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The Psychological Impact of Child Sexual Abuse on Primary Caregivers

W Zimba[1], JA Menon[2*], K Thankian[3], SOC Mwaba[4]

[1,2,4] *Department of Psychology, University of Zambia, Zambia.*
[3] *Department of Gender Studies, University of Zambia, Zambia.*

ABSTRACT

Research on child sexual abuse (CSA) suggest that support and protection from the caregiver provide the child an effective platform for quick recovery and improvement in mental health and social functioning. Nonetheless, not all caregivers are supportive of survivors; recent research findings, instead, show that incidents of CSA have debilitating psychological impact on survivors' caregivers which impair their functioning. This study explored whether a systematic link exists between an incident of CSA and psychological changes in caregivers, thereby justifying their psychological care. The objectives of the study were to 1) explore if a relationship exists between an incident of CSA and changes in mental health of primary caregivers of abused children and 2) identify symptoms of the psychological impact of CSA on primary caregivers of abused children.

Participants in the study were 34 caregivers of CSA survivors from at Victim Support Unit (VSU), Young Women's Christians Association (YWCA) and/or University Teaching Hospital (UTH), Lusaka. Perceived Stress Scale (PSS) and a semi-structured interview schedule were used for data collection. Overall PSS scores indicated that an incident of CSA results in a debilitating psychological impact on caregivers of the survivors, there were. significant difference in the levels of perceived stress experienced by maternal caregivers (Mean rank = 19.38, n = 29) and paternal ones (Mean rank = 6.60, n = 5): z = 2.66, p .01).

Symptoms of psychological distress experienced by caregivers after an incident of CSA included anxiety, fear, depression, anger, insomnia, and functional impairment. About half the care givers in the study (n= 19, 55.88%) showed support and protection for their children; others (n = 15, 44.12%) were hostile toward and blamed their children for the abuse. The caregivers therefore may need psychological services to improve their mental health and provide support to their children.

INTRODUCTION

Child Sexual Abuse (CSA) is a pervasive travesty against the most vulnerable section of humanity, children. James and Gilliland have characterized it as a unique serious crime that threatens people of all ages and stations of life [1]. Durand and Barlow characterize sexual abuse of children (or very young adolescents) as the most tragic sexual deviance, second only to murder. Some characterize child sexual abuse as a pervasive social and public health problem [2].

Survivors of child sexual abuse are of either sex and so are the perpetrators. According to Dubrand and Barlow, individuals with this pattern of arousal may be attracted to male children, female children or both [3]. Durand and Barlow have distinguished two

***Corresponding author:**
JA Menon,
Department of Psychology,
University of Zambia,
P.O. Box 32379, Lusaka, Zambia,
E-mail: anithamenon316@gmail.com

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broad categories of CSO; which can either be paedophilic or non-pedophilic where paedophilia is characterized by a sexual deviation involving strong sexual attraction toward children [2]. He further observed that CSA perpetrators did not seem to be aware of the psychological damage that their victims suffered, yet these interactions often destroy the child's trust and ability to share intimacy even in the future [2]. Children often feel responsible for the abuse because no out-ward force or threat might have been used by the adult. Only after the abused children grow-up are they able to understand that they were powerless to protect themselves and not responsible for what was done to them [2]. To reinforce this self attribution, the child might have been convinced by the perpetrator and even by those who should have been providing protection that the child itself was the cause [4].

Al-Mahroos et al explained that professional and public concerns about CSA are justified by its serious short and long term consequences [2]. James and Gilliland asserted that the devastating impacts of CSA on physical, mental and psycho-logical well-being of children and future adults adversely affect the individual, the family and society [1]. It was thus observed that this problem holds profound implications for mental health and well-being of a very large proportion of all people [4]. Survivors of rape and sexual abuse are said to often experience prolonged trauma symptoms which are difficult for them to transcend and are challenging for the caregivers who seek to help them [1,4]. A South African study suggests that it can also affect their school functioning, emotional reactions to the abuse were found to have interfered with their ability to concentrate in class, as their minds were preoccupied with thoughts about their experience [5].

Psychosocial services and other remedies to address concerns and effects of CSA largely depend on disclosure of the vice and how well it is managed [1]. For one thing, there is evidence that lack of maternal support at the time of disclosure leads to increased symptoms in the child [4] such as disturbed school performance [5]. The response by care-givers and professionals seem to affect disclosure and could be responsible for recantation [6]. On the other hand, maternal responses that convey protection and support have been found to be associated with survivors' improved mental health and social functioning [6]. Thus, the support of a non-offending caregiver seems essential to improve the child's chances of recovery and to forestall prolonged psychopathological effects [7].

