

Original Article

**Profiling the Psychosocial Impacts of
Child Sexual Abuse in Ethiopia**

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Abstract

Objective: This study sought to study the psychosocial effects of child sexual abuse (CSA) and to provide some insight about appropriate interventions.

Method: Data was collected from 318 female children who were sexually abused through early marriage (n = 114), rape (n = 118), and child prostitution (n = 86). The Amharic version of the Children's Impact of Traumatic Events Scale-Revised (CITES-R) and the Rosenberg Self-Esteem Scale (RSES) were employed.

Results: K-means cluster analysis classified respondents into four distinct and clinically meaningful clusters labelled by further discriminant analysis as acute trauma, chronic trauma, avoidant, and resilient. While more than half (53%) of the respondents belonged to the acute trauma cluster, the remaining 16%, 17%, and 14% to the chronic trauma, avoidant, and resilient clusters, respectively. A discriminant analysis predicted that there was a 96% hit rate of cluster membership. Specific predicted membership rate ranged from 98% in respondents belonging to the acute trauma and resilient clusters to 91% in the avoidant trauma cluster. ANOVA and the associated post hoc tests on personality related validating variables, and a Chi-square test on abuse related and demographic validating variables yielded significant and valid associations with the clusters.

Conclusion: Findings of the present study are important in that the four clusters formed based on abuse consequences were found to be distinct, valid, and clinically meaningful.

Practice Implications: Differential therapeutic and counselling interventions targeted to eliminate symptoms and to promote approach coping over avoidance coping are recommended.

Key words: Psychosocial impacts, child sexual abuse, cluster analyses, Ethiopia

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Introduction

A proliferation of research documenting epidemiological data at international (Pereda, Guilera, Forns & Gómez-Benito, 2009; Finkelhor, 1994), and regional (Ménard & Ruback, 2003; Oaksford & Frude, 2001; Madus & Peltzer, 2000) levels shows that child sexual abuse (CSA) is an important mental health problem. Contrary to the widely held belief that CSA is very rare in Africa, the prevalence and incidence of the problem in Sub-Saharan Africa is reported to be higher than in other regions of the world (Lalor, 2004). Although lack of studies with representative data hampers knowledge of CSA in Ethiopia, the few reports of small scale studies indicates that there is a high prevalence, mainly as a result of early marriage, rape, and child prostitution (Wondie & Abdi, 2008; CSA-Ethiopia & ORC MACRO USA, 2005; MoLSA, 2005).

Studies conducted with college students, clinical populations, community based studies, and national probability samples have documented a range of short and long-term psychological, behavioural, emotional, and interpersonal difficulties that seem associated with CSA. These include depression, dissociation, posttraumatic stress disorder, personality disorders, anxiety and fear, revictimization and substance abuse (Wondie, Zemene, Tafesse, Reschke & Schroeder, 2011a; Polusny & Follette, 1995; Kendall-Tackett, Williams & Finkelhor, 1993; Beitchman, Zucker, Hood & DaCosta, 1992; Beichman, Uucker, Hood, DaCosta & Akman, 1991). However, there is considerable doubt whether CSA per se causes these psychological problems. Factors related to the severity of the abuse (Bennett, Hughes & Luke, 2000; Williams, 1993), the social milieu in which the abuse takes place (Edwards & Alexander, 1992), personal factors, and the coping styles that CSA survivors employed (Proulx, Koverola, Fedorowicz & Kral, 1995; Spaccarelli, 1994) were reported to play moderating and mediating roles between CSA and the multifaceted consequences. Specifically, long standing abuse duration, use of force, close relationship to the perpetrator, and early age at which abuse first occurred are associated with severe outcomes (Wondie, Zemene, Reschke & Schroeder, 2011b; Merrill et al., 2001). Besides, according to the transac-

tional theory, outcomes are determined by multiple transactions between appraisals and coping responses as well as environmental factors (Spaccarelli, 1994). For example, various family characteristics, such as family dysfunction and pathology (i.e. low levels of parental support, and high levels of parental conflict) may worsen the impact of abuse events or impede the child's coping ability (Spaccarelli, 1994). On the other hand, support from the non-offending parent may act as a protective factor by promoting the use of effective coping strategies (Spaccarelli, 1994). Hence, coping and family characteristics, especially parental support, are among the key mediators proposed to explain the link between sexual abuse and emotional distress (Whiffen & MacIntosh, 2005; Barker-Collo & Read, 2003). However, some have argued that coping is more influential in determining later adjustment than the characteristics of the abuse (Johnson & Kenkel, 1991).

Coping refers to the strategies (i.e. cognitive, affective, or behavioural) that an abuse victim uses to manage the internal and external stress generated by the abuse experience (Proulx, Koverola, Fedorowicz & Kral, 1995; Spaccarelli, 1994). Such efforts may be adaptive or maladaptive, and the form that coping processes assume affects how successful the resolution of a stressor will be (Taylor, & Stanton, 2007). It is well recognized in the stress and adaptation literature that reliance on active coping or approach strategies are associated with a better adjustment, while the use of avoidant coping appears to be related to an increase of distress (Ebata & Moos, 1994; Leitenberg, Greenwald, and Cado, 1992). For example, the results of a study of children confronted with parental break-ups revealed that children who generally used avoidant coping strategies to face different life problems were found to be more depressed, anxious, and exhibited more conduct behavior problems (Sandler, Tein, & West, 1994).

However, some studies reported conflicting results, showing that there was little relationship between the effect of CSA and these environmental and personal factors (Tremblay, Hébert & Piché, 1999; Sigmon, Greene, Rohan & Nichols, 1996). Other findings have also shown that some CSA survivors exhibit little to no symptomatology after the abuse (Hecht & Hansen, 1999; Kendall-Tackett et al., 1993). This has been partly attributed

to methodological issues in analyzing data obtained from CSA survivors. In fact, variable-orientated analyses allow for statistical control of covariance and draw on the statistical power of the full sample. However, it has been argued that measuring the consequences of CSA with such diverse background correlates of the survivors grouped together may lead to inconclusive outcomes (Jonzon & Lindblad, 2006; Sawyer, Tvakar, Yancey, Hansen & Flood, 2005).

In research on resilience, however, person-oriented approaches have been proposed by some researchers who have been studying the psychosocial sequelae of CSA (Hébert et al., 2006; Jonzon & Lindbald, 2006; Sawyer et al., 2005). Aimed at finding groups with different profiles or patterns of individual characteristics, cluster analysis is considered an excellent method to study heterogeneous populations (Hébert et al., 2006; Borgen & Barnett, 1987). Its main purpose is to classify subjects into subgroups on the basis of similarities of selected variables. Given the heterogeneity of the participants in terms of the contexts in which they experienced the sexual abuse, it was expected that the consequences would also be diverse. The present study, therefore, aimed at objectively classifying the respondents based on the psychosocial aftermath using cluster analysis.

Methods and Materials

Data was collected from 318 randomly selected respondents who were sexually abused through early marriage ($n = 114$), rape ($n = 118$), and child prostitution ($n = 86$). With current age ranging from 7 to 22 years ($M = 16.55$, $SD = 1.82$), their ages at the vital reproductive health related life stages were the following: menarche ($n = 309$) varied from 9 to 17 years ($M = 13.60$, $SD = 1.25$), age at first marriage ($n = 160$) ranged from 7 to 17 years ($M = 12.87$, $SD = 2.51$), whereas age at first coitus varied from 7 to 17 years ($M = 13.98$, $SD = 2.00$), age at first pregnancy ($n = 136$) ranged from 11 to 21 years ($M = 15.40$, $SD = 1.61$), and age at first delivery ($n = 127$) varied from 12 to 21 years ($M = 16.21$, $SD = 1.62$). Fifty per cent of the respondents had once been married with 67% now divorced. The majority of the respondents (56%) were illiterate, while the remaining one-fourth (25%) and one-fifth (20%) attended

elementary and junior secondary schools respectively. The respondents were recruited from the Addis Ababa Fistula Hospital, Family Guidance Association of Ethiopia (FGAE) Model Clinic, Children Aid Ethiopia, in Addis Ababa, as well as the Bahir Dar Hamelin Fistula Centre, and the Forum on Street Children in Bahir Dar, northwest Ethiopia.

Instruments

The Children's Impact of Traumatic Events Scale-Revised (CITES-R): The CITES-R is among the few instruments specifically designed for sexually abused children available to measure such comprehensive dimensions as PTSD symptoms, eroticism, and mediating factors such as social reactions and abuse attributions (Chaffin & Shultz, 2001). Crouch et al. (1999) describe each of the sub-scales. The respondents were asked to rate their experiences, feelings and opinions in each item as "very true", "somewhat true", or "not true". A value of 3, 2 and 1 was assigned for each scale, respectively. A principal component factor analysis of the present study yielded two-factor solutions of the self-blame/guilt scale of the CITES-R abuse attribution dimension as self-blame and guilt (Wondie, Zemene, Reschke & Schroeder, 2012). Studies that employed this instrument reported internal consistencies ranging from 0.57 to 0.91 for the CITES-R scales and sub-scales (Wolfe et al., 1991; Chaffin & Shultz, 2001; Crouch et al., 1999).

The Rosenberg Self-esteem Scale (RSES): The RSES is a 10-item measure of global self-worth half of which are positively and the other half negatively worded. With responses arranged in a four point Likert's scale ranging from "strongly agree" to "strongly disagree", the items assess overall feelings of self-worth or self-acceptance (Rosenberg, 1965). A value ranging from 3 to 0 was assigned for "strongly agree", "agree", "disagree", and "strongly disagree" respectively.

