.251	.01
Anxiety	1.30 (.65)	1.42 (.75)	-1.044	.15
Hostility	1.17 (.78)	1.28 (.74)	-.905	.18
Phobic anxiety	1.18 (.64)	1.61 (.78)	-3.476	.00
Paranoid ideation	1.64 (.96)	1.89 (.89)	-1.602	.06
Psychoticism	1.28 (.88)	1.65 (.86)	-2.498	.01
Global severity index	1.30 (.58)	1.57 (.62)	-2.686	.01

As presented in table 4.1 the mean score on psychological distress by victims of actual sex perpetrated by family members is (M = 1.57, SD = .62) a mean score that is higher than that of victims of actual sex perpetrated by others (M = 1.31, SD = .58). The mean difference is shown by the result to be statistically significant (t = 2.69, df 137, p = .01, two-tailed). This therefore

supports the hypothesis being tested. The magnitude of the difference was moderate .05. This difference is also observed on sub-domains of distress such as somatization, obsession compulsion, depression, phobic anxiety and Psychoticism.

Hypothesis Five

Hypothesis five states that there will be a significant relationship between experience of CSA and general satisfaction with life. Using the Pearson Product-Moment Correlation Coefficient (Pearson r), the result is shown in the table 4.5.

Table 4.5: Summary of Pearson r Test showing Means, SD and relationship between Experience of CSA and, General life satisfaction.

Variable	**N**	**Mean**	***SD***	***r***	***p***
CSA	376	18.23	6.40	-.041	.433
Well-being	376	.82	.38		

From the result presented in table 4.5 a negative but not significantly correlation exist between experience of sexual abuse and life satisfaction (r = -.047, p = .43). Thus, the hypothesis is not supported.

Hypothesis Six

This hypothesis states that family relationships will significantly moderate the relationship between CSA experience and psychological distress. To test this hypothesis, the procedure

proposed by Baron and Kenny (1986) for testing moderation effect using regression was used. According to Baron and Kenny, testing a moderation effect involves the following steps;

- Step 1 - Centre (standardize) both the predictor and the moderator. Centering is a linear transformation method which eliminates problems associated with multi-collinearity. It is achieved by subtracting the mean value for a variable from each score for that variable (Lingard & Francis, 2006).
- Step 2 - Calculate the interaction term (i.e., predictor X moderator) using the standardized values.
- Step 3 - Regress the outcome variable on the predictor, moderator, and their interaction. That is, in the hierarchical regression analysis, the predictor should be entered in the first block, the moderator(s) in the second block and the interaction terms in the third block.
- Step 4 - If the interaction effect is significant (i.e., if β of predictor X moderator is significant), then there is a moderation effect. However, if the interaction term was not significant, no moderation effect is found.

Following this, in the fifth hypothesis, the dependent variable, that is, Global severity Index (measure of psychological distress) was regressed on experience of CSA and quality of family relationships and then on the interaction term. Specifically, experience of CSA (the independent variable) was entered in the first block, quality of family (the moderator) in the second block and experience of CSA x quality of family (the interaction term) in the third block.

Table 4.6: Results of Linear Regression Analyses for the moderation effect of Family relationship on the experience of CSA and Psychological well-being relationship.

Model	B	SE B	β
(Constant)	1.20	.070	
Experience of CSA	.205	.077	.136*
(Constant)	1.646	.115	
Experience of CSA	.196	.075	.130
FRI	-.036	.008	-.225**
(Constant)	1.643	.116	
Experience of CSA	.197	.076	.131
FRI	-.035	.008	.224
Interaction	-.008	.030	-.014

R2 =.019 and .069, .069 for steps 1, 2 and 3respectively; ΔR2=.050 and .00 for step2 step 2 and 3 respectively;

p < .05;p< .001, FRI = Family Relationship Index**

The results in table 4.6 indicates in the first model, experience of CSA significantly influences psychological distress [$F_{(1, 374)} = 7.770$, $p = .008$], accounting for 13% ($R^2 = 0.13$) variance in psychological distress. In the second model family relationships is also predicting psychological distress accounting for 22.5% variance in psychological distress. Contrary to expectation however, experience of CSA did not interact with quality of family relationships (experience of CSA x quality of family) to significantly predict psychological distress ($\beta = -.787$, $p > .05$). This means that the hypothesis being tested is not supported.

Additional findings

There were other findings such as significantly higher negative outcomes exhibited by students who have experienced CSA as compared to students who have not experienced CSA (Refer to

the results in table 2 in Appendix III). This is in line with numerous other researches which postulate that CSA is impacts with a range of mental, psychological and physical well-being of an individual (Jonas et al., 2010; Auslander et al., 2002; Jonson-Reid & Way, 2001; Lipschitz, Rasmusson, Anyan, Cromwell, & Southwick, 2000; Cheasty, Clare & Collins, 1998; Briggs & Joyce, 1997; Finkelhor, 1994; Kendal-Tackett, William & Finkelhor 1993). As stated earlier CSA assumes the properties of other traumatic experiences and affect the way victims view and relate to their environment (Van der Kolk, McFarlane, & Weisaeth, 1996). Additionally coping with these emotions and distortions as postulated by Finkelhor and Browne (1985) Traumagenic dynamics, may gives rise to the diverse negatives psychological correlates observed among victims of CSA.

Family relationships were also found to predict psychological well-being accounting for 22.5% variance in psychological distress. There was no significant association found between sexual abuse and psychological distress after controlling for physical abuse.

Referring to the results in table 1 in Appendix III in the first model, experience of physical abuse significantly influences psychological distress [$F_{(1, 374)} = 23{,}447$, $p = .000$], accounting for 24% variance in psychological distress. Holding experience of physical abuse constant and adding sexual abuse to the model at step 2, no significant influence was found on psychological distress [$F_{(1, 373)} = 1.188$, $p = .276$].

Summary of Findings

1. Female and male students who experienced CSA have similar levels of psychological well-being**.**
2. Psychological well-being (that purpose in life, self-acceptance, autonomy, positive relations, personal growth, environmental mastery and the global score) and psychological distress of victims of CSA are significantly related.
3. Victims who experience both forms of CSA have reported higher psychological well-being than those with no form of CSA but not than those who experienced only one form of CSA.
4. Victims of CSA who experience actual sex perpetrated by family members also showed higher levels of psychological distress than those who experience actual sex perpetrated by others
5. There is no significant relationship between the experience of CSA and satisfaction with life.
6. Family relationship does not significantly moderate the relationship between the experience of CSA and psychological distress.

CHAPTER FIVE

DISCUSSION

Introduction

The current study investigated the impact of child sexual abuse on psychological well-being among high school students. The main objective of the present study was to examine the relationship between experience of CSA and measures of psychological well-being and life satisfaction. This study also aimed to examine if quality of family relationships influence psychological well-being. Further, it investigated weather experience of CSA will be significant after experience of physical abuse is controlled.

Findings of the Study

Results from the analyses indicated that no apparent difference exists between female and male students who experienced CSA on levels of psychological well-being; psychological well-being (that purpose in life, self acceptance, autonomy, positive relations, personal growth, environmental mastery and the global score) and psychological distress of victims of CSA are related; victims who experience both forms of CSA reported higher psychological well-being than those with no form of CSA but not than those who experienced only one form of CSA; victims of CSA who experience actual sex perpetrated by family members also showed higher levels of psychological distress than those who experience actual sex perpetrated by others; and no significant relationship was found between the experience of CSA and satisfaction with life.

Gender and psychological well-being among victims of CSA

The first objective of this study was to find out if there are gender differences in the effects of the experience of CSA. The result confirms previous researches postulating a lack of a gender difference between the sexes on experience of CSA and subsequent psychological correlates. Some of these studies showing similar effects of CSA for both male and females include Jumper (1995), Rind and Tromovitch (1997). As stated earlier that traumatic experiences (CSA) profoundly impact the ways in which people deal with their emotions and their environments (Van der Kolk, McFarlane, & Weisaeth, 1996), this impact can be said to be non-dependent on sex. Likewise Finkelhor and Browne (1985) Traumagenic dynamics, postulates that regardless of the sex of the child the emotional and mental orientation of that child is disturbed by the event of sexual abuse. This makes the child's view of the self and the world altered in his/her mind. Also, the ability to experience and express emotions is similarly disturbed. Thus, coping with these changes might lead to the observed psychological and behavioral effects of childhood sexual abuse, irrespective of that child's gender.

Other studies have suggested a gender difference in the impact of CSA (e.g. Chandy, 1996; Rind, et al., 1998; Sherman & Sigfusdottir, 2009). These studies have suggested that the differences are due to the coping strategies employed by males and females with males engaging in externalizing behaviors and females engaging in internalizing behaviors (Chandy, 1996).

A possible reason for the conflicting results could be the methodological differences employed by studies. Some studies use children, others use adolescent verse adult samples, and still others report retrospectively, differing definitions of CSA, clinical verse non-clinical samples

etc (Maikovich-fong, & Jaffee, 2010; Dube, et al., 2005). This makes cross-sectional multi comparisons difficult and further drives home the need for additional research to ascertain whether one gender experience of CSA is different and more damaging than the other.

Relationship between Psychological well-being and psychological distress

It was hypothesized that psychological well-being will be significantly related with psychological distress. The result supported the prediction, indicating that while the psychological well-being of children with CSA increases, their distresses tend to decrease and the vice versa. As indicated earlier, the concepts of psychological well-being and psychological distress have been an issue of debate with various researchers arguing about the independent nature of both concepts (Larsen, McGraw & Cacioppo, 2001). However, this position could be quite handicapped in the view of this current finding. As it stands, the finding concurs with the other researchers who argue that although these two concepts are independent there must be an interrelation of the two in an individual's existence (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes 2011; Keyes, 2005) with variables positively associated with psychological distress being negatively associated with psychological well-being and vice versa.

As defined, psychological distress which indicates the presence of negative emotional states presupposes that it will leave the individual with less wellbeing since wellness or wellbeing has to be the presence of positive emotional state is usually conceptualizes as including a balance of negative affect as well as a cognitive appraisal of one's life as satisfactory (Deci & Ryan 2008). Distress points to a more negative situation which some has even linked to clinical diagnoses of some psychiatric and/or psychological problems and further serves as an indicator

of the severity of those disorders (Phillips, 2009; Watson, 2009). Clearly, when distress disposes one to such conditions, it is capable of adversely affecting their well-being.

It is therefore clear by this finding that children who suffer CSA and as a result suffer a heightened level of psychological distresses are more likely to experience reduced level of psychological well-being. This makes it necessary for programs addressing well-being to look out for possible domains of distress and their respective levels for prompt remedy.

Forms of Childhood Sexual Abuse and Psychological Well-being

Another objective of this study was to explore how forms of child sexual abuse impact on the psychological well-being of students with students who experienced both forms of CSA (contact and non-contact) exhibiting lower psychological well-being as compared to students who experienced no CSA or only one form (contact or non-contact). The results indicated that students who experience both forms of CSA differ significantly from those who experience no CSA by scoring higher on psychological well-being. This contradicts past researches (Beitchman, Zucker, Hood, Da-Costa, & Akman, 1991; Beitchman et al., 1992; Kendal-Tackett et al., 1993) which demonstrated that more severe forms of CSA resulted in adverse psychological correlates.

Previous researches have provided evidence that experience of more severe forms of CSA (no abuse, non-contact, contact and both forms of CSA) are associated with increasing adverse levels of psychological well-being. In their study Kendal-Tackett et al (1993) observed there was a significant relationship between contact forms of abuse involving penetration and negative psychological correlates. It was also observed by Kendal-Tackett et al (1993) that

another reason why some children show no symptoms at all might be because they have experience less damaging forms of sexual abuse (non-contact forms of sexual abuse) and they had more resilience, more social and psychological support and access to treatment. They conclude that contact forms of CSA involving oral, anal and vaginal penetration was associated with a greater number of symptoms in children. This however was not the case in the current finding.

The nature and extent of trauma caused during sexual abuse depends on the degree of verbal aggression, physical violence and force that was used. Miller, Johnson and Johnson (1991) also postulated that both males and females were more bothered by the more severe types of UESE than they were by the less severe types. They defined severe forms of UESE to include group included anal and vaginal intercourse and oral-genital contact while less severe forms were included experiences such as exhibitionism and touching or fondling of sexual organs. According to one study even noncontact sexual abuse is significantly associated with increased odds of all three psychological outcomes (Li, Saifuddin & Zabin, 2012). Maybe for the group of participants used in this current study, some more coping methods were adopted to overturn the effects of their experiences. However, this result must be carefully interpreted in order not to undermine the effect of the more severe forms of CSA.

Victims' Relationship with Perpetrator and Psychological Distress

The third objective also sought to investigate the relationship between type of perpetrator and symptom severity on psychological measures. The results revealed that students who have experienced actual sex perpetrated by family members experience significantly higher

psychological distress than students who experienced actual sex perpetrated by others (neighbors, strangers, peers and teachers)

Previous studies have demonstrated that CSA perpetrated by family members or people with whom the child share a close and /or nurturing relationship with has the potential for resulting in poorer psychological outcomes than CSA perpetrated by others (De Witt, 2009; Barker & Hodes, 2007; Spies, 2006; Barker-Collo & Read, 2003; Haj-Yahia & Tamish, 2001; Kendall-Tackett, Williams, & Finkelhor, 1993; Finkelhor & Browne 1985). The family unit in Ghana and especially in the Northern region where the child is cared for by the whole extended family might rather be the institution that is putting that child at a further risk of CSA.

Finkelhor and Browne (1985) third dynamic points to the probability of sexual abuse experiences that are perpetrated by family members or other trusted persons (neighbors and peers) to potentially involving more betrayal than those that involve strangers. Furthermore, victims of CSA by family members may experience betrayal as they discover that members of the institution that were supposed to protect them are the very ones that are perpetrating CSA against them. The sexually abused child may feel further lost by the mixed feelings experienced and the messages received from the abuser and might also feel stigmatized as a result of all the negative nuances (such as shame, guilt and depravity) associated with the experience by the other family members or the society during the abuse experience and upon disclosure. Finally, the relationship of trust is destroyed and the child's privacy is violated and this makes the CSA committed by a family member or by a close friend (De Witt, 2009; Barker & Hodes, 2007; Spies, 2006) potentially more damaging.

The dynamic of powerlessness also comes into play as the children/victims might be trapped in the very family institutions that are abusing them or are forced to share close quarters with their perpetrators with no alternative of escaping from their perpetrator and abusers. Similarly the dynamic of powerlessness might leave the child feeling a sense of reduced productivity and disempowerment due to for example repeated and undesired invasion of the body through threat and deceit. In relation to the above Banyard, Williams, and Siegel (2004) found similar results as the findings of this study. They argued that victims of CSA often feel lack of control over the abuse experience, which might create the situation of "powerlessness." This sense of a lack of control or "powerlessness" invariably acquires the properties of a stressor which in turn has effects on neurodevelopment on victims of CSA.

This study is in line with Haj-Yahia and Tamish (2001) which demonstrates that survivors of CSA who were sexually abused by a family member showed significantly higher levels on somatization, obsession-compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism as compared to those who were sexually abused by someone other than a family member. In a similar vein those who had experienced sexual abuse by a relative or known person reported significantly higher levels of symptomatology than other sexually abused counterparts who have been abused by non-relatives or strangers. In line with the above studies this study thus confirms that the closer the perpetrator (family members, neighbors, peers and teachers) is to the child the more potentially damaging the experience of CSA becomes.

Child Sexual Abuse and General Satisfaction with Life

The fifth hypothesis states that there will be a significant negative relationship between experience of CSA and life satisfaction Findings revealed that there was a negative relationship between experience of CSA and life satisfaction. Although not significant this means experience of CSA is associated with a decrease in level of life satisfaction. Conversely, life satisfaction is adversely affected by experience of CSA. This is inconsistent with some findings that predicted significantly worse outcomes between experience of CSA and life satisfaction (Fassler, Amodeo, Griffin, Clay, & Ellis, 2005; Callahan, Tolman, & Saunders, 2003). In their study Fassler et al., (2005) found women with more severe CSA scored worse on social adjustment, self-esteem, and life satisfaction, and were more likely to have psychiatric problems. Likewise Callahan, Tolman, and Saunders, (2003) in their study reported that for both boys and girls, victimization was related to lower levels of life satisfaction, but not after controlling for the demographic, family violence, and social desirability variables in the case of girls.

One possible explanation for this finding could be that life satisfaction can be seen as a judgmental process in which individuals subjectively assess their life on the basis of their own unique criteria in comparison with their current experience. If there is a match the individual reports higher life satisfaction (Pavot & Diener, 1993). Thus it is possible that for the present sample, students who have experienced CSA though experiencing lower psychological well-being however, did not know better nor evaluated their life situation as threatening or harmful.

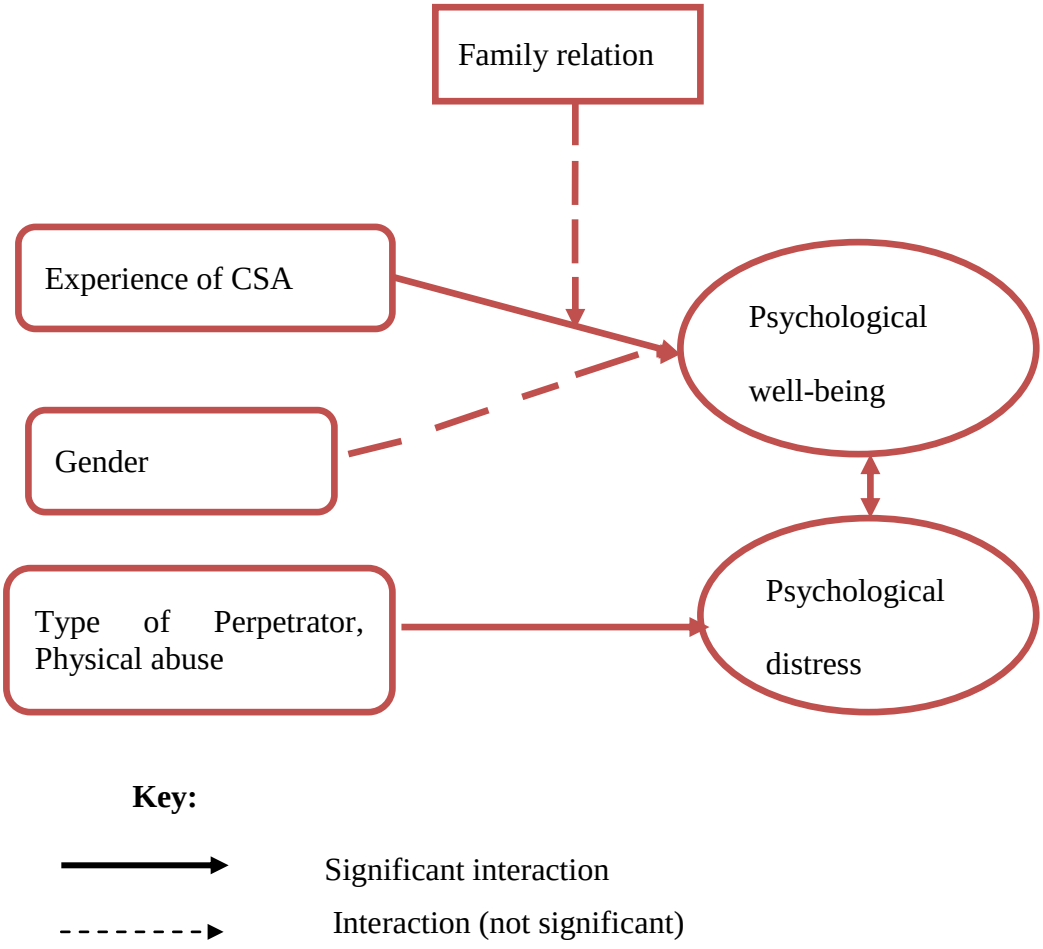
The Role of Family Relationship on the relationship between CSA and psychological distress

The study also sought to find out the moderating role of family relationships on effects of child sexual abuse. Using the procedures proposed by Baron and Kenny (1986) for testing moderation effect using regression, results indicated that family relationships did not significantly moderate the relationship between experience of CSA and psychosocial well-being. This implies that for individuals who experienced CSA, the interaction of that experience and family relationships did not in any way affect their psychological outcome.

Results from this study showed that CSA experience accounted for 13% variance in psychological distress (as measured by the brief symptoms checklist). This finding is consistent with previous studies which show that CSA has an impact on psychological well-being (McPherson, 2002; Zlotnick et al., 2001; McLeer et al., 1998; Kendal-Tackett, William & Finkelhor, 1993). Family variables were also shown to account for 22.5% variance in psychological well-being.

This finding is inconsistent with the other research findings which highlight the moderating effects of family environment on effects of CSA (Steer, & Lippman, 1999; Mannarino & Cohen, 1996; Deblinger, et al., 1999; Kendall-Tackett, et al., 1993). One possible explanation for the difference in finding with other research findings could be that dysfunctional family relations have the potential to play a dual and sometimes independent role. This is because family relations might generally puts children at a higher risk for experiencing CSA and/or at the same time increases their experience of negative psychological outcomes. Thus in the current study the analysis reveal that family relationships play the latter role.

Figure 5.1: Observed conceptual framework



From the revised model, experience of CSA had a direct relationship with psychological well-being. In other words, experience of CSA significantly affects psychological well-being. From the same model, there was a significant interaction between psychological wellbeing and psychological distress. The type of perpetrator also affected psychological distress in a significant way, whereas there was no gender related effect on psychological wellbeing. Finally, family relation does not moderate the relationship between the experience of CSA and psychological wellbeing.

Implications of Findings for Clinical Practice and Recommendations

The findings of this study confirm that CSA is usually associated with negative psychological correlates and highlights the need to first of all provide education, and counselling services and /or activities that address CSA among young people. This is because neither school activities, nor STI/AIDS prevention programs nor reproductive health and family planning services typically address these concerns. This must be integrated into existing sexuality education programs and extended to out of school youth so as to equip them with the knowledge on what constitute CSA. Knowledge it is said is power and with this students would be able to protect themselves from unwanted sexual advances and also be in the position to take appropriate action should such incidents occur. Research has indicated that most often it is in retrospection that children only realize that they have in fact experienced CSA (although it might have and still continues to affect them). Additionally the results of this study provides evidence for the need of the Ministry of education to employ qualified educational psychologist and/or trained school counselors to be stationed in schools and professionally identify and handle cases of such nature.

In the same vein the Ministries of Health and Defense in the country as well can earnestly take up employing qualified psychologist or at least train medical personal and some security forces on how to handle cases of CSA. This is because studies have revealed the negative behaviors exhibited by some health workers towards victims of sexual abuse contribute to their psychological well-being and even later adjustment (Guedes et al. 2002). This sort of training would also benefit the country's security forces (policemen and women) as they are sometimes the first line of people who come into contact with victims of CSA.

Furthermore routine assessment of victims of CSA can be integrated into existing hospital and school policies so as to know the current level of well-being among victims of CSA. This is also to be able to help survivors who do not show emotionally distresses immediately as research has shown that sometimes symptoms develop overtime (Kendal-Tackett, William & Finkelhor, 1993).

Again, the prevalence of CSA against males in this study is quiet high and more over the analysis of this study revealed that the impact of CSA is the same for both males and females. This fact lends emphasis of the need to design programs and interventions that are gender sensitive in the country especially in the Northern region. This is crucial as this region in particular is dominated by patriarchal attitudes which further hinder male acknowledgement and reportage of CSA and prevents males from coming forward and getting the psychological help they will need. Furthermore the information on male CSA provided by this study could also be used to counter and modify traditional gender stereotypes and current societal beliefs (males cannot be raped, males should not show emotions even when they are hurt, seeking any form of help is showing weakness as a man etc). These would in no small way give voice to probably the countless male CSA survivors to come forward and received the help that they might need.

Finally although this study did not actually differentiated among which members of the family perpetrated CSA the negative psychological correlates of abuse by family member's and the significant contribution family relationships has on psychological distress signals the need to take a closer look at the family unit. The family unit as seen in this study both serves as a risk factor as well as a potential buffer that contributes to the psychological well-being of the

individual. In light of this, effort should be made to educate and apprise adults especially parents on the reality of CSA by other family members and the need to provide an open and trusting environment where by their wards can confide in them about sexual issues especially those of such sensitive nature. Likewise other stakeholders (teachers, police, doctors etc) that children interact with should be vigilant and not rule out the possibility that close family members are more often than not the very perpetrators of CSA. They should also provide a supportive and non-judgmental environment upon disclosure of CSA.

Limitations of the Current Study

The most significant limitation of the study was the paucity of peer reviewed research and data on child sexual abuse in Africa especially in the Sub-Saharan region. This made the tone of the questionnaires to be structured along western definitions and conceptualization of the study subject. This may have given room to some cultural biases.

The study was also purely quantitative. In quantitative studies, room is not created for further responses and questions for participants. Future researches should use qualitative methods in addition to the quantitative method as this will allow researchers to gain a better understanding of the phenomena (CSA) under study in the Ghanaian context. Future research should also include interviews to allow the participant to explain the information they were giving and this would also allow for some participants to verbalize their feelings and gain the necessary help they might need.

Another limitation of the study is the fact that it is a retrospective study and the weaknesses of such a study, chiefly are loss and distortion of memories by participants.

Direction for future research

There is a need for further studies to be done in the other regions in the country and sub region for the following reasons:

- More culturally sensitive questionnaires should be developed to adequately cater for the Ghanaian and African population especially on definition and measure of CSA and aspects of psychological well –being
- To gain a true reflection of the possible negative psychological impact on students and how this can be mitigated.
- To inform all stakeholders especially the government agencies on the need of professionally trained counsellors and psychologist to be strategically positioned in schools, hospitals and police stations to provide services to trauma victims especially those who have experienced CSA

Further, it is important that longitudinal studies are conducted by future researches in Ghana and Sub-Saharan Africa to help understand and evaluate the effects of CSA on psychological well-being as one fourth of all sexually abused children report negative symptoms. Additionally, some child victims of CSA may not present with any significant psychological distress within two years, thus such studies will go a long way to give a clear picture and provide concrete evidence on the phenomena of CSA in Ghana and Sub-Saharan Africa.

This study used a broader definition of a child (any individual below 18); hence future researches can also include victims of all ages as this will provide a comprehensive source of information for intervention programs. This is because such programs will be beneficial for victims only when much information is acquired about them.

Conclusions

The specific aims of the present study were two-fold.

1. To examine the possible effect of child sexual abuse on psychological functioning.
2. To explore the contributory role of family relationships on psychological effects of CSA.

Child sexual abuse as demonstrated by the current study generally affects the psychological well-being of students. Overall, the current findings are consistent with the extensive literature indicating that the impact of CSA is usually negative. Unfortunately, the emotional or psychological effects of CSA in Ghana are not truly appreciated and measures are not taken to identify, address and manage the psychological needs of survivors.

The study has also helped increase understanding of the potentially independent function of family relationships and physical abuse on psychological well-being irrespective of the presence of sexual abuse. This is crucial as it adds to the spotlight on the child's family as invariably on important stake holder in the protection and care of the child.

The knowledge presented here can suggest assessment and treatment modalities for CSA victims that are not strictly medical or physically centered but rather incorporate or encourage the use of services that are psychological in nature. Additionally findings of the current study also bring to bear male CSA and the need to adopt and develop a more gender sensitive approach that places both genders on the forefront as recipients of psychological or other services following identification, assessment and management of CSA.

Generally, the findings of the study are favorable and could ultimately contribute to the development of clinical practice guidelines that can be employed in health care and educational settings. Thus the various governmental and non governmental agencies could put in place strategies to stop, curb or at least help manage the adverse psychological correlates of CSA.

REFERENCES

Ah-Hing, A.D. (2010). *The impact of child sexual abuse (CSA) on the school life experience and academic performance of adult CSA survivors*. Thesis submitted for the award of Doctor of Educations Degree Nelson Mandela Metropolitan University.

Amoakohene, M. I. (2004). Violence against women in Ghana: a look at women's perceptions and review of policy and social responses. *Social Science & Medicine, 59, 2373–2385.*

Ampofo, A. A., Osman, A., Francis, A., Deborah A., & Moses, D. (2007). 'Examining the Sexual Exploitation of Children on the Street of Accra' Ghana: UNICEF/Institute of African Studies, Legon.

American Psychological Association (2002). *Ethical principles of psychologists and Code of Conduct*. Retrieved July 14, 2012, from http/www.apa.org/ethics/code.

American Psychological Association (2010). *Understanding child sexual abuse: Education, prevention, and recovery*. Washington, DC: Author. Retrieved November 10, 2012, from http://www.apa.org/pubs/info/brochures/sex-abuse.aspx

Armstrong, A. (1998). Consent and compensation: The sexual abuse of girls in Zimbabwe. In W. Ncube (Ed.), *Law, culture, tradition and children's rights in Eastern and Southern Africa*. (129–149). Ashgate Dartmouth: Aldershot.

ANPPCAN. (2000). *Awareness and views regarding child abuse and child rights in selected communities in Kenya*. Nairobi: ANPPCAN.

ANPPCAN. (2007). The First International Conference In Africa On Child Sexual, (September). *Enhancing knowledge through research, practice and partnership to protect children against sexual abuse.* Retrieved from

http://www.anppcan.org/files/File/Report%20of%20the%201st%20International%20Conference%20in%20Africa%20on%20Child%20Sexual%20Abuse.pdf.

ANPPCAN. (2012). The Second International Conference In Africa On Child Sexual, (March). *Taking Stock of the Status of Child Sexual Abuse in Africa since the First International Conference in Africa on Child Sexual Abuse in 2007*. Retrieved from http://www.anppcan.org/newsite/files/report%20second%20csa.pdf.

Appiah, D. C. and Cusack, K. (ed.) (1999). *Breaking The Silence And Challenging The Myths Of Violence Against Women And Children In Ghana*. Gender Studies and Human Rights Documentation Centre.

Ardayfio-Schandorf, E. (2005). Violence against women: The Ghanaian case. *World Health*, 11– 14. Ardayfio-Schandorf, E. (2000). Violence against Women: The Ghanaian case *Violence against women: a statistical overview, challenges and gaps in data collection and methodology and approaches for overcoming them.*

Aryeetey, E. (2004). Coming to terms with sexual harassment in Ghana, (64). Institute of Statistical, Social & Economic Research (ISSER) University of Ghana. Retrieved from; http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle.

Auslander, W. F., McMillen, J. C., Elze, D., Thompson, R., Jonson-Reid, M., & Stiffman, A. (2002). Mental health problems and sexual abuse among adolescents in foster care: Relationship to HIV risk behaviors and intentions. *AIDS and Behavior*, 6(4), 351–359.

Banyard VL, Williams LM, Siegel JA. Childhood sexual abuse: a gender perspective on context and consequences. Child Maltreatment 2004; 9, 223–38.

Barker-Collo, S., & Read, J. (2003). Models of response to childhood sexual abuse: Their implications for treatment. *Trauma, Violence, & Abuse,* 4, 95-111.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology,* 51, 1173–1182.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect,* 16, 101–118.

Beitchman, J. H., Zucker, K. J., Hood, J. E., daCosta, G. A., Ackman, D., & Casavia, E. (1991). A review of the short-term effects of child sexual abuse. *Child Abuse & Neglect,* 15, 537- 556.

Benedict, L.L.W. & Zautra, A.A.J. (1993). Family environmental characteristics as risk factors for child sexual abuse. *Journal of Clinical Psychology*, 22(3), 365-347.

Bhandari, S., Winter, D., Messer, D., & Metcalfe, C. (2011). Family characteristics and long-term effects of childhood sexual abuse. *The British journal of clinical psychology*, 50(4), Bifulco A, Brown, G.W., Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *British Journal of Psychiatry*, 159, 115–122.

Briere, J., Runtz, M. (1990) Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect*, 14, 357–364.

Briere, J. N., & Elliot, D. M. (1994). Immediate and long-term impacts of child sexual abuse. *The Future of Children,* 4, 54-69.

Briere, J. & Elliott, D. M. (2003). Prevalence and psychological squeal of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*. 16, 1205-1222.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Harvard University Press.

Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723-742.

Brown, C. K. (2003) 'Sexual Abuse of School Children in Ghana'. Ghana: Centre for Development Studies, University of Cape Coast.

Callahan, M. R., Tolman, R. M., & Saunders, D. G. (2003). Adolescent Dating Violence Victimization and Psychological Well-Being. *Journal of Adolescent Research*, 18(6), 664–681. doi:10.1177/0743558403254784.

Centers for Disease Control and Prevention, (2005). Youth risk behavioral surveillance – United States, 2005. MMWR; 55 (No. SS-5).

Centers for Disease Control and Prevention. (2007). Injury Statistics Query and Reporting System (WISQARS). National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (producer). [2007 July 09]. Available from URL: www.cdc.gov/ncipc/wisqars/default.htm.

Chandy, J.,M., Blum, R.,W., Resnick, M ., D .(1996). Gender-specific outcomes for sexually abused adolescents. *Child Abuse Neglect*, 20, 1219 –31.

Cheasty M., Clare A.W., Collins C. (1998). *Relation Between Sexual Abuse in Childhood and Adult Depression: Case-Control Study.* BMJ. 316, 198-201.

Coohey, C. (2010). Child Abuse & Neglect Gender differences in internalizing problems among sexually abused early adolescents, 34, 856–862.

Deblinger, E., Steer, R., & Lippman, J. (1999). Maternal factors associated with sexually abused children's psychosocial adjustment. *Child Maltreatment*, 4, 13−20.

Deblinger, E., Steer, R., & Lippman, J. (1999). Two-year follow-up study of cognitive - behavioral therapy for sexually abused children suffering posttraumatic stress symptoms. *Child Abuse & Neglect*, 23, 1371–1378.

Deci, E. L., & Ryan, R. M. (2008). Hedonia, eudaimonia, and well-being: An introduction. Journal of Happiness Studies, 9, 1–11.

Defferary, T. E. M. (2008). *Assessing Unwanted Early Sexual Experiences: A South African University Study.* Thesis submitted to the University of Fort Hare (East London Campus).

Derogatis, L. R. (1977). *The SCL-R-90 Manual I: Scoring, Administration and Procedures for the SCL-90*. Baltimore, MD: Clinical Psychometric Research.

Derogatis, L. R. (1993). *BSI Brief Symptom Inventory. Administration, Scoring, and Procedures Manual (4th Ed.).* Minneapolis, MN: National Computer Systems.

Diener, E., Emmons, R. A., Larson, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment*, 49, 71–75.

Diener, E. (2006). Understanding Scores on the Satisfaction with Life Scale, 6-7. Standing Scores on the Satisfaction with Life Scale, 6–7. Retrieved from http://internal.psychology.illinois.edu/~ediener/SWLS.html

De Witt, M. (2009). *The Young Child in Context: A Thematic Approach. Perspectives from educational psychology and socio-pedagogics.* Pretoria: Van Schaik.

Dinwiddie S, Heath AC, Dunne MP et al. (2000). Early sexual abuse and lifetime psychopathology: a co-twin-control study. *Psychological Medicine,* 30:41–52.

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H.

(2005). Long-Term Consequences of Childhood Sexual Abuse by Gender of Victim, *28*(5).

Domestic Violence Act (Act 732) 4 (2007) (Ghana).

Domestic Violence Victim and Support Unit of the Ghana Police (2000-2008) 'Annual Reports'. Government of Ghana.

Fassler, I. R., Amodeo, M., Griffin, M. L., Clay, C. M., & Ellis, M. A. (2005). Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment, 29, 269–284.

Feiring, C., Taska, L.S., & Lewis, M. (1999). Age and gender differences in children and adolescent's adaptation to sexual abuse. Child Abuse and Neglect. 23:115-128.

Fergusson, D. M. & Mullen, P. E. (1999). *Childhood sexual abuse: An evidence based perspective.* California: SAGE.

Fergusson, D. M., Horwood, L. J., & Lynskey, M. T. (1997). Childhood sexual abuse, adolescent sexual behaviors, and sexual revictimization. *Child Abuse and Neglect*, 21, 789–803.

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse: A

conceptualization. *American Journal of Orthopsychiatry*, 55 (4), 530-541.

Finkelhor, D. & Browne, A. (1986). "Initial and long-term effects: a conceptual framework," *A Sourcebook on Child Sexual Abuse*, ed.

Finkelhor, D. (1994). The international epidemiology of child sexual abuse, *Child Abuse & Neglect* 18, 409–417.

Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). Poly-victimization: Children's exposure to multiple types of violence, crime, and abuse (pgs. 1-12). *Juvenile Justice Bulletin – NCJ 235504*. Washington, DC: U.S. Government Printing Office.

Fleming, J.M. (1997). Prevalence of childhood sexual abuse in a community sample of Australia women, *Medical Journal of Australia* 166, 65–68.

Foa, E.B., Davidson, J.R.T., Frances A., & Ross, R. (1999). Expert Consensus Guideline Series: Treatment for Posttraumatic Stress Disorder. *Journal of Clinical Psychiatry*. 60 (16).

Fromuth, M. E. (2002). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse and Neglect,* 22 (1), 5 - 15.

Government of Ghana. (1992). *The Constitution for the Fourth Republic of Ghana*, Accra, Ghana.

Guma, M. & Henda, N. (2007). The Socio-cultural context of child abuse: a betrayal of trust. In Richter, L. Dawes, A. and Higson-Smith. C. 2007. *Sexual Abuse of Young Children in Southern Africa.* Cape Town: HSRC Press.

Haj-Yahia, M.M.(PI), & Tamish, S. (C) (2001). The rates of child sexual abuse and its

psychological consequences as revealed by a study among Palestinian university students. *Child Abuse & Neglect,* 25(10), 1303-1327.

Himelein, M. J. & McElrath, J. A. (1996). Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse & Neglect*, 20 (8), 747–758.

Holmes, W.C. & Slap, G.B. (1998). Sexual abuse of boys: definitions, prevalence, correlates, sequelae and management. *Journal of the American Medical Association*, 280(21), 1855-1862.

Hornor, G. (2010). Child Sexual Abuse: Consequences and Implications. *Journal of Pediatric Health Care*, 24, (6).

Hyde, J.S. (2003). The use of meta-analysis in understanding the effects of child sexual abuse. In J. Bancroft (Ed.) *Sexual development in childhood (pp. 82 – 91).* Indiana: Indiana University Press.

Jewkes R., Sen P., García-Moreno C. (2002) "Sexual violence". In: E.G. Krug et al. (Eds.) *World report on violence and Health*, Pg, 149. Geneva. World Health Organisation Population.

Jewkes R., Penn-Kekana L., Rose-Junius H. (2005). "If they rape me, I can't blame them". Reflections on Gender in the social concept of Child rape in South Africa and Namibia. *Social Science & Medicine* 61,1809-1820.

Jonas, S., Bebbington P., McMans, S., Meltzer, H., Jenkins, R.., Kuipers E., Cooper C., King M., Brugha, T. (2010). *Sexual Abuse and Psychiatric Disorder in England: Results from the 2007 Adult Psychiatric Morbidity Survey.* Psychol Med. 10,1-11.

Jones, D.P.H., & McQuiston, M.G. (1988). Interviewing the sexually abused child**.** Royal College of Psychiatrists: Gaskell.

Jonson-Reid, M., & Way, I. (2001). Adolescent sexual offenders: Incidence of childhood maltreatment, serious emotional disturbance, and prior offenses. *American Journal of Orthopsychiatry*, 71, 120–130.

Jovanovic, V. (2011). Personality and subjective well-being: One neglected model of personality and two forgotten aspects of subjective well-being. *Personality and Individual Differences*, 50(5), 631–635.

Jumper, S. A. (1995). A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect*. 19(6), 715–728.

Kakhongwe, P., & Mkandawire, E. (1999). Malawi: Rape and defilement study. Zomba, Malawi: CSR, Centre for Social Research.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993).Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological-Bulletin;* 113, 164-180.

Kendler, K. S., Bulik, C. M., Silberg, J., Hettema, J. M., Myers, J., Prescott, C. A. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: an epidemiological and cotwin control analysis. *Archives of General Psychiatry*, 57, 953–959.

Kessler, R. C., Sonnega, A, Bromet, E, Hughes, M, & Nelson, C, B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52

(12): 1048-60.

Keyes, C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of mental health. *Journal of Consulting and Clinical Psychology*, 73, 539–548.

Kilonzo, N., & Taegtmeyer, M. (2005). Comprehensive Post-Rape Care Services in Resource-Poor Settings: Lessons learnt from Kenya. Liverpool School of Tropical Medicine. Nairobi, Kenya, Liverpool VCT Kenya. Policy Briefings for Health Sector Reform: No. 6, September 2005.

Kinnally, E. L., Huang, Y., Haverly, R., Burke, A. K., Galfalvy, H., Brent, D. P., Mann, J. J. (2009). Parental care moderates the influence of MAOA-uVNTR genotype and childhood stressors on trait impulsivity and aggression in adult women. Psychiatric Genetics, 19, 126-133.

Kisekka, M. N., & Otesanya, B. (1988). Sexually transmitted diseases as a gender issue: Examples from Nigeria and Uganda. Paper given at the AFARD/AAWORD Third General Assembly and Seminar on The African Crisis and the Women's Vision of the Way Out, Dakar, August 1988.

Krejcie & Morgan (1970), 'Determining sample size for research activities', Educational and Psychological Measurement, 30, 607-10.

Krug, Etienne, Linda Dalhberg, James Mercy, Anthony Zwi, and Rafael Lozano, Eds. 2002. *World Report on Violence and Health*. Geneva: WHO. http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf.

Lachman, P. (1996). Child protection in Africa: The road ahead. *Child Abuse & Neglect*, 20(7), 543–547.

Lalor, K. (2004). Child sexual abuse in sub-Saharan Africa: a literature review. *Child abuse & neglect*, 28(4), 439-60.

Lalor, K. (2004). Child sexual abuse in Tanzania and Kenya. *Child Abuse & Neglect*, 28, 833−844.

Lamers, S. M. A., Westerhof, G. J., Bohlmeijer, E. T., ten Klooster, P. M., & Keyes, C. L. M. (2011). Evaluating the psychometric properties of the Mental Health Continuum-Short Form (MHC-SF). *Journal of Clinical Psychology*, 67, 99–110.

Lanz, J. B. (1995). Psychological, behavioral, and social characteristics associated with early forced sexual intercourse among pregnant adolescents. *Journal of Interpersonal Violence*, 10, 188–200.

Larsen, J. T., McGraw, A. P., & Cacioppo, J. T. (2001). Can people feel happy and sad at the same time? Journal of Personality and Social Psychology, 81, 684–696.

Leach, F., Fiscian, F., Kadzamira, E., Lemani, E., and Machakanja, P. (2003) An investigative study of the abuse of girls in African schools. London: DFID. Available at: http://www.dfid.gov.uk/pubs/files/investudyafricaedpaper54.

Lema, V. M. (1997). Sexual abuse of minors: Emerging medical and social problem in Malawi. East African Medical Journal, 74(11), 743–746.

Lindberg, F. H., & Distad, L. J. (1985). Survival responses to incest: Adolescent in crisis. *Child Abuse and Neglect*, 9: 521-526.

Lipschitz, D. S., Rasmusson, A., Anyan, W., Cromwell, P., & Southwick, S. (2000). Clinical and functional correlates of posttraumatic stress disorder in urban adolescent girls at a primary care clinic. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 1104-1111.

Luster, T. (1997). Sexual abuse history and problems in adolescence: Exploring the effects of moderating variables. *Journal of Marriage and the Family*, 59(1), 131-142.

Madu, S. N., & Peltzer, K. (2000). Risk factors and child sexual abuse among secondary school students in the Northern Province (South Africa). *Child Abuse & Neglect*, 24(2), 259–268.

Madu, S. N., & Peltzer, K. (2001). Prevalence and patterns of child sexual abuse and victim-perpetrator relationship among secondary school students in the Northern Province (South Africa). *Archives of Sexual Behavior*, 30(3), 311–321.

Maikovich-fong, A. K., & Jaffee, S. R. (2010). Child Abuse & Neglect Sex differences in childhood sexual abuse characteristics and victims' emotional and behavioral problems: Findings from a national sample of youth. *Child Abuse & Neglect*, 34(6), 429–437.

Maniglio R. (2009). *The Impact of Child Sexual Abuse on Health: A Systematic Review of Reviews.* Clinical Psychology Review. 29: 647-657.

Mannarino, A. P., & Cohen, J. A. (1996). Abuse-related attributions and perceptions, general attributions, and locus of control in sexually abused girls. *Journal of Interpersonal Violence*, 11, 162–180.

McLeer, S. V., Dixon, J. F., Henry, D., Ruggiero, K., Escovitz, K., Niedda, T. & Scholle, R. (1998). Psychopathology in non-clinical referred sexually abused children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(12): 1326-1333.

McNulty, J. K., & Fincham, F. D. (2012). Beyond positive psychology? Toward a contextual view of psychological processes and well-being. *The American psychologist*, 67(2), 101–10.

McPherson, T. (2002). Cries for help: A literature review of the psychological effects of child maltreatment. *International Child Care and Youth Network Bulletin,* 38: 16-19.

Meursing, K., Vos, T., Coutinho, O., Moyo, M., Mpofu, S., Oneko, O., Mundy, V., Dube, S., Mahlangu, T., & Sibindi, F. (1995). Child sexual abuse in Matabeleland, Zimbabwe. Social Sciences and Medicine, 41(12), 1693–1704.

Mian, M., Marton, P. & LeBaron, D. (1996). The effects of sexual abuse on 3- to 5-year-old girls. *Child Abuse and Neglect,* 20: 731 -745.

Miller, R.S., Johnson, J.A., & Johnson, J.K. (1991). Assessing the prevalence of unwanted childhood sexual experiences. *Journal of Psychology and Human Sexuality,* 4(3), 43-52.

Mullen, P.E, Martin, J.L, Anderson, J.C, Romans, S.E., Herbison, G.P. (1996). The long-term impact of the physical, emotional, and sexual abuse of children: a community study. *Child Abuse and Neglect*, 20, 7–21.

Mullen, P. E., King, N., & Tonge, B. (2000). Child Sexual Abuse: An Overview. *Behaviour Change*, 17(1), 2-14.

Moos, H.H., & Moos, B.S. (1981). Family Environment Scale Manual. California: Psychologists Press.

Nan Li., Saifuddin, Ahmed., Laurie, S. Zabin. (2012). Association between childhood sexual abuse and adverse psychological outcomes among youth in Taipei. Journal of Adolescent Health, 50 (3), 45-51.

Pavot, W., & Diener, E. (1993). Review of the Satisfaction with Life Scale. *Psychological Assessment, 5*, 164-172.

Phillips, M.R. (2009). "Is distress a symptom of mental disorders, a marker of impairment, both or neither?" *World Psychiatry* no. 8, 91-92.

Plan Ghana (2009) *Child Sexual Abuse in Schools*, Accra: Ghana. http://plan-international.org/learnwithoutfear/files/ghana-child-sexual-abuse-in-schools-study-brief-english.

Priebe, G., & Svedin, C. G. (2008). Child sexual abuse is largely hidden from the adult society. An epidemiological study of adolescents' disclosures. *Child abuse & neglect*, 32(12), 1095–108.

Punch, K. F. (2005). *Introduction to Social Research: Quantitative and Qualitative Approach* (2nd ed.). London: Sage Publications.

Ridner, S.H. 2004. "Psychological distress: concept analysis." *Journal of Advanced Nursing* 45, 536-545.

Rind, B., & Tromovitch, P. (1997). A meta-analytic review of findings from national samples on psychological correlates of child sexual abuse. *Journal of Sex Research,* 34, 237–255.

Rind, B., Tromovitch, P., & Bauserman, R. (1998). A meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin*, 124, 22–53.

Resick, P. A. (1993). The psychological impact of rape. *Journal of Interpersonal Violence*, 8, 223-255.

Resnick, H., Acierno, R. & Waldrop, A. E. (2007). Randomized Controlled Evaluation of an Early Intervention to Prevent Post-Rape Psychopathology. *Behavavior Research Therapy*. 45(10), 2432-2447.

Ryff, C.D., & Keyes, C.L.M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology*, 69, 719-727.

Sanders-Phillips, K., Moisan P.A., Wadlington S, Morgan, S. & English, K (1995). Ethnic differences in psychological functioning among black and Latino sexually abused girls. *Child Abuse Neglect*, 19(6), 691-706.

Sachs-Ericsson, N., Kendall-Tackett, K., & Hernandez, A. (2007). Childhood abuse, chronic pain and depression in the National Comorbidity Survey. *Child Abuse & Neglect*, 3, 531–547.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, 55, 5–14.

Sherman, M.G., Silver, E., and Sigfusdottir, I.D. (2009). Gender and the associated impairments of childhood sexual abuse: A national study of Icelandic youth, *Social Science and Medicine*, Epub ahead of print http://dx.doi.org/10.1016/j.socscimed.2009.08.037.

Smith, M.E., Kelly, L. M. (2001). The journey of recovery after a rape experience. *Issues in Mental Health Nursing.*22, 337-352.

Spies, G.M. (Ed.) (2006). *Sexual Abuse: Dynamics, Assessment and Healing.* Pretoria: Van Schaik.

Spies, G.M. (2006). An explanation of the dynamics of incest families. In Spies, G.M. (Ed.) 2006. *Sexual Abuse: Dynamics, Assessment and Healing.* Pretoria: Van Schaik.

Spila, B., Makara, M., Kozak, G., & Urbanska, A. (2008). Abuse in Childhood and Mental Disorder in Adult Life. *Child Abuse Review*, 17, 133-138.

Stern, A. E., Lynch, D. L., Oates, R. K., O'Toole, B. I., & Cooney, G. (1995). Self-esteem, depression, behavior, and family functioning in sexually abused children. *Journal of Child Psychology & Psychiatry*, 36, 1077−1089.

Stoltenborgh, M., Van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment,* 26 (2), 79-101.

The Ark Foundation, Ghana. (2010). Identifying Child Abuse in the School Environment. *A manual for teachers, caregivers, parents and students.*

Trickett, P.R. Noll, J. G. & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, 23, 453–476.

Ulrich, H. M. (2008). *Examining the variability in the long term adjustment*. Thesis submitted for the award of Doctor of Philosophy submitted to the Department of Psychology, The University of Montana Missoula, MT.

United Nations (1989). Convention on the Rights of the child, Adapted by the General Assembly of the United Nations on 20th November 1989.

van der Kolk, B. A., McFarlane, A. C., & Weisaeth, L. (1996) (Ed): *Traumatic Stress: the effects of overwhelming experience on mind, body and society.* New York, Guilford Press, 1996.

WAJU. (2003). Statistics compiled by the Women and Juvenile Unit of the Ghana Police Service.

Walsh, Christine A., MacMillan, H., Harriet L., Trocme, N., Jamieson, E., & Boyle, M. H. (2008). *Child Abuse & Neglect*, 32, 1037–1057.Retrieved from February 2012 http://francais.mcgill.ca/files/crcf/2008-CEVQ_Validation.pdf.

Watson, D. 2009. "Differentiating the mood and anxiety disorders: A quadripartite model." *Annual Review of Clinical Psychology* no. 5, 221-247.

Wheaton, B. 2007. "The twain meets: distress, disorder and the continuing conundrum of categories (comment on Horwitz)." *Health* no. 11, 303-319.

World Health Organization WHO. (2006). *World Health, 19*(3), 237. Retrieved from http://www.who.int/whr/2006/whr06_en.pdf.

Wyatt, G. E. (1985). The sexual abuse of Afro-American and White American women in childhood. *Child Abuse & Neglect*, 9, 507–519.

Zlotnick, C., Mattia, J.I., & Zimmerman, M. (2001). Clinical features of survivors of sexual buse with major depression. *Child Abuse and Neglect*, 25, 357-367.

APPENDICES

Appendix I: Subject Information and Consent Form Child Assent Form

Introduction

My name is Mohammed Salma and I am from the Psychology Department at University of Ghana. I am conducting a research study entitled Impact of Sexual Abuse on Psychological Well-being among Senior High School Students in Northern Ghana. I am asking you to take part in this research study because I am trying to learn more about the relationship between child sexual and later psychological functioning among student populations in Northern Ghana. The entire research will last for about 45 minutes to 1 hour.

Possible Risks and Discomforts

The anticipated risks involved in this research will boredom or tiredness. This might be due to the number of items on the questionnaire. Therefore, ample time will be sought so as to give enough room for recuperation. Furthermore I acknowledge that some questions will ask you about your past or current sexual victimization, associated symptom severity of psychological distress/functioning and family relationships. This might be distressing and may make you feel uncomfortable. In such a situation you are free to stop responding to any section of it. Phone numbers (of the supervisor and the principal investigator) will be provided to help you in a free therapy session.

Possible Benefits

This research is not designed to benefit you directly but information gained in this study will go a long way to give an up-to-data information on childhood sexual abuse and improve preventive measures and management of survivors in the country.

Confidentiality

Any information obtained from you during this study will be confidential. Your privacy will be protected at all times. You will not be identified individually in any way as a result of your participation in this research.

Compensation

Participants will receive a pen that has been embossed with University of Ghana inscription.

Voluntary Participation and Right to Leave the Research

You are free to withdraw or stop responding to the questionnaire or any section of it at any point in time without any penalty or loss of rights.

Contacts for Additional Information

The following numbers can be contacted in case of any discomfort, explanation or further information.

Researcher: Mohammed Salma (Tel: 054 346 4867)

Supervisor: Dr. Atindanbila: Tel: 0277532705

VOLUNTARY AGREEMENT

By making a mark or thumb-printing below, it means that you understand and know the issues concerning this research study. If you do not want to participate in this study, please do not sign this assent form. You and your parents will be given a copy of this form after you have signed it.

This assent form which describes the benefits, risks and procedures for the research titled Impact of Sexual Abuse on Psychological Well-being among Senior High School Students in Northern Ghana has been read and or explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate.

Child's Name:

Researcher's Name:

Child's Mark/Thumbprint……

Researcher's Signature:

Date: ……

Date: ……

PARENTAL CONSENT FORM

Title: Impact of Sexual Abuse on Psychological Well-being among Senior High School Students in Northern Ghana

Principal Investigator: Salma Mohammed

Principal Supervisor: Dr. Atindanbila

Secondary Supervisor: Dr. Afrifa

Address: Department of Psychology, University of Ghana, Legon.

General Information about Research

Your ward is being asked to participate in our study of Impact of Sexual Abuse on Psychological Well-being among Senior High Students in the Northern Region of Ghana. We are investigating this topic in order to further our understanding of the relationship between child sexual abuse and later psychological functioning among a student population in Northern Ghana. Please read and/or listen to the following information carefully. Feel free to ask questions if you do not understand something.

If your ward participate in this study, your ward will be asked to: respond to psychological questionnaires consisting of pencil/pen and paper tests designed to assess, sexual victimization, nine symptom dimensions of psychological distress, areas of positive functioning, general life satisfaction and family relations. The entire research will last for about 45 minutes to 1 hour.

Possible Risks and Discomforts

We do not foresee any short or long term risks involved for your ward in this study. The anticipated risks involved in this research will be that of boredom or tiredness. This might be due to the number of items on the questionnaires. Therefore, ample time will be sought so as to give you enough room for recuperation. Furthermore, we acknowledge that some questions will ask you about your past or current sexual victimization and associated symptom severity of psychological distress/functioning and family relationships. This might be distressing and may make you feel uncomfortable. In such a situation your ward is free to stop responding to the questionnaire or any section of it. Your ward is also entitled to free counseling session. Phone numbers (of the supervisor and the principal investigator) will also be provided to help any respondent who will have problems in a free therapy session.

Possible Benefits

This research is not designed to benefit your ward directly but information gained in this study will go a long way to give up-to-date information on childhood sexual abuse and improve preventive measures and management of survivors in the country. It will also bring to light the possible psychological harm experienced by these survivors.

Confidentiality

The research will ensure absolute anonymity of your ward's responses since there would not be

Any tag (either name or code) to identify him/her in any way.

Compensation

Your ward will receive a pen that has been embossed with University of Ghana inscription.

Voluntary Participation and Right to Leave the Research

Your ward is free to withdraw or stop responding to the questionnaire or any section of it at any point in time without any penalty or loss of rights.

Contacts for Additional Information

The following numbers can be contacted in case of any discomfort, explanation or further information. Researcher: Salma Mohammed: Tel: 0543464867:

Supervisor: Dr. Atindanbila: Tel: 0277532705

Your ward's rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the landline 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org .You may also contact the chairman, Rev. Dr. Ayete-Nyampong through mobile number 0208152360 when necessary.

GUARDIAN/PARENTAL AGREEMENT

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to me (Guardian/Parent) as well as my ward. Hence he/she can go ahead to participate in the study.

_____ _____

Date Name and Signature of Guardian/Parent

II. QUESTIONNAIRE

SECTION A: DEMOGRAPHICS

1. **Sex :**
   a). Male _ b). Female _
2. **Age …….**
3. **Class/Form**
   ……..…..……
4. **District……..**
5. Whom do you stay with? a). Alone _ b). Both parents _ c). Father alone d). Mother alone _ e). Father and Stepmother _ f). Mother and stepfather g). Uncle _ h). Auntie _ i). Boarding/hostel _ a) Other: Specify……
6. Occupation of Parent/Guardian

   a). Trader _ b). Farmer _ c). Teacher _ d). Dressmaker _

   e). Tradesman _ f). Driver _ g).Other Specify ……..……

SECTION B: CHILDHOOD EXPERIENCE OF VIOLENCE QUESTIONNAIRE

FORMS OF ABUSE

This questionnaire asks about things that may have happened to you in your school, in your neighbourhood, or in your family. It will ask questions about some situations where you might have been hurt or afraid you were going to get hurt. All your answers will be kept strictly confidential. All your answers are private. We will not tell anyone about anything you have answered on this form. If you need help or would like to talk to someone about any of these experiences please contact the principal researcher for further assistance.

1. Sometimes kids get hassled or picked on by other kids who say hurtful or mean things to them.

How many times has this happened to you?

i.	Never	*if never, go to next Question*
ii.	1 to 2 times	iv. 3 to 5 times
iii.	6 to 10 times	v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school	iv. In primary 1 to 6
ii. In junior high school	v. In senior high school
iii. Is happening now	

b. Who did this to you? Please mark all that apply.

i.	Brother/Sister/ Stepbrother/ Stepsister	iv. Kids at school
ii.	Kids in your neighbourhood	v. Boyfriend/Girlfriend
iii.	Other, Who?_____	

2. Sometimes kids get pushed around, hit or beaten up by other kids or a group of kids.

How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
iv. In primary 1 to 6
iv. In senior high school

b. Who did this to you? Please mark all that apply.

i. Brother/Sister /Stepbrother/ Stepsister
ii. Kids in your neighbourhood
iii. Other, Who?_____
iv. Kids at school
v. Boyfriend/Girlfriend

c. Have you ever seen a doctor because of this? i. No ii. Yes

3. How many times have you ever seen or heard any one of your parents (step-parents or guardians) say hurtful or mean things to each other or to another adult in your home?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
iv. In primary 1 to 6
v. In senior high school

4. How many times have you ever seen or heard any one of your parents (step-parents or guardians) hit each other or another adult in your home?

iv. Never □*if never, go to next Question*
v. 1 to 2 times
vi. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
iii. In junior high school
v. Is happening now
ii. In primary 1 to 6
iv. In senior high school

b. Were the police ever called because of this? i. No ii. Yes

c. Did anyone go to the hospital because of this? i. No ii. Yes

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor
v. Friend

5. How many times has any one of your parents (or step-parents or guardians) said hurtful or mean things to you?

i. Never *if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In primary 1 to 6
iii. In junior high school
iv. In senior high school
iv. Is happening now

6. How many times has an adult spanked you with their hand on your bottom (bum), or slapped you on your hand?

i. Never *if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

b. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi. Peer
x. Other Who?_____

7. How many times has an adult slapped you on the face, head or ears?

i. Never *if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

b. Who did this to you? Please mark all that apply.

i. Father
ii. Mother
ii. Stepfather/ Mother's boyfriend
iv. Stepmother/Father's girlfriend
iii. Relative, Who?_____
vi. Neighbor
iv. Stranger
viii. Peer
v. Teacher
x. Other Who?_____

8. How many times has an adult hit or spanked you with something like a belt, wooden spoon or something hard?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iv. 3 to 5 times
iii. 6 to 10 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
vi. In primary 1 to 6
ii. In junior high school
v. In senior high school
iii. Is happening now

b. Who did this to you? Please mark all that apply.

i. Father
ii. Mother
ii. Stepfather/ Mother's boyfriend
iv. Stepmother/Father's girlfriend
iii. Relative, Who?_____
vi. Neighbor
iv. Stranger
viii. Peer
v. Teacher
x. Other Who?_____

9. How many times has an adult pushed, grabbed, or shoved you to hurt you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iv. 3 to 5 times
iii. 6 to 10 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
vi. In primary 1 to 6
ii. In junior high school
v. In senior high school
iii. Is happening now

b. Who did this to you? Please mark all that apply.

i. Father
vi. Mother
ii. Stepfather/ Mother's boyfriend
vii. Stepmother/Father's girlfriend
iii. Relative, Who?_____
viii. Neighbor
iv. Stranger
xi.Peer
v. Teacher
x. Other Who?_____

c. Have you ever seen a doctor because of this? i. No ii. Yes

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

10. How many times has an adult thrown something at you to hurt you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

b. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

c. Have you ever seen a doctor because of this? i. No ii. Yes

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

11. How many times has an adult kicked, bit, or punched you to hurt you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

b. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

c. Have you ever seen a doctor because of this? i. No ii. Yes

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

12. How many times has an adult choked, burned or physically attacked you in some other way?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

a. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

b. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

c. Did this ever involve a weapon, like a knife or a gun? i. No ii. Yes

d. Have you ever seen a doctor because of this? i. No ii. Yes

e. Have you ever told anyone about this? i. No ii. Yes

f. If yes, who did you tell? Please mark all that apply

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv.
iv. Teacher/ guidance counsellor.
v. Friend

13. Did anyone ever show their private parts to you when you didn't want them to?

i. No □*if no, go to next Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times iv. 3 to 5 times
iii. 6 to 10 times v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school vi. In primary 1 to 6
ii. In junior high school v. In senior high school
iii. Is happening now

c. Who did this to you? Please mark all that apply.

i. Father vi. Mother
ii. Stepfather/ Mother's boyfriend vii. Stepmother/Father's girlfriend
iii. Relative, Who?_____ viii. Neighbor
iv. Stranger xi.Peer
v. Teacher x. Other Who?_____

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian iv. Teacher/ guidance counsellor.
ii. Police/Children's Aid worker v. Friend
iii. Other, Who?_____

14. Did anyone ever make you show them your private parts when you did not want them to?

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times iv. 3 to 5 times
iii. 6 to 10 times v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school vi. In primary 1 to 6
ii. In junior high school v. In senior high school
iii. Is happening now

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever told anyone about this? i. No ii. Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

15. Did anyone ever threaten to have sex with you when you didn't want them to?

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever seen a doctor because of this? i. No ii. Yes

e. Have you ever told anyone about this? i. No ii. Yes

f. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv.
iv. Teacher/ guidance counsellor.
v. Friend

16. Did anyone ever touch the private parts of your body or make you touch their private parts when you didn't want them to?

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever seen a doctor because of this? i. No ii. Yes

e. Have you ever told anyone about this? i. No ii. Yes

f. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

17. Did anyone ever have sex with you when you didn't want them to or sexually force themselves on you in some other way?

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever seen a doctor because of this? i. No ii. Yes

e. Have you ever told anyone about this? i. No ii. Yes

f. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

18. Did anyone ever make you see magazines, pictures, videos, Internet sites, etc. that had to do with sex when you did not want to see it?

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever told anyone about this? i. No ii Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

19. Have you ever experienced digital penetration (e.g. use of fingers) or object penetration

i. No □*if no, go to Question* ii. Yes

a. How many times has this happened to you?

i. Never □*if never, go to next Question*
ii. 1 to 2 times
iii. 6 to 10 times
iv. 3 to 5 times
v. More than 10 times

b. When did this happen? Please mark all that apply.

i. Before primary school
ii. In junior high school
iii. Is happening now
vi. In primary 1 to 6
v. In senior high school

c. Who did this to you? Please mark all that apply.

i. Father
ii. Stepfather/ Mother's boyfriend
iii. Relative, Who?_____
iv. Stranger
v. Teacher
vi. Mother
vii. Stepmother/Father's girlfriend
viii. Neighbor
xi.Peer
x. Other Who?_____

d. Have you ever told anyone about this? i. No ii Yes

e. If yes, who did you tell? Please mark all that apply.

i. Parent/ step-parent/guardian
ii. Police/Children's Aid worker
iii. Other, Who?_____
iv. Teacher/ guidance counsellor.
v. Friend

20. How difficult was this questionnaire to complete?

□ □ □ □ □ □ □

1 2 3 4 5 6 7

Very Easy — Very difficult

21. How comfortable did you feel answering this questionnaire?

□ □ □ □ □ □ □

1 2 3 4 5 6 7

Very Uncomfortable — Very comfortable

22. How traumatic did you find it to answer this questionnaire?

□ □ □ □ □ □ □

1 2 3 4 5 6 7

Not Traumatic — Very Traumatic

SECTION C: THE BRIEF SYMPTOM INVENTORY

SIGNS AND SYMPTOMS OF PSYCHOLOGICAL DISTRESS

How much that problem has distressed or bothered you <u>during the past 7 days including today</u>. These are the answers I want you to use.

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit

4 = Extremely

	ITEMS	**0**	**1**	**2**	**3**	**4**
1.	Nervousness or shakiness inside Positive Relations					
2.	Faintness or dizziness					
3.	The idea that someone else can control your thought					
4.	Feeling others are to blame for most of your troubles					
5.	Trouble remembering things					
6.	Feeling easily annoyed or irritated					
7.	Pains in the heart or chest					
8.	Feeling afraid in open spaces					
9.	Thoughts of ending your life					
10.	Feeling that most people cannot be trusted					
11.	Poor appetite					
12.	Suddenly scared for no reason					
13.	Temper outbursts that you could not control					
14.	Feeling lonely even when you are with people					
15.	Feeling blocked in getting things done					

16.	Feeling lonely					
17.	Feeling blue					
18.	Feeling no interest in things……					
19.	Feeling fearful					
20.	Your feelings being easily hurt					
21.	Feeling that people are unfriendly or dislike you					
22.	Feeling inferior to others					
23.	Nausea or upset stomach					
24.	Feeling that you are watched or talked about by others					
25.	Trouble falling asleep					
26.	Having to check and double check what you do					
27.	Difficulty making decisions					
28.	Feeling afraid to travel on buses, subways, or trains					
29.	Trouble getting your breath					
30.	Hot or cold spells…					
31.	Having to avoid certain things, places, or activities because they frighten you					
32.	Your mind going blank					
33.	Numbness or tingling in parts of your body					
34.	The idea that you should be punished for your sins					
35.	Feeling hopeless about the future					
36.	Trouble concentrating					

37.	Feeling weak in parts of your body					
38.	Feeling tense or keyed up					
39.	Thoughts of death or dying					
40.	Having urges to beat, injure, or harm someone					
41.	Having urges to break or smash things					
42.	Feeling very self-conscious with others					
43.	Feeling uneasy in crowds					
44.	Never feeling close to another person					
45.	Spells of terror or panic					
46.	Getting into frequent arguments					
47.	Feeling nervous when you are left alone					
48.	Others not giving you proper credit for your achievements					
49.	Feeling so restless you couldn't sit still					
50.	Feelings of worthlessness					
51.	Feeling that people will take advantage of you if you let them					
52.	Feeling of guilt					
53.	The idea that something is wrong with your mind					

SECTION D: THE RYFF SCALES OF PSYCHOLOGICAL WELL-BEING

LEVEL OF PSYCHOLOGICAL FUNCTIONING

Please choose the response that best describe your experiences
1= Strongly agree 2= Moderately agree 3= Slightly agree 4= Slightly disagree

5= Moderately disagree

	ITEMS	**1**	**2**	**3**	**4**	**5**	**6**
	Autonomy Items						
1	My decisions are not usually influenced by what everyone else is doing						
2	I have confidence in my own opinions, even if they are different from the way most other people think.						
3	I tend to worry about what other people think of me						
4	I often change my mind about decisions if my friends or family disagree						
5	I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people						
6	Being happy with myself is more important to me than having others approve of me						
7	It's difficult for me to voice my opinions on controversial matters						
8	I tend to be influenced by people with strong opinions						
9	I judge myself by what I think is important, not by what others think is important.						
	Environmental Mastery						
10	I am good at juggling my time so that I can fit everything in that needs to get done						
11	I often feel overwhelmed by my responsibilities						
12	I am good at managing the responsibilities of daily life						

13	I do not fit very well with the people and community around me						
14	I have difficulty arranging my life in a way that is satisfying to me						
15	I have been able to create a lifestyle for myself that is much to my liking						
16	I generally do a good job of taking care of my personal finances and affairs						
17	In general, I feel I am in charge of the situation in which I live						
18	The demands of everyday life often get me down						
	Personal Growth						
19	I am not interested in activities that will expand my horizons.						
20	I have the sense that I have developed a lot as a person over time.						
21	When I think about it, I haven't really improved much as a person over the years						
22	I think it is important to have new experiences that challenge how I think about myself and the world						
23	I don't want to try new ways of doing things -- my life is fine the way it is						
24	I do not enjoy being in new situations that require me to change my old familiar ways of doing things						
25	There is truth to the saying you can't teach an old dog new tricks						
26	For me, life has been a continuous process of learning, changing, and growth.						
27	I gave up trying to make big improvements or changes in my life a long time ago						
	Positive Relations						

28	I don't have many people who want to listen when I need to talk						
29	I enjoy personal and mutual conversations with family members and friends						
30	I often feel lonely because I have few close friends with whom to share my concerns						
31	It seems to me that most other people have more friends than I do						
32	People would describe me as a giving person, willing to share my time with others						
33	Most people see me as loving and affectionate						
34	I know I can trust my friends, and they know they can trust me						
35	Maintaining close relationships has been difficult and frustrating for me						
36	I have not experienced many warm and trusting relationships with others						
	Purpose in Life						
37	I enjoy making plans for the future and working to make them a reality.						
38	My daily activities often seem trivial and unimportant to me.						
39	I am an active person in carrying out the plans I set for myself.						
40	I tend to focus on the present, because the future nearly always brings me problems.						
41	I don't have a good sense of what it is I'm trying to accomplish in life.						
42	I sometimes feel as if I have done all there is to do in life						
43	I used to set goals for myself, but that now seems like						

	a waste of time.						
44	Some people wander aimlessly through life but I am not one of them.						
45	I live life one day at a time and don't really think about the future						
	Self-Acceptance						
46	I feel like many of the people I know have gotten more out of life than I have						
47	In general, I feel confident and positive about myself						
48	When I compare myself to friends and acquaintances, it makes me feel good about who I am.						
49	My attitude about myself is probably not as positive as most people feel about themselves.						
50	I made some mistakes in the past, but I feel that all in all everything has worked out for the best.						
51	The past had its ups and downs, but in general, I wouldn't want to change it						
52	In many ways, I feel disappointed about my achievements in life.						
53	When I look at the story of my life, I am pleased with how things have turned out so far						
54	I like most aspects of my personality						

SECTION E: SATISFACTION WITH LIFE SCALE

GENERAL LIFE SATISFACTION

DIRECTIONS: Below are five statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by placing the appropriate number in the line preceding that item. Please be open and honest in your responding.

1 = Strongly Disagree 2 = Disagree 3 = Slightly Disagree 4 = Neither Agree or Disagree 5 = Slightly Agree 6 = Agree 7 = Strongly Agree

	ITEMS	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1	**In most ways my life is close to my ideal.**							
2	**The conditions of my life are excellent.**							
3	**I am satisfied with life.**							
4	**So far I have gotten the important things I want in life.**							
5	**If I could live my life over, I would change almost nothing.**							

SECTION F: THE FAMILY RELATIONSHIPS INDEX (FRI)

The following statements help us to understand your family. Please read each statement below and place a tick in the column marked strongly disagree, disagree, agree or strongly agree if you think the statement indicate the situation in your family.

No	Item	Strongly disagree	Disagree	Agree	Strongly agree
1	Family members really help and support one another.				
2	Family members often keep their feelings to themselves.				
3	We fight a lot in our family.				
4	We often seem to be killing time at home.				
5	We say anything we want to around				

	home.				
6	Family members rarely become openly angry				
7	We put a lot of energy into what we do at home.				
8	It is hard to 'blow off steam' at home without upsetting somebody.				
9	Family members sometimes get so angry they throw things.				
10	There is a feeling of togetherness in our family.				
11	We tell each other about our personal problems.				
12	Family members hardly ever lose their tempers.				

THE END: Thank you very much for taking the time to complete this questionnaire. Some of these questions may have made you feel uncomfortable. If you would like to talk about any of your concerns then please contact the principal researcher for further assistance.

Appendix III: Additional Findings

Table 1

Results of Linear Regression Analyses for the moderation effect of Family relationship on the experience of CSA and Psychological well-being relationship.

Model	B	SE B	β
(Constant)	1.221	.047	
Experience of Physical Abuse	.147	.030	.243**
(Constant)	1.163	.071	
Experience of Physical Abuse	.135	.032	.222
Experience of Sexual Abuse	.088	.081	.058

R2 =.059and.057 for steps 1 and 2; ΔR2=.003 for step2; ***p< .001

Table 2

Summary of means (standard deviations) and independent-t test of victims and non victims of CSA on psychological well-being measures.

Psychological well-being measures	**Victims N= 311**	**Non victims N=65**	***df*=373**	***T***	***p***
	Mean (SD)	**Mean (SD)**			
Brief Symptom Inventory	1.43 (.57)	1.23 (.55)		3.31	.004
Ryff psychological wellbeing scale	1.29 (25.87)	1.19 (21.33)		.906	.000

M=Mean, SD= Standard deviation

Appendix IV: Cross Tabulation of Sex of Participants and Forms of Sexual Abuse

Sex * Forms of Sexual Abuse Cross Tabulation

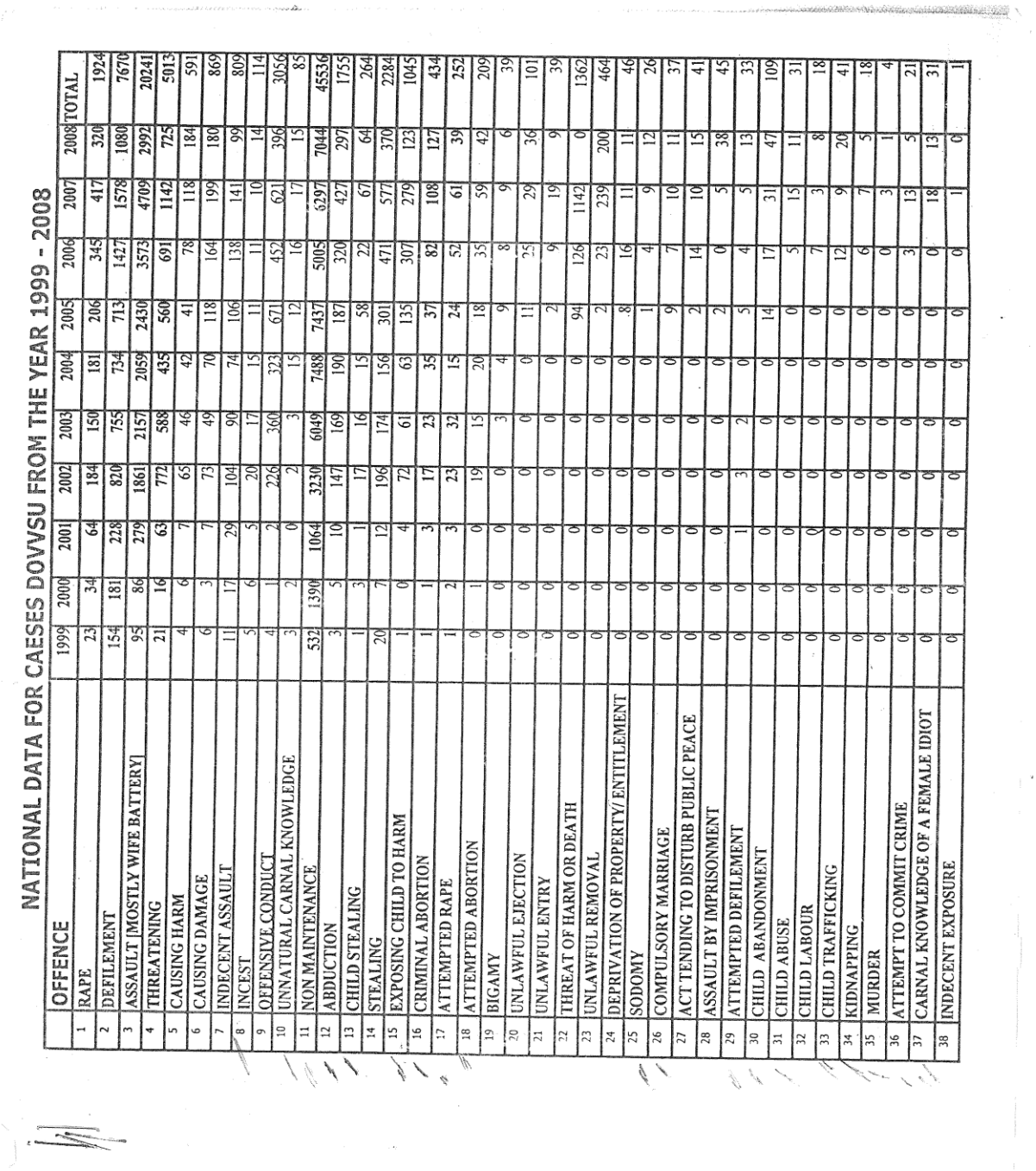
			Forms of Sexual Abuse				
			No contact	non-contact	both	Total	
Sex	Male	Count	32	8	40	111	191
		% within Forms of Sexual Abuse	49.2%	44.4%	59.7%	49.1%	50.8%
		% of Total	8.5%	2.1%	10.6%	29.5%	50.8%
	Female	Count	33	10	27	115	185
		% within Forms of Sexual Abuse	50.8%	55.6%	40.3%	50.9%	49.2%
		% of Total	8.8%	2.7%	7.2%	30.6%	49.2%
Total		Count	65	18	67	226	376
		% within Forms of Sexual Abuse	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	17.3%	4.8%	17.8%	60.1%	100.0%

Appendix V: Cross Tabulation of Experience of Physical Abuse and Experience of Sexual Abuse

Experience of Physical Abuse * Experience of Sexual Abuse Cross Tabulation

			Experience of Sexual Abuse		
			No	Yes	Total
Experience of Physical Abuse	No	Count	42	58	100
		% within Experience of Sexual Abuse	64.6%	18.7%	26.7%
		% of Total	11.2%	15.5%	26.7%
	Yes	Count	23	252	275
		% within Experience of Sexual Abuse	35.4%	81.3%	73.3%
		% of Total	6.1%	67.2%	73.3%
Total		Count	65	310	375
		% within Experience of Sexual Abuse	100.0%	100.0%	100.0%
		% of Total	17.3%	82.7%	100.0%

Appendix VI: National Data on Reported Violence cases to DOVVSU (1999 To 2008)



NATIONAL DATA FOR CAESES DOVVSU FROM THE YEAR 1999 - 2008

	OFFENCE	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	TOTAL
1	RAPE	23	34	64	184	150	181	206	345	417	320	1924
2	DEFILEMENT	154	181	228	820	755	734	713	1427	1578	1080	7670
3	ASSAULT [MOSTLY WIFE BATTERY]	95	86	279	1861	2157	2059	2430	3573	4709	2992	20241
4	THREATENING	21	16	63	772	588	435	560	691	1142	725	5013
5	CAUSING HARM	4	6	7	65	46	42	41	78	118	184	591
6	CAUSING DAMAGE	6	3	7	73	49	70	118	164	199	180	869
7	INDECENT ASSAULT	11	17	29	104	90	74	106	138	141	99	809
8	INCEST	5	6	5	20	17	15	11	11	10	14	114
9	OFFENSIVE CONDUCT	4	1	2	226	360	323	671	452	621	396	3056
10	UNNATURAL CARNAL KNOWLEDGE	3	2	0	2	3	15	12	16	17	15	85
11	NON MAINTENANCE	532	1390	1064	3230	6049	7488	7437	5005	6297	7044	45536
12	ABDUCTION	3	5	10	147	169	190	187	320	427	297	1755
13	CHILD STEALING	1	3	1	17	16	15	58	22	67	64	264
14	STEALING	20	7	12	196	174	156	301	471	577	370	2284
15	EXPOSING CHILD TO HARM	1	0	4	72	61	63	135	307	279	123	1045
16	CRIMINAL ABORTION	1	1	3	17	23	35	37	82	108	127	434
17	ATTEMPTED RAPE	1	2	3	23	32	15	24	52	61	39	252
18	ATTEMPTED ABORTION	0	1	0	19	15	20	18	35	59	42	209
19	BIGAMY	0	0	0	0	3	4	9	8	9	6	39
20	UNLAWFUL EJECTION	0	0	0	0	0	0	11	25	29	36	101
21	UNLAWFUL ENTRY	0	0	0	0	0	0	2	9	19	9	39
22	THREAT OF HARM OR DEATH	0	0	0	0	0	0	94	126	1142	0	1362
23	UNLAWFUL REMOVAL	0	0	0	0	0	0	2	23	239	200	464
24	DEPRIVATION OF PROPERTY/ ENTITLEMENT	0	0	0	0	0	0	8	16	11	11	46
25	SODOMY	0	0	0	0	0	0	1	4	9	12	26
26	COMPULSORY MARRIAGE	0	0	0	0	0	0	9	7	10	11	37
27	ACT TENDING TO DISTURB PUBLIC PEACE	0	0	0	0	0	0	2	14	10	15	41
28	ASSAULT BY IMPRISONMENT	0	0	0	0	0	0	2	0	5	38	45
29	ATTEMPTED DEFILEMENT	0	0	1	3	2	0	5	4	5	13	33
30	CHILD ABANDONMENT	0	0	0	0	0	0	14	17	31	47	109
31	CHILD ABUSE	0	0	0	0	0	0	0	5	15	11	31
32	CHILD LABOUR	0	0	0	0	0	0	0	7	3	8	18
33	CHILD TRAFFICKING	0	0	0	0	0	0	0	12	9	20	41
34	KIDNAPPING	0	0	0	0	0	0	0	6	7	5	18
35	MURDER	0	0	0	0	0	0	0	0	3	1	4
36	ATTEMPT TO COMMIT CRIME	0	0	0	0	0	0	0	3	13	5	21
37	CARNAL KNOWLEDGE OF A FEMALE IDIOT	0	0	0	0	0	0	0	0	18	13	31
38	INDECENT EXPOSURE	0	0	0	0	0	0	0	0	1	0	1

Source : Domestic Violence and Victim Support U