Heriot identified certain factors as being closely associated with the attitude taken by the non-offending caregiver following the disclosure of child sexual abuse [8]. Among the key ones was the extent of the relationship of the perpetrator to the non-offending caregiver. The issue of relatedness between the care-giver and the perpetrator appears particularly fundamental to the attitude that the non-offending guardian takes. For example, mothers were found to very likely protect the child if their feelings toward the perpetrator were negative or the perpetrator was not their partner [8]. To that effect, Bolen and Lamb [7] hypothesize that ambivalence in support reflects the confluence between the non-offending guardian's valence toward the child and perpetrator.

When the child discloses sexual abuse, the parent's reaction seems to influence continued disclosure, openness to legal investigation, and willingness to engage in therapy [4]. Thus, primary caregivers seem to have significant influence in the survivor's recovery and family health [9,10,11]. Sadly, caregivers suffer a lot of their own losses when it gets known that an incident of CSA has occurred [7,8,12]. In this vein, guardian's failure to support the child during the disclosure process seems to arise from impairment symptomatic of his/her mental ill-health [10]. For example, mother's clinical level of psychological distress seems to interfere with her ability to optimally respond to the sexually abused child's needs [9].

Leonard Hellerstedin a study of 99 non-offending African American mothers of sexually abused

children aged 4 to 12 years, found that 38 were un-supportive of their children [13]. He reported that reported high levels of persistent distress in mothers and their children, maternal distress was also strongly associated with mother's assessments of child functioning and was less strongly associated with the children's own assessment of their status [13].

Although mothers are often seen as playing a central role in facilitating the recovery of a sexually abused child, there has been little focus on their own needs and profiles [9]. Mothers of sexually abused children are frequently overlooked and marginalized by the child welfare system in the formulation of security and treatment plans targeted at the child [12,6]. According to Manion et al, such findings underscored the need to expand the focus of child sexual abuse beyond the child survivors to the traumatized families and to treat all close family members to be vulnerable to experiencing adjustment difficulties following an incident of child sexual abuse [14]. The overall significance of these findings seems to suggest that comprehensive intervention with the family might be an efficient route to child recovery after disclosure of sexual abuse [13].This hypothesis suggesting that an incident of CSA has a debilitating psychological impact on survivors' primary caregivers that impair their parental functioning implies that, to enhance their supportive functioning, they deserve psychological care [15]. To subscribe to such a justification, authorities would need to be informed by empirical evidence.

The objectives of this study were to:(1) explore if a relationship exists between an incident of CSA and stress in primary caregivers of abused children and (2) identify symptoms of the psychological impact of CSA on primary caregivers.

METHODOLOGY

Thirty-four (n =34) primary caregivers of sexually abused children were recruited from University Teaching Hospital (UTH) and Young Women's Christian's Association (YWCA) Lusaka. Convenience sampling was used to select participants from among those who reported incidents of CSA to any one of the above centers. The inclusion criteria was that disclosure of the incident should have happened in no longer than previous one month. It was expected that within this time frame, the primary caregivers would still be dealing with psychological effects; otherwise any longer time period would permit majority of the respondents to have dealt with the initial shock and trauma and levels of perceived psychological changes would have been ameliorated by personal coping resources [15,16] and the evidence would have been lost.

Perceived Stress Scale (PSS) and a semi-structured interview schedule were the instruments of data collection. Perceived Stressed scale, developed by Cohen Kamarck, & Mermelstein measures the degree to which situations in one's life are appraised as stressful [16]. The Scale's items are designed to tap how unpredictable, uncontrollable and overloaded respondents find their lives to be. In this study, an incident of child sexual abuse was assumed to be an event that elicits depressive symptoms which Cohen et al listed among those responsible for eliciting distress tapped by Perceived stress Scale [16]. High external validity of the Scale has been reported by Cohen et al [16] when measuring stress levels in stressful situations. The scale has a history of successful use in Zambia to measure stress by previous researchers [17].

The participants' interpretation of the items of the interview schedule hardly varied. The questions were, thus, judged to be sufficiently unambiguous to all the groups. Strangely, market women and those at the health centre showed some unease with delving into details of sexual acts and naming private parts. As it was administered orally to them, change to indirect reference to both sexual acts and private parts yielded comparable results. Thus, the pilot interviews underscored the need for caution in how the questions needed to be phrased and handled.

PSS was self-administered and yielded quantitative data representing participants' perceived stress. Ten

items constitute the PSS. The individual participant's scores are summed up to yield individual total scores. The total scores are then referenced to norm table of data recommended by the authors of the Scale to be the approximate stress levels of those persons not facing distress eliciting incidents such as incidents of CSA. The reference data was analyzed by sexand age. If, in the event that an individual score for a primary caregiver was found to be above or below the reference means relevant to his/her gender, age it would be interpreted as being either above or below that mean. If one's score is found to be above the relevant mean, it would be interpreted that s/he is distressed. If equal to or below the mean, the participant would be interpreted as experiencing normal mental health. In other words, the PSS measured how significantly levels of distress in the participants changed from the norm following the incident of CSA. Mann-Whitney U Test was applied to measure differences between the perceived stress experienced by male and female participants. Semi-structured interviews yielded qualitative data, mainly recorded narratives. Thematic analyses involving transcription and identification of themes were applied on the narratives. Of interest to the Study were both verbal and emotional expressions which were analyzed for symptoms of the mental well-being: anger, anxiety, grief, depression, denial, disappointment etc.

