THE PREVALENCE OF POST-TRAUMATIC STRESS DISORDER AMONG SEXUALLY ABUSED CHILDREN SEEN AT THE GENDER BASED VIOLENCE RECOVERY CENTRE AT KENYATTA NATIONAL HOSPITAL (KNH)

A DISSERTATION SUBMITTED IN PARTIAL FULFILMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY AT THE UNIVERSITY OF NAIROBI

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STUDENTS DECLARATION

I, Caroline Atieno Ombok declare that this dissertation is my original work carried out in part fulfillment of the requirement for the award of the degree of Masters of Science in Clinical Psychology at the University of Nairobi. I further declare that this dissertation has not been submitted for the award of any other degree or to any other university.

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DEDICATION

This Proposal is dedicated to all children and adolescents who are affected in one way or another by Post Traumatic Stress Disorder as a result of sexual abuse.

LIST OF ABBREVIATIONS

AMREF	**-**	**African Medical and Research Foundation**
ANPCAN	**-**	**African Network for the Prevention and Protection of Child Abuse and Neglect.**
APA	**-**	**American Psychological Association**
CSA	**-**	**Child Sexual Abuse**
CSEC	**-**	**Commercial Sexual Exploitation of Children**
CSEIC	**-**	**Child Sexual Exploitation Intelligence Centre**
ECPIK	**-**	**End Child Prostitution in Kenya**
GBVRC	**-**	**Gender Based Violence Recovery Centre**
ILO	**-**	**International Labour Organization**
KNH	**-**	**Kenyatta National Hospital**
NVAWS	**-**	**National Violence Against Women Survey**
PSRI	**-**	**Population Studies and Research Institute**
PSC	**-**	**Patient Support Centre**
PTSD	**-**	**Post-Traumatic Stress Disorder**
SPSS	**-**	**Statistical Package for Social Sciences**
SAP	**-**	**Sexual Abuse Profile**
SEC	**-**	**Sexual Exploitation of Children**
STD	**-**	**Sexual Transmitted Disease**
UNICEF	**-**	**United Nation Children Educational Fund**
WHO	**-**	**World Health Organization**

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ABSTRACT

Introduction: Post Traumatic Stress Disorder develops following some stressful events.

There has been increasing recognition that children who have been exposed to traumatic events like child sexual abuse can develop post-traumatic stress disorder just like adults.

Objective: To determine prevalence of PTSD in sexually abused children seen at the Gender Based Violence Recovery Centre at Kenyatta National Hospital.

Research design: A cross sectional descriptive study of the prevalence of PTSD among the sexually abused children as seen at Gender Based Violence Recovery Centre at Kenyatta National Hospital.

Study site: Gender Based Violence Recovery Centre – Kenyatta National Hospital.

Study Population: Sexually abused children seen at the GBVRC-KNH.

Sampling Procedure: Study participants were selected using purposive sampling

Study Instruments: Socio-demographic Questionnaire, Sexual Abuse Profile, Posttraumatic Stress Disorder index for DSM-IV, and Art Assessment for Children.

Data Management and Analysis: Data was analyzed by use of the Statistical Package for Social Sciences (SPSS) version 15.

Results: One hundred and forty-nine (n = 149) sexually abused children were recruited in the study where by 127 (85.2%) were females. The mean age of the children was 13.2 years (SD 4.2) and the age at which sexual abuse most frequently (55%) occurred between 15-17 years. Sixty three percent of children reported that the perpetrator was known to them, and 76.5% of perpetrators used verbal or physical force during sexual assault. The prevalence of PTSD among the sexually abused children was 49% (n = 73). PTSD was significantly associated with duration of sexual abuse ($p = 0.005$), severity of injuries sustained during assault ($p = 0.023$), parent's marital status ($p = 0.003$) and the family's way of sorting out their disagreements ($p < 0.001$). Findings from art

assessment of 38 (25.5%) children's drawings showed emotional disturbance commonly manifesting as impulsive behavior (10.5%), mixed feelings (10.5%), and aggression or hostility (7.9%).

Conclusions: This study highlights the high prevalence of PTSD among sexually abused children. PTSD is associated with the degree of physical or verbal abuse during sexual abuse, injuries during assault, and parent-child relationships. These findings are important in formulation of appropriate prevention and care interventions to be implemented by families and other stakeholders.

CHAPTER ONE

1.1 INTRODUCTION

1.1.1 Post traumatic stress disorder

PTSD is an anxiety disorder that can develop after exposure to one or more traumatic events that caused great physical and psychological harm. The condition develops following some stressful events such as sleep disturbance, recurrent dreams, withdrawal, frightening thoughts and memories or flashbacks of the ordeal. (DSM-IV)

Posttraumatic Stress Disorder (PTSD) first appeared in the DSM-III in 1980. The impetus for the development of this diagnosis category arose primarily from the need to account for the characteristics array of symptoms displayed by Vietnam veterans in the United States, and as such PTSD was conceptualized around traumatized adults (Kaminer et al.2005). However, since that time there has been increasing recognition that children, too, can develop severe and debilitating reactions to traumatization.

1.1.2 Child Sexual abuse

Child sexual abuse is a form of child abuse in which an adult or older adolescent abuses a child for sexual stimulation (Acuff *et al.,* 2008). In addition, Roosa *et al* (2006) stipulates that, forms of CSA include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposure of the genitals to a child, displaying pornography to a child, actual sexual contact against a child, physical contact with the child's genitals, viewing of the child's genitalia without physical contact, or using a child to produce child pornography.

Under the law ‘child sexual abuse’ is an umbrella term describing criminal and civil offences in which an adult engages in sexual activity with a minor or exploits a minor for the purpose of sexual gratification (CSEC), (Estes & Weinner 2002).

Kenya ratified the Convention on the Rights of the Child on 30 July 1990 and also signed the Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography. In order to bring its legislation in conformity with international obligations, Parliament enacted the Children's Act in 2002, which defines a child as anyone who is under the age of 18 and provides protection from sexual exploitation, including prostitution and pornography. It also includes provisions guaranteeing free basic education and the right to health care for children. Under the Children's Act the National Council for Children's Services and Children's Courts have also been established to promote and protect the best interests of the child (UNICEF, 2002).

Child sexual abuse occurs in all parts of society. Institutions, which have an extensive range of activities involving children and young people, are no exception. In addition, Church communities, and faith-based organizations that work with children, have not been exempted from cases of child sexual abuse. There have been many high profile court cases and inquiries over the past decade. The research that has been done on offences by clergy has focused on the Roman Catholic Church (Rossetti, 1995; Haywood et al, 1996) on child sexual abuse cases in faith based organizations activities for children and young people.

1.1.3 Causes of child abuse

According to the child right's organization, ECPIK, part of the ECPAT International network, independent agents with multilingual skills facilitate contact between children and sex tourists in Mombasa and Malindi bars, nightclubs and discotheques. An estimated 2.1 million adults and children live with HIV/AIDS in Kenya, which has the ninth highest HIV prevalence rate in the world. U.S. Census Bureau projections for 2005 indicated that there would be about 820 deaths per day from AIDS in Kenya and to date there are some 1.8 million AIDS orphans who are particularly vulnerable to sexual abuse because of the lack of parental oversight. In addition, there are other children who are at increasing risk

due to the prevalent belief that having sex with a young child reduces the possibility of HIV infection or, with an infant, cure the infection. The rising number of AIDS orphans has contributed to the increase in children being sexually exploited in the sex industry. According to the International Labour Organization some 30,000 girls under the age of 19 years are engaged in prostitution in the country. This figure is believed to be an underestimation of the true extent of the problem.

Research indicates that most early marriage is forced upon young girls who are taken as second or third wives. These girls suffer from domestic violence and poverty because they are often abandoned once their husbands take another wife. Not enough is known about their condition, but they are clearly a highly exploited group that has little recourse to any assistance or care. Child labor is prevalent in Kenya, with an estimated 41.3 percent of children between 10 and 14 years of age being exploited for cheap labor, (Amnesty International Report 1997). Children in domestic service, especially in residences catering or owned by expatriates are potentially at risk of sexual exploitation. Reportedly, in Malindi, some young girls working as domestic help have had child abusive images taken for distribution to people abroad (Amnesty International Report 1997).

The US Government Accountability Office concluded, "The existence of a cycle of sexual abuse was not established." Prior to 1996, there was greater belief in the theory of a "cycle of violence," because most of the research done was retrospective—abusers were asked if they had experienced past abuse. Even the majority of studies found that most adult sex offenders said they had not been sexually abused during childhood, but studies varied in terms of their estimates of the percentage of such offenders who had been abused, from zero to 79 percent. More recent prospective longitudinal research—studying children with documented cases of sexual abuse over time to determine what percentage become adult offenders—has demonstrated that the cycle of violence theory is not an adequate explanation for why people molest children.

1.2 Background information

1.2.1 Posttraumatic stress disorder

Studies indicate that children can develop PTSD after exposure to a range of traumatic stressors, including violent crime, sexual abuse, natural disaster, and war. Where relatively standardized assessment methods have been used, epidemiology studies of the prevalence of PTSD among children in the general. However, community studies in the United States have consistently indicated that around 40% of high school students have experienced some form of domestic or community violence, and between 3 and 6% have PTSD, (Tjaden & Thornnes 1998).

High rates of trauma exposure and evidence of PTSD among child populations suggest that mental health practitioner's worldwide need to be able to recognize those posttraumatic reactions in children that require intervention, and offer timeous and effective treatments. Psychologists and psychiatrists particularly use this as a framework for the treatment of sexually abused children. It is valuable in identifying the existence of specific behaviours that should be addressed in therapy. PTSD describes symptoms, which are characteristics in many cases of sexual abuse. PTSD can sometimes appear many years after the original event. A diagnosis of PTSD is often used in court reports e.g. for applications for criminal Injuries compensation. The criteria for a diagnosis of PTSD according to DSM IV are:

1. The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone.

2. The re-experiencing of the trauma in at least one of the following;
   - Recurrent and intrusive recollection of the event
   - Recurrent distressing dreams of the event

- Sudden acting or feeling as if the event were recurring e.g. “flashbacks” episodes, hallucinations, illusions.
- Intense psychological distress at exposure to events that symbolize or resemble an aspect of the trauma event.

3. A numbing of responsive or reduced involvement in the external world some time after the trauma, indicated by:
   - Diminished interest in activities and/or
   - Feelings of detachments from others
   - Constricted affect e.g. unable to have loving feelings or to feel anger

4. In addition, at least two of the following sets of symptoms must be present
- Hyper alertness or being easily startled
- Sleep problem
- Guilt about surviving or behaviour required to survive
- Problems with memory or concentration
- Avoidance of activities that arouse recollection
- Intensification of symptoms if events symbolize or resemble the traumatic event.

1.2.2 Psychological Causes of Post traumatic stress disorder

Child sexual abuse can result in both short term and long term harm including psychopathology in later life (Dunne et al*., 2000).* These are: -

Fear: the offender may swear the child to secrecy and say that if they tell something bad will happen. Sexually abuse is usually accompanied by coercion, bribery or threats. The child is afraid to tell because of what the consequences might be.

Helplessness: Children in this situation often feel that they have no control over their own lives or even their own bodies. They feel they have no choices available to them.

Guilt and Shame: The child knows that something is wrong and starts blaming him/herself. The offender will often encourage the child to feel that the abuse is his/her fault and sometimes she/he will feel that he/she is a bad person.

Responsibility: The offender often makes the child feel responsible for keeping the abuse a secret. Sometimes the child also feels responsible for keeping the family together and the burden of this responsibility interferes with experiencing a normal childhood.

Isolation: incest victims feel different from other children. They must usually be secretive. This even isolates them from non-offending parents and brothers and sisters.

Betrayal: Children feel betrayed because they are dependent upon adults for nurturing and protection and the offender is someone who they should be able to love and trust. They may also feel betrayed by a non-offending parent who they feel has failed to protect them.

Anger: Not surprisingly, this is one of the strongest feelings, which many children have about their sexual assault. Children may feel anger against the perpetrator and also against others who they feel failed to protect them.

Sadness: Children may feel grief due to a sense of loss, especially if the perpetrator was loved and trusted by the child.

Flashbacks: these can be like nightmares, which happen while the child is awake. They are are-experience of the sexual assault and the child may experience all the feelings again which they felt at the time.

1.2.3. Consequences of child sexual abuse

In long term as an adult a child may experience a number of effects. These include:

Depression, anxiety, trouble sleeping, low self esteem, "damaged good" syndrome i.e. negative body image due to guilt and self blame (Wisdom, 1999) anxiety, (Levitan *et al.,* 2003) propensity to re-victimization in adulthood,(Terry *et al.,*2000) and (Dinwiddie,. 2000) reported physical injury to the child, among other problems. Sexual abuse by a family member is a form of incest, and can result in more serious and long-term psychological trauma, especially in the case of parental incest (Courtois, 1988).

The child may also develop social isolation, relationship problems such as an inability to trust, poor social skills or reluctance to disclose details about themselves. There are also elements of self-destructive behaviour such as substance abuse or suicidal attempts. Sexual difficulties such as fear of sex or intimacy, indiscriminate multiple sex partners or difficulty in reaching orgasm. There may also be parenting problems such as fear of being a bad parent, fear of abusing the child or being overprotective. Other underlying issues may be sense of guilt or loss, flash back and or panic attacks. Child sexual abuse is a significant public health problem in the Africa. In the United States one out of three females and one out of five males have been victims of sexual abuse before the age of 18 years (UNICEF, 1999).

There are a significant number of negative short-term effects of sexual abuse that impact a child's functioning. The most commonly experienced effect of sexual abuse is posttraumatic stress disorder (PTSD). Another short term effect of sexual abuse is the development of sexualized behavior, also called sexually

reactive behavior. Children who have been sexually abused engage in more sexualized behavior when compared to children who are not victims of sexual abuse, and when compared to clinical samples of children with other mental health issues.

Typically, children who experience the most serious types of abuse—abuse involving family members and high degrees of physical force—exhibit behavior problems ranging from separation anxiety to posttraumatic stress disorder. However, children who are the victims of sexual abuse are also often exposed to a variety of other stressors and difficult circumstances in their lives, including parental substance abuse. The sexual abuse and its aftermath may be only part of the child's negative experiences and subsequent behaviors (Terry *et al.* 2000).

1.3 Statement of the Problem

1.3.1 Globally

The prevalence of child sexual abuse has been reported by several studies. For example, a survey of nearly 1000 students in Victoria reported that 27.6% of girls and 9% of boys had been sexually abused before the age of 16 (Goldman & Goldman, 1988). Ministry of Women and Child Development (2007), published the “Study of Child Abuse: in India. The study sampled 12447 children; and looked at different forms of child abuse. The main findings showed that 53.22% of children had been sexually abused. Among them 52.94% were boys and 47.06 % girls. Andhra, *et al. (2007)* reported the highest percentage of sexual abuse among boys and girls as well as the highest incidences of sexual assaults. In this study, 21.90% of the respondents faced severe forms of sexual abuse, 5.69% had been sexually assaulted and 50.76% reported other forms of sexual abuse. Mazza *et al,* (2001), in a general population study of women aged between 51 and 62 years of age found that 42% had experienced non-contact sexual abuse, and 36% had experienced contact sexual abuse before the age of 16.

1.3.2 Africa

Child sexual abuse is a significant public health problem in Africa. One out of three females and one out of five males have been victims of sexual abuse before the age of 18 years (AMREF, 1993).The prevalence of child sexual abuse in Africa is compounded by a belief that sexual intercourse with a virgin can cure a man of HIV/AIDS (UNDP 2002). Unfortunately, sexual abuse is considered a relatively common experience in the lives of children (Elulkar *et al, .*1998). Sexual abuse occurs across all ethnic/racial, socioeconomic, and religious groups.

1.3.3 Kenya

Approximately two hundred (200) child abuse cases are reported per year at KNH-GBVRC (2008). However this figure represents all child abuse and not specifically sexual abuse. In this case there is no data available on prevalence of PTSD that can help in policy making and implementation. Child sexual abuse is under-researched in Kenya. Studies by UN agencies such as United Nations Children's Fund (UNICEF) and the international Labour Organization (ILO) have focused on the commercial sexual exploitation of children, to the neglect of more pervasive abuse in children's own communities by family, relatives, and neighbours but not on the trauma that comes with the sexual abuse.

Poor and unprotected Kenyan children are exposed to various kinds of commercial sexual and labour exploitation. Many of them are children from rural areas, children living in city slums, refugees and AIDS orphans left alone after the death of their parents. The myriad forms of exploitation are interlinked and continue to deny children their rights. (Kenya National Bureau of statistics, 2005)

In the past few years there has been a rise in cases of sexual violence in Kenya. For instance (CRADLE, 2005) stipulated that rape was leading crime in terms of reported cases according to figures provided by the Kenya police (2007). Even though all people are vulnerable to abuse, children are more susceptible than

adults. 'Broken trust', a study by (CRADLE, 2007) found out that the highest risk age is between 12 to 14 years followed by 15 to 18 years. Ages 3 to 5 years were also vulnerable, where as ages 0 to 2 are the least at risk with only 4 %.

Nationwide surveys of the general population are required for an empirical understanding of this topic.

Child sexual abuse and PTSD

Although child sexual abuse in relation to PTSD has been under-researched globally, regionally, and nationally, the prevalence of PTSD in sexually abused children, could just be as prevalent as child sexual abuse. The few studies that are available suggest that PTSD is one of the psychological consequences of child sexual abuse. For example, It is estimated that approximately one third of child sexual abuse victims experience PTSD as adult survivors (Widom, 1999). Among women whose abuse involved penetration, an increased risk associated for the development of PTSD is experienced, resulting in about two thirds of this population developing PTSD at some point during their lifetime (Anderson et al., 2002).

A recent review article suggested that over 50% of sexually abused children meet at least partial criteria of PTSD and another study suggested a third of all sexually abused children develop full diagnostic criteria of PTSD (Morer et al. 2008). A recent report suggested that about a third of children who have been sexually abused subsequently manifest PTSD symptoms (Kendler et al., 2000). And, if not effectively addressed, PTSD can become a chronic problem affecting the child well into adulthood.

The problem and extent of underreporting, or non-disclosure, is a primary obstacle in determining frequency of child sexual abuse and its relationship with PTSD. The issue of whether prevalence of PTSD is an increasing consequence

of child sexual abuse is difficult to determine in the absence of current depth of information.

It is against this background that it is important to study the prevalence of PTSD among sexually abused children so as to come up with proper strategies for intervention that can reduce the problem.

1.4 Justification and significance of the study

- Lack of adequate documentation on prevalence of PTSD is a challenge to Government, public health planers and communities. There is therefore need to determine the prevalence of PTSD in order to generate information for policy formulation to reduce the burden.
- The study will assist in having a systemic and integrated approach in tracking psychological impact of childhood sexual abuse.
- It will also assist planners; policy makers and implementers to assess the focus of the work in an effort to fill gaps identified in the study and find a solution to the problem of child sexual abuse.
- The study will assist practitioners to be able to recognize and treat posttraumatic stress reactions in children.
- The study will address the issues in institutions like churches, children homes, and faith based organizations that work with children.

1.5 Objectives

1.5.1 *Main Objective*

To establish the prevalence of PSTD among sexually abused children seen at the Gender Based Recovery Centre at Kenyatta National Hospital.

1.5.2 Specific Objectives

(i) To determine the socio-demographic variables of the study group

(ii) To assess the relationship between the abused child and the perpetrator

(iii) To determine the age of the children at which sexual abuse is most prevalent

(iv) To determine the duration and the frequency of the abusive incidents

1.6 Hypothesis

Null hypothesis

There is no PTSD among sexually abused children who are seen at the GBRC at Kenyatta National Hospital.

Alternative Hypothesis

There is PTSD among sexually abused children who are seen at the GBRC at Kenyatta National Hospital.

1.7 RESEARCH QUESTIONS

1. What is prevalence of PTSD among sexually abused children attending GBVRC at KNH?
2. What is the most prevalent age of children who are sexually abused?
3. What is the duration and frequency of the sexual abuse incidents to the study population?
4. What is the relationship between the abused children and the perpetrator?

CHAPTER 2

2.0 LITERATURE REVIEW

2.1 Child sexual abuse

Child sexual abuse became a public issue in the 1970s and 1980s. Prior to this point in time sexual abuse remained rather secretive and socially unspeakable and in Africa it was and still remains a taboo in some cultures. Studies on child molestation were nonexistent until the 1920s and the first national estimate of the number of child sexual abuse cases was published in 1948. By 1968, 44 out of 50 States in the United States had enacted mandatory laws that required physicians to report cases of suspicious child abuse.

According to *Medline Plus* (2009), Child sexual abuse is a form of child abuse in which an adult or older adolescent abuses a child for sexual stimulation. Forms of CSA include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposure of the genitals to a child, displaying pornography to a child, actual sexual contact against a child, physical contact with the child's genitals, viewing of the child's genitalia without physical contact, or using a child to produce child pornography (Martin *et al.* , 1993)

However, a central characteristic (Mdungi & Mhagama, 2000) of any abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity.

By the early 21st century, the issue of child sexual abuse has become a legitimate focus of professional attention, while increasingly separated from second wave feminism. As child sexual abuse becomes absorbed into the larger field of interpersonal trauma studies, child sexual abuse studies and intervention strategies have become degendered and largely unaware of their political origins in modern feminism and other vibrant political movements of the 1970s. One may hope that unlike in the past, this rediscovery of child sexual abuse that began in the 70s will not again be followed by collective amnesia. The institutionalization

of child maltreatment interventions in federally funded centers, national and international societies, and a host of research studies (in which the United States continues to lead the world) offer grounds for cautious optimism. Nevertheless, as Judith Herman (1992) argues cogently, 'the systematic study of psychological trauma depends on the support of a political movement' (Cling, 2004).

Child sexual abuse can result in both short-term and long-term harm, including psychopathology in later life (Nelson, 2002 & Dinwiddie, 2000). According to (Wisdom *et al,.*2007) notes psychological, emotional, physical, and social effects including depression, and (Arnow. 2004) includes post-traumatic stress disorder too, whereas according to (Levitan *et al,.* 2003), anxiety eating disorders, poor self-esteem, dissociative and anxiety disorders; general psychological distress and disorders such as somatization, neurosis, chronic pain also impacts in a child's life, sexualized behavior, school/learning problems; and behavior problems including substance abuse, moreover, (Faller,.1993), and (NIDA ,.2002) revealed, destructive behavior, criminality in adulthood and suicide. A specific characteristic pattern of symptoms has not been identified (Fergusson, *et al.* 1999), and there are several hypotheses on the causality of these associations (Kendler *et al.* 2000).

Under the law, "child sexual abuse" is an umbrella term describing criminal and civil offenses in which an adult engages in sexual activity with a minor or exploits a minor for the purpose of sexual gratification (SEC, 2001). The American Psychiatric Association states that "children cannot consent to sexual activity with adults", and condemns any such action by an adult: "An adult who engages in sexual activity with a child is performing a criminal and immoral act which never can be considered normal or socially acceptable behavior." (Nelson *et al.* 2002).

However, Mazza *et al.* [2001] states that sexual exploitation includes conduct involving matter depicting minors engaged in obscene acts; promoting, aiding, or assisting a minor to engage in prostitution; a live performance involving obscene sexual conduct, or posing for a pictorial depiction involving obscene conduct for commercial purposes; and depicting a child in or knowingly developing a pictorial

depiction in which a child engages in obscene sexual conduct. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. Child sexual abuse is not solely restricted to physical contact; such abuse could include no contact abuse, such as exposure, voyeurism, and child pornography. Abuse by peers also occurs (Goldman & Goldman, 1988).

Accurate statistics on the prevalence of child and adolescent sexual abuse are difficult to collect because of problems of underreporting and the lack of one definition of what constitutes such abuse. However, there is general agreement among mental health and child protection professionals that child sexual abuse is not uncommon and is a serious problem. Children and adolescents, regardless of their race, culture, or economic status, appear to be at approximately equal risk for sexual victimization. Statistics show that girls are sexually abused more often than boys are. However, boys' and, later, men's, tendency not to report their victimization may affect these statistics. Some men even feel societal pressure to be proud of early sexual activity (no matter how unwanted it may have been at the time). It is telling, however, to note that men who have been abused are more commonly seen in the criminal justice system than in clinical mental health settings.

2.2 Types of children's sexual abuse

Non-Contact

· Photographing the child for sexual purposes
· Showing the child pornographic materials
· Sexualized talk with the child
· Making fun of or ridiculing the child's sexual development, preferences, or organs
· Verbal and emotional abuse of a sexual nature
· "Peeping" in on child while dressing, showering, using the restroom
· Masturbating in front of the child

· Making the child witness others being sexually abused (John Jay College, 2004).

Contact

· Touching the child sexually
· Invasive care of the child's genitals
· Stripping the child to hit/spank; obtaining sexual gratification out of hitting
· Making the child touch the adult sexually
· Making the child masturbate the adult
· Making the child engage in oral sex
· Making the child engage in vaginal or anal intercourse
· Making the child engage in prostitution
· Making the child engage in sexual activity with animals (John Jay College, 2004).

2.3 Perpetrators of Child Sexual Abuse

"Among tourists, Italians, Germans and Swiss ranked as the most common clients of child sex workers at 18 percent, 14 percent and 12 percent respectively," According to UNICEF 1997 "Ugandans and Tanzanians rank fifth and sixth in the client group, while British and Saudi Arabian men ranked seventh and eighth – but representatives of virtually every nationality visiting Kenya are named in the report."

Studies on who commits child sexual abuse vary in their findings, but the most common finding is that the majority of sexual offenders is a family member or is otherwise known to the child (CRADLE, 2007). Sexual abuse by strangers is not nearly as common as sexual abuse by family members. Research further shows that men perpetrate most instances of sexual abuse, but there are cases in which women are the offenders.

Despite a common myth, homosexual men are not more likely to sexually abuse children than heterosexual men are (CAN, 2009).

2.4 Effects of Sexual Abuse

The impact of sexual abuse can range from no apparent effects to very severe ones. Typically, children who experience the most serious types of abuse involving family members and high degrees of physical force—exhibit behavior problems ranging from separation anxiety to posttraumatic stress disorder.

Nevertheless, (Levitan, 2003) stipulates the effects of child sexual abuse to include depression, post-traumatic stress disorder, anxiety, propensity to re-victimization in adulthood, and physical injury to the child, among other problems.

Sexual abuse by a family member is a form of incest, and can result in more serious and long-term psychological trauma, especially in the case of parental incest (Langevin *et al.* 2000)

However, children who are the victims of sexual abuse are also often exposed to a variety of other stressors and difficult circumstances in their lives, including parental substance abuse. The sexual abuse and its aftermath may be only part of the child's negative experiences and subsequent behaviors. Therefore, correctly diagnosing abuse is often complex. Conclusive physical evidence of sexual abuse is relatively rare in suspected cases. For all of these reasons, when abuse is suspected, an appropriately trained health professional should be consulted (Faller, 1993)

Children and adolescents who have been sexually abused can suffer a range of psychological and behavioral problems, from mild to severe, in both the short and long term (Courtois, 1988). These problems typically include depression, anxiety, guilt, fear, sexual dysfunction, withdrawal, and acting out. Depending on the severity of the incident, victims of sexual abuse may also develop fear and anxiety regarding the opposite sex or sexual issues and may display inappropriate sexual behavior (Dinwiddie *et al.* 2000).

However, the strongest indication that a child has been sexually abused is inappropriate sexual knowledge, sexual interest, and sexual acting out by that

child. The initial or short-term effects of abuse usually occur within 2 years of the termination of the abuse. These effects vary depending upon the circumstances of the abuse and the child's developmental stage but may include regressive behaviors (such as a return to thumb-sucking or bed-wetting), sleep disturbances, eating problems, behavior and/or performance problems at school, and nonparticipation in school and social activities (Farell *et al.* 2000).

Nevertheless, the negative effects of child sexual abuse can affect the victim for many years and into adulthood (Cling, 2004). Adults who were sexually abused as children commonly experience depression. Additionally, high levels of anxiety in these adults can result in self-destructive behaviors, such as alcoholism or drug abuse, anxiety attacks, situation-specific anxiety disorders, and insomnia. Many victims also encounter problems in their adult relationships and in their adult sexual functioning. Re-victimization is also a common phenomenon among people abused as children. Research has shown that child sexual abuse victims are more likely to be the victims of rape or to be involved in physically abusive relationships as adults. In short, the ill effects of child sexual abuse are wide ranging (CPPS, 2008).

There is no one set of symptoms or outcomes that victim's experience. Some children even report little or no psychological distress from the abuse, but these children may be either afraid to express their true emotions or may be denying their feelings as a coping mechanism. Other children may have what is called "sleeper effects." They may experience no harm in the short run, but suffer serious problems later in life.

Furthermore, there are a significant number of negative short-term effects of sexual abuse that impact a child's functioning. The most commonly experienced effect of sexual abuse is posttraumatic stress disorder (PTSD). Posttraumatic stress disorder is a clinical syndrome whose symptoms fall into three clusters: reenactment of the traumatic event; avoidance of cues associated with the event or general withdrawal; and physiological hyper-reactivity (*Kathleen,* 1993) A

recent review article suggested over 50% of sexually abused children meet at least partial criteria of PTSD and another study suggested a third of all sexually abused children develop full diagnostic criteria. (Morer et al. 2008) And, if not effectively addressed, PTSD can become a chronic problem affecting the child well into adulthood. The development of sexualized behavior, also called sexually reactive behavior, is another common negative short-term effect of sexual abuse. Children who have been sexually abused engage in more sexualized behavior when compared to children who are not victims of sexual abuse, and when compared to clinical samples of children with other mental health issues. A recent report suggested that about a third of children who have been sexually abused subsequently manifest PTSD symptoms.

Additionally, a third or more of child victims of sexual abuse report depression and anxiety. Other frequently occurring symptoms include promiscuity (38%), general behavior problems (30%), poor self-esteem (35%), and disruptive behavior disorders (23%). In some important recent research conducted, in part, by the Centers for Disease Control, risk for health problems in adult life including heart disease were increased by adverse childhood events, including sexual abuse. It is estimated that somewhere between 21-49% of child sexual abuse victims appear asymptomatic post-victimization. Potential explanations for this include: difficulties with the methods used to detect problems in children, delays in symptom development post-sexual abuse, underreporting of symptoms, resiliency, and mitigating factors that may make the impact of the abuse less severe for some children, (CRADLE, 2005)

Mitigating factors can increase or decrease distress related to sexual abuse and include characteristics of the crime itself, characteristics of the individual child, and characteristics of the environment. Regarding the crime itself, sexual abuse involving force and penetration are associated with increased distress as are multiple victimizations. If the perpetrator of the crime is a parent rather than an adult stranger or older child, the child is also more likely to experience distress. Child characteristics include age and developmental level. With advanced

cognitive development, a child's perspective regarding the victimization may include more or less distress. Children with lower self-esteem experience increased levels of distress. Children whose coping methods include avoidance are also more apt to develop distress symptoms. Characteristics of the environment include children who have a supportive relationship with an adult, parent, or sibling. These individuals generally have better adjustment than children who experience little support. Similarly, family cohesiveness is also a positive buffer for child victims of sexual abuse. Parental distress is associated with child distress, i.e., the more the parent is negatively affected by the crime, and the more the child is negatively affected. (Dunne, etal.2000)

Evidence suggests that the negative psychological impact of child sexual abuse persists over time, often into adulthood. Potential long-term effects of child sexual abuse include depression, anxiety, posttraumatic stress disorder, sexual dysfunction, and substance abuse. Further, among the female adult outpatient population, individuals with sexual abuse histories as children were twice more likely to attempt suicide than their non-abused counterparts. Across the lifespan, individuals who were sexually abused as children are four times more likely to be at risk for developing a psychiatric disorder and are about three times more likely to abuse substances than their non-abused counterparts. (Rennison, 2003)

CHAPTER THREE

3.0 METHODS

3.1 Study design

This was a descriptive cross-sectional study conducted prospectively among children presenting with sexual abuse complaints at GBVRC in KNH.

3.2 Study site

This study was conducted at Kenyatta National Hospital Patient Support Centre at the Gender Based Violence Recovery Centre. Kenyatta National Hospital is about 4 kilometers from the city centre and covers an area of approximately 46 hectares. The Hospital is situated in the Northern side of Nairobi city. KNH was founded in 1909 with a bed capacity of 40 patients. It was then named King George VI in 1952 and later renamed Kenyatta National Hospital after the late Jomo Kenyatta following independence from the British.

It is currently the largest Referral and Training Hospital in the country with a capacity of 1800 beds and over 6000 staff members. The University of Nairobi, Kenya Medical Training Centre and other governmental and Non governmental agencies are located within the campus.

3.3 Study Setting and Population

The study focused on sexually abused children aged between of 5 to 17 years from the Gender Based Violence Recovery Centre at Kenyatta National Hospital.

3.4 Sampling Method

Sexually abused children between 5-17 years attending GVBVRC at KNH were were purposively sampled.

3.5 Sample Size

The sample size was calculated using the formula by Fisher *et al (*1998).

$$n = \frac{Np\,(1-p)}{(N-1)\,(B^2/4) + (p)(1-p)}$$

Where:

Calculations:

$$n = \frac{200\,(.5)\,(1-.5)}{(200-1)\,(.05^{2)}/4) + (.5)(1-.5)}$$

$$n = \frac{200}{(799)\,(.000625) + .25}$$

$$n = \frac{200}{(799)\,(.000625) + .25}$$

$$n = \frac{200}{0.75}$$

= 266.66

= Total 267

3.5.1 Inclusion criteria

The following categories of persons were included:-

(i) Children aged between 5-17yrs.

(ii) Respondents/caregivers who were willing to give Informed consent.

(iii) Participants at the KNH Gender Based Violence Recovery Centre.

(iv) Those who understood either English or Kiswahili.

3.5.2 Exclusion criteria

The following categories of persons were excluded:-

(i) Respondents/ caregivers who were unwilling to give consent.

(ii) Participants outside the Gender violence recovery centre.

(iii) Participants who were in treatment for PTSD.

(iv) Children aged below 5 years.

(v) Those who did not understand either English or Kiswahili.

3.5.3 Justification for not including children below the age of 5 years

- Children above 5 years who were in the Pre-operational Cognitive stage. They were able to explain and express their feelings, remember past events of which children below 5 years may not be able to do.

- There was a language barrier while working with children below 5 years hence need for a translator, at times translators might not understand the need for precision and accuracy of the information and would paraphrase instead of reporting what the child would have said. This could have led to either underreporting or over reporting.
- Children above 5 years were more spontaneous in their way of communication unlike children below 5 years.
- There would have been complexity of getting information from the children below 5 years in terms of play and drawing.
- Given the time span for the research inclusion of children below 5 years would have been time consuming since there would have been need for a lot of patience to be able to get tangible information.

3.5.4 Informed consent

Consent and consent explanations form was incorporated in all the questionnaires and covering explanation and reasons for the study, risks, inconveniences and benefits, voluntary nature of the study and the right to decline or withdraw consent at any time without loss of benefits. This was explained to all participants by the research assistants, who later sought patients' permission. Confidentiality was assured and maintained by giving anonymous study number to protect specific details and access to the study forms. The study participants were educated about the study using both Swahili and English and only those who provided written consent participated in the study.

3.6 Data Collection instruments

The study utilized the use of structured/close ended questionnaires and PTSD tools.

3.6.1 Socio demographic profiles

Researchers designed questionnaires which helped in obtaining demographic information on age, gender, ethnicity, composition of the home, level of school attended by the child, parental marital status, parental occupation, family income and substance use, psychiatry morbidity and social setting. This helped in establishing factors that determine the vulnerability of the child to sexual abuse.

3.6.2 Sexual Abuse profile

This instrument helped in determining the history of sexual abuse i.e. when it started and when it ended and also the relationship between the perpetrator and the child.

It also helped in establishing the following indicators: duration and frequency of the abusive incidents, extent of injury sustained and the psychosocial effect of the incident on the child.

3.6.3 PTS D INDEX FOR DSM-IV (Parent /Child/Adolescence Version)

The instruments were used and the status of each child was combined because it was important to get direct reports from parents/caregivers and also observe the child as an important component for evaluation. It was borne in mind that parents/caregivers often minimize the child's PTSD symptomatology. The researcher recommended the use of multiple instruments and multiple informants to measure PTSD across different areas of functioning.

3.6.4 Art Assessment for Children

This was a researcher designed Art Assessment tool. Children drawings were expression of the child's perception of the environment they live in. The body

image drawn is shaped by external and maturational factors. Therefore Art was a representation of what children can remember; it was a mental impression of their emotional element of what was important to them.

Pictures and colours helped in observing the child's innermost thoughts and feeling that the child was not able to put in words. Pictures were also used in testing of intelligence which expressed more than intellectual maturity.

3.7 Data collection procedure

Children attending GBVRC at KNH were purposively selected for the study. Consent was sought and patients who consented to participate were recruited into the study. Informed signed consent was provided by the parent/caregiver after being given explanation about the study. Each participant filled the Socio demographic questionnaire in the presence of the researcher, Sexual Abuse Profile (SAP) guided by the researcher. PTSD Index for DSM IV and Art Assessment for children were administered by the researcher to the individual subjects.

3.8 Data management

3.8.1. Data collection and processing

The data was coded, input and cleaned, using SPSS version 15.

3.8.2. Data analysis

Data analysis was conducted using both descriptive and inferential statistics. The descriptive analysis included summarizing sample characteristic by calculation means and standard deviations for continous variables e.g. age, duration and calculating percentages for various levels of categorical variables. The distribution of subjects in different categories was presented using frequency tables, pie charts and graphs. Next the sexual assault profile for the children in the study including age at which abuse occurred; frequency and duration of abuse and pepetration of abuse were described. A PTSD index score was

calculated for each child and a diagnosis was made based on the individual score.The percentage of children with the the main study outcome of PTSD was calculated and compared to percentages of categorical demographic variables using the chi square test to identify factors associated with PTSD.

3.9 Ethical consideration

Ethical approval

This protocol had been designed with the patient's confidentiality in mind. The code of professional conduct and discipline (1949) Medical ethics and the 1965 declaration of Helsinki (on human experimentation and statute laws) were adhered to in this research. Patient whos clinical status after examination was found to need treatment were attended to with liason to the clinician at the Gender Based Violence Recovery Centre (KNH). The research process begun by obtaining approval from the department of psychiatry, University of Nairobi and application of research permit from KNH research and ethics committee as well as an informed consent form and assent form that were filled by the participant and parents / guardians respectively.

Risks

There were expected risks in that the subjects had emotional painful re-experiencing, as they reflect on the experience related to their conditions. When that situation arose, It was normalized by using relaxation techniques and progressive muscle relaxation under the supervision of the researcher who gave appropriate help and reffered them when necessary.

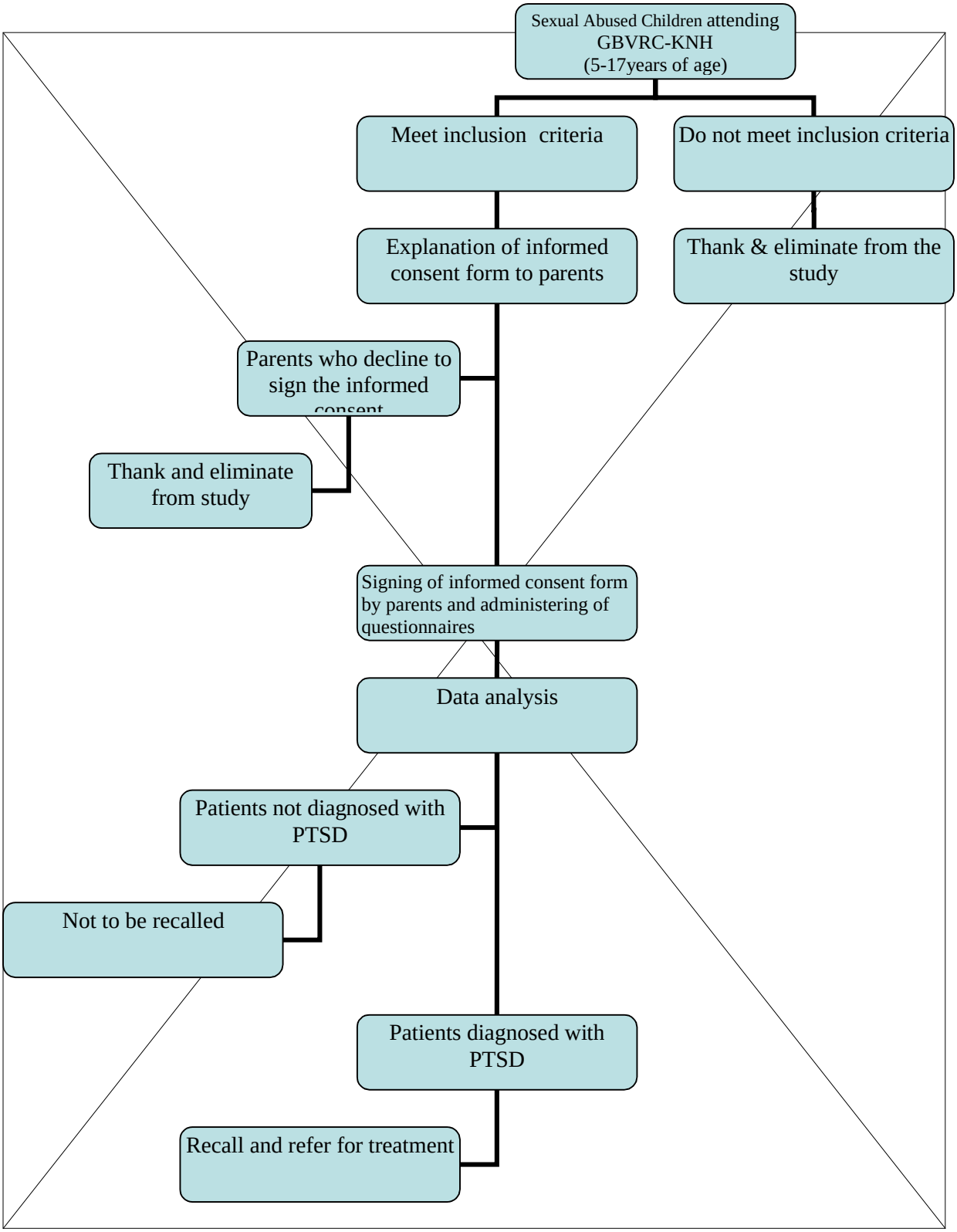
Benefits: The outcome from the study will enable an understanding on the prevalence of PTSD in sexually abused children and the impact it has to the individuals later in their lives. This will help in managing children with PTSD thereby improve their quality of life psychologically, emotionally, socially, and physically. The policy makers will use the information obtained in planning the

needed psychosocial interventions and in training the necessary human resource.

Confidentiality: Confidentiality was observed. To protect the patients' privacy their names were not used but instead, they were assigned serial numbers. The researcher was to keep the records in a safe place and she was the only one allowed to access and use them. The patients' names and other facts that might point to them did not appear when the researcher presented this study and published the results.

Participation of the subjects was voluntary. If any of them did not want to join the study, there was no victimization in any way. The patients could withdraw from the study at any time without any loss of benefits or any victimization whatsoever. If they had any questions about their rights as subjects, they got in touch with the officer in charge of that particular institution.

3.10 Study Flow Chart



3.11 Time frame March 2010 – February 2011

	PERIOD (MONTH)											
ACTIVITY	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**	**May**	**June**	**July**
Proposal preparation and presentation												
Preparation of research instruments												
Pretesting period												
Ethical Committee												
Data collection and cleaning												
Data analysis, compilation												
Report writing												
Handing in report Presentation												

CHAPTER 4

4.0 RESULTS

The study recruited a total of 149 children aged 5 to 17 years who had reported to the gender based violence recovery center at KNH following sexual abuse. The descriptive analysis of the demographic characteristics of the study participants and their socioeconomic status are presented in the following sections.

4.1 Socio -demographic characteristics

Table 1: Socio-demographic characteristics sexually abused children enrolled in the study

	Number of participants (n)	Percentage (%)
Age of child		
5-9 years	40	26.9
10-14 years	27	18.1
15-17 years	82	55.0
Gender		
Male	22	14.8
Female	127	85.2
Attending school		
Yes	107	74.3
No	37	25.7
Level of formal education		
Primary	60	50.0
Secondary	55	45.8
College	5	4.2

Age of participants

The mean age of children in the study was mean 13.2 (SD 4.2) years and the modal age at which sexual abuse occurred was 17 years of age with 43 (28.9%) children reporting they were 17 years old. The age distribution of the participants is shown in Table 1. Sexual abuse was most prevalent in children aged between 15 and 17 years who represented 55% (n = 82) of all children visiting the gender recovery center at KNH. This age group was followed by that of children aged 5-

9 years who accounted for 40 (26.9%) out of the 149 children reporting sexual abuse in this study. Children aged between 10-14 years constituted 18.1% of the sample.

Gender

The ratio of male to female children in this study was 1: 5.8 representing a total of 22 (14.8%) male children and 127 (85.2%) females (Table 1). As shown in Figure 1 most children across all age groups were female.

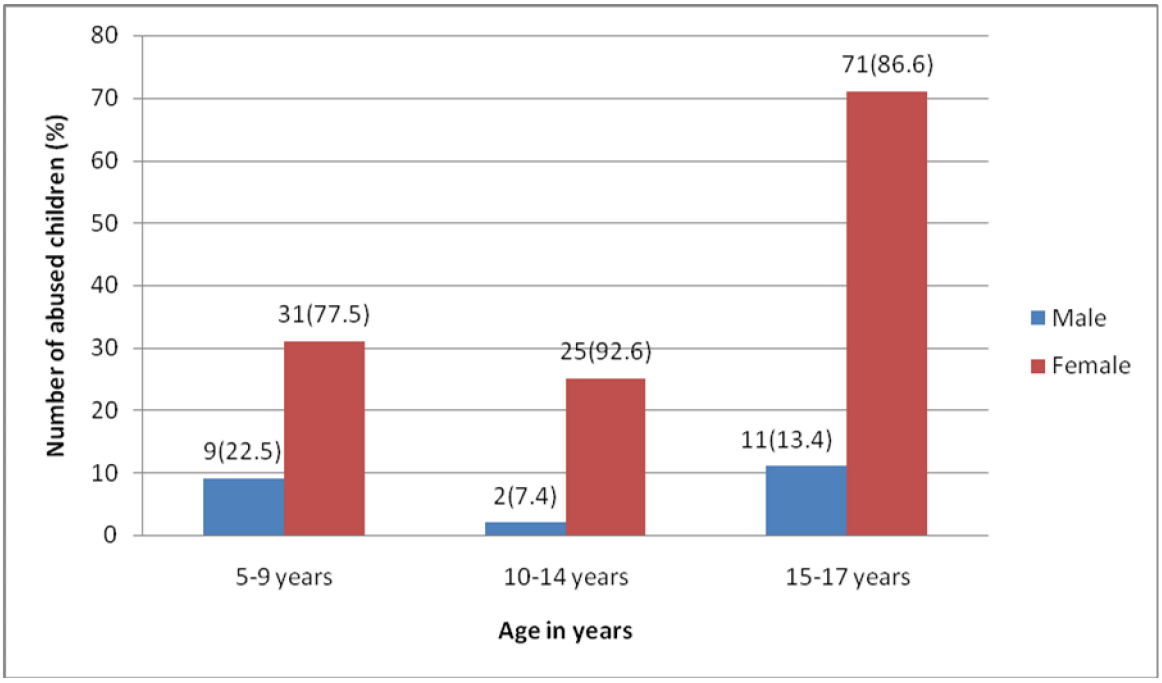


Figure 1: Association between gender and age of sexually abused children seen at KNH

Approximately three-quarters (77.5%) of children aged 5 to 9 years were female. Similarly 92.6% and 56.6% of children 10 to 14 years and 15 to 17 years respectively were female. This associations between age and gender of sexually abused children were however not statistically significant ($\chi^2 = 3.2$, $p = 0.25$).

Formal education attendance

Out of the 149 participants, 107 (85.2%) reported that they were attending primary school. Fifty five (45.8%) children were in secondary school and five (4.2%) reported that they were currently attending college (see table 1).

4.2 Socio-economic factors

Table 2: Socio-economic characteristics of families with sexually abused children at KNH

Parents	Frequency (n)	Percent (%)
Both parents	74	49.7
Mother only	41	27.5
Father only	10	6.7
None	24	16.1
Parent's marital status		
Married	62	41.6
Separated	27	18.1
Cohabiting/ Divorced	9	6.1
Others	32	21.5
Not stated	19	12.8
Children with step parents		
Yes	63	42.3
No	76	51.0
Don't know	8	5.4
Not stated	2	1.3
Presence of siblings		
Yes	135	90.6
No	14	9..4
Brought up by		
Both parents	81	54.4
Mother only	42	28.2
Father only	5	3.4
Others	19	12.8
Not stated	2	1.3
Parents or guardians income		
Less than Kshs. 100 per day	4	2.7
Kshs. 100 per day	36	24.2
More than Kshs. 100 per day	103	69.1
Not stated	6	4.0
Parents or guardians occupation		
Professional	75	50.3
Skilled	22	14.8
Unskilled	47	31.5
Not stated	5	3.4

Family support

Sixteen percent of the sexually abused children did not live with a parent, 49.7% lived with both parents and 27.5% lived with mother only while 6.7% lived with father only (see table 2). Among the 24 (16.1%) children who did not live with their parents three (2%) lived alone and 21 (14.1%) lived with a relative. Sixty-three (42.3%) children lived with a non-biological parent and 64 (42.9%) lived with biological parents. Ten (15.9%) out of the 63 children living with non-biological parents were abused by either a non-biological parent or caregiver in position of trust. A similar number (n =10, 15.6%) of children living with biological parents were abused by them.

Forty-one percent of the parents were married, and 18.1% separated. Of all the sexually abused children 135 (90.6%) had at least one sibling (see table 2).

Economic factors

Approximately 25% of the children were from families with estimated incomes of less than Kshs. 100 per day (2.7%) or Kshs. 100 per day (24.2%). Most of the parents were either professional (50.3%) or unskilled workers (31.5%).

Substance abuse among parents or guardians

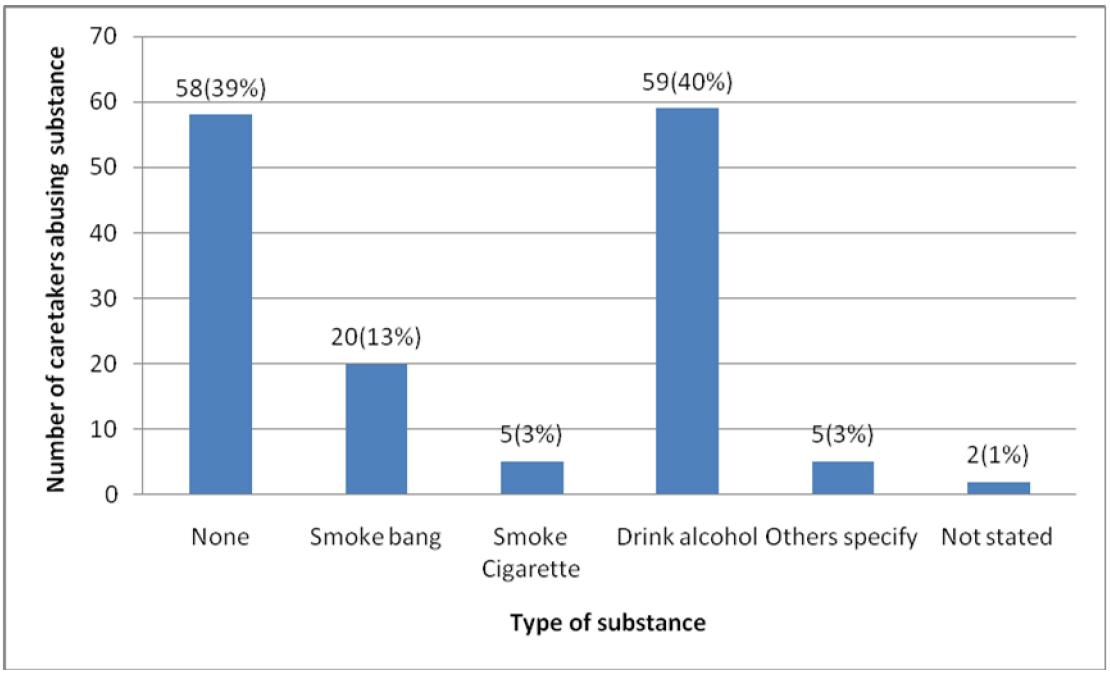


Figure 2: Substance abuse among parents or guardians of participants

Thirty nine percent of the children reported that their parents did not use any substances of abuse (see figure 2). On the other hand alcohol was the most commonly abused substance among caregivers of sexually abused children with 40% of all caregivers abusing the substance. This was followed by bhang smoking (20%), cigarette smoking (3%) and other types of substance (3%).

Resolution of family conflicts

Table 3: Reported means used by caregivers to resolve family conflicts

	Frequency (n)	Percent (%)
Family disagreement settlement		
By talking	71	47.7
By fighting	46	30.9
Don't know	28	18.8
Not stated	4	2.7
Total	149	100

Table 3 shows that 47.7% of parent resolved conflicts between them and their children by talking to them. It was reported however, that 46 (30.9%) commonly resorted to fights whenever there were conflicts between them and other members of their families including their children.

4.3 Sexual assault profile

Age at onset and end of sexual abuse

Table 4: Age distribution of sexually abused children at KNH during onset and end of sexual abuse

Age group	Beginning of sexual abuse n (%)	End of sexual abuse n (%)
5-9 years	27 (18.1)	37 (24.8)
10-14 years	29 (19.5)	28 (18.8)
15-17 years	70 (47)	75 (50.3)
Not stated	23 (15.4)	9 (6)
Total	149 (100)	149 (100)

The mean age of children at the onset of sexual abuse was 12.4 (SD 4.6) years and the modal age at which sexual abuse began was 17 years with 19.2% of children reporting that sexual abuse began at this age. On average, sexual abuse among children in this sample lasted for a duration of 7.7 months (95% CI, 4.8 to 9.6 months). The reported mean age at which sexual abuse ended was 13 (SD 4.2) years and modal age was 17 years (25% of children).

The distributions of ages of children at the point at which sexual abuse started and ended are shown in Table 4 below. Most children were between 15 and 17 years of age both at the time when sexual abuse began (47%) and ended (50.3%).

Duration and frequency of abusive incidents

Table 5: Duration and frequency of sexual abuse among abused children attending KNH

	Frequency n (%)
Frequency of abusive incidents	
Once	87 (58.4)
Twice	15 (10.1)
Three times	6 (4.0)
Four times	9 (6.0)
More than four times	32 (21.5)
Duration of abuse	
Days	101 (67.8)
Weeks	9 (6.0)
Months	7 (4.7)
Years	13 (8.7)
Not stated	19 (12.8)

More than half (58.4%) of the children reported that they had been abused only once. Ten percent of the children had been abused twice, and 21.5% of children had been sexually abused more than four times (see table 5).
The duration of sexual abuse were variable and ranged from days to several years. Most (67.8%) of the children reported that the assaults had lasted days

(Table 5). Approximately 9% of the children reported that they had been sexually assaulted for a period longer than one year. Six percent and 4.7% of the children reported assaults for periods lasting several weeks and months, respectively.

Perpetration of sexual abuse

Table 6: Perpetration of sexual abuse among children attending KNH for treatment

	Frequency n (%)
Perpetrator known to child	
Yes	95 (63.8)
No	47 (31.5)
Not stated	7 (4.7)
Relationship of perpetrator with child	
Acquaintance	52 (34.9)
Stranger	38 (25.5)
Biological parent	10 (6.1)
Non biological parent/caregiver	8 (5.4)
Non-parental caregiver in position of trust	2 (1.3)
Other	23 (15.4)
Not stated	16 (10.7)
Perpetrator's acts	
Vaginal/anal penetration	114 (76.5)
Touching the genitals	17 (11.4)
Non-genital contact	7 (4.7)
Exhibitionsim	2 (1.3)
Not stated	8 (5.4)
Use of verbal or physical force	
No	35 (23.5)
Mild	55 (36.9)
Moderate	43 (28.9)
Severe	5 (3.4)
Others	3 (2.0)
Not stated	8 (5.4)
Child sustained injuries	
No injury	32 (22.1)
Mild injuries	55 (37.9)
Moderate injuries	51 (35.2)
Severe injuries	5 (3.5)
Others	2 (1.4)

Approximately two-thirds (63.8%) of all children reporting that they had been sexually assaulted also reported that the perpetrator was known to them. The relationships reported between the assaulted child and the perpetrators are shown in Table 6. Children were most commonly assaulted by an acquaintance (34.9 %). Twenty five percent of all sexual assaults were done by strangers, biological parents were reported to have sexually assaulted 6.1% of the children and non-biological parents or caregivers were responsible for 5.4% of all sexual abuses.

Approximately three-quarter (76.5%) of all reported incidents of sexual abuse involved vaginal or anal penetration. Other common acts reported to occur during sexual abuse were touching of genitals in 11.4% of abuses and non-genital contact in 4.7% of sexual abuse incidents. In 23.5% of the incidents reported there was no use of physical or verbal force during the abuse. When physical or verbal force was used it was commonly mild (36.9%) or moderate (28.9%) force. In 3.4% of all sexual abuses children reported that the perpetrator used severe verbal or physical force. Injuries commonly occurred during sexual abuse and the severity of these injuries ranged from mild (36.9%), moderate (28.9%) to severe (3.4%).

Child's perception of sexual abuse

Most (61.7%) of the sexually abused children reported that they did not feel responsible for the abuse. On the other hand 26 (17.5%) children felt that they were partly responsible for the abuse while the remaining 31 (20.8%) children felt that they were fully responsible for the abuse.

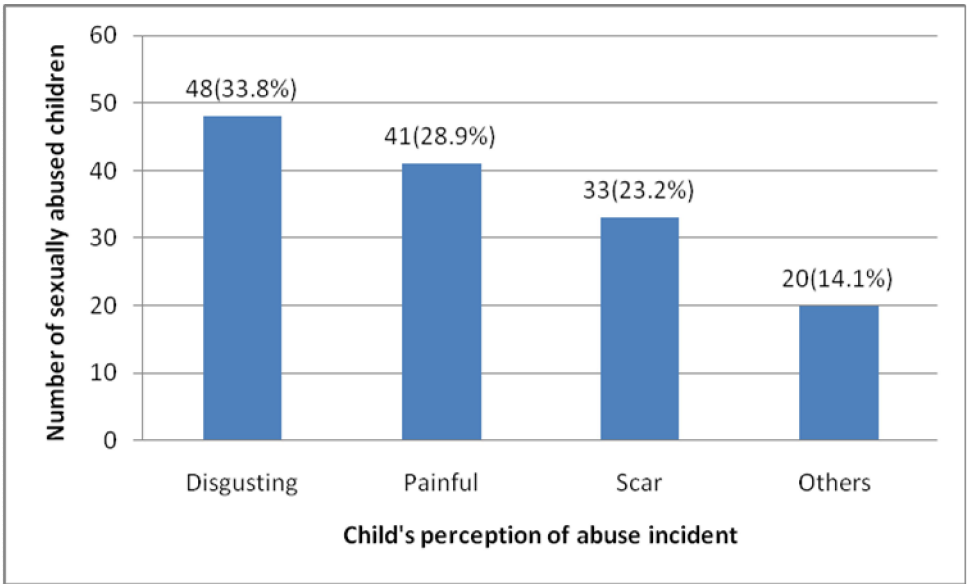


Figure 3: Perception of sexual abuse among sexually abused children at KNH gender recovery center

Forty eight (33.8%) of children perceived the abuse as disgusting, 28.9% reported that it was painful, 23.2% felt that the assault had left them scarred and 14.1% reported other perceptions, confusion and not knowing what to make of the incident (figure 3).

4.4 Post traumatic stress disorder

The prevalence of post traumatic stress disorder among sexually abused children attending the gender recovery center at KNH was 49% with 73 out of the 149 sexually abused children meeting the criteria for PTSD diagnosis (see figure 4).

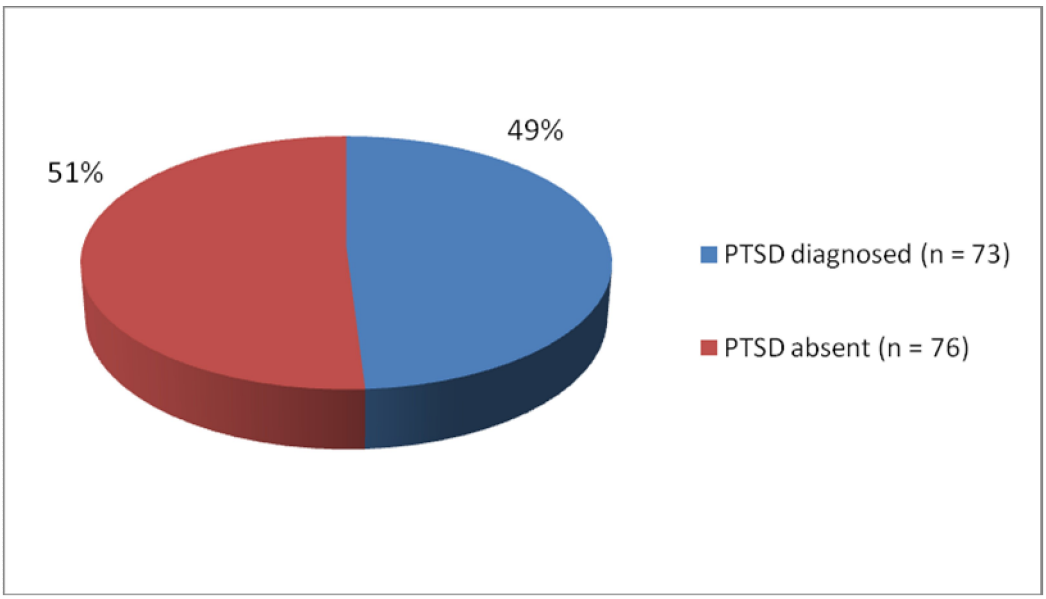


Figure 4: Prevalence of PTSD among sexually abused children at KNH

Results of the PTSD index scores are presented in Table 7 for PTSD severity score. The mean overall PTSD score was 38.1 (SD 9.6), while the mean score for criteria B, C, and D were 11.4 (3.2), 15.3 (4.8), and 11.5 (4.8).

Table 7: PTSD severity scores for 149 sexually abused children seen at KNH

	Mean (SD)	Range
Overall PTDS severity	38.1 (9.6)	20-72
Criteria B severity	11.4 (3.2)	3-18
Criteria C severity	15.3 (4.8)	5-25
Criteria D severity	11.5 (4.8)	2-41

4.5 Factors associated with PTSD prevalence

The prevalence of PTSD showed statistically significant associations with parents' marital status (χ^2= 15.31, p =0.003), duration of sexual abuse (χ^2= 20.96, 0.005), whether injury was sustained during abuse (χ^2= 10.68, 0.023) and parent-child or family relationships (χ^2= 11.95, p < 0.001), see table 8.

As shown in Table 8 children who sustained injuries during sexual abuse were more likely to develop PTSD compared to those who did not sustain any injuries.

Only 31% of children with no injuries had PTSD compared to 51% of children with mild injuries and 61% of those with moderate injuries who also had PTSD. The prevalence of PTSD was highest among children with severe injuries with 80% of these children developing PTSD. Children of parents who resorted to fights in order to resolve conflicts were also at higher risk of PTSD (67%) compared to those of parents who resolved conflicts by talking (31%).

The prevalence of PTSD among children of separated, cohabiting parents and parents in other marital status was high at over 50% for each group (Table 8). Only 35% of children of married parents had PTSD. The lowest prevalence of PTSD was seen among children of divorced parents with a prevalence of 25%.

The duration of sexual abuse was also statistically significantly associated with PTSD (Table 8). Eighty-five percent of children who reported that they had been sexually abused for years had PTSD compared to lower PTSD prevalence among children abused for days (52%), weeks (11%) or months (57%).

Table 8 also shows that there was no significant difference in PTSD prevalence among boys (50%) and girls (49%), $p = 0.9$, or children in the different age groups, $p = 0.02$. Having siblings ($\chi^2 = 0.41$, $p = 0.58$) or knowledge of the perpetrator ($\chi^2 = 0.6$, $p = 0.48$) did not show a significant association with developing PTSD following sexual assaults.

Table 8: characteristics of sexually abused children with PTSD and without PTSD seen at KNH

	PTSD	No PTSD	Chi statistic	P value
Sex	N (%)	N (%)		
Male	11 (50)	11 (50)	0.011	0.9
Female	62 (49)	65 (51)		
Age categories				
5-9 years	21 (53)	19 (47)	3.23	0.20
10-14 years	9 (33)	18 (67)		
15-17 years	43 (52)	39 (48)		
Parent or guardians marital status				
Married	22 (35)	40 (65)	15.31	0.003
Separated	15 (56)	12 (44)		
Cohabiting	5 (100)	0		
Divorced	1 (25)	3 (75)		
Other	21 (66)	11 (34)		
Child with siblings				
Yes	65 (48)	70 (52)	0.41	0.58
No	8 (57)	6 (43)		
Family disagreement settlement				
By talking	29 (31)	49 (69)	11.95	< 0.001
By fighting	31 (67)	15 (33)		
Don't know	17 (61)	11 (39)		
Perpetrator known to child				
Yes	46 (48)	49 (52)	0.6	0.48
No	26 (55)	21 (45)		
Child sustained injuries during assault				
No injury	10 (31)	22 (67)	10.68	0.023
Mild injuries	28 (51)	27 (49)		
Moderate injuries	31 (61)	20 (39)		
Severe injuries	4 (80)	1 (20)		
Others	0	2 (100)		
Duration of abuse				
Days	48 (52)	53 (48)	20.96	0.005
Weeks	1 (11)	18 (89)		
Months	4 (57)	3 (43)		
Years	11 (85)	2 (15)		

4.6 Art Assessment of children

A sub sample of 38 (25.5%) children from the 149 sexually abused children attending KNH was selected to participate in an Art Assessment exercise.

Table 9: Art assessment of pictures drawn by sexually abused children during art therapy

	Frequency n (%)
Disorganized drawing	5(13.2)
Impulsive behavior	4(10.5)
Mixed feelings	4(10.5)
Self sufficient/ confident	4(10.5)
Aggression/ hostility	3(7.9)
Attention seeking	3(7.9)
Emotionally disturbed	3(7.9)
Anxiety	2(5.3)
Overwhelmed	2(5.3)
Low self esteem/ insecurity	2(5.3)
Unhappy	1(2.6)
Sibling rivalry	1(2.6)
Enthusiastic	1(2.6)
Dominance	1(2.6)
Emotional control	1(2.6)
Depressed	1(2.6)
Total	38(100)

Among these children selected for Art Therapy Assessment five (13.2%) drew disorganized pictures of family members.

Further funnel analysis of the remaining 15 drawings showed that these sexually abused children expressed different feelings through their pictures (see table 9). The common expressions were impulsive behaviour (10.5%), self sufficiency or confidence (10.5%), mixed feelings (10.5%), and aggression or hostility (7.9%). Children also commonly expressed feelings of emotional disturbance (7.9%), anxiety (5.5%) and showed attention seeking (7.9%).

CHAPTER FIVE

5.1 DISCUSSION

This study conducted among sexually abused children presenting at the main tertiary referral hospital in Nairobi showed sexual abuse was common among teenage female children that the prevalence of PTSD was high affecting 49% of sexual abuse cases.

There was a high proportion (85.2%) of girls in this study. Gender was the most prominent demographic characteristic showing imbalance in the sample. This appears to be consistent with both international and local estimates of gender distribution of cases of childhood sexual abuse. The results of a recent meta-analysis reported that Africa had the lowest rate of childhood sexual abuse for boys compared to other regions of the world (Stoltenborgh, 2011). In Kenya, 99% of sexually abused children (7-17 years) in a psychiatric hospital were female (Syengo-Mutisya, 2008).

Most of the children reporting sexual abuse were adolescents aged between 15-17 years. The risk of abuse in this age group in Kenyan children has previously been reported to be lower than that among children 12 to 14 years (CRADLE, 2007). It is noteworthy that the mean age at which sexual abuse occurred was 13 years comparing with the age at highest risk of abuse in the CRADLE study and that even in the CRADLE study children aged 15 to 17 years had the second highest risk of sexual abuse (CRADLE, 2007). In both studies the young school going children were also vulnerable to sexual abuse.

The perpetrators of sexual abuse were usually known to their victims and penetration occurred in most of the reported cases of assault. Most (66.9%) of

the survivors were abused by acquaintances such as neighbours, caregivers and parents. In two earlier Kenyan studies it was reported that between 71.5% and 82% of child sexual abuse were perpetrated by people known to the victim (Saidi 2008; Syengo-Mutisya 2008). In the 1998 South Africa Demographic and Health Survey, the largest group of perpetrators (33%) of child sexual abuse was school teachers. (Jewkes 2002) Similar reports exist in for the wider sub-Saharan Africa region indicating that Child sexual abuse is most frequently perpetrated by family members, relatives, neighbors or others known to the child (Lalor 2004). However, in a study from 1984-1985 at KNH strangers and people familiar to the child were equally implicated as assailants (Nduati 1992).

Penetrative sexual abuse was a common occurrence during child sexual assault and injuries were frequently reported. It is estimated that, between 1.8% and 6 % of all children in high HIV-incidence countries in Southern Africa will experience penetrative sexual abuse before 18 years of age (Lalor 2004). The high incidence of injuries confirms earlier reports from KNH that 66.7% victims of childhood sexual abuse present with injuries (Nduati, 1992).

This study conducted among sexually abused children and teenagers seeking treatment in KNH demonstrated that PTSD had a high prevalence (49%) among sexually abused Kenyan children. This finding is consistent with a previous study on trauma exposure including sexual assault among school age children in Nairobi and Cape Town (Seedat 2007). Seedat and colleagues reported that sexual assault is the trauma type most likely to be associated with PTSD among children attending urban schools in Nairobi. This study confirms the findings of

studies conducted elsewhere that report PTSD prevalence ranging from 33% to 50% among sexually abused children.

Additional findings in the current study indicate that PTSD prevalence was significantly associated with injuries sustained during assault. In addition the prevalence of PTSD increased with increasing severity of injuries providing support for the argument that physical scarring could lead to psychological problems following traumatic experiences in childhood. This also consistent with the reported association in the literature between degrees of physical force experienced during sexual abuse and development of behavior problem ranging from separation anxiety to PTSD (Terry 2000).

An additional finding related to family pathology and showed that the way families resolved conflicts was associated with PTSD prevalence. Family's way of sorting their disagreements showed a statistically significant difference in predicting presence or absence of PTSD in the present study. Similar findings have been reported among Kenyan children admitted to hospital with psychiatric morbidity (Syengo-Mutisya). This highlights the critical role that social support has on psychological well being. Children with supportive parents and good caring family relationships are less likely to experience PTSD compared to those from physically abusive families. This finding was also consistent with the finding that PTSD prevalence was significantly associated with the parental marital status which could serve as a proxy for dysfunctional family relationships. Children in families with functional marital relationships reported lower rates of PTSD symptoms compared to those in dysfunctional families.

Parental substance abuse did not show significant association with PTSD prevalence neither did presence or absence of siblings. The lack of a significant association between PTSD and duration of sexual abuse in this study was surprising since previous studies have reported significant associations between duration of abuse and PTSD prevalence. However, this lack of significance could be explained by the fact that more than half (58.4%) of the children reported that they had been abused only once. There were relatively fewer children reporting prolonged abuse over several years making it harder to statistically demonstrate the effect of duration of abuse on PTSD.

Because of the highly selected nature of the sample the findings of varying level of emotional disturbance among study participants during Art Assessment was expected. About one-fifth of pictures were disorganized. The level of disorganization in these picture varied representing different levels of dislike for the individual contained in the pictures. This observation agrees with the report in the entire sample of children that perpetrators of sexual abuse were known to most children and frequently included family members and acquaintances.

The features of one drawing were interpreted to depict a child with emotional disorder and possibly depression.

5.2 LIMITATIONS OF THE STUDY

The reported results should be interpreted while considering the possible limitations of this study. Firstly, the cross-sectional study design used might have captured children at different stages of the recovery following sexual abuse

introducing possible biases related to duration of present PTSD episode. It is difficult to quantify and address such biases with the cross sectional study design. Examples of such biases include recall bias with recently abused children being more likely to recall details of sexual abuse and provide more accurate sexual abuse profiles compared to children who were abused earlier on.
Secondly, there are few existing studies conducted among Kenyan children documenting the appropriate threshold for determining PTSD criteria. The threshold used for a frequency of PTSD symptoms in this study was “most of the time”. This threshold was previously used among Kenyan school children by Seedat and colleagues who considered it to be a relatively high threshold for PTSD criteria. In addition the diagnosis of PTSD was based on reported symptoms only and not the assessment of functional impairment.
Thirdly, the number of children recruited for Art Assessment was limited mainly because the older children dislike drawing. Therefore Art Assessment is more useful in therapy and facilitating communication in trauma when used on its own.

The findings of this study can be generalized to children in Kenya and similar settings. It is however, important to note that this population excludes children below five years of age although this group also bears a significant burden of sexual abuse. In studies that have included children in this age group it has been shown that vulnerability is particularly high between in the ages of 3 and 5 years (Saidi 2008).

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

In conclusion, this study highlights the high prevalence of PTSD among sexually abused children. PTSD is associated with the degree of physical or verbal abuse during sexual abuse, injuries during assault, and parent-child relationships. These findings are important in formulation of appropriate prevention and care interventions to be implemented by families and other stakeholders. Future studies to find could explore further the type of associations reported in this study.

6.2 Recommendations

The key recommendations of this study are:

- Parents and Caregivers need to be sensitized on the impact of parent child social relationship and family support on the risk of PTSD among sexually abused children.
- All parents caregivers and children regardless of their social economic status need to be sensitized about childhood sexual abuse and the fact that majority of the perpetrators are acquaintances.
- Since PTSD is common affecting at least one out of every two sexually abused children all children who have been sexually abused need to be evaluated for PTSD regardless of their social demographic profile, social status of the parents and abuse profile.
- Health workers/ clinicians should also be sensitized on the importance of screening for PTSD in these children with emphasis on recognizing the

symptoms and signs of PTSD associated with past history of sexual abuse in children.

- There is need to increase awareness across the spectrum of health care professionals who care for sexually abused children about the high level of PTSD through pastoral counseling, group discussion, life coping skills and seminars.
- Parents/Caregivers whose children suffer from PTSD should also be screened for the same when they accompany their children to the clinic. To rule out if there is any underlying stress brought about by the parents/caregivers.
- Future studies and analysis on PTSD among sexually abused children should be conducted using other epidemiological study designs that overcome the limitations of the cross sectional design e.g. cohort studies to document details such as duration of PTSD and PTSD incidence rates. These studies should also include children outside the ages 5 to 17 years who formed the population of the current study.

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APPENDIX I.

A. CONSENT EXPLANATION FOR THE INSTITUTION

I am Caroline Atieno Ombok, a Master's student in Clinical psychology at the University of Nairobi. I am collecting data on **The prevalence of Post-Traumatic Stress Disorder among sexually abused children (ages 5-17 years) seen at the Gender Based Violence Recovery Centre at Kenyatta National Hospital, Patient |Support Centre**. If you agree we would like to ask the patients some questions about these problems and how it affects their quality of life.

Risks / Discomfort

There are expected risks in that the subjects might re- experience past event(s), when this arises, there will be need to normalize the situation by using relaxation techniques and progressive muscle relaxation.

Benefits

The information obtained from the study will enable an understanding on the prevalence of PTSD in sexually abused children and the impact it has to the individuals later in their lives. This will help in managing children with PTSD thereby improve their quality of life psychologically, emotionally, socially, physically etc.

Confidentiality: Confidentiality will be observed. To protect the patients' privacy we will not use their names but instead we will assign them serial numbers. The researcher will keep the records in a safe place and only (she) will be allowed to access and use them. The patients' names and other facts that might point to them will not appear when the researcher presents this study and publishes the results.Participation of the subjects will be voluntary. If any of them does not want to join the study, they will not be victimized in any way. The patients can withdraw from the study at any time without any loss of benefits or any victimization whatsoever. If they have any questions about their rights as subjects, they can get in touch with the officer in charge of that particular institution.

B: Informed Consent Explanation

My name is Caroline Atieno Ombok of Psychiatric Department, University of Nairobi. I am doing a research on **prevalence of Post-Traumatic Stress Disorder among sexually abused children and adolescent (ages 5-17 years) seen at the Gender Based Violence Recovery Centre at Kenyatta National Hospital (KNH),** I will use the information for my Master's Degree Dissertation in Clinical psychology from the same University. I have been given permission by the management of the Hospital to talk to you but I would first like to explain to you what I intent to do so that you can decide whether you, your child/Adolescence can participate or not.

I would like to request your participation in the research to determine the **prevalence of Post-Traumatic Stress Disorder among sexually abused children and adolescent (ages 5-17 years) seen at the Gender Based Violence Recovery Centre at Kenyatta National Hospital (KNH),** If you agree to participate I will ask you to read and respond appropriately to a list of questions that ask about your personal details, feelings and experiences. This exercise will not take more than 30 minutes in total. No tests of physical examination will be done on you and the only risk may be the uncomfortable feeling you might experience as you recall the sexual assault that you went through. However should this happen I will discuss this further with you and with your permission refer you to your counselors within the hospital for further care and support. The information obtained from the study will help managing children with PTSD thereby improve their quality of life. All the information you give will be in confidence and will not disclose anything to your parents/caregivers without your permission. I would like you to know that I will also get information from your parents/caregivers.
If you have any questions do not hesitate to contact me on telephone Number 0722392358

C: Consent form

I …….. (Name of Parent/Guardian) parent/guardian of ……. Child/Adolescence having been explained the nature of the study and the implication of my participation by **Caroline Atieno Ombok** (Name of Researcher) **Tel: 0722392358 P. O. Box 20815-0202 NAIROBI**, do hereby give consent for my Child/Adolescence to participate in the research study entitled: **The Prevalence Of Post-Trauma Stress Disorder Among Sexually Abused Children And Adolescent (Ages 5-17 Years) seen at The Gender Based Violence Recovery Centre at Kenyatta National Hospital (KNH),** I also accept to give any other relevant information about my child/Adolescence.

I have been given the opportunity to ask questions concerning this study and these questions have been answered to my satisfaction. I understand that I may at any time during the course of this study revoke my consent and withdraw from the study without any penalty or loss of benefit to which I and my child/Adolescence are otherwise entitled.

By signing this consent form I am once again affirming that I have understood everything contained in the consent explanation.

Parent/Guardian…… Signature……Date……

SUPERVISORS

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D. Institutional head consent statement:

The above study has been explained to and I agree to allow patients to take part. If I change my mind and decide to withdraw the permission at any time, I understand that I and my patients will not be victimized in any way.

Institutional Head ----------

Signature ----------

Witness Name ----------

Signature ----------

Researcher Name ----------

Signature ----------

APPENDIX 2

A. SOCIO-DEMOGRAPHIC QUESTIONNAIRE

1. Code Number..…….
2. Age……..……..……
3. Sex.……
4. Residential Physical Address……..
5. Place of Birth……..
6. Are you attending school? 1 Yes ( ) 2 No. ( )

a) If yes, which class? b) If no Skip to Q 7

1 Primary ( )
2. Secondary ( )
3 College ( )

7. Do you have your parent(s): If (4) skip to Q 11

1 Both Mother and Father ( )
2 Only Mother ( )
3 Only Father ( )
4 None ( )

8. Are your parents alive?

1 Yes ( )
2 .No ( )
3. Don't know ( )

9. If (1), (2) (3) in (7) above are they?

1. Married ( )
2. Separated ( )
3. Cohabiting ( )
4. Divorced ( )
5. Others,

specify…….....

10. If (1) or (3) in (7) above. Does your father have more than one wife?

1 Yes ( )

2. No ( )

3 Don't Know ( )

11. If (4) in (7), whom do you live with?

1. Good Samaritan ( )
2. Neighbours ( )
3. Guardian ( )
4. Friends ( )
5. Caregiver ( )
6. Other(s) specify…….....

12. Do you have step parents?

1 Yes ( )

2 No ( )

3 Don't Know ( )

13. What is the occupation of mother/father/caregiver?

1. Professional ( )
2. Skilled ( )
3. Unskilled ( )

14. How much does your mother/father/caregiver earn?

1. Less than a 100/= a day ( )
2. 100/= a day ( )

3 More than a 100/= a day ( )

15. How many are you in your family?

1. Less than 3 siblings ( )
2. 3 or more siblings ( )

16. How many brothers do you have?.....

17 How many sisters do you have?.....

18 What is your birth position in the family?.....

19. Who brought you up?

1. Both Mother and Father ( )
2. Only Mother ( )
3. Only Father ( )
4. Others specify……

20 Is there any history of mental illness in your family?

1. Yes ( )
2. No. ( )
3. Don't know ( )

21. Do your parent(s) or guardian take any of the following?

1. None ( )
2. Smoke bang ( )
3. Smoke Cigarette ( )
4. Drink Alcohol ( )
5. Chew Miraa ( )
6. Other(s) specify ……

22. How does your parent(s) or caregiver sort out disagreement in the family?

1. By talking ( )
2 By fighting ( )
3 Don't know ( )
4 Other(s) specify…….

B. SEXUAL ASSAULT PROFILE

1. How old were you when the abuse:
    1. Began ……
    2. Ended ……
    3. Was reported to the authority ……

2 a) Has any of your siblings/parents or caregiver gone through an experience similar to what you have gone through?

1	Yes	( )	If No. or don't know go to Q 3
2.	No	( )	
3.	Don't know	( )	

b) If yes please specify whether it is a sister brother, parent or caregiver

---

3 On which date did the assault happen to you? D:…… M:……Y:…….
If it happened more than once indicate the date's as well if you can remember:-……

4. On which day of the week did the assaults happen?

1.	Monday	( )
2.	Tuesday	( )
3.	Wednesday	( )
4.	Thursday	( )
5.	Friday	( )
6.	Saturday	( )
7.	Sunday	( )

5. What time of the day or night did the assault happen?.....

6 Where did the assault happen?

1.	Your bedroom	( )
2.	The perpetrators bedroom	( )
3.	Sitting Room	( )
4	Other Specify):……	

7. Is the perpetrator known to you? i. Yes ( ) ii. No. ( )

If yes what is your relationship with the perpetrator

1. Stranger ( )
2. Acquaintance (Neighbour, Boyfriend, Classmate ( )
3. Non-parental caregiver in position of trust e.g. relative baby sitter ( )
4. Biological parent ( )
5 Non biological parent/caregiver (e.g. step or foster parent)( )
6. Other(s) Specify……

8 What acts did the perpetrator do?

1. Vaginal anal Penetration ( )
2. Touching the genitals ( )
3. Non genitals contact ( )
4. Exhibitionism (removed all his cloths) ( )
5. Other(s) specify ……..

9 What did he/she make you do?

1. Nothing ( )
2. Touching his/her genitals ( )
3. Oral copulation ( )
4. Other(s) specify……

10(a) What was the frequency of the abusive incidents?

1. Once ( )
2. Twice ( )
3. Three times ( )
4. Four times ( )
5. More than four times ( )

10 (b) For how long has the abuse taken place

1. Days ( )
2. Weeks ( )
3. Months ( )
4. Years ( )

11. Were you injured during the abuse?

1. No injury ( )
2. Mild Injuries ( )
3. Moderate Injuries ( )
4. Severe Injuries (broken bone) ( )
5. Other(s) explain ……..

12 Did the perpetrator use verbal or physical force to do what he did?

1. No ( )
2. Mild (e.g. Push or shove ( )
3. Moderate (e.g. holding arm down during the incident) ( )
4 Severe (tying the victim down, holding a weapon to the victims head)
5. Other(s) specify……

13 What did you do when you were being abused?

1. Made an effort to resist ( )
2. Passively submitted ( )
3. Pretended it was not happening ( )
4. Other(s) specify…….

14 How did you perceive the abuse?

1. Disgusting ( )
2. Painful ( )
3. Scary ( )
4 Other (Specify)……

15 Do you feel responsible for the abuse?

1. No ( )
2. Partly ( )
3. Fully ( )

16 What makes you think that you were not responsible, partly responsible or fully responsible (explain):……...
……..

17. At what stage did it occur to you that you have been abused?

1 Within 48 hours

2 Two days to 2 weeks

3 Two weeks to one month

4 One month to six months

5 More than six months

Other(s) specify ……..

18. How did the caregiver get the information?

……..

……..

20. Did your parent/caregiver react in a supportive way when the incident was reported?

1 Yes ( ) 2. ( ) No

21 a) If yes how did he/she react? Explain:-

……

……

……..

b) If no how did he/she react? Explain:-……..

……..

……..

……..

(i) PTSD INDEX FOR DSM IV (Parent Version - Revised)

Child's name Age
*Jina la Mtoto*_____ *Miaka*_____ *Code No.*_____
Primary Caregiver's Name Relationship to Child
*Jina la mlezi wa mtoto*_____ *Uhusiano kwa mtoto*_____
Today's date Sex Girl Boy
*Tarehe ya leo :*_____*JinsiaViringa)* *Msichana* _____ *Mvulana*_____
School Class in school Town/Village
*Shule :*_____*Kiwango au darasa Shuleni* _____ *Mji/Kijiji*_____

_____

Listed below are **VERY SCARY, DANGEROUS OR VIOLENT** things that sometimes happen to children. There are times where someone was **HURT VERY BADLY OR KILLED**, or could have been. Some children have had experiences whereas others have not. Please be honest in answering if the violent thing happened to your child or if it did not happen to your child.

Hapa chini ni orodha ya vitu vya kuogopesha/hatari au vurungu ambavyo hutokea kwa watoto. Huu ni wakati ambapo mtu aliumizwa vibaya au kuuliwa, au angeumizwa au kuuliwa. Watoto wengine wamepitia haya, wengine hawajapitia. Tafadhali kuwa mkweli unapojibu kama vurugu lilitokea kwa mtoto wako, au kama haikutokea kwa mtoto wako..

FOR EACH QUESTION:
Tick "Yes" if this scary thing **HAPPENED TO YOUR CHILD**
Tick "No." if this scary thing **DID NOT HAPPEN TO YOUR CHILD**

KWA KILA SWALI:

Tia alama "Ndiyo" kama hichi kitu cha kuogopesha kilitokea kwa mtoto wako
Tia alama "La" kama hakikutokea kwa mtoto wako

_____

1	.In the past six months, experienced anything scary or violent? *Kwa miezi misita iliopita, ulishuhudia tukio la kuogopesha au vurugu .*	Y ( ) N ( ) N L
2.	Been in a **disaster** like a fire of flood *Kuwa katika msiba kama moto au mafuriko.*	Y ( ) N ( ) N L
3.	Been in a bad **accident,** like a **very serious** car accident. *Kuwa kwa ajali mbaya kama ajali mbaya ya gari.*	Y ( ) N ( ) N L
4	Been in a place where a **war** was going on around your child. *Kuwa sehemu ambayo vita viliendelea kuzunguka mtoto wako*	Y ( ) N ( ) N L
5.	Been **hit, punched, or kicked very hard** at home. **DO NOT INCLUDE** ordinary fights between brothers & sisters) *Kupigwa, ngumi au kupigwa ngumi au teke kwa nguvu sana ukiwa nyumbani.* (*Usiweke vita vya kawaida kati ya dada na kaka*)	Y ( ) N ( ) N L
6.	Seen a family member being **hit, punched or kicked very hard** at home **DO NOT INCLUDE** ordinary fights between brother & sisters) *Kuona mmoja wa familia akipigwa teke kwa nguvu sana ukiwa nyumbani.* *(Usiweke vita vya kawaida kati ya dada na kaka)*	Y ( ) N ( ) N L
7.	Been **beaten up, shot at or threatened to be hurt badly** in your town. *Kupigwa, kulengwa risasi au kutisha kuumizwa vibaya katika mji wako*	Y ( ) N ( ) N L
8.	Seen someone in your town **being beaten, shot at or killed**. *Kuona mtu katika mji wako akipigwa, akilengwa risasi au akiuliwa*	Y ( ) N ( ) N L

9. Seen a **dead body** in your town (do not include funerals) Y ( ) N ( )
Kuona maiti katika mji wako (usiandike mazishi) N L

10. Have an adult or someone much older touch your child's **Private Sexual body parts** when your child did not want them to. Y ( ) N ( )
Kuwa na mtu mzima au mzee akishika sehemu za siri za mototo wako kama hataki N L

11. Heard about the **violent death or serious injury** of a loved one. Y ( ) N ( )
Kusikia kuhusu kifo kinachotokana na vurugu au dhari la hatari kwa unayempenda N L

12. Have **painful and scary medical treatment in a hospital** when your child was very sick or badly injured. Y ( ) N ( )
Kupata uchungu na matibabu ya kuogopesha kwa hospitali mtoto wako akiwa mgojwa sana au ameumizwa vibaya N L

13. OTHER than the situations described above has **ANYTHING ELSE** ever happened to your child that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Y ( ) N ( )
N L

Please write what happened: _____

_____

Mbali na mikasa iliyosimuliwa/elezewa juu, kuna kitu chochote kilichomtokea mtoto wako ambacho kilikuwa cha kuogopesha, hatari au vurugu?. Tafadhali andika kilichotokea

14. A) If you answered "**YES**" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13 in this blank # _____
Kama umejibu "NDIYO" kwa kitu kimoja pekee katika hiyo orodha ya maswali # 1 mpaka #13 weka/andika nambari ya hicho kitu (# mpaka #13) katika hili pengo #_____.

B) If you answered "**YES**" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank # _____
Kama umejibu "NDIYO" kwa kitu zaidi ya kimoja weka/andika nambari kitu ambacho kinamsumbua mtoto wako zaidi kwenye hili pengo #_____.

C) About how long ago did this bad thing (your answer to A or B) happen to your child?
Ni muda gani tangu hicho kitu kibaya (jibu lako la A au B) kitokee kwa mtoto wako?

( ) Less than I month ago (Isiyozidi mwezi moja uliopita)
( ) Between 1 month and 3 months ago (*Kati ya mwezi moja na miezi tatu zilizopita)*
( ) Between 3 months and 6 months ago *(Kati ya miezi tatu zilizopita na miezi sita zilizopita)*
( ) between 6 months and one year. (*Kati ya miezi sita na mwaka moja uliopita)*

D) Please write what happened: _____
Tafadhali andika nini kilitendeka

_____

FOR THE NEXT QUESTIONS, please **TICK "Yes, No. or Don't know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Don't know" if you absolutely cannot give an answer.

KWA MASWALI YANAYOFUATA, tafadhali **TIA ALAMA "*Ndiyo, La, au Sijui"*** *kujibu* ***VILE*** **MTOTO WAKO ALIHISI** *wakati* ***au punde baada*** *ya mkasa ulioandika kwenye swali nambari 14. Tia alama "Sijui" kama unuhakika hauwezi kupeana jibu.*

15. Was your child afraid that he/she would die? Y ( ) N ( ) DK ( )
Je mtoto wako aliogopa kuwa angekufa? N L *Sijui*

16. Was your child afraid that he/she would be seriously injured? Y ( ) N ( ) DK ( )
Je mtoto wako aliogopa kuwa angeumizwa sana? N L *Sijui*

17. Was your child seriously injured? Y ( ) N ( ) DK ( )
Je mtoto wako aliumizwa sana? N L *Sijui*

18. Was your child afraid that someone else would die? Y ( ) N ( ) DK ( )
Je mtoto wako aliogopa kuwa mtu mwingine angekufa? N L *Sijui*

19. Was your child afraid that someone else would be seriously? Injured? Y ( ) N ( ) DK ( )
Je mtoto wako aliogopa kuwa mtu mwingine angeumia vibaya? N L *Sijui*

20. Was someone else injured? Y ( ) N ( ) DK ( )
Je kuna mtu mwingine aliyeumizwa vibaya N L *Sijui*

21. Did someone die? Y ( ) N ( ) DK ( )
Kuna mtu aliyekufa? N L *Sijui*

22. Did your child feel terrified? Y ( ) N ( ) DK ( )
Je mtoto wako alihisi ametishika N L *Sijui*

23. Did your child feel intense helplessness? Y ( ) N ( ) DK ( )
Je mtoto wako alijikuta katika hali asiyoweza kabisa kufanya chochote? N L *Sijui*

24. Did your child feel horrified; was what he/she saw disgusting or gross? Y ( ) N ( ) DK ( )
Je mtoto wako alihisi kuogopa: Je kile aliona Kilimchukiza au kumpa uzito mkubwa? N L *Sijui*

25. Did your child get hysterical or run around? Y ( ) N ( ) DK ( )
Je mtoto wako hupagawa au kukimbia? N L *Sijui*

26. Did your child feel very confused? Y ( ) N ( ) DK ( )
Je mtoto wako alichanganyikiwa sana? N L *Sijui*

27. Did your child feel like what was happening did not seem real, like it was going on in a movie instead of real life? Y ( ) N ( ) DK ( )
Je mtoto wako alihisi kama kilichokuwa kikitokea hakikuwa kweli kwa njia nyingine, kama ilikuwa ikiendelea kwa filamu badala ya kweli? N L *Sijui*

Below is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in question #14. Then, read each problem on the list carefully, CIRCLE one of the numbers (0, 1,2,3,4, or 5) that tells how often the problem has happened to your child **in the past month.** Refer to the **Rating Sheet** (on page 4) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, try to make your best estimation. **Only** circle **"Don't know"** if you absolutely **cannot** give am answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

Hapa ni orodha ya matatizo ambavyo watoto wakati mwingine huwa nayo baada ya kupitia matukio yakufadhaisha. Tafadhali fikiria kuhusu matukio ya mfadhaiko yaliyotokea mtoto wako ambayo uliandika katika swali la 14 kisha soma kila tatizo katika orodha kwa makini. VIRINGA moja ya nambari (0,1,2,3,4 ama 5) ambayp inakueleza ni mara ngapi tatizo hilo limefanyanyika kwa mtoto wako ***kwa muda wa mwezi uliopita.*** *Rejelia* ***katika ukurasa wa kukadiri Matokeo*** *(ukurasa wa nne) ili kukusaidia kuamua ni mara ngapi hili limefanyika. Kumbuka: Ikiwa hauna uhakika kuhusu mara ngapi mtoto wako amepitia tatizo Fulani, basi jaribu viringa "Sijui" kama unauhakika kabisa hauwezi kujibu.*

TAFADHALI HAKIKISHA UMEJIBU MASWALI YOTE

	HOW MUCH TIME DURING THE PAST MONTH? NI MARA NGAPI KATIKA MWEZI ULIOPITA?	N0one	Little	Some	Much	Most	Don't Know
1	My child watches out for danger or things that he/she is afraid of. *Mtoto wangu anatahadhari kabla ya hatari au vitu anvyoogopesha?*	0	1	2	3	4	5
2	When something reminds my child of what happened he/she gets upset, scared or sad. *Kiti/jambo kilimkumbusha mtoto wangu juu ya yaliotendeka anfadhaika, anaogopa au anakasirika.*	0	1	2	3	4	5
3	My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to. *Mtoto wangu anamafikira ya kufadhaisha picha au sauti za yaliotokea inmjia kwenye akili yake kama hataki*	0	1	2	3	4	5
4	My child feels grouchy, angry or mad. *Mtoto wangu anahisi kunung'unika/hasira au kukasirika sana.*	0	1	2	3	4	5
5	My child has dreams about what happened or other bad dreams. *Mtoto wangu anakuwa na ndoto kuhusu yaliotokea au ndoto nyengine mbaya.*	0	1	2	3	4	5
6	My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again. *Mtoto wangu*	0	1	2	3	4	5

	anamarejeleo/anakumbuka yaliyotokea, anahisi kama amerudi wakati huo mkasa ulitendeka.						
7	My child feels like staying by him/herself and not being with his/her friends. *Mtoto wangu uhisi kuwa peke yake na sio na marafiki.*	0	1	2	3	4	5
8	My child feels alone inside and not close to other people. *Mtoto wangu uhisi upweke ndani sio na uhusiano wa karibu na watu.*	0	1	2	3	4	5
9	My child tries not to talk about, think about, or have feelings about what happened. *Mtoto wangu hujaribu asiongee wala kufikiria au kuhisi kilichotendeka*	0	1	2	3	4	5
10	My child has trouble feeling happiness or love. *Mtoto wangu anasumbuka kuhisi furaha au mapenzi.*	0	1	2	3	4	5
11	My child has trouble feeling sadness or anger. *Mtoto wangu anasumbuka kuhisis uzuri au hasira.*	0	1	2	3	4	5
12	My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her. *Mtoto wangu huwa hatulii na hushituka upesi kwa mfano anaposikia sauti au kuona kitu kinachomshangaza.*	0	1	2	3	4	5
13	My child has trouble going to sleep or wakes up often during the night. *Mtoto wangu huwa anasumbuka kulala (kupata usingizi) au huamka mara kwa mara usiku.*	0	1	2	3	4	5
14	My child feels that some part of what happened is his/her fault *Mtoto wangu anajilaumu kwa machache yale yaliyo tendeka.*	0	1	2	3	4	5
15	My child has trouble remembering important parts of what happened. *Mtoto wangu anasumbuka kukumbuka sehemu muhimu ya yaliotokea*	0	1	2	3	4	5
16	My child has trouble concentrating or paying attention. *Mtoto wangu anasumbuka kutulia au kuwa makini.*	0	1	2	3	4	5
17	My child tries to stay away from people, places, or things that make him/her remember what happened. *Mtoto wangu anajaribu kukaa mbali/kando na watu, sehemu au vitu vinavyofanya akumbuke kilichotokea*	0	1	2	3	4	5
18	When something reminds my child of what happened he/she has strong feelings in his/her body like heart beating fast, headaches, or stomach aches. *Kitu kikimkumbusha mtoto wangu kuhusu yaliyotokea yeye huwa na hisia kali kwenye mwili kama moyo kupiga haraka, kichwa kuuma au tumbo kuuma.*	0	1	2	3	4	5
19	My child thinks that he/she will not live long life. *Mtoto wangu anafikiria kuwa hataishi maisha marefu*	0	1	2	3	4	5
20	My child is afraid the bad thing will happen again. *Mtoto wangu anaogopa kuwa mambo mabaya yatatokea tena.*	0	1	2	3	4	5
21	My child plays games or draws pictures that are like some part of what happened. *Mtoto wangu hucheza michezo au huchora picha ambazo zimefanana na baadhi ya mambo yaliyotendeka.*	0	1	2	3	4	5

FREQUENCY RATING SHEET
UKURASA/SUHIFA LA KUKADIRI MATOKEO

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH THAT IS SINCE _____ , DOES THE PROBLEM HAPPEN?
Ni mara ngapi au wingi wa wakati wa mwezi uliopita, hiyo ni tangu _____ je shida hiyo inatokea?

S	M	T	W	T	F	S

0 – NONE – NEVER
Hakuna - Kamwe

S	M	T	W	T	F	S
	X					
					X	

1- Little - Two times a Month
Kidogo - Mara Mbili Kwa mwezi

S	M	T	W	T	F	S
		X			X	
		X				
			X			
		X		X		

2- Some - 1-2 Times a week
Kiasi - 1-2 Kwa wiki

S	M	T	W	T	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

3- Much - 2-3 Times each week
Wingi – 2-3 Kila Wiki

S	M	T	W	T	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

4-Most - Almost Everyday
Sana - Karibu kila siku

(ii) PTSD INDEX FOR DSM IV (Child Version - Revised)

Child's name Age
*Jina la Mtoto*_____ *Miaka*_____ *Code No.*_____

Primary Caregiver's Name Relationship to Child
*Jina la mlezi wa mtoto*_____ *Uhusiano kwa mtoto*_____
Today's date Sex Girl Boy
*Tarehe ya leo :*_____*JinsiaViringa)* *Msichana* _____ *Mvulana*_____
School Class in school Town/Village
*Shule :*_____*Kiwango au darasa Shuleni* _____ *Mji/Kijiji*_____

Listed below are **VERY SCARY, DANGEROUS OR VIOLENT** things that sometimes happen to people. There are times where someone was **HURT VERY BADLY OR KILLED**, or could have been. Some people have had these experiences whereas others have not had. Please be honest in answering if the violent thing happened to you or if it did not happen to you.

Hapa chini ni orodha ya vitu vya kuogopesha/hatari au vurungu ambavyo hutokea kwa watu. Huu ni wakati ambapo mtu aliumizwa vibaya au kuuliwa, au angeumizwa au kuuliwa. Watuo wengine wamepitia haya, wengine hawajapitia. Tafadhali kuwa mkweli unapojibu kama vurugu lilitokea kwako, au kama haikutokea kwako..

FOR EACH QUESTION:
Tick "Yes" if this scary thing **HAPPENED TO YOU**
Tick "No." if this scary thing **DID NOT HAPPEN TO YOU**

KWA KILA SWALI:

Tia alama "Ndiyo" kama hichi kitu cha kuogopesha kilitokea kwako
Tia alama "La" kama hakikutokea kwako

1	.In the past six months, experienced anything scary or violent? *Kwa miezi misita iliopita, ulishuhudia tukio la kuogopesha au vurugu .*	Y ( ) N ( ) N L
2.	Been in a **disaster** like a fire of flood *Kuwa katika msiba kama moto au mafuriko.*	Y ( ) N ( ) N L
3.	Been in a bad **accident,** like a **very serious** car accident. *Kuwa kwa ajali mbaya kama ajali mbaya ya gari.*	Y ( ) N ( ) N L
4	Been in a place where a **war** was going on around you. *Kuwa sehemu ambayo vita viliendelea kukuzunguka*	Y ( ) N ( ) N L
5.	Been **hit, punched, or kicked very hard** at home. **DO NOT INCLUDE** ordinary fights between brothers & sisters) *Kupigwa, ngumi au kupigwa teke kwa nguvu sana ukiwa nyumbani.* (*Usiweke vita vya kawaida kati ya dada na kaka*)	Y ( ) N ( ) N L
6.	Seen a family member being **hit, punched or kicked very hard** at home **DO NOT INCLUDE** ordinary fights between brother & sisters) *Kuona mmoja wa familia akipigwa ngumi au teke kwa nguvu sana ukiwa nyumbani.* *(Usiweke vita vya kawaida kati ya dada na kaka)*	Y ( ) N ( ) N L
7.	Been **beaten up, shot at or threatened to be hurt badly** in your town. *Kupigwa, kulengwa risasi au kutishwa kuumizwa vibaya katika mji wako*	Y ( ) N ( ) N L
8.	Seen someone in your town **being beaten up, shot at or killed**.	Y ( ) N ( )

Kuona mtu katika mji wako akipigwa, akilengwa risasi au akiuliwa N L

9. Seen a **dead body** in your town (do not include funerals) Y ( ) N ( )
Kuona maiti katika mji wako (usiandike mazishi) N L

10. Have an adult or someone much older touch your **Private Sexual body parts** when you did not want them to. Y ( ) N ( )
Kuwa na mtu mzima au mzee akishika sehemu zako za siri kama hutaki N L

11. Heard about the **violent death or serious injury** of a loved one. Y ( ) N ( )
Kusikia kuhusu kifo kinachotokana na vurugu au dhari la hatari kwa unayempenda N L

12. Have **painful and scary medical treatment in a hospital** when you were very sick or badly injured. Y ( ) N ( )
Kupata uchungu na matibabu ya kuogopesha kwa hospitali ukiwa mgojwa sana au umeumizwa vibaya N L

13. OTHER than the situations described above has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?**
Y ( )
N ( )
N L

Please write what happened: _____

_____

Mbali na mikasa iliyosimuliwa/elezewa juu, kuna kitu chochote kilichokutokea ambacho kilikuwa cha kuogopesha, hatari au vurugu?. Tafadhali andika kilichotokea

14. A) If you answered "**YES**" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13 in this blank # _____
Kama umejibu "NDIYO" kwa kitu kimoja pekee katika hiyo orodha ya maswali # 1 mpaka #13 weka/andika nambari ya hicho kitu (#1 mpaka #13) katika hili pengo #_____.

B) If you answered "**YES**" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU MOST NOW** in this blank # _____
Kama umejibu "NDIYO" kwa kitu zaidi ya kimoja weka/andika nambari ya kitu ambacho kinakusumbua zaidi sana kwenye hili pengo #_____.

C) About how long ago did this bad thing (your answer to A or B) happen to you?
Ni muda gani tangu hicho kitu kibaya (jibu lako la A au B) kikutendekee?

( ) Less than I month ago (Isiyozidi mwezi moja uliopita)
( ) Between 1 month and 3 months ago(*Kati ya mwezi moja na miezi tatu zilizopita)*
( ) Between 3 months and 6 months ago *(Kati ya miezi tatu*

na miezi sita zilizopita)

( ) between 6 months and one year ago. (*Kati ya miezi sita na mwaka mjoja uliopita)*

D) Please write what happened: _____
Tafadhali andika nini kilitendeka

_____

FOR THE NEXT QUESTIONS, please **TICK "Yes or No.** to answer **HOW YOU FELT during or right after** the experience happened that you just wrote about in Question 14.

KWA MASWALI YANAYOFUATA, tafadhali **TIA ALAMA "Ndiyo, au La,** kujibu **VILE WEWE ULIHISI** wakati **au punde baada** ya mkasa kutokea ulioandika kwenye swali nambari 14.

15.	Were you scared that you would die? *Je uliogopa kuwa ungekufa?*	Y ( ) N ( ) N L
16.	Were you scared that you would be hurt badly? *Je uliogopa kuwa ungeumizwa sana*?	Y ( ) N ( ) N L
17.	Were you hurt badly? *Je uliumizwa sana?*	Y ( ) N ( ) N L
18.	Were you scared that someone else would die? *Je uliogopa kuwa mtu mwingine angekufa*?	Y ( ) N ( ) N L
19.	Were you scared that someone else would be hurt badly? *Je uliogopa kuwa mtu mwingine angeumia vibaya*?	Y ( ) N ( ) N L
20.	Was someone else hurt badly? *Je kuna mtu mwingine aliyeumizwa vibaya*	Y ( ) N ( ) N L
21.	Did someone die? *Kuna mtu aliyekufa?*	Y ( ) N ( ) N L
22.	Did you feel scared, like this was the most scary experience ever? *Je ulihisi uliogopa, kama jambo hili lilikuwa la kuogopesha maishani mwako?*	Y ( ) N ( ) N L
23.	Did you feel that you could not stop what was happening or that you needed someone to help? *Je ulihisi ya kwamba haungeweza kusimamisha jambo hili kutokea au iulihitaji usaidizi wa mtu mwingine?*	Y ( ) N ( ) N L

24. Did you feel that what you saw disgusting or gross? Y ( ) N ( )
Je ulihisi kitu kile uliona kilikuchukiza au kukupa uzito mkubwa? N L

25. Did you run around or act like you were very upset? Y ( ) N ( )
Je ulikimbia au kupagawa sana? N L

26. Did you feel very confused? Y ( ) N ( )
Je ulichanganyikiwa sana? N L

27. Did you feel like what was happening did not seem real, like it was going on in a movie instead of real life? Y ( ) N ( )
Jeulihisi kama kilichokuwa kikitokeahakikuwa kweli kwa njia nyingine, kama ilikuwa ikiendelea kwa filamu badala ya kweli? N L

Below is a list of problems people sometimes have after very stressful experiences. Please think about the bad thing that happened to you that wrote about in question #14. Then, read each problem on the list carefully, CIRCLE one of the numbers (0, 1,2,3,4, or 5) that tells how often the problem has happened to you **in the past month.** Refer to the **Rating Sheet** (on page 4) to help you decide how often the problem has happened. **Please be sure to answer all questions.**
PLEASE BE SURE TO ANSWER ALL QUESTIONS

Hapa ni orodha ya matatizo ambayo watu wakati mwingine huwa nayo baada ya kupitia matukio yakufadhaisha. Tafadhali fikiria kuhusu matukio ya mfadhaiko yaliyotokea kwako ambayo uliandika katika swali la 14 kisha soma kila tatizo katika orodha kwa makini. VIRINGA moja ya nambari (0,1,2,3,4 ama 5) ambayp inakuelezea ni mara ngapi tatizo hilo limefanyanyika kwako ***kwa muda wa mwezi uliopita.*** *Rejelia* ***katika ukurasa wa kukadiria Matokeo*** *(ukurasa wa nne) ili kukusaidia kuamua ni mara ngapi tatizo hili limefanyika.*

TAFADHALI HAKIKISHA UMEJIBU MASWALI YOTE

	HOW MUCH TIME DURING THE PAST MONTH? NI MARA NGAPI KATIKA MWEZI ULIOPITA?	None Hakuna	Little Kidogo	Some Kiasi	Much Wingi	Most Sana	D/K Sijui
1	I watch out for danger or things that I am scared of. Ni*natahadhari kabla ya hatari au vitu vinavyo niogopesha?*	0	1	2	3	4	5
2	When something reminds me of what happened l get very upset, scared or sad. *Wakati Kiti/jambo linalonikumbusha juu ya yaliotendeka ninafadhaika, ,ninanaogopa au ninakasirika*.	0	1	2	3	4	5
3	I have upsetting thoughts, pictures or sounds of what happened come into my mind when I do not want them to. Ni*namafikira ya kufadhaisha, picha au sauti za yaliotokea yakinijia kwenye akili yangu kama sitaki*	0	1	2	3	4	5
4	I feel grouchy, angry or mad*. Ninahisi kunung'unika /hasira au kukasirika sana.*	0	1	2	3	4	5
5	I have dreams about what happened or other bad dreams. *Ninakuwa na ndoto kuhusu yaliotokea au ndoto nyengine mbaya.*	0	1	2	3	4	5

6	I feel like I am back at the time when the bad thing happened, living through it again.,*Ninahisi kama nimerudi wakati huo mkasa ulipotendeka.*	0	1	2	3	4	5
7	I feel like staying by myself and not being with my friends. *Ninahisi kuwa peke yangu na sio na marafiki.*	0	1	2	3	4	5
8	I feel alone inside and not close to other people. *Nina hisi upweke ndani sio na uhusiano wa karibu na watu.*	0	1	2	3	4	5
9	I try not to talk about, think about, or have feelings about what happened. H*ujaribu nisiongee wala kufikiria au kuhisi kilichotendeka*	0	1	2	3	4	5
10	I have trouble feeling happiness or love. *Nina sumbuka kuhisi furaha au mapenzi.*	0	1	2	3	4	5
11	I have trouble feeling sadness or anger. *Ninasumbuka kuhisi huzuni au hasira.*	0	1	2	3	4	5
12	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me. *Huwa situlii na hushtuka upesi kwa mfano ninaposikia sauti ya juu au kuona kitu kinachonishangaza.*	0	1	2	3	4	5
13	I have trouble going to sleep or wake up often during the night. *Ninasumbuka kulala (kupata usingizi) au huamka mara kwa mara usiku.*	0	1	2	3	4	5
14	I think that some part of what happened is my fault Ni*najilaumu kwa machache yale yaliyo tendeka.*	0	1	2	3	4	5
15	I have trouble remembering important parts of what happened. *Ninanasumbuka kukumbuka sehemu muhimu ya yaliotokea*	0	1	2	3	4	5
16	I have trouble concentrating or paying attention. *Nina sumbuka kuwa makini.*	0	1	2	3	4	5
17	I stay away from people, places, or things that make me remember what happened. *ninajaribu kukaa mbali/kando na watu, sehemu au vitu vinavyofanya nikumbuke kilichotokea*	0	1	2	3	4	5
18	When something reminds me of what happened I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches. *Kitu kikinikumbusha kuhusu yaliyotokea, huwa na hisia kali kwenye mwili kama moyo kupiga haraka, kichwa kuuma au tumbo kuuma.*	0	1	2	3	4	5
19	I think that I will not live a long life. *Ninafikiria kuwa sitaishi maisha marefu*	0	1	2	3	4	5
20	I am scared that the bad thing will happen again. *Ninaogopa kuwa mambo mabaya yatatokea tena.*	0	1	2	3	4	5
21	I have arguments or physical fights. Mimi hugombana au kupigana	0	1	2	3	4	5
22	I feel pessimistic or negative about my future. Huhisi sina matumaini au nina mtazamo mbaya kuhusu maisha yangu ya baadaye.	0	1	2	3	4	5

FREQUENCY RATING SHEET
UKURASA/SUHIFA LA KUKADIRI MATOKEO

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH THAT IS SINCE _____ , DOES THE PROBLEM HAPPEN?

Ni mara ngapi au wingi wa wakati wa mwezi uliopita, hiyo ni tangu _____ je shida hiyo inatokea?

S	M	T	W	T	F	S

0 – NONE – NEVER
Hakuna - Kamwe

S	M	T	W	T	F	S
	X					
					X	

1- Little - Two times a Month
Kidogo - Mara Mbili Kwa mwezi

S	M	T	W	T	F	S
		X			X	
		X				
			X			
		X		X		

2- Some - 1-2 Times a week
Kiasi - 1-2 Kwa wiki

S	M	T	W	T	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

3- Much - 2-3 Times each week
Wingi – 2-3 Kila Wiki

S	M	T	W	T	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

4-Most - Almost Everyday
Sana - Karibu kila siku

(iii) PTSD INDEX FOR DSM IV (Adolescent Version - Revised)

Child's name Age
*Jina la Mtoto*_____ *Miaka*_____ *Code No.*_____

Primary Caregiver's Name Relationship to Child
*Jina la mlezi wa mtoto*_____ *Uhusiano kwa mtoto*_____
Today's date Sex Girl Boy
*Tarehe ya leo :*_____*JinsiaViringa)* *Msichana* _____ *Mvulana*_____
School Class in school Town/Village
*Shule :*_____*Kiwango au darasa Shuleni* _____ *Mji/Kijiji*_____

Listed below are **VERY SCARY, DANGEROUS OR VIOLENT** things that sometimes happen to people. There are times where someone was **HURT VERY BADLY OR KILLED**, or could have been. Some people have had these experiences whereas others have not had. Please be honest in answering if the violent thing happened to you or if it did not happen to you.

Hapa chini ni orodha ya vitu vya kuogopesha/hatari au vurungu ambavyo hutokea kwa watu. Huu ni wakati ambapo mtu aliumizwa vibaya au kuuliwa, au angeumizwa au kuuliwa. Watuo wengine wamepitia haya, wengine hawajapitia. Tafadhali kuwa mkweli unapojibu kama vurugu lilitokea kwako, au kama haikutokea kwako..

FOR EACH QUESTION:
Tick "Yes" if this scary thing **HAPPENED TO YOU**
Tick "No." if this scary thing **DID NOT HAPPEN TO YOU**

KWA KILA SWALI:

Tia alama "Ndiyo" kama hichi kitu cha kuogopesha kilitokea kwako
Tia alama "La" kama hakikutokea kwako

1	.In the past six months, experienced anything scary or violent? *Kwa miezi misita iliopita, ulishuhudia tukio la kuogopesha au vurugu .*	Y ( ) N ( ) N L
2.	Been in a **disaster** like a fire of flood *Kuwa katika msiba kama moto au mafuriko.*	Y ( ) N ( ) N L
3.	Been in a bad **accident,** like a **very serious** car accident. *Kuwa kwa ajali mbaya kama ajali mbaya ya gari.*	Y ( ) N ( ) N L
4	Been in a place where a **war** was going on around you. *Kuwa sehemu ambayo vita viliendelea kukuzunguka*	Y ( ) N ( ) N L
5.	Been **hit, punched, or kicked very hard** at home. **DO NOT INCLUDE** ordinary fights between brothers & sisters) *Kupigwa, ngumi au kupigwa teke kwa nguvu sana ukiwa nyumbani.* (*Usiweke vita vya kawaida kati ya dada na kaka*)	Y ( ) N ( ) N L
6.	Seen a family member being **hit, punched or kicked very hard** at home **DO NOT INCLUDE** ordinary fights between brother & sisters) *Kuona mmoja wa familia akipigwa ngumi au teke kwa nguvu sana ukiwa nyumbani.* *(Usiweke vita vya kawaida kati ya dada na kaka)*	Y ( ) N ( ) N L
7.	Been **beaten up, shot at or threatened to be hurt badly** in your town. *Kupigwa, kulengwa risasi au kutishwa kuumizwa vibaya katika mji wako*	Y ( ) N ( ) N L
8.	Seen someone in your town **being beaten up, shot at or killed**.	Y ( ) N ( )

Kuona mtu katika mji wako akipigwa, akilengwa risasi au akiuliwa N L

9. Seen a **dead body** in your town (do not include funerals) Y ( ) N ( )
Kuona maiti katika mji wako (usiandike mazishi) N L

10. Have an adult or someone much older touch your **Private Sexual body parts** when you did not want them to. Y ( ) N ( )
Kuwa na mtu mzima au mzee akishika sehemu zako za siri kama hutaki N L

11. Heard about the **violent death or serious injury** of a loved one. Y ( ) N ( )
Kusikia kuhusu kifo kinachotokana na vurugu au dhari la hatari kwa unayempenda N L

12. Have **painful and scary medical treatment in a hospital** when you were very sick or badly injured. Y ( ) N ( )
Kupata uchungu na matibabu ya kuogopesha kwa hospitali ukiwa mgojwa sana au umeumizwa vibaya N L

13. OTHER than the situations described above has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS OR VIOLENT?** Y ( )
N ( )
N L

Please write what happened: _____

_____

Mbali na mikasa iliyosimuliwa/elezewa juu, kuna kitu chochote kilichokutokea ambacho kilikuwa cha kuogopesha, hatari au vurugu?. Tafadhali andika kilichotokea

14. A) If you answered "**YES**" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13 in this blank # _____
Kama umejibu "NDIYO" kwa kitu kimoja pekee katika hiyo orodha ya maswali # 1 mpaka #13 weka/andika nambari ya hicho kitu (#1 mpaka #13) katika hili pengo #_____.

B) If you answered "**YES**" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU MOST NOW** in this blank # _____
Kama umejibu "NDIYO" kwa kitu zaidi ya kimoja weka/andika nambari ya kitu ambacho kinakusumbua zaidi sana kwenye hili pengo #_____.

C) About how long ago did this bad thing (your answer to A or B) happen to you?
Ni muda gani tangu hicho kitu kibaya (jibu lako la A au B)kikutendekee?

( ) Less than I month ago (Isiyozidi mwezi moja uliopita)
( ) Between 1 month and 3 months ago(*Kati ya mwezi moja na miezi tatu zilizopita)*
( ) Between 3 months and 6 months ago *(Kati ya miezi tatu*

na miezi sita zilizopita)

( ) between 6 months and one year ago. (*Kati ya miezi sita na mwaka mjoja uliopita)*

D) Please write what happened: _____
Tafadhali andika nini kilitendeka

_____

FOR THE NEXT QUESTIONS, please **TICK "Yes or No.** to answer **HOW YOU FELT during or right after** the experience happened that you just wrote about in Question 14.

KWA MASWALI YANAYOFUATA, tafadhali **TIA ALAMA "Ndiyo, au La,** kujibu **VILE WEWE ULIHISI** wakati **au punde baada** ya mkasa kutokea ulioandika kwenye swali nambari 14.

15.	Were you scared that you would die? *Je uliogopa kuwa ungekufa?*	Y ( ) N ( ) N L
16.	Were you scared that you would be hurt badly? *Je uliogopa kuwa ungeumizwa sana*?	Y ( ) N ( ) N L
17.	Were you hurt badly? *Je uliumizwa sana?*	Y ( ) N ( ) N L
18.	Were you scared that someone else would die? *Je uliogopa kuwa mtu mwingine angekufa*?	Y ( ) N ( ) N L
19.	Were you scared that someone else would be hurt badly? *Je uliogopa kuwa mtu mwingine angeumia vibaya*?	Y ( ) N ( ) N L
20.	Was someone else hurt badly? *Je kuna mtu mwingine aliyeumizwa vibaya*	Y ( ) N ( ) N L
21.	Did someone die? *Kuna mtu aliyekufa?*	Y ( ) N ( ) N L
22.	Did you feel scared, like this was the most scary experience ever? *Je ulihisi uliogopa, kama jambo hili lilikuwa la kuogopesha maishani mwako?*	Y ( ) N ( ) N L
23.	Did you feel that you could not stop what was happening or that you needed someone to help? *Je ulihisi ya kwamba haungeweza kusimamisha jambo hili kutokea au iulihitaji usaidizi wa mtu mwingine?*	Y ( ) N ( ) N L
24.	Did you feel that what you saw disgusting or gross? *Je ulihisi kitu kile uliona kilikuchukiza au kukupa uzito mkubwa*	Y ( ) N ( ) N L

25. Did you run around or act like you were very upset? Y ( ) N ( )
Je ulikimbia au kupagawa sana? N L

26. Did you feel very confused? Y ( ) N ( )
Je ulichanganyikiwa sana? N L

27. Did you feel like what was happening did not seem real, like it was going on in a movie instead of real life? Y ( ) N ( )
Jeulihisi kama kilichokuwa kikitokeahakikuwa kweli kwa njia nyingine, kama ilikuwa ikiendelea kwa filamu badala ya kweli? N L

Below is a list of problems people sometimes have after very stressful experiences. Please think about the bad thing that happened to you that wrote about in question #14. Then, read each problem on the list carefully, CIRCLE one of the numbers (0, 1,2,3,4, or 5) that tells how often the problem has happened to you **in the past month.** Refer to the **Rating Sheet** (on page 4) to help you decide how often the problem has happened. **Please be sure to answer all questions.**
PLEASE BE SURE TO ANSWER ALL QUESTIONS

Hapa ni orodha ya matatizo ambayo watu wakati mwingine huwa nayo baada ya kupitia matukio yakufadhaisha. Tafadhali fikiria kuhusu matukio ya mfadhaiko yaliyotokea kwako ambayo uliandika katika swali la 14 kisha soma kila tatizo katika orodha kwa makini. VIRINGA moja ya nambari (0,1,2,3,4 ama 5) ambayp inakuelezea ni mara ngapi tatizo hilo limefanyanyika kwako ***kwa muda wa mwezi uliopita.*** *Rejelia* ***katika ukurasa wa kukadiria Matokeo*** *(ukurasa wa nne) ili kukusaidia kuamua ni mara ngapi tatizo hili limefanyika.*

TAFADHALI HAKIKISHA UMEJIBU MASWALI YOTE

	HOW MUCH TIME DURING THE PAST MONTH? NI MARA NGAPI KATIKA MWEZI ULIOPITA?	None Hakuna	Little Kidogo	Some Kiasi	Much Wingi	Most Sana	D/K Sijui
1	I watch out for danger or things that I am scared of. Ni*natahadhari kabla ya hatari au vitu vinavyo niogopesha?*	0	1	2	3	4	5
2	When something reminds me of what happened l get very upset, scared or sad. *Wakati Kiti/jambo linalonikumbusha juu ya yaliotendeka ninafadhaika, ,ninanaogopa au ninakasirika*.	0	1	2	3	4	5
3	I have upsetting thoughts, pictures or sounds of what happened come into my mind when I do not want them to. Ni*namafikira ya kufadhaisha, picha au sauti za yaliotokea yakinijia kwenye akili yangu kama sitaki*	0	1	2	3	4	5
4	I feel grouchy, angry or mad*. Ninahisi kunung'unika /hasira au kukasirika sana.*	0	1	2	3	4	5
5	I have dreams about what happened or other bad dreams. *Ninakuwa na ndoto kuhusu yaliotokea au ndoto nyengine mbaya.*	0	1	2	3	4	5
6	I feel like I am back at the time when the bad thing	0	1	2	3	4	5

	happened, living through it again.,*Ninahisi kama nimerudi wakati huo mkasa ulipotendeka.*						
7	I feel like staying by myself and not being with my friends. *Ninahisi kuwa peke yangu na sio na marafiki.*	0	1	2	3	4	5
8	I feel alone inside and not close to other people. *Nina hisi upweke ndani sio na uhusiano wa karibu na watu.*	0	1	2	3	4	5
9	I try not to talk about, think about, or have feelings about what happened. H*ujaribu nisiongee wala kufikiria au kuhisi kilichotendeka*	0	1	2	3	4	5
10	I have trouble feeling happiness or love. *Nina sumbuka kuhisi furaha au mapenzi.*	0	1	2	3	4	5
11	I have trouble feeling sadness or anger. *Ninasumbuka kuhisi huzuni au hasira.*	0	1	2	3	4	5
12	I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me. *Huwa situlii na hushtuka upesi kwa mfano ninaposikia sauti ya juu au kuona kitu kinachonishangaza.*	0	1	2	3	4	5
13	I have trouble going to sleep or wake up often during the night. *Ninasumbuka kulala (kupata usingizi) au huamka mara kwa mara usiku.*	0	1	2	3	4	5
14	I think that some part of what happened is my fault N*inajilaumu kwa machache yale yaliyo tendeka*.	0	1	2	3	4	5
15	I have trouble remembering important parts of what happened*. Ninanasumbuka kukumbuka sehemu muhimu ya yaliotokea*	0	1	2	3	4	5
16	I have trouble concentrating or paying attention. *Nina sumbuka kuwa makini.*	0	1	2	3	4	5
17	I stay away from people, places, or things that make me remember what happened. *ninajaribu kukaa mbali/kando na watu, sehemu au vitu vinavyofanya nikumbuke kilichotokea*	0	1	2	3	4	5
18	When something reminds me of what happened I have strong feelings in my body like my heart beats fast, my head aches, or my stomach aches. *Kitu kikinikumbusha kuhusu yaliyotokea, huwa na hisia kali kwenye mwili kama moyo kupiga haraka, kichwa kuuma au tumbo kuuma.*	0	1	2	3	4	5
19	I think that I will not live a long life. *Ninafikiria kuwa sitaishi maisha marefu*	0	1	2	3	4	5
20	I am scared that the bad thing will happen again. *Ninaogopa kuwa mambo mabaya yatatokea tena.*	0	1	2	3	4	5
21	I have arguments or physical fights. Mimi hugombana au kupigana	0	1	2	3	4	5
22	I feel pessimistic or negative about my future. Huhisi sina matumaini au nina mtazamo mbaya kuhusu maisha yangu ya baadaye.	0	1	2	3	4	5

FREQUENCY RATING SHEET
UKURASA/SUHIFA LA KUKADIRI MATOKEO

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH THAT IS SINCE _____ , DOES THE PROBLEM HAPPEN?

Ni mara ngapi au wingi wa wakati wa mwezi uliopita, hiyo ni tangu _____ je shida hiyo inatokea?

S	M	T	W	T	F	S

0 – NONE – NEVER
Hakuna - Kamwe

S	M	T	W	T	F	S
	X					
					X	

1- Little - Two times a Month
Kidogo - Mara Mbili Kwa mwezi

S	M	T	W	T	F	S
		X			X	
		X				
			X			
		X		X		

2- Some - 1-2 Times a week
Kiasi - 1-2 Kwa wiki

S	M	T	W	T	F	S
	X		X		X	
X		X		X		
	X		X		X	
X	X	X				

3- Much - 2-3 Times each week
Wingi – 2-3 Kila Wiki

S	M	T	W	T	F	S
X	X	X	X	X	X	X
	X	X	X	X		
	X	X		X	X	
X	X	X	X	X	X	X

4-Most - Almost Everyday
Sana - Karibu kila siku

D. ART ASSESSMENT FOR CHILDREN

WHAT THE CHILD NEEDS TO DO

1. **DRAW A CIRCLE**
2. **DRAW A PERSON AND COLOUR**
3. **DRAW SELF AND COLOUR**
4. **DRAW YOUR FAMILY AND COLOUR**
5. **DRAW ANYTHING ELSE YOU ARE THINKING ABOUT AND COLOUR**

In the drawings the researcher will use funnel analysis to check on: -

- Internal structures
- Fine details

For signs of anxiety the researcher will check on: -

- Omissions
- Distortions
- Heavy line pressure
- Turned down mouth,
- Raised arms
- Arms turned inwards
- Small unsupported feet
- Exaggerated size of the parent

Colour and emotions-The researcher will check on the following: -

- Circle test for Emotional Health
- What a picture reveals about friendship
- Assessing family portrait – Dominance/Rivalry
- Insight about the pictures
- Interpretation of colours used in the picture

3.12 BUDGET FOR RESEARCH PROJECT 2011

	Category/Item	Duration	Total (Kshs)
1.	Computer Services	3 months	50,000
2.	Data Collection and cleaning	1 month	50,000
3.	Data Analysis	1 month	30,000
4.	Report writing	3 month	40,000
5.	Contingency	10%	24,000
6.	Utilities e.g. Internet	3 months	30,000
	Grand total		**224,000 [Kshs]**

Any organization or institution is not funding the researcher. It is self-sponsored.