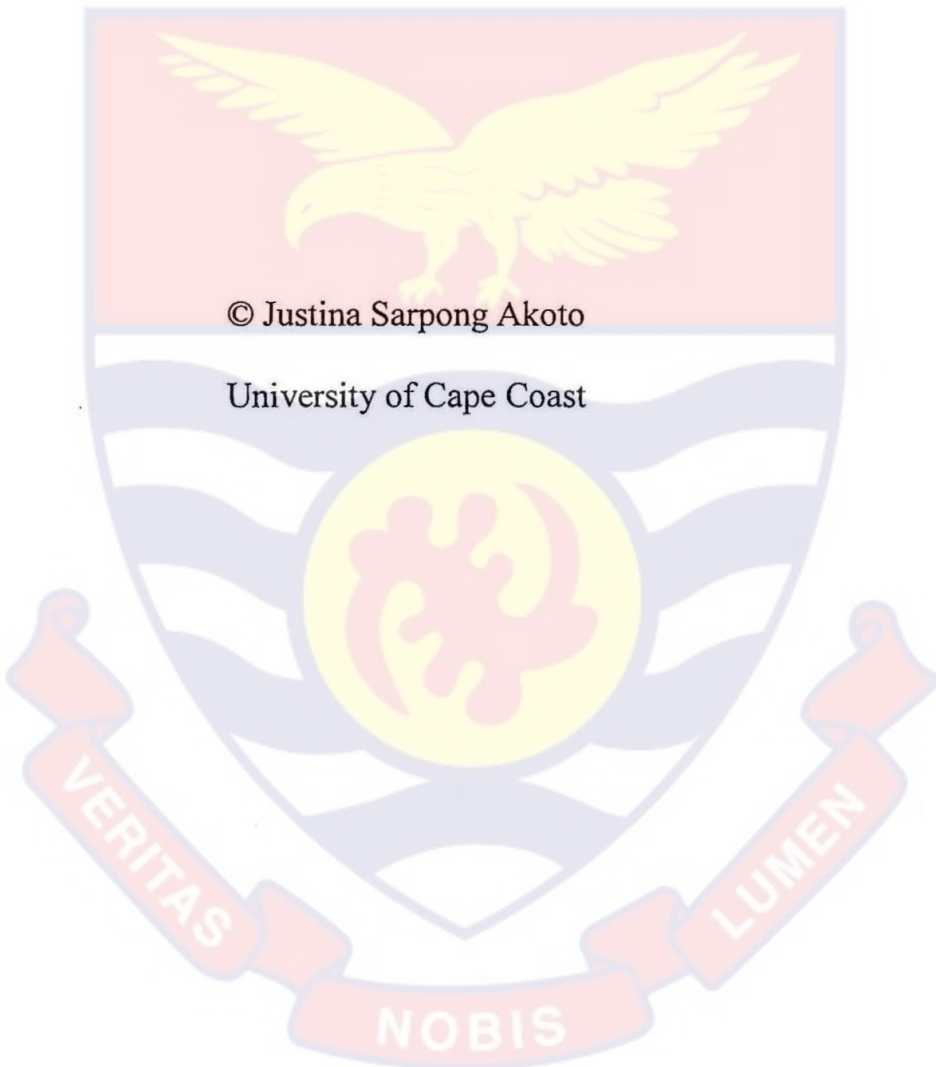

UNIVERSITY OF CAPE COAST

USING REBT AND INDIVIDUAL PSYCHOLOGY TO ALLEVIATE PSYCHOLOGICAL PAINS OF CHILD SEXUAL ABUSE VICTIMS IN CAPE COAST METROPOLIS, GHANA

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Thesis submitted to the Department of Guidance and Counselling of the Faculty of Educational Foundations, College of Education Studies, University of Cape Coast in partial fulfilment of the requirements for the award of Doctor of Philosophy Degree in Guidance and Counselling.

NOVEMBER 2020

DECLARATION

Candidate's Declaration

I hereby declare that this thesis is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature ..... Date 25/10/21

Name: JUSTINA SARPONG AKOTO

Supervisors' Declaration

We hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the University of Cape Coast.