RESULTS

The study had a sample size of 34primary caregivers of sexually abused children recruited from YWCA (n = 6, 17.65%) and UTH Pediatric Centre of Excellence (n = 28, 85.35%).It comprised mothers (n= 22, 64.70%), fathers (n= 3, 8.82%), grandmothers (n= 3, 8.82%), stepmothers (n= 2, 5.88%), aunts (n= 2, 5.88%), a cousin (n= 1, 2.94%) and a brother-in-law (n=1, 2.94%). On the whole, there were more female primary caregivers (n= 29, 85.29%) than male ones (n= 5, 14.71%). The caregivers' mean age was 37 years (SD: 8.8, Range: 25 - 55 years). Participants were a combination of married (n=26, 76.47%), widowed (n= 4, 11.76%), divorced (n= 2, 5.88%) and single (n= 2, 5.88%) primary caregivers. PSS scores showed higher levels of stress experienced by caregivers of survivors of CSA than the norm group. Statistically significant differences in scores of maternal versus paternal primary caregivers were found (Table 1), maternal primary caregivers reported higher levels of stress than paternal Primary caregivers.

Table1: Variations in PSS Scores between male and female participants

PSS Questions	Z	Mean Ranks	
		Male	Female
In the last month, how often have you been upset because of something that happened unexpectedly?	–1.47	12.20	18.41
In the last month, how often have you felt that you were unable to control the important things in your life?	–2.68**	7.20	19.28
In the last month, how often have you felt nervous and stressed?	–2.02*	10.30	18.74
In the last month, how often have you felt confident about your ability to handle your personal problems?	–2.42	8.00	19.14
In the last month, how often have you felt that things were going away?	–1.52	11.60	18.52
In the last month, how often have you found that you could not cope with all things that you had to do?	–2.22	9.10	18.95
In the last month, how often have you been able to control irritations in your life?	–.28	16.40	17.69
In the last month, how often have you felt that you were on top of things?	–1.84	10.40	18.74
In the last month, how often have you been angered because of things that were outside of your control?	–.60	15.20	17.90
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	–2.93	6.30	19.43
PSS Overall	–2.66	32	35

*= P– .5, ** = P – .01

From the narratives of the participants, it was evident that they experienced some deep emotions arising from the incident of CSA of their children. They expressed anger, deep sadness, anxiety, helplessness, frustrations, functional impairment and sometimes shame. In some cases, many of these

emotions were expressed in the same breath by the same participant. One participant, for example, reported feeling worse than if she had been nursing a terminally ill child or relative. She felt angry and helpless.

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

Depression and sleep disturbance: Others reported depression and sleep disturbance following the disclosure of CSA.

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

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

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

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

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

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

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

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

Anger: Other participants said they felt angry with the incident because it distracted them from more pressing concerns of seeking livelihood for their families. These wanted the matters resolved quickly so that they could press on with their lives. Twelve such participants expressed anger with their children.

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

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

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

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

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

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

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

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

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

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

DISCUSSION

These findings of the current study suggest that CSA has a debilitating psychological impact on survivors' primary caregivers. This result is consistent with past research findings which also linked incidents of CSA to elevated levels of social distress in caregivers [12,14,18,11]. The symptomatology of the psychological impact of CSA on the caregiver, including anger, anxiety, depression, guilty, insomnia, and functional impairment are shared with those of anxiety and depressed mood episodes. This finding is consistent with those of previous studies [12,14,15] which implicated CSA in depressed mood and anxiety.

Participants in this study recounted varying symptoms of psychological impact of CSA that they had experienced. Notable among them were depression and sleep disturbance, functional impairment, fear and anxiety, anger and wish for revenge, disappointment and frustration, and shame and stigma. In other words, incidents of child sexual abuse gave rise to emotional symptoms reminiscent of mood and anxiety disorders [19,3]. The results of this study are widely consistent with findings of other previous researchers [15,12,14]. Mayekiso and Mbokaziwho found that most prevalent symptoms of maternal psychopathology in the aftermath of an incident of CSA were found to be internalizing behavioral problems including anger, anxiety, guilt, depression, insomnia, headache and fatigue [15]. In general, other studies found that primary caregivers of survivors of CSA faced a higher risk than those of comparison group to score in the clinically distressed range [12,14].

The practical implication of these findings is that to improve their mental health and strengthen their parental functioning, caregivers of abused children require psychological services that, hitherto, have tended to be reserved for their children. The nature of psychological services that would be appropriate and efficacious is beyond the scope of this study and is one important area for future research.

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