Procedure

The English versions of both the CITES-R and the RSES were first translated into Amharic, the federal language of Ethiopia, by the principal investigator. They were then given to an expert in the Amharic language for further proof

of the accuracy of the translation. The Amharic versions were then given to an expert in the English language and were translated back into English. Finally, the differences that resulted from both the forward and backward translations were compromised at a joint discussion of the two groups of translators moderated by the principal investigator. Five female research assistants were purposefully selected from each research site, each assistant recruited had a minimum of grade 12 certificate, previous experience of data collection and experience in working with abused children. Training on data collection, interviewing, and rapport establishment with the CSA survivors was given for one day at each site. The training focused on theoretical explanations and practical demonstrations with each trainee afterwards. The principal investigator closely supervised the data collection process.

Ethical considerations

Oral as well as written informed consent was secured from the respondents. In addition, written permission was obtained from the respective officials of the institutions and organizations where the respondents were recruited based on an official request letter issued by the University of Gondar.

Results

Two sets of criterion variables were selected for cluster formation from a list of 14 variables. While the first set was constituted by the PTSD and the social reactions variables, termed as symptom and consequence of CSA, the second set was composed of the abuse attributions variables, termed as personality related variables. The symptom and consequence variables were taken as clustering variables, while the personality related variables were employed for validating the clusters.

Selection of the Cluster Solutions: All the measures were converted into Z scores, and k-means cluster analysis was employed. The k-means algorithm partitions the data field into non-empty, non-overlapping regions so that points in different clusters are as widely separated as possible, whereas those in the same cluster are close together (Sugar et al., 2004). As a set off

point, hierarchical cluster analysis with the square Euclidean distance as a measure of similarity and Ward hierarchical cluster method as clustering algorithm were employed with objectively specified cluster numbers in the k-means analysis. Initially, five cluster solutions were suggested; further inspection of the analysis with 3 clusters and 4 clusters showed that the analysis with 4 cluster solutions was found to be commendably interpretable.

Description of the Clusters: Four distinct clusters became apparent (Figure 1). Respondents in cluster I were characterized by elevated standard scores of sexual anxiety, hyperarousal, intrusive thoughts, negative reactions by others, and social support, but a lower degree of avoidance. Respondents in cluster II showed an even more elevated degree of hyperarousal, intrusive thoughts, and avoidance than respondents in cluster I.

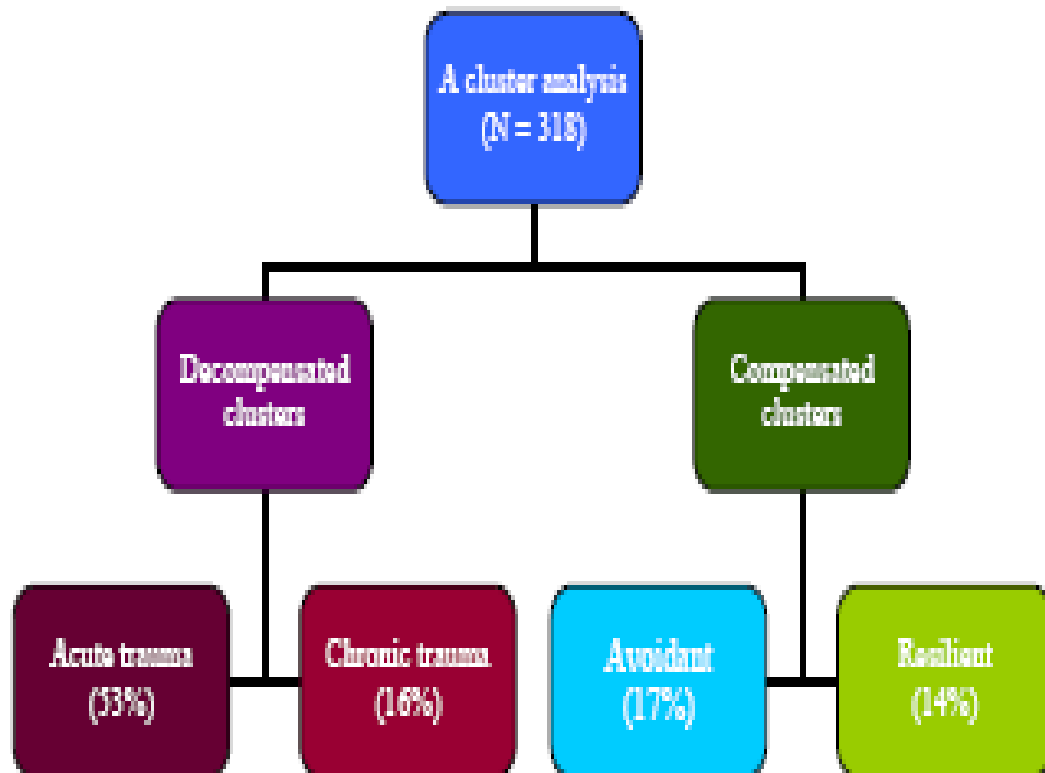


Figure 1: Proportion of respondents associated with each cluster

Conversely, respondents in cluster III were characterized by a higher degree of avoidance but a lower degree of the other symptoms and social reactions variables. Finally, respondents belonging to cluster IV were characterized by the highest degree of social support and the lowest degree of negative reactions by others. They were also identified with lower degrees of the other symptom variables.

