THE PSYCHOLOGICAL IMPACT OF CHILD SEXUAL ABUSE ON PRIMARY CAREGIVERS IN LUSAKA, ZAMBIA

By

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Declaration

I declare that this dissertation represents my own work and it has not been submitted for a degree, diploma or other qualification at this or other university.

Signed……Date……

Abstract

Many previous researchers on child sexual abuse (CSA) found that support and protection from the caregiver provide the child an effective platform for quick recovery and improvement in mental health and social functioning (Lovett, 2004). Nonetheless, not all caregivers are supportive of survivors; recent research findings, instead, show that incidents of CSA have debilitating psychological impact on survivors' caregivers which impair their parental functioning (Bolan & Lamb, 2004; Manion et al, 1996). There is a suggestion that, to improve their own mental health and enhance their parental functioning, such caregivers be exposed to psychological care. Such a justification need to be informed by empirical evidence. This study explored whether a systematic link exists between an incident of CSA and psychological changes in caregivers, thereby justifying their psychological care.

Participants in the study were 34 caregivers of CSA survivors who brought their cases to Victim Support Unit (VSU), Young Women's Christians Association (YWCA) and/or University Teaching Hospital (UTH) in Lusaka. Perceived Stress Scale (PSS) and a semi-structured interview schedule formed the key instruments of data collection. Nonparametric Kruskal-Wallis Test, Mann-Whitney U Test and Chi-Square Test for Independence were applied to measure various relationships in the data as explained below. Thematic analyses were conducted on caregivers' narratives which formed the core qualitative data.

Overall PSS scores indicated that an incident of CSA results in a debilitating psychological impact on caregivers of the survivors. Further, a Mann-Whitney U test gave a statistically significant difference in the levels of perceived stress experienced by maternal caregivers (Mean rank = 19.38, n = 29) and paternal ones (Mean rank = 6.60, n = 5): $z = -2.66$, $p < .01$). Maternal caregivers reported greater overall distress than paternal ones. The Kruskal_Wallis Test showed no significant relationship between PSS scores and survivors' demographic variables measured in the Study.

Thematic analyses of narratives showed that some caregivers were supportive and protective of their children; others were angry with them. The difference appeared to be explained by a number of socio-demographic and abuse related factors: age, schooling, type of abuse, number of incidents of CSA and injuries sustained. A Chi-Square Test showed a significant link between these factors and caregivers' level of support for their children (See Table 10). Perceived powerlessness of the survivor in the abuse process represented by young age, once-off sexual intercourse, perpetrator's use of force and injuries was linked to high levels of caregiver's support. Caregivers' hostility toward the survivor was linked to child's old age, school enrollment, elopement, absence of use of force, high number of episodes of CSA and lack of injuries.

It was found that caregivers' level of support for their children also affected what caregivers considered to be appropriate intervention for them: those who supported their

children focused on their health; unsupportive caregivers focused on their children's behavioral correction.

Going by these findings, it is recommended that, to improve their own mental health and strengthen their parental functioning, caregivers of CSA survivors require psychotherapy.

Dedication

I dedicate this work to my late grandfather Nation ‘Mavi’ Zimba, my mother Chengo Zimba, dear Wife Mary Mwale-Zimba and children: Dafless, Ulanda, Khumbo, Chawezi and Chengo, and now my grand daughter Machilu.

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I thank Dr. S. O. C. Mwaba for conveying to me one unlikely lesson, that in your dealings with those under your leadership, strict adherence to discipline, on the one hand, and being friendly and generous to them, on the other, are not incompatible ethos. Dedication, discipline, honesty and sensitivity toward those you lead are essential in fostering fruitful engagement with them. His simple lesson is that one’s commitment to discipline need not mean cold aloofness toward those that one leads. Indeed, Dr. Mwaba’s generosity and authenticity to course participants deserve special acknowledgement.

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My mother, Chengo 'Nyaukavu' Zimba is my heroine. Despite existing in extreme socio-economic deprivation, and being a single parent, she managed, through thin and thick to send me to school. I feel humbled by her hard work and parental commitment. I cannot thank her enough.

I would probably have achieved very little in my academic life without the inspiration and financial support from my beloved Uncle, Professor R. F. Zimba. He instilled in me the mentality that education should be taken as a matter of course by and for any one, especially children; that education should be perceived as intrinsically valuable. Because of him, I avoided ever being a victim of current scourge in which education is valued purely for its extrinsic and material benefit; for this reason, I perceive learning through reading as the number one form of mental stimulation and growth. He will remain my inspiration.

I want to extend my most heartfelt gratitude to my Wife Mary Mwale-Zimba for enabling me to undertake studies at the time our children had grown up and required the attention of both of us. She was left alone to care for them when our resources were at the lowest. Her perseverance and acceptance of these circumstances humble me to the

core. I thank her; I look forward to making her circumstances a lot better. The exemplary behavior of all my children, Dafless, Ulanda, Khumbo, Chawezi and Chengo, has inspired me more than I ever imagined. I had been concerned that they would turn to other ways of making up for the loss of a fatherly presence and the accompanying economic protection; I feel humbled that my children proved more resilient than I feared. I thank them unreservedly.

Mulungushi University Management deserves very special thanks for sponsoring me for the programme. It is no longer common for an employer to fund training. Indeed, I have no reason to complain of any shortcomings in honoring their obligations in our agreement. Their commitment motivated me to keep my side of the agreement too. I thank them for emphasizing nothing less than excellence.

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List of Abbreviations

***CSA**, Child Sexual Abuse*

***HIV**, Human Immunodeficiency Virus*

***NHST**, Null Hypothesis Statistical Test*

***No**., Number*

***PTSD**, Post-Traumatic Stress Disorder*

***SA**, Sexual Abuse*

***STD**, Sexually Transmitted Disease*

UNZA, The University of Zambia

***UTH**, University Teaching Hospital*

***VSU**, Victim Support Unit*

***YWCA**, Young Women's Christian Association*

Guideline of the Citation of References in the Dissertation

In this Dissertation, American Psychological Association (APA) guidelines for citations have been used.

Chapter One

1.0. Introduction

Child sexual abuse (CSA) is a crime against the most vulnerable section of the population, the children (James & Gilliland, 2001; Durand & Barlow, 2006). The crime flourishes in secrecy promoted by the perpetrator and sometimes the family wishing to maintain and protect family honor (Cosentino & Collins, 1996). The physical and psychological effects of CSA on the child survivor are well documented (Cosentino & Collins, 1996); many of them having life time dysfunctional consequences. The role and effectiveness of the primary caregiver as a protector is a subject of many recent studies. For example, research evidence shows that a good proportion of parents respond with ambivalence in the face of an incident of child sexual abuse; specifically, these studies estimate that up to a third of mothers faced with CSA exhibit hostility toward their children (Bolen & Lamb, 2004). Such caregivers are vilified for failing to show and render the necessary support for their children when it is required most. However, new evidence seems to suggest that primary caregivers undergo psychological changes following an incident of CSA involving their child (Newberger, Gremy, Waternaux & Newberger, 1993). Such studies hypothesize that the apparent ambivalence in caregiver's response results from these psychological effects that CSA has on these caregivers and is symptomatic of psychological confusion for which the caregivers should undergo psychotherapy (Mayekiso & Mbokazi, 2007). However, on the contrary, the well-being of caregivers and other family members are ignored by institutional responders of CSA; instead they focus solely on the children (Mayekiso & Mbokazi, 2007). Yet, it is apparent that poor caregiver response to child sexual abuse exacerbates psychological sequaele on the child survivor and delays her recovery (Hebert, Daigeault, Collin-Vezino & Mireille, 2007; Willingham, 2007; Leifer, Kilbane & Grossman, 2001). This study was aimed at filling in the gaps in literature on the psychological impact that CSA has the survivors' caregivers.

1.1. *Background to the Problem*

Under the Zambian law, it is illegal to have sexual relations with a child under the age of 16 years (Daka, 2005). Child sexual abuse, referred to as defilement or sexual assault in the Zambian law[1], is a criminal offence punishable by a prison sentence. It does not matter whether such relations are carried out with the consent of the child or not; it remains a pervasive criminal act (Daka, 2005; Schwartz, 2000).

In Zambia, reports of incidents of child sexual abuse are not uncommon. Some survivors get infected with sexually transmitted infections, among them human immune deficiency virus (HIV). They also suffer severe symptoms of traumatic disorders because of the abuse (James & Gilliland, 2001; Cosentino & Collins, 1996).

Societal concerns arising from the deterioration of state of child rights due to this abuse motivated the government of Zambia to stiffen the law against the vice (Daka, 2005). Notwithstanding, Daka (2005) observes that only a small proportion of the cases of CSA are actually disclosed for prosecution in the courts of law; ultimately, this means that many survivors suffer psychological disorders in silence and without professional help.

There are many factors associated with low levels of disclosure; sadly, the primary caregiver, usually the biological parent, is implicated in not only perpetuating the silence but also in the victimization of the child by not believing him/her and, even, blaming the abuse on him/her (Cosentino & Collins, 1996). Such attitude and behavior of the 'natural protector' only go to worsen the psychological symptoms suffered by the child in the aftermath of the sexual abuse (Cosentino & Collins, 1996).

When the child discloses sexual abuse, their caregivers' reaction seems to influence openness to legal investigations, and willingness to engage in therapy (Cosentino & Collins, 1996). Mothers have significant influence in the survivor's recovery and the family health (Leifer, Kilbane and Grossman, 2001). Sadly, a remarkably high proportion of mothers are found to act ambivalently upon the disclosure that their

[1] Defilement refers to CSA only when a girl child is the victim. Sexual assault is neutral, i.e., whether victim is girl or boy.

child has been sexually abused. Research evidence shows that up to a third of non-offending guardians respond in an ambivalent manner, more concerned with maintaining good relations with the perpetrator (Bolen & Lamb, 2004; Heriot, 1996). The likelihood that a guardian will support the child tends to be a function of the perceived cost (Bolen & Lamb, 2004), such as loss of trust in a partner (as it happens in cases of incest), loss of confidence in self as a mother, a wife and a woman in general (Mayekiso & Mbokazi, 2007, p. 52). Should the abuse involve their sexual partners, the caregivers may also feel sexually inadequate (Mayekiso & Mbokazi, 2007), troubled that the partner preferred to have sex with their child instead of them. They might feel responsible, guilty, and blame themselves for what happened to the child (Mayekiso & Mbokazi, 2007). Bolen and Lamb (2004) also found that ambivalent response to the disclosure may be a precursor to and an effect of the traumatic outcomes of CSA in the non-offending guardian him/herself. Thus, failure to support the child may be symptomatic of the negative effect of CSA on the guardian's mental health, just like it does on the child.

Leifer, Kilbane and Grossman (2001), in a study of 99 non-offending African American mothers of sexually abused children aged 4 to 12 years, found that 38 were unsupportive of their children. In turn, the unsupportive mothers showed more substance abuse, criminal behavior and endured problematic relationships with partners. Whether these symptoms of mental ill-health arose out of psychological impact of CSA or vice versa, this study gives credence to the hypothesis that caregivers who fail to support their abused children are victims of mental health problems themselves.

It has been observed that when the perpetrator is close to the family of sexually abused child, "the mother will experience heightened feelings of confusion and ambivalence", thereby negatively affecting her subsequent relationship with the child (Mayekiso & Mbokazi, 2007). Nevertheless, the blame game against such a primary caregiver from human service providers abounds, viewing her ambivalence as a sign that she is incapable of caring for the child. In this case, shock and other symptoms of distress on her part are misconstrued for lack of support for the child.

It is now increasingly appreciated that the mother's negativity during the period following CSA disclosure is a manifestation of mental confusion that impairs her functioning (James & Gilliland, 2001). Mayekiso and Mbokazi (2007) discovered that the major themes for parents after disclosure of child sexual abuse were similar to those of grief and loss, namely, shock and denial, anger, bargaining, depression and acceptance. In short, mothers are traumatized by the incident of the sexual abuse (Mayekiso & Mbokazi, 2007). The most prevalent symptoms of this maternal psychopathology were found to be internalizing behavioral problems including "an

ger, anxiety, guilty, depression, insomnia, headache and fatigue" (Mayekiso & Mbokazi, 2007, p.51).

Some researchers have explained that the typical reaction of human services providers that disparages caregivers who exhibit negativity toward their abused children fails to appreciate that such a response is symptomatic of shock and denial and that the blame game only contributes to the mother getting stuck in the denial stage (James & Gilliland, 2001). It is contended that this blame game by human services professionals leads to the caregiver's grief process being interrupted, thereby interfering with his/her ability to regain emotional stability said to be essential for providing support to the victim. Thus, because of shock and denial, caregivers are unable to initially make effective decisions and assume responsibility for the child (Mayekiso & Mbokazi, 2007). To reach a level of normal mental functioning, mothers require time and healing (James & Gilliland, 2001).

The evidence suggesting a negative psychological impact of CSA on caregivers has made some researchers, among them Mayekiso and Mbokazi (2007, p. 55), to recommend that caregivers should be involved in treatment programmes following the disclosure of sexual abuse of their children. Cocoran (2004) (in Mayekiso & Mbokazi, 2007) has suggested that caregivers' intervention programmes should be aimed at increasing their supportive attitude toward their children, addressing issues of anger, guilt, depression and so on; further, it needs to address effects of secondary traumatization. Mayekiso and Mbokazi, (2007) observed that mothers who are stuck in the stage of shock and disbelief are unlikely to offer emotional

support to their daughters and to make informed decisions about parental relationships. The assistance which the caregivers need should convey the message that neither they nor their children can take responsibility for the abuse but only the perpetrators should do so. In this treatment, they advised that mothers need to be made aware of the fact that their daughters are likely to direct their anger towards them. To be able to provide the support needed by their daughters, the mothers require skills to deal with this anger. This skill should enable mothers to deal with their emotional and psychological sequelae arising from their daughters' sexual abuse. Psychological intervention could also assist the mothers to work through their initial reactions and to move from stage of shock and denial to the stage of acceptance (James & Gilliland, 2001; Mayekiso & Mbokazi 2007). Thus, there seems to be a widely shared belief in the evidence suggesting a negative psychological impact on the primary caregiver upon an incident of CSA.

It is important to study caregivers' behavior following an incident of CSA for several reasons. First, if caregivers do, indeed, suffer significantly following the sexual abuse of their child, they should be acknowledged as victims and given appropriate psychological support. Second, because of the well-documented association between parental psychopathology and child survivor's mental health, it is possible that maternal distress may impede children's recovery following disclosure (Billings & Moos, 1983; Griest, Forehand, Wells & McMahon, 1980). In general, research evidence demonstrates that children of depressed mothers show higher levels of psychological symptomatology than children in normative samples (Cox, Puckering, Pound, & Mills, 1987; Downey & Coyne, 1990). Hence, it is reasonable to predict that recovery of sexually abused children may similarly be influenced by their mothers' emotional responses (*Conte, 1985, 1987; Newberger & De Vos, 1988*). Failure to acknowledge this psychological impact on the primary caregivers is widely apparent, resulting in denying them therapy.

This study investigated the psychological impact of CSA on primary caregivers, with the rationale of providing evidence to justify a paradigm shift from apportioning blame on those caregivers who respond poorly to incidents of CSA to co-opting

them into therapy regimes aimed at strengthening their parental support for the child survivors.

In the study, the two **key variables** were:

1.2.1 Independent Variables

- ✓ incidents of child sexual abuse

1.2.2. Dependent Variable

- ✓ The psychological impact of CSA on primary caregivers

1.3. Statement of the Problem

Following an incident of child sexual abuse (CSA), a good number of primary caregivers fail to provide their children with the necessary support. Up to a third of mothers respond in this ambivalent and unsupportive manner, seemingly being more concerned with maintaining family honor and good relations with the perpetrator (Bolen & Lamb, 2004). This negative response of the caregivers robs the child of the opportunity to correctly attribute responsibility for the abuse to the perpetrator; instead the child starts to blame him/herself for the abuse thereby accentuating the appearance of psychopathological symptoms in the child (Bolan & Lamb, 2004; Heriot, 1996).

Increasingly, it is now suggested that, following an incident of CSA, caregivers, especially mothers suffer mental confusion characterized by shock and denial that impair their caregiving functioning (Bolan & Lamb, 2004). In short, mothers seem to be traumatized by the incident of the CSA involving their children (Mayekiso & Mbokazi, 2007). The traumatic effect is reported to take the form of disbelief and, at times, leads caregivers to blame the child for the abuse, ultimately damaging relations with the child and exacerbating and prolonging the survivor's traumatic experiences (Cosentino & Collins, 1996).

This apparent dearth of caregiver support for sexually abused children by their caregivers seems not to be appropriately acknowledged as arising from psychological impact of CSA on the caregiver. Instead, they are vilified as irresponsible and unworthy of caring for the child. It is suggested that this attitude of blaming the caregivers by those at the forefront of helping sexually abused children interferes

with caregivers' grief process and the restoration of their ability to provide care for the abused child (Mayekiso & Mbokazi, 2007).

The proponents of the argument that CSA has stressful psychological impacts on caregivers (among them Mayekiso & Mbokazi, 2007; James & Gilliland, 2001) recommend that they should receive psychological treatment aimed at ameliorating their own distress as well as strengthening their supportive role for their child.

To enable such a justification to be made, there is need to gain empirical evidence of negative psychological impact of CSA on the primary caregivers. This is important because of the suggestion that such psychological impacts impair the caregiver's parenting roles that are essential for the child to recover from physical and psychological trauma of CSA.

1.4. Rationale

Some previous research findings show that caregivers facing an incident of CSA sometimes inappropriately respond with hostility toward child survivors. This growing body of research evidence suggests that incidents of CSA have a negative psychological impact on such primary caregivers. The psychological impact is implicated in impairing their parental functioning and ability to make informed decisions; hence, the observed hostility toward the child.

This hypothesis has led some scholars to recommend that caregivers be provided with psychotherapy for the psychological impact of CSA, with the objective of strengthening their parenting functioning. To justify such a recommendation, more localized research evidence of the negative psychological impact of CSA on caregivers is required; hence this study. Thus, this study was important for the following reasons:

- First, if caregivers do, indeed, suffer significantly following an incident of the sexual abuse of their child, they should be acknowledged as victims who merit appropriate psychological support and care.
- Second, because of the well-documented association between parental distress and survivor's mental health, providing psychotherapy to caregivers

may enhance their recovery (Billings & Moos, 1983; Griest, Forehand, Wells & McMahon, 1980; Cox, Puckering, Pound, & Mills, 1987; Downey & Coyne, 1990; *Conte, 1985, 1987; Newberger & De Vos, 1988*).

Therefore, this study aimed at filling in the gaps in literature as well as make recommendations of care and support to be made available to primary caregivers.

1.5.0. Aim of the Study

The aim of the study was to investigate the psychological impact that incidents of child sexual abuse have on primary caregivers.

1.5.1. Objectives

The study was guided by four specific objectives, namely:

1. To explore if a relationship exists between an incident of CSA and changes in mental health of primary caregivers of abused children.
2. To identify symptoms of psychological impacts of CSA on primary caregivers of abused children.
3. To examine if there are associations between socio-demographic factors and nature of the psychological impact of CSA on primary caregivers.
4. To identify which socio-demographic factors determine whether the primary caregiver will be angry or not angry with the child survivor of CSA.

Table 1. Variable, Operational Definitions and Measures

Variable	Type of Variable	Operational Definition	Measure(s)
Incident of Child Sexual Abuse	Independent	The reported act of CSA involving caregiver's child	Semi-structured interview schedule
Socio-Demographic factors related to Child, perpetrator and primary caregiver	Independent	Generally, describes who and what these players are; includes their shared relationships.	Semi-structured interview schedule
Symptoms of the psychological impact of CSA	Dependent	Self-reported perceived level of stress related to CSA	Semi-structured interview schedule
Psychosocial Impact of CSA	Dependent	Changes in caregiver's perceived stress level upon a report of an incident of CSA	Perceived Stress Scale (PSS) and semi- structured Interview schedule
Caregiver's Stress level	Dependent	Caregiver's perceived stress level relative to a norm group	Perceived Stress scale

Being Angry or Not Angry with child	Dependent	Whether or not caregiver reported being 'angry with the child' or 'not angry with child'	Semi-structured interview schedule

1.5.2. Research Questions

i. Is there a relationship between an incident of CSA and changes in mental health of the primary caregiver of the abused child?

ii. What are the symptoms of the psychological impact of CSA on primary caregivers?

iii. Is there a relationship between socio-demographic factors and the psychological impact CSA has on primary caregivers?

iv. What socio-demographic factors are related to whether a primary caregiver will be angry or not angry with his/her sexually abused child?

1.5.3. Theoretical Framework

This study was based on Transactional model of stress and coping by Lazarus (in Glanz, K., Rimer, B.K. & Lewis, F.M., 2002). Transactional model stresses the interaction between a person and his environment as being the cause of stress. Simply, Transactional model attributes psychological stress to our evaluation of events in the environment as being beyond our control and ability to overcome. Thus, we become stressed when we perceive an event as exceeding our coping resources.

In this study, the primary caregiver was hypothesized to evaluate an incident of child sexual abuse as an abnormal event demanding extra-ordinary coping resources which s/he was unlikely to have learned. Hence, many primary caregivers were unlikely to possess coping strategies to manage pressure. Consequently, many primary caregivers were expected to experience psychological stress because of the incident of CSA.

1.5.4. Assumptions of the Study

The conception of this study was underpinned by a number of beliefs, vis-a-vis, that the child's socio-demographic characteristics play a role in influencing the impact of CSA on the primary caregivers. It was believed that a caregiver would be more distressed the younger his/her abused child. There was no presumption about the ef-

fect of child's gender on the Impact of CSA; nevertheless, it was believed that the abuse of a boy by a man as compared to his abuse by a woman would have different impacts on the primary caregiver because of how Zambian generally loathe homosexuality. On a similar score, it was expected that the caregiver whose child was in school as compared to one who was not in school would be impacted qualitatively differently. It was assumed that caregivers attach different values to their children depending on whether they are investing in their schooling or not; consequently, it was expected that there would be differences in response to the children based on this characteristic.

With regard to the existing nature of the relationship between the child and the perpetrator, it was assumed that the closer the familial relationship between them, the higher the sense of betrayal that the caregiver would feel upon disclosure of CSA. Accordingly, it was assumed that the level of distress suffered by the caregiver would be qualitatively different depending on this relationship. Similarly, it was assumed that the extent of CSA, from fondling to actual vaginal/anal penetration and so forth, would have some effect on the quality of impact of the abuse on the caregiver. Further, it was assumed that the number of episodes of abuse would influence the nature of the psychological impact of CSA on the caregivers; it was supposed that the higher the number of contacts, the worse would be the distress the caregiver would suffer. It was assumed that physical injuries of the abuse on the child would influence the stress level of the caregivers: the worse the physical injuries of the abuse, the worse would be the impact on the primary caregiver.

Chapter Two

2.0. LITERATURE REVIEW

2.1. Nature of Child Sexual Abuse

Child sexual abuse (CSA) is a pervasive travesty against the most vulnerable section of humanity, children. Many commentators attest to this degree of monstrosity of CSA. James and Gilliland (2001) characterized it as a uniquely serious crime that threatens people of all ages and stations of life. Durand and Barlow (2006) characterize sexual abuse of children (or very young adolescents) as the most tragic sexual deviance, second only to murder. Others characterize child sexual abuse as a pervasive social and public health problem (Al-Mahroos et al., 2011).

Survivors of child sexual abuse are of either sex and so are the perpetrators. According to Durand and Barlow (2006), individuals with this pattern of arousal may be attracted to male children, female children or both. In a survey, Fagan et al., (in Durand & Barlow, 2006) found that as many as 12% of men and 17% of women reported being touched inappropriately by adults when they were children. They also found that 90% of abusers are male and 10% are female (Fagan et al in Durand & Barlow, 2006). In a content analysis study carried out in Bahrain, it was revealed that 354 (86%) of the child sexual offenders (CSO) were found to be males and 57 (14%) were females (Al-Mahroos et al., 2011, p. 1), closely conforming to Fagan's et al., estimate.

Durand and Barlow (2006) distinguished two broad categories of CSO; they can either be paedophilic and non-paedophilic CSO. According to them, paedophilia is characterized by a sexual deviation involving strong sexual attraction toward children. Thus, child sexual offenders constitute a heterogeneous group with different backgrounds, characteristics and approaches to CSA victimization (Al-Mahroos et al., 2011). American Psychiatric Association (2000) defined paedophilia as "the recurrent and intense sexual thoughts, fantasies, or urges involving pre-pubertal children lasting over six months. These fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. American Psychiatric Association (2000) further categorized

such a person to be at least 16 years old and at least 5 years older than the abused child. The American Psychiatric Association working group for DSM-V development reported to have recommended renaming Paedophilia to Paedohebephilic disorder to include sexual interest in pre-pubertal and pubertal children (Al-Mahroos et al., 2011). Despite the focus on paedophiles, Al-Mahroos et al. point out that most CSO are non-paedophilic child molesters who tend to also have adult partners, and who have a late onset of offending with fewer victims. In Western countries, the prevalence rate of paedophilia is estimated at 3% to 9%. Paedophiles start offending at puberty; offend more often and with a greater number of victims than non-paedophilic perpetrators (Al-Mahroos et al., 2011).

Another very important variation in the dynamics of CSA is the factor of incest and attachment of abused child to the perpetrator. Many child sexual offenders are reported to be known to the abused child, "(81%) perpetrators were well known to the child" (Al-Mahroos et al., 2011, p. 1). Durand and Barlow (2006) differentiated incest from paedophilia, albeit ambivalently:

> *"If children are the person's relatives, (the paedophilia) takes the form of incest. Although, paedophilia and incest have much in common, victims of paedophilia tend to be young children and victims of incest tend to be girls who are beginning to mature physically…incestuous relations are, in general, more aroused to adult women than are males with paedophilia, who tend to exclusively focus on children. The incestuous relationship may have more to do with availability and interpersonal issues ongoing in the family than is the case with paedophilia" (*Durand & Barlow, 2006, *p. 375).*

Unlike in a paedophilic case, the incest offender loves the victim as a relative and is bitterly disappointed and depressed over his/her behavior (Durand & Barlow, 2006). Al-Mahroos et al., (2011) revealed that incest was a major factor to the child abuse dynamics. They found that in Bahrain, 10% of the cases were committed by fathers, 20% by other relatives, and 4% by siblings. This was exacerbated when neighbors, friends, and baby sitters and so on were brought into the picture. Al-Mahroos et al.

(2011, p. 2) reported that neighbors committed 19% of the CSA offences; house maids/baby sitters, 11.7%, friends, 7%, school mates, 4.8% and so on.

Most molesters of children are reported to be not physically abusive (Durand & Barlow, 2006). Rarely is the child physically forced or injured. From the molester's perspective, no harm is done because there is no physical force or threat (Durand & Barlow, 2006). Child molesters rationalize their behavior as "loving" the child or teaching the child useful lessons about sexuality (Durand & Barlow, 2006). Al-Mahroos et al. (2011, p.2) give the following descriptive of a typical child sex offender:

> *"Child sexual offenders groom and manipulate children by showing interest in them outside the sexual activity with extra attention, outing activities and showering the child with gifts. The abuser might attempt to fill the emotional void which may exist in the child's life. The abuser convinces the child that he is loved by the abuser and coerced to prevent disclosure. CSA typically occurs over a long period with the offender desensitizing the child by starting with touches which escalates over time to fondling and full intercourse".*

Mulenga (2010, p.1) revealed that the Zambian scene was not different. According to him, there was a growing body of evidence suggesting that "the majority of cases of sexual abuse (SA) of children take place within the home, and is perpetrated by those close to the child, in a position of trust and are in many cases the primary caregivers of the children". He further revealed that CSA took forms that were clouded by dynamics peculiar to Zambia: child marriages that were outlawed by the statutory law but legalized by customary law and yet both legal regimes were recognized by the Constitution, thus:

> *"Zambia has a dual legal system propagated by statutory and customary laws. The duo system poses serious challenges in offering effective protection to children from sexual abuse and commercial sexual exploitation. The Zambian Constitution recognizes the application of customary law. The existence of child marriages is promoted by cultural practices which are highly respected and rooted in the African customary law, let alone the Zambian Customs*

> *and traditions...The existence of the dual laws makes it difficult to protect children against commercial sexual exploitation and sexual abuse of children. Whereas statutory law prohibits child marriages, on the contrary customary law legalizes it (Mulenga, 2010: p. 2).*

Mulenga (p. 2) outlined the other forms of CSA of special concern in Zambia as including Child pornography cum Child prostitution. He discussed those forms under the umbrella term Commercial sexual exploitation, thus:

> *"It involves the sexual exploitation of a girl-child in return for money or other valuable considerations to the girl, her parents or other third parties. Commercial sexual exploitation includes child prostitution, sex tourism, trafficking in girls for the purposes of prostitution or forced marriages. It also includes child pornography".*

Notably, commercial sexual exploitation increasingly takes the form of child trafficking, moving in children from one place to another for purposes of profiting from it (Mulenga, 2010).

Thus, CSA comes in variant forms which make it problematic to agree on what it represents as well as what form its management should take, a dilemma well argued by Mulenga (2010) in his presentation of the existence of dual laws related to the subject above.

2.2. Risk Factors to CSA

Cosentino and Collins (1996) pointed to the fact of being female as the only sociodemographic risk factor. In other words, girl children face the risk of CSA for merely being female. According to these researchers, conservative figures indicate that 1 out of 3 and 1 out of 10 of girls and boys respectively are affected by CSA by age 18. This finding collaborates the results of many surveys that continue to show that girls are disproportionally affected by the problem of CSA. The high vulnerability of girls to CSA may then explain why in the Zambian law, CSA appears targeted for protection of girls at the exclusion of boys; for example, the term defilement under the Zambian penal code solely applies to girl survivors of CSA (Daka, 2003).

Nevertheless, Cosentino and Collins (1996) outlined situational factors that heighten the risk of CSA. The presence of a stepfather in the home as opposed to growing up with their natural fathers was said to increase sevenfold the risk of children being sexually abused. Secondly, children growing up without their mothers or without one or both their natural parents were said to be at greater risk of abuse whether to extra-or-intra-familial CSA. Thirdly, constant absence from home or inability of the primary caregiver due to illness or physical or mental disability to effectively monitor activities in the home put children at increased risk to CSA. This factor was said to be compounded by poor or punitive parenting by the primary caregiver. Fourthly, they associated parents living in a violent relationship with heightened risk to SA for their children.

When it came to the age of the child, Cosentino and Collins (1996) pointed out that CSA, among boys and girls, rises in pre-adolescence, with a dramatic rise at age 10. They also contended that early CSA cases may be underreported due to repression of early memories.

Tavkar (2010) found that, in addition to girl children being at higher risk to CSA than boys, they were more likely to disclose SA compared to boys. Cosentino and Collins (1996) also argued that while estimates show a proportion of up to 29% of survivors of CSA being boys, they tended to be underrepresented due to stigma associated with homosexuality.

With regard to extra-versus-intra-familial CSA, extra-familial SA was said to be more common than the latter for both boys and girls (Cosentino & Collins, 1996). However, girls stood more likely to be victimized by family members while boys tended to be victimized outside the family. As to the apparent socio-economic-class character of incidents of CSA across many societies, Cosentino and Collins (1996) asserted that the problem knew no boundaries of race, religion or socio-economic grouping. They observed that surveys showed that CSA was neither more common among the lower social class nor were they less common in higher socio-economic strata. However, reported cases show disproportionate number of children from lower socio-economic classes (Cosentino & Collins, 1996).

2.3. Effects of Child Sexual Abuse on the Child

Durand and Barlow (2006) observed that CSA perpetrators did not seem to be aware of the psychological damage that their victims suffered, yet these interactions often destroy the child's trust and ability to share intimacy even in the future. They further observe that child molesters rarely gauged their power over the children, who may participate in the molestation without protest and yet be frightened and unwilling. Such children often feel responsible for the abuse because no outward force or threat might have been used by the adult. Only after the abused children grow-up are they able to understand that they were powerless to protect themselves and not responsible for what was done to them (Durand and Barlow, 2006). To reinforce this self attribution, the child might have been convinced by the perpetrator and even by those who should have been providing protection that the child itself was the cause (James & Gilliland, 2001).

Al-Mahroos et al (2011) explained that professional and public concerns about CSA are justified by the serious short and long term consequences. James and Gilliland (2001) asserted that the devastating impacts of CSA on physical, mental and psychological well-being of children and future adults spurn the individual, the family and society. It was thus observed that this problem holds profound implications for mental health and well-being of a very large proportion of all people (Cosentino & Collins, 1996). Survivors of rape and sexual abuse are said to often experience prolonged trauma symptoms which are difficult for them to transcend and are challenging for the caregivers who seek to help them (James & Gilliland, 2001; Cosentino & Collins, 1996). More worrisome was said to be the phenomenon of survivors in future turning into offenders, thereby perpetuating the vicious cycle of CSA which then continues from generation to generation (Cosentino & Collins, 1996).

In the last decade, a proliferation of studies on the effects of child sexual abuse has been noted (Cosentino & Collins, 1996; James & Gilliland, 2001; Willingham, 2007). Cosentino and Collins contended that a very broad range of behavioral difficulties had been identified in sexually abused children. Notable ones being sexualized behavior patterns such as open and compulsive masturbation, sexualized play with dolls, seductive behavior, age-inappropriate sexual knowledge, and sexual aggres-

sion (that is, coercing others to repeat and re-enact the sexual victimization); this is often considered to be among the most salient effects of child sexual abuse in children. Other psychosexual problems have also been found among sexually abused school-aged children and adolescents, such as cross-gender behavior (including acting like and wishing to be the opposite sex), gender identity conflict, and sexual identity confusion (p.50).

In a South African study, Phasha (2007, pp. 57- 66) investigated school functioning of individuals with childhood sexual experiences. The study investigated 24 survivors (23 female and 1 male) of child sexual abuse. Their ages ranged from 15 to 23 years. They came from three racial backgrounds: 11 were white, 6 were mixed race and 5 were black. Data collection was done through semi-structured interview method. The findings revealed that survivors' school functioning had been negatively affected. Their emotional reactions to the abuse were found to have interfered with their ability to concentrate in class, as their minds were preoccupied with the thought about the experience.

Paradoxically, one finding was that concentration in school work was disturbed whether the sexual experience was accompanied by violence or love and tenderness. Nevertheless, the study revealed that the survivors narrated the experience differently and explained the disturbed class concentration differently depending on the nature of the experienced CSA. Those who had experienced violence attributed their disturbed concentration to troubling emotions such as anger, shame and anxiety. On the other hand, those whose sexual experience involved intimacy felt disturbed because they were preoccupied with sexual fantasies. In the long term, such fantasies were thought to reflect distorted views about sex and naive interpretation of sexual activities with the perpetrators (Finkelhor, 1979 in Phasha, 2007) posing possible long term negative outcomes in marital life. Phasha also notes that, for those who had experienced violence, the disturbed school concentration was exacerbated when they continued to live at the place where the abuse had taken place and/or continued to live with the perpetrator in the same house.

Phasha also found that the effects of CSA on school attendance were found to linearly vary with the nature and identity of the child sexual abuse and perpetrator(s) respectively. Skipping class was found to be a common negative effect of CSA on school attendance but mostly if their disclosure was not believed by their non-abusive parents. Staying away from school for many days in succession was found to be common only among survivors of once-off rape perpetrated by non-relatives. On the other hand, survivors of long term intra-familial sexual abuse attended school regularly, conforming to a widely known effect of CSA, thus:

> *"Sexually abused children come early to school and stay late and are rarely, if ever, absent"*, (James & Gilliland, p. 246).

Furthermore, Phasha also found that children whose disclosure was not believed by their own parents withdrew from social contact in apparent avoidance of people capable of causing them harm. Unfortunately, this avoidance of other people included their own peers, meaning that they were incapable of cultivating meaningful social relationships with their peers.

James and Gilliland asserted that different children manifest different problems as they work through the trauma of the abuse. Boys will typically perpetuate sexual assaults on other children, bully other kids, vandalize property and generally direct their anger outwards. Phasha's study collaborated this when he found that some victims of child sexual abuse tended to exhibit aggressive and rebellious behaviors towards peers and teachers. These behaviors could be physical such as fights with and bullying other students or use verbal abuse to their teachers such as disrespectful ways of speaking, being rude, shouting and swearing. In the long term, such children exhibit universal characteristics like lying, stealing and promiscuity in the aftermath of the abuse (James & Gilliland, 2001).

Girls typically turn their anger inwards and may consequently engage in alcohol and drug abuse, promiscuity and suffer eating disorders (James & Gilliland, p. 261). Phasha found evidence of this when he found that some of the affected students were in the habit of exhibiting sexual tendencies toward peers and teachers by admiring them and/or exhibiting sexually explicit behaviors. Such students were also found to

have suffered abuse before the age of 8 years, and which had gone on for 5 years or longer. James and Gilliland asserted that this tendency is rooted in what they term boundary issues, a child's drive for positive feedback and attention conditioned by feedback and attention they received from the long term association with their perpetrators. Thus, such children transfer and generalize this mode of attention seeking strategies over to a variety of other situations and interactions with other people. "Long term sexual assault turns understanding of normal boundaries with different people upside down; love, attention and sex are rolled into one as far as such abused kids are concerned"(p. 162). They may exhibit behaviors aimed at seducing people of similar standing with the perpetrator in their wish for attention and feedback. Parents are horrified by these previously unseen behaviors (James & Gilliland, p. 262); at times they find out that their young children are attempting to engage in sexual intimacy inappropriate with their age. In the event that the perpetrator is a member of the family and is removed, the child's need for love and affection and his/her confusion over boundaries make any new person a target for the child's comingled notions of love and sex; s/he mistakenly believes that s/he can obtain attention and love through sexual gratification. Phasha notes that, while such dispositions may be associated with traumatic sexualisation, it was also the case that neither survivor exhibiting such acts ever reported being supported by any of their female relatives, thereby underscoring the importance of caregiver support in children's journey to overcoming the effects of CSA.

On another extreme, Phasha showed for those survivors, those who had expressed hostility toward their own abusers, they seemed to have transferred it to their male teachers irrespective of the age at which the sexual abuse had occurred; they also avoided their male class mates and all activities requiring joint activities with them (James and Gilliland, 2001).

A growing body of literature shows that some of the characteristics of the abuse experience and the aftermath have been found to affect the degree to which symptoms appear in the survivors (Cosentino & Collins, 1996; Willingham, 2007). It is pointed out, for example, that abuse that was perpetrated by someone who was close to the child (such as fathers or stepfathers), over a long duration, with a high

frequency of sexual contact is associated with more severe symptoms (Cosentino & Collins, 1996). In addition, abuse that includes sexual acts such as oral, anal, or vaginal penetration and abuse that is violent or involves physical force were associated with increased trauma (Cosentino & Collins, 1996).

In turn, specific moderating variables or protective factors against appearance of severe symptoms have also been identified (Cosentino & Collins, 1996, p. 50). These include a supportive family reaction at the time of disclosure, the presence of a supportive non-abusive adult caretaker, and attributing responsibility for the abuse to the offender (James and Gilliland, 2001). These are commended as strong mitigating factors against later appearance of symptoms.

2.4. Caregiver Support and Disclosure Outcomes

Psychosocial services and other remedies to address concerns and effects of CSA largely depend on disclosure of the vice and how well it is managed (James and Gilliland, 2001). For one thing, there is evidence that lack of maternal support at the time of disclosure leads to increased symptoms in the child (Cosentino & Collins, 1996) such as disturbed school performance (Phasha, 2007). The response by caregivers and professionals seem to affect disclosure and could be responsible for recantation (Lovett, 2004). On the other hand, maternal responses that convey protection and support have been found to be associated with survivors' improved mental health and social functioning (Lovett, 2004). Thus, the support of non-offending caregiver seems essential to improve the child's chances of recovery and to forestall prolonged psychopathological effects (Bolen & Lamb, 2004).

Unfortunately, at worst, disclosure does not take place. Because of diverse motivational and cognitive explanations, children have been found to fail to disclose their experiences of sexual abuse (Sjoberg & Lindblad, 2002). In a study to examine the disclosure process in sexually abused children (aged 3–17 yrs), Sorensen and Snow (1991) showed that the disclosure process typically proceeded from denial to tentative and active disclosure and that children often recanted but later reaffirmed: with affirmation rates proceeding from as low as 11% at the time of the initial interview; with 79% of the children either initially denying the abuse or would still be toying around with the idea of disclosing (Sorensen & Snow, 1991). Sorensen and

Snow (1991) also showed that 74% of the children disclosed accidentally though sexualized behavior and inappropriate statements. The conclusion is that professionals will most likely never be able to identify all cases of sexual abuse on the basis of children's narratives. Daka (2005) acknowledges this by pointing out that Zambian disclosure figures are much lower than the actual prevalence of the problem in the country.

As a consequence, in many societies, authorities are not able to estimate the true scope of the problem of child sexual abuse (Cosentino & Collins, 1996). Cosentino and Collins showed that the majority of sexually abused children do not come to the attention of child protection agencies or professionals. The nature of sexual abuse, the secrecy and shame surrounding it, the criminal prohibitions against it, and the young age and dependent status of its victim, seems to inhibit voluntary disclosure (Cosentino & Collins, 1996, p. 47). On the other hand, Sorensen and Snow (1991) believed that peer and educational programmes often motivated disclosure.

2.5. Caregiver Response following CSA Disclosure

What many studies have demonstrated is that disclosure is an essential element in how society responds to the incidents of CSA. Closely linked to the disclosure process seems to be the support of the non-offending caregiver for the child (Bolen & Lamb, 2004; Lovett, 2004). According to Willingham (2007), all studies that have examined CSA, non-offending caregivers, and traumatic experiences in children have demonstrated the importance of child-caregiver relationship in facilitating recovery. Lovett (2004) elucidated that those maternal responses which convey protection and support were associated with survivors' improved mental health and social functioning. On the whole, Willingham (2007) found that mothers believed and protected their children after the incident of CSA.

However, Willingham (2007) also found that maternal supportive response toward the child depended on many factors, among them caregivers' capacity to cope with their own current distress and their level of emotional and financial dependency on their child's perpetrator. This might explain other studies' findings that suggest that

up to a third of non-offending caregivers respond in an ambivalent manner, more concerned with maintaining good relations with the perpetrator (Bolen & Lamb, 2004; Heriot, 1996). The likelihood that a non-offending caregiver would support the child during disclosure seems to be a function of the perceived cost, notably socio-economic cost such as stigma, loss of economic support from perpetrator and the like (Bolen & Lamb, 2004). The higher the perceived cost, the more normative will be the non-offending guardian's response to be ambivalent. Bolen and Lamb (2004) also found that ambivalent response to the disclosure might be a precursor to and an effect of the traumatic outcomes of the disclosure even on the non-offending guardian. Thus, failure to support the child during the disclosure process might be symptomatic of negative effect that CSA has on the guardian's mental well-being, just like it does on the child.

Lawson and Chaffin (1992) carried out a study of 28 children of ages 3 to menarche, who presented symptoms of sexually transmitted diseases but had not disclosed or been suspected of sexual abuse. Symptoms notwithstanding, they found that only 43% of them gave any verbal confirmation of sexual contact; the other 57% gave false negatives. Thus, with all the evidence, CSA disclosure was still difficult to extract.

On a broader scale, this study also found a strong link between the attitude taken by the child's caretaker toward the possibility of abuse and CSA disclosure. To that extent, the study found that children whose caretaker accepted the possibility of abuse disclosed at the rate almost 3.5 times as great as those whose caretakers denied any possibility of abuse (63% vs. 17%). Their conclusion was that caretaker attitude and support constitute a critical variable in the child's disclosure process and a valuable target for intervention and prevention efforts.

Heriot (1996) studied and identified certain factors as being closely associated with the attitude taken by the non-offending caregiver following the disclosure of child sexual abuse. Among the key ones was the extent of the relationship of the perpetrator to the non-offending caregiver. The issue of relatedness between the caregiver and the perpetrator appears particularly fundamental to the attitude that the

non-offending guardian takes. For example, mothers were found to very likely protect the child if their feelings toward the perpetrator were negative or the perpetrator was not their partner (Heriot, 1996). To that effect, Bolen and Lamb (2004: p. 185) hypothesize "that ambivalence in support reflects the confluence between the non-offending guardian's valence toward the child and perpetrator".

The next important factor seems to be the nature of the act involved in the abuse. Heriot (1996) found that the non-offending caregiver was likely to protect the child if the act involved did not go as far as intercourse. Furthermore, she also found the age of the child to have an inverse effect on the attitude taken by the non-offending guardian; mothers of teenaged survivors were less likely to protect them while those mothers of much younger children were more likely to protect their children. She also found that non-offending guardians who abused drugs or alcohol were at risk of non-protection.

2.6. Emotional Impact of Child Sexual Abuse on Primary Caregivers

Willingham (2007) observed that despite wide availability of a large body of literature that had identified and examined many aspects of CSA, less was known about the non-offending caregivers of the sexually abused children. Notwithstanding, she asserted that, on the whole, CSA is stressful for both the child and caregiver and it affects the child-caregiver relationship. When the child discloses sexual abuse, the parent's reaction seems to influence continued disclosure, openness to legal investigation, and willingness to engage in therapy (Cosentino & Collins, 1996). Thus, primary caregivers seem to have significant influence in the survivor's recovery and the family health (Hebert et al, 2007; Leifer et al, 2001; Willingham, 2007). Sadly, caregivers suffer a lot of their own losses when it gets known that an incident of CSA has occurred (Bolen & Lamb, 2004; Heriot, 1996; Newberger et al, 1993). In this vein, guardian's failure to support the child during the disclosure process seems to arise from impairment symptomatic of his/her mental ill-health (Leifer et al, 2001). For example, mother's clinical level of psychological distress seems to interfere with her ability to optimally respond to the sexually abused child's needs (Hebert et al, 2007).

Leifer, Kilbane and Grossman (2001), in a study of 99 non-offending African American mothers of sexually abused children aged 4 to 12 years, found that 38 were unsupportive of their children. In turn, such unsupportive mothers showed more substance abuse, criminal behavior and problematic relationships with partners. Whether symptoms of mental ill-health arose out of their response to the disclosure of the abuse of their children or vice versa, it seems to confirm that mothers who fail to support their abused children were victims of mental health problems themselves.

Newberger, Gremy, Waternaux and Newberger (1993) noted constant clinicians' reports of mothers of sexually abused children experiencing distress following their children's victimization. In a study to examine this, they found that indeed mothers of sexually abused children experienced serious psychological symptoms following disclosure of the abuse. The symptoms included depression, anxiety, hostility, somatic symptoms, paranoid ideation and psychoticism. In extreme cases, parents have been reported to attempt suicide or require hospitalization; in short they often display symptoms of PTSD and grief. These are symptomatic of mood and anxiety disorders that normally justify expenditure of public resources to implement therapeutic interventions for the sufferers (Durand & Barrow, 2006; Schwartz, 2000).

Tavkar (2010) noted that non-offending caretakers often experienced elevated levels of social distress for up to 2 years on average following the incident. Manion, McIntyre, Firestone, Ligenzinska, Ensom and Wells (1996) adduced evidence suggesting that mothers of sexually abused children, in comparison to mothers of non-abused children, experienced greater overall emotional distress, poorer family functioning and lower satisfaction in their parenting role. Fathers of sexually abused children also were found to experience greater overall emotional distress relative to comparison fathers but their level of distress remained below that of mothers.

Leonard, Hellerstedl, and Josten (1997) assessed psychological impact of disclosure of sexual abuse on both the child survivors and their mothers, and evaluated whether there was an association between maternal level of distress and a report

of child behavioral and psychological problems. In that study, mothers reported high levels of persistent distress for both themselves and their children. Additionally, Leonard et al (1997) found that maternal distress was strongly associated with mother's assessments of child functioning and was less strongly associated with the children's own assessment of their status.

Some studies have taken the premise that primary caregivers of sexually abused children face a higher risk than those of the comparison group to score in the clinically distressed range (Newberger et al. 1993; Manion et al. 1996 & 1998). Thus, there appears a whole body of literature underpinning the assumption that caregivers of sexually abused children suffer higher levels of psychological distress than mothers of comparison group.

In these studies, primary caregivers were often perceived as playing a central role in facilitating the recovery of sexually abused child. Although this might be the case, there seems little focus on their own needs and profiles (Hebert, Daigeault, Collin-Vezino and Mireille, 2007). The child welfare system frequently overlooks and marginalizes primary caregivers in the formulation of security and treatment plans for targeted at the child (Newberger et al 1993; Lovett, 2004). To Manion et al (1996), such findings underscored the need to expand the focus of child sexual abuse beyond the child survivors to the traumatized families and to treat all close family members to be vulnerable to experience adjustment difficulties following an incident of child sexual abuse. The overall significance of these findings seem to suggest that comprehensive intervention with the family might be an efficient route to child recovery after disclosure of sexual abuse (Leonard et al, 1997).

2.7. Caregiver's Needs for Support

In additional to psychological difficulties, non-offending parents may also experience considerable social, emotional and economic consequences. Tavkar (2010) examined support needs of caregivers of sexually abused children. He found that non-offending caregivers of sexually abused children suffered heavy burden of psychosocial effects: stigma, increased feeling of isolation, loss of a partner and disruption of family (in case of intra-familial CSA), loss of income and dependence on govern-

ment assistance and so forth. He noted that frequent changes of residence and social isolation were more common among families where sexual abuse had occurred (Tavkar, 2010).

Regehr (1990 in Tavkar, 2010) has categorized the psychosocial difficulties across four domains, namely:

- Toward Self
- Toward Child,
- Toward the system
- Toward the offender

Toward Self: The primary caregiver seemed weighed down by guilt for not being able to protect the child from sexual assault; s/he might be embarrassed due to the fact that her/his child had been assaulted. Such parents reported growing over-protectiveness over their children by severely restricting their activities, especially of older children.

Toward Child: Caregivers reported feelings of anger toward the child for not having prevented the abuse or disclosing the abuse earlier or at all; such seemed particularly so for older children. The children might also be blamed for disrupting the parent's lives.

Toward the System: Eventually, primary caregivers reported being unsure of whether their decision to report the incident had been a wise one. They became conscious of the overbearing attitude of investigators pushing them to be more socially responsible in prosecuting the abuser and further discovered that the system and the investigation might have been traumatizing the child.

Toward the Offender: Typically, primary caregivers reported feeling intense desire for retribution or revenge toward the perpetrator. They reported wanting to harm him. On the other hand, they report that at times they had felt harbor some guilt for potentially marring the offender's name and family. Such a caregiver attitude might explain retractions by caregivers.

2.8. Practical Implications of Research in CSA and Primary Caregivers

These various findings on CSA, albeit predominantly addressing them in relation to the child (Willingham, 2007), have lately focused on the need and importance of addressing caregiver (principally maternal) distress and its apparent association with the child's treatment and recovery from the effects of CSA (Newberger et al, 1993). However, showed that studies on the subject conducted in conditions nearly representative to those of Zambian so far seem to be South Africa (Phasha, 2007; Mayekiso & Mbokazi, 2007), the glaring differences in socio-demographic conditions between the two societies notwithstanding. Thus, in addition to the need for justifying and informing psychosocial treatment for primary caregivers, this study and others alike may serve the need for cultural validation of findings on the subject.

Chapter Three

3.0. Methodology

3.1. Research Design

The study applied the mixed method research design as both quantitative and qualitative research methods were utilized to collect and analyze data (Creswell, 2012). Because of the characteristics of the sample, especially its small size, more female than male participants etc, the choice of mixed methods design enabled both quantitative and qualitative data to provide a better understanding of the research problem than either by itself (Creswell, 2012).

3.2. Sampling Frame

The sampling frame of the study encompassed primary caregivers of sexually abused children who reported CSA incidents to the recruitment sites at the time of data collection.

3.2.1. Sampling techniques and Selection Criteria

Convenience and purposive sampling were used to select primary caregivers, entailing that whichever caregivers reported their cases to the sites were selected (Leary, 2008; Spatz & kardas, 2008; Leedy & Ormrod, 2005) provided they met the inclusion criteria below:

i. Caregivers whose children would have been sexually abused and their cases reported to at least one of recruitment sites below.

ii. That the incident of CSA would not have happened in no longer than previous one month. In the opinion of this researcher, within this time frame, the caregivers would still be dealing with psychological effects; otherwise any longer time would permit majority of the respondents to have dealt with the initial shock and trauma and levels of perceived psychological changes would have been ameliorated by personal coping resources (Mayekiso & Mbokazi, 2007; Cohen, S., Kamarck, T. & Mermelstein, R. 1983), and the evidence would have been lost.

iii. The said abused children would be aged no-more than 15 years as per the Zambian law on CSA.

3.2.2. Sample

Descriptions of socio-demographic characteristics of the sampled caregivers are presented in Figure 1 and Table 3 below. The study had a sample size of 34 primary caregivers of sexually abused children recruited from YWCA (n = 6, 17.65%) and UTH Paediatric Centre of Excellence (n = 28, 85.35%). It comprised mothers (n= 22, 64.70%), fathers (n= 3, 8.82%), grandmothers (n= 3, 8.82%), stepmothers (n= 2, 5.88%), aunts (n= 2, 5.88%), a cousin (n= 1, 2.94%) and a brother-in-law (n=1, 2.94%). On the whole, there were more female primary caregivers (n= 29, 85.29%) than male ones (n= 5, 14.71%). The caregivers' mean age was 37 years (SD: 8.8, Range: 25 - 55 years). Participants were a combination of married (n=26, 76.47%), widowed (n= 4, 11.76%), divorced (n= 2, 5.88%) and single (n= 2, 5.88%) primary caregivers. The single comprised those who had never been married before.

Figure 1 (a): Caregiver's Relationship with Child

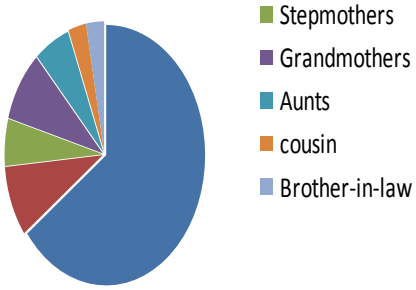


Figure 1 (b): Caregiver's Employment Status

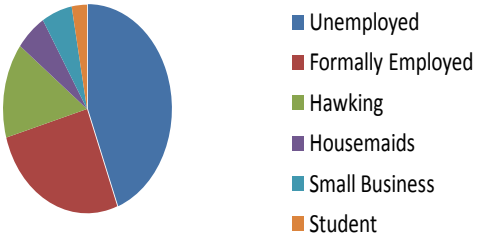
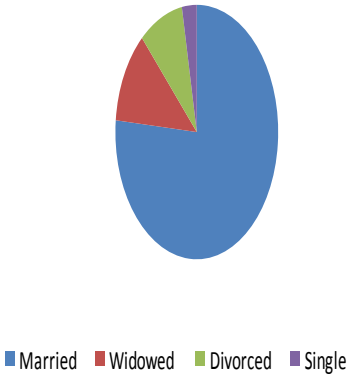


Figure 1 (c): Marital Status



Similar to the differences in age, there existed variations among the primary caregivers' employment status. Their employment status consisted of the majority being the unemployed (n= 13, 38.24%), followed by formally employed (n= 9, 26.47%), hawkers (n= 5, 14.71%), housemaids (n= 3, 8.82%), small business persons (n= 3, 8.82%) and a student (n= 1, 2.94%). Thus, in this study, in terms of employment status of primary caregivers, the unemployed formed the majority, followed by formally employed and then those engaged in hawking trade.

Table 2: Caregivers' Socio-Demographic Characteristics

Age	Mean= 37 years, SD= 8.8 years, Range= 25 - 55 years.
Gender	Female, n= 29 (85.29%) Male, n= 5 (14.70%)
Marital Status	Married n= 26(76.47%), Widowed n= 4(11.76%), Divorced n= 2 (5.88%) Single n= 2(5.88%).
Employment Status	Unemployed n= 13 (38.24%), Formally Employed n= 9 (26.47%) Hawking n= 5 (14.71%) Housemaids n= 3 (8.82%) Small Business n= 3 (8.82%), Student n= 1 (2.94%)
Child-Caregiver Relationship	Mothers n= 22 (64.71%), Fathers n= 3 (8.82%). Grandmothers n=3, (8.82%) Stepmothers n= 2(5.88%) Aunts n= 2 (5.88%) Cousins n=1 (2.94%) Brothers-in-law n= 1 (2.94%)

3.2.3. Selected Recruitment Sites

As explained above, the initial contact with participants was achieved through Young Women's Christian Association (YWCA), University Teaching Hospital (UTH) Paediatric Centre of Excellence and Victim Support Unit (VSU) of Zambia Police Service, all in Lusaka.

Purposive sampling was applied in selecting these institutions as they are some of the main agencies which provide various interventions for survivors of child sexual abuse (CSA) in Zambia. The VSU is the police wing that has the mandate to receive and process CSA complaints for criminal prosecution. The UTH Paediatric Centre of Excellence is the main medical centre to which VSU, among others, refer complainants for medical diagnoses and treatment after a child has been sexually abused. VSU has staff presence among members of staff at Paediatric Centre of Excellence at UTH. The YWCA provides psychosocial and accompanying support to the abused children.

Thus, use of purposive sampling to select these organizations was justified because, in the researcher's judgment (Leary, 2008); they provided high probability that primary caregivers of CSA survivors will be accessed through them.

3.3. Procedures

A letter from Psychology Department at UNZA to each of the heads of the selected institutions, namely YWCA, UTH and VSU was sent. In the letter, they were requested to authorize the use of their sites for participant recruitment. It also explained the objectives and rationale of the study. Since the study had to undergo an ethics scrutiny and clearance procedure by the University of Zambia's Humanities and Social Sciences' Research Ethics Committee, enclosed in the letter were documents demonstrating that authority to conduct the same had been obtained from the Committee.

Among the said documents was the Participant Information Sheet (see Appendix) that summarized the research proposal which led to the study. At UTH Paediatric Centre of Excellence, they demanded a copy of the full research proposal, which was made available to them.

Guided by the participant information sheet, the study was explained to respondents in English or Nyanja, a Zambian language which the majority of the participants understood. Those who chose to participate in the study signed an informed consent form to signify their free will.

The semi-structured interview was administered by this researcher and a female officer at YWCA. Which option was utilized depended on this researcher's judgment of how best to enhance rapport and openness on the part of, at times, agitated respondents. The interview captured socio-demographic and emotional and incident related information pertaining to the primary caregiver and the child. With the full consent of individual respondents, their responses were audio-tapped and later transcribed. Thereafter, the transcriptions were coded and analyzed in line with objectives of this study.

Having administered the interview, the respondents were then requested to answer a questionnaire, namely, the Perceived Stress Scale. The respondents were expected to answer the questionnaire as they understood it. It was not explained to them to avoid acquiescence (Leary, 2008).

3.4. Instruments

As revealed above, two instruments were administered in the study:

- Semi-structured interview
- Perceived Stress Scale

3.4.1. Semi-Structured Interview Schedule

The semi-structured interview format was applied because it allowed the interviewer flexibility in the manner the interviews were conducted (Mayekiso & Mbokazi, 2007). It provided the researcher the opportunity to probe for more information and clarifications where necessary.

The interview schedule consisted of both open- and closed-ended questions. Closed-ended questions pertained to socio-demographic data about the caregiver, the child and perpetrator such as biological and relatedness information pertaining to the caregiver, the child and the perpetrator. The interview schedule also covered the caregivers' emotional responses to the disclosure that an incident of child sexual abuse had occurred. See Table 2 below:

The schedule was developed by the researcher. The process of developing questions was guided by the objectives and research questions as presented in Chapter One. They were tailored to provide answers to the research questions. Thereafter, the schedule was tested on market women at Green market, mothers who had brought their children to Mulungushi University Health Centre and teachers from Muteteshi Basic School, all in Kabwe. Ten (n = 10) participants of both genders and in age range of 28 - 56 took part in the exercise. The purpose was test for ambiguity in the questions.

The participants' interpretation of the items of the interview schedule hardly varied. The questions were, thus, judged to be sufficiently unambiguous to all the groups.

Strangely, market women and those at the health centre showed some unease with delving into details of sexual acts and naming private parts. As it was administered orally to them, change to indirect reference to both sexual acts and private parts yielded comparable results. Thus, the pilot interviews underscored the need for caution in how the questions needed to be phrased and handled.

3.4.2. Perceived Stress Scale

The psychological impact of CSA on the individual primary caregivers was measured by the use of Perceived Stress Scale (PSS). Perceived Stressed scale, developed by Cohen S., Kamarck, T., and Mermelstein, R (1983), measures the degree to which situations in one's life are appraised as stressful. It is a self-administered questionnaire (See copy at Appendix 1).

The authors have explained that the items are designed to tap how unpredictable, uncontrollable and overloaded respondents find their lives to be. Among situations listed as responsible for eliciting distress tapped by Perceived Stress Scale is greater vulnerability to stressful life-event-elicited depressive symptoms. In this study, an incident of child sexual abuse was assumed to be one such life event that elicits depressive symptoms.

Although the scale was designed for participants of at least junior high school level of education, the items were found to be easy to understand and the response alternatives simple to grasp. The questions are of a general nature and relatively free of content specific to any subpopulation group such as the participants in this study. Thus, the questionnaire is generally suitable for measuring stress levels whatever relations one is exploring. In addition, the scale meets the one-month participants' inclusion criterion as it asks about feelings and thoughts during the previous one month.

High external validity has been reported by Cohen et al (1988) when measuring stress levels in situations associated with, among others:

- People's failure to quit smoking,
- Failure among diabetics to control blood sugar levels, and

- People facing stressful life-events.

Further, the authors have demonstrated correlations between Perceived Stress Scale and other stress measures including:

- Self-Reported Health and Health Services Measures,
- Health Behavior Measures,
- Smoking Status measures, and
- Help Seeking Behavior measures.

Moreover, the validity of the scale in Zambian can be attested to by its use by previous researchers, notably Menon, Munalula and Glazebrook (2007) who applied it to measure stress in doctors at the University Teaching Hospital in Lusaka, Zambia. The successful application of the scale in Zambia, thus, attests to its acceptable levels of reliability and validity to measuring stress, the use of American reference data notwithstanding.

3.5. Ethical Considerations

3.5.1. Recruitment

Primary caregivers whose child would have been sexually abused in no longer than the previous one month and their case reported to Victim Support Unit, YWCA or UTH, Lusaka and surrounding areas were asked to take part in this study. To participate in the study, their informed consent was sought from them.

3.5.2. *Voluntary Participation and Withdrawal*:

Participants were assured that their participation in this study was entirely voluntary, i.e., they did not have to participate if they did not wish to. They were also assured that to decline to take part would not attract any penalty nor would they suffer any loss of services to which they were otherwise entitled.

When they willingly decided to take part, they were guaranteed freedom to withdraw at any time without penalty or loss of services and without giving any reason for their withdrawal. Nevertheless, even when they chose to participate in this exercise, it was explained that they could still decline to answer particular questions

that would be asked. It was further explained that if they felt that they preferred not to discuss anything, they were free to say so.

3.5.3. *Protection during Data Collection*

The study required caregivers to answer a few verbal and written questions. Verbal questions were related to their age, gender, marital status, employment status; their child's age, his/her gender, how the discovery of the incident of CSA was made, whether the offender was previously known to them and the child; and what emotional/bodily effects showed up in the child arising from the abuse. The written format inquired into their **feelings and thoughts** in the past **one month.** They were **not** required to put down their names. However, a voice record of the interviews was made with their permission, but their identities remained confidential.

3.5.4. Possible risks and benefits

The participants were informed that some of the questions might rouse bad memories. However, they were assured that this possibility was not intended and that efforts had been made to minimize that possibility. It was explained that information obtained through the exercise might be helpful in better understanding what other caregivers who face incidents of CSA experience so that they might be assisted to deal with possible negative psychological outcomes.

It was further explained that the study might aid concerned individual and agencies get better informed of what particular assistance is needed for such caregivers. Nevertheless, they were reminded that their privacy was of utmost importance; should they feel uncomfortable, they were assured of the freedom to suspend their participation in the study to a further date of their choosing or withdraw for good.

Chapter Four

3.0. Results

4.1. Socio- Demographic Characteristics of abused Children

The Socio-demographic characteristics of child survivors whose primary caregivers participated in this study are presented in Table 4 below. The characteristics relate to age, gender, schooling status, child-perpetrator relatedness, nature of the abuse, number of episodes of CSA before disclosure or discovery was made and nature and gravity of physical injuries sustained.

Table 3: Children's Socio-Demographic Characteristics and Nature of CSA

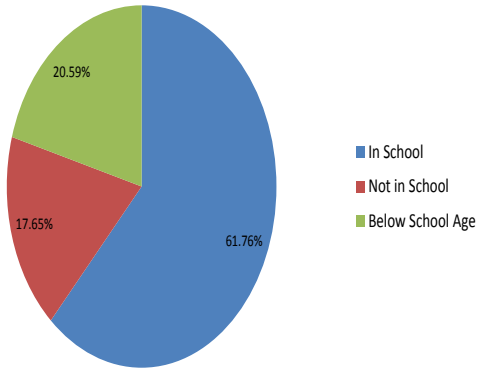
<table>
<tr><td rowspan="2">Age</td><td colspan="2">Mean: 10.56 years
SD: 4.8 years
Range: 2 – 15 years</td></tr>
<tr><td>Analysis 1
0 – 5 years (n=6, 17.65%)
6 – 9 years (n= 5, 14.06%)
10 – 12 years (n= 5, 14.06%)
13 – 14 years (n=12, 35.29%)
15 – 16 years (n=6, 17.65%)
Total (n = 34)</td><td>Analysis 2
0 – 5 years (n = 6, 17.65%)
6 – 10 years (n = 5, 14.06%)
11 – 15 years (n = 22.71%)
Total (n = 34)</td></tr>
<tr><td>Gender</td><td colspan="2">Male (n= 1, 2.94%)
Female (n= 33, 97.06%)</td></tr>
<tr><td>Schooling Status</td><td colspan="2">Going to School (n= 21, 61.76%)
Not Going to Schooling (n= 6, 17.65%)
Below school going age (n= 7, 20.59%)</td></tr>
<tr><td>Child-Perpetrator Related-ness</td><td colspan="2">Extra-familial n=26, 76.53%
• Neighbors n= 17, 50.00%
• Unknown persons n= 9, 26.47%
Intra-Familial n = 8, 23.53%
• Cousins n= 4, 11.76%
• Uncles n= 3, 8.82%
• Stepfathers n= 1, 2.94%</td></tr>
<tr><td>Nature of CSA</td><td colspan="2">Sexual (penile-vaginal) intercourse alone n= 18, 52.94%
Sexual Intercourse with Abduction/Elopement n= 9, 26.47%
Sexual Intercourse with force/coercion n= 7, 20.58%</td></tr>
<tr><td>Whether force accompanied assault</td><td colspan="2">With force: n= 7, 20.58%
Without force: n= 27, 79.41%</td></tr>
<tr><td>No. of CSA Episodes</td><td colspan="2">Once n= 16, 47.06%
Twice and over a few days n= 5, 14.71%
Several times and over weeks or months n= 13, 38.24%</td></tr>
<tr><td>Nature of Physical Symp-toms</td><td colspan="2">NO injuries sustained n= 18, 52.94%
Bruises sustained n= 6, 17.65%
Serious injuries with possible infections of STD/HIV n= 8, 23.53%
Made pregnant n = 2, 5.88%</td></tr>
</table>

Children's Age: Table 4 shows that abused children's mean age was 10. 56 years (SD: 4.48; range: 2 – 15 years). The whole breakdown was as follows: 0 to 5 years n= 6 (17.65%), 6 to 9 years n= 5 (14.71%), 10 to 12 years n= 5 (14.71%), 13 to 14 years n= 12 (35.29%) and 15 to 16 years n= 6 (17.65%).Therefore, the majority of children reported in this study were aged 13 and 14 years, with the other three clusters appearing relatively equal.

Children's Gender: As regards children's gender, all but one of the cases involved girl survivors (n= 33, 97.06%); thus, leaving only 1 case which involved a boy. Thus, due to this near absence of boy survivors, the possible relationship between this variable and psychological impact of CSA on primary caregivers was not examined.

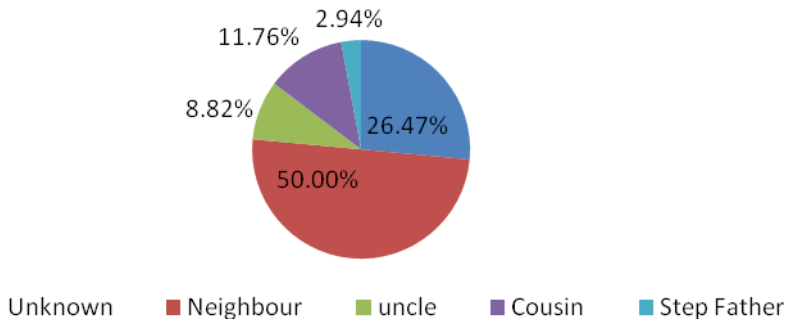
Children's Schooling Status: On schooling, 21(61.76%) of the survivors were in school. This left 6 (17.65%) grown-up children who were not registered in school at the time of the study. Of these not attending schools, only one (2.94%) reportedly dropped out of school due to CSA. Others, n= 7 (20. 59%) were below the age of going to school.

Figure 2: Children's Schooling Status



Child-Perpetrator Relatedness: Perpetrators in this study were identified as neighbors (n= 17, 50.00%), unknown persons (n= 9, 26.47%), Cousins (n= 4, 11.76%), uncles (n= 3, 8.82%) and a Stepfather (n= 1, 2.94%). Neighbors and unknown persons (constituting 76.47%), on the one hand, and cousins, uncles and the stepfather (23.53%), on the other, may be categorized as extra-and intra-familial CSOs respectively.

Figure 3: Child- Perpetrator Relatedness



Thus, when taken together, the neighbors (50.00%) and the intra-familial players (23.53%) constitute those whom the child knew before the incident of CSA; thus, most of the children knew and possibly trusted their perpetrators (n= 25, 73.53%).

One other important aspect that the study found was that the younger the child was, the higher the probability that the perpetrator was well known to him/her (See Table 5 below).

Table 4: Child- Perpetrator Linkages by Age

		Children's ages		
		0 - 5 years	6 - 10 years	11 - 15 years
Child, Perpetrator Related-ness	Step Parent	0	0	1
	Step Sibling/Cousin	1	3	0
	Uncle	0	1	2
	Neighbor	4	1	12
	Unknown Person	2	0	7

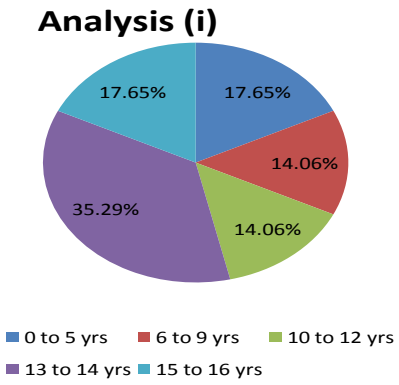
No unknown offender assaulted any of the children who were below age 10. All cases involving unknown perpetrators (n= 7) were associated with victimization of girls of ages 13 to 15 years (n= 7, 77.78%). Thus, by taking into account the foot-note[2] below, it can be safely reported that none of the children below age 10 years was found to have been victimized by unknown perpetrators.

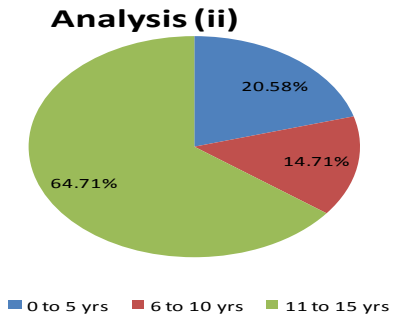
[2] It was later explained to me that one of the 2 unknown perpetrators was actually a neighbor but the caregiver didn't know him. The other case referring to the unknown perpetrator didn't exist as

Nature of CSA:

Age and nature of CSA: In terms of age, this study found that 11 to 15 year old children formed the majority of the abused children (See Figure 5 below).

Figure 4: Frequency of Abused Children by Age

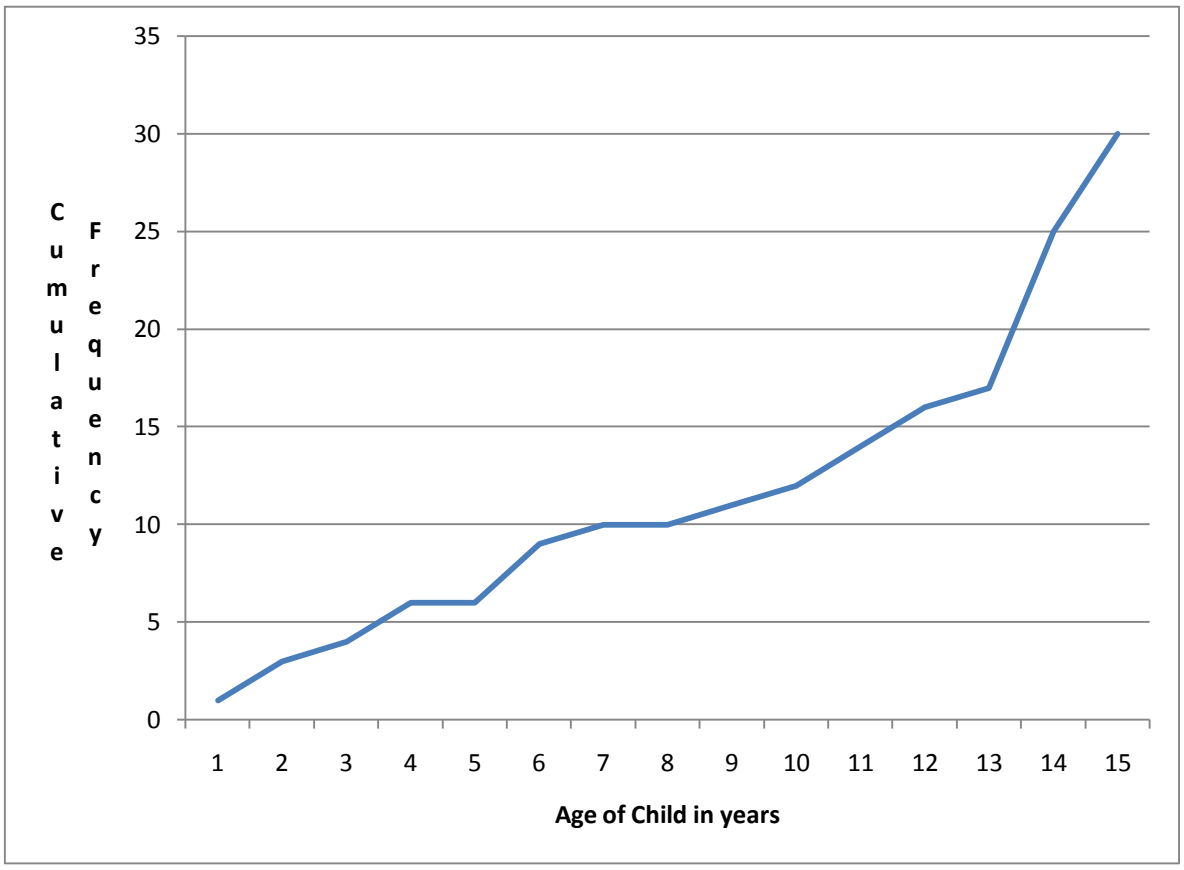




no CSA actually happened; the caregiver merely panicked from the symptoms that turned out to have been caused by natural causes.

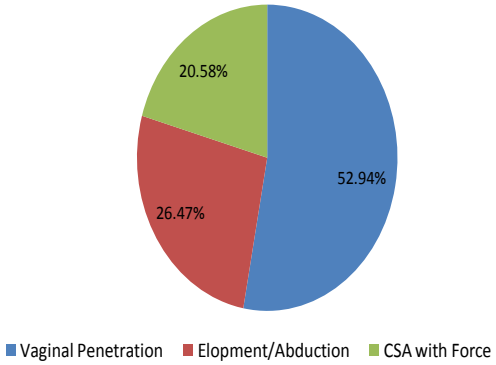
Additionally, when a cummulative frequency chart was developed (see Figure 6 below), it demonstrated a reasonably steady rate of increase in incidences of CSA across the ages until age 12/13 years at what point an exponential increase in incidences was noticed. This may suggest that children's risk to CSA increases during this age group.

Figure 5: Incidences of CSA



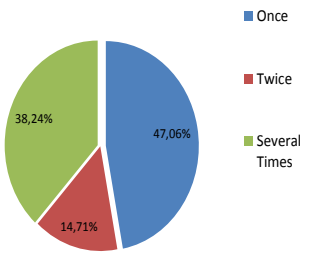
Type of sexual abuse: All the cases in this study (n= 34, 100%) involved an act of sexual intercourse (or vaginal/penile penetration). When the data were rearranged to distinguish mere sexual intercourse from those cases which involved elopement/abduction or use of force, more than half of the number of survivors (n=18, 52.94%) suffered vaginal penetration alone, followed by those who eloped with the perpetrator (n= 9, 26.47%) and the rest, n= 7 (20.58%) had faced either threat of or actual physical force preceding or in the process of CSA.

Figure 6: Type of CSA



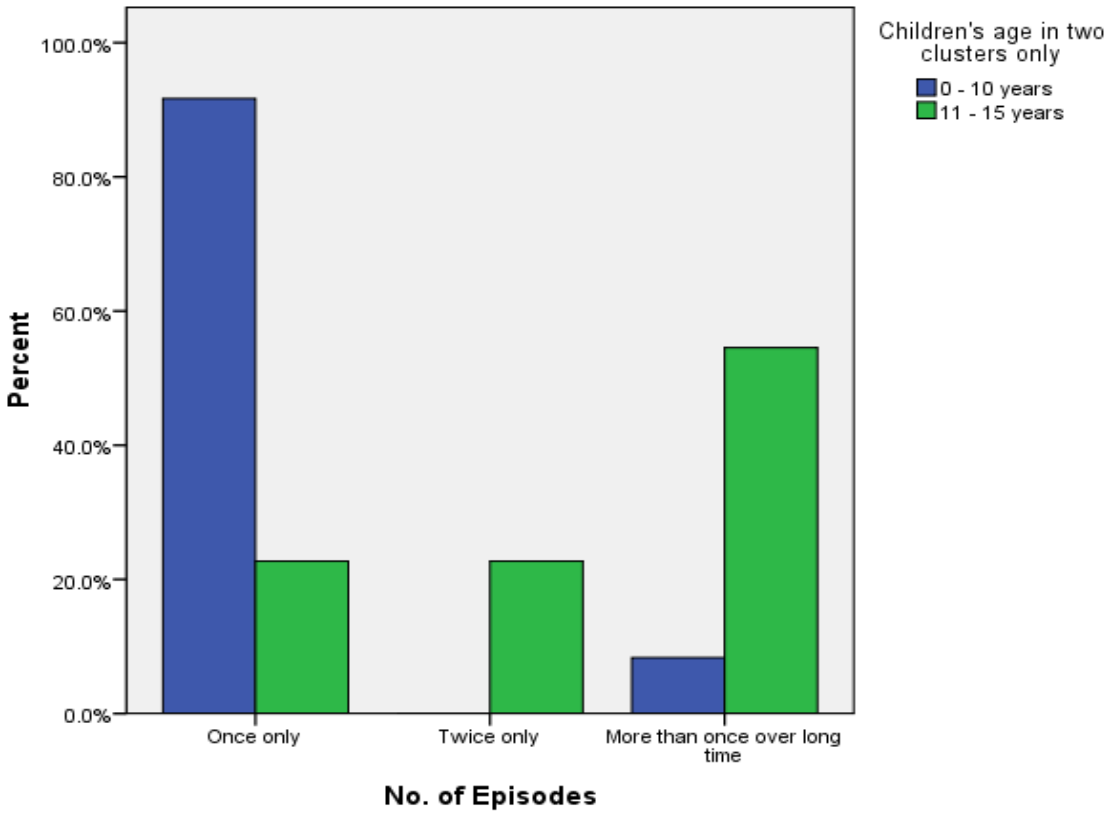
Number of Episodes of Abuse: The number of episodes of CSA that an individual child had experienced from the same perpetrator was investigated. The data showed that those who reportedly suffered CSA once were 16 (47.06%) while those who had suffered twice over a few days numbered 5 (14.71%). There was a group of children, n= 13 (38.24%) which reportedly had undergone abuse several times over an extended length of time.

Figure 7: No. of Episodes of Abuse



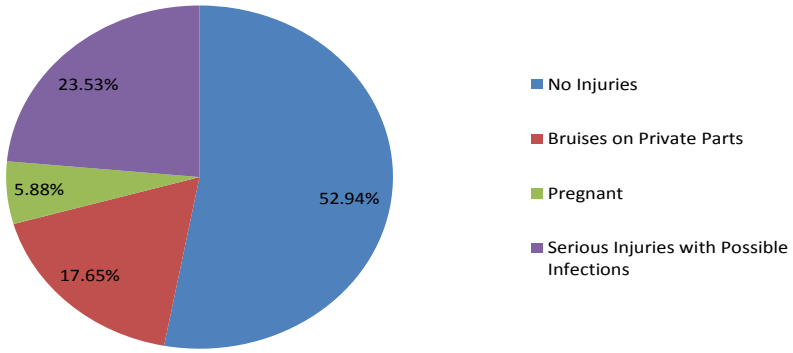
Further, with reference to figure 9 below, data examination suggested that the number of episodes of abuse over a length of time appeared to vary with the ages of the survivors. Majority of those 10 years old or younger experienced CSA only once; those aged above 10 years old had experienced multiple episodes over extended period of time.

Figure 8: No. of Episodes of CSA by children's Ages



Injuries Sustained from Incidents of CSA: In this study, Survivors of CSA were also classified as either having or not having suffered injuries resulting from the abuse. This variable was categorized as either 1) no injuries suffered, 2) bruises suffered, 3) serious injuries suffered with possible infections of STD/HIV or 4) Impregnated from abuse. The results were as presented in Figure 10 below.

Figure 9: Nature of Injuries sustained from Abuse



Eighteen (52.94%) did not report any injuries at all; 6 (17.65%) reported bruises on their private parts and 8 (23.53%) had reported serious physical injuries with possible infections of STD/HIV. Additionally, two (n= 2, 5.88%) had been made pregnant in the process of the abuse.

Physical injuries also tended to vary with age. The younger the child, the more likely it was found that they had suffered physical injuries resulting from CSA. It will be noticed from Table 6 and Figure 11 below that the majority of injuries (from bruises to serious physical ones) were suffered by children aged 10 years or below. Of the 12 (100%) 0 to 10 year olds, the majority (n= 9, 75.00%) complained of either serious injuries (n= 3, 25%) or bruises on private parts (n=6, 50%). On the other hand, for those aged 11 to 15 years (n= 22, 100%), the majority (n= 15, 68.18%) reported having experienced no injuries at all, with only 5 (22.73%) having suffered serious injuries.

Table 5: Distribution of Survivor's Injuries by Age

Physical Injuries	Children's Ages		
	0 to 5 Years	**6 to 10 Years**	**11 to 15 years**
No Injuries	1 (14.29%)	2 (40%)	15 (68.18%)
Bruises	4 (57.14%)	2 (40%)	0 (0%)
Serious Injuries with potential for STD/HIV	2 (28.57%)	1 (20%)	5 (22.73%)
Impregnated	0 (0%)	0 (0%)	2 (9.09%)

A further examination showed that the nature of these injuries also had a pattern that suggested age relations. A cross-tabulation of variables: *child's age, use of force* and extent of *injuries* shown in Table 7 below indicated that for those survivors aged 0 to 10 years, their injuries were apparently as a result of penile/vaginal penetration as they had ***not*** also experienced physical force. On the other hand, the number of those who reported injuries among the 11 to 15 year olds (n = 5) approximated those who had also experienced physical force (n = 4) from the perpetrator, thereby suggesting a relationship between force and the injuries. Thus it appears that the injuries for this group were a direct result of coercion from the perpetrator rather than being related to sexual intercourse itself.

Table 6: Relating Physical Injuries and Use of Force by Children's Age

Physical Injuries	Force Used			
	No		**Yes**	
	0 – 10 years	11 – 15 years	0 – 10 years	11 – 15 years
No Injuries	3	13	0	2
Minor Bruises	5	0	1	0
Serious Injuries STD/HIV	3	1	0	4
Impregnated	0	2	0	0

4.1. *The PSS Scores and Stress Levels of Primary Caregivers of Sexually Abused Children*

The PSS was used to measure participants' self-perceived stress levels in this study. The participants brought cases of CSA involving children under their care. PSS was self-administered and the scores reflect how the participants felt on 10 questions that it comprises. Judging the stress level of an individual participant involved calcu-

lating the individual total score. To decide whether the individual caregiver's stress level had significantly departed from the norm, the participants' individual total scores were compared with the norm data provided by the authors (See norm Table in Appendix One). All the total individual scores in this study could be summarized as: mean (M) = 30. 65; SD = 5.515, and range= 20 - 40. The most valuable score in making this decision was the range as it shows that all scores fell within the 20 – 40 *bracket;* thus, it facilitated analyses and interpretation of the data (See Methodology, paragraph 3.4.2. for a fuller description of the Scale).

In this study, all individual totals were above any of the reference means given by the authors. This was interpreted to mean that the participants in the study felt significantly more distressed than the norm group regardless of gender or age. Further, the above mean (M) score of 30.65 (SD = 5.52) is higher than 26.1 (SD = 6.01) which, in a study conducted in Zambia by Menon et al (2007), was found to be indicative of a higher stress level than existed in general Zambian population. As they were all facing incidents of CSA, the heightened distress levels were interpreted to have been linked to those incidents of CSA which they faced.

Common Symptoms of Psychological Impact of CSA on Primary Caregivers

From the narratives of the participants, it was evident that they experienced some deep emotions arising from the incident of CSA of their children. They expressed anger, deep sadness, anxiety, helplessness, frustrations, functional impairment and sometimes shame. In some cases, many of these emotions were expressed in the same breath by the same participant. One participant, for example, reported feeling worse than if she had been nursing a terminally ill child or relative. She felt angry and helpless.

> *"At least one would know what to expect from an illness. In this case, we don't know what to do and where we're going," she cried.*

Depression and sleep disturbance: Others reported depression and sleep disturbance following the disclosure of CSA. Among such were five participants.

"Being a widow, can you imagine what I'm going through? This girl should have been kind to me. I go through a lot to take care of these children. And here she's, misbehaving as if she's rich! Do I sleep! No!" cried one female participant.

"I feel cursed. Divorced and now my first born daughter is defiled! What should I live for?" cried another participant.

Functional Impairment: In addition, some caregivers reported suffering intense depression to the extent of being psychologically and functionally impaired to perform self-directed behaviors. Two participants expressed emotions symptomatic of this dimension. One participant reported that her husband had to be given free days-off from work by his employers to deal with the incident; she narrated that he had been unable to concentrate at his functions at work.

Another participant not only expressed deep sadness, depression and insomnia but also loss of concern for marriage as a wife and her job as a teacher.

"I've stopped reporting for work. I considered leaving this man (her husband)," she said.

Fear and Anxiety: Many participants also expressed deep anxiety, fearing that their child might have been infected with HIV. Six such participants were typical of those who expressed this emotion.

"I fear that my daughter might have been infected with HIV. I have always wanted the best for my children; that's why I send them to private schools. Now this!" cried paternal participant.

"The most disturbing fear I've is for HIV. I've worked so hard to be HIV negative because I don't want my children to be infected through me. She can come and get the problem herself, not through me. Now this devil! I really pray she's not infected," said one participant.

Anger: Other participants said they felt angry with the incident because it distracted them from more pressing concerns of seeking livelihood for their families. These

wanted the matters resolved quickly so that they could press on with their lives. Twelve such participants expressed anger with their children.

> *"This child does not listen to me and does not care about what we are going through, my suffering. This situation will exacerbate our bad economic situation; my widowhood and again this problem!" cried one participant.*

> *"I'm a poor divorcee. None of my children go to school now nor do they have proper clothes. This girl is irresponsible, a bad girl!" complained a participant whose daughter got impregnated.*

> *"This case has disturbed my business because I'm in constant fear that every opportunity she has, she'll go away to flirt," said one participant.*

Disappointment and Frustration: Other participants emphasized the dreams they had in their children prior to the disclosure of CSA. They felt disappointed and angry fearing that the effects of CSA on their children would threaten the achievement of these dreams. Six such caregivers reported planning to invest or were already investing in the education of their children.

> *"I don't want her school to be disturbed. She's an intelligent girl, you know. I'd a lot of faith that she'd make it in life. Look at what she's chosen to do!" said one participant.*

> *"I feel so angry! I'd wanted to give her the future I never had. Her father doesn't want us to have many children so that we can provide the best education for the two we have," reported another participant.*

Stigma and Shame: Other caregivers expressed shame because of the incident. Four such caregivers felt stigmatized by the incident of CSA.

> *"She's shameful! It's shameful to the neighbors, that my daughter's done this sort of thing!" said one male participant.*

> *"This girl's behavior has caused people to pass scorn on us; people are laughing at us," complained a female participant.*

"I'm embarrassed in the neighborhood. This girl, is this the way to thank me?" complained a stepmother.

4.1.1. Participants' Socio-Demographic Characteristics and PSS Scores

This study also examined the relationship between participants' socio-demographic characteristics and their stress levels measured by PSS. This study found that only the variable of caregivers' gender showed a systematic relationship with the differences in PSS total scores. The Mann-Whitney U test score for differences in overall perceived stress levels of paternal caregivers (Mean Rank = 32, n = 5) and maternal caregivers (Mean rank = 35, n = 29), z = −2.66, ($p < .01$) was found to be significant. Thus, while both paternal and maternal primary caregivers reported significantly higher levels of distress than the norm group, judging by the mean ranks, the maternal primary caregivers felt significantly more distressed than their male counterparts.

Significant differences were also established between paternal and maternal caregivers across a number of questions of the PSS as shown in Table 8 below.

Table 7: Mann-Whitney U Test Scores on variations in PSS Scores between male and female participants

Last one month, how often one felt:	**Mann-Whitney U**	**Z**	**Mean Ranks**	
			Male	**Female**
Upset	46.00	−1.47	12.20	18.41
Unable	**21.00****	**−2.68.**	**7.20**	**19.28**
Nervous and stressed	**36.50***	**−2.02**	**10.30**	**18.74**
Confident	**25.00***	**−2.42**	**8.00**	**19.14**
Things being right	43.00	−1.52	11.60	18.52
Couldn't cope	**30.50***	**−2.22**	**9.10**	**18.95**
Insurmountable irritation	67.00	−.28	16.40	17.69
Being on top of things	37.00	−1.84	10.40	18.74
Angered	61.00	−.60	15.20	17.90
Insurmountable Difficulties	**2.93****	**−2.93**	**6.30**	**19.43**
Generally Distressed	**18.00****	**−2.66**	**32**	**35**

*= P< .5, ** = P < .01

4.1.2. Child's Socio-Demographic Characteristics and Caregivers' Stress Level

This study further examined PSS scores for any differences between groups of primary caregivers determined by their children's socio-demographic characteristics. For example, there were three groups of primary caregivers determined by the age groups of their abused children: those whose children were 0 to 5 years, others were 6 to 10 years and the final group had children aged 11 to 15 years. As can be noted from Table 9, they were also different from one another based on other socio-demographic factors related to their children: schooling status, its relationship with abuser (or perpetrator), perpetrator's use of force, number of episodes of abuse and the nature of injuries sustained by the child. The study examined whether these different groups reported different stress levels that could be explained by their children's socio-demographic differences.

This analysis involved conducting nonparametric Kruskal-Wallis Test on the primary caregivers' PSS scores as shown in Table 9 below.

Table 8: The Kruskal-Wallis test results on how child's socio-demographic seemed to affect caregivers' stress levels

Child's Demographics	Categories	Chi-Square Scores	α Level
Age	0 – 5 years 6 – 10 years 11 – 15 years	17.21	P = .509
Schooling Status	Yes No N/A	19.85	P = .342
Relation with Abuser	Intra-familial Extra- Familial	18.42	P = .428
Type of CSA	Sexual Intercourse Abduction Violence	12.28	P = .832
Perpetrator's Use of Force	Yes No	13.71	P = .748
No. of Episodes of CSA	Once Twice Many times Over	16.35	P = .568
Physical Injuries Sustained	No Injuries Bruises Serious Injuries Pregnancy	13.32	P = .772

Judging by the p scores (α Level), no statistically significant differences in PSS scores were found between primary caregivers which could be explained by their children's socio-demographic characteristics. This means that it was difficult to attribute any variability in the primary caregivers' stress levels to their children's socio-demographic characteristics.

4.1.4 Factors Associated with Caregiver's Support or Hostility for the Child Survivor

When participants' emotional narratives were transcribed and then coded for whether *they felt 'angry with the child' or 'not angry with the child'*, the standings were as follows:

- Angry with the Child, n = 15 (44.1%)
- Not angry with the child, n = 19 (55.9%)

Thus, the study showed that, typically, participants who faced an incident of CSA either formed a negative attitude toward the child, in which case they were angry with the child or they developed a more supportive attitude, in which case they did not express hostility to the child.

Primary caregivers' socio-demographic characteristics did not appear to be related to the attitude which they took toward the child. On the other hand, the children's socio-demographic characteristics had wide implications on the attitude that primary caregivers assumed toward their children (See Table 10 Below).

Table 10 clearly shows that in this study, the proportion of unsupportive primary caregivers whose children were aged 10 years or younger were significantly more than those who were supportive of their children. The Chi-Square Test for Independence indicated a significant relationship between children's age and level of support (being "Angry with Child" or being "Not Angry with the Child"): χ^2 (2, n = 34) = 9.808, $p < .01$.

Thus, for those survivors aged 10 years old and below, only one (8.33%) primary caregiver expressed being angry with his/her child. On the other hand, for those Aged 11 to 15 years, 14 (63.64%) expressed anger toward their children, if not blamed them for the abuse.

The relationship between the attitudes the primary caregivers took toward their children and children's socio-demographic factors was inferred though conducting a Chi-Square test for independence. The Chi-Square test was chosen because both

these classes of variables were categorical (Refer to pp. 34 and 35). The relevant elements from the SPSS output were as shown in Table 10 below.

Table 10 shows that, among the given variables, the factors of *going to school, type of sexual abuse, use of force, the number of episodes and physical injuries sustained*, all had a statistically significant relationship with the variable of being "angry or not angry with the child". No statistically significant relationship was found between the variable of child-perpetrator relatedness and being "angry or not angry with the child".

Table 9: Chi-Square Test Scores for Relationship between child's Socio-Demographic Characteristics and Primary Caregiver's Support-Hostility with Child

Children's Socio-Demographic Factors	χ^2	Categories	Angry with Child	Not Angry with Child
Age	10.106**	0 – 5 years	n = 0 (0%)	n = 7 (100%)
		6 – 10 years	n = 1 (20%)	n = 4 (80%)
		11 – 15 years	n = 14 (63.64%)	n = 8 (36.36%)
School	7.056*	Yes	n =12 (57.1%)	n = 9 (42.9%)
		No	n = 3 (50%)	n = 3 (50.0%)
		N/A	n = 0 (0%)	n = 7 (100%)
Child & Perpetrator Relatedness	5.103	—	—	—
Type of Abuse	13.043**	Sexual Intercourse	n = 7 (38.9%)	n = 11 (61.12%)
		Abduction	n = 8 (88.9%)	n = 1 (11.1%)
		Violence	n = 0 (0%)	n = 7 (100%)
Force Used	4.888*	Yes	n= 0 (0%)	n = 6 (100%)
		No	n =15 (55.6%)	n = 12 (44.4%)
No. of Episodes of Abuse	8.388*	Once	n = 3 (18.8%)	n = 13 (81.2%)
		Twice	n = 4 (80.0%)	n = 1 (20.0%)
		Many times Over	n = 8 (61.5%)	n = 5 (38.5%)
Physical Injuries	19.343***	No Injuries	n= 13 (72.2%)	n = 5 (27.8%)
		Bruises	n = 0 (0%)	n = 6 (100%)
		Serious Injuries	n = 0 (0%)	n = 8 (100%)
		Pregnancy	n = 2 (100%)	n = 0 (0%)

*= $P < .05$, ** = $P < .01$, *** = $P < .001$ (& where no *) $P > .05$.

The interpretation of these statistics was based on analyzing categories and proportions in scores of those who expressed or not expressed anger toward their children. Typical of Chi-square test for Independence, the interpretation is based on proportional differences as shown in the Table once the existence of significant re-

lationship has been established. As it turned out in this study, statistical significance was established for the relationships between the factors shown and the variable of being “angry or not angry with the child”.

Specific to this relationship, the factor of a child being in school was associated with increased anger from the primary caregiver toward it. In other words, to a reasonable degree of certainty, one could predict a primary caregiver to be angry with the child by the ‘Yes’ entry for going to school.

The result could be attributed to two factors. First, it will be noted that those who attended school were also much older daughters with whom the majority of primary caregivers (63.64%) were angry for the added reason of their age (As already in Table 10 above). Secondly, themes of shattered dreams expressed in some primary caregivers’ narratives due to the daughter’s indulgence were common. Thus, the high negativity might be expressions of caregivers’ frustrations over shattered dreams they might have invested in their children’s schooling which the incident of CSA appeared to undermine. For that matter, six primary caregivers expressed frustration with the incident of CSA because they felt that the child would not fulfill their dreams of having an educated daughter, thus:

> *“I don’t want her school to be disturbed. She’s an intelligent girl, you know. I’d a lot of faith that she’d make it in life. Look at what she’s chosen to do!” said one participant.*
>
> *“I feel so angry! I’d wanted to give her the future I never had. Her father doesn’t want us to have many children so that we can provide the best education for the two we have,” reported another.*

The relationship between the type of CSA, whether sexual intercourse, abduction/elopement and use of force, and the attitude that the primary caregivers took toward their children showed that sexual intercourse and force were associated with being ‘not angry with child’. You will note that there was a more dramatic association between being ‘not angry with child’ and use of force. On the other hand, elopement was highly associated with being ‘angry with child’.

Similarly, the number of incidents of CSA that the child was believed to have experienced with the same perpetrator also showed a statistically significant relationship with being 'angry or not angry with child'. A one-off incident of CSA was associated with being 'not angry with child' while repeated episodes were associated with being 'angry with the child'. It appears that primary caregivers facing repeated episodes of CSA perceived their children to have volunteered in the abuse.

When it came to injuries, being 'not injured' was associated with caregiver being 'angry with the child'. On the other hand, being injured, whether as mere 'bruises' or 'serious injuries', was associated with being 'not angry with the child' on the part of the primary caregiver. Paradoxically, being impregnated was associated with being 'angry with child', probably because it implied child's failure to disclose early enough.

4.1.3. *Child's socio-demographics and participants' feelings of "anger or grief"*

In addition, there appeared a difference in primary caregivers' perceptions of their emotions, that is, whether being angry with the child or being aggrieved with the incident. Children's socio-demographic factors seemed to influence whether caregiver's emotion would be predominantly perceived as anger toward the child which predisposes aggression or as mere grief over the incident. Examination of caregivers' narratives demonstrated that age of the child affected how angry they felt with child. This might have been so because they felt that the children willfully consented to their abuse. Generally, it was revealed that the older the child, the higher the probability that its primary caregiver felt that the child had volunteered in the abuse and, hence, was worthy of blame and vilification. Typical among these were seven caregivers who expressed anger with their children for this reason. It was noted that all concerned survivors were aged between 12 and 15 years.

One primary caregiver felt that the child was just difficult and had always been so. This posture might have underpinned the reported actions taken by the family, among them corporal punishment and the once-upon-a-time transfer of the child to their relatives in the "less dangerous" home village environment. It had been hoped

that the village environment would have a therapeutic effect on the child. The mother hardly made mention of the role of the perpetrator in the CSA problem.

Two other primary caregivers reported a joint case of abduction and sexual abuse of their daughters aged 12 and 14 years by an elderly male neighbor. The caregivers were desperately poor old women, both widowed. They exhibited high levels of distress following the incident. They seemed to equally blame their children more for the disruption of their routines and livelihoods of gathering vegetables for sale at the market than for their health and well-being.

> *"Can you imagine," lamented one of them, "what her misconduct has caused me; here I am, very far! How do we go back home? Where do we get transport money? I would have been at the market today… the vegetables I gathered have withered, they won't be sold! What do I do now? This girl's unkind to me."*

This attitude suggests that these two mothers were stressed because the incident had placed an extra-burden on their lives and disrupted their livelihoods rather than being concerned with the safety and well-being of their children. Indeed, a further check at the hospital showed that the two caregivers did not return for the subsequent procedures in the therapy of their children.

On the other hand, five of the primary caregivers whose children were much younger appeared much more aggrieved than those of much older children.

> *"I got scared, very scared! It happened to my neighbor's child before. I panicked!" cried one participant.*

The above was the mother of a daughter aged 2 years. This was a return case, albeit the case being less than a month old. She appeared more relaxed than the others. The toddler looked healthy although distressed because of the bleeding procedure she had just undergone at the clinic. This mother appeared more confident with the hospital treatment and care for the child. Nonetheless, she expressed fears and wish for revenge against the perpetrator apparently motivated by the health and safety of her children, thus:

"I collapsed when I got the report from other children that my unmarried neighbor had slept with my baby. Oh, my poor baby!" she cried.

The anger and the distress appeared to have been on equal scale with another mother, whose child, while aged 14, was both intellectually and physically disabled. This mother expressed deep rooted anguish and wish for revenge against the perpetrator.

4.1.4. *Health Effects of CSA and Primary Caregiver's Attitude toward Child*

In all the cases involving much younger survivors, the distress seemed to have been motivated by fear of physical and health effects of the abuse on their children. In their narratives, some primary caregivers lamented the potential health effects of CSA on their children, thus:

"My daughter may die," cried one caregiver. "Why did I marry this monster? Why did I take so long to see it coming? That bleeding! The bed, wherever she sat, all bloody! He threatened to kill me along with her if she disclosed. Only God will help us!"

These effects took the forms of infections and survivors getting pregnant. Two participants expressed fear and anxiety over the possibilities of their children being infected with HIV.

"I've been shocked and alarmed! The information I've is that the girl who assaulted my nephew is HIV positive. I can't believe that such things can happen!" exclaimed the primary caregiver of the only male survivor in this study.

"I fear that my child might have been infected, even with HIV," cried another caregiver.

Other two caregivers faced an added problem of their children getting pregnant from their victimization. One of these participants broke down upon being told that the daughter was actually pregnant.

"I want an abortion!" she cried. And upon being asked about the daughter's feelings, she exclaimed, "I don't care how she feels! You think I care for this girl. No! What am I going to do with the baby? I'm too poor!'

4.1.5. *Type of the Sexual Abuse and Primary Caregiver's Attitude toward Child*

As already demonstrated above, the data in this study showed that the nature of sexual assault shared some relationship with the attitude and posture the primary caregiver took toward the child. The variable of nature of sexual assault concerned whether sexual intercourse was also accompanied by physical force or not. When physical force was involved, age did not appear to play a mediatory role in what attitude the primary caregivers assumed toward the child.

One such case involved a girl, 13 years old, who had been abducted, drugged unconscious, sexually assaulted and then dumped by the wayside. Another survivor, aged 12, had been hired for piecework to clean the home of the perpetrator. In the process, she was viciously raped, leaving her with facial and head injuries. Still another girl, aged 15, was waylaid and viciously raped. Her friend reported the incident to the primary caregiver. In all these cases, the emotional expressions were reminiscent of grief; none of the survivors was vilified by their respective caregivers despite their advanced ages, thus:

"I feel cursed! Divorced and now my child is defiled," on caregiver lamented.

4.1.6. Attribution of Blame for CSA

On to the perception of who was to shoulder the most blame for the incident of CSA, this study found that primary caregivers tended to apportion blame to the child, the perpetrator or themselves (or self). A close relationship was found between the primary caregiver's attitude toward the child and attribution of blame. Furthermore, it also showed that the younger the child, the higher the probability that the primary caregiver would be *not angry with the child* as well as *not blame it* for the abuse*;* conversely, the older the child, the more likely that the primary caregiver would be *angry with the child* as well as blame it for the abuse.

Blaming the Perpetrator: From the Table 11 below, it is clear that those primary caregivers (n = 12) whose children were 10 years old or younger, save for one, all blamed the perpetrator or self for the abuse.

Table 10: Caregiver's Attitude toward Child, Caregiver's attribution of Blame and Children's Ages

Attribution of Blame	Caregiver's Attitude toward Child			
	Angry with Child		Not Angry with Child	
	0 – 10 years	11 – 15 years	0 – 10 years	11 – 15 years
Child	1	13	0	0
Perpetrator	0	0	7	6
Self	0	1	2	2
Self & Perpe-trator	0	0	2	0

In their narratives, some of them expressed deep anger and wish for revenge against the perpetrator.

> *"That man should go to prison; I'll see to it!" vowed one caregiver.*
>
> *"I won't let my baby to get anywhere near that horrible man; she'll be like a handbag from now onwards" cried the mother of a 2 and half years old survivor.*

The data of this study also appear to suggest that, age notwithstanding, when the survivor is physically and/or mentally disabled, blame seems to be attributed to the perpetrator. The mother of a physically and mentally disabled child, albeit aged 14 years, wholly attributed blame for the abuse on the perpetrator, a teacher resident next door to her residence. This appears atypical of primary caregiver whose abused children were aged above 11 years.

Similar perceptions seem to have been shared with other primary caregivers whose children had faced physical violence in addition to sexual abuse. Four participants' narratives provided evidence of this. One such participant brought the above case of abduction, drugging, assaulting and dumping of her daughter, aged 13 years, by

unknown perpetrators. Another one reported the case of a girl duped into accepting piecework to clean the home of the perpetrator, then being violently gagged before being sexually assaulted. The violence resulted in the survivor suffering facial and head injuries. A grandmother reported a case involving a girl, aged 15, who had been raped by unknown perpetrators. Finally, another grandmother brought a case which involved a girl, aged 13 years, who had eloped with a married man and on being discovered, was physically assaulted by the wife of the perpetrator.

In all these cases involving violence, blame seemed to have been attributed exclusively to the perpetrators without any of it being placed on the survivors.

> *"I pray that the perpetrator and wife will be jailed," cried a grandmother. "Although our child might have played a role in this case, I hold the man wholly responsible; he's an elderly person," she further observed.*
>
> *This was a case of murder; they (perpetrators) wanted to kill her. We would have picked up a body," cried the other grandmother.*

One participant, a stepmother felt distressed and blamed herself for having moved the child into her home from her biological mother's care.

> *"She had lived under very poor environment with her mother but she'd been safe. Now, she has been defiled; we don't know…she might have been infected with what? We don't know. I don't even know whether he (perpetrator) hasn't defiled others (her biological daughters) in the home. I'm currently unable to report for work because I'm so depressed".*

It further appears that in the cases of intra-familial sexual abuse dealt with in this study, age notwithstanding, blame appears to have been attributed to the perpetrator. One participant reported an intra-familial case of CSA involving her husband, the stepfather of the survivor. The child had been violated for months until she had the first menstruation. The bleeding appeared too much out of the ordinary and upon enquiries, the girl confirmed many incidents of abuse at the hands of the stepfather.

There was also a case involving a double orphaned girl, aged 13 years old. She was brought to UTH by her aunt, the late father's younger sister. Hitherto, the survivor had lived under the care of a younger sister of her (survivor's) late mother and her husband (hence referred to as uncle). The case was of the uncle repeatedly sexually abusing the survivor until he was discovered. In all these cases, the primary caregivers were unforgiving of the perpetrators.

> *"The wider family is all shocked. Every family member from all over want this man jailed. Tifuna na eve akadye beans mwamene mwana wathu azaka mwera ma ARVs (We want him to go and eat beans (in prison) just as our child will be taking ARVs)," vowed the latter participant.*
>
> *"Let God judge him!" lamented the stepmother, referring to the perpetrator, adding that she wanted him out of her home.*
>
> *"I blame myself for staying married to that horrible man. He had attempted rape on my older daughter earlier but I didn't act then. I've been married to a dog!" cried the other mother.*

Blaming the Child: In the cases involving older girls, the perception of the primary caregivers seemed to suggest that survivors had voluntarily participated in the sexual assault and therefore shared in the blame. There were 15 such participants who typically attributed blame to their children. All the children involved were aged between 11 and 15 years old.

> *"I blame my daughter for this; she gives in to that man," insisted one mother.*
>
> *"My daughter is irresponsible…I'm unconcerned about how she feels," declared another.*
>
> *"It's shameful… that my daughter has done this," said one father.*
>
> *"She reports home late, sometimes 21 hours," observed one participant. "My uncle (the survivor's father) seems to have given-up on this girl."*
>
> *"I don't blame the perpetrator," observed one participant. "Lately, he's helped us to find the girl. I blame my daughter."*

Blaming the One's Self: Some primary caregivers attributed blame on themselves for the abuse of their children. This seems to have been more common among participants whose assaulted children were either 10 years old or younger or there had been aversive consequences to the sexual abuse, use of physical violence, sustaining injuries etc. Typical among those whose children were 10 years or younger and attributed blame on themselves observed:

> *"I didn't act like a responsible mother by leaving the child in the care of the young man (the perpetrator)," cried one mother.*
>
> *"I won't be leaving the child alone anymore," promised one mother whose assaulted child was aged 2 and half years.*
>
> *"I fear what her father will do to me when he comes for this assault," cried one grandmother of a child, aged 3 years old.*

One participant, in blaming herself, felt that she should have been more accommodating to her child's previous clinging behaviors, thus:

> *"I used to chase her whenever she insisted on following me wherever I used to go. I didn't read the signs then; now I've come to understand why. There was something going on."*

For those whose children had been forcibly violated, they expressed the feeling that they had not been there for them. Typical among them narrated:

> *"I was negligent; I'd not cared for her enough," regretted one mother of the daughter found unconscious and dumped by the wayside.*
>
> *"I feel negligent, because people may suspect that I used to send her to carry out piecework," observed one male caregiver of the child who had sustained facial and head injuries.*

Intra-familial incidents of CSA also seemed to be associated with primary caregivers who engaged in self-attribution of blame. One participant blamed herself for not noticing earlier the abuse of her daughter by her husband (survivor's step-father), declaring:

"I'll not marry again after this!"

"I blame myself for having brought this girl into our home; I can't bear the burden of my daughter being found with HIV," cried the stepmother of girl aged 10 and abused by a 17 year old male grade 12 cousin.

4.1.7. Caregiver's perception of the needs of their children

The results of this study also demonstrated that the attitude that a primary caregiver assumed toward the child also tended to determine what they considered to be the priority outcomes of their report to UTH, YWCA and/or VSU.

Table 11: Caregiver's attitude toward child and Caregiver's Therapeutic Priority

Caregiver's Therapeutic Priority	Angry with child	Not angry with child
Behavioral Correction	8	1
Medical treatment; prison for perpetrator	6	18
Prison for perpetrator	1	0
Total	15	19

Participants in the study appeared motivated by two different perceived needs of their children: on the one hand, treatment of their children's health effects arising directly from victimization or, on the other, reformation of their children's recent behaviors that might have led to the abuse. As shown in Table 12 above, those who appeared to be not angry with their children and blamed the perpetrators typically appeared motivated by the quest for their children's health and other forms of well-being; included in this group were mostly those whose victimized children were aged 10 years or below and who had been violently victimized.

"I spent the whole night standing in the cold; here at UTH seeking assistance," cried one caregiver of the violently assaulted girl dumped by the wayside. "My only prayer is that my child has not been infected…I feel so much more affection for her now than ever before," she confessed.

"The most painful aspect of this problem is the possibility that she could have been infected with HIV…this time I'll enroll her at the childcare centre to safeguard her," said mother of girl aged 2 years.

On the other hand, those caregivers who wished their children to be reformed appeared to have judged their children not necessarily as survivors but legitimate transgressors rightly deserving of punishment and correction. Seven participants fell into the latter group.

"I want nothing more than the child settling down and stop this running around with men," hoped one Mother.

"I'm so depressed by the behavior of this girl…I'm wondering where such a young girl copied such behavior and attitude toward life," said one mother. She added, "I dream of a time when the girl will come back to me; she used to be such a nice girl. I hope I can get counseling services for her…we can pay anything."

"This child should have been kind to me…her father died leaving me with small children, she's the last born," cried another mother. She added, "My dream is for her to change her conduct."

4.1.8. *Child-Caregiver Relationship in the Aftermath of an Incident of CSA*

The study revealed evidence suggesting that CSA might lead to strained relations between the survivors and their caregivers. It also seems to be the case not only of those who participated in the study but other survivors' significant relatives as well. One such participant reported the case of her double orphaned niece having been threatened by her own aunt (her mother's younger sister) with death by poisoning should she disclose that her husband had been sexually assaulting her.

The narratives of the participating caregivers suggested that children's socio-demographic status play a role in influencing changes in the child-caregiver relationships in the aftermath of CSA. For example, it appears that the younger and the more helpless the child was perceived to be, the less strained their relationship turned out to be when the incident of CSA was discovered. This seemed to be the

case also when the perpetrator was accused of having threatened or used force to gain the survivor's submission. Incidents have already been presented in this study involving violence and participants expressing support for their children rather than hostility toward their children, despite their children being aged 11 to 15 years.

Nonetheless, when the child was much older, 11 to 15 years, unless the aforementioned factors were at play, the attitude of the caregivers toward the survivor was hostile (Having not interviewed the children, one cannot report on their attitude!).

> *In wishing the survivor to change her conduct, one participant castigated her child and declared, "I don't have a child in this girl."*
>
> *"I'm unconcerned about how this girl feels; she's irresponsible!" declared another.*
>
> *"She's shameful; I don't know whether she's infected or not; whether she's pregnant or not; I'm disappointed!" said one father.*
>
> *One mother retorted, "This girl was disciplined (referring to corporal punishment) by the father the other week but she still ran away from home; for days! I can't do anything about this girl. Where did I go wrong?"*

Chapter Five

5. Discussion

This chapter discusses the results of the study with reference to the aim and objectives earlier conceived in Chapter One. The discussion is a synthesis of the current knowledge based on the literature reviewed and the data collected via field research. The goal is to disseminate as accurately as possible what the psychological impact of CSA on primary caregivers was found to be in this study. The study explored what may be the likely mediatory factors to the appearance of the symptoms of the psychological impact of CSA on primary caregivers. Reflecting on the rationale of the study, find highlighted what was considered to be the practical implications of these results. Under limitations of the study, a precautionary note has been raised regarding what should not be read into the results. Finally, the study has proposed areas of future research.

5.1. Interpretation and Theoretical Implications of Results

5.1.1. Overall Psychological Impact of CSA on Primary Caregivers

The administration of the Perceived Stress Scale (PSS) questionnaire provided data which demonstrated that primary caregivers facing an incident of CSA experienced significantly higher stress levels than their daily norm. This decision was inferred through comparing participants' PSS scores (M = 30.65, SD = 5.52, Range = 20 - 40) with norm data recommended by the Authors (See Table at Appendix 1). The analysis showed that all PSS scores of the participants were well above the recommended norm average regardless of gender, age or race. This was interpreted to mean that these participants felt significantly more distressed than did their peers in the population.

This was also found to be true when these scores were compared with findings of a previous study in which the PSS was a key measure conducted in Zambia by Menon et al (2007) that found a mean score of 26.1 (SD = 6.01) to be indicative of higher stress than exists in the normal population. Since all participants in this study faced recent disclosures of CSA, the heightened levels of distress were assumed to be symptomatic of the psychological impact of CSA on primary caregivers.

This result is consistent with past research findings which also showed that incidents of CSA result in serious psychological symptoms characterized by elevated levels of social distress in primary caregivers of children involved (Hebert et al, 2007; Newberger et al, 1993; Manion et al, 1996; Leonard et al, 1997; Tavkar, 2010; Willingham2007).

5.1.2. Symptoms of Psychological Impact of CSA on Primary Caregivers

Through analyses of their narratives, participants in this study recounted varying symptoms of psychological impact of CSA that they had experienced. Notable among them were depression and sleep disturbance, functional impairment, fear and anxiety, anger and wish for revenge, disappointment and frustration, and shame and stigma. In other words, incidents of child sexual abuse gave rise to emotional symptoms reminiscent of mood and anxiety disorders (Schwartz, 2000; Durand & Barlow, 2006). This result is widely consistent with findings of other previous researchers (Mayekiso & Mbokazi, 2007; Newberger et al 1993; Manion et al, 1996). Mayekiso and Mbokazi (2007) found that most prevalent symptoms of maternal psychopathology in the aftermath of an incident of CSA were found to be internalizing behavioral problems including anger, anxiety, guilt, depression, insomnia, headache and fatigue. In general, other studies found that primary caregivers of survivors of CSA faced a higher risk than those of comparison group to score in the clinically distressed range (Newberger et al, 1993; Manion et al, 1996 & 1998).

5.1.3. Socio-Demographic Factors and the Psychological Impact of CSA on Primary Caregivers

5.1.3.1. Primary Caregivers

In this study, all but 5 of the 34 participating caregivers were female. The breakdown of the caregivers was biological mothers, fathers, grandmothers, stepmothers, aunts, cousins and brothers- in-law. The majority of the primary caregivers were the mothers, followed by fathers and grandmothers, then stepmothers and aunts and finally only one each of cousin and brother-in-law. This seems to reflect and underscore the socio-demographic composition of Zambian families, at least to the extent of who constitutes primary caregivers of children in general in Zambia, an extended family system characteristic of the broader African culture.

The disparity between female and male primary caregivers among participants seems to tie with the level of participation in child caregiving responsibilities socially apportioned to men and women among the Zambian population groups. This might also be reflective of differing levels of distress experienced when faced with CSA between maternal and other female primary caregivers, on the one hand, and fathers and other male caregivers on the other.

In this regard, this study found statistically significant differences in the levels of perceived stress reported by female and male participants' PSS scores. This was inferred by conducting a Mann-Whitney U test on the PSS scores of the two groups which yielded significant test result: maternal (Mean rank = 19.38, n = 29) and paternal (Men rank = 6.60, n = 5): $z = -2.66$, $p < .01$ (See Table 10); thus, this result demonstrated a significant difference in perceived stress levels between the two groups explained by their gender difference.

Judging by the differences in mean rank scores, the overall result was that female caregivers scored significantly higher than their male counterparts on the PSS questionnaire. Simply, female participants reported higher levels of general distress than their male counterparts. This difference notwithstanding, it needs to be emphasized that the core result is that both male and female caregivers of survivors of CSA reported stress levels which were higher than their daily norm but that part of the variance between them could be explained by the participants' gender.

This result is consistent with the finding of Manion et al (1996), which was that, while both mothers and fathers of sexually abused children suffer greater overall distress, the level of distress experienced by mothers remains above that of fathers; thus, the disparity in the number of maternal versus paternal caregivers in bringing cases to the recruitment centers might be a manifestation of differences in the gravity of perceived emotional distress explained by gender.

When it came to marital status, the results of this study have shown that children could come from any household. Of the participating primary caregivers, proportionally more of them (n= 26, 76.47%) were married than unmarried. For those unmarried, 11.76% (n= 4) were widows; 5.88% (n= 2) had been divorced and an equal

number of them (5.88%) were single. The possible explanation of this is that these proportions mirror the marital status of primary caregivers generally as they stand today in Zambia. There are certainly more households taking care of children where there are married couples than single ones; there is also a higher probability that a widowed or divorced person might be a primary caregiver of a child than a single one.

While the above may be justifiably true by the nature of it, when it came to socio-economic status, estimated by caregiver's employment status, the results show that participants who could be considered high in socio-economic status (those in secure formal employment) constituted only 26.47%. Those considered of low socio-economic status consisted of the unemployed, who constituted the majority slot (38.24%), followed by hawkers (14.71%), housemaids and small business persons (each at 5.88%). This result is consistent with Cosentino and Collins (1996) assertion that, while sexually abused children can hail from any household of any socio-economic status as shown above, reported cases of CSA tend to arise disproportionately more from lower social classes.

Cosentino and Collins (1996) have also argued that those primary caregivers who are extensively out of home such as the employed, hawkers, small business persons and housemaids face a high risk of having their children sexually assaulted. This might explain why hawkers showed such a fairly high representation among primary caregivers facing CSA relative to their normal proportions in Zambian society.

5.1.3.2. Children

- ***Children's Gender***

Despite the fairly wide variations in socio-demographics of primary caregivers who brought the cases to the recruitment centers, all but one of the survivors of CSA was a boy child. There could be different explanations for this result. At the very basic, this is reflective of findings of previous studies which consistently demonstrated that girls are at higher risk for CSA than boys (Cosentino & Collins, 1996). Tavkar (2010) also found that female children were more likely to disclose CSA compared to male ones. Going by this finding, so many female children could have

been brought to the recruitment centers supposedly because they disclosed more frequently than did their male counterparts.

The alternative explanation offered by Newberger et al (1993) is that mothers of daughters undergo more psychological distress than do mothers of sons. Hence, the mothers whose daughters were sexually abused could have suffered more distress than their counterparts whose sons had been abused; this could mean that the former were more likely to come forward to report the abuse. This finding implies that the result that girls were the majority of the survivors in this study is by itself an expression of relatively higher levels of distress experienced by primary caregivers of sexually abused girls compared to those of boys. The bottom line appears to be that gender of the child had a mediatory effect on the reported psychological impact of CSA on the primary caregiver.

Overall, by bringing their children to agencies seeking various services aimed at correcting a sexual and health wrong, caregivers demonstrated a concern for the well-being of their children. This is consistent with the assertion by Willingham (2007), who observed that, on the whole, primary caregivers believe and protect their children after the incident of CSA.

- ***Children's Age***

Guided by the Zambian law which recognizes CSA to only involve children below the age of 16 years, the age differences among those reported in this study were clustered into 0 to 5 years, 6 to 10 years, 11to 15 years. Age clusters comprising 11 to 15 years together represented a clear majority; this group constituted 64.71% of all the survivors. This is consistent with previous research findings that show that the risk for sexual abuse among survivors, whether boys or girls, peaks at 10 years of age (Cosentino & Collins, 1996).

This result, therefore, supports the differential designation of CSA offences as being either paedophilic or non-paedophilic. Many of the CSA incidents involving victimization of pre-pubertal children, herein represented by age range 0 to 10 years, satisfy a paedophilic classification (American Psychiatric Association, 2000) while those

involving older preadolescent and adolescent children (11 to 15 year old) suggest a non-paedophilic classification. The result that the majority of CSA offences are non-paedophilic is consistent with a previous finding by Al-Mahroos et al (2011) which showed that most of CSO were non-paedophilic child molesters.

The result showing the existence of both paedophilic and non-paedophilic CSO among the current perpetrators is important for primary caregivers and agencies involved in child care and protection because it brings to the fore the previous findings that paedophilic offenders have the tendency of committing sex offences more often and with a greater number of children (Al-Mahroos et al, 2011). Thus, paedophilic perpetrators may be a greater danger to children than non-paedophilic sex offenders who ordinarily tend to have adult partners and offend with fewer children (Al-Mahroos et al, 2011); they only do so because of ease of access to the girls (Durand & Barlow, 2006).

While the factor of children's age did not yield a statistically significant relationship with the PSS measured perceived stress scores, a relationship was found between age of the child and the attitude of the primary caregivers toward the survivor (whether 'angry with child' or 'not angry with the child'). In this study, anger was identified to be a key symptom of the psychological impact of CSA on primary caregivers. Overall, it was found that an increase in children's age was associated with increasing negativity or anger toward the survivor from the primary caregiver while a decrease in children's age was associated with increasing support and protection for the child from the primary caregiver.

This result is consistent with previous research findings, notably by Heriot (1996), which showed that age of the child survivor had an inverse effect on the attitude taken by the non-offending guardian; mothers of teenage children were found to be less likely to emotionally protect them during CSA crises.

5.1.4. Perpetrators

In this study, the factor of child-perpetrator relatedness varied widely across the concerned children. All but one of the perpetrators was male. This result is in line

with various previous research findings which showed that majority of perpetrators of CSA are men (Cosentino & Collins, 1996; Durand & Barlow, 2006; Al-Mahroos et al, 2011). The perpetrators comprised neighbors, unknown persons, cousins, uncles and stepfathers. The majority were neighbors (52.94%), followed by unknown persons (23.53%)[3], cousins (11.76%), uncles (8.82%) and step fathers (2.94%). Despite over-representation of unknown persons among the perpetrators and if we suppose that neighbors were actually known to the children, this result is still consistent with earlier studies that show that majority of perpetrators are known to the survivors prior to their victimization (Al-Mahroos et al, 2011; Cosentino & Collins, 1996).

These results could be analyzed as representing two broadly different categories of sexual victimization: extra-familial and intra-familial child sexual abuse (Cosentino & Collins, 1996). These results demonstrated a clear representation of both. Neighbors and unknown persons committed extra-familial CSA while cousins, uncles and step fathers committed the intra-familial CSA. The above percentages show that majority of CSA cases were extra-familial (76.47% to 23.52%). This is consistent with earlier research findings which showed that extra-familial CSA is more common (Cosentino & Collins, 1996) but inconsistent with the belief that majority of sexual abuse of children take place within the home… by primary caregivers of the children" (Mulenga, 2010).

The other result is that unknown perpetrators victimized only children above the age of 11 years while none of the prepubertal children (0 – 10 years) were found to have been victimized by the unknown persons (See Table 5). This might actually suggest collusions between the children and the perpetrators, which collusions are unlikely to be entered into by much younger children.

For fear of downplaying the importance of intra-familial CSA incidents, this study acknowledges their existence. All intra-familial relations between the perpetrator and the child fit into what Durand and Barlow (2006) classified as incest. Research

[3] Please take note that unknown persons were unknown to primary caregivers rather than to the victim. Majority were boy friends of the victims.

findings also show that survivors of incestuous relationships tend to be girls (Cosentino & Collins, 1996). Consistent with this finding, this study found that children victimized by family members were all girls. This result is important because of its underlying implications on the primary caregiver's attitude and behavior toward the other two key players: the survivor and perpetrator. Close familial relationship between, on the one hand, the primary caregiver and the child, and the perpetrator on the other, has important implication for the caregiver's continued defence and support of the child.

However, this study has not produced statistically significant relationship between this factor of child-perpetrator relatedness and the level of stress experienced by the primary caregivers. Thus, primary caregivers did not differ significantly on how much stress they felt because of the extent of relatedness between the perpetrator and the child. This is contrary to other previous research findings which showed a relationship between these variables.

Heriot (1996) contended that the extent of the relationship between the perpetrator and the non-offending caregiver, invariably with the child, affects how stressed the caregiver might feel and the level of support s/he renders to the child. She qualified this assertion by submitting that primary caregivers support for the child is a function of their feelings toward the perpetrator; primary caregivers tend to be supportive of their children if their feelings toward their perpetrators are negative. Bolen and Lamb (2004) asserted that the level of caregiver's negativity toward the self and the child reflects confluence between non-offending guardian's valence toward the child and perpetrator. Willingham (2007) argues that caregivers' emotional response to an incident of CSA and the child depends on their capacity to cope with emotional and economic dependence on their child's perpetrator.

In the case of the results in this study, neither of the primary caregivers expressed their dependence on the perpetrators of their children, including those involving family members. Indeed, all those involved with intra-familial CSA cases felt disdain toward the perpetrators. In short, lack of psycho-social and economic dependence of primary caregivers on perpetrators may explain the lack of systematic variance in

perceived stress among caregivers between those who faced intra-and-extra-familial CSA.

5.1.5. Type of abuse

In this study, all children experienced sexual intercourse (or vaginal penetration) as the primary type of CSA. While, for female children, it involved male perpetrator undertaking penile penetration of the vaginal cavity; for the only male survivor, it took the female perpetrator to induce him to undertake penile penetration of her vagina. This study has referred to both acts as sexual intercourse (or vaginal penetration).

It was important to examine this variable because other studies have previously found a relationship between it and maternal symptomatology; specifically, primary caregivers weighed anal or vaginal intercourse more heavily than merely kissing and/or fondling (Newberger et al, 1993**)**. This weighting in favor of this type of CSA above all others might explain why primary caregivers in this study felt compelled to report it to hospital and government's law enforcement wings; in fact, they might have considered it as the only one grave enough to be reported. However, this result homogeneity means that the factor of type of CSA and its association with the psychological impact of CSA on primary caregivers could not be further analyzed.

Nonetheless, in this study, differences were noted among caregivers' self-reports related to whether or not force had been applied by the perpetrator to secure the survivor's submission. However, PSS scores did not vary in any significant ways between those of primary caregivers whose children had experienced force and those who had not.

On the other hand, clear difference emerged when analyses of caregivers' narratives were conducted through Chi-Square test of independence to determine the existence of a relationship between force used and primary caregiver's attitude toward his child. Those primary caregivers whose children were survivors of threats or actual use of violence tended to be more supportive of their children than others in similar situation but low on this variable. In this case, statistically significant Chi-

Square scores (χ^2 (1, n = 34) = 11.765, $p < .01$) was found between the perpetrator's use of force and primary caregiver's attitude assumed toward the child. The statistic was interpreted as meaning that use of force against the child by the perpetrator was associated with increased support for the child by the primary caregiver.

This is consistent with Newberger et al (1993) who found that use of force is associated with maternal distress following an incident of CSA, in this case expressed as grief over the abuse of one's child, translated into support for the child.

When it came to injuries sustained during the abuse, the study found that many children (n = 18, 52.94%) were not injured. Of those injured, the notable picture is that among the 0 to 10 year old survivors, 70% reported suffering bruises or serious injuries. The nature of injuries also varied across age groups: for the 0 to 10 year olds, injuries resulted exclusively from vaginal penetration, while for those who were much older; they sustained injuries from physical force that had accompanied the CSA. On the whole, the younger the child, the more likely it was found that they had suffered physical injuries arising from CSA.

Thus, injuries were more prevalent among the 0 to 10 year old survivors and arose primarily from sexual acts; injuries among the 11 to 15 year olds were less prevalent and when they arose, they were caused by perpetrators acts of coercion. To that end, this study shows that injuries during incidents of CSA tend to vary inversely with age.

5.1.6. Typical Response to CSA by Primary Caregivers

Many studies (James & Gilliland, 2001; Lovett, 2004; Bolen & Lamb, 2004 and Cosentino & Collins, 1996) have found that expression of support for the child by the primary caregiver is essential for successful mitigation of severe symptoms in those children. Notwithstanding, the results of this study show that primary caregivers did not always provide the child with the essential support, but took varying postures toward it ranging from being angry with the child to being supportive and protective of the child. Overall, 19 against 15 primary caregivers expressed support and protection for their children while the latter were angry with their children.

This study revealed that the age of the child had a lot to do with which posture the primary caregiver took. A statistically significant Chi-Square score (χ^2 (1, n = 34) = 10.11, $p < .01$) was found demonstrating a high probability of the existence of a systematic relationship between children's ages and the attitude primary caregivers exhibited toward the survivors (See Table 12). Simply, this statistic meant that the older the child, the higher the probability that the primary caregiver would be angry with it. The anger toward teenage children seemed to arise from a feeling that the child could have avoided the victimization.

> *"You could have avoided this!" some caregivers seemed to be saying to the child.*

This is consistent with what Tavkar (2010) observed that caregivers, in particular those of older children, become angry with the child apparently for not preventing the abuse or for not disclosing earlier or at all. Heriot (1996) found that mothers of teenagers were less likely to protect their victimized children than those mothers whose children were much younger.

In the narratives of the participants, teenage children were also maligned by their primary caregivers for disrupting their daily lives. CSA incidents meant that primary caregivers had to travel and appear before human services and law enforcement personnel, very traumatizing experiences to many people. This result is consistent with Tavkar's (2010) observation that some caregivers blame their children because of disrupting their lives.

The evidence of primary caregivers only sometimes being fully supportive of their children was a regular theme in many narratives of primary caregivers of teenage children. In addition, the frequency of negative themes toward the children also seemed to increase or reduce when certain socio-demographic variables were at play. Some of these variables were *child's school status, perpetrators use of force, number of episodes of abuse and the extent of the injuries* sustained during the CSA acts. As already reported and discussed, statistically significant relationships were found between these socio-demographic variables and the attitude that a primary caregiver took toward its child.

In brief, the statistics meant that if the child had been physically abused and/or had suffered injuries, the probability of its primary caregiver exhibiting hostility toward it was low; conversely, the likelihood of such children being supported and protected by their primary caregivers was high.

This result is consistent with the finding by Newberger et al (1993) that maternal grief can be exacerbated by the survivor's level of distress resulting out of either severity of the abuse or the perpetrator's use of force, threatened or applied. They Characterized severity of CSA as the extent of sexual act such as kissing, fondling or sexual intercourse. Newberger and her colleagues postulated that primary caregivers weigh vaginal intercourse more than kissing and fondling. This might explain why all reported cases in this study primarily involved vaginal intercourse. It also gives credence to the interpretation of the gravity of psychological impact of CSA as being underpinned by perception of helplessness of the child in the act.

The school status of the child also yielded a statistically significant Chi-Square score with the attitude of the primary caregiver toward its child after CSA disclosure. This statistic meant that those children attending school faced a higher probability of facing hostility from their primary caregivers than those who weren't. One hypothesis to explain this unexpected result lies in the age group of survivors involved; the school going survivors tended to be older, teenage girls. Secondly, in their narratives, primary caregivers of school going children tended to express more disappointment with the incidents of CSA because of dreams they had tended to hold in their children's schooling and future.

The type of posture adopted by primary caregivers of younger and powerless children also appeared to have been motivated by fear of physical and health effects of CSA on the survivors, such as HIV infections.

5.1.7. Explaining Attribution of Blame

Factors that seemed to influence what posture a primary caregiver exhibited toward the child also appear to have influenced whom s/he considered shouldered the most responsibility for the incidents of CSA. This study showed that blame was

attributed either to the perpetrator, the child or self, primary caregiver. In line with the results of this study, primary caregivers attributed blame to the perpetrator when the child was 10 years old or younger, was perceived to be powerless, force of coercion had been used, the abuse had happened only once and/or there had been injuries.

It was also revealed that many primary caregivers of older children, 11 to 15 years perceived their children to have voluntarily participated in the abuse and hence deserved to be vilified, if not punished for their misconduct.

A few primary caregivers attributed some responsibility for CSA to themselves. Factors that appeared to underpin blame for perpetrators also seemed to be at play here: the younger and more helpless the child, the more likely the primary caregiver tended to blame him/herself for having been negligent and ultimately a poor caregiver.

James and Gilliland (2001) commended attributing blame to the perpetrator because it underpins supportive family reaction to CSA survivors and against appearance of severe pathological symptoms in the child.

5.1.8. Caregiver's Attitude and the Choice of Therapy for Survivors

This study has revealed that participants varied on what they perceived as the most suitable outcome of the intervention that they were seeking for their children. The participants tended to ask for either treatment of the child for medical and/or psychological shocks arising from sexual victimization or counseling for their children's behavioral correction and reformation.

Primary caregivers of younger or children perceived as having been powerless in the victimization were mostly motivated by health and psychological concerns of their children; therefore, they tended to seek medical treatment for their children of possible infections.

On the other hand, primary caregivers of much older children appeared to perceive them as truant and, therefore, the best they wished for them was reformation from behaviors that they assumed led to CSA in the first place. Some of such children

were reported to have run away from parental homes. Thus, they were perceived as legitimate transgressors who rightly deserved to be punished and corrected.

5.1.9. Relationships in the Aftermath of the incident of CSA

This study revealed that an incident of CSA might lead to strained relations not only between the primary caregiver and the perpetrator but also between the primary caregiver and the child. A classic example is that of a primary caregiver who narrated how she rescued the child from an aunt who had threatened to kill her by poisoning if she dared to disclose that her husband had sexually abused her.

Factors that seemed to have influenced the nature of the child-caregiver relationship in the aftermath of CSA seem to be the same as those which underlay attribution of blame, the choice of treatment outcomes etc. The younger the child and more helpless the child was perceived to be, the less strained the child-caregiver relationship turned out to be. This also seems to have been the case when force was said to have been used by the perpetrator to achieve submission; the child-caregiver relationships seemed to remain positive.

Conversely, primary caregivers of much older children expressed hostility toward their children and requested the human services providers to help reform them. It will be noted that such primary caregivers also tended to blame the survivors for the abuse.

5.2. Summary

The results of this study show that primary caregivers of sexually abused children undergo serious distress as a psychological impact of child sexual abuse. Participants' Perceived Stress Scale (PSS) scores were all significantly higher than the norm (or reference) scores recommended by Cohen et al. (9183), the Authors of the scale. To that end, participants in this study experienced significantly higher levels of stress than did those not facing incidents of CSA.

The symptoms of the psychological impact of CSA seem to have taken the form of depression and sleep disturbance, functional impairment, fear and anxiety, anger, grief and wish for revenge, disappointment and frustration, and stigma and shame.

These psychopathological symptoms were generally consistent with those found by other previous researchers such as Cosentino and Collins (1996), Mayeksio and Mbokazi (2007), Lovett (2004), Newberger et al. (1993) and Manion et al. (1996).

The study also found that these symptoms tended to vary across participating primary caregivers. A statistically significant relationship was found in this study between being male/female and the extent of distress measured by PSS, symptomatic of psychological impact of CSA. The result showed that, on average, female primary caregivers scored higher on PSS than males. The interpretation was that female participants felt more distressed and impaired than did their male counterparts. Nonetheless, the core result is that all primary caregivers, their gender regardless, suffered psychological distress as a result of facing an incident of CSA.

On the other hand, other than this variable of gender, no evidence has been inferred linking other primary caregivers' socio-demographic characteristics with their perceived rise in distress associated with the incident of CSA.

Further examination of narratives of participating primary caregivers showed a number of differences in symptomatology of the psychological impact of CSA on primary caregivers which could be explained by pre-identified factors related to the child and nature of CSA.

Gender of the child could not be analyzed for its influence on the psychological impact of CSA on primary caregivers since only one of them was male.

A statistically significant association was found between the types of CSA, characterized as vaginal intercourse alone, vaginal intercourse with elopement/abduction or vaginal intercourse with use of coercion, and the psychological impact of CSA on primary caregivers. Sexual intercourse alone and use of coercion were found to be associated with the primary caregivers being not angry with the survivors. Elopement was found to be highly associated with the primary caregivers being angry with the survivor. On the whole, the homogeneity of sexual intercourse being the primary type of CSA reported in all of the cases implies that penile cum vaginal penetration might have been the only sexual victimization that these participants con-

sidered grave enough to be brought to the attention of judicial and health authorities. In any case, penile, vaginal and anal penetrations are what they examine for at UTH to prove before the courts of law that CSA had taken place.

Fears of physical or health effects of CSA were found to exacerbate the symptoms of the psychological impact of CSA on primary caregivers. Many caregivers tended to express anxiety over the dangers of their children being infected with HIV. This was expressed as a major motivator of bringing abused children to UTH for health care services. Primary caregivers of those who had got pregnant in the process of CSA tended to be more concerned and distressed about responsibility of caring for the baby to be born than with the immediate health of the child.

Ultimately, results of this study show statistically significant differences in the attitudes taken by different primary caregivers toward their children. While a slight majority (19 to 15) of primary caregivers showed unwavering support for their children, others did demonstrate hostility toward survivors of CSA and attributed the blame for the abuse to them.

Many such attitudinal differences were noted in primary caregivers' narratives and could reasonably be explained by socio-demographic data related to the children. Overall, primary caregivers of pre-pubertal (0 – 10 years old) children tended to express more supportive and protective attitude for their children than their counterparts involved with teenage children. In many instances, primary caregivers of younger children also expressed wish for revenge against the perpetrator.

When the incident of CSA was accompanied by coercion from the perpetrator, the various primary caregivers were found to express more sympathetic and protective feelings toward their children. Additionally, primary caregivers of children who were perceived to be powerless, because either force had been used by the perpetrator or there had been injuries from the abuse, tended to exhibit support and protection for their children. Conversely, other than for these reasons, primary caregivers of teenage children tended to express less support and protection for them than those of much younger children. These results are consistent with previous research findings (e.g., Heriot, 1996; Bolen & Lamb, 2004) that showed that the age of the chil-

dren has a moderating effect on the nature of the psychological impact of CSA on primary caregivers.

In some cases, an attitude taken by a participant toward its child could be explained by the child's schooling. Primary caregivers of abused school-going children expressed more anger and disappointment in them than in those not in school. A statistically significant relationship was inferred in this study linking the child's schooling with increased hostility of the primary caregiver toward it. This might be explained by the factor of age differences; school going girls were generally teenagers and therefore older, while those not going to school comprised a significantly high number of pre-pubertal (0 – 10 year old) ones. Secondly, this association between caregiver's negativity toward their children and her schooling might be explained by shattered dreams about the future of the children that many such primary caregivers expressed in sending them to school.

In this study, primary caregivers expressed equal amount of hostility toward both intra-and extra-familial CSO. To that end, the factor of survivor-perpetrator relatedness did not appear to determine the nature or gravity of the psychological impact of CSA on primary caregivers. This might be explained by the apparent lack of positive relationship between the participants and the perpetrators, even those related to the primary caregivers.

5.3. Conclusion

The findings in this study were consistent with the predictions of Transactional model of Stress and Coping by Lazarus (in Glanz, K., Rimer, B.K. & Lewis, F.M., 2002). To that end, this model provides a satisfactory framework for explaining and predicting what psychological experiences happen to the primary caregivers of sexually abused children.

Fundamentally, in this study, primary caregivers reported experiencing above normal psychological stress characterized by anxiety and depressed mood following an incident of CSA. Hence, psychological distress experienced by these primary caregivers can be explained by this model as having arisen out of evaluation of the inci-

dent of CSA as abnormal. Consistent with the predictions of Transactional model of stress and coping, primary caregivers sought outside assistance to cope with the effects of CSA thereby demonstrating that they had evaluated that the incident required coping resources beyond what they possessed. Thus, Transactional model of stress and coping ably explains and predicts the psychological impact of CSA on primary caregivers of victimized children.

5.4. Practical Implications of Results

Although it is difficult to anticipate how human services organizations may choose to apply some of these results, a number of practical implications can be deduced. Some of these implications relate to the overall finding that primary caregivers of sexually abused children experience aversive psychological effects following the disclosure of CSA. The study noted that the key symptoms of the psychological impact of CSA on primary caregivers included depression, functional impairment, anxiety, anger, grief, vengeance, shame and stigma. These results are in support of other previous research findings among them Manion et al (1996); Newberger et al (1993) and Mayekiso and Mbokazi (2007) which demonstrated similar results of negative emotional outcomes of CSA on primary caregivers of the survivors.

One practical implication is that concerned social services organizations including Victims Support Unit of the Zambia Police Service, Paediatric Centre of Excellence at UTH and YWCA need to diversify their interventions in service to survivors of CSA to include primary caregivers, more so mothers and other maternal caregivers. Manion et al (1996) have referred to this need as expanding "our focus beyond the child victims to traumatized families". The interventions could include design and implementation of therapies aimed at remedying the caregiver's negative psychological impacts.

It will be noted that many studies (Phasha, 2007; Cosentino & Collins, 1996; James & Gilliland, 2001) emphasize the therapeutic effects of a psychologically stable and well functioning mentality of the primary caregiver as an essential platform for the children's recovery and adjustment from the psychopathologies of CSA. Phasha (2007) underscores the importance of primary caregivers believing the contents of

the survivors' stories regarding the incident of CSA. Earlier, Lovett (2004) had concluded that maternal responses that convey protection and support had been found to be associated with survivor's improved mental health and social functioning. However, while they referred their children to the human services agencies for medication and therapy, some primary caregivers were not fully supportive and protective of their children; they continued to attribute blame to them for the abuse, thereby denying them emotional support.

This result supports the case for therapy for these primary caregivers, if not for themselves but for their victimized children. Such a therapeutic regime could focus on strengthening their parental capacities to deal with fallouts of the abuse on their children. Lawson and Chaffin (1992) observed that caretaker's attitude and support for their children constitute a critical target for intervention and prevention efforts because as other researchers have found, primary caregiver support is essential for successful mitigation of severe symptoms in the victimized children (James & Gilliland, 2001; Lovett, 2004; Bolen & Lamb, 2004 and Cosentino & Collins, 1996).

The results of this study also showed that while both female and male children fall victim to CSA, girls are disproportionately at higher risk of being sexually abused than boys. The flipside is that males, including some male children, constitute the main culprits of victimizing other children. To that end, Government and other non-state actors may consider designing and implementing targeted education programmes differentially aimed at girls and boys. In any case, in Zambia, children older than 8 years are subject to imprisonment upon conviction for any offence. This could be emphasized as one danger of boys engaging in premature sexual activities. To do this would be in support of other researchers' observations, notably Sorensen and Snow (1991) who observed that peer and public educational programmes are often effective in motivating prevention of CSA.

5.5. Some Limitations of the Study

This study involved primary caregivers who had brought their sexually abused children to the YWCA and/or UTH Paediatric Centre of Excellence, both of Lusaka for various prescribed therapeutic procedures. There is a wide spread assertion backed

by many scientific surveys that attest to many CSA incidents not being disclosed to authorities for therapy. To that extent, the cases in this study are of those who volunteered to deal with the problem. It would be reasonable to speculate that these primary caregivers could indeed have been psychopathologically impacted for them to have been motivated to seek assistance for their children. It would also be reasonable to suspect that those who chose not to refer their victimized children for therapy could have been less distressed by CSA. Because of the difficulty of identifying and approaching such less distressed primary caregivers, we shall never get to know the extent to which we can generalize results such as the ones in this study to the whole populace of primary caregivers facing incidents of CSA of their children.

The use of PSS and its reference norm data based on American samples poses validation concerns. Are we comparing our data with the appropriately representative data? However, in the absence of locally validated norm data, we can only work with what we have at hand. Therefore, it will remain a legitimate concern that we might be over-or-underestimating the symptomatology of CSA on primary caregivers by using this Scale and its reference data.

The need to translate the PSS into Nyanja, the lingua franca of many of the participants in this Study was inevitable. The linguistic and cultural differences between the American and Zambian samples entail confounding variables and the related reliability difficulties. One can only hope that a validated local language version will be done to improve the efficacy of research results using the PSS.

5.6. Future Research

This study was carried out in centers serving predominantly urban populations. The results of the study might reflect the psychological impact of CSA on urban primary caregivers in exclusion of rural ones. This is significant if stories that rural primary caregivers condone early marriages are believed. Would disclosure of CSA provoke a comparable nature of psychological impact on a rural primary caregiver as on an urban one? To what extent would there be a convergence of emotional responses between urban and rural primary caregivers explained by important factors such as age of the child?

The other major result of this study shows that preadolescent and adolescent (11 to 15 year old) girls constituted the core group of survivors. However, it is commonly acknowledged that permissible age for girls to get married in many traditional rural communities is much lower than the 16 years provided by law in Zambia. Going by this discrepancy between traditional and legal provisions, would a survey in rural settings produce a relatively similar or significantly different picture to the one in this report?

This study revealed evidence suggesting that some primary caregivers took a negative posture toward the child. We do not currently know the extent to which this negative posture has psychopathological effect on the child in the immediate, medium and long term. A longitudinal study to investigate the long term effect of such negative postures toward the CSA survivors could be enlightening and useful.

This study and similar others show a high probability of the appearance of negative psychological impact of CSA on primary caregivers following disclosure of CSA. If this finding can provide a valid rationale for the design and administration of therapeutic regimes for the good of the primary caregivers and their children, it would then be necessary to explore a suitable mode of psychotherapy to suit socio-demographic conditions of the target groups in Zambia. For example, one would want to investigate the efficacy of using group versus individual therapies in managing the negative symptoms of the psychological impact of CSA on primary caregivers and the related caregiving impairments experienced in the aftermath of CSA.

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7. Appendix

1: Perceived Stress Scale

2: PSS Coding

3: Semi-Structured Interview Schedule

4: Coding for Semi-Structured Schedule

5: Informed Consent Form

6: Participant Information sheet

7: Copy of Letter to Recruitment Centers: VSU, YWCA and UTH

8: Ethics Clearance Confirmation Letter

1. Perceived Stress Scale

The Perceived Stress Scale (PSS) is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situation in one's life are appraised as stressful. Items were designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. the scale also includes a number of direct queries about current levels of experienced stress. The PSS was designed for use in community samples with at least a junior high school education. The items are easy to understand, and hence are relatively free of content specific to any subpopulation group. The questions in the PSS ask about feelings and thoughts during the last month. In each case, respondents are asked how often they felt a certain way.

Evidence for Validity: Higher PSS scores were associated with (for example):

- Failure to quit smoking
- Failure among diabetics to control blood sugar levels
- Greater vulnerability to stressful life-event-elicited depressive symptoms
- More colds

Health status relationship to PSS: Cohen et al. (1998) show correlations with PSS and: Stress Measures, Self-Reported Health and Health Services Measures, Health Behavior Measures, Smoking Status, Help Seeking Behavior.

Temporal Nature: Because levels of appraised stress should be influenced by daily hassles, major events, and changes in coping resources, predictive validity of the PSS is expected to fall off rapidly after four to eight weeks.

Scoring: PSS score are obtained by reversing responses (e.g., 0 = 4, 1 = 3, 2 = 2, 3 = 1 & 4 = 0) to the four positively stated items (items 4, 5, 7, & 8) and then summing across all scale items. A short 4 items scale can be made from questions 2, 4, 5, and 10 of the PSS 10 item scale.

Norm Group: L. Harris Poll gathered information on 2,387 respondents in the U.S.

Norm Table for the PSS 10 Item Inventory

Category	N	Mean	S.D.
Gender			
Male	926	12.1	5.9
Female	1406	13.7	6.6
Age			
18-29	645	14.2	6.2
30-44	750	13.0	6.2
45-54	285	12.6	6.1
55-64	282	11.9	6.9

65 &older	296	12.0	6.3
Race			
White	1924	12.8	6.2
Hispanic	98	14.0	6.9
Black	176	14.7	7.2
Other Minority	50	14.1	5.0

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you will be asked to indicate by ticking *how often* you felt or thought a certain way.

Age---------- Gender: (Circle) **M F,** Date----------

***Key*: 0= Never, 1= Almost Never, 2= Sometimes, 3= Fairly Often, and 4= Very Often**

1. In the last month, how often have you been upset because of something that happened unexpectedly?

0	1	2	3	4

2. In the last month, how often have you felt that you were unable to control the important things in your life?

0	1	2	3	4

3. In the last month, how often have you felt nervous and "stressed"?

0	1	2	3	4

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

0	1	2	3	4

5. In the last month, how often have you felt that things were going your way?

0	1	2	3	4

6. In the last month, how often have you found that you could not cope with all the things that you had to do?

0	1	2	3	4

7. In the last month, how often have you been able to control irritations in your life?

0	1	2	3	4

8. In the last month, how often have you felt that you were on top of things?

0	1	2	3	4

9. In the last month, how often have you been angered because of things that were outside of your control?

0	1	2	3	4

10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

0	1	2	3	4

Thank you very much.

2. Data Coding procedure for PSS

Item	Entered Score	Coded Score
1.	3	3
2.	3	3
3.	2	2
4.	2	2 (reversed)
5.	1	3 (reversed)
6.	3	3
7.	0	4(reversed)
8.	2	2 (reversed)
9.	3	3
10.	3	3
Individual perceived stress score		**27**

3. Semi-Structured Interview

Guide to the Interviewer

This interview relates to the personal experiences that the respondent as a caregiver has undergone in dealing with a painful case of child sexual abuse (CSA). This calls for utmost sensitivity in the manner that this interview is handled. The respondent should be assured by you of the liberty to volunteer or withhold his/her answer(s) sought herein and every effort should be made to ensure that no hint of pressure is implied in the event that s/he feels that a certain question is intruding on his/her privacy.

There is no time limit to taking this interview; it can be suspended for good or to a future date if the respondent so wishes.

As it may be noticed, some of the questions need not be asked; the answers can be noted by the interviewer through observation. Nevertheless, they have been indicated here so as not to ignore the aspects that they relate to.

Schedule

1. Caregiver's sex/gender
2. Caregiver's age
3. Caregiver's marital status
4. Caregiver's employment status
5. Caregiver's relationship with the survivor child
6. Child's sex/gender
7. Child's age
8. Child's schooling status (answer only whether at school or not)
9. What actually happened to the child?
10. How many times do you think the act could have happened?
11. For how long does the respondent suspect the child suffered the abuse?
12. How did the respondent get to know that the abuse was/had occurring/occurred?
13. Can the respondent remember how s/he felt when s/he first knew the abuse was/had happening/happened in relation to
    - the child? and
    - the perpetrator?
14. Has this feeling since changed? In what way?
15. What action did s/he take upon knowing that CSA had occurred?
16. How did other people in the community react to the discovery of the abuse? Any specific example of this reaction?
17. How did they get to know about it?

18. Could s/he generally characterize the community reaction as supportive or upsetting?
19. Can the respondent describe any change in the child that they may remember that has taken place following or because of the abuse in terms of
    - physical illness? or
    - mood or demeanor?
20. Would they recall any peculiar change in the child that they may associate with CSA in form of:
    - acts/behavior? or
    - mood or demeanor?
21. Has there been any change in relations between the child and the respondent? In what way has this happened? Would s/he give an example?
22. What was the sex/gender of the perpetrator?
23. Did the child know the perpetrator? To what extent might they have been related?
24. Would they mind stating what aspects make this case upsetting to them?
25. How has this incident affected what they feel about themselves, the child, the perpetrator and the community?
26. What service does the respondent wish to receive for and on behalf of the child from agencies like VSU, YWCA and hospital?
27. What do they wish most for as an outcome of this case?

Thank the respondent and undertake that you will answer any question they may have, now or in future.

Wilson Zimba
Researcher

4. Coding Guide for Semi-structured Interviews

Variable	Defining criteria
1. Caregiver's Sex/Gender:	1. 1 for Male and 2 for female.
2. Caregiver's Age:	2. Age ranges: 1 for 16 to 25; 2 for 26 to 34; 3 for 35 to 44; 4 for 45 to 54; and 5 for 56 or older.
3. Caregiver's Marital Status:	3. 1 for Married, 2 for widowed; 3 for divorced and 4 for single.
4. Caregiver's Employment status:	4. 1 for Unemployed, 2 for Formally Employed, 3 for Hawker, 4 for Housemaids, 5 for Small Business, and 6 for Student
5. Perpetrator's Relationship to child survivor:	5. 1 for biological parent; 2 for step parent/partner; 3 for sibling; 4 for step sibling/cousin; 5 for uncle/aunt; 6 for neighbor/family friend; and 7 for unknown person.
6. Child's relationship with primary caregiver:	6. 1 for own biological child; 2 for step child; 3 for grandchild, neph-ew/niece/ cousin.
7. Child's sex/gender:	7. 1 for Male and 2 for Female.
8. Child's age:	8. Age ranges: 1 for 0- 5 years; 2 for 6-9 years; 3 for 10- 12 years; 4 for 13 to 14 years; 5 for 15 to 16 years.
9. School status:	9. 1 for (YES) Attending School; and 2 for (NO) Not attending school, and 3 for under school age.
10. Nature of Abuse:	10. 1 for vaginal penetration; 2 for being abduction/elopement and 3 for physical force used.
11. Number of CSA episodes before disclosure	11. 1 for once; 2 for more than once and over a few days; 3 for more than once over many weeks or months.
12. Physical symptoms	12. 1 for NO injuries sustained, 2 for Bruises sustained, 3 for Serious inju-ries with possible infections of STD/HIV, and 4 for Made pregnant

5. *Consent Form*

REC

FORM 1b

THE UNIVERSITY OF ZAMBIA
DIRECTORATE OF RESEARCH ND GRADUATE STUDIES

Telephone: 290258/

P. O. Box 32379
Fax: +260-1-290258/253937 Lusaka, Zambia
E-mail drgs@unza.zm

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

CONSENT FORM

TITLE OF RESEARCH: The Psychological Impact of Child Sexual Abuse Disclosure on Primary Caregivers

REFERENCE TO PARTICIPANT INFORMATION SHEET:

1. Make sure that you read the Information Sheet carefully, or that it has been explained to you to your satisfaction.

2. Your permission is required if tape or audio recording is being used.

3. Your participation in this research is entirely voluntary, i.e. you do not have to participate if you do not wish to.

4. Refusal to take part will involve no penalty or loss of services to which you are otherwise entitled.

5. If you decide to take part, you are still free to withdraw at any time without penalty or loss of services and without giving a reason for your withdrawal.

6. You may choose not to answer particular questions that are asked in the study. If there is anything that you would prefer not to discuss, please feel free to say so.

7. The information collected in this interview will be kept strictly confidential.

8. If you choose to participate in this research study, your signed consent is required below before I proceed with the interview with you.

VOLUNTARY CONSENT

I have read (or have had explained to me) the information about this research as contained in the Participant Information Sheet. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction.

I now consent voluntarily to be a participant in this project and understand that I have the right to end the interview at any time, and to choose not to answer particular questions that are asked in the study.

My signature below says that I am willing to participate in this research:

Participant's name (Printed): ……

Participant's signature:…… Consent Date: ……

Researcher Conducting Informed Consent (Printed): ***Wilson Zimba***

Signature of Researcher: …….. Date: ……

Signature of parent/guardian: …….. Date: ……

6. PARTICIPANT INFORMATION SHEET

DIRECTORATE OF RESEARCH AND GRADUATE STUDIES

Telephone: *290258/* *P O Box 32379*

Fax: *+260-1-290258/253937* *Lusaka, Zambia*

E-mail *Director@drgs.unza.zm*

HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

PARTICIPANT INFORMATION SHEET

TITLE OF RESEARCH: The Psychological Impact of Child Sexual Abuse on Primary Caregivers

PURPOSE OF THE STUDY: To investigate the psychological impact of child sexual abuse on primary caregivers.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT: The study will require you to answer a few oral questions on particulars of your child being sexually abused. These could be related to your age, gender, marital status, employment status; child's age, his/her gender, how the discovery was made, whether the offender was known to you and the child before you discovered what was happening; and what emotional/bodily effects showed up in the child arising from the abuse. Please note that your responses will be audio-tapped for ease of later transcribing and understanding them. We shall be grateful if you will be as honest as you can. There are no incorrect or wrong answers. Further, there is no time limit to taking this interview; it can be suspended for good or to a future date if you so wish.

The other group of questions will be in written format and you may choose whether to answer on your own or with someone reading them to you. These are very few

and short; they will merely ask you about your **feelings and thoughts** in the past **one month**. The questions are of the general nature and are free of content specific to your situation or circumstance. It is expected that the interview and the written format together will not take more two hours. Please answer the questions as you understand them.

CONFIDENTIALITY:

The information collected in this interview and questionnaire(s) will be kept strictly confidential. Further, the study shall not require you to give a name or any form of identification of self, your child or of the offender. This is to safeguard your privacy.

VOLUNTARY PARTICIPATION AND WITHDRAWAL: We would like you to know that your participation in this study is entirely voluntary, i.e. you do not have to participate if you do not wish to. If you refuse to take part, be assured that you will not be penalized or suffer any loss of services to which you are otherwise entitled.

If you do decide to take part, you are still free to withdraw at any time without penalty or loss of services and without giving a reason for your withdrawal. Nevertheless, even if you choose to participate in this exercise, you may still choose not to answer particular questions that are asked. If there is anything that you would prefer not to discuss, please feel free to say so.

RISKS AND BENEFITS: We want you to know that some of the questions may remind you of things that may make you feel uncomfortable and distressed; if necessary we can refer you to a counselor or psychologist who can help you deal with these. The information obtained through this research will be helpful in better understanding what impact child sexual abuse has on the caregiver. We may also get better informed on what particular assistance is needed for such caregivers.

INFORMED CONSENT: If you choose to participate in this research study, your signed consent is required below before I proceed with the interview with you.

CONTACTS FOR QUESTIONS (Names, addresses, phone numbers and E-mail of the following):

1. Principal Investigator: Wilson Zimba, B22 Marshlands Village, The University of Zambia, Great East Road, PO Box 32379, Lusaka, Mobile phone No. +0977 206 600; email: wilsonzimba@yahoo.com.

2. Chairperson, Humanities and Social Sciences, Research Ethics Committee, University of Zambia

3. The Director, Directorate of Research and Graduate Studies

7. Letter Seeking Research Sites

Psychology Department
School of Humanities and Social Sciences
The University of Zambia
PO Box 32379
Lusaka

July 17, 2012

The Inspector General of Police
Zambia Police Service H/Q
Lusaka

Attention:
The Director
Victim Support Unit
Zambia Police Service H/Q
Lusaka

Dear Madam
RE: Request for Permission to Carryout Research with VSU, Mr. Wilson Zimba

Allow us to introduce to you Mr. Wilson Zimba, a student in MA in Child and Adolescent Psychology Programme. He has completed the course work of the programme; in compliance with our requirements for the award of the MA degree, he is required to conduct a field study and produce a report of the findings of the study. He has chosen to carryout a study in the area of **Psychological Impact of Child Sexual Abuse on Primary Caregivers**. You will find attached a one-paged abstract outlining the details thereof. Should you deem it necessary, a full text of the research plan shall be availed to you.

We have attached an ethical undertaking to respect the rights and wishes of those wishing to participate in the study. We require that our students to strictly adhere to this ethical requirement. Besides, the study and the report will be utilized for academic purposes only and not for public consumption.

Your permission is hereby sought to allow Mr. Zimba to access to complainants of child sexual abuse for non-intrusive interviews. Attendance of one of your officers during the researcher's contacts with the complainants will be welcome.

Your cooperation will be appreciated.

Yours Faithfully

Dr. Mwiya Imasiku, PhD

8. Letter of Ethics Clearance

THE UNIVERSITY OF ZAMBIA
DEPARTMENT OF PSYCHOLOGY
P.O.BOX 32379
LUSAKA,
ZAMBIA

6th December 2012

To: The Director
Paediatric Centre of Excellence
University Teaching Hospital,
Lusaka

RE: MR. WILSON ZIMBA'S MASTERS RESEARCH PROJECT- THE PSYCHOLOGICAL IMPACT OF CHILD SEXUAL ABUSE ON PRIMARY CAREGIVERS

Mr. Wilson Zimba is a Masters student in Child and Adolescent Psychology in the Psychology Department, University of Zambia and is being supervised by me on his Masters research project. His research proposal was subject to a review by the supervisor and two others reviewers from the Department of Psychology. After satisfactorily having implemented the suggestions of the reviewers, it was submitted to the Graduate Studies Committee, School of Humanities and Social Sciences which approved his research proposal. When the proposal was submitted to the Ethics Committee, HSS, the Chairperson Dr Kapungwe advised that this process wasn't necessary, only proposals recommended for ethics review by the Graduate Studies Committee will be subject to review by the HSS Ethics Committee. The Chairperson advised the student to go ahead with data collection.

As his supervisor, I am confident that Mr. Zimba has put in measures to deal with the ethical issues arising from the study. He is fully aware of the issues of voluntary participation and informed consent and will not keep any personal identifiers of the participants he collects data from. Mr. Zimba will not have any direct contact with the sexually abused children and will not collect data from primary care givers who are undergoing prosecution. In case it is necessary, Mr. Zimba has made arrangements to refer participants to psychological services.

I hereby request you to grant him permission to collect data from your institution. If you require further clarifications, please do get in touch. Your favorable consideration will highly be appreciated.

Yours sincerely,

Dr. J. Anitha Menon
Head, Department of Psychology, University of Zambia,
Lusaka, Zambia (**Email: amenon@unza.zm, Mobile: 0977846116)**