Principal Supervisor's Signature ..... Date 25/10/21

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KEYWORDS

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Betrayal

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Individual Psychology

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Rational Beliefs

Rational Emotive Behaviour Therapy

Sexualisation

Stigmatisation

Victim(s)

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DEDICATION

In memory of my Grandmother, Ama Asantewaa Broni

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LIST OF ACRONYMS

AT	-	Adlerian Therapy
CSA	-	Child Sexual Abuse
DOVVSU	-	Domestic Violence and Victims support Unit
REBT	-	Rational Emotive Behavioural Therapy
IP	-	Individual Psychology

CHAPTER ONE

INTRODUCTION

Literature shows that a traumatic occurrence during childhood may have lasting psychological effects on the victims and close relatives (Forde, 2004; Muhammed, 2014; Sanderson, 2006). One of such inhumane practices meted out on children is sexual abuse. Since the impact of child sexual abuse (CSA) can be lasting, it is only necessary that victims receive psychotherapy (Bagley & King, 2004).

This Chapter looks at the overview of CSA and the parameters of the study. Precisely, it looks at the background to the study; briefly highlights some incidence, and impacts of CSA. The statement of the problem segment discusses the CSA phenomenon as situated in the Cape Cosat Metropolis, Central Region of Ghana. Also, this Chapter, enumerates the purpose, research questions, and hypotheses for the study. Furthermore, the chapter discusses the significance, delimitations, limitations of the study, operational definitions of terms in the study as well as the organisation of the rest of the Chapters in the report.

Background to the Study

Sexual abuse against children is one of the demeaning acts which often occur alongside other violence that leaves the victim with devastating consequences, such as relational, psychological, behavioural, and developmental (Sanderson, 2006). The personal accounts of individuals who experienced sexual abuse in their childhood have revealed that the aftermath

of CSA is pervasive. These associated effects can last into adulthood if the victim does not receive therapy early enough to leverage the adverse outcomes (Bagley & King, 2004).

CSA occurs when an adult or a more powerful child, for his or her sexual gratification, engages another child in any form of the sexual act (World Health Organisation, 1999). The child may give consent, but the act can still be termed as CSA once it involves a child below 18 years. Collin-Vézina, Daigneault and Hébert (2013) and Sika-Bright and Nnorom (2013) attributed factors such as the absence of one or both parents, the presence of a stepfather, parental conflicts, and family adversity to a higher risk for CSA. It is common knowledge that perpetrators can either be male or female, who may or may not be known to the child. Gallagher, Bradford and Pease (2008) exposed that 6.7% of abusers of CSA were strangers. This figure implies that the majority of abusers are known to the child but not necessarily family members. The perpetrators use either physical force or seductive ways to engage their victims in a wide range of contact and non-physical contact of sexual behaviours.

The physical contact form of CSA includes kissing, fondling, or penile intercourse. With the non-physical CSA, the perpetrator and the victim do not have any direct bodily engagement. However, the abuser acts in a way that harasses the victim sexually, such as exhibitionism, sexual comment, filming the child in sexually explicit poses, and exposing the child to pornographic materials (Sanderson, 2006). Justino et al. (2016) established in its population-based study that 38.2% of females had experienced different forms of sexual violence before attaining 18 years. In other words, 67% of females had

incurred sexual comments, 49% had suffered fondling, and 19% endured defilement. Ampong, Donbesuur and Samanhyia (2016) also re-counted 17.9% defilement cases in their report.

No society is yet sexually abused free (Collin-Vézina et al., 2013). It can happen to children of all ages and sex. Essabar, Khalqallah and Benjelloun (2015) summarized a 20-year review of clinical reports and found that 15% of sexual victims were below 5 years, 48% were from 6 to 10 years, and 26% fell within the 11-15 age brackets. Saul and Audage (2007) reported that 42% of the sexual abuse cases amongst females in the United States happened for the first time before their 18th birthday. The males, on the other hand, experienced sexual abuse earlier than the females. A study by PLAN Ghana (2009) also revealed 14% of sexual abuse cases among school children.

A retrospective account shows a rise in CSA cases in Ghana. Between the year 2010 and 2017, a total of 10,745 children were defiled in Ghana (Europa, 2016; Statistics and Information Technology Unit, 2016; Too much focus on sex abuse stories, not enough on the victim – Expert, 2018). The Statistics and Information Technology Unit (2017) also revealed that at least three children were defiled daily in 2016 and 2017. This prevalence indicates a 25.7% rise in the sexual abuse cases of children in Ghana. Also, the National Coordinating Director for Domestic Violence and Victims Support Unit (DOVVSU) reiterated that their outfit records sexual violence daily (Tobiah, 2018). A sample of 655 school children, parents, and headteachers in Ghana also showed that 11.2% of the children had been abused sexually (Agu, Brown, Adamu-Issah, & Duncan, 2018).

The Central Region of Ghana is known for its cluster of schools and tourist attractions such as, the Castels, ocean and the Kakum National Park, to mention but a few (Awiah, 2018). The Ghana Statistical Service (2012) indicated that about 309,621 adolescents were married. The same report showed about 0.7% and 2.7% of the population ranged from 12-14 years and 15-19 years, respectively, were in consensual sexual relationships. The region is also confronted with commercial sexual exploitation of children (Ghana: Global study on sexual exploitation of children in travel and tourism, 2016). A report of the Government of Ghana/UNICEF (2016) showed that 59.3% of children in the region were engaged in exchanging sex for money and other favours.

There was a 42.9% rise in the defilement cases from the years 2015 to 2016 in the Centrl Region, Ghana. In the year 2016 alone, the DOVVSU of the Central Region recorded 273 defilement cases ("Cases of defilement, rape increase in Central Region," 2017). It is also on record that a father had sexual relationships with his three step-daughters and got the youngest one (16 years) in one of the communities in the Region (Yarbio-Tetteh, 2019).

A large body of researchers have attributed various psychological distortions to the incidence of sexual abuse of children (Cohen, Berliner & Mannarino, 2003; Forde, 2004; Herman, 1997; Kendall-Tackett, Williams & Finkelhor, 1993; Muhammed, 2014; Nalavany, Ryan & Hinterlong, 2009). However, Cohen et al. (2003) are of the view that not all the victims exhibit psychological impacts. They ascribed reasons such as the severity of the sexual abuse, practitioner's inability to detect the impacts, victim's coping strategies, and resilience to mask the effects as some causes of the symptom-

free of CSA. William and Nelson-Gardell (2012) added support from non-offending parent(s), favourable family functioning, and secure attachment to the reasons of asymptomatic. In addition to the reasons is the issue of re-victimization (Hébert, Collin-Vézina, Daigneault, Parent, & Tremblay, 2006).

Researchers have found support for the dire psychological consequences among CSA victims in Ghana and the world as a whole in spite of these reasons for asymptomatic. Fergusson, Boden and Horwood (2008) warned that CSA is strongly linked to mental health problems than any other form of abuse. Fergusson et al. (2008) believed that findings on the psychological effects of CSA have been consistent than any other type of abuse. Muhammed (2014) conducted a study in the Northern Region of Ghana. She indicated that these victims develop difficulty in discerning between appropriate and inappropriate behaviours and end up adopting sexualised actions as a means of showing care. Victims exhibit Post Traumatic Stress Disorder (PTSD) (Springer & Misurell, 2015), loss of trust in relationships, betrayal, and low self-esteem (Böhm, 2017). Forde (2004) revealed that sexually abused girls in the Central Region acted out in areas like eating and sleeping disorders.

Different researchers have used diverse pathological models to investigate the psychological consequences of CSA on the victims. Ullman, Najdowski, and Filipas (2009) investigated the PTSD among women with the history of CSA and found a link between the two variables. The self-esteem model had also been investigated with the impact of CSA (Kim, Park & Park, 2017). In this current work, the researcher resorted to the Traumagenic Dynamic Model or Four-factor model of the psychological impact of trauma

by Finkelhor and Browne (1987) to assess the nature and level of psychological distress experienced by the victims. The model comprehensively explains the variety of psychological impacts of CSA under four main factors: traumatic sexualisation, betrayal, stigmatisation, and powerlessness (Collin-Vézina et al., 2013).

This model proposes that all forms of abuse cause trauma by distorting a child's self-concept, perception and emotional strength (Finkelhor, 1987). Nonetheless, the possibility of the conjunction of all the four factors occurring in victims of CSA is high. The model explains that aside the sexual act itself, issues about the abuser, behaviours of the non-offending parents after disclosure, and before the abuse can all be traumatic to the child (Finkelhor & Browne, 1985).

Traumatic sexualisation occurs when the experience of CSA shapes and distorts the victim's sense of sexuality. Betrayal arises when CSA victims lose trust in people whom they perceive to have failed in protecting them from the abuse or have caused them pain (Collin-Vézina et al., 2013). The loss of trust can ensue from the perpetrator(s), non-offending parent/caregiver, or a confidant who failed to believe or support upon disclosure. Powerlessness occurs where the victim feels helpless despite the threat of harm and the violation of their sexual rights (Finkelhor, 1987). Stigmatisation arises when a victim of CSA bears negative thoughts and feelings about him/herself as a result of the sexual abuse experiences. Makhija (2014) discovered that CSA has different effects depending on a variety of dynamics of the abuse.

Each of the four factors can influence the victim's identity formation and total development (Vigil & Geary, 2010; Dukett, 2015). One possible

expression is for the victims to seek power aggressively. The feeling of superiority becomes a priority in his/her life. This power is used as a defensive mechanism so that no other person can ever harm him/her in any way again. Likewise, he or she may develop a breakdown of self-autonomy and discouragement (Herman, 1997). The victims can endure these psychological impacts of the trauma throughout their lifetime (Fisher, Goldsmith, Hurcombe & Soares, 2017).

Recognising the prevalence of CSA, as well as its psychological impacts, is critical in the healing process (Boyd, 2011). Researchers have used diverse strategies to treat the effects of CSA on the victims (Feiring, Simon & Cleland, 2009; Putnam, 2003; Sawyer, Cronch, Flood & Hansen, 2004). The current study employed the principles and techniques of Rational Emotive Behaviour Therapy (REBT) and Individual Psychology (IP) as interventions for the victims. These two therapies have different ideologies and techniques. Each theory has assumptions that apply to the treatment of the Four-factor model of CSA developed by Finkelhor & Browne (1987).

The REBT assumes that sexual abuse itself does not cause psychological distress rather, the dysfunctional belief the child holds about the incidence of sexual abuse creates the problems for the child. As a result, the theory proposes a biopsychosocial way of how human beings feel, think, and behave (Engler, 2014). The theory assumes that "… one's thinking becomes one's emotion and emotion becomes one's thought" (Engler, pp. 397). Humans are social-cultural beings in which thinking and emoting overlap and interrelated, hence, develop into a cause-and-effect relationship (Corey, 2009). It applies the cognitive behavioural theory approach. The therapy assumes that

one's emotions and behaviours are influenced by how one thinks about himself and his world (Engler, 2014). That is, behaviour and feelings are based mainly on what one thinks, feels, or believes about situations and not the situations themselves. The REBT further proposes that a person's biological make-up and environment can influence the belief system and the way of life (Sommers-Flanagan & Sommers-Flanagan, 2004).

In sum, REBT suggests that human beings create their own emotional and behavioural consequences. Engler (2014) explained that human beings are goal-oriented, active, and they have capacity to change. The REBT further proposes that humans have the tendency to live, be happy, seek pleasure, avoid pain, and a compulsion to fulfill their potential (Engler, 2014). Therefore, the goal of REBT therapy is to teach the CSA victim to identify and change dysfunctional beliefs causing the negative consequences. These changes can occur at different levels (Sommers-Flanagan & Sommers-Flanagan, 2004).

Alfred Adler is the father of Individual Psychology (IP), which is sometimes described as Adlerian Therapy (Corey, 2009). Adlerian therapy is an encouragement-focused counselling approach (Hands, 2019) that is incorporated in all four phases of therapy. The approach is considered a critical component of Adlerian therapy (Ansbacher & Ansbacher, as cited in Hands, 2019). Adlerian believes that clients come for therapy because they are discouraged, and through encouragement, these clients will attain superiority (Hands, 2019). That change occurs in clients when they begin to act with the newly discovered courage to face and resolve their difficulties.

Adlerian offers encouragement strategies through the recognition of the therapist's and the client's effort, confidence, and acceptance (Dinkmeyer & Losoncy, as cited in Hands, 2019). Adler believed that each individual is a product of the past, present, and the future. In other words, the individual's perception of the future can significantly influence his or her present worldview, and experiences in the past can as well influence one's future (Neukrug, 2011). Therefore, the individual creates a lifestyle based on life experiences, its interpretation, and strives to achieve a sense of superiority. Trauma experienced in early stages of development could impact on individual emotional development and perception in life. Adler believed that people with psychological disorders are not suffering from an illness. Instead, they have set negative or immature goals for themselves. The trauma distorts the victims' self-concept, worldview, and affection. To determine healthy interaction, Adlerian therapists employ a wholistic approach that comprises both self-interest and community interest. Psychotherapy includes examining the client's lifestyle. This assessment process allows Adlerian therapists to understand the individual's issues, which aid with treatment (Sommers-Flanagan & Sommers-Flanagan, 2004).

Studies have shown that the incidences of CSA disclosed to the appropriate institutions are few (Boakye, 2009; Sanderson, 2006; Sika-Bright & Nnorom, 2013). By implication, only a small portion of the victims are likely to get the needed support. To ascertain the lived experiences of the CSA victims and administer psychological treatment, mixed method design was used.

Statement of the Problem

Due to the adverse effects of CSA, several researchers in different parts of Ghana have recommended the need for therapy to alleviate these psychological pains (Aboagye, 2013; Agyepong, 2010; Osei, 2016). Nevertheless, the actual component of the counselling recommended remains unexplored. There also appears to be a dearth of research on the psychological supports for these vulnerable and stigmatised people in Ghana (Mitchell & Nyadzi, 2011).

Several studies have shown that the psychological consequences of CSA are multi-facet and demand a broad framework to assess and treat it wholistically (Boakye, 2009; Muhammed, 2014; Osei, 2016; Sanderson, 2006). This research adapted the Four-factor model by Finkelhor and Browne (1987) and the mixed method approach which comprehensively assess the psychological impacts on CSA victims (Engler, 2014). In view of the complex nature of the dire impact of CSA, the REBT and IP techniques were employed to alleviate the psychological pains of the victims. The REBT recommends cognitive, emotive and behavioural techniques to teach CSA victims to identify and change the dysfunctional beliefs associated with CSA (Engler, 2014). The justification for the IP is to broadly examine the individual's lifestyle in connection with the self and the community (Sommers-Flanagan & Sommers-Flanagan, 2004).

Sika-Bright and Nnorom (2013) discovered that some children in five basic schools in the Cape Coast Metropolis agreed that watching of pornographic materials was unacceptable; but saw nothing wrong to engage in it with adult's encouragement. They further indicated that sexual activities

such as fondling, kissing, and penetrations with an adult constituted can lead to some developmental challenges (Forde, 2004). These challenges, such as the feeling of vulnerability, betrayed, low self-esteem, frightening memories (Muhammed, 2014), and eating disorders (Forde, 2004), sometimes are overwhelming to the victims (Boakye, 2009) yet, are likely to bear the pain alone.

The study of Sika-Bright and Nnorom (2013) further revealed that for majority of the children within the Metropolis, teachers were their main source of information on CSA. The children, however, indicated that they felt insecure to disclose their CSA experiences to neither their teachers nor their parents. Hence their inability to get the appropriate psychological help. It is necessary to add that the reduced psychological assistance is likely to culminate in the adverse reactions of the victims (Starzynski & Ullman, 2014; Ullman, 2007; Ullman & Peter-Hagene, 2014). Indeed, the impact of CSA is "grossly intrusive in the lives of children and harmful to their normal psychological, emotional, and sexual development in ways which no just or humane society can tolerate." (Bagley & King, 2004, pp. 2).

Since the majority of school children acquire information on CSA from their teachers, but felt uncomfortable disclosing their experiences because they might doubt their story, it is likely that the victims might suffer in silence. Accordingly, there was the need to extend the psychological help to them to ameliorate their sufferings. Therefore, the study was carried out in three selected basic schools within the Cape Coast Metropolis.

Purpose of the Study

The primary purpose of the study was to apply the techniques of REBT and Individual Psychology to treat the four factors of the psychological impact CSA victims experience. The objectives are:

1. to assess the efficacies of brief therapy for the REBT and IP as compared to the control group,
2. to explore the grooming strategies used by the abusers,
3. to determine the nature of the CSA in the Cape Coast Metropolis,
4. to establish the type and the level of the psychological impacts of CSA on the victims, and
5. to measure the influence of biological and social factors on the effects of the treatments.

Research Questions

1. Which types of CSA are perpetuated in the Cape Coast Metropolis?
2. What factors of psychological impacts do CSA victims experience in the Cape Coast Metropolis?
3. How do child sexual abusers in the Cape Coast Metropolis groom their victims?

Hypotheses

$H_0$1: There is no significant difference in the effect of REBT, IP, and Control on the psychological consequences of CSA.

H_A1: There is a significant difference in the effect of REBT, IP, and Control on the psychological consequences of CSA.

$H_0$2: There is no significant difference in the effect of REBT and IP on the Four-factor model of the psychological consequences of CSA.

H_A2: There is a significant difference in the effect of REBT and IP on the Four-factor model of the psychological consequences of CSA.

$H_0 3$: There is no significant association between the biological factors of the victims and the effectiveness of the treatments.

H_A3: There is a significant association between the biological factors of the victims and the effectiveness of treatments.

$H_0 4$: There is no significant association between the social factors of the victims of CSA and the effect of treatments.

H_A4: There is a significant association between the social factors of the victims of CSA and the effect of treatments.

Significance of the Study

It is hoped that the findings of the study will:

1. serve as empirical data for further intervention strategies for victims of CSA in Ghana.
2. inform school guidance coordinators and parents on the strategies of the perpetrators.
3. reinforce the need to provide the needed psychological support for sexually abused children.
4. inform policymakers on the nature of CSA in schools and inculcate sex education in the schools' curriculum.
5. agencies such as Domestic Violence and Victims Support Unit (DOVVSU) and Department of Social Welfare (DSW) may adapt the techniques of the therapies in their operations.

Delimitations

Child sexual abuse as a construct is broad and has many facets. The scope of this study was basically on the four factors of the psychological difficulties experienced by CSA victims. Though children of all ages are predisposed to CSA, the focus was on both boys and girls from 12 - 17 years. The work was also delimited to only two therapies that are useful in dealing with these psychological impacts of sexual abuse. As stated earlier, CSA is a global issue, and it occurs in all the 16 Regions of Ghana. However, only the Cape Coast Metropolis, Central Region of Ghana was involved in the study. This region is on record as having the highest number of CSA in the year 2017 (Awiah, 2018).

Limitations

There were several difficulties the researcher encountered in the course of this research. The prominent ones were accessing permission from the three participating schools and the respondents' parents. To reduce the influence of this limitation on the study, permission was sought from the Central Regional Guidance Coordinator for Basic Schools. Regarding the informed consent, the headteachers and the schools guidance coordinators facilitated the process. They helped the researcher to speek with the parents.

Also, the respondents initially felt uncomfortable participating in the study. To mitigate this limitation, they were assured of confidentiality and anonymity during the individual assessment interviews. Smaller therapy groups were formed to motivate the participants' full involvement.

Another challenge faced was getting a place/room for psychological treatments. With the support of the headteachers and the guidance

coordinators in the three schools, the team managed to get some empty classrooms after school hours. Though not very convenient for group therapy, it served its purpose.

Definition of Terms

The operational definitions of the concepts used in the study are as follows:

Biological parent(s): they are the birth parents of the child with whom the child stays. It could either be only the mother, father or both parents of the child.

Child: is an adolescent boy or girl who may or may not have a history of sexual abuse.

Child Sexual Abuse (CSA): is any single or series of sexual activit(ies) with a child between 12 - 17 years. This sexual intercourse or relationship can occur between children or peers below 18 years. Likewise, the relationship can also happen between an adult and a child with or without the child's consent. It includes all the spectrum of sexual assault, harassment, or sexual crime against a child.

Dysfunctional belief: any harmful thoughts or psychological challenges a child demonstrates as a result of the sexual abuse. An example of such expressions is, "I am not attractive because of the abuse"; a CSA victim attaches to the sexual experiences that can make him or her feel miserable.

Non-biological parent(s): is a caregiver who may or may not have a blood relationship with the child. It could be a step-parent, siblings, friend, or any guardian, other than the child's biological parent(s) who has taken up the responsibility to care for the child.

Observable behaviours: are the actions that a victim of CSA overtly demonstrates to indicate that he or she is suffering from psychological distress as a result of the CSA experience.

Perpetrator(s): any man or woman who engages a child in any form of sexual activity such as penetrative sex, touching of breasts or penis, kissing, guestures and comments of sexual nature. It can be a family member, a stranger, neighbour, friend, or peer who involves the child in either physical contact or non-contact form of CSA.

Victim(s): is any boy or girl in the age range of 12-17 who has ever experienced any form of sexual abuse – fondling, penetrative sex, or verbal comments of sexual nature.

Traumagenic dynamics (TD): represents the four dimensions of the psychological impacts of CSA. These four constructs (sexualisation, powerlessness, betrayal, and stigmatisation) were used to measure the psychological trauma of the CSA victims in the study. The TD is used interchangeably with the Four-factor model

Organisation of the Study

There are five chapters in this report. Following Chapter One is Chapter Two, which is a review of the literature of various concepts and theories on CSA, the conceptual framework and empirical review of studies that incorporated the different elements highlighted. The Chapter Three focused on methodology. This included research design, study area, population, sampling procedure, sample size, data collection instrument and procedure, data processing and analysis as well as the treatment plan for the study. Chapter Four catered for the analysis of the biological and social data of

all the 286 respondents, including the 24 victims used in the experimental study. It also looked at the interpretations of the analysis and discussions in relation to the theories and prior findings on CSA abusers' strategies, activities, and their psychological impacts on the victims.

The final chapter for the report was Chapter Five. Here, the results of the study were summarised. Conclusion, recommendations, implications for counselling, and the researcher's suggestions for further studies, were drawn from the findings. Chapter Five ended with a section on the study's contribution to knowledge and policy.

Chapter Summary

The first Chapter in this study looked at the background of the study and the statement of the problem. Three research questions and four hypotheses were raised to give direction to the study. There were sections on the purpose and significance of the study. Some limitations and delimitations of the study were also discussed. The various terms frequently found in the write up were also defined.

CHAPTER TWO

LITERATURE REVIEW

The purpose of this research was to apply Rational Emotive Behaviour Therapy (REBT) and Individual Psychology (IP) techniques to treat four factors of the psychological impact of CSA victims. Related literature on the nature of CSA, Four-factor model of CSA, and the therapies were reviewed under three main sections - conceptual, theoretical, and empirical review.

Theoretical Framework

The theoretical review looked at the significant theories that guided the research – REBT, IP, Bioecological theory of human development, and the Four-factor model of the psychological impact of CSA.

Rational Emotive Behaviour Therapy (REBT) by Albert Ellis.

Albert Ellis propounded REBT. As a boy, Ellis was described as a sick boy with kidney problems, phobia, and parental difficulties. He, however, had a propensity towards handling difficult times logically and rationally. Ellis developed some strategies to deal with his challenges by himself. Some of the self-taught strategies developed in childhood formed the foreshadowing of his theory (Neukrug, 2011).

He became dissatisfied with the assumptions of the psychoanalysis theory in the year 1953 after practicing since 1947 (Sharf, 2015). He questioned the scientific basis and effectiveness of psychoanalysis and then began to develop his approach. An approach, he believed, could explain thoughts and behaviour (Ellis, as cited in Neukrug, 2011). Consequently, Ellis

introduced Rational Theory in the 1950s. Albert Ellis presented his first paper on Rational Theory in 1956, which he faced much criticism. He later changed it to Rational Emotive Therapy in 1959. In 1992, it was revised to its current name, Rational Emotive Behaviour Theory. The Rational Emotive Behaviour Theory was one of the first Cognitive Behaviour Therapies Theory (Corey, 2009).

Underlying Assumptions and Philosophical Underpinnings of REBT

Albert Ellis was influenced in his theory development by philosophers who dealt with issues of happiness, cognition, and rationality. The work of philosophers, such as Baruch Spinoza, John Dewey, and Karl Popper influenced Albert Ellis in developing his theory (Sharf, 2015). According to Corey (2009), REBT has commonalities with therapies that are oriented towards cognition. The theory also stresses on judging, deciding, analysing, and doing. Corey listed the following as assumptions of the REBT:

1. The underlying assumption of REBT is that people contribute to their psychological problems by the way they interpret events and situations,
2. Humans create their emotional disturbances by firmly believing in absolutistic, dysfunctional beliefs. Human emotions stem mainly from their beliefs, evaluations, interpretations, and reactions to life situations.
3. It is also based on the assumption that cognitions, emotions, and behaviours interact significantly and have a reciprocal cause-and-effect relationship. If they modify their thoughts, they may change many of their emotional and behavioural reactions.

4. People can learn skills to identify and dispute irrational beliefs that have been acquired and self-constructed. Human beings can reconstruct their meaning-making system by applying the REBT theory.
5. The individual has a distinct measure of self-determination or free will, and they can better actively choose to be disturbed or undisturbed themselves (Neukrug, 2011).

The REBT therapists believed that a person's worldview is developed via his adherence to values and beliefs. According to Sharf (2015), one of the philosophical underpinnings of REBT is that people have to focus on long-term enjoyment. Ellis believed that enjoyment is an essential goal in life, which must be focused on long-term pleasure rather than the short term. This type of enjoyment is called *Responsible hedonism*. It is concerned with maintaining pleasure over the long term by avoiding short-term pleasures that lead to pain. Individuals with a responsible attitude towards hedonism think through the consequences of their behaviour on themselves and others.

REBT therapists emphasise that humans are creators of meaning, and users of rational means to predict the future. Ellis believed that relying on religious or superhuman entities and powers are likely to bring poor emotional health satisfaction (Ellis, 1980). Human beings use efficient, logical, and scientific ways to achieve their values and goals. The scientific approach means that the counsellor identifies the client's cognitive distortions and its accompanying beliefs. He then challenges the client to see how the thinking process is illogical and leads to emotional and behavioural dysfunctions. This approach does not imply the absence of emotion or feelings but showing clients that

they can get more of what they want from life by being rational or logical (Neukrug, 2011).

The A - B - C Concept

Essential to the REBT is Ellis' A-B-C theory of personality, *A* - an activating event that happened to the client or the client perceived happened. *B* - the rational or irrational beliefs of the client that lead to positive or disturbing feelings or behaviour. *C* - the consequences of irrational cognitive interpretations of an event or issue. *D* is the process of disputing irrational beliefs. *E* - the new effective way of behaviour and feelings. Ellis used the A-B-C model to explain how personality develops and the changes that take place in the individual. The ABC model of personality explains that consequences are not caused by the A, but by the individual's belief system (B). It is the cognitive interpretation the individual gives to an issue that results in either healthy or unhealthy consequences. If the individual reasonably perceives an event, then the consequence is adaptive or constructive behaviour. However, if irrational thought is attached to such events, then problematic behaviour is likely to occur in the individual. A person's belief system is seen to be a product of biological and social factors (Froggatt, 2005).

The biological factor implies that human beings have innate tendencies to react to events in specific patterns, regardless of environmental factors. They have the biological tendency to either disturb themselves with issues or fight. This factor mainly makes the nature of the irrational beliefs of males often different from that of females. Bistamam, et al., (2015) found no significant difference between gender and the results of REBT. Social factors

such as families, peers, schools, religion have an impact on the expectations that the individual has of themselves and others. People are likely to define themselves as evil or worthwhile, depending on how they see others reacting to them. Those who feel worthless about themselves mostly care much about what others say about them. This factor predisposes the individual to accept several societal expectations as irrational beliefs that they must accommodate. Ellis mentioned that the biological and societal factors form the basis for the development of rational or irrational thinking. However, it is the individual who sustains his or her unique way of thinking (Sharf, 2015). The individual responds consciously or unconsciously to the belief system, not the event.

According to Sharf (2015), the A, B, and C can each have elements that are emotional, behavioural, or cognitive. Human beings disturb themselves with irrational beliefs in the form of demands, which are themselves illogical and unrealistic through negative self-talk. Once the negative self-talk enters the person's head, it affects everything he or she does (Epstein 1998a). These types of self-talks are irrational because they lead to negative consequences. Nevertheless, if the reaction is positive self-talk, there is healthy emotional behaviour.

Types of Disturbances

Albert Ellis believed that maladaptive behaviour and feelings are caused by the individual's repetition of irrational thoughts. REBT theory mainly focuses on how irrational thoughts affect people and how these thoughts act as barriers to a happy self-fulfilling life (Dryden, 2002). Ellis initially identified ten irrational beliefs and expanded these to 12. He again revised it before his death and collapsed the 12 illogical thinking to 3 core

irrational beliefs (Ellis, 2003). Some REBT therapists still use the 12 illogical thoughts in their practice. The core values are used in this write up because it fuses all the 12 illogical thoughts. It also shows the rigid demands the individual makes about him, others, and conditions in which he finds himself. The three core values of dysfunctional beliefs (Ellis, 2003) are:

1. "I absolutely must, under practically all conditions and at all times, perform well or outstandingly well and win the approval or complete love of significant others." "If I fail in these important – and sacred-respects, that is awful, and I am a bad, incompetent, unworthy person, who will probably always fail; and deserve to suffer."
2. "Other people with whom I relate or associate, absolutely must, under practically all conditions and at all times, treat me nicely, considerably and fairly. Otherwise, it is terrible, and they are rotten, bad, unworthy people who will always mistreat me and do not deserve a good life and should be severely punished for acting so abominably to me".
3. "The conditions under which I live absolutely must, at practically all times, be favourable, safe, hassle-free, and quick and easily enjoyable, and if they are not that way, it is awful and horrible, and I cannot bear it. I cannot ever enjoy myself at all. My life is impossible and hardly worth living".

Ellis believes that the continuous internalisation of these core beliefs cause distress. When a person turns desires into *absolutistic musts* and *should*, *awfulising*, *I cