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The Psychological Problems Faced By Sexually Abused Children (12-15 Years) In Harare

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Abstract: *Child sexual abuse is one of the most pervasive social problems faced by this society. Its impact is profound because of the sheer frequency with which it occurs and because of the trauma brought to the lives of children who have experienced this crime. Its impact can be classified under short and long term effects which in most cases incapacitate adult life. Historically, however, the sexual abuse of children was dismissed as a "family problem". Within the past decade, it has been addressed by a sometimes reluctant criminal justice system. It is only in more recent years that the profession of mental health has begun to understand child sexual abuse not only as a criminal justice problem, but also as a mental health concern. This realization has been unavoidable as clinicians have repeatedly seen the manifestation of sexual abuse in the lives of their clients. Most children were sometimes depressed, although frequency and severity differed. Sleepdisturbance,somatic complaintslike headaches were reported, anxiety manifested in these children through bladder incontinence, school problem presented through difficulties with school work and concentration, and personality changes were reported. On the other hand caregivers noticed and reported several psychological problems on their children which they attributed to sexual abuse. Among them drug and substance misuse especially marijuana, insomnia, resentfulness, other behavioural problems. The severity of psychological problems experienced by survivors of sexual abusehas been found to vary based on the age of the victim, the relationship between the victim and the offender, the violent or coercive nature of the crime, the length of time during which the molestation occurred, and other factors*.

I. Introduction

Child sexual abuse(CSA) is 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 social taboos of family roles (Kempe,1989 cited by Jones and Brown, 1990).Forms of child sexual abuse include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposureof the genitals to a child, exposing a child to pornography, penetration, physical contact with the child's genitals, viewing of the child's genitalia for the purpose of sexual gratification, or using a child to shoot pornographic material.In Zimbabwe, the Children's Act (Chapter 5:06) defined a child as "a person under the age of 18." It sets out the law for the care and protection of children. In this research focus was on the children below the age of 16 years, "young persons" because they have no right to consent to sexual relations**.**

The incidence based on official statistics showed that child sexual abuse had increased drastically (U.S. Department of Health and Human Services, 1998). Research shows that CSA may occur from any age that is, from birth to 16 years in any ethnic group and socioeconomic standing. Due to HIV/AIDS, economic hardships and migration of parents to other countries children have been predisposed to CSA because children are left in the care of relatives and friends who are likely to abuse them.

Donnely and Oates (2000) highlighted that there are typical immediate and long term effects of child sexual abuse. Some psychological problems come as a reaction to the physical problems of abuse. The physical symptoms such as pregnancy in girls (Hansson, 1992), gynaecological problems such as vaginal discharges and bladder infections and sexually transmitted diseases may result into psychological problems. Kessler and Hyden, (1991), postulate the child may suffer tears, cuts and bleeding in the vagina or rectum or infection resulting from such tears (Kessler and Hyden, 1991) and back aches, tension headaches and nausea may also result (Hansson, 1992).

Short term psychological symptomsthat may be observed are crying, difficulty in concentration, restlessness, loss of interest in playing, socializing, not wanting to be left alone, stammering or stuttering, avoidance of familiar place or specific person, regression to earlier childhood behaviors such as thumb sucking, bedwetting and baby talk, changes in school performance (Finkelhor, 2008)

Long Term Effects of Child Sexual Abuse

Higgins and Ramchandani (2008) note that CSA was associated with increased risks of psychological problems in adulthood. Many women and men who have been subjected to severe physical or sexual abuse during childhood suffer from long-term psychological disturbances. Sexual abuse victims may be invaded by nightmares and flashbacks much like survivors of war or may freeze into benumbed calm in situations of extreme stress. Mood swings, depression or suicidal ideations are some of the short term effects of CSA (Bridgeman and Keating, 2008 and Higgins and Ramchandani, 2008).

Green(1993)cited by Donnely and Oates (2000) noted that these symptoms can be exhibited by non-abused children with various psychological disorders and as such the diagnosis of child sexual abuse should be done carefully through integrated careful history taking, physical examination and an estimation of the child's functioning before the abuse.

Shapiro (2006) noted that sexually abused children and non abused children differ because of family, child and environmental factors. Sexually abused children when compared to non abused children experience greater vulnerability and disadvantaged across multiple aspects and phases of their life. Mothers of sexually abused children reported higher rates of child problems than mothers of non abused children.

Forward (1993) as cited by United Nations Commentary (2007) noted that it is estimated that there are 60 million survivors of childhood sexual abuse in USA. According to the USA National Resource Center on Child Sexual Abuse (1992), it was estimated that children with disabilities are 4 to 10 times more vulnerable to sexual abuse than their non-disabled peers.

Browne and Finkelhor (1986) and Higgins and Ramchandani (2008) noted that long term effects of child abuse include fear, anxiety, depression, anger, hostility, inappropriate sexual behavior, poor self esteem, tendency toward substance abuse and difficulty with close relationships. Tsai and Wagner (1978) cited by Finkelhor, (2008) suggested that clinical findings of adult victims of sexual abuse include problems in interpersonal relationships associated with an underlying mistrust. The study showed that adult victims of incest have a severely strained relationship with their parents that are marked by feelings of mistrust, fear, ambivalence, hatred, and betrayal. Such feelings may extend to all family members. Higgins and Ramchandani (2008) also support this view by suggesting that such victims may externalize or internalize inappropriate sexual behaviours.Furthermore, Tsai and Wagner (1978) showed that guilt is generally experienced by virtually all victims. Courtois and Watts described this as "sexual guilt" which is "guilt derived from sexual pleasure". Whitlock & Gillman, (1989) noted that sexuality is regarded not simply as a part of the self restricted to genitals, discrete behaviors, or biological aspects of reproduction, but as one component of the total personality that affects one's concept of personal identity and self-esteem.

Brown et al (2002)observed that adolescents with a history of sexual abuse were significantly more likely than their counterparts to engage in sexual behavior that put them at risk for HIV. The study also revealed that inconsistent condom use was three times more likely among youths who had been sexually abused than those who had not been abused sexually. A history of sexual abuse was also significantly associated with less impulse control and higher rates of sexually transmitted diseases (STDs). Bromberg and Johnson (2001) also support this view when they observed that victims of CSA were more likely to become abusers later in life or whilst still minors.

According to the United States Department of Justice (1991), approximately 31% of women in prisons state that they had been abused as children. It has also been studied that approximately 95% of teenage prostitutes have been sexually abused.

However, Bromberg and Johnson (2001) noted that although victims typically suffered from CSA, surprisingly some evidence suggested that some victims of CSA can exhibit neutral or even positive outcomes as they become very responsible citizens.

In a study by Kendler (2000) it was revealed that young girls who were forced to have sex were three times more likely to develop psychiatric disorders or abuse alcohol and drugs in adulthood, than girls who were not sexually abused. Sexual abuse was also more strongly linked with substance abuse than with other psychiatric disorders. It was also suggested that sexual abuse may lead some girls to become sexually active at an earlier age and seek out older boyfriends who would then introduce them to drugs. Psychiatric disorders were from 2.6 to 3.3 times more common among women whose CSA included intercourse and according to the results the risk of substance abuse was increased more than four times. The research also showed that family factors such as parental education, parenting behavior, family financial status and church attendance had little impact on the prevalence of psychiatric or substance abuse disorders among these women.

Ball, Kennedy and Lee (1999) suggested that unwanted sexual experiences (USE), particularly childhood sexual abuse was a major risk factor for the development of disordered eating. Among both adolescent girls and boys, a history of sexual or physical abuse appeared to increase the risk of disordered eating behaviors, such as self-induced vomiting or use of laxatives to avoid gaining weight. Young girls who were sexually abused were more likely to develop eating disorders when they become adolescents. The findings also

contributed to research suggesting that trauma in childhood increased the risk of developing an eating disorder. Abused girls were more dissatisfied with their weight and more likely to diet and purge their food by vomiting or using laxatives and diuretics. Abused girls were also more likely to restrict their eating when they were bored or emotionally upset.

Wonderlich (2000) suggested that abused girls might experience higher levels of emotional distress, possibly linked to their abuse, and have trouble coping. Food restriction and perhaps other eating disorder behaviors reflected their efforts to cope with such experiences. The report also indicated that girls who were abused were less likely to exhibit perfectionist tendencies such as making extreme efforts to avoid disappointing others and a need to be 'the best'. They tended to want thinner bodies than girls who had not been abused.

Tsai and Wagner (1984) also noted that sexual victimisation might greatly impede with and alter the development of attitudes toward self, sexuality, and trusting relationships during the critical early years of development. Courtois and Watts, (1982), Tsai and Wagner (1984) (cited by Donnely and Oates, 2000) also supported the view that if the child victim does not resolve the trauma, sexuality may become an area of adult conflict as they may have difficulties forming and maintaining intimate relationships.Finkelhor (2008) showed that children who feel compelled to keep sexual abuse a secret suffer greater psychological distress than victims who disclose the secret and receive assistance and support before other complex psychological conditions occur.

According to Bagley (1991,1992), Finkelhor et al, (1990), Whitlock and Gillman, (1989), (cited in Finkelhor 2008), agreed that early identification of sexual abuse victims appeared to be crucial to the reduction of suffering of abused youth and to the establishment of support systems for assistance in pursuing appropriate psychological development and healthier adult functioning. As long as disclosure continues to be a problem for young victims, then fear, suffering, and psychological distress would, resembling the secret, remain with the victim.It should be noted however that not all children who suffer child sexual abuse would experience the above symptoms. The severity of long and short term symptoms of sexually abused children is dependent on a number of variables such as age and developmental stage of the child, the child's pre-existing personality and resilience, onset, duration and frequency of the abuse, degree of closeness of relationship between the child and the perpetrator, social support available in response to disclosure, professional support such as medical, investigation and the legal procedure and the availability of therapeutic intervention (Bridgeman and Keating, 2008).

II. Methodology

Descriptive survey research method, with both qualitative and quantitative methods was used. A convenient sample of 100 research participants who were drawn from Victim Friendly Courts at Harare Rotten Row Court was used. The participants included 50 sexually abused children who were abused within the past 12 months and 50 parents and caregivers of the victims. All participants would have reported the matter to the police and undergone some medical examination and counseling before the inception of the research.

Measures

The Child Psychological Health Checklist for sexually abused children which has been used before by Dlodlo-Sibanda (1999) was used. The questionnaire has 48 questions and 6 open ended questions were added to allow probing at greater length.

III. Results and discussion

Gender Characteristics of the Children

Table 2 :Binomial Test

		Category	N	Observed Prop.	Test Prop.	Asymp. Sig. (2-tailed)
Sex	Group 1	Female	49	.98	.50	.000[a]
	Group 2	Male	1	.02		
	Total		50	1.00		

a. Based on Z Approximation.

Using the Binomial test there was a significant difference between females (98%) and males (2%) who came for hearing for court hearing during the period of study of the research (p=.000,two tailed). Previous research showed that girls were more likely to be sexually abused than boys. In the USA one out of three females and one out of five males have been victims of sexual abuse before the age of 18 years. There are gender differences with regard to sexual abuse incidents. Specifically, girls were at twice the risk than boys for sexual victimization throughout childhood and eight times the risk during adolescence (Dominguez et al 2006). It may also be an indication that boys were less likely to report cases of sexual abuse than girls.

Psychological Health Checklist in Sexual Abuse According to Sexually Abused Children

Depression

One-Sample Test						
	Test Value = 2					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Withdrawal from everyday activities e.g play	2.597	50	.012	.44000	.0995	.7805
Usually sad or quiet	2.605	50	.012	.46000	.1051	.8149
Avoids other people's company	2.302	50	.026	.40000	.0507	.7493
Average depression	2.583	50	.013	.433	.10	.77

One-Sample Test						
	Test Value = 5					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Average depression	-15.300	50	.000	-2.567	-2.90	-2.23

Table above reflected that there was a significant difference in depression among the children. Most of the children were not considered depressed practically all the time but were above sometimes depressed (t(50)=15.3,p=.00, 2 tailed). This may be an indication that most children suffered from depression after sexual abuse. Although the frequency and severity differed with each child, depression was evident as a result of child sexual abuse. Of significance was that 74% of the respondents noted that their children withdrew from everyday activities, 72% were reported as usually sad or quiet and 70% avoided other people's company. In the most severe cases, 6% of the children practically withdrew from everyday activities, 3% were sad or quiet all the time while 2% avoided other people's company all the time. The symptom of being sad or quiet most of the time was the most significant under the psychological problem of depression.

Sleep Disturbance

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Agitation during sleep	50	2.7200	1.22957	.17389
Nightmares or bad dreams	50	2.7600	1.20475	.17038
Trouble getting to sleep	50	2.8600	1.41436	.20002
Sleeping too much	50	2.3400	1.33417	.18868
Waking out often and having problems getting back to sleep	50	2.8200	1.39518	.19731
Needing the light on at night	50	2.9600	1.47025	.20792
Average Sleep disturbance	50	2.74	1.162	.164

One-Sample Test						
	Test Value = 2					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Agitation during sleep	4.141	49	.000	.72000	.3706	1.0694
Nightmares or bad dreams	4.461	49	.000	.76000	.4176	1.1024
Trouble getting to sleep	4.300	49	.000	.86000	.4580	1.2620
Sleeping too much	1.802	49	.078	.34000	-.0392	.7192
Waking out often and having problems getting back to sleep	4.156	49	.000	.82000	.4235	1.2165
Needing the light on at night	4.617	49	.000	.96000	.5422	1.3778
Average Sleep disturbance	4.523	49	.000	.743	.41	1.07

The above tables show that sleep disturbance is often experienced by sexually abused children. There is a significant difference in the sleep disturbances between sleeping too much and the other items which all vary in the same direction (t(50) 1.80,p=.078, 2 tailed). The amount of sleep disturbance is also not practically all the time but also not significantly different from often. It was observed that waking up during the night, experiencing agitation during sleep and trouble getting to sleep were the three most common symptoms of the sleep disturbance psychological problems.

Somatic Complaints and Appetite Disturbance

One-Sample Test						
	Test Value = 2					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Awkward way of walking caused by pain	-7.537	49	.000	-.74000	-.9373	-.5427
Stomach aches	6.926	49	.000	1.16000	.8234	1.4966
Headaches and other bodily pains	2.933	49	.005	1.82000	.5730	3.0670
Refusal to eat or loss of appetite	3.625	49	.001	.82000	.3654	1.2746
Compulsive eater	-.596	47	.554	-.12500	-.5470	.2970

The table above indicated that headaches and other somatic complaints were experienced often to very often but there was no significant difference between the two (p=.005). Compulsive eating had a very low significance in this study (p=.554). The majority of the children, did not experience awkward walking due to pain but suffered from headaches and other bodily pains after the abuse. Eating and appetite disturbances were also evident in the sexually abused children as the children noted that they had refused to eat or had lost appetite after the abuse. However the majority of the children noted that they did not experience the compulsive eating. This psychological problem was observed by Ball, Kenardy and Lee (1999) who noted that unwanted sexual experiences (USE) particularly childhood sexual abuse is a major risk factor to the development of eating disorders. The most significant symptoms in this psychological disorder were headaches and bodily pains followed by refusal to eat by sexually abused children.

Anxiety

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Fear or avoidance of a familiar fault	50	2.3469	1.47974	.21139
Fearful to be bathed or to change clothes	50	1.8367	1.10580	.15797
Fear or Avoidance of a familiar place	50	2.0213	1.51068	.22035
Thumbsucking	50	1.2292	.59213	.08547
Betwetting	50	2.0204	1.12712	.16102
Urinating	50	1.5714	.97895	.13985
Separating anxiety	50	2.4286	1.50000	.21429
Average Anxiety	50	1.91	.785	.116

One-Sample Test						
	Test Value = 3					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Fear or avoidance of a familiar fault	-3.089	48	.003	-.65306	-1.0781	-.2280
Fearful to be bathed or to change clothes	-7.364	48	.000	-1.16327	-1.4809	-.8456
Fear or Avoidance of a familiar place	-4.442	46	.000	-.97872	-1.4223	-.5352
Thumb sucking	-20.720	47	.000	-1.77083	-1.9428	-1.5989
Bedwetting	-6.084	48	.000	-.97959	-1.3033	-.6558
Urinating	-10.215	48	.000	-1.42857	-1.7098	-1.1474
Separating anxiety	-2.667	48	.010	-.57143	-1.0023	-.1406
Average Anxiety	-9.418	45	.000	-1.090	-1.32	-.86

Although there is a difference in severity, the information according to the children on psychological problems may indicate that anxiety may be experienced as a result of child sexual abuse. Thumb-sucking, urinating often were significantly lower (p=.00), while separation anxiety was significantly higher (p=0.10). Using a value of 3, often, there is however no significant difference among the symptoms since the means are lower than 3.

School problems

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Attention/concentration	50	2.6667	1.26042	.18193
Difficulty with school work	50	2.6458	1.34464	.19408
Disobedience	50	1.8125	1.19674	.17273
Problems with other children	50	2.3125	1.27423	.18392
Average school	50	2.36	1.036	.150

One-Sample Test						
	Test Value = 3					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Attention/concentration	-1.832	47	.073	-.33333	-.6993	.0327
Difficulty with school work	-1.825	47	.074	-.35417	-.7446	.0363
Disobidence	-6.875	47	.000	-1.18750	-1.5350	-.8400
Problems with other children	-3.738	47	.001	-.68750	-1.0575	-.3175
Average school	-4.282	47	.000	-.641	-.94	-.34

Using the one sample test, table above signified that school problems are some of the psychological problems that significantly higher as experienced by sexually abused children. Using a value of 3, often, there is no significant difference between the first two symptoms of attention and concentration as well as difficulty in school work. Disobedience and problems with other children are significantly lower (p=.00). However research by Jones, Trudinger and Crawford (1996) showed that although little is known about the prevalence of intellectual and academic problems in sexually abused children, the Child Behaviour Checklist from their research showed that 14% were intellectually impaired while 14% showed academic underachievement. They noted that most children would require learning support at school to compensate for this problem.

Personality Change Problems

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Lying	50	1.5600	.97227	.13750
Normally confident and outgoing becomes withdrawn, shy or insecure	50	2.0400	1.06828	.15108
Shy quiet child becomes aggressive and looks for trouble with adults and other children	50	2.0600	1.11410	.15756
Easily tearful	50	3.2200	1.38932	.19648
Easily angry	50	3.2600	1.39694	.19756
Showing sexual behaviour inappropriate for child	50	1.3800	1.00793	.14254
Inappropriate way of showing love eg unclothing	50	1.1000	.41650	.05890
Average personality	50	2.09	.799	.113

One-Sample Test

	Test Value = 3					
					95% Confidence Interval of the Difference	
	t	df	Sig. (2-tailed)	Mean Difference	Lower	Upper
Lying	-10.473	49	.000	-1.44000	-1.7163	-1.1637
Normally confident and outgoing becomes withdrawn, shy or insecure	-6.354	49	.000	-.96000	-1.2636	-.6564
Shy quiet child becomes aggressive and looks for trouble with adults and other children	-5.966	49	.000	-.94000	-1.2566	-.6234
Easily tearful	1.120	49	.268	.22000	-.1748	.6148
Easily angry	1.316	49	.194	.26000	-.1370	.6570
Showing sexual behaviour inappropriate for child	-11.365	49	.000	-1.62000	-1.9064	-1.3336
Inappropriate way of showing love eg unclothing	-32.257	49	.000	-1.90000	-2.0184	-1.7816
Average personality	-8.069	49	.000	-.911	-1.14	-.68

Table above is an illustration that personality changes are other psychological problems experienced by the sexually abused children after the abuse. Using the one t-test test value of 3, often, it was observed that there is no significant difference in personality change among sexually abused children (p=.00, 2 tailed). Easily tearful and easily angry/irritable were significantly higher than the other behaviors under personality change. However 90% of the children did not show inappropriate sexual behaviour and all children denied inappropriate showing of love.

The Most Prevalent Psychological Problems faced by Sexually Abused Children as Reported by the Children

Table :Principal Psychological Health Checklist Results

Total Variance Explained						
Component	Initial Eigenvalues			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	15.316	40.305	40.305	11.065	29.119	29.119
2	4.437	11.677	51.982	4.813	12.665	41.784
3	2.712	7.138	59.120	4.301	11.318	53.102
4	2.376	6.252	65.371	2.600	6.841	59.943
5	1.973	5.193	70.564	2.506	6.594	66.537
6	1.692	4.452	75.016	2.165	5.697	72.234
7	1.216	3.201	78.217	1.522	4.005	76.239
8	1.113	2.929	81.146	1.520	4.001	80.240
9	1.072	2.820	83.966	1.416	3.726	83.966
10	.976	2.568	86.535			
11	.825	2.171	88.706			
12	.802	2.109	90.815			
13	.674	1.774	92.589			
Extraction Method: Principal Component Analysi						

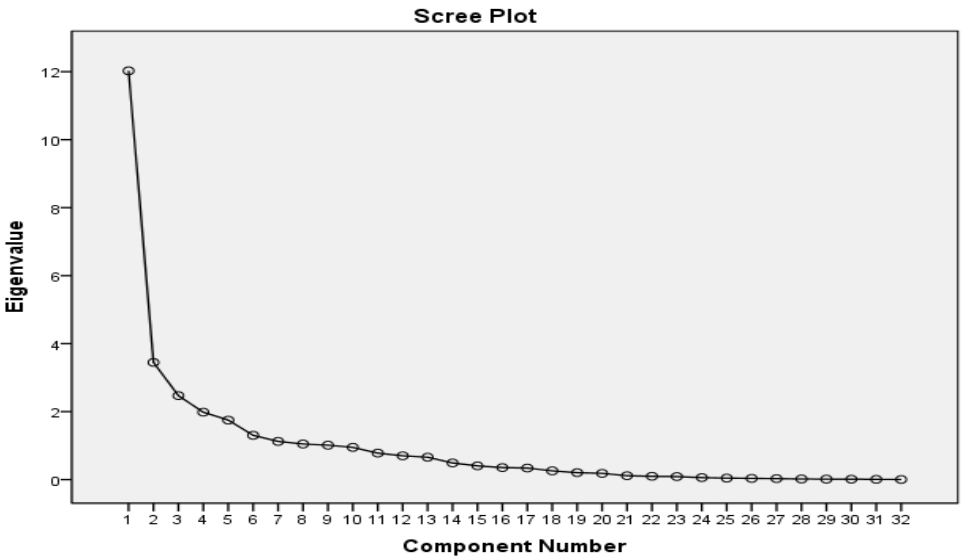

Fig 4.1 : Principal Psychologicial Health Checklist Components Extracted.

The above is a summary of the Child Psychology Health Checklist in sexual abuse according to the perceptions of child caregivers in order of increase in impact dimension reduction method (Exploratory Factor Analysis). Only nine components were extracted as very important indicators and accounted for nearly 84% of the total variance of thirty-eight indicators. Two of the depression symptoms were extracted as the most influential indicators of the Child Psychological Health Checklist factor. Avoiding other people's company and usually sad and quiet were reported as number one and two respectively accounting for a total of nearly 42% of the total variance between them.

Sleep disturbances indicators of needing the light on at night, nightmares/bad dreams, trouble getting sleep and agitation during sleep were reported third, fourth, fifth and sixth as possible symptoms experienced by sexually abused child. The sleep disturbance symptoms constituted 30% of the total variance.

Personality change was found to have an impact though to a lesser extent than depression and sleep disorders. Personality indicators, that is, easily angry/irritable, easily tearful and shy quiet child who became talkative were ranked seventh, eighth and ninth most important indicators and accounted for a total of 24% of the total variance among them. The extracted components were extracted on a scale of Eigen value of 1 and a Scree Plot indicates the principal components considered as significant or influential under this context.

Content Analysis for Open Ended Questions for Responses from Caregivers

The caregivers noted that their children had experienced different psychological problems such as withdrawal from family, some of the children had been caught smoking marijuana while some had experienced concentration and difficulties in school work. Loneliness was also pointed out by the caregivers as another behavioural problem as most children isolated themselves. Feelings of guilt were also reported as having been experienced by sexually abused children as in some cases the abuse had led to parents' divorce and led to disruptions of marriages. The parents also illustrated that the children experienced repeated trauma at the sight of the accused, through nightmares or spent nights awake showing symptoms of PTSD.

Some parents/caregivers reported that their children were resentful against other family members for not sharing their suffering. Caregivers also noted that the abuse was distressing to them and also suffered from depression as they cared for the abused children. Generally the parents noted that distress and negative psychological effects had resulted from the abuse. There was a significant impairment in the individual's social and cognitive function which hampered the individual's ability to participate freely in activities, because there was a lot of uncertainty about the future. The sexual abuse was also evident as a trigger to the onset psychotic symptoms through stressful life events, family environment or some form of loss (Myers et al 1972) since one child had been reported to have experienced a nervous breakdown.

Also the evidence shown by the Child Psychological Health Checklist indicated that although some victims typically suffered from sexual abuse, surprisingly there was evidence that suggested that some victims could exhibit neutral or even positive outcomes.

IV. Conclusions

The study revealed that sexually abused children experienced a lot of psychological problems such as sleep disturbances, eating disturbances, depression, anxiety and school disturbances among others. The revelation provides strong support for the negative psychological effects of sexual abuse. Childhood sexual abuse appears both to have unrelenting impacts on psychological functioning in many survivors and to have the potential for motivating the emergent of behaviors that, while seen as adaptive in the immediate context, often pose long-term self-injurious consequences. However , these data suggest that the extent to which abused children manifests abuserelated symptomatology and distress is a function of an undetermined number of abuse-specific variables, individual factors such as coping and environmental factors that existed prior to, subsequent to and after the incidents of sexual abuse.

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