PSYCHOLOGICAL EFFECTS ON SEXUALLY ABUSED CHILDREN IN NWFP

By
Asghar Ali Shah

A Dissertation submitted to the
Department of Psychology, University of Peshawar
in partial fulfillment of the requirement for the

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IN
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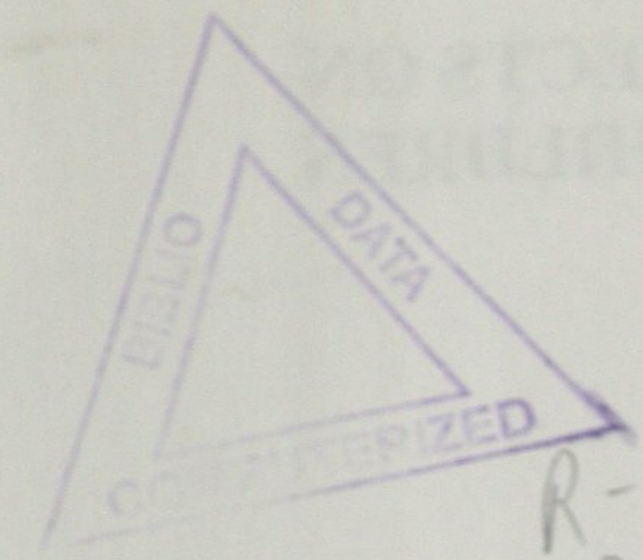
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Approval Certificate

It is certified that this dissertation titled, "PSYCHOLOGICAL EFFECTS ON SEXUALLY ABUSED CHILDREN IN NWFP" submitted by Asghar Ali Shah conform to acceptable standards, and as such in fully adequate in scope and quality. It is therefore approved as the fulfillment of the dissertation requirement for the degree of Doctor of Philosophy in Psychology.

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Contents

List of Tables		i
List of Annexure		iii
Acknowledgements		iv
Abstract		v
Chapter I	INTRODUCTION	1
	Forms of Sexual Abuse.	4
	Theories of Child Sexual Abuse	12
	Psycho-social Theory of Child Sexual Abuse.	12
	Psychoanalytic theory of Child Sexual Abuse	13
	Antecedents and Factors of Child Sexual Abuse	14
	Long-term effects on male sexual abuse.	16
Chapter II	Objectives and Research Design	31
	Objectives and Research Design	31
	Hypotheses	31
	Research Design	36

Chapter III	Method	40
	Study I	40
	Items Generation	40
	Subjective evaluation.	40
	Empirical evaluation.	41
	Results	41
Chapter IV	Main Study	44
	Method	44
	Sample	44
	Instruments	45
	Procedure	50
	Results	57
	Discussion	77
	Summary	95
Chapter V	Conclusions and Suggestions	97
References		100
Annexure		

List of Tables

		Page N0.
Table: 1	Item –total correlations of Social Functioning Scale (N=100).	42
Table: 2	Age distribution of the subjects in years (N=100)	51
Table: 3	Age distribution of victims, CSA group in years, (N=50)	52
Table: 4	Age distribution of non- abused group in years, (N=50)	53
Table: 5	Education level of subjects, N= 100	54
Table: 6	Education level of subjects, child sexual abused (CSA) group, N=50	55
Table: 7	Education level of subjects, non-abused group, N=50	56
Table: 8	Alpha reliability coefficient of three scales for total sample (N=100)	57
Table: 9	Alpha reliability coefficient of three scales for abused group (N=50)	58
Table: 10	Alpha reliability coefficient of three scales for non-abused group (N=50)	59
Table: 11	Alpha reliability coefficient of four sub scales of SPS for total sample (N=100)	60
Table: 12	Alpha reliability coefficient of four sub scales of SPS for abused group (N=50)	61
Table: 13	Alpha reliability coefficient of four sub scales of SPS for non-abused group (N=50).	62
Table: 14	Correlation of Social Functioning Scale (SFS), Salma Shah Depression Scale (SSDS) and Suicide Probability Scale (SPS), (N=100).	63
Table: 15	Inter scale correlations (N=100).	64

Table: 16 Mean score differences between abused and non-abused group on Social Functioning Scale (SFS) of subjects (N=100). 66

Table: 17 Means, Standard deviations and t-value on the Depression Scale (SSDS) of Sexually abused and Non-abused subjects (N=100) 67

Table: 18 Mean score differences between the subjects of CSA and non-abused on Total Weighted scores of Suicide Probability Scale (SPS) (N=100). 68

Table: 19 Mean score differences between the subjects of CSA and non-abused on Suicide Probability score of Suicide Probability Scale (SPS) (N=100). 69

Table: 20 Mean score differences between abused (CSA) and non-abused on sub scale Hopelessness of SPS (N=100). 70

Table: 21 Mean score differences between the victims of CSA and non-abused on Suicide Ideation, sub scale of SPS (N=100). 71

Table: 22 Mean score differences between CSA and non-abused on Negative self-evaluation, sub scale of SPS (N=100). 72

Table:23 Mean score differences between abused and non-abused on Hostility, Sub- scale of SPS (N=100). 73

Table: 24 Means, Standard Deviation and F-values on scales of sexually abused subjects, in terms of Education, Metric, Intermediate, Graduate and Post-graduate Group, (N=50). 74

Table: 25 Means, Standard Deviation and Standard Error of Mean on scales in term of their age, abuse group (n=50). 75

Table: 26 Means, Standard Deviation and t- values on scales in term of their age (N=100). 76

LIST OF ANNEXURES

Annexure A	Information Sheet (Urdu Version)
Annexure B	Social Functioning Scale (Urdu Version)
Annexure C	Salma Shah Depression Scale (Urdu Version)
Annexure D	Suicide Probability Scale
Annexure E	TAT Cards

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ABSTRACT

The purpose of the present research was to investigate the psychological effects of child sexual abuse (CSA) on adults. One hundreds male adults ranging in age eighteen to thirty years from the different cities of North Western Frontier Province, Pakistan acted as subjects. Half of them having the experience of child sexual abuse in their childhood and the remaining fifty subjects were non-victims of CSA. Social functioning, depression, suicide ideation, hopelessness, negative self-evaluation, hostility and suicide probability are the major symptoms and psychological effects investigated in the study. According to the symptoms, clinical observations, and behaviors of the victims of CSA, a scale comprising 17 items for assessment of social functioning of the subjects was device. The reliability of the scale was quite high. Salma Shah Depression Scale (SSDS 1992) was used for assessment of depression among the subjects. Suicide Probability Scale (SPS) measured suicide ideation and suicide probability. The same scales, SPS containing the subscales mentioned above, assessed hostility, hopelessness, negative self-evaluation and suicide probability . Thematic Apperception Test (TAT) measured depression and suicide ideation among the subjects.

The findings of the research indicate that there is a significant difference on depression, suicide ideation, hostility, hopelessness and suicide ideation among the victims of CSA and non-victims. Social functioning of the victims of CSA is poor as compared to non-abused adults. The findings indicate non-significant difference) on sub-scale of SPS for assessment of negative-self-evaluation of the sexual abused and non-abused groups. Non-significant differences are formulated in terms

of education and age of the subjects indicated that the age and education of the subjects did not affect the results and the intensity of psychological effects. The results demonstrated that social functioning, depression, suicide ideation, hostility, hopelessness and suicide ideation are significantly higher among the victims of CSA adults as compared to non-victims of the present sample.

INTRODUCTION

CHAPTER 1

INTRODUCTION

Child Sexual Abuse (CSA) is a phenomenon in which the child become the victim of sexual abuse by elders. In different cultures, the age of sexual abuse victims and abusers are determined differently by researchers. The victimization of CSA is also defined by different researches in many ways. There are several common definitions are found in literature and all the researchers working in this field are not agree on one definition and the age of abuser or victim. A common definition was given in literature, that, "sexual victimization" is sexual encounters of children under age thirteen with person at least five years older than themselves and encounters of children thirteen to sixteen with person at least ten years older. Some researchers broadened the definition that sexual abuse include any activity that brings gratification to the child and abuser. Other common definition is, a child (any one under sixteen years) is sexually abused when another person, who is sexually mature, involve the child in any activity which the other person expects to lead their sexual arousal. Some researchers defined sexual abuse as the involvement of dependent, developmentally immature children and adolescent in sexual activities they do not truly comprehend, to which they are unable to give informed consent or that violate the social taboos of family roles. An other working definition of child sexual abuse was provided by the Standing Committee on Sexually Abused Children (1984) that, any child below the age of consent may be deemed to have been sexually abused when a sexually mature person has by design or by neglect of their usual societal or specific responsibilities in relation to the child, engaged or permitted the engagement of that child in any activity of sexual nature which is intended to lead to the sexual gratification of the sexually mature person. Child sexual abuse is the use of a child as an object of gratification for adult sexual desires, may not usually result in physical injury but cause the victims, an enormous psychological damage including long term feelings of mistrust, poor self-image, depression, guilt, social withdrawl,

poor school performance and difficulty with sexual intimacy. Secrecy, denial, sham, guilt and principal components of child sexual abuse (Glazer, D. and Frosh, S. 1993).

Finkelhor (1984) defines sexual victimization as sexual encounters of children under age 13 with person at least 5 years old than themselves and encounter of children 13-16 years with person at least 10 years older. A child is a person under age 16, and a sexual experience is abusive if verbal threats were used and the person feels negatively about the experience. A child is a person under 14 years old, and sexual abuse must involve physical force. Baker and Duncan (1985) define child any one under 16 years is sexually abused when an other person, who is sexually mature in any activity which the other person expects to lead to their sexual arousal. Schechter and Roberg (1976) define child sexual abuse as, the involvement of dependent, developmentally immature children and adolescent in sexual activities they do not truly comprehend, to which they are unable to give informed consent, or that violate the social taboos of family roles. Collings (1995) defined sexual abuse as unwanted sexual experiences taking place before the age of 18 years. He found that 29% of the 284 male respondents had been sexually abused, with 20% reporting non-contact abuse and 6% reporting abuse experiences involving physical contact.

Child sexual abuse is any sexual contact between a child and another person from fondling to rape, with or without force. It is a heinous crime and has a direct and potentially permanent impact on the victim's self-esteem. Few victims enter adulthood without symptoms of the crime perpetrated against them as children. Incest is another form of child sexual abuse in which sexual intercourse is occurred between blood relatives and it is illegal to marry because of a close relationship. Incest is the imposition of sexually inappropriate acts with sexual overtones by one or more persons who derive authority through on going emotional bonding with the child. Using of authority or power mostly done by immediate family members, baby sitters, school teachers, scout masters, ministers and extended family members. Courtois (1988) recognized that incest between an adult and a related child or adolescent is the most prevalent form of child sexual abuse, damaging to the child.

Browne and finkelhor (1986) concluded that approximately 40% of all victims of sexual abuse suffer after effects seriously that include inability to trust, fear of intimacy, depression, suicidal ideation, guilt, anger, isolation and alienation from others, drug and alcohol dependency and eating disorders. Brier (1988) discussed about the psychiatric labels used for victims of child sexual abuse. He suggests that the psychological disturbances experienced by sexually abused be considered post sexual abuse trauma, leads to some symptomatic behaviors adopted initially by victims of child sexual abuse (CSA) that affects the personality development process.

Children are easily manipulated or bribed by an adult. Therefore, force is rarely required by the perpetrator of child sexual assault except where the assault comes from a stranger. Surprisingly, most cases of child sexual assault come from a person known to the victim. Pedophile (a person who prefers sexual activity with a child) instruct their victims not to tell or insist that what they are doing is normal but a secret. Some child sexual abusers are other children (about one in six). Abusers can be homosexual or heterosexual in their daily life. Children almost never invent stories of sexual abuse. Children don't play games with something as serious as this nor do they have the knowledge to invent details of this type of assault. Most offenders are male and they come from the poor and wealthy backgrounds. It could be a professional or a homeless person. There is no typical socio-economic or intelligence profile for a pedophile. Most child abuse occurs in either the victim or the offender's home. It typically starts with touching and may evolve to intercourse. In many cases, the abuse grows over a period of time as the offender exercises greater control over the victim.

Child molestation is no longer a secret or something that can only happen to other people. It crosses all socio-economic levels. Sex offenders come in all shapes and sizes, from any part of society and can be of any sexual preference. The chance is great, that the victim knows the offender. Child sexual abuse (CSA) occurs, when sexual activity such as exposure of genitalia, fondling, intercourse, oral sex, or pornography (exposure to or involvement in) is enacted by a person who holds power over the event. The power difference eliminates consent.

Forms of Sexual Abuse.

Traditionally, sexual abuse of children was considered either incest or pedophilia. Now, it is viewed as being on a continuum. While some incestuous men have sex only with their own children, according to one study, at least 44%, abuse children outside the home during the time they are having sexual contact with their own children, and other men have sex with children they aren't related to. Characteristics that offenders have in common are, dependent, inadequate individuals with early family histories characterized by conflict, disruption, abandonment, abuse and exploitation. (Encyclopedia of Social Work, 1987). Not all offenders are men. While some offenders were sexually abused as children, they still need to be held accountable for their abuse of children and receive sex offender treatment.

Following are the major types of CSA.

Voyeurism.

In this form the abuser feels sexual pleasure by watching children naked.

Exhibitionism.

The abuser exposed his genitals to children and feel pleasure.

Pornography.

Exposing a child to naked photographs.

Kissing.

Touching a child with sexual intent.

Fondling.

Touching of breasts and genitals of the child with love. Forcing a child to fondle the abuser's genitals.

Masturbation.

Masturbate with the child as either participant or observer.

Oral sex.

Putting penis in the mouth or enforcing child for sucking penis.

Intercourse.

Anal or vaginal penetration by penis, finger or any other object.

Prostitution. Using a child for sexual activities to others.

Six forms of sexual crimes have been identified to record information. These include murder after sexual assault, gang rape and gang sodomy, rape, sodomy, abduction for sexual purposes and molestation.

Sahil (an NGO) has conducted a secondary study from 1997-2000 gleaning reports from 11 national and 4 Sindhi newspapers. They categorized their information. A quantitative module was developed to record the data. This module helped in recording age of the child victims, information on the nature of the sexual crime, separate information on gender vis-à-vis a particular crime, identification of the abuser, place of the crime, provincial distribution of the crime, and finally the urban rural divide.

Rozen (1999), an NGO has conducted a study on children in Pakistan by asking them to write letters to an organization, regarding the issue of child sexual abuse. The analysis of these letters indicated that the abusers were sexually abused when they were children. Among these respondents, ten percent were abusers of children and three percent were sexually abused in their childhood. Acting out was the defense mechanism adopted by these sexually abused children for dealing with anger, humiliation and feeling of helplessness.

These are some of the most important methodological issues in research conducted on adults to estimate prevalence rates of child sexual abuse. Keeping these

issues in mind, and the built-in biases of certain methods any research study, even one with the most effective methodology, is likely to underestimate the actual prevalence of sexual abuse in the population being investigated. There is evidence emerging that as many as one in three incidents of child sexual abuse are not remembered by adults who experienced them, and that the younger the child was at the time of the abuse, and the closer the relationship to the abuser, the more likely one is not to remember.

One girl in four is sexually abused before the age of 18 years. For boys, the odds are one in eight. The average age of child sexual abuse is eleven years, although some psychopaths have been known to strike upon children much younger. It is estimated that 90% of the cases are not reported in Pakistan and the problem of child sexual abuse is wide spread. In fact it is widely believed that the number of abuse cases are steadily increasing. According to a survey carried out in 1996 of boys in grades nine and ten, 70% had been abused at some point in their life, (The Nation Daily, June 4, 1998).

Mezy and King (1992) found that incidence measures of non-consensual sex amongst adult males in the general population have to been calculated 3% in the United Kingdom. Offenders have personality disorders and they are dependent, inadequate individuals with early family histories characterized by conflict, disruption, abandonment, abuse and exploitation.

Studies conducted by NGOs in year 2000, the abusers are categorized with their existing incidents of child sexual abuse in Pakistan. Out of 957 abusers, 739 were acquaintance, 109 were strangers, 38 were police, 24 female abettors, 17 relatives, 13 next-door neighbor, 6 were incest and four each were teachers and maulvis. The data revealed about the age of the victims sexually abused during this period. Out of 324 female children, 7 girls were below the age of five years. Thirty-eight girls were below the age of 10 years and 124 were below the age of 15 years. Out of 324 female victims, 155 were below the age of 18 years. In this study, out of 155 male victims of CSA, six were under five years. Twenty-eight male victims were under 10 years, 93 were under age of 15 years and 24 were below the age of 18 years. These children were victimized at different places and the data shows that out of 475 cases of CSA, 161 were happened at

acquaintance's places, 145 at unknown places and 99 at victim's home. Thirty-two cases were took place at fields, 19 at streets, 7 at mosque, 3 each at shop, park and friend's house. Only one case were took place at hotel.

Out of 475 cases of CSA reported in Pakistan (2000), 260 cases were reported from urban areas and 215 from rural areas. One hundreds and seventy-eight cases were reported from urban area and 161 were from rural area of the Punjab province (Total 339). Forty-seven cases were reported from the urban area of the province Sindh and 53 from rural area of the same province. Twenty-seven cases from urban area and one case from rural area were registered in NWFP. Only eight cases were reported from the urban area of the province Baluchistan. Two hundreds and sixty-five female and 117 male were sexually abused only once upon a time out of 475 reported cases. Fourteen female and 7 male were abused for one day or less, 21 female and 22 male for one week or less, 22 female and 5 male for six months or less and two female were victimized for more than six months of the sample.

Fromuth and Burkhart (1987) have conducted a study on students in two separate schools and found higher prevalence rates of 20% and 24%. They compared the effect of different definitions of sexual abuse on prevalence rates. The highest rates of 20% and 24% came from the most inclusive definition: the same as Finkelhor's 1979 study (including non-contact and age differential criteria), but with the addition that sexual contact between peers involving force or threat was categorized as abuse. Fritz, Stoll and Wagner (1981) have conducted a study on male college students and found prevalence rates from 4.8% to 28%. At the lower extreme of 4.8%, in which 412 students responded to a self-report questionnaire that required them to label their experiences as abusive. Risin and Koss (1987) obtained a rate of 7.3% in a national sample of 2,972 male college students. They used eight self-report behavioral descriptions about sexual behaviors before age 14 years. As pure behavioral descriptions, none of the items included the word "abuse." Finkelhor (1979) used a similar list of behavioral self-report items in a study of 266 college students and found 8.3% prevalence rate. He included non-contact experiences and used specific age criteria (if under 14 years there had to be a 5 year age difference with the perpetrator, if 14-15, a 10 year difference).

Non-contact experiences (e.g., a relative exposing her or his genitals to a child) were investigated because such acts are sexually exploitive and can have negative long-term psychological and interpersonal effects. However, this definition also includes experiences, like a single, flashing episode involving a stranger, that many would argue are not abusive because the subject suffered no significant or lasting harm, if any at all.

Lisak and Luster (1994) and Lisak, Hopper, and Song (1996) deliberately chose to weight their definition of sexual abuse in terms of the power differential accompanying significant age differences and the older person's presumed deliberate sexual use and exploitation of the younger subject. So long as significant differences in age and power existed, they defined incidents as abusive, regardless of subject's emotional appraisal or lasting effects. Lisak and his colleagues (1994, 1996) used an anonymous questionnaire that has 17 behavioral descriptions of possible experiences and an 18th item for other experiences, subjects describe. If subjects endorsed an item, they were then directed to provide further information about the experience, which was used to categorize the experience as abusive or not. If the subject was age 13 or younger when the incident occurred and the other person was at least 5 years older, the incident was classified as sexually abusive. If the subject was age 13 or younger when the incident occurred and the other person was less than 5 years older, two criteria had to be met for the incident to be classified as abusive. Firstly, the subject reported negative feelings about it and secondly reported that the other person used some degree of coercion. Similar principles apply to incidents occurring when the subject was age 14-15 years: the incident was classified as abusive if the other person was at least 10 years older. If the other person was less than 10 years older, the other person assigned the abuse classification only if the subject reported feeling negative about it and reported some level of coercion. Lisak and his colleagues (1994, 1996) have conducted a research on college students having an average age of 25 years, and average socioeconomic background more typical of the surrounding community from where many college student populations used in this research. They found approximately 17% for child sexual abuse of males involving physical contact and over 25% when non-contact forms of abuse were included.

Finkelhor (1979) reported that the boys have different experiences from girls. They are primarily homosexual and they less often involve family members. However, boys do seem to be victims of force and coercion just as often as girls. Both girls and boys report that in over half the incidents some form of coercion was used.

The print media reported a total of 4078 men who have sexually assaulted 2309 children in Pakistan during the year 2000. These numbers do not represent the total number of such incidents in Pakistan, because ours is a closed society, where such issues are taboo and any discussion on these is labeled as immoral. Moreover, since sexual abuse is always linked with family honor, most cases go unreported to the police and subsequently newspapers. Resultantly, any attempt to quantify the issue of child sexual abuse is bound to be limited in scope. Regardless of some limitations, the statistics do provide us with some insight into the nature and prevalence of this crime. The society in Pakistan is generally reluctant to talk about the subject either because of its sensitivity or the belief that it does not exist. The fact is that the problem of sexual abuse does exist. People know about it and have also been victim of it, yet continue to be reluctant to discuss it.

This reluctance and taboo discourages children from seeking proper guidance and assistance and the victims continue to live a life of guilt, shame and fear. The children continue to suffer because of the attitude that is adopted by the adults in this country. It is estimated that more than 90% cases are not reported in Pakistan. According to a survey on boys in grades nine and ten, 70% has been abused at some point in their life, (Anwar, 2001).

Media has started to highlight the issue but the method remains sensation. Sahil, an NGO found that despite a Supreme Court of Pakistan ruling of May 22, 1997 banning the identification of the victims and percentage while reporting rape cases, most reporters identified the victims and extensively described the case putting the victims in an embarrassing situation. According to a study of ten national newspapers carried out by Sahil (an NGO) since the day of the judgment till March 31, 1998, 304 cases of child

sexual abuse were reported in an undesired manner, by revealing names and printing pictures of the victims.

It was reported by Sahil that almost 500 children were sexually assaulted in Pakistan in 1997.These are the cases that have been reported in the various national newspapers. Sahil found that the victims knew 80% of the abusers. Half of the victims were females between the ages of 10 to 15 years while 48% of the boys were below the age of ten years. Sahil (an NGO) reported that during the year 1998, 1,601 men abused 848 children. From this total 1,216 were acquaintances or relatives, according to a report, 69 of the children were killed, 55% of the victims were boys, (The Frontier Post,1999).

Aurat Foundation (an NGO) has conducted a survey in the first half of 1998, over 400 children were molested while 884 pedophiles were involved in molestation. Out of the total number of pedophiles, 665 were relatives. In the first quarter of 1999, a total of 219 children were victims of 385 male abusers. Out of this, 59% were female which is a change in the trend from last year,249 of the abusers were either acquaintances or relatives of the victims, (The Dawn, May 1999).

Although male children are regularly subjected to sexual assault but their number is still significantly low as compared to female children in the first two years, but in 1999, 44% of the total victims were male children. Out of the total 2309 child victims, 1495 (65 percent) were female children and 814 (35 percent) were male children during the period of three years. This could be due to the fact that the female gender is seen as a sex object, as more vulnerable and resultantly one that can be taken advantage of more easily. Simultaneously, the female gender is also dishonored by men as a means to settle outstanding scores with rivals. The print media has reported numerous incidents of rape and gang rape where men have raped girls for this very reason.

Urquiza and Keating, 1990 reported that telephone interview also demonstrate the profound effects of single questions including the word abuse, rather than instruments with multiple behavioral descriptions on two random samples. In one study the former method was employed, and it produced a rate of 2.8% with a sample of 357; in the other study the latter method yielded a prevalence rate of 11% with a sample of 777.

Bagley, Wood and Young (1994) conducted a community study of men aged 18 to 27 in the Canadian city of Calgary. They first contacted subjects by telephone, then administered anonymous questionnaires in their homes via programs on portable computers. Their questionnaire asked about unwanted experiences before the age of 17 years. This wording is likely to result in under-reporting because people who have been sexually abused, but especially males, are sometimes convinced that they wanted and were responsible for the sexual contact. Bagley and his colleagues (1994) found a prevalence rate of 15.5%, and that 6.9% of their subjects had experienced multiple episodes of sexual abuse. This rate for multiple episodes was identical to that found for women in a previous study that employed the same methodology, despite the fact that the prevalence rate for any unwanted sexual experiences in that study was 32%, or double that found for males (Bagley, 1991).

The highest community-sample prevalence rate of 16% was found in a random telephone survey of 2,626 men, known as the "L.A. Times survey" (Finkelhor, 1990). These findings are very difficult to interpret, since the wording of the questions would be expected to produce contradictory effects. Each question used the word abuse, but ended with the phrase, or anything like that. Urquiza and Keating (1990) found very low prevalence rate among male in contrast to studies with women, using face-to-face interviews with men, perhaps due to subjects' adherence to stereotypes about males not being victims. Finkelhor's (1984) found the prevalence rate of 6% during face-to-face interview with Boston-area fathers in an other study. Siegel and colleagues (1987), found a prevalence rate of 3.8% using gate-question interviews with 1,480 Los Angeles-area men. Baker and Duncan (1985) used a single question that described various sexual acts and found the highest face-to-face prevalence rate of 8% in their random sample of 970 men in Great Britain. Belkin, Greene, Rodrique, & Boggs (1994) have obtained prevalence rates from 3% to 23% with clinical samples. Ellerstein and Canavan (1980) found an 11% prevalence rate, the lowest rate from a study that used psychological records of 954 male and female patients of a large regional medical center in a chart review of emergency room records of a Buffalo, New York hospital.

DeJong, Emmett, and Hervada (1982) reviewed several clinical studies and found rates from 11% to 17%, and in their own hospital population found a rate of just under 14%. Metcalfe and his associates (1990) found a prevalence of 23% in their survey of 100 male psychiatric inpatients.

Theories of Child Sexual Abuse.

Child sexual abuse (CSA) is viewed as a social phenomenon related to general attitudes and practices towards children and to the ways sexual relationships are organized and regulated in any particular society. For clinical assessment and rehabilitation purposes of victims of CSA, micro social features particularly the psychosocial factors of abuses and interpersonal networks in which abuse occurs are important element. To understand this issue, it is also important to focus on the sexuality of men, children and family processes that make abuse more likely to occur. It is also important to distinguish between the immediate cause of sexual abuse that emphasized on the psychological factors of the abuser and the constellation of relationships, social management and values that make particular children more or less likely to be victimized.

Psycho-social theory of Child Sexual Abuse.

Finkelhor (1984) describes four preconditions model of sexual abuse that distinguishes between the motivation to sexual abuse and three inhibiting factors that have to be overcome before abuse actually occurs. Motivation is related to the abuser's sexuality, either internal to an individual or at the level of socio-cultural values. The factor motivation is concerned with the arousal of sexual desires towards children of abusers and the socio-cultural factors related to values are the male tendencies to sexualize all emotional needs.

There are three inhibiting factors related to internal and external inhibitions and if these are not properly controlled and managed, the chances of sexual abuse may increase in rate and the prevention of child sexual abuse is poor in any society and culture. The internal inhibition is controlled by moral values of the abusers and external inhibition is manipulated by others in the form of supervision and the resistance by the children. Finkelhor (1984) suggested many factors that affect these inhibitions and become the cause of child sexual abuse. Internal inhibition may be overcome by alcohol, drug addiction, cognitive distortions and other psychopathological tendencies. External inhibitions can be affected due to the illness of the mothers, loose supervision of parents and availability of children. Children's personal vulnerability due to emotional insecurity, isolation or age can also loose inhibition. According to these theoretical foundations, masculine sexuality and abusiveness are interlinked with each other and the abuser is responsible for a specific act of CSA when it occurs.

Psychoanalytic theory of Child Sexual Abuse

Masson (1984) reported that seduction theory of neurosis beginning by Sigmund Freud explained hysteria as the result of real childhood sexual victimization. In theory of fantasy, memories of victimization were interpreted as wishes of the patients. If the genuineness of the abuse was impossible to ignore, it was seen as to provoke by the child- a spilling over of unconscious desires into real life.

Psychoanalysis has contributed in supported the victims of CSA for prohibition by minimizing their vulnerability towards continuity of abuses other children. It helped the victims through therapeutic process, decreased feelings of guilt, distress and confusion and reconstruction of cognition that indirectly provide support for preventing the act of abuse in future.

Freud (1896) was the first to recognize the connection between adult survivors' mental health problems and the past histories of child sexual abuse. This led to his seduction theory. After much uproar by his contemporaries (many of whom were

implicated as perpetrators), Freud denounced the seduction theory and replaced it with the oedipal theory. The oedipal theory viewed incestuous accounts by victims as mere sexual fantasies (Russell, 1986).

Antecedents and Factors of Child Sexual Abuse

Some people refer important human conditions that are considered as an important issue for child sexual abuse. These issues include that all human beings suffer painful experiences, and some of these occur in childhood. All caregivers of children are sometimes unable to protect them from painful experiences. To deal with the effects of painful experiences we all need love and support for coping with emotions.

Many coping or self-regulation strategies work in ignoring painful feelings may reduce one's conscious experience of them. But it also prevents one from learning how to manage them in smaller doses, let alone larger ones - which makes one vulnerable to alternating between feeling little or no emotions and being overwhelmed and unable to cope with them. Another form of coping mechanism is avoiding getting close to people and trying to hide all of one's pain and vulnerabilities may create a sense of safety. But this approach to relationships leads to a great deal of loneliness, prevents experiences and learning about developing true intimacy and trust, and makes one vulnerable to desperately and naively putting trust in the wrong people and being betrayed again.

At the extreme, getting really drunk can block out painful memories and feelings, including the feeling of being disconnected from others cause lots of other problems and disconnections from people. Some people suffer more painful experiences than others, and abuse is one of many possible causes of extreme emotional pain as compared to other severe psychosocial stresses of life. Some people get more love and support from their families and friends than others, and families in which abuse occurs tend to provide less of the love and support needed to recover from abuse. But families in which abuse does not happen can also experience significant problems, and can make it hard for family members to deal with the inevitable painful experiences in life.

We have learned from many people's experiences and a great deal of research that the effects of abuse and neglect depend on a variety of factors. These effects are grouped into those which research has shown to influence negative outcomes, and a variety of other factors that are harder to measure for research purposes or may be very important for some people but not others. These factors include age of the child when the abuse happened. Younger is usually more damaging, but different effects are associated with different developmental periods. Other factor is, who committed the abuse. Effects are generally worse when it was a parent, step parent or trusted adult than a stranger. This is also important factor that whether the child told anyone, and if so, the person's response. Doubting, ignoring, blaming and shaming responses can be extremely damaging than the abuse itself. Whether or not violence was involved, and if so, how severe and how long the abuse went on.

Additional factors that are difficult to research or may differ in significance for different people are deliberately involvement of abuse, how normal such abuse was in the extended family and local culture. Whether the child had loving family members, or knew that someone loved her or him, whether the child had some good relationships with siblings, friends, teachers, coaches, etc and whether the child had relationships in which negative feelings were acceptable, and could be expressed and managed safely and constructively.

A great deal of research has been conducted, and continues to be conducted, on how such factors determine outcomes for those abused in childhood. Factors that increase the likelihood of negative outcomes have been referred to as risk factors, and ones that decrease the likelihood of negative outcomes as protective factors. Every person who has experienced abuse is unique. And every person who has experienced abuse has a unique combination of risk and protective factors that have influenced, and continue to influence, the effects in his or her life.

The children exhibit some behaviors and symptoms who were the victims of sexual abuse. Ebrahim and Zofeen (1999) found the behavior and symptoms like hyperactivity, depression, change in sleeping and eating habits, difficulty at bath and bed

time, regression in behaviors and self-destructive behaviors. They also exhibits behaviors like talking non-sense, moodiness, increase in accidents, bad dreams, social difficulties, fall behind in school, play violently with dolls, hurts animals and lies. Sexually abused children have unaccountable fears, loss of trust and care, shattering of self-image/esteem, losses of control over body, losses of childhood opportunity to play and normal attitude of loving and nurturing and fragmented personality. They have fear of separation and being alone, difficulty in sleeping and nightmares, with-drawl or isolation, infant-like behaviors, sudden changes in mood and aggression. They are prone to motivate in drug addiction and suicidal tendencies. They exhibit difficulty in walking and sitting, unexplained pain in the genital area, itching, soreness, discharge or unexplained bleeding in the genital or anal area, recurrent urinary tract infections and sexually transmitted diseases. The greater the duration and frequency of sexual child abuse, the more harmful of its effects, and in extreme cases the abused child becomes suicidal.

Long-term effects on male sexual abuse.

Child sexual abuse has both immediate and long-term effects, not only on the individual but also on the family and community. These effects are physical, emotional and behavioral. They have inability to trust, fear of intimacy, depression, suicidal ideation, self and other destructive behaviors, low self-esteem, guilt anger, isolation and alienation from others, drug and alcohol dependency and eating disorders. They also have problems like inability to sustain or enter intimate relationships, inability to function sexually, marital problems, vulnerability to further abuse and exploitation, prostitution and the risk of becoming an abuser.

MacMillan, H. L., Fleming, J. E., Streiner, D. L., Lin, E., Boyle, M. H., Jamieson, E., *et al.* (2001) have conducted a long-term study on the victims of sexual and physical abused. They found that the sexually abused adults have psychiatric disorders in their adulthood. Studies have found that sexual and physical abuse to be associated with the experience of generalized pain, a symptom of anxiety, (Green, Flowe-Valencia, Rosenblum, and Tait, 2001; Kendall-Tackett, 2001), Pelvic pain (Lampe, A., Doering,

S., Rumpold, G.m, Soelder, E., Krismer, M., Kantner-Rumplmair, W., *et al* (2003), and obesity, (Williamson, Thompson, Anda, Deitz, and Felitti, 2002). Golding (2003) consistently found a relationship between life time sexual abuse and measure of overall health. Childhood sexual abuse has also been found to be associated with chronic fatigue, asthma, and heart problems (Romans, Martin, Morris, and Raffi, 2002).

Kendler, K, S., Bulik, C, M., Silberd, J., Hettema, J. M,m Myers, J., and Prescott, C. A. (2000) investigated that psychiatric problems are consistently found to be higher among individuals who experienced abuse. Molnar, B. E., Buka, S. L., and Kessler, R. C. (2001) found high rates of psychiatric disorders associated with childhood aversive experiences including sexual and physical abuse. Kendall-Tackett (2002) argued that health problems among the victims of child abuse lead to an increase vulnerability to psychiatric disorders. These psychological problems may include low self-esteem, poor coping skills, disturb self-identity, poor interpersonal skills and increased vulnerability to stress (Becker-Lausen and Mallon-Kraft, 1997; Romans et al., 2002). Golding, Wilsnack, and Cooper, (2002) have conducted a study on the social aspect of the personality of the victims of CSA. They argued that the individuals with a history of sexual abuse were found to have less contact with and to have received less support from friends and family. This factor leads to poor social functioning of the victims of CSA in their adulthood life.

Researchers among the victims of CSA also found some neurological problems. Heim and Nemeroff, (2002) and Kendall-Tacket, (2000) reported that the early abused experiences may affect the developing brain of young children. This may cause chronic hyper-arousal that may lead individuals to become more vulnerable to stress. Vulnerability to stress may be a diathesis for both psychiatric and health problems. It was found that increased activity in hypothalamic-pituitary-adrenal axes has been shown to suppress immune functioning (Altemus, Cloitre, and Dhabhar, 2003). Depression has also been shown to be associated with impaired immune functioning, with increased cytokine secretion and deregulation of cortisole implicated as mechanism by which the immune system may be suppressed (Connor and Leonard, 1998; Maes, Bosmans, and Meltzer, 1995; Raison and Miller, 2003). Several other studies have found an additive effect of

abuse experiences in predicting the severity of negative health outcomes, (Golding *et* al 1997, Kessler, Davis and Kendler, 1997). Walker, Gelfand, Katon, Koss, Van Korff, Bernstein, and Russon, (1999) found that physical, sexual and emotional abuse experiences has additive effects on the number of distressing physical symptoms.

Lisak (1994) reported the following symptoms of the victims of CSA. These are anger, fear, homosexuality issues, helplessness, isolation, legitimacy, loss, masculinity issues, negative childhood peer relations, negative schemas about people and self, problems with sexuality, self-blame, shame, guilt and humiliation.

Some researchers used standardized measures and found different combinations of the symptoms. Lew (1988), Myers (1989) and Hunter (1990) found guilt and self-blame among the victims of CSA adults. Lew (1988) and Myers (1989) studied the long term effects of victimization of CSA on adults and found low self-esteem and negative self-image. Bruckner and Johnson, (1987), Dimock, (1988), Lew, (1988), Krug, (1989) and Hunter, (1990) reported that the victims of CSA adults have problems with intimacy. Bruckner & Johnson, (1987), Johnson and Shrier (1987), Dimock, (1988), Lew, (1988), Myers (1989) and Hunter, (1990) found sexual problems compulsions or dysfunctions among the adults having the experience of CSA in their childhood. Krug, (1989) found depression and substance abuse among the adults suffered in the trauma of CSA. Myers (1989) describe the symptoms of post-traumatic stress disorders studied as lasting effect of CSA on adults.

Some of the long-term effects of sexual abuse are related to the development of gender identity. A number of clinician's case studies indicate that male survivors of childhood sexual abuse may experience attempts to prove their masculinity by having multiple female sexual partners, sexually victimizing others, or engaging in dangerous or violent behaviors, (Bruckner & Johnson, 1987, and Lew, 1988). Nasjleti, (1980), Bruckner & Johnson, (1987), Johnson & Shrier, (1987), Dimock, (1988), Lew, (1988), Myers, (1989), and Gilgun & Reiser, (1990) studied the lasting effects of CSA on adults and found confusion over their gender and sexual identities. Dimock, (1988), Lew, (1988), Myers, (1989), and Pierce & Pierce, (1985) found that the victims of CSA have

sense of being inadequate as men. Myers, (1989) also found resembling results that the victims of CSA have sense of lost power, control, and confidence in their manhood.

Suicidal ideation and behavior and dissociative disorders have been reported in victims of sexual abuse. These responses appear to be closely associated with a history of sexual abuse and with the severity of sexual trauma. Several authors have been reported a higher rate of suicidal ideation and attempts in sexual abuse victims, compared with non-abused populations (Briere; 1988; Briere &Runtz, 1986, 1988b; Conte, 1988; Edwall, Hoffmann, & Harrison, 1989). Suicide attempts occurred in a higher percentage of sex abuse cases involving incest or incest plus abuse by others than in cases of extra familial abuse or cases with no sexual abuse history. Victims of incest reported the higher percentage of suicide attempts only. Briere (1988) found a strong relationship between the occurrence of intercourse in an abuse history and subsequent suicide ideation. Traumatic sexual abuse appears to increase substantially the probability of escape through suicidal ideation and behavior.

Aggression and related externalizing behaviors have been suggested as outcome of sexual abuse, (Browne & Finkelore, 1986; Conte, 1988). They also found depression as the most common symptom noted in clinical reports on adults who were sexually victimized in childhood. Associated features of depression, includes feelings of helplessness (Agosta and Loring, 1988; Donaldson & Gardner, 1985), negative self-concept and poor self-esteem (Gelinas, 1988), significant self-blame (Goodman & Nowak-Scibelli, 1985) and guilt feeling (Haller and Alter-Reid, 1986; Herman and Schatzow, 1984) also have been noted in clinical population.

The most striking difficulties of adults who were sexually abused are associated with their interpersonal relationships (Tsai and Wagner, 1978; Van Buskirk and Cole, 1983). Such difficulties tend to occur in all type of relationships, including marital and other intimate relationships, parental, and friendships (Deighton and Mcpeek, 1985). Kelly, MacDonald, & Waterman, (1987) found that men who were sexually abused in their childhood indicated a significant problems including emotional reaction (e.g., depression and anxiety), negative self-perception, self-destructive behavior, dissociation,

interpersonal problems, and problems with social functioning. Common difficulties that were reported in these men were dissatisfaction with sexual relationships (67%), feelings of isolation (88%), and depression (88%).

Sheldrich (1991) noted that depression is the symptom most commonly reported among adults who were sexually abused as children. Depression is most common symptom noted in clinical reports on adults who were sexually abused in their early childhood (Browne and Finkhlore 1986). Johanek (1988) found depression in male victims of child sexual abuse (CSA) common. Agosta and Loring (1988) found associated feature of depression including feelings of helplessness among the adults who were the victims of CSA. Donaldson and Gardner (1985) also indicated depression and feelings of helplessness among the adults having experience of CSA in their childhood. Gelinas and Steel (1988), and Alenxander (1981) found negative self-concept and poor self-esteem among the victims of CSA adults. Goodman and Nowak-Scibelli (1985) and Jehu (1988) said that the victims of CSA have significant self-blame as symptoms of long- term effects of victimization of CSA as an adults.

Goodman and Nowak-Scibelli (1985) and Jehu (1988) concluded that the victims of CSA have significant self-blame as a symptom of long-term effects of victimization of CSA. Haller and Alter-Reid (1986) and Herman and Shatzow (1984) found guilt feelings among the victims of CSA as adults in a clinical population. Briere, Evans, Runtz, & Wall, (1988) studied on out patient sample and found that male and female victims reported significantly greater levels of depression than non-abused adults. Bagley and Ramsey (1986), Brier and Runtz (1988a) and Sedney and Brooks (1984) have conducted some empirical studies on non-clinical samples and supported the previous clinical observations that victims of CSA have significant problems with depression. Alexander and Lupfer (1987) found poor self-esteem among the victims of CSA adults.

Several community studies of adults who were sexually abused as children have assessed psychiatric diagnoses using criteria outlines in the Diagnostic and Statistical Manual (DSM-III; American Psychiatric Association, 1980). Endicott and Spitzer (1979)

examined the impact of contact (involved intentional and unambiguous sexual behavior of physical nature) and non-contact (verbal solicitation of a sexual nature) abuse in comparison to non-victims. The prevalence of major depressive episodes diagnosed since age 18 years was significantly greater in victims of contact abuse (85%) than in victims of no contact abuse (59%) or non-victims (66%). Victims of contact abuse reported a greater total number of major depressive episodes than victims of non-contact abuse or non-victims. These results suggest that the impact of abuse in terms of depressive symptoms may relate to the degree of intrusiveness of the sexual behavior. Victims of childhood rape had a 75% greater risk and victims of molestation had a 65% greater risk than non-victims for having a life-time prevalence of major depression. Victims of childhood molestation and victims of non-contact sexual abuse in childhood were three times more likely to have a major depressive episode at the time of interview than were non-victims. These studies provide support for the notion that the increased sexual intrusiveness of the abuse related to increased problem with depression. Contact abuse was associated with greater life time prevalence of major depression, less intrusive types of abuse were associated with current major depression.

Stein, Golding, Seigel, Burnam& Sorenson, (1988) provides information about the relationship between demographic variables and the psychosocial effects of CSA. In general, victims of CSA had a higher prevalence of major depressive disorder (18.6%) than did non-victims (4.7%). A multivariate logistic regression model that examine the influence of adult sexual victimization, both adults and child sexual assault, gender, age, ethnicity and education on the rates of psychiatric disorder yielded results indicating that CSA continued to be associated with both life time and current incident of major depressive disorder even after the effects of demographic variables were controlled for. This suggests that CSA places an individual at significant risk for developing depression regardless of demographic characteristics.

Paykel (1974) has noted that depression usually occurs due to one of the following environmental events (1) interpersonal losses (2) threatening events or (3) blows to self-esteem. Some theorists agreed that all these three events develop depression

among the victims of CSA. According to psychoanalytic perspective the loss and ambivalence are included in the etiology of depression (Freud 1917/1950). Goodman and Nowak-Scibelli (1985) suggest that the view may be useful in understanding the depression of adult victims because they experience many losses in their lives that may affect the development of depression. Finkelhor and Browne (1985) suggest that betrayal inherent in abuse perpetrated by a trusted adult reflects a loss of significant proportion and may result in a type of grief reaction. In cases of interfamilial abuse, victims are deprived of a caring and nurturing relationship with one or both of their parents. Dynamics within a family in which sexual abuse occurs reflect the loss of appropriate childhood experiences. Gold (1986) and Seligman (1971) discuss a second theoretical perspective that may account for depression in abuse victims is, the learned helplessness model. This view suggests that depression occurs as a result of exposure to unpredictable, unavoidable aversive stimulation from which there is no possibility of escape.

Finkelhor and Browne (1985) and Summit (1983) argued that the power inequality inherent in an adult child relationship characterizes the CSA experience and leaves the child with strong feelings of helplessness, inability to avoid, escape control or stop the abuse from occurring. These experiences may alter individual's beliefs regarding their ability to control themselves in other situations and victims often feel that they are powerless to affect the world around them (McCann, Pearlman, Sakkein and Abrahamson 1988). Finkelhor (1988) suggests that the sense of powerlessness may have the effects of decreasing the individual's sense of self-efficacy and compromised coping abilities are viewed as pervasive and contributing to the depressive experience of victims.

The sense of helplessness may be a function of entrapment strategies utilized by the offender to gain the victim's cooperation and secrecy and may relate to victim's inability to control their own physiological responses to the inappropriate sexual stimulation (Jehu 1988). Victims of CSA often experience guilt and feelings of self-blame engendered by their participation and possible physical pleasure obtained during the abuse (Fritz, Stoll and Wagner 1981, Haller and Alter-Reid 1986; Sgroi and Bunk 1988 and Tsai and Wagner 1978). Most researchers found a significant degree of self-

blame associated with the fact that they complied with the demands of the offender and did not disclose the abuse. Finkelhor and Browne (1985) argued that the second dynamic that appear to blaming and guilt is stigmatization. This refers to the child's feelings that he is somehow different and had because of the abuse and this reinforces the child's view that negatively impacts the child's self-esteem. Such experiences may result in negative cognitions about the self (Briere and Runtz 1988b) and contribute to depression. A sense of inadequacy in the victims is often fostered through the dynamics within the family of origin. Adults may expect things from child victims that are unrealistic or inappropriate and may enact other behaviors that place the child in a parental role. Such expectations may be beyond the child's developmental capabilities and may result in negative feelings about the self (Sgroi and Bunk 1988). Disruption in the schema result in a significant degree of negative self-evaluation that is likely to contribute to depression. Beck (1976) proposed a theory of depression among the victims of CSA adults. He said that victims are not immune to the myths concerning sexual abuse that permeate our society. They often feel that they have done something wrong. The victims of CSA experience frightening and confusing experience that may be responded to by disbelief from parents or professionals, victims may feel worthless and ashamed. If the reaction of family and society are rejecting to the abuse the victim may adopt many negative self-statements that can facilitate depression (Kilpatrick, Veronen and Rerick 1982).

The victim of CSA experiences a significant degree of anger toward abuser and others. They are mostly found angry toward their mothers for not protecting them and toward their father's exploitation and lack of accountability (Haller and Alter-Reid 1986). Tsai and Wagner (1978) also investigated a clinical sample of CSA and noted that many victims expressed considerable anger toward their mother for not protecting them or in case of incest for colluding with the father.

The abuse situation has taught the victims that at least some people behave in harmful ways and in cases where the offender happened to be previously trusted individual, the victims learns that trust can be illusory. Having been betrayed may influence the victim to feel bitterness, anger and resentment not only towards the offender

who perpetrated direct harm to, but also to those, like their mothers who through lack of protection may have indirectly perpetrated harm. These negative feelings appear to generalize to others and may be a mechanism of self-protection from future betrayals (Finkelhor, 1988). The victims may feel continuously angry toward the offender whose behavior undermined their sense of power and control and may generalize their anger to others who reinforced their powerlessness. Stigmatization within the abuse situation may lead victims to be angry with offenders for being responsible for ruining them. Disruption of esteem may result in a victim's developing the belief that people are inherently bad and interested in harming others (McCann, L., Pearlman, L. A., Sakheim,D.K., and Abrahamson, D. J. 1988).

Tsai and Wagner (1978) and Van Buskirk and Cole (1983) argued that the most striking difficulties of adults who were victims of sexual abuse are associated with their interpersonal relationships. Deighton and McPeek (1985) found that difficulties in interpersonal relations include difficulties in marital, parental relationship and friendship. Murphy, Kilpatrick, Amick-McMulan, Veronen, Paduhovich, Best, Villeponteaux, & Saunders (1988) found that victim of CSA in adolescence scored higher than non-victims on Interpersonal Sensitivity subscale of the Symptom Checklist 90-Revised (SCL 90-R; Derogatis, 1977), suggesting that victim's experience significantly more problems related to feelings of personal inadequacy in relation to others, marked discomfort in interpersonal situations, self-consciousness, general uneasiness and negative expectancies with respect to interpersonal interactions than do non-victims.

McCann, Pearlman, Sakheim, and Abrahamson, (1988) found that early experiences of abuse subsequently affect the victim's ability to trust others. Herman (1981) concluded that the victims of CSA often expect to be treated poorly by others. Haller and Alter-Reid (1986) suggest that victims tend to create a protective shield around them selves and interact with others on superficial level. On these reasons the individual attempts to avoid the discomfort of anyone becoming too close and hurting them again which, in turn, has the effect of exacerbating their social isolation.

Social stigmatization and the sense of oneself as different, bad, dirty or unworthy may also interfere with adult survivors ability to become intimate with other persons for fears that they will be rejected or hurt (Finkelhor and Browne, 1985; Haller and Alter-Reid 1986; Herman 1981and McCann *et al* 1988). Victims often fear that they will be rejected if others know about the abuse (Sgroi and Bunk, 1988). As a resultant reaction of such fears, victims may isolate themselves from others and subsequently feel alienated from people because of their abuse experiences (Agosta and Loring, 1988; Blake-White and Kline, 1985; Haller and Alter-Ried, 1986; Lindberg and Distad, 1985; Steel and Alexander, 1981; Tsai and Wagner, 1978).

The incident of abuse generally occurs in secrecy, victims often maintain secretiveness within their relationships. Sgroi and Bunk (1988) suggest that maintaining secrecy about the abuse or other aspects of one's life can be a mechanism for fostering a sense of control, but it also can act as a barrier to intimacy. Herman (1981) argued that secrecy may relate to negative feelings related to stigmatization and tends to contribute to social isolation.

In interfamily sexual abuse there is faulty learning in the family of origin that is responsible for interpersonal problems of adults. Gelinas (1988) noted that a victim of CSA learns that relationships take rather than give. Victims learn to expect that the environment will not meet their needs or supportive because their experiences in childhood were that their needs were subordinated to those of the offender and the rest of the family (Steele and Alexander, 1981). As a function of learning these patterns of relating to others, the individual does not learn to be assertive. Anger and resentment may be experienced toward others for not meeting their needs even though it may be that they become involved with others who are not capable of having a mutually satisfying relationship (Gelinas, 1988). Sgroi and Bunk (1988) suggested that the victims within the family learn that nurturance and protection from adult caretaker are not predictable. The lack of predictability of positive relational interactions may result in a great deal of uncertainty regarding what to expect from a relationship. Victims may become confused

about relationships with adult's role model and how adults interact with each other and with children and this affects their future adult relationships (Bagley and Ramsay 1986).

The victims of CSA have common problem of self-destructive behaviors and suicidal ideations and attempts (Blake-White and Kline, 1985; Sgroi and Bunk 1988). It was found by Lindberg and Distad (1985) that 25% of their clinical sample had made at least one suicide attempt, and 23% reported suicide ideation. Some findings indicate that there were no significant differences in suicide ideation among the abused and non-abused clinical sample because the treatment seeker were also have suicide ideation. In one study conducted on clinical sample by Meiselman (1978), indicated that the victims have percentage of twenty for suicide ideation as compared to non-victims having 18%.

Several studies have been conducted to see the difference in destructive behavior among victims and non-victims. Brier (1984) found that 51% victims of CSA had made at least one suicide attempt as compared to non-victims having 34% among a clinical sample. Brier and Runtz (1986) found that 59.4% victims of CSA attempted suicide at least once as compared to non-victims, with the percentage of 22.6. In other study, it was found by Brier and Runtz (1988b) that the victims of CSA are more likely than non-victims to indicate a history of suicide attempts (57% vs 33.7%) respectively. The victims of CSA were about twice likely as non-victims to have made suicide attempt in the past regardless of whether they were male or female. In an other study it was found (by Brier *et al* 1987) that patients with suicidal ideation or behavior were more than three times as likely to be victims of CSA than were subjects without these symptoms. The present study was conducted on inpatient psychiatric sample. Brier and Runtz (1986) noted that individuals presenting suicide ideation were more likely to report the history of victimization of CSA (53.6%) than were non-suicidal intakes (22.6%).

Sedney and Brooks (1984) have conducted a study on a non-clinical sample of college going students. They observed that victims of CSA were more than two times as likely to have made a suicide attempt or to have had thoughts of hurting themselves than were non-victims. Peters (1988) have taken a within community sample and found that

the victims of contact or non-contact abuse were approximately three times more likely to have made a suicide attempt than non-victims. Some investigations have been made on community sample by Saunders, Villeponteaus, Kilpatrick, & Veronen, (1987) and they found that victims of childhood rape or molestation were more likely than non-victims to have had suicide ideation or attempt at some time in their life. They concluded that the victims of molestation have a life time prevalence of suicide attempt of 15.8% and the victims of childhood rape have 17.9%. They found that these percentages were about three times greater than the prevalence of suicide attempt for non-victims. Brier and Runtz (1986) argued that more severe forms of abuse is related to the development of self-destructive behaviors in victims of CSA. They found that the number of suicide attempts was significantly correlated with physical and sexual abuse together. They noted that the number of suicide attempts was also related with abuse involving intercourse.

Brier and Runtz (1986, 1988b) and McCann et al (1988) have discussed the self-destructive behavior of adults with history of CSA related to poor self-esteem and self-blaming behavior. The victims who have lost self-esteem see themselves as unworthy, undeserving of life and ineffective in coping with stress. Jehu (1988) found that the high degree of self-blame lead to develop a belief among victims that they should punish themselves for their involvement. Brier and Runtz (1986, 1988b) argued that powerlessness among the victims lead to self-destructiveness. The victims feel themselves powerless to cope with situations with which they are confronted with limited coping strategies. These self-destructive behaviors may be mal-adoptive coping mechanism by which the individual hopes to escape or avoid emotional pain and bad feelings (Blake and White 1985; Brier and Runtz 1986). They also comment that these victims may perceive that they have no other mechanism for communicating their pain.

The present study is designed to investigate the long-term psychological effects on adults who has the history of victimization of child sexual abuse. The victims exhibits some psychological symptoms without telling about the incident of sexual abuse in their past history. When the researcher was busy in psychotherapy of patients having major depression and obsessive compulsive disorders and some patients were using a lot of ego

defenses during the diagnostic and psychotherapeutic process, this situation developed a gap in knowledge about the causes of deep depression. When these patients were treated for a long period of time and provided the opportunity for breaking their ego defenses, they gave details about the incident of sexual abuse in their early childhood.

Those patients who were the victims of sexual abuse have the long term psychological problems like poor social functioning, depression, obsessive compulsive disorders, suicide thinking, hopelessness and aggressive feelings. They provide an idea about the further investigation in detail related to the long term psychological effects of the victimization of sexual abuse. This investigation provided a chance to these victims to resolve their conflicts about the taboo of open the secret incident of sexual abuse.

Some hypotheses were formulated to see the long term psychological effects of victimization of sexual abuse in the early childhood of adult patients. These hypotheses were tested on a non-clinical sample taken from the province of NWFP.

The victims did not tell the story to any one when they were investigated in detail during the interview. Due to prolonged secrecy about the incident of sexual abuse, the victims have invested a lot of mental energy for survival and kept them emotionally stable. Their training, institutional learning and personal capacity did not provide a chance to overcome the stresses and anxieties related to the incident of sexual abuse. These prolong psychological problems lead to serious mental illness like suicide ideation, suicide attempts, feeling of hopelessness, aggression, hostility, depression and poor interpersonal relations. There was no chance of emotional catharsis for these victims where they can vent their disturbing material from their conscious or unconscious. They kept all the material secret and suffered several serious psychological traumas during the period of defensiveness.

The traditions of the province concerning sexual abuse did not allowed them to open their secret material to any one in their family or friends. This is a taboo to discuss the sexual experiences to any one and specially the incident of sexual abuse. The people of NWFP feel guilty, shame and disgrace if some body will come to know about the

secret incident of sexual abuse. The family of the victims of sexual abuse also feels guilty if the community came to know about the sexual abuse in their family. The culture of this province permits the elders to involve in such type of activities like sexual abuse of children. The norms related to keep children for sexual gratification with them is present in several communities of NWFP. Several community influential keep young children at their houses for sexual activities and it is known to every body. Important is the defensive attitude of the community to open the incident of sexual abuse. The abuser has no serious fear of punishment by elders, community and the relatives of the victims due to defensive attitude of the people. Family members always keep secret and did not show hostility because there are chances of prolong feelings of aggression and hostility toward the abuser. A serious conflict may arise among the families of abuser and the victims of sexual abuse. To avoid the dangerous and damaging situations the families did not take the incident of sexual abuse seriously and did not report to police or any local body.

Media highlights the incident of sexual abuse in such a way that the victims always feel guilty and shame. Self-blaming and hopelessness feelings are the resultant in case of projection the incident of sexual abuse among the victims. They feel that the abusers are more powerful and they can't take any action against them. Some times media report the case in such a way that this is the fault of victims and they are guilty. The family elders of the victims mostly avoid to report the case against the abuser in police station, traditional court and electronic and print media. Their policy of saving their honor leads to several psychological problems among the victims. The victims become depress, feel helplessness and develop suicide ideation.

At the end of the study the researcher found that the victims of sexual abused have some psychological problems and they need some support and psychotherapeutic interventions to overcome these problems. The traditions, cultural patterns, social values and general circumstances did not allow these victims to disclose their secret experiences of sexual abuse. They keep these experiences always secret and need some special help to overcome the defenses used for ego survival. Their psycho-pathology always disturb their normal life and they left behind in achievements of life. This study also provide a chance

to new researchers in this field that how effectively they can break the defenses sued for victims of sexual abuse and what type of psychological problems they have in their life.

OBJECTIVES AND RESEARCH DESIGN

Chapter II

OBJECTIVES OF THE RESEARCH.

Objectives of the Research

The main objective of the study was to investigate the long-term psychological effects of victimization of child sexual abuse on adults.

The following additional objectives were also examined:

1. To develop an indigenous scale of social functioning and establish its psychometric properties

2. To investigate the effect of age on the severity of psychological effects.

3. To investigate the effects of level of education of the abused on their severity of symptoms.

Hypotheses

On the basis of the research findings related to the long term psychological effects of sexual child abuse and their symptoms like poor social functioning, depression, suicide ideation, hopelessness, negative self-evaluation and hostility the following hypotheses were formulated. These hypotheses were related to the differences of symptoms and psychological problems of the victims of sexual child abuse and non-abused adults.

The victims of child sexual abuse develop depression, anxiety and feelings of mistrust that affects their interpersonal relationships (Tsai and Wagner, 1978; Van Buskirk and Cole, 1983). In many cases the abusers are relatives, family friends, neighbors, teachers, coaches and in some cases they are living in the same house with the victims. As a result of that isolation, loneliness and social with-drawl are the major symptoms which affects the interpersonal relations of the victims of CSA. They have developed negative feelings about the environment around them and a feeling of

inadequacy leads to isolation and poor social relations. They feel general uneasiness, self-conscious and develop negative expectations from the environment. There are feelings of rejection by others and they think that the environment is not supportive.(McCann, L., Pearlman, L. A., Sakheim,D.K., and Abrahamson, D. J. 1988, Herman, 1981; Haller and Alter-Reid,1986). Within family the victims have received unpredictable nurturance and neglect that resulted in mistrust and confusion about the relationships.

Hypothesis I:

Social functioning of the victims of sexually abused adults will be

poor as compare to non-abused adults.

According to the clinical observations of the victims of CSA adults and research findings, anxiety, depression, feelings of guilt, shame, self-blaming, fear of loosing honor and respect in front of others, and poor self-esteem are common symptoms among them (Kelly, R.J., MacDonald, V.M., & Waterman, J.M. 1987). They have developed the fear of loosing secrecy and always feel threatening situation that increase the tendency toward depression and anxiety. Excessive utilization of ego-defenses, lack of emotional catharsis due to the sensitivity of the issue and discomfort, the situation leads to depression among victims of CSA. Living in the same circumstances, village, city even within the same house of the abuser leads to discomfort, anxiety and depression among the victims of CSA (Sheldrich 1991). They have losses in their lives and have a lot of grief reaction. In intra-familial situation the victims are deprived of a caring, nurturing relationship with one or both of parents. Due to social isolation, they have loss of appropriate childhood experiences, learned helplessness and feelings of powerless limits their ability to cope with stressors of life (McCann, *te al* 1988; Finkelhor, 1988).

Hypothesis II:

The sexually abused adults will show high depression as compare to non-abused adults.

Deep depression due to the victimization of CSA, long life depressive state, feelings of helplessness, self directed hostility, self-blaming and negative self-evaluation leads to severe suicide ideation and tendencies towards self-destructive behaviors. Negative attitude of the community, parents, siblings, friends, teachers and coworkers towards the victimization increased the feelings of guilt, shame and poor self-esteem resulting high risks of suicide probability and suicide ideation among the victims of CSA adults(Agosta and Loring, 1988; Donaldson & Gardner, 1985; Gelinas, 1988; Goodman & Nowak-Scibelli, 1985; Haller and Alter-Reid, 1986; Herman and Schatzow, 1984).

. They see themselves as unworthy, non-deserving of life and ineffective for coping with stresses in their present life. They often think that they should punish themselves for their involvement in the incident of abuse. Feelings of powerlessness, mal-adoptive coping mechanism and hopes to avoid or escape from emotional pain leads to destructive behaviors among the victims of CSA, (Briere; 1988; Briere &Runtz, 1986, 1988b; Conte, 1988; Edwall *et al*., 1989).

Hypothesis III:

The victims of child sexual abuse adult will obtain high scores

on suicide ideation scale as compared to non-victims adult.

After the incident of sexual abuse, the victims always criticize themselves, that they are responsible for the victimization. They think that this is their fault and they are dirty, sinner and have committed very serious crime. The negative feelings and attitudes towards themselves lead to negative self-evaluation among the victims of CSA adults. (Agosta and Loring, 1988; Donaldson & Gardner, 1985; Gelinas, 1988; Goodman & Nowak-Scibelli, 1985) lack of sex education, poor judgment of reality, and being the

target of others comments have also increased the self-blaming tendencies among the victims.

Hypothesis IV:

The victims of CSA adults will express negative self- evaluation as compare to non-victims.

The victims of CSA do not share their feelings about the incident of victimization to any one and they always keep it secret. They have a serious desire to take action against the abuser but due to some barriers they remain calm and frustrated. The social stigma and fear of losing respect and honor in the community compels the victims to repress their hostile and aggressive feelings toward abuser. This emotional state of the victims raises hostility and aggression in general and particularly toward abuser in consequent to the disruption of their self-esteem. (Browne & Finkelore, 1986; Conte, 1988). The victims of CSA feels lack of protection by mothers and unaccountability of fathers also develop general hostility.

Hypothesis V:

The scores of the victims of CSA adults on hostility scale will be high as compared to the scores of non-victims adults.

In intra-familial situation the victims are deprived of a caring, nurturing relationship with one or both of parents. Due to social isolation, they have loss of appropriate childhood experiences, learned helplessness and feelings of powerless limits their ability to cope with stressors of life. The victims of CSA have sense of lost power, control, and confidence in their manhood, (Mayers, 1989). Brier and Runtz (1986, 1988b) argued that powerlessness among the victims may lead to self-destructiveness. The

victims feel themselves powerless to cope with situations with which they are confronted with limited coping strategies. The victim of CSA experiences a significant degree of anger toward abuser and others. They are mostly found angry toward their mothers for not protecting them and toward their father's exploitation and lack of accountability (Haller and Alter-Reid 1986).

Hypothesis VI:

The feelings of hopelessness will be high among victims of CSA adult as compared to non-victims.

Long life depressive state, feelings of helplessness, self-blaming and negative self-evaluation leads to severe suicide ideation and tendencies towards self-destructive behaviors. Feelings of powerlessness, mal-adoptive coping mechanism and hopes to avoid or escape from emotional pain leads to destructive behaviors among the victims of CSA. They see themselves as unworthy, non-deserving of life and ineffective for coping with stresses in their present life. They often think that they should punish themselves for their involvement in the incident of abuse,(Jehu 1988). The victims of CSA have common problem of self-destructive behaviors and suicidal ideations and attempts (Blake-White and Kline, 1985; Sgroi and Bunk 1988). Brier and Runtz (1988b) found that the victims of CSA are more likely than non-victims to indicate a history of suicide attempts.

Sedney and Brooks (1984) observed that victims of CSA were more than two times as likely to have made a suicide attempt or to have had thoughts of hurting themselves than were non-victims among a sample of college going students. Peters (1988) have taken a within community sample and found that the victims of contact or non-contact abuse were approximately three times more likely to have made a suicide attempt than non-victims. These self-destructive behaviors may be mal-adoptive coping

mechanism by which the individual hopes to escape or avoid emotional pain and bad feelings (Blake and White 1985; Brier and Runtz 1986).

Hypothesis VII:

Suicide probability among the victims of CSA adults will be high

as compare to non-victims.

Research Design.

The present research was designed to investigate the psychological effects of child sexual abuse among adults and the differences among the obtained scores on different scales. The independent variable structured the victimization of child sexual abuse. The dependent variables were the negative psychological effects on the victims of child sexual abuse and were studied in the present research.

The presented research was carried out in two parts, i.e Study I and Main Study.

The study I concerned the development and validation of an indigenous social functioning scale to be used in the main study.

Study-I

Study-I aimed at the development and validation of a social functioning scale and this study was carried out in three steps.

Step 1: Items Generation.

Step 2: Subjective Evaluation.

Step 4: Empirical Evaluation.

Study-II

Study-II was the main study and its aim was to investigate the psychological effects of child sexual abuse among adults. It also aimed to see the difference in severity of symptoms among abused and non-abused groups. Furthermore, the effects of age and educational level on the severity of the symptoms was also investigated.

Following are the dependent variables measured by different scales in the present study.

I. Social Functioning.

The victims of CSA are expected to have disturbed interpersonal relations due to feelings of inadequacy, general uneasiness, self-conscious and negative expectations from the environment. Social isolation, feelings of rejection by others and unpredictable nurturance and protection in the environment affects interpersonal relations of the victims of CSA. This variable is studied by formulating hypothesis that the victims of CSA have poor social functioning as compared to non-victims. A scale for assessment of social functioning was constructed and its psychometric properties were tested. Social Functioning Scale, developed and validated in study-1 was used to measure the social functioning of the subjects to see the difference among abused and non-abused groups.

II. Depression.

High depression is expected among the victims of CSA adults as compared to non-abused adults. Shame, guilt, self-blaming and many losses in life leads to severe depression among the victims of CSA. A hypothesis in the present study is tested to see the difference in level of depression among the victims of CSA and non-abused adults. The present hypothesis reveals that there is a significant difference among the abused and non-abused group on scores of depression scale. Salma Shah Depression Scale (SSDS) was administered on both the groups to see the difference.

III. Suicide Ideation.

Long life depressive state, feelings of helplessness, self-directed hostility, self-blaming and negative self-evaluation leads to severe suicide ideation and tendencies towards self-destructive behaviors. Ineffective for coping with stresses, feelings of powerlessness, mal-adaptive coping mechanism and hopes to avoid or escape from emotional pain leads to destructive behaviors among the victims of CSA. Suicide ideation is measured as dependent variable among the victims of CSA and a hypothesis is formulated to see the difference on suicide thinking scale expecting the higher scores of victims of CSA as compared to non-victims. Suicide Probability Scale (SPS) was administered to see the difference in score among the victims of sexual abused and non-abused adults.

IV. Negative Self-evaluation.

Self-criticism, negative feelings and attitudes towards themselves leads to negative self-evaluation among the victims of CSA adults. They think that they are involved in the crime and blame themselves. The present dependent variable is measured among the abused and non-abused groups with expectation of high scores on the scale by experimental group as compared to control group. Negative Self-evaluation, the sub-scale of Suicide Probability Scale (SPS) was administered to see the difference in score among the victims of sexual abuse and non-abuse adults.

V. Hostility.

Social stigma and fear of losing respect and honor in the community, develop hostility among the victims of CSA. They feel lack of poor protection by mothers and un-accountability of fathers leads to general hostility. This dependent variable is measured by administering a scale and hypothesized that the victims of CSA obtained high scores as compared to non-victims. Hostility, the sub-scale of Suicide Probability Scale (SPS)

was administered to see the difference in score among the victims of sexual abuse and non-abuse adults.

VI. Hopelessness.

The victims of CSA suffered in major depression and hopelessness is included as associated feature of depression. It was also concluded that depression and feelings of helplessness are found among the adults having the experience of CSA in their past. An other theoretical prospective was presented by some theorists that postulated about learned helplessness. This view suggests that depression occurs as a result of exposure to unpredictable, unavoidable aversive stimulation from which there is no possibility of escape. The variable hopelessness is measured by applying Suicide Probability Scale and the Hopelessness, sub-scale of SPS is administered to see the difference in scorers among the sexually abused and non-abused groups.

VII. Suicide Probability.

Long life depressive state, feelings of helplessness, self-directed hostility, self-blaming and negative self-evaluation leads to severe suicide ideation and tendencies towards self-destructive behaviors. Ineffective for coping with stresses, feelings of powerlessness, mal-adaptive coping mechanism and hopes to avoid or escape from emotional pain leads to destructive behaviors among the victims of CSA. Suicide probability is measured as dependent variable among the victims of CSA and a hypothesis is formulated to see the difference on suicide thinking scale expecting the higher scores of victims of CSA as compared to non-victims. The total scores of all the sub-scales on SPS are converted into suicide probability score and the tendency of suicide is determined on the basis of these total scores.

The differences on the scores among the abused and non-abused adults indicate the negative psychological effects of child sexual abuse on victims

STUDY 1

Chapter III

STUDY-1

METHOD

The purpose of the study-1 was to develop an indigenous scale for assessment of Social Functioning of adults to be used in testing hypotheses formulated for the research. It was carried out in three steps, comprising of item generation, , its empirical evaluation and the establishment of its psychometric properties. The following steps were followed to develop a Social Functioning Scale (SFS).

Step 1: Items Generation

The items of social functioning scale were generated on the basis of clinical interviews, behaviors, symptoms and attitudes exhibited by victims of CSA. A literature survey was conducted to find out the possible indicators for social functioning of victims of CSA. Twenty-five items were selected for scale construction and further proceeding.

Step 2: Subjective evaiuation.

Three Psychologists, two of them having M. Phil., degree with Diploma in clinical psychology and one having Ph.D degree with experience in counseling psychology, working at Department of Psychology were requested to evalute the items. Both the clinical psychologists were trained and having vast experience in the field of clinical psychology.

These experts were briefed about the purpose of the study and 25 items were presented for discussion. Five items were excluded on the basis of their ambiguity. These experts retained twenty items for further process.

Step 3: Empirical evaluation.

The scale was administered on a randomly selected sample of 100 adults. The internal criteria of item analysis was followed. Item analysis was carried out to determine the effectiveness of items. Only those items were retained that were significantly correlated with the total score. The psychometric properties of these items retaine on the basis of items analysis, were established.

Sample

A sample of 100 subjects, ranging age from 18 to 30 years was randomly taken from the main city of NWFP. All the subjects were educated from Matric to Post Graduate level and were migrated from different cities of the Province, NWFP.

Procedure

The subjects were approached individually at their residences, hostels and offices. The instructions and purpose of the study was explained to all the subjects individually and scale was given for recording their responses. There was no time limit for completion of the scale but they were asked only not to waste their time. After the completion of data, the statistical treatment was don for its psychometric evaluation.

Results

To develop the social functioning scale the responses from the subjects were subjected to item-analysis.

Table 1.

Item –total correlations of Social Functioning Scale (N=100).

Item No	Item Total Correlation.	*p*
1	.018	.861
2	.384	.000
3	.401	.000
4	.356	.000
5	.369	.000
6	.446	.000
7	.403	.000
8	.418	.000
9	.608	.000
10	.398	.000
11	.205	. 042
12	.350	.000
13	.490	.000
14	.078	.440
15	.267	.004
16	.185	.007
17	.178	.077
18	.283	.005
19	.289	.004
20	.439	.000

Table 1 shows that 17 out of 20 items are significantly correlated with the total scores while item 1, 14 and 17 have no correlation with total scores. The Alpha Reliability Coefficient of Social Functioning Scale is .62.

The item 1 of the scale was a direct question about the dealing of the subject with others and it was asked about the trust, the subject have on others. It is possible that the subjects may use defenses and did not reply that they have no trust on others. This factor may not be directly related to social functioning of the subjects.

Item 14 was measured the discipline and punctuality in the life of the subjects. These factors does not affected due to poor social functioning of individuals and subjects may have punctuality and discipline in their life. Item 17 was related to the boldness and courage of the subjects and it was asked that either they are afraid from darkness or not. Most of the subjects reply that they are not afraid of darkness.

This scale was administered on sample of sexually abused and non-abused adults to see the difference in their social functioning.

STUDY II

MAIN STUDY

METHOD

The purpose of the study was to see the difference in the scores on scales measure social functioning, depression, negative self-evaluation, suicide ideation, hostility, hopelessness and suicide probability among the sexually abused and non-abused adults. The victims of child sexual abused will have shown high scores on these scales as compared to non-abused.

Sample

A sample of one hundred male adults ranging from 18 to 30 years in age, (M=22; SD=3.71) residing at different districts of NWFP was taken. Among this sample fifty subjects who were sexually abused in their childhood and fifty subjects have no experience of sexual abuse in their childhood. The fifty subjects having the experience of CSA group were randomly selected from twelve districts of NWFP. The details of which are as follows:

Twenty-two subjects were taken from district Peshawar and majority of them were migrated from different districts of NWFP due to their education and jobs. In most cases the parents of the subjects also shifted to Peshawar because of their jobs and business. Eleven subjects were belonged to district Nowshehra located on the boundary of district Peshawar. Four subjects were taken from district Charsada that is also near Peshawar. Five subjects were taken from district Chitral and they were living in hostels of different Universities and Colleges located at Peshawar. Two subjects were taken from district Swat and were contacted in their hostels at University of Peshawar. One subject was taken from each district of D.I.Khan, Dir, Haripur, Malakand, Karak and Lucky Marwat.

The educational qualification of the subjects of CSA group was from Metric to post graduate level. Thirty percent of them were post-graduate and twenty-six percent were graduate. Forty percent subjects of CSA group have intermediate education level and only four percent were metric.

Fifty subjects of non-abused group were randomly selected from various districts of NWFP. Twenty-four subjects were taken from district Peshawar and majority of them were migrated from different cities of NWFP due to their jobs, education and jobs of their parents at Peshawar. Eight subjects belonged to district, Nowshehra. Four subjects were chosen from district Charsada. Four subjects belong to district Chitral.Three subjects were selected from district Mardan.Two subjects were taken from district Dir. One subject wastaken from each district of D.I.Khan, Hangu, Swabi, Malakand and Kurram Agency.

The educational qualification of the subjects were from Metric to post graduation. Fifty percent subjects of the non-abused group were intermediate, thirty-two percent were graduates, and eighteen percent were postgraduate. They belonged to middle and lower middle socioeconomic group.

The education level is marked from 1 to 4, (1=Matric, 2= Intermediate, 3= Graduate and 4= Post graduate), (M=2.75, SD=0.85).

Instruments

The following instruments were used in order to measure the demographic information, incident of child sexual abuse, social functioning, depression, Hopelessness, Suicide ideation, Negative self-evaluation and Hostility of the victims of child sexual abused and non-abused adults.

Information Sheet

This Information Sheet was formulated to get some demographic information and knowledge about the incident of sexual abuse in the past history of adults. The help of this Information Sheet noted the name, age, academic qualification and occupation of the subject. There were twenty-five items in this Information Sheet. All these items were included on the basis of the symptoms and behaviors which may the victims of child sexual abuse exhibits. These items were taken from the literature, clinical observations and reported by victims of CSA adults. The administration of this Information Sheet was helpful in identification of the victims. Those subjects, who got high scores on this Sheet provided an idea about further investigation for the incident of sexual abuse in their past. (See Annexure 1).

Social Functioning Scale (SFS)

The scale was formulated to test the hypotheses about social functioning of the victims of child sexual abused. Social Functioning Scale was developed by the scholar as a part of study 1.The scale consists of 17 items, rated on 3 point scale ranging from Never (0) to Always (2). The alpha reliability coefficient of the scale is .62. The reliability coefficient for the present sample of sexually abused and non-abused group, (N=100) is .82. The reliability coefficient for the present sample of sexually abused group, (N=50) is .54 and for non-abused group, (N=50) is .64. High scores on this scale indicate the poor social functioning of the subjects.

Salma Shah Depression Scale (SSDS)

Salma Shah Depression Scale was developed by Salma and Shah in 1992. This is a 4-point scale containing 34 items reflecting depression level of subjects. It includes hopelessness, (7 items); worthlessness (6 items); interpersonal conflicts (5 items); and complaints of body functioning (4 items). Salma and Shah found alpha coefficient of a

clinical sample .91 and for non-clinical sample .89. The reliability coefficient for the total sample is .92. The whole reliability coefficient for the sample of sexually abused group, (N=50) is .90 and for non-abused group, (N=50) is .72.

The SSDS have the following scoring procedure.

Category	Score
Always	4
Often	3
Sometimes	2
Never	1

Each item has intensity value, and each obtained score is multiplied by its intensity. Sum of the earned points by the subjects total score point. The high scores on the scale indicate high depression and vice versa.

Suicide Probability Scale (SPS)

The scale is a brief, self-report measure designed to aid in the assessment of suicide risk in adults, (Cull, and Gill, 1982). SPS has 36 items and individuals are asked to rate the frequency of their subjective experience and past behaviors using 4-point scale ranging from "None or a little of the time" to "Most or all of the time".

The responses are hand scored to evaluate suicide risk along several key dimensions. An overall assessment is reflected in the summary scores, total weighted score (sum of 4 sub scales) and the suicide probability score.

SPS provides four clinical subscales; Hopelessness, Suicide ideation, Negative self-evaluation and Hostility. Subscale Hopelessness assess an individual's overall dissatisfaction with life and generalized negative expectations about the future. This scale

have 12 items among total items (36) of SPS. The suicide ideation subscale reflects the extent to which an individual reports thoughts or behavior associated with suicide. There are 8 items for measurement of suicide ideation. Negative self-evaluation subscale reflects an individual's subjective appraisal that things are not going well, that others are distant and uncaring and that it is difficult to do any thing worthwhile. This sub-scale have 9 items out of total items of SPS. Hostility subscale reflects aggression, isolation and upset feelings. Seven items are specified for measurement of hostility.

The reliability coefficient of SPS for the present sample of sexually abused and non-abused group, (N=100) is .87. The reliability coefficient for the present sample of sexually abused group, (N=50) is .79 and for non-abused group, (N=50) is .80. The reliability coefficient of Hopelessness, the subscale of SPS for the present sample of sexually abused and non-abused group, (N=100) is .72, of sexually abused group is .50 and for non-abused group is .66. The reliability coefficient of Suicide Ideation, the subscale of SPS for the present sample, (N=100) is .79, of sexually abused group is .75 and for non-abused group is .60. The reliability coefficient of Negative Self-evaluation, the subscale of SPS for the present sample of sexually abused and non-abused group, (N=100) is .49, of sexually abused group is .36 and for non-abused group is .48. The reliability coefficient of Hostility, the subscale of SPS for the present sample of sexually abused and non-abused group, (N=100) is .68, of sexually abused group is .49 and for non-abused group is .59.

Thematic Apperception Test (TAT)

The test has 30 pictures and one blank card. The pictures have been selected in such a way that there are four sets of 20 cards each. Few cards are specified as boys, girls and females (Murray, H. A. 1943). Administration of the test depends upon the purpose of testing. Instructions were given to produce a particular kind of directing sets that the examiner wants. Particular words were used in the instructions to motivate the subject to cooperate or to arouse only a minimum of resistance. A few cards can be selected for assessment of specific clinical situation either for research or diagnosis. Different specific approaches are appropriate to different purposes for which the test is being used. In the

present study, five selected cards having numbers, card No 1, 3BM, 9BM, 12 M, and card No 14, were used on the subjects.

Card No 1.

A young boy is contemplating a violin that rests on a table in front of him.

Card No 3BM.

On the floor against a coach is the huddled form of a boy with his head bowed on his right arm. Beside him on the floor is a revolver. The purpose of selection of the present card was to measure suicide ideation, tendencies and depression among the victims of CSA adults.

Card No 9BM.

Four men in overalls are lying on the grass taking it easy. This card help in assessment of homosexual tendencies and may recall the incident of CSA.

Card No 12 M

A young man is lying on a coach with his eyes closed . Leaning over him is the gaunt form of an elderly man, his hand stretched out above the face of the reclining figure. This picture may recall the tragedy of CSA among the adults victims.

Card No 14

The silhouette of a man (or woman) against a bright window. The rest of the picture is totally black. The picture may helpful in assessment of suicide thinking among the subjects.

Procedure

A pilot study was conducted in which the researcher identified five cases of child sexual abuse before going to conduct the major study during the clinical experience. These clinical samples were reported to the researcher as patients having the symptoms of depression. This clinical experience provided major idea about further investigation and selection of psychological tests. Depression, suicide ideation, negative self-evaluation, hopelessness, hostility and suicide probability were measured through valid scales.

A self-constructed Information Sheet was formulated for assessment of the incident of child sexual abuse among the adults. The items of the Information Sheet were selected from the literature about child sexual abuse and clinical observations. The Information Sheet was helpful in providing some indications for detailed investigation about the incident of child sexual abuse. The present Information Sheet was administered on a large sample of adults. Those adults having the experience of child sexual abuse have provided some indicators and further investigations were carried out to probe the real history of the abuse. The researcher faced a lot of problems during the investigation due to the defensive styles of the victims. Many subjects in spite of having the symptoms and clinical picture of sexual abuse did not break their defenses and were excluded from further testing. During the process of identification child sexual abuse, several efforts were gone wasted and the process of data collection was delayed due to social and psychological resistances among the adults having the experience of child sexual abuse.

The psychological tests and scales were administered in such a sequence, Social Functioning Scale (SFS), Salma Shah Depression Scale (SSDS), Suicide Probability Scale (SPS) and Thematic Apperception Test (TAT). All the subjects were tested individually in a calm and quite place. The researcher strictly followed the confidentiality and other ethical issues.The same number of subjects (N=50) was selected randomly from the same community for control group who had no experience of child sexual abuse. All the psychological tests and scales were administered with same instructions and circumstances. The purpose of study was properly communicated and the factor of child sexual abuse were ruled out.

Table 3

Age distribution of victims, CSA group in years, (N=50)

Age	*f*	%
18	5	10.0
19	2	4.0
20	7	14.0
21	5	10.0
22	9	18.0
23	2	4.0
24	5	10.0
25	5	10.0
26	0	0.0
27	2	4.0
28	4	8.0
29	0	0.0
30	4	8.0
Total	50	100.0

Table 3 shows the age distribution of the victims of CSA. Majority of the subjects, (66%) subjects belong to age group ranging 20-25 years.

Table 4

Age distribution of non- abused group in years, (N=50)

Age	*f*	%
18	4	8.0
19	4	8.0
20	8	16.0
21	7	14.0
22	3	6.0
23	5	10.0
24	1	2.0
25	6	12.0
26	5	10.0
27	2	4.0
28	0	0.0
29	0	0.0
30	5	10.0
Total	50	100.0

Table 4 indicate the age distribution of subjects without any experience of CSA. Majority of the subjects, i.e (60%) belongs to the age group of 20-25 years.

Table 5

Education level of subjects, N= 100

Education	*f*	%
Matric	2	2.00
F.A	45	45.00
B.A	29	29.00
M.A	24	24.00
Total	100	100.00

Table 5 indicate the education level of the subjects. Only two subjects belonged to secondary level education. Forty-five subjects i.e (45%) belong to higher secondary level. Twenty-nine percent and 24% subjects belonged to graduate and post-graduate level respectively.

Table 6

Education level of subjects, child sexual abused (CSA) group, N=50

Education level	*f*	%
Matric	2	4.0
F.A	20	40.0
B.A	13	26.0
M.A	15	30.0
Total	50	100

Table 6 indicate the frequency of education level of subjects having the experience of CSA in their childhood. There are only two subjects among the sample who were metric.

Table 7

Education level of subjects, non-abused group, N=50

Education level	*f*	%
Matric	0	0.0
F.A	25	50.0
B.A	16	32.0
M.A	9	18.0
Total	50	100

Table 7 indicate the education level of the subjects having no experience of CSA in their past. There is not a single subject having the education level till metric as two subjects were present in the CSA group. Half of the subjects (50%) were of intermediate level. The rest of them have qualification till graduation and post graduation, 32% and 18% respectively.

RESULTS

Table 8

Alpha reliability coefficient of three scales for total sample (N=100)

Scale	*No of items*	*Alpha reliability coefficient*
SFS	17	.82
SSDS	36	.92
SPS	36	.87

Table 8 indicate the values of reliability coefficient of Social Functioning Scale, Salma Shah Depression Scale and Suicide Probability Scale administered on the present sample of 100 subjects. These values are significant at .01 level indicating significant correlation among each others.

Table 9

Alpha reliability coefficient of three scales for abused group (N=50)

Scale	*No of items*	*Alpha reliability coefficient*
SFS	17	.54
SSDS	36	.90
SPS	36	.79

Table 9 indicate the values of reliability coefficient of Social Functioning Scale, Salma Shah Depression Scale and Suicide Probability Scale administered for the sexually abused subjects (N=50). These values are significant at .01 level indicating significant correlation among each others for the group of CSA.

Table 10

Alpha reliability coefficient of three scales for non-abused group (N=50)

Scale	*No of items*	*Alpha reliability coefficient*
SFS	17	.64
SSDS	36	.72
SPS	36	.80

Table 10 indicate the values of reliability coefficient of Social Functioning Scale, Salma Shah Depression Scale and Suicide Probability Scale administered for the non-abused subjects (N=50). These values are significant at .01 level indicating significant correlation among each others for non-abused group.

Table 11

Alpha reliability coefficient of four sub scales of SPS for total sample (N=100)

Scale	*No of items*	*Alpha reliability coefficient*
Hopelessness	12	.72
Suicide ideation	8	.79
Negative self-evaluation	9	.45
Hostility	7	.68

Table 11 indicate the values of reliability coefficient of four sub-scale of Suicide Probability Scale administered for the sexually abuse and non-abused subjects (N=100). These values are significant at .01 level indicating significant correlation among each others for abused and non-abused group.

Table 12

Alpha reliability coefficient of four sub scales of SPS for abused group (N=50)

Scale	*No of items*	*Alpha reliability coefficient*
Hopelessness	12	.50
Suicide Ideation	8	.75
Negative Self-evaluation	9	.36
Hostility	7	.49

Table 12 indicate the values of reliability coefficient of four sub-scale of Suicide Probability Scale administered for the sexually abuse subjects (N=50). These values are significant at .01 level indicating significant correlation among each others for abused group. The sub-scale Negative Self-evaluation of SPS has poor correlation (.36)with other sub-scales of SPS.

Table 13

Alpha reliability coefficient of four sub scales of SPS for non-abused group (N=50).

Scale	*No of items*	*Alpha reliability coefficient*
Hopelessness	12	.66
Suicide ideation	8	.60
Negative self-evaluation	9	.48
Hostility	7	.59

Table 13 indicate the values of reliability coefficient of four sub-scales of Suicide Probability Scale administered for the non-abuse subjects (N=50). These values are significant at .01 level indicating significant correlation among each others for non-abused group.

Table 14

Correlation of Social Functioning Scale (SFS), Salma Shah Depression Scale (SSDS) and Suicide Probability Scale (SPS), (N=100).

	SFS	SSDS	SPS
SFS			
SSDS	.715		
SPS	.631	.615	

Table 14 shows significant correlation among the scales used for assessment of depression, social functioning and suicide ideation among the victims of CSA and non-abused. Significant correlation among SSDS and SPS indicate that depression and suicide ideation are the major symptoms of depression among the victims of CSA adults. Hopelessness, negative self- evaluation and hostility are also the symptoms of depression and psychological distress found among the victims of CSA adults. Significant correlation among the SSDS and SFS indicate that those subjects obtained high scores on SSDS, also obtained high scores for poor social functioning. The relationship also indicate that depressed subjects perform poorly in any social situation. Subjects obtained high scores on SPS also indicate poor social functioning as a result of negative self-evaluation, helplessness, hostility and suicide ideation. Significant correlation among the scores on SFS and SPS indicate that the victimization of CSA affects the social functioning and cause depression with suicide ideation among the subjects.

Table 15

Inter scale correlations (N=100).

Scales	I	II	III	IV	V	VI	VII	VIII
I SFS	___							
II SSDS	.715***	____						
III Hopeless-ness	.631***	.615***	____					
IV Suicide Ideation	.596***	.584***	.684***	____				
V Negative self-evaluation	.224*	.208*	.136	.240*	____			
VI Hostility	.677***	.645***	.658***	.672***	.264**	____		
VII Total weighted Score on SPS	.688***	.669***	.842***	.843***	.365***	.841***	____	
VIII Suicide Probability score	.688***	.662***	.808***	.899***	.365***	.802***	.915***	___

Table 15 shows significant correlation among the scales and sub scales. Negative self-evaluation, the subscale of SPS shows poor correlation with SSDS, SFS and the other subscales of SPS. This subscale shows significant correlation with total score of SPS ($p=.365$, $p<.01$). The subscale, negative self-evaluation measure the present self esteem and attitudes of the individuals towards themselves. The incident of CSA has been occurred in past and with the passage of time the attitude and perception about themselves may change and the victims of CSA show positive attitude toward themselves. Mean scores and standard deviation on the Salma Shah Depression Scale (SSDS) of Sexually abused and Non-abused subjects indicate the depression level among them. The difference in mean scores indicate high depression among the victims of CSA adults as compared to non-victims.

Table 16

Mean score differences between abused and non-abused group on Social Functioning Scale (SFS) of subjects (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	19.44	4.52	11.975	.000
Non-abuse	50	8.66	4.48		

Table 16 indicate significant difference on Social Functioning Scale (SFS) among the CSA adults and non-abused. The victims of CSA obtained high mean scores (19.44) as compared to non-victims (8.66) indicating the poor social functioning of victims as compared to non-abused. The t-value of the scores obtained by Social Functioning Scale also indicate the significance value showing difference in social functioning among the victims of CSA and non-abused adults. Depression and other psychological problems as a result of victimization of CSA, affect the social functioning of the adults negatively and the victims exhibits poor social functioning as compared to non-victims.

Table 17

Means, Standard deviations and t-value on the Depression Scale (SSDS) of Sexually abused and Non-abused subjects (N=100)

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abuse	50	82.89	37.56		
				8.190	.000
Non-abuse	50	34.36	18.63		

Table 17 shows significant difference between the subjects of CSA and non-abused on SSDS. The high scores on depression scale of the victims of CSA as compared to non-abused indicate the difference in level of depression. The mean difference among the scores on SSDS indicate high depression among the victims of CSA adults. Significant difference among the scores of depression also indicate that the victims of CSA adults are more depress as compared to non-abused adults.

Table 18

Mean score differences between the subjects of CSA and non-abused on Total Weighted scores of Suicide Probability Scale (SPS) (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	79.70	16.02		
				7.602	.000
Non-abuse	50	56.68	14.20		

Table 18 shows a significant difference between the subjects CSA and non-abused on the total weighted scores of Suicide Probability Scale (SPS). The mean score obtained by victims of CSA are clearly higher, (79.70) as compared to the mean score of non-victims, (56.68) on total weighted score on SPS. The difference indicated higher suicide probability among the victims of CSA adults as compared to non-abused.

Table 19

Mean score differences between the subjects of CSA and non-abused on Suicide Probability score of Suicide Probability Scale (SPS) (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	48.88	24.63	7.079	.000
Non-abuse	50	21.28	12.39		

Table 19 shows a significant difference between the subjects CSA and non-abused on the scores suicide probability of Suicide Probability Scale (SPS).

The difference indicated the victims of CSA have more probability of suicide as compared to non-abused subjects. The victims obtained Mean score (48.88) and non-victims (21.28) on Suicide Probability. The difference indicated higher suicide probability among the victims of CSA adults as compared to non-abused.

Table 20

Mean score differences between abused (CSA) and non-abused on sub scale Hopelessness of SPS (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	27.48	6.27	6.709	.000
Non-abuse	50	18.80	6.66		

Table 20 shows significant difference between the subjects, victims of CSA and non-abused on Hopelessness, subscale of SPS. The victims of CSA obtained higher mean scores (27.48) as compared to non-victims (18.80) that indicate high rate of hopelessness feelings as compared to non-abused adults.

Table 21

Mean score differences between the victims of CSA and non-abused on Suicide Ideation, sub scale of SPS (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	20.76	7.41	6.451	.000
Non-abuse	50	12.72	4.77		

Table 21 shows significant difference on subscale Suicide Ideation of SPS among the subjects, victims of CSA and non-abused. The victims of CSA adults obtained higher mean score (20.76) as compared to non-abused (12.72) on Suicide Ideation, sub-scale of SPS. The result indicate higher rate of suicide ideation among the victims of CSA as compared to non-abused adults.

Table 22

Mean score differences between CSA and non-abused on Negative self-evaluation, sub scale of SPS (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	15.44	3.35	1.807	.074
Non-abuse	50	14.14	3.83		

Table 22 shows non-significant difference on Negative self-evaluation, subscale of SPS between the subjects, victims of CSA and non-abused. Mean score of Victims of CSA (15.44) is slightly higher than the mean score of non-abused (14.14) but the t-value did not show significant difference among them on this sub-scale of SPS. The results indicate that the victims of CSA and non-abused adults have same attitude and self-evaluation about them selves.

Table 23

Mean score differences between abused and non-abused on Hostility, Sub- scale of SPS (N=100).

Group	*n*	*Mean*	*SD*	*t-value*	*p*
Abused	50	16.80	4.55		
				7.089	.074
Non-abuse	50	10.86	3.79		

Table 23 shows significant difference among the subjects, victims of CSA and non-abused on Hostility, sub-scale of SPS. The mean score (16.80) of the victims of CSA is higher than the mean score (10.86) of non-abused adults that indicate higher rate of hostile feelings among the victims of CSA adults. The t-value also clearly indicate significant difference among the victims of CSA and non-abused on hostility, sub-scale of Suicide Probability Scale.

Table 24

Means, Standard Deviation and F-values on scales of sexually abused subjects, in terms of Education, Matric, Intermediate, Graduate and Post-graduate Group, (N=50).

Scale	*Matric*		*Intermediate*		*Graduate*		*Postgraduate*		F	*p*
	M	*S.D*	*M*	*S.D*	*M*	*S.D*	*M*	*S.D*		
SFS	20.50	.71	18.45	5.05	20.62	4.19	19.60	4.34	.642	.592
SSDS	118.50	43.13	83.05	42.58	82.62	39.68	78.27	28.11	.661	.580
Helplessness	30.50	4.95	24.40	6.32	28.54	6.67	30.27	4.40	3.275	.029
Suicide Ideation	29.00	4.24	18.85	6.62	20.69	7.94	22.27	7.74	1.522	.221
Negative Self-evaluation	15.00	4.24	16.05	3.53	15.00	2.65	15.07	3.75	.356	.785
Hostility	14.00	2.83	16.10	4.85	17.23	4.95	17.73	4.01	.644	.591
Total score SPS	92.50	9.19	75.60	16.46	81.46	15.91	81.93	15.88	1.012	.396
Suicide Probability Score	69.00	18.38	41.60	23.92	49.46	24.72	55.40	24.89	1.415	.250

Table 24 indicate non-significant difference on all the scales in terms of education level of the victims of CSA group. The results indicate that the education level of the subjects did not affect the scores they obtained on all the scales and sub-scales administered on the present sample of subjects, abused group.

Table 25

Means, Standard Deviation and Standard Error of Mean on scales in term of their age, abuse group (n=50)

Scale	Group 1 (n=28) Age 18-22 years			Group 2 (n= 22) Age 23-30 years		
	Mean	*SD*	*Std Error Mean*	*Mean*	*SD*	*Std. Error Mean*
SFS	18.39	4.60	.87	20.77	4.14	.88
SSDS	80.14	39.66	7.50	86.45	35.29	7.52
Helpless -ness	36.14	6.56	1.24	29.18	5.56	1.19
Suicide Ideation	20.25	6.97	1.32	21.41	8.05	1.72
Negative Self-evaluation	15.93	3.20	.60	14.82	3.50	.75
Hostility	16.39	4.94	.93	17.32	4.06	.87
Total score SPS	79.14	16.17	3.06	80.41	16.18	3.45
Suicide Probability Score	47.46	24.89	4.70	50.68	24.75	5.28

Table 25 indicates non-significant difference between the two age groups belongs to sexually abuse adults. It shows that age is not contributory factor on assessment and does not affect the results.

Table 26

Means, Standard Deviation and t- values on scales in term of their age (N=100)

	Group 1 Age 18-22 years (N= 54)		*Group 2 Age 23-30 years (N=46)*			
Scale	Mean	SD	Mean	SD	t-value	Sig (2-tailed)
SFS	14.57	5.98	13.43	8.11	.806	.422
SSDS	59.81	37.86	57.26	39.15	.331	.741
Helpless-ness	22.78	7.86	23.57	7.74	.503	.616
Suicide Ideation	16.61	7.35	16.89	7.53	.188	.851
Negative Self-evaluation	15.39	3.61	14.09	3.59	1.804	.074
Hostility	13.61	5.25	14.09	5.03	.461	.645
Total score SPS	68.70	19.70	67.59	18.32	.292	.771
Suicide Probability Score	35.54	24.26	34.54	23.60	.207	.837

Table 26 indicates non-significant difference between the two age groups. It shows that age is not a contributory factor on assessment of psychological effects of sexual abuse and does not affect the results. These findings indicate that with the passage of time and maturity in age the severity of psychological symptoms remain same.

DISCUSSION

The objective of the study was to investigate the psychological effects of child sexual abuse on adults. Seven hypotheses were formulated to see the difference on social functioning, depression, suicide ideation, negative self-evaluation, hostility, hopelessness and suicide probability among sexually abused and non-abused adults.

The results indicate a significant difference between abused and non-abused adults and their details according to hypotheses are as follows.

Hypothesis 1

Our first hypothesis claims that the social functioning of sexually abused adults is poor as compared to non-abused adults. The mean score of Child Sexual Abused (CSA) is higher as compared to non-abused on Social Functioning Scale (SFS). The results indicate the difference in the scores on SFS between CSA and non-abused adults. These differences in scores indicate that the victims of CSA have poor social functioning as compared to non-abused.

Our results are supported by earlier studies conducted by different researchers. Browne and Finkelhor (1986) concluded that the victims of CSA have more interpersonal problems as compared to non-victims. Van Buskirk and Cole (1983) found that adults who were the victims of CSA have difficulties in interpersonal relationships. Tsai and Wagner (1978) also found positive correlation between the victimization of CSA and social functioning among adults. Deighton and McPeek (1985) studied the relationship between the victimization of CSA and interpersonal relations. They found that the victims of CSA have problems in marital, parental and friendship relations. Murphy *et al* (1988) found that victims of CSA scored higher than non-victims on interpersonal sensitivity subscale of the Symptom Checklist-90 Revised (SCL- 90- R; Derogatis 77).

They have suggested that victims of CSA experience significantly more problems related to feelings of personal inadequacy in relation to others, marked discomfort in interpersonal situations, self-consciousness, general uneasiness and negative expectancies with respect to interpersonal interactions than do non-victims.

These research findings supported the results and it is concluded that victimization of CSA is positively correlated with social functioning and the victims have poor social functioning as compared to non-victims.

There are some other psychological factors that lead to poor social functioning of the victims of CSA. High level of fear and anxiety was reported among victims of CSA adults. Johanek (1988) found that anxiety and fear, the reported symptoms among the victims might affect their interpersonal relationship. General anxiety leads to discomfort and uneasiness among the victims in any social situation and due to abnormal and uncontrolled non-verbal communication affect their dealing with people. The victims are not able to continue discussions on daily life matters due to anxiety and the other people may feel discomfort with them. Fear generally leads to uneasiness in any social situation and the victims can't maintain healthy relationships. They mostly did not attend several meetings and often avoid social gathering. They also avoid people with whom they fear of disclosing their secrecy. Some people know about their history of victimization and the victims feel discomfort in their presence. The victims also feel guilty and shame and feel discomfort in expressing their ideas and feelings in front of them.

Brier *et al* (1988) found that both female and male victims tended to report high levels of anxiety than their non-abused counterparts. It develops nervousness among them that cause their maladaptive behaviors related to their social functioning at different situations. Some victims displayed several abnormal behaviors, which may be noticed and commented by other people in any social situation. A few experiences of such distressing situation develop avoidant behavior among the victims and they deny attend such meetings again where they feel discomfort. These circumstances may develop long-term fears and high levels of generalized anxiety among the victims of CSA adults.

Stein *et al* (1988) found that victims of CSA had a significantly higher life-time prevalence of anxiety disorders (29.2%) than non-victims (10.9%). These findings provide support to the conclusion that high level of anxiety among the victims of CSA affects their social functioning. Saunders *et al* (1987) found that victims of contact abuse had a higher prevalence of a variety of anxiety disorder than non-victims. It was also concluded that the rape victims had a six times greater risk of having life time diagnosis of obsessive compulsive disorders, a five times greater risk of agoraphobia and a four time greater risk of social phobia than did non-victims. These findings provide support in concluding that victimization of CSA leads to abnormal social functioning of the victims of CSA. The victims having the obsessive-compulsive disorder may develop some abnormal thinking pattern concerning social situation that affects their performance in front of others. Others notice some compulsions in any social circumstances of victims of CSA. These observable behaviors may become the source of guilt, shame and general uneasiness for the victims. To avoid such bothering situation, the victims avoid attending social gatherings and family meetings. These habits develop avoidant behavior among the victims and their social functioning becomes poor. Obsession keeps the victims busy and they are not properly attentive to others in any social set up. Poor concentration and lack of attention on current situation affects their performance and participation in current activity that affects their social functioning. Some patients of obsessive-compulsive disorder lost their jobs due to affected interpersonal relations with their colleagues and coworkers. In some cases the victims having severe disorders avoid to participate in demanding situation due to the fear of poor achievement.

Social phobia and agoraphobia may develop as a result of victimization that affects the social functioning of the victims of CSA. The phobias related to social situation generally develop avoidant behavior among the victims of CSA. Stein *et al* (1987) conducted a study on victims of childhood rape. They concluded that these victims are more likely to have a current diagnosis of agoraphobia (sixteen times greater risk), panic disorder (Five times greater risk), obsessive-compulsive disorders (4.5 times greater risk) and social phobia (four times greater risk). These studies provide support to the findings that the social functioning of the victims of CSA is affected due to these disorders found among them.

Brier and Runtz (1988b) discussed the etiology of anxiety difficulties in childhood victims in terms of classical conditioning model. The abusive experience may represent a situation that is out of the victim's control and perceived, as threat to physical and psychological safety and that is frightening. These painful experiences of abuse are responded by the victims in the form of high level of fear and anxiety. This experience can be conceptualized as a classical conditioning situation in which the entrapment, helplessness, pain and threat of physical harm are unconditioned stimuli that evoked unconditioned responses of fear and anxiety. Conditioned stimuli such as person, situation, and events present at the time of abuse acquire the capacity to produce conditioned responses of fear and anxiety through their association with abuse-induced fear and anxiety. Some stimuli that are present throughout the abuse situation such as characteristics of offender and cues associated with the behavior are likely to become conditioned stimuli for many abuse victims. This classical conditioning model predicts that a victim's observed fears are related to the particular circumstances of the abuse situation. On the classical conditioning model, it can be suggested that fear and anxiety responses can be generalized to other stimuli similar to conditioned stimulus present during the abuse. Social functioning of the victims may be affected by such situation and we can conclude that victims of CSA develop fear and anxiety that affect their performance in any social situation. Repetition of these reactions to different situation provides strength to maladaptive behaviors of victims in social set up.

On the basis of findings and results, it is concluded that the victims of sexual abuse adults have many problems related to their social life. Mostly they have poor social functioning as compare to non-abused adults and behave differently in social set up. Their achievements concerning their social life, social attitude, behaviors and conduct are mostly poor as compared to non-abused adults.

Hypothesis II

This hypothesis states that depression among victims of CSA is higher as compared to non-victims adults. The results indicate that the victims of CSA obtained

higher mean scores as compared to non-victims on SSDS (Selma Shah Depression Scale). The results indicate the significant difference in scores of victims of CSA and non-abused.

Several studies on the differences in severity of depression among victims of CSA and non-abused supported the results. Sheldrick (1991) concluded that depression is the most common symptom among the victims of CSA. Stein *et al* (1988) found that victims of CSA had a higher prevalence of major depressive disorder that did non-victims (18.6% vs. 4.7% respectively). Johanek (1988) studied the depression among the victims of CSA and found positive correlation between them. Kelly *et al* (1988) reported high depression among victims of CSA. Agosta and Loring (1988) reported high depression among victims of CSA adults. Brier et al (1988) found depression in CSA adults as compared to non-victims. Jehu (1988) reported depression among victims of CSA adults. Bagley and Ramsay (1986) studied the non-clinical sample of CSA. Their results indicate significant prevalence of depression in victims of CSA. Conte and Schuerman (1988) reported that depression and guilt are significantly related to CSA. Haugaard and Repucci (1988) found relationship between depression and CSA. Shaprio (1989) reported the feelings of helplessness among the CSA adults. Browne and Finkelhor (1986) found that the symptoms of negative moods were common among CSA victims. Goodman and Nowak-Scibelli (1985) stated that the victims of CSA develop depression. Black-White and Kline (1985) reported depression among CSA adults. Donaldson and Gardner (1985) said that there is greater depression among victims of CSA as compared to non-victims. Sedney and Brooks (1984) have conducted a study on a non-clinical sample of CSA. They concluded that CSA adults were with significant problems of depression. Herman and Schatzow (1984) reported depression among CSA victims. Lindberg and Distad (1985) found depression in CSA adults.

Our results are supported by earlier studies that the victims of CSA have high depression as compared to non-victims adults. Several community studies have been conducted on adults who were sexually abused and it was found that victims had developed some psychiatric disorders. Peters (1988) examined the impact of contact (involving intentional and unambiguous sexual behavior of a physical nature) and non-

contact (verbal solicitation of a sexual nature) abuse in comparison to non-victims. The major depression was found significantly greater in victims of contact abuse (85%) than in victims of non-contact abuse (59%) or non-victims (66%), since age eighteen years. Victims of contact abuse reported a greater total number of major depressive episodes than victims of non-contact abuse or non-victims. Some studies indicate that victims of childhood rape had a 75% greater risk and victims of molestation had a 65% greater risk than non-victims for having a lifetime prevalence of major depression. On conducting clinical interviews about presenting problems of victims of CSA, it was found that victims of childhood molestation and victims of non-contact sexual abuse in childhood were three times more likely to have a major depressive episode than were non-victims. These studies indicate that the increased sexual intrusiveness of the abuse related to increased problems with depression. Contact abuse was associated with a greater life-time prevalence of major depression and less intrusive types of abuse were associated with current major depression.

Paykel (1974) has noted that depression usually occurs following one of three environmental events (1) interpersonal losses (2) threatening events and (3) blows to self-esteem. Goodman and Nowak-Scibelli (1985) suggested that victims of CSA experience many losses in their lives that may trigger the development of depression.

Childhood experiences of sexual abuse develop depression among the victims of CSA as a result of learning process. Due to the feelings of powerlessness, the abuse is not able to take any serious action against the abusers and they learn helplessness by such circumstances. They feel isolation because they believe that no body from their family could provide protection and safety. They do not participate in several social activities that lead to loneliness and with-drawl feelings. They lose their childhood and their personality development affected negatively. The victims of CSA perceive themselves different from other normal children and avoid to free mixing with them. Their participation in games, sports and other social activities become poor and they have few friends. These loneliness-feeling become the source of depression found among the victims of CSA.

Finkelhor & Browne (1985) and Summit (1983) found that the feelings of powerlessness among the victims of CSA and inequality of power develop the strong feelings of helplessness, being unable to avoid, escape, control or stop the abuse from occurring. These feeling and experiences have negative effects on individual's belief that they can survive in other situation. The ability of victims to cope with stresses decreases the sense of self-efficacy and to cope with stresses. Jehu (1988) suggest that these beliefs and lack of ability to exercise control on themselves, poor control on situation, poor sense of efficacy and compromising coping abilities are viewed as pervasive and contributing to the depressive experience.

It was found that the victims often experience guilt and feelings of self-blame due to the feelings of their participation and obtaining of some physical pleasure during the abuse (Fritz, Stoll and Wagner, 1981; Haller and Alter-Reid 1986; Sgroi and Bunk 1988; Tsai and Wagner 1978). In such situation the victims give regard the demand of abuser and keep this very secret. If abuser or family of victims, or society discloses the incident of abuse, the victims feel guiltier by criticizing themselves. This state produces strong feelings of depression among the victims. The victims criticized by their own family members and other members of society also develop the feelings of self-blaming resulting in depression among them.

The stigmatization of CSA has different intensity in various societies. In traditional societies like the province NWFP of Pakistan, community criticize the victims of CSA. The parents and family members of the abused mostly do not disclose to any one if the sexual abuse happens within their family. Some families feel insecure and threatened by the abuser family and avoid creating conflict between two families. These families mostly criticize the victims, by saying that this was their fault. They blame the victims that their involvement in the process of abuse was the source of victimization. This situation develops feelings of insecurity, helplessness and negative self-evaluation among the victims and result is depression. Families avoid disclosing the incident of abuse for protecting their honor in the community. This situation develops feelings of lack of protection and deprivation in nurturance among the victims of CSA. The individuals belonging to such rigid and traditional societies become depressed. Finkelhor

and Browne (1988) suggest that the stigmatization is the basic source of guilt feelings and self-blaming among the victims of CSA. Brier and Runtz (1988b) concluded that such experiences related to sever stigmatization might result in negative cognitions about the self of victims and contribute to depression.

Adults who are aware about the victims may expect some unrealistic or inappropriate sexual behavior and may enact other behaviors of the child. Such expectations may be beyond the child's developmental capabilities. It may result in negative feelings about the self (Sgroi and Bunk 1988). The negative self-evaluation of victims about themselves contributes to depression among the victims of CSA. Beck (1976) argued that the child as victims of sexual abuse is not immune to the myths related to sexual abuse present in the society. The victims often feel that they have done some thing wrong within the abuse situation or that the abuse was punishment for having done some thing wrong. Due to frightening and confusing experience of abuse, the victims may feel worthless and ashamed. These feelings also develop depression among the victims. Kilpatrik, Veronen and Resik (1982) suggest that if the family and society rejects the victims and their reactions are negative toward victims, as a result the victims may adopt many negative self-statements that contribute depression among them.

Our results supported the hypothesis that the victims of child sexual abuse exhibit severe depression as compared to non-abuse adults. Prolonged negative feelings towards themselves, hopelessness, poor self-esteem and anxieties leads to severe depression among the victims of CSA. In our communities the individuals having any experience of sexual abuse in his childhood did not given positive personal regards and his self esteem always affected negatively. Fears, feelings of helplessness, poor psychological support system and negative attitudes of the community towards victim of CSA leads to severe depression among them. The results clearly indicate that the victims of CSA have severe depression as compared to non-abused adults.

Hypothesis III

The hypothesis states that there is a significant difference in score on suicidal ideation and probability among the victims of CSA and non-abused. Suicide ideation is measured by subscale of SPS (Suicide Probability Scale), total weighted scores on SPS and suicide probability score on SPS. The mean score of victims of CSA is higher than mean score of non-abused on subscale for suicide ideation of Suicide Probability Scale (SPS). The results indicate the significant difference among the victims of CSA and non-abused about having suicide ideation. The mean score of total weighted score is higher than mean score of non-abused on SPS. These results indicate the significant difference among victims of CSA and non-victims on total weighted score of SPS. The mean score of victims of CSA is higher than the mean score of non-abused on suicide probability score on SPS. The results indicate significant difference among victims of CSA and non-victims on Suicide Probability Scale (SPS).

The studies conducted by different researchers in past supported the results and they found that the victims of CSA adults have severe suicide ideation as compared to non-abused. Edwall et al (1989) found higher rate of suicide ideation among victims of CSA as compared to non-victims. Brier (1988) also found higher rate of suicide ideation in victims of CSA as compared to non-abused. Conte (1988) reported high rate of suicide ideation in victims of CSA than non-abused. Brier and Runtz (1986,88b) also found significant difference in suicide ideation between CSA and non-abused adults. In a comparative study, Sydney and Brooks (1984) also found higher rate of suicide ideation in CSA and non-abused adults.

TAT (Thematic Apperception Test) was also administered for assessment of suicide ideation on both the groups. The results indicate the higher percentage (26%) of victims of CSA on projected indication for suicide ideation as compared to percentage (20%) of non-abused on TAT. There is no significant difference among the Projection of suicide ideation on TAT among the adults having the experience of CSA and non-abused. Researches concerning the differences on projective test of CSA did not provided

support. Wysocki and Wysocki (1977) administered projective tests to a group of incest and found no difference among victims of CSA and non-abused.

These findings supported the hypothesis that suicide ideation among the victims of CSA is higher as compared to non-abused. The results also indicate the same findings that there is a significant difference in suicide probability among victims of CSA and non-abused.

Some non-clinical sample was taken from college student's community and after investigation it was reported that the victims of CSA are likely to become self-destructive. This information was gathered through clinical interviews of college going students. It was noted that the victims were more than two times as likely to have made a suicide attempt or to have had thoughts of hurting themselves than were non-victims. Saunders *et al* (1987) have conducted a study on a community sample. They found that victims of childhood rape or molestation were more likely to have suicide ideation or to have made a suicide attempt at some time in their life, than non-victims. It was concluded by these researchers that a lifetime prevalence of suicide attempt is 15.8% of molestation victims and 17.9% of childhood rape. These findings were about three times greater than the prevalence for non-victims. It was also concluded that about one-third of the molestation and rape victims reported suicide ideation at some time during their lives compared with 19.6% of non-victims.

Severity of abuse is related to the development of self-destructive behaviors among the victims of CSA. Brier and Runtz (1986) found that the number of suicide attempts and current suicide thinking were significantly correlated with compound abuse (physical and sexual together) and the number of perpetrators. It was also concluded that longer duration of abuse, physical abuse and sexual abuse jointly, bizarre abuse and several attempts were associated with suicide ideation and attempt. The self-destructive behaviors, like suicide ideation and attempt are likely emerge as a result of guilt, self blaming and poor self-esteem of victims of CSA (Brier and Runtz, 1986, 1988b; McCann et al, 1988).

The victims suggest that they see themselves as unworthy, undeserving of life and ineffective in coping with stress. As a result of these feelings, they lose their self-esteem leading to suicide ıdeation or attempt. Some victims fell that they should punish themselves for their involvement in the abuse. These feelings trigger their self-destructive intentions in the form of suicide ideation and attempt (Brier and Runtz 1986; Jehu, 1988).

The sense of powerlessness among the victims also leads to self-destructive behaviors. They think that the abusers are more powerful and they can't express their hostility and aggression directly to them. Other important factor related to powerlessness is lack of confrontation to the situation and poor coping methods. The individuals faced such circumstances adopted pathological patterns of coping methods to escape or avoid emotional pain.

Blake-White and Kline, (1985); Brier and Runtz (1986) suggest that victims adopted such coping mechanism that leads to self-destructive behavior like suicide ideation and attempt. It was also noted that victims believe that there is not any other way to communicate their pain except self-destructive behaviors.

The results clearly indicated that the victims of CSA adults have severe suicide ideation in their present life situation as compared to non-abused. Closed society, negative attitudes of community towards the victims of CSA and lack of opportunities for emotional catharsis leads to self destructive behaviors among the victims of CSA in the form of suicide ideation.

Hypothesis IV

This hypothesis states that negative self-evaluation among the victims of CSA is higher than non-victims. Results do not indicate significant difference among the victims of CSA and non-abused subjects. The mean score of abused is slightly higher than mean score of non-abused adults on subscale of SPS. The results indicate non-significant difference between the victims of CSA and non-abused.

The studies related to negative self-evaluation indicate that the victims of CSA mostly evaluated them selves negatively but the scale used for assessment of the symptom of negative self-evaluation was the sub scale of Suicide Probability Scale, (SPS). According tc the manual of the SPS, the individual gives responses on this subscale related to his present circumstances and how he perceives the current environment around him. This scale measured the feelings of the respondent about the present situation, how he is feeling now and how the things are going on currently. With the passage of time the circumstances and environment around the individuals may change due to long duration and the intensity of the incident of CSA may loose its negative feelings about the environment. Due to change in physical condition of the individuals, power and attitude toward the environment may affect the results that they showed non-significant correlation between the factor of CSA and negative self-evaluation.

Institutional, academic and organizational environments sometimes have positive influences on the attitudes of the individuals concerning their circumstances. Some individuals when changed their places for the purpose of education, jobs or trainings, these institutions play an important role in changing the attitude of the individuals positively.

The results did not support the hypothesis that the victims of CSA adults evaluate them selves negatively. With the passage of time, the negative feelings about them selves may change and some situational factors contribute in changing their attitude towards them selves. The sub scale of Suicide Probability Scale measuring the negative self-evaluation of the subjects may be responded in a defensive style by them and some cultural and psycho-social patterns affects the results negatively.

Hypothesis V

The hypothesis states that the victims of CSA have more hostility as compared non-victims. The mean score of victims of CSA is higher than the mean score of non-victims on the subscale, hostility of SPS. The results indicate the significant difference among the victims of CSA and non-abused.

These findings are supported by different researches conducted in past indicating that the level of hostility among the victims of CSA is greater than the non-victims. Researches conducted in past on the hostility among the victims of CSA indicate that victimization of CSA develops hostility among them. Conte (1988) found hostility as the outcome of CSA among adults. Browne and Finkelhor (1986) concluded that victims of CSA develop hostility. Gomes-Schwartz *et al* (1990) have concluded that the victims of CSA were more aggressive than community norms for aggression but less than clinical norms. These studies supported our results that the victims of CSA have greater feelings of hostility as compared to non-victims.

The victims of CSA often exhibit aggression and hostility towards others especially toward the abuser, their parents and care takers. The hostile feelings towards abusers are natural, as they wish to take the revenge, and towards parents and care takers due to lack of protection. The victims think that their parents did not take any steps against the abusers and other related persons who were the source of guilt, shame and worthlessness for them. Haller and Alter-Reid (1986) suggest that clinical observations of victims of CSA indicate anger and hostile feelings towards their mothers for lack of protection and their fathers for lack of accountability and exploitation.

The abuse situation provide an insight to victims that at least some people behave in a harmful ways. If the abuser is known to victims or happens to be a trusted individual, the victim learns that trust can be illusory. The victims feel anger, bitterness and resentment toward the offender who harm them. These feelings of hostility and anger appear to generalize to others and may be a mechanism of self-protection from future abuse (Finkelhor, 1988). It was further suggested that the victim may feel continuous anger towards the offender whose behavior undermined his sense of power and control

and may generalize his anger to others who reinforce their powerlessness. Exposure to abuser is also a source of frustration for not taking any step against the abuser due to powerlessness. This frustration leads to aggression and hostility towards abuser. The feelings of guilt and shame are the source of hostile feelings towards others in a traditional society where community criticize the victim and not the abuser.

Loss of esteem in front of others may result in development of negative attitude among the victims toward others, that people are inherently bad and interested in harming others. These dynamics may lead the victim to a chronic experience of rage (Brier and Runtz, 1988b).

The results clearly indicate that the victims of CSA have strong feelings of hostility as compared to non-abused. Living in the same environment with the abuser and other members of the society who did not take any action against the abuser mostly develop hostile feelings towards others and aggression among the victims of CSA adults. The feelings of helplessness and defensive style of the victims also leads to hostile feelings toward others.

Hypothesis VI

A subscale of SPS assesses hopelessness between both the groups. The results indicate a significant difference among the scores of victims of CSA and non-abused adults. These results indicate that the victims of CSA have more feelings of hopelessness as compared to non-victims.

Previous researches supported the results that the victims of CSA feel hopelessness. Donaldson and Gardner (1985) indicated depression and feelings of helplessness among the adults having experience of CSA in their childhood. They claimed that the victims of CSA suffered in prolong depression that leads to the feeling of hopelessness. The victims remain close to the abuser and mostly have social contact with him due to closed secrecy of the incident. The victims did not tell the story of incident of sexual abuse to any one and they will have to face the situation even confronting the

abusers in their daily life. Due to this social set up the victims did not exhibit any hostile feelings directly toward the abuser. These circumstances always develop the feelings of hopelessness among the victims of CSA in any society and specially closed societies like the community of the NWFP.

Lisak (1994) reported the symptoms of helplessness, isolation, and self-blame among the victims of CSA. These symptoms collectively leads to the feelings of hopelessness among them. Agosta and Loring (1988) found associated feature of depression including feelings of helplessness among the adults who were the victims of CSA. Donaldson and Gardner (1985) also indicated depression and feelings of helplessness among the adults having experience of CSA in their childhood.

Our results clearly indicated that the victims of CSA adults of the present sample have more feelings of helplessness as compared to the non-abused sample. The victims of the present society did not open the secret like sexual abuse because they feel shame and guilt when the community came to know about the incident. They keep it always secret and have prolong hostile feelings towards the abuser. This situation leads to the feelings of hopelessness as a result of depression and social barriers for exhibition of aggressive feelings towards the abuser.

Hypothesis VII

This hypothesis was formulated to see the suicide probability among the victims of CSA and to the difference in scores among the abuse and non-abuse subjects. The results clearly indicate the significant difference in scores among the victims of CSA and non-abused adults.

Our results are supported by several studies conducted by researchers in past showing that the suicide probability among the victims of CSA was high as compared to non-abused adults. Brier and Runtz (1988b) found that the victims of CSA are more likely than non-victims to indicate a history of suicide attempts. These findings indicate

that the victims of CSA have more suicide thinking and have the history of suicide attempt in their life as compared to non-victims. Blake-White and Kline, (1985); and Sgroi and Bunk(1988) found that the victims of CSA have common problem of self-destructive behaviors and suicidal ideations and attempts as compared to non-abused. These findings also supported the results that the victims of CSA adults have more suicide probability as compared to non-abused adults.

Jehu (1988) has conducted a study on the victims of CSA adults and found that they often think that they should punish themselves for their involvement in the incident of abuse. The feelings of guilt, shame and self destructive behaviors among the victims of CSA leads to suicide ideation and attempt.

In an other study, Sedney and Brooks (1984) observed that victims of CSA were more than two times as likely to have made a suicide attempt or to have had thoughts of hurting themselves than were non-victims among a sample of college going students. These findings also supported the results that the victims of CSA have a history of suicide thinking in their life and they may have attempt suicide any time. Further these findings also supported the hypothesis that the victims of CSA adults have a tendency of suicide thinking and attempt in future.

Peters (1988) have taken a within community sample and found that the victims of contact or non-contact abuse were approximately three times more likely to have made a suicide attempt than non-victims. The present study also supported the results that the victims of CSA are always at a risk of suicide attempt as compared to non-abused adults.

Lisak (1994) also reported the symptoms of helplessness, isolation self-blame, shame, guilt and humiliation among the victims of CSA. These findings also supported the the results that the victims of CSA adults have several psychological problems and the cluster of symptoms that lead to self destructive behaviors in the form of suicide ideation or attempt.

It was found and hypothesized by several researchers in past that the long life depressive state, feelings of helplessness, self-blaming and negative self-evaluation leads to severe suicide ideation and tendencies towards self-destructive behaviors. Feelings of

powerlessness, mal-adoptive coping mechanism and hopes to avoid or escape from emotional pain leads to destructive behaviors among the victims of CSA. They see themselves as unworthy, non-deserving of life and ineffective for coping with stresses in their present life.

We have also analyzed the data by age of the subjects having the experience of CSA and non-abused. The distribution of age of the subjects (N=100) is ranged from 18 to 30 years. The difference on scores of all the scales between the subjects of CSA and non-abused in terms of their age are non-significant. The subjects were divided into two age groups having the range of 18-22 and 23-30 years. The results indicate non-significant difference on all the scales for assessment of depression, social functioning and suicide probability and ideation in terms of their age. These findings indicate that with the passage of time, maturity in age and growth did not affect the intensity of the symptoms as a result of the victimization of sexual abuse. The victims of CSA of young age have the same intensity of psychological symptoms as the older victims have in their present life. In some cultures where there are the chances of natural rehabilitation are present about the psychological effects of victimization of sexual abuse, the victims recovered automatically and the intensity of symptoms may decreased. But in those cultures where there are no such opportunities are present, the intensity of the psychological symptoms remain same. The victims of the present society did not exposed to any situation where they have a chance to disclose the incident of sexual abuse and get any psychotherapeutic support for overcoming the psychological problems. These factors affect the individuals for a long period of time and the symptoms related to the victimization of sexual abuse remain with the same intensity among the abused adults.

Four groups were formulated of the subjects in terms of their education levels. First group was of those subjects whose education level was Matric, second was of F.A. then B.A. and finally of M.A.). The differences in the scores of both the groups on all the scales in terms of their education were non-significant.

The results of non-significant differences within the groups in terms of education clearly indicated that the education level of the subjects did not affect the results and the level of education has no role in the intensity of the symptoms of depression, poor social functioning and suicide ideation among the victims of CSA and non-abused adults. The level of education is mostly related to institutional learning and some institutions and departments are assumed to provide some chances for adults to deal with their psychological problems. The academic institutions and working environments in Pakistani society and specially of NWFP are not equipped with any facility where the victims of CSA could overcome on the psychological symptoms as a result of victimization. The teachers and coworkers did not discuss such issues openly and the victims of sexual abuse did not open themselves in front of any body. Department fellows, classmates, close friends and tutors does not aware about the incident of victimization and this is the reason that the victims did not obtained any social and psychological support by them.

Summary

The purpose of the present study was to investigate the long-term psychological effects of child sexual abuse on adults. A pilot study was conducted on a few subjects who were the victims of child sexual abuse in their childhood. Clinical observations, psychological symptoms and behaviors of the victims of CSA provide guideline for designing a study for assessment of long-term effects upon them. Social functioning, depression, suicide ideation, hopelessness, negative self-evaluation and hostility were the major dependent variables in the study measured long-term psychological effects of CSA on adults.

It was hypothesized that anxiety and feelings of mistrust affects the interpersonal relationships of victims. Isolation, feelings of loneliness and social with-drawl affects social functioning of adults having the experience of CSA. Due to social stigma of sexual abuse the victims developed negative feelings about environment, general uneasiness, self-consciousness and negative expectations from the environment that affects their social functioning.

Guilt feelings, self-blaming, shame, poor self-esteem and fear of losing self respect developed depression among the victims of CSA adults. Salma Shah Depression Scale (SSDS) Urdu version was administered on adults having the experience of CSA to see the difference in scores comparing with control group, non-abused.

Prolonged depression, helplessness feelings, self-blaming and negative self-evaluation developed suicide ideation among the victims of CSA. Suicide Probability Scale (SPS) was administered on experimental and control group to see the difference. Self-criticism, negative feelings and attitudes towards themselves developed negative self-evaluation among the victims of CSA. One hypothesis was formulated and tested to see the difference on scores of negative self-evaluation, the sub-scale of SPS. Desires to take action against abuser, frustration and repression of hostile feelings developed hostility among the victims. The difference on hostility was measured among the victims of CSA and non-abused by administering the sub-scale of SPS for hostility.

The sample of one hundreds subjects was randomly selected from the North Western Frontier Province of Pakistan. Half of the subjects were acted as experimental group who

have the experience of CSA in their childhood. The rest of them acted as control group having no history of sexual abuse in their childhood.

Social functioning scale was constructed by self and it's items were selected on the basis of clinical observations, literature review and behaviors of victims of CSA. Items generation, empirical evaluation and item analysis carried out the validity and reliability of the scale. High scores on social functioning scale indicate the poor social functioning of the subjects.

Projective test (TAT) was administered on both the groups to see the deference of depression and suicide ideation projected in the stories.

All the psychological tests and scores were administered individually on the subjects at their own places and there was no group testing.

Significant inter-scale correlations of social functioning scale, Salma Shah Depression Scale and Suicide Probability Scale of experimental and control group was found. The inter-scale correlation of control and experimental group on sub-scales, hopelessness, hostility and suicide ideation was also found significant.

The results indicate significant differences of abused and non-abused on depression, social functioning, suicide ideation, hostility, hopelessness and suicide probability. Non-significant difference was found between the experimental and control group on negative self-evaluation. Non-significant difference was also found on projective test between the two groups. Age and education of the subjects did not affects the results and non-significant differences were found on all the scales and tests in terms of their age and education.

CONCLUSION, SUGGESTIONS

AND SUMMARY

CONCLUSION AND SUGGESTIONS

Chapter V

Conclusion

The present study provided evidence suggesting that the victims of child sexual abuse adults suffered some psychological problems. Significant differences are formulated on measurement of depression, social functioning, suicide ideation, hostility and hopelessness among the subjects having the experience of sexual abuse in their childhood and non-abused. The strength of the relationship between the victimization of child sexual abuse and its long-term psychological effects on the adults is particularly noteworthy.

The factor victimization of child sexual abuse (CSA) affected the personality and general development of the subjects. Due to the feelings of inadequacy, self-consciousness and general uneasiness disturbed their social behavior. Social isolation due to guilt and fear of breaking secrecy, feelings of rejections by other members of society affected the interpersonal relations of the victims of CSA. Fears related to protection and nurturance in the environment affected their social functioning.

The present study also revealed that the adults having the experience of CSA in their childhood may suffer shame, guilt and self-blaming that develops depression among the victims. Prolong depression, feelings of helplessness, negative self-evaluation and self directed hostility may develop suicide ideation and tendencies towards suicide attempt among the victims of CSA. Lack of social and psychological support system and rehabilitation facilities, the victims of CSA found them ineffective for coping with stresses related to the issue of CSA alone. For avoiding or escaping from emotional pain of memories of victimization developed destructive behaviors among them in the form of suicide ideation or attempt.

The victims of CSA considered the phenomenon of victimization as a social stigma and developed fear of loosing respect and honor. They feel lack of protection and accountability by parents and society that develop hostility among them.

It may be concluded that the victims of child sexual abuse adults suffered high depression, poor social functioning, suicide ideation, hostility, hopelessness and high risk

in suicide probability. The study revealed a significant difference among the victims of CSA and non-abused on depression, social functioning, suicide ideation, hopelessness, hostility and suicide probability on measurement of these symptoms by scales and tests. It is concluded that the results are significant ($p<.01$) except negative self-evaluation of the victims of CSA and non-abused ($p>.01$ and $p>.05$) measured by sub-scale of Suicide Probability Scale (SPS).

Suggestions

During the present study, a few factors are identified to explore and given particular attention in further investigations related to the issue of psychological effects of child sexual abuse (CSA) on adults.

The present study was conducted on a small sample due to non-availability of adults having the experience of CSA as a result of social stigma in the community. A large sample may refine the results.

A valid and reliable scale adopted in Pakistani culture measured depression but suicide ideation, hostility, negative self-evaluation and suicide probability is measured by Suicide Probability Scale (SPS) that is not adopted in Pakistani culture. This cross culture factor related to the adaptation of the scale may affect the results. Culturally adopted psychological tests and scales may assess the subjects better as compared to culturally bound scales and tests.

There is a need to identify the exact age level of the victims of CSA when the incident of sexual victimization was occurred. In the present study the researcher that may affect the results did not record the age of victimization. Some previous researches indicate that sexual abuse at young age has poor psychological damages as compared to the incident of sexual abuse if happened at mature age in childhood. During the investigation of long-term psychological effects of CSA, It is important to identify the frequency of abuse. Several studies show that frequency of victimization is important factor related to the long-term effects of CSA and it was found that the prolonged victimization has sever effects as compared to a single incident.

Incest should be explored independently and the other forms of CSA are not investigated with incest. Studies indicate that incest have serious psychological damages as compared to another form of CSA.

The discriminative validity of Social Functioning Scale (SFS) needs further strengthen by applying on other patients having different diagnosis.

The long period between the incident of victimization of CSA and the time of investigation may affects the results measured by projective technique. Projective tests may help in assessment of victims personality in current circumstances but the effects of victimization are not seems to be measured properly by projective tests. It is suggested that the selection of projective test for assessment of long-term psychological effects of CSA should be carefully designed.

The clinical sample of the victims of CSA who seek help for counseling and psychotherapy may provide complete information about the incident and provide a chance to a counselor or psychotherapist for breaking the secrecy and defenses. This sample should be tested for investigation of long-term psychological effects of CSA.

Free and low cost services for counseling and psychotherapy may encourage and mobilize the victims towards psychological rehabilitation and recovery. This trend among the victims of CSA may helpful in breaking the cycle of sexual child abuse by victims to other children. Parent's counseling and awareness about the issue of CSA may mobilize them for taking steps to care and protect their children by avoiding all the risks of child sexual abuse.

Progressive groups after training can be formulated to combat with abusers in the community. Print and electronic media can play important role in awareness raising and preventive measures about the issue.

Community should be sensitizing to discuss the issue openly and teachers should communicate the relevant information to children at school level. Awareness among the parents, siblings and other related personals may help the children to open the issue and get help by counselor or psychologist. The important advantage of awareness is to provide support in data collection to researchers on the issue of CSA.

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ANNEXURE

ANNEXURE

سوالنامہ 1

اس سوالنامے میں آپ کی شخصیت کے متعلق کچھ سوالات درج ہیں۔آپ سے گذارش ہے کہ ان کے صحیح جوابات دیں تا کہ موجودہ تحقیق پایہ تکمیل تک پہنچ سکے۔ ہر بیان کو غور سے پڑھیں اور جو بیان آپ پر لاگو ہوتا ہو۔اس پر ٹک (✓) کا نشان لگائیں۔ ہر بیان کو تین درجوں میں تقسیم کیا گیا ہے۔

نام ---------- عمر ---------- پیشہ ---------- تعلیم ----------

پتہ ----------

نمبر شمار		نہیں	کبھی کبھی	ہاں
.1	پرائمری تعلیم کے دوران میری کارکردگی سکول میں اچھی تھی۔			
.2	مجھے بچپن کے واقعات اچھے لگتے ہیں۔			
.3	میں الگ تھلگ رہنا پسند کرتا تھا۔			
.4	مجھے بڑا کام کرنے یا اس میں شریک ہونے سے ڈر نہیں لگتا تھا۔			
.5	میں دوسروں پر بھروسہ نہیں کرتا تھا۔			
.6	مجھے غصہ جلد اور زیادہ آتا تھا۔			
.7	میں اپنے آپ میں گم سم رہتا تھا۔			
.8	میں اپنے آپ کو بیمار اور کمزور سمجھتا ہوں۔			
.9	میں کوئی نشہ آور چیز استعمال کرتا ہوں۔			
.10	میں اپنے آپ کو کمتر سمجھتا ہوں۔			
.11	مجھے خودکشی کرنے کے خیالات آتے تھے۔			
.12	بچپن کے کچھ واقعات مجھے بہت تنگ کرتے ہیں۔			
.13	عمر میں بڑے لڑکے میرے ساتھ زیادتی کرتے تھے۔			
.14	مجھے اپنے راز عیاں ہو جانے کا ڈر رہتا تھا۔			
.15	میں اپنے آپ سے بہت نفرت کرتا تھا۔			
.16	میں اکثر خوفزدہ رہتا تھا۔			

نمبر شمار	نہیں	کبھی کبھی	ہاں
17. میں اپنے دل کی بات دوسروں کو بتانے کیلئے بے تاب رہتا تھا۔	17.		
18. مجھے بچپن میں اکثر لوگ چوما کرتے تھے۔	18.		
19. میں اپنے آپ کو الجھا ہوا محسوس کرتا ہوں۔	19.		
20. بڑے مجھے ننگا دیکھنا پسند کرتے تھے۔	20		
21. کچھ لوگ مجھے بہت بُرے لگتے تھے۔	21.		
22. مجھے ڈراونے خواب آتے تھے۔	22.		
23. بڑے لوگ مجھے اپنے آپ کو ننگا دکھاتے تھے۔	23.		
24. لوگوں کے ہجوم میں میری طبیعت جلد خراب ہو جاتی ہے۔	24.		
25. بچپن میں میں اپنے ناخن دانتوں سے کاٹتا تھا۔	25.		

ٹوٹل نمبر:۔

Prepared by:

S.Asghar Ali Shah

Clinical Psychologist.

سوالنامہ 2

اس سوالنامے میں آپ کی شخصیت کے متعلق کچھ سولات موجود ہیں۔آپ سے گذارش ہے کہ ان سولات کے صحیح جوابات دیں تا کہ موجودہ تحقیق پایہ تکمیل تک پہنچ سکے۔ شکریہ!

ہدایات: ہر بیان کو غور سے پڑہیں اور جو بیان آپ کے متعلق درست ہو اس کے سامنے دیئے گئے درجے پر نشان لگائیں۔

نام_____ولدیت_____ عمر_____

بیانات:

	نہیں / کبھی کبھی / ہاں
.1	میں دوسروں پر بھروسہ نہیں کرتا ہوں۔
.2	ہجوم میں مجھے گھبراہٹ ہوتی ہے۔
.3	میں دوسروں کے جذبات کو شک کی نظر سے دیکھتا ہوں۔
.4	اگر میری کوئی مدد کرنا چاہے تو میں اس پر شک کرتا ہوں۔
.5	میں دوستوں کے ساتھ زیادہ محبت نہیں کرتا۔
.6	دوسروں کے ساتھ تعلقات جلد ختم ہو جاتے ہیں۔
.7	میں اپنے آپ کو الجھا ہوا محسوس کرتا ہوں۔
.8	حالات سے فرار اختیار کرنا میری عادت ہے۔
.9	میرا موڈ بہت جلد تبدیل ہو جاتا ہے۔
.10	مجھے بلاوجہ غصہ آتا ہے۔
.11	شرارت کرنا مجھے اچھا لگتا ہے۔
.12	میں اپنے آپ میں گم سم رہتا ہوں۔
.13	میرے مزاج کا کچھ پتہ نہیں چلتا۔
.14	میں ہر کام ٹھیک اور وقت پر کرنے کا عادی ہوں۔
.15	میں کوئی نشہ آور چیز استعمال کرتا ہوں۔

نہیں	کبھی کبھی	ہاں
.1		
.2		
.3		
.4		
.5		
.6		
.7		
.8		
.9		
.10		
.11		
.12		
.13		
.14		
.15		

	ہاں	کبھی کبھی	نہیں
16. میں دوسروں کی تنقید برداشت نہیں کرسکتا۔			
17. مجھے اندھیرے سے ڈر لگتا ہے۔			
18. خریداری کے دوران میں زیادہ بحث نہیں کرتا۔			
19. تقریبات میں جانا مجھے پسند نہیں۔			
20. بڑی شخصیت سے ملنے سے کترانا میری عادت ہے۔			

ٹوٹل نمبر:۔

Prepared by:

S.Asghar Ali Shah

Clinical Psychologist.

Annexure V — The 36 Items obtained from Phase II (Study I)

یہ سوال مرد کی مختلف سوچ اور احساسات کو بیان کرتا ہے ہر بیان کے سامنے چار کالم دیئے گئے ہیں جو ان سوچ اور احساسات کے مختلف درجوں کو ظاہر کرتے ہیں۔ آپ سے درخواست ہے کہ غور سے پڑھیں اور وہ جس حد تک آپ پر لاگو ہوتے ہیں ان کا اظہار دیئے گئے درجوں کی مدد سے کریں مثلاً اگر ایک بیان آپ پر "کبھی نہیں" لاگو ہوتا ہے تو پہلے کالم درست (✓) کا نشان لگائیں اور اگر بیان "ہر وقت" صادق آتا ہے تو آخری کالم میں درست (✓) کا نشان لگائیں۔ اسی طرح کالم نمبر ۲ اور ۳ کو استعمال کریں۔

		کبھی نہیں	کبھی کبھار	اکثر اوقات	ہر وقت
۱۔	میں بہت ناامید ہو گیا ہوں / ہو گئی ہوں۔				
۲۔	میں اپنے آپ کو الجھا ہوا محسوس کرتا ہوں / کرتی ہوں۔				
۳۔	میں بہت بدنصیب ہوں۔	✓			
۴۔	میری بھوک تقریباً ختم ہو چکی ہے۔				
۵۔	میری دعائیں قبول نہیں ہوتیں۔				
۶۔	میرا اپنے والدین سے اختلاف رہتا ہے۔				
۷۔	لوگ مجھ پر ہمیشہ تنقید کرتے ہیں۔				
۸۔	میرا زور زور سے رونے کو دل چاہتا ہے۔				
۹۔	میں کوئی کام ڈھنگ سے نہیں کر سکتا / کر سکتی۔				
۱۰۔	مجھے اپنے کئے کی سزا مل رہی ہے۔				
۱۱۔	میرے دل کی دھڑکن یکدم تیز ہو جاتی ہے۔				
۱۲۔	کامیابی اور ناکامی قسمت کا کھیل ہے۔				
۱۳۔	میری زندگی ختم ہونے والی ہے۔				
۱۴۔	مجھے کچھ کھو دینے کا احساس دامن گیر رہتا ہے۔				
۱۵۔	مجھ میں کسی چیز کی کمی ہے۔				
۱۶۔	میں اپنے آپ کو بہت بے قیمت محسوس کرتا ہوں / کرتی ہوں۔				
۱۰۔	دوسرے لوگ ہمیشہ مجھ پر حاوی رہتے ہیں۔				
۱۸۔	میں بہت جلد پریشان ہو جاتا ہوں / ہو جاتی ہوں۔				
۱۹۔	مجھے اپنی زندگی سے نفرت ہے۔				
۲۰۔	میں اپنے آپ کو تنہا محسوس کرتا ہوں / کرتی ہوں۔				
۲۱۔	مجھے اپنا جسم تھکا تھکا سا لگتا ہے۔				
۲۲۔	میں ایک ناکارہ شخص ہوں۔				
۲۳۔	مجھ میں بہت سی خامیاں ہیں۔				
۲۴	دوست میرے احساسات کو سمجھ نہیں پاتے۔				
۲۵۔	میں بہت جلد حوصلہ ہار دیتا ہوں / دیتی ہوں۔				
۲۶۔	میں نالائق ہوں۔				
۲۷۔	میں اوروں سے کم تر ہوں۔				
۲۸۔	میرا دل اب بالکل اچاٹ ہو گیا ہے۔				
۲۹۔	میں ایک قابلِ نفرت انسان ہوں۔				
۳۰۔	میرے دوست مجھے خود غرض لگتے ہیں۔				
۳۱۔	مجھے ماضی کی یاد اداس کر دیتی ہے۔				
۳۲۔	مجھے ٹھیک سے نیند نہیں آتی۔				
۳۳۔	میں اپنے مستقبل سے بے حد مایوس ہوں۔				
۳۴۔	میں اپنے والدین کے مثالی بچے کے تصور پر پورا نہیں اترتا / اترتی۔				
۳۵۔	زیادہ تر لوگ بھروسے کے لائق نہیں ہوتے۔				
۳۶۔	میں شدت سے موت کی خواہش کرتا ہوں / کرتی ہوں۔				

SALMA SHAH DEPRESSION SCALE

SPS
Rating Form
John G. Cull, Ph.D. and Wayne S. Gill, Ph.D.

Published by

WPS WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025

Name: _____ Sex: M F Age: _____ Marital Status: _____

Education: _____ Race: _____ Usual Occupation: _____ Today's Date: _____

Have you had any major upsets or stresses in the last two years? ☐ Yes ☐ No. If yes, what were they and about how long ago did they occur?

_____

DIRECTIONS

Listed below are a series of statements that some people might use to describe their feelings and behaviors. Please read each statement and determine how often the statement is true for you. Then circle the letter T in the appropriate box to indicate how often you feel the statement applies to you.

Be sure to rate every item. When you are through, return the completed rating form to the person who gave it to you.

Example:

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel anxious.	T	(T)	T	T

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. When I get mad I throw things.	T	T	T	T
2. I feel many people care for me deeply.	T	T	T	T
3. I feel I tend to be impulsive.	T	T	T	T
4. I think of things too bad to share with others.	T	T	T	T
5. I think I have too much responsibility.	T	T	T	T
6. I feel there is much I can do which is worthwhile.	T	T	T	T
7. In order to punish others I think of suicide.	T	T	T	T
8. I feel hostile toward others.	T	T	T	T
9. I feel isolated from people.	T	T	T	T
10. I feel people appreciate the real me.	T	T	T	T
11. I feel many people will be sorry if I die.	T	T	T	T
12. I feel so lonely I cannot stand it.	T	T	T	T
13. Others feel hostile toward me.	T	T	T	T
14. I feel, if I could start over, I would make many changes in my life.	T	T	T	T
15. I feel I am not able to do many things well.	T	T	T	T
16. I have trouble finding and keeping a job I like.	T	T	T	T
17. I think that no one will miss me when I am gone.	T	T	T	T
18. Things seem to go well for me.	T	T	T	T
19. I feel people expect too much of me.	T	T	T	T
20. I feel I need to punish myself for things I have done and thought.	T	T	T	T
21. I feel the world is not worth continuing to live in.	T	T	T	T
22. I plan for the future very carefully.	T	T	T	T
23. I feel I don't have many friends I can count on.	T	T	T	T
24. I feel people would be better off if I were dead.	T	T	T	T
25. I feel it would be less painful to die than to keep living the way things are.	T	T	T	T
26. I feel/felt close to my mother.	T	T	T	T
27. I feel/felt close to my mate.	T	T	T	T
28. I feel hopeless that things will get better.	T	T	T	T
29. I feel people do not approve of me or what I do.	T	T	T	T
30. I have thought of how to do myself in.	T	T	T	T
31. I worry about money.	T	T	T	T
32. I think of suicide.	T	T	T	T
33. I feel tired and listless.	T	T	T	T
34. When I get mad I break things.	T	T	T	T
35. I feel/felt close to my father.	T	T	T	T
36. I feel I can't be happy no matter where I am.	T	T	T	T

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W-172A

Suicide Probability Scale (SPS)

Rating Form

John G. Cull, Ph.D. and Wayne S. Gill, Ph.D.

Published by

WPS WESTERN PSYCHOLOGICAL SERVICES
Publishers and Distributors
12031 Wilshire Boulevard
Los Angeles, California 90025

Total Weighted Score _____

Index Score _____

Probability Score _____

Suicide Risk:

Mild Moderate Severe

Name: _____ Sex: M F Age: _____ Marital Status: _____

Education: _____ Race: _____ Usual Occupation: _____ Today's Date: _____

Have you had any major upsets or stresses in the last two years? ☐ Yes ☐ No. If yes, what were they and about how long ago did they occur?

_____

Life Events*

☐ Psychosocial Stressors (DSM-III, Axis IV) (most recent listed first):

	Nature	Date	*Severity*
1.			1 2 3 4 5 6
2.			1 2 3 4 5 6
3.			1 2 3 4 5 6

☐ Previous History of Suicide Attempts:

	Method	Date	Seriousness
1.			
2.			
3.			

*1 = minimal; 2 = mild; 3 = moderate; 4 = severe; 5 = extreme; 6 = catastrophic.

Indicators for Major Depressive Episode (DSM-III)

☐ Dysphoric Mood

☐ Other Clinical Indicators (at least four consistently present during last 2 weeks):

- ○ Disturbed appetite
- ○ Sleep disturbance
- ○ Psychomotor agitation/ retardation
- ○ Loss of interest/ pleasure
- ○ Loss of energy, fatigue
- ○ Feelings of worthlessness
- ○ Diminished ability to think
- ○ Recurrent thoughts of suicide

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. When I get mad I throw things.	1	3	3	4
2. I feel many people care for me deeply.	4	2	1	1
3. I feel I tend to be impulsive.	1	1	2	3
4. I think of things too bad to share with others.	1	2	2	5
5. I think I have too much responsibility.	1	1	2	4
6. I feel there is much I can do which is worthwhile.	3	3	1	1
7. In order to punish others I think of suicide.	1	4	5	5
8. I feel hostile toward others.	1	2	3	5
9. I feel isolated from people.	1	2	4	5
10. I feel people appreciate the real me.	3	2	0	2
11. I feel many people will be sorry if I die.	2	2	1	2
12. I feel so lonely I cannot stand it.	0	3	3	5
13. Others feel hostile toward me.	1	2	4	5
14. I feel, if I could start over, I would make many changes in my life.	0	1	2	4
15. I feel I am not able to do many things well.	1	2	3	4
16. I have trouble finding and keeping a job I like.	1	3	4	5
17. I think that no one will miss me when I am gone.	1	2	3	4
18. Things seem to go well for me.	4	3	0	1
19. I feel people expect too much of me.	1	1	2	4
20. I feel I need to punish myself for things I have done and thought.	1	2	4	4
21. I feel the world is not worth continuing to live in.	1	3	4	5
22. I plan for the future very carefully.	3	2	1	2
23. I feel I don't have many friends I can count on.	1	2	3	4
24. I feel people would be better off if I were dead.	1	4	5	5
25. I feel it would be less painful to die than to keep living the way things are.	1	3	4	5
26. I feel/felt close to my mother.	3	2	1	1
27. I feel/felt close to my mate.	3	2	1	1
28. I feel hopeless that things will get better.	0	2	3	4
29. I feel people do not approve of me or what I do.	1	2	3	4
30. I have thought of how to do myself in.	1	3	4	5
31. I worry about money.	1	1	2	3
32. I think of suicide.	1	3	5	5
33. I feel tired and listless.	1	1	3	5
34. When I get mad I break things.	1	2	4	5
35. I feel/felt close to my father.	2	2	1	1
36. I feel I can't be happy no matter where I am.	0	3	4	4

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W-172A

Suicide Probability Scale (SPS)
Profile Form

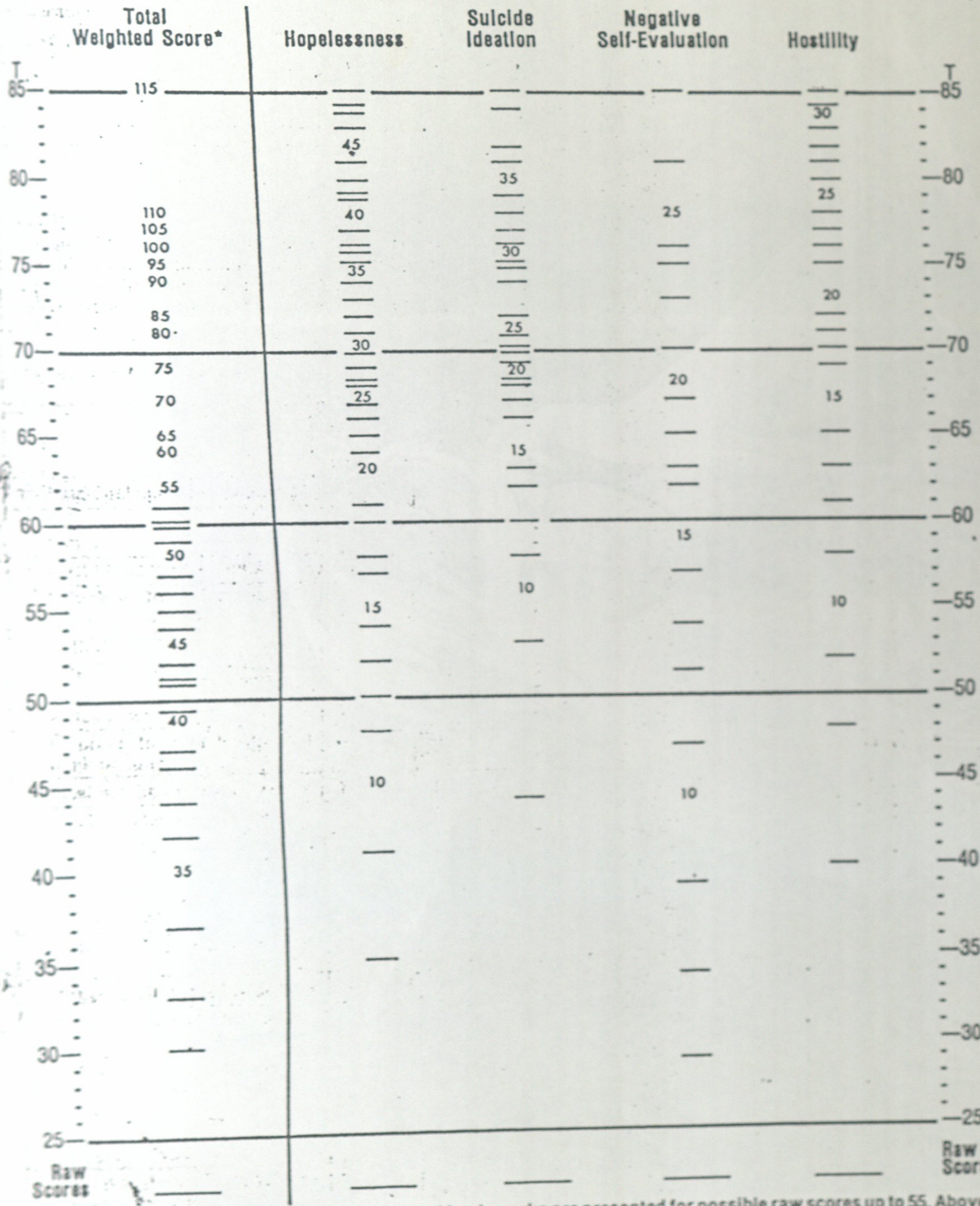
John G. Cull, Ph.D. and Wayne S. Gill, Ph.D.

Published by

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12031 Wilshire Boulevard
Los Angeles, California 90025

Name: _____ Sex: M F Age: _____ Marital Status: _____

Education: _____ Race: _____ Usual Occupation: _____ Date: _____



* For the total weighted score, numbers and hash marks are presented for possible raw scores up to 55. Above a raw score of 55, only numerical values for every five raw scores are listed.

RAW SCORES

Hopelessness
Item 5 ____
Item 12 ____
Item 14 ____
Item 15 ____
Item 17 ____
Item 19 ____
Item 23 ____
Item 28 ____
Item 29 ____
Item 31 ____
Item 33 ____
Item 36 ____
Total _____

Suicide Ideation
Item 4 ____
Item 7 ____
Item 20 ____
Item 21 ____
Item 24 ____
Item 25 ____
Item 30 ____
Item 32 ____
Total _____

Negative Self-Evaluation
Item 2 ____
Item 6 ____
Item 10 ____
Item 11 ____
Item 18 ____
Item 22 ____
Item 26 ____
Item 27 ____
Item 35 ____
Total _____

Hostility
Item 1 ____
Item 3 ____
Item 8 ____
Item 9 ____
Item 13 ____
Item 16 ____
Item 34 ____
Total _____

Total Weighted Score (Sum of all subscale scores)
_____

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W-172C

TAT CARD No. 1



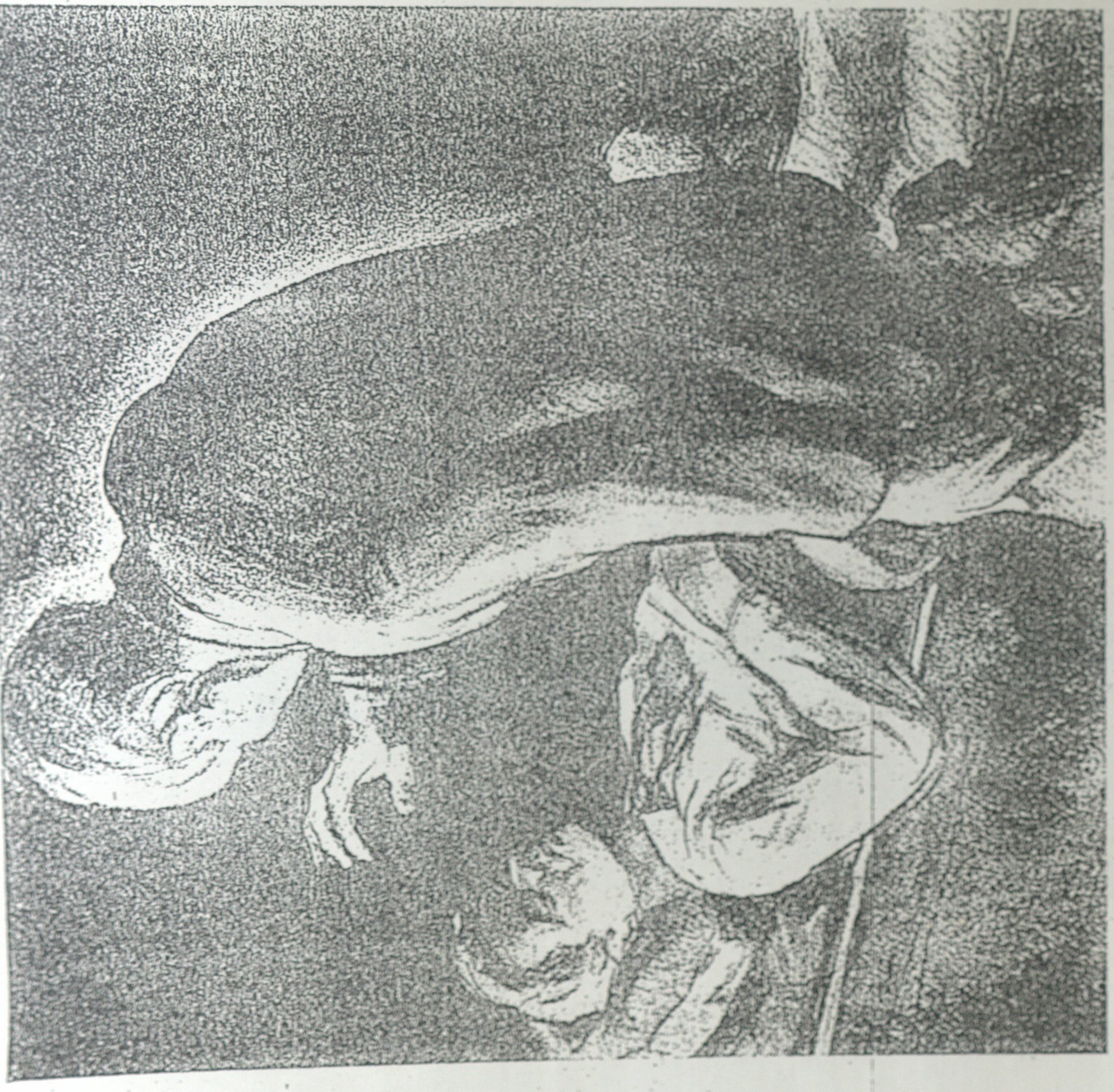
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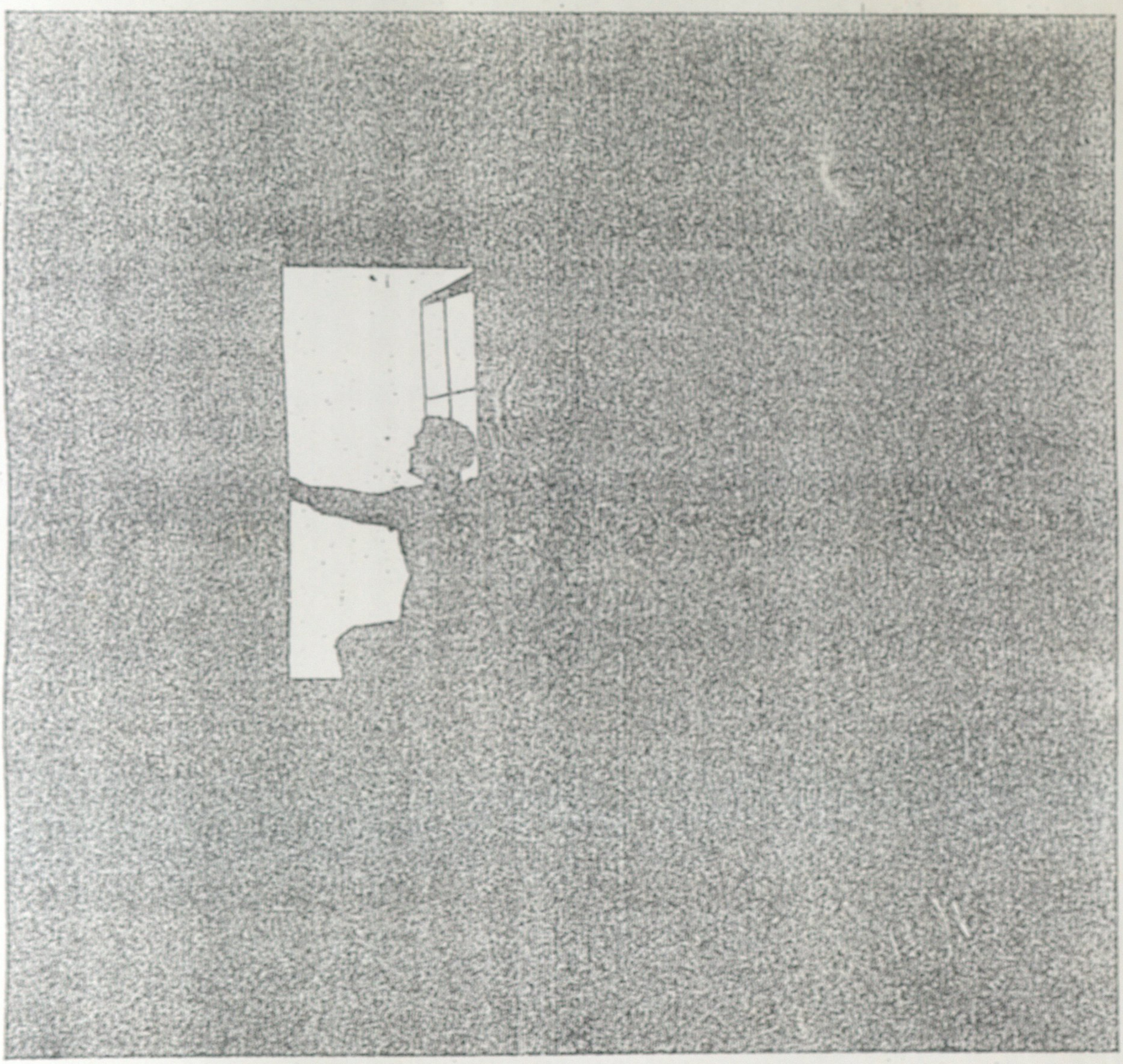


IAT CARD No. 98M

TAT CARD NO 12M



TAT CARD NO 14



① child abuse - NWFP

② child sexual abuse - Social functioning - NWFP

③ " " " - Psychological " - "