Reclassification and interpretation of the Clusters Solutions: A discriminant function analysis was run for the description of the clusters whose determination variables contributed to the distinctions. The result revealed that all the discriminant functions, namely function 1 ($\lambda = .07$, $c^2(18) = 798.26$, $p < .001$, canonical $R^2 = .88$), function 2 ($\lambda = .35$, $c^2(10) = 327.21$, $p < .001$, canonical $R^2 = .78$), and function 3 ($\lambda = 0.88$, $c^2(4) = 38.12$, $p < .001$, canonical $R^2 = 0.34$) reliably differentiated the clusters. With eigenvalue of 3.53, 1.53, and 0.13, Function 1, 2, and 3 accounted for 68%, 29.4%, and 2.5% of the between-group variability, respectively. Besides, cluster membership was predicted for each participant based on the discriminant functions. Results revealed that 96% of the respondents were correctly classified. Specifically, 98% of the respondents in Cluster I, 96% in Cluster II, 91% in Cluster III, and 98% in Cluster IV were correctly classified. The following clustering variables showed the highest absolute values. These are Function 1: higher degrees of hyper-arousal, intrusive thoughts, and negative reactions by others; Function 2: sexual anxiety; and Function 3: social support, and avoidance (Table 1).

Apart from this, a follow-up ANOVA using the scores of discriminant functions as dependent variables and the cluster groups as an independent variable was conducted. The results revealed that all Function 1 ($F(3, 314) = 369$, $p < 0.001$), Function 2 ($F(3, 314) = 159$, $p < 0.001$), and Function 3 ($F(3, 314) = 13.60$, $p < 0.001$) significantly differentiated from each other. Further, post hoc tests also showed that discriminant functions significantly differentiated all clusters from one another except between cluster II and IV in Function 3.

Table 1: Discriminant function-variable correlation, and group centroids

Variables	Function 1	Function 2	Function 3
Hyper arousal	0.75*	-0.22	-0.42
Intrusive thoughts	0.70*	-0.20	-0.45
Negative reactions by others	0.32*	0.20	0.26
Sexual anxiety	0.49	0.50*	0.50
Social support	-0.01	0.46	-0.56*
Avoidance	0.09	-0.42	0.47*
Centroids			
Cluster I	1.38	0.67	---
Cluster II	0.54	- 2.18	0.52
Cluster III	-1.90	- 1.20	0.60
Cluster IV	- 3.65	1.42	- 0.40

* Largest absolute correlation between each variable and a discriminant function

Note the discriminating variables: IT- intrusive thoughts, AV- avoidance, HA- hyperarousal, SA- sexual anxiety, NRO- negative reactions by others, SS- social support

Based on the Z scores of the clusters (Figure 1) and the discriminant analyses (Table 1), the respondents in each of the four clusters were labelled. Accordingly, because the level of avoidance was found to have been much lower than that of the other PTSD core symptoms in respondents belonging to cluster I, this cluster was termed “acute trauma”. Conversely, since the degree of avoidance coping in respondents associated with cluster II was as high as the remaining symptoms of PTSD, this cluster was named “chronic trauma”. Finally, respondents in cluster III who demonstrated a higher degree of avoidance coping but lower symptoms were termed “avoidant”, and those in cluster IV who showed a higher degree of social support but lower symptoms were termed “resilient”.

Validation of the Clusters: Two sets of variables were used for validating the clusters. The first set consisted of personality related variables and the sec-

ond set was composed of abuse related and socio-demographic variables. To this end, a series of ANOVAs and post hoc tests for the interval variables and Chi-square tests for the categorical variables were conducted. The ANOVA revealed that all the personality related validating variables, such as guilt ($F(3, 314) = 37.69, p < 0.001$), empowerment ($F(3, 314) = 37.57, p < 0.001$), dangerous world ($F(3, 314) = 27.46, p < 0.001$), personal vulnerability ($F(3, 314) = 16.66, p < 0.001$), and self-blame ($F(3, 314) = 4.59, p < 0.05$) significantly differentiated between the clusters (Table 2).

The Bonferroni test revealed that respondents in the chronic trauma cluster reported a significantly higher degree of guilt than those in the avoidant and resilient ($p < 0.001$) clusters. No significant difference was however observed either in the two compensated (i.e. avoidant & resilient) or decompensated (i.e. acute & chronic) trauma clusters. Similarly, respondents in the acute and chronic trauma clusters revealed slightly higher degrees of self-blame than those in the avoidant and resilient ($p < 0.05$) clusters. No significant differences, however, were observed between the decompensated clusters. While respondents in the acute trauma cluster perceived the world to be significantly more dangerous than their counterparts in the resilient, avoidant, and chronic trauma ($p < 0.001$) clusters, they still demonstrated a significantly higher degree of empowerment than the avoidant and chronic trauma ($p < 0.001$) clusters. Respondents in the resilient cluster were found to have a significantly higher degree of this internal resource than the avoidant and the chronic trauma ($p < 0.001$) clusters. In a similar analysis, the respondents in the resilient and acute trauma clusters demonstrated a significantly lower degree of personal vulnerability than those in the avoidant and chronic trauma ($p < 0.001$) clusters. Significant difference was not, however, observed between respondents in the chronic trauma and the avoidant clusters or between the resilient and acute trauma clusters.

The results on the abuse related and socio-demographic variables revealed that CSA context ($c^2(6) = 63.19, p < 0.001$), marital status ($c^2(6) = 67.39, p < 0.001$), and time elapsed since first coitus ($F(3, 314) = 2.74, p < 0.05$) had significant associations between the clusters. Further inspection of the re-

sults showed that there were meaningful relationships between the contexts in which the respondents experienced the sexual abuse and their marital status as the function of the respective clusters to which they belonged (Table 2).

Table 2: ANOVA and c^2 test results of cluster validating variables

Validating variables	Cluster I Acute	Cluster II Chronic	Cluster III Avoidant	Cluster IV Resilient	F(3,314)
	M (SD)	M (SD)	M (SD)	M (SD)	
Pers. vulnerability	1.83 (0.51)	2.20 (0.67)	2.30 (0.58)	1.67 (0.59)	16.66***
Self-blame	1.26 (0.55)	1.16 (0.46)	1.03 (0.25)	1.05 (0.27)	4.59**
Guilt	2.28 (0.61)	2.36 (0.54)	1.67 (0.59)	1.42 (0.53)	37.69***
Dangerous world	2.81 (0.32)	2.39 (0.54)	2.35 (0.52)	2.32 (0.63)	27.46***
Empowerment	2.31 (0.56)	1.56 (0.60)	1.50 (0.57)	2.15 (0.77)	37.57***
CSA context	Nr. (%)	Nr. (%)	Nr. (%)	Nr. (%)	c^2 (6)
Early marriage	32 (18.8)	27(54.0)	29 (52.7%)	26 (60.5)	63.19***
Rape	91 (53.5)	6 (12.0)	9 (16.4%)	12 (27.9)	
C. prostitution	47 (27.6)	17(34.0)	17 (30.9%)	5 (11.6)	
Marital status	Nr. (%)	Nr. (%)	Nr. (%)	Nr. (%)	c^2 (6)
Never married	110 (64.7)	18 (30.6)	19 (34.5)	13 (30.2)	67.39***
Married	5 (2.9)	10 (20.0)	15 (27.3)	20 (46.5)	
Divorced	55 (32.4)	22. (44.0)	21(38.2)	10 (23.3)	

Discussion

The results showed that cluster analysis classified the respondents into four distinct and clinically meaningful clusters. Of these, two were decompensated and the remaining two were compensated clusters (Figure 2). A validation analysis showed that more than half (53%) of the respondents who belonged to the acute trauma cluster (n = 170) were found to have been rape survivors compared to their early married and child prostitute counterparts. Respondents belonging to this cluster were also by and large never married compared to those married and divorced. Further validation of the respondents in this cluster showed that they demonstrated high scores of external

abuse attribution of dangerous world as well as internal attribution of self-blame and guilt. Interestingly, however, respondents belonging to this cluster demonstrated a higher score of positive abuse control perception of empowerment. Perhaps this could be attributed to the extent of the abuse experience. The majority of the rape survivor respondents (82%) were raped only once.

Such validation of the acute trauma cluster with abuse related, socio-demographic and personality related variables was consistent with Terr's type I trauma (Terr, 1991). According to Terr, type I traumas are short-term, unexpected, single blow, isolated, sudden, surprising, more likely to lead to typical PTSD symptoms, and more likely to have a quicker recovery. Consistent with Terr (1991) and others who were inspired by her conceptualizations (Wolfe & Birt, 1995), symptom expression of the respondents in the acute trauma cluster was characterized by higher degree of intrusive thoughts, lower degree of avoidance, and higher degree of hyperarousal. Interestingly also, the present findings seem to have replicated the result of a recent study in the Netherlands aimed at determining the factor structure of acute post-traumatic symptoms in two recently traumatized samples: sample 1 (n = 203) civilian trauma survivors, and sample 2 (n = 182) civilian treatment seeking trauma survivors who were administered the Davidson Trauma Scale (Olf, Sijbrandij, Opmeer, Carlier & Gersons, 2009). They came up with four factors (re-experiencing, active avoidance, dysphoria, and hyperarousal) that best represented their data in the two samples.

On the other hand, those who married early (54%), and divorced (44%) constituted respondents in the chronic trauma cluster (n = 50) to a larger extent compared to those who survived rape (12%), and those who were in intact marital relationship (20%). This implies that it was not early marriage per se that contributed to such long-ranged trauma, rather the way the respondents perceived the marriage and the extent of support in the marital tie. This is evidenced by the divorced respondents who might not have adjusted to the very early marriage and hence divorced to escape from their spouses. Respondents in this cluster were found to demonstrate higher scores in guilt and negative abuse control perception of personal vulnerability, but a lower

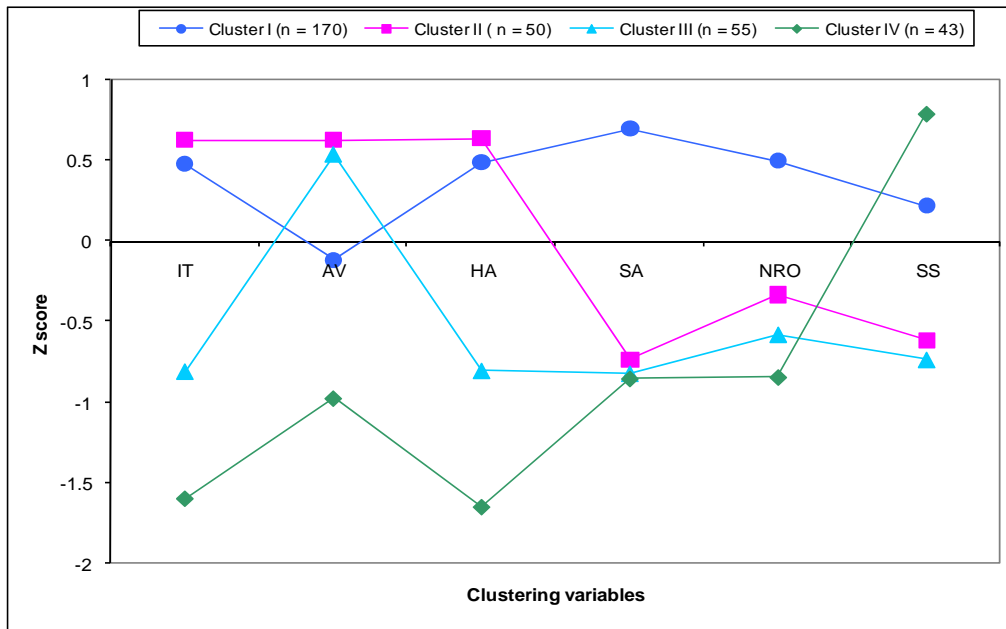


Figure 1: Graphical manifestation of the cluster solutions

Note the clustering variables: IT- intrusive thoughts, AV- avoidance, HA- hyperarousal, SA- sexual anxiety, NRO- negative reactions by others, SS- social support

score in positive control perception of empowerment. This cluster typically confirms the characteristic features of type II trauma which according to Terr (1991) follow from long standing or repeated exposure to extreme external events like ongoing physical or sexual abuse. Such chronic and long standing trauma may lead to an altered view of the self and of the world with accompanying feelings of guilt, shame and worthlessness. It is also more likely to lead to long-standing interpersonal problems and more likely to have poorer recovery (Wolfe & Birt, 1995; Terr, 1991).

Respondents in the chronic trauma cluster were characterized by having comparatively higher scores of the core symptoms of PTSD such as intrusive thoughts, avoidance and hyperarousal. This is in line with Horowitz's cognitive behavioural theory which states that such posttraumatic reactions happen when survivors fail to process the traumatic information in their attempt to harmonize the new traumatic information with the existing schema. This then leads to persistent posttraumatic reactions as the information remains in active memory and continues to intrude and needs to be

avoided (in Brewin & Holmes, 2003).

Of the respondents belonging to the avoidant cluster ($n = 55$) more than half (52.7%) were married early compared to their rape survivor counterparts and divorced (38%) compared to those in intact marital relationships. Respondents of this cluster demonstrated higher scores of personal vulnerability but lower scores of positive abuse control perception of empowerment. Such validations showed that this group of respondents are highly likely to resemble those in the chronic cluster except that the former, with a high degree of self control (Tremblay, Hébert & Piché, 1999), seem to have managed to cope with the trauma hence the core PTSD symptoms were very low. However, studies show that avoidance is a risky survival strategy in that the likelihood of destroying such coping would be higher when survivors are under stressful conditions (Tremblay, Hébert & Piché, 1999). Moreover, excessive avoidance may result in social isolation, depression, psychological distress, substance abuse problems, and other forms of psychopathology (Hayes et al., 1996; Polusny & Follette, 1995). Why do survivors of CSA rely on such maladaptive ways of coping? Results of the present study are consistent with other studies related to this issue (Littleton & Breitkopf, 2006; Roth & Newman, 1991). Factors like negative sequelae (i.e. feelings of shame and embarrassment, self-blaming cognitions and stigmatizations) that victims experience following CSA and lack of availability of coping resources were the major factors that lead survivors to depend on avoidance coping.

Finally, only 43 (14%) of the CSA survivor respondents were found to be resilient. Of this, the great majority (60%) were married early compared to child prostitutes (11%). As well, those who were in intact marital relationship (46%) proved to be resilient as compared to those who were divorced (23%). Presumably, this group of respondents demonstrated the lowest scores of the core PTSD symptoms, perceived the lowest degree of negative reactions by others, but the highest degree of social support. Further validation of the respondents in the resilient cluster revealed that they showed lower degree of internal attributions of self-blame and guilt, external attributions of dangerous world, and negative abuse control perception of personal vulnerability. On the other hand, they demonstrated far higher scores of positive abuse

control perception of empowerment. Resilient coping in response to extreme stress and trauma is said to be a multifaceted phenomena characterized as a complex repertoire of behavioral tendencies (Agaibi & Wilson, 2005). The social, cognitive, and personality factors that provide this group of respondents with a psychosocial resilience were consistent with a number of studies on the science of resilience. For example, a study conducted on abused and neglected children revealed that a supportive partner was a good predictor of resilience (DuMont, Widom & Czaja, 2007). Another study (n =43) on sexually abused girls documented that a warm and supportive relationship with a non-offending parent correlated strongly with resilience. Moreover, lower levels of abuse-related stress, fewer negative cognitive appraisals of the abusive relationship, and less reliance on aggressive coping behaviors were found to be significant predictors of resilience based on the absence of clinical levels of symptomatology.

In conclusion, the present study is perhaps the first to consider CSA survivors, reported to be prevalent in Ethiopia, using a fairly large sample. It was found that a higher degree of social support, higher degree of abuse control perception, and being in an intact marital relationship all contributed to resilience. On the other hand, long-range abuse as manifested in the early married and divorced respondents seemed to be associated with chronic trauma symptoms and reliance on avoidance coping. On the other hand, shorter abuse duration, as evidenced by the rape survivors, was associated with acute trauma symptoms. The present findings are, therefore, immensely important for clinicians who are designing differential therapeutic schemes for survivors of CSA. This study, however, does not claim that the problem has been exhaustively investigated, for other possible consequences of CSA, such as depression, dissociation and other abuse related and socio-demographic variables need to be studied.

References

- Barker-Collo, S. & Read, J. (2003). Models of Response to Childhood Sexual Abuse: their Implications for Treatment. *Trauma Violence and Abuse* 4 (2), 95-111.

- Beitchman, J.H., Zucker, K J., Hood, J. E. & DaCosta, G. A. (1992). A Review of the Long-term Effects of Child Sexual Abuse. *Child Abuse & Neglect* 16, 101-118.
- Bennett, S.E., Hughes, H.H. & Luke, D. A. (2000). Heterogeneity in Patterns of Child Sexual Abuse, Family Functioning, and Long-term Adjustment. *Journal of Interpersonal Violence* 15, 134-157.
- Chaffin, M. & Shultz, S.K. (2001). Psychometric Evaluation of the Children's Impact of Traumatic Events Scale-Revised. *Child Abuse & Neglect* 25, 401-411.
- Crouch, J.L., Smith, D.W., Ezzell, C.L. & Sounders, B. E. (1999). Measuring Reaction to Sexual Trauma among Children: Comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. *Child Maltreatment* 4 (3), 255-263
- CSA-Ethiopia & ORC USA. (2005). *Ethiopia Demographic and Health Survey*. Central Statistical Agency, Addis Ababa Ethiopia.
- Ebata, A.T. & Moos, R.H. (1994). Personal, Situational, and Contextual Correlates of Coping in Adolescence. *Journal of Research on Adolescence* 4, 99-125.
- Edwards, J.J. & Alexander, P.C. (1992). The Contribution of Family Background to the Long-term Adjustment of Women Sexually Abused as Children. *Journal of Interpersonal Violence* 7, 306-320.
- Finkelhor, D. (1994). The International Epidemiology of Child Sexual Abuse. *Child Abuse & Neglect* 18 (5), 409-417.
- Hébert, M., Parent, N., Daignault, I.V. & Tourigny, M. (2006). A Typological Analysis of Behavioral Profiles of Sexually Abused Children. *Child Maltreatment* 11 (3), 203-216.
- Hecht, D.B. & Hansen, D.J. (1999). Adolescent Victims and Intergenerational Issues in Sexual Abuse. In: V. B. Van Hasselt & M. Hersen (Eds.), *Handbook of Psychological Treatment with Violent Offenders: Contemporary Strategies and Issues* (pp. 303-328). New York: Kluwer Academic/Plenum Publishers.
- Johnson, B.K. & Kenkel, M.B. (1991). Stress, Coping, and Adjustment in Female Adolescent Incest Victims. *Child Abuse & Neglect* 15, 293-305.

- Jonzon, E. & Lindbald, F. (2006). Risk Factors and Protective Factors in Relation to Subjective Health among Adult Female Victims of Child Sexual Abuse. *Child Abuse & Neglect* 30, 127-143.
- 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.
- 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.
- Lalor, K. (2004). Child Sexual Abuse in Sub-Saharan Africa: a Literature Review. *Child Abuse and Neglect* 28, 439-460.
- Leitenberg, H., Greenwald, E., & Cado, S. (1992). A Retrospective Study of Long-term Methods of Coping with having been Sexually Abused during Childhood. *Child Abuse & Neglect* 1, 399-407.
- M'enard, K.M. & Ruback, R.B. (2003). Prevalence and Processing of Child Sexual Abuse: a Multi-Data-Set Analysis of Urban and Rural Counties. *Law and Human Behavior* 27 (4), 385-402.
- Madu, S.N. and Peltzer, K. (2000) Risk Factors and Child Sexual Abuse among Secondary School Students in the Northern Province (South Africa). *Child Abuse and Neglect* 24, 259-268.
- Merill, L.L., Thomsen, C.J., Sinclair, B.B., Gold, S. R. & Milner, J. S. (2001). Predicting the Impact of Child Sexual Abuse on Women: the Role of Abuse Severity, Parental Support, and Coping Strategies. *Journal of Consulting and Clinical Psychology* 69 (6), 992-1006.
- MoLSA (2005) *National Action Plan on Sexual Abuse and Exploitation of Children 2006 – 2010*. Ministry of Labour and Social Affairs, Addis Ababa, Ethiopia.
- Oaksford, K.L. & Frude, N. (2001). A Review of the Epidemiological Research on Child Sexual Abuse: Community and College Student Samples. *Child Abuse Review* 10, 49-59.
- Pereda, N., Guilera, G., Forns, M. & Gómez-Benito, J. (2009). The Prevalence of Child Sexual Abuse in Community and Student Samples: A Meta-Analysis. *Clinical Psychology Review* 29: 328-338.

- Polusny, M.A. & Follette, V.M. (1995). Long Term Correlates of Child Sexual Abuse: Theory and Review of the Empirical Literature. *Applied and Preventive Psychology* 4, 143-166.
- Proulx, J., Koverola, C., Fedorowicz, A. & Kral, M. (1995). Coping Strategies as Predictors of Distress in Survivors of Single and Multiple Sexual Victimization and Non Victimized Controls. *Journal of Applied Social Psychology* 25, 1464-1483.
- Sandler, I.N., Tein, J.Y., & West, S.G. (1994). Coping, Stress, and the Psychological Symptoms of Children of Divorce: a Cross-sectional and Longitudinal Study. *Child Development* 65, 1744-1763.
- Sawyer, G.K., Tavkar, P., Yancey, C.T., Hansen, D.J. & Flood, M.F. (2005). Heterogeneity of Symptom Presentation in Sexually Abused Youth: Complex Profiles of a Complex Problem. poster presented at the 39th Annual Convention of the Association for Behavioral and Cognitive Therapies, Washington, DC, November, 2005.
- Sigmon, S. T., Greene, M. P., Rohan, K. J. & Nichols, J. E. (1996). Coping and Adjustment in Male and Female Survivors of Childhood Sexual Abuse. *Journal of Child Sexual Abuse* 5 (3), 57-75.
- Spaccarelli, S. (1994). Stress, Appraisal, and Coping in Child Sexual abuse: a Theoretical and Empirical Review. *Psychological Bulletin* 116 (2), 340-362.
- Taylor, S.E. & Stanton, A.L. (2007). Coping Resources, Coping Processes, and Mental Health. *Annual Review of Clinical Psychology* 3, 377-401.
- Tremblay, C., Hébert, M. & Piché, C. (1999). Coping Strategies and Social Support as Mediators of Consequences in Child Sexual Abuse Victims. *Child Abuse and Neglect* 23 (9), 929-945.
- Whiffen, V.E., & MacIntosh, H.B. (2005). Mediators of the Link between Childhood Sexual Abuse and Emotional Distress. *Trauma, Violence, & Abuse* 6 (1), 24-39.
- Williams, M.B. (1993). Assessing the Traumatic Impact of Child Sexual Abuse: What Makes It More Severe? *Journal of Child Sexual Abuse* 2 (2), 41-59.
- Wolfe, V. V., Gentile, C., Michienzi, T., Sas, L., & Wolfe, D. A. (1991). The

Children's Impact of Traumatic Events Scale: a Measure of Post-Sexual-Abuse PTSD Symptoms. *Behavioral Assessment* 13, 359-383.

Wondi, Y., Zemene, W., Tafesse, B. Reschke, K. & Schröder, H. (2011a): The Psychosocial Consequences of Child Sexual Abuse Survivors in Ethiopia: a Case-Control Comparative Analysis. *Journal of Interpersonal Violence* 26 (10), 2025-2041.

Wondi, Y., Zemene, W., Reschke, K. & Schröder, H. (2011b): Early Marriage, Rape, Child Prostitution, and Related Factors Determining the Psychosocial Effects Severity of Child Sexual Abuse in Ethiopia. *Journal of Child Sexual Abuse* 20, 305-321.

Wondi, Y., Zemene, W., Reschke, K. & Schröder, H. (2012): The Psychometric Properties of the Amharic Version of the Children's Impact of Traumatic Events Scale-Revised: a Study on Child Sexual Abuse Survivors in Ethiopia. *Journal of Child & Adolescent Trauma* 5 (4), 367-378.

Wondie, Y. & Yusuf, O. A. (2008). Sexual Abuse and its Psychosocial Effects on Female Children in Addis Ababa. *Ethiopian Journal of Health and Biomedical Sciences* 1 (1), 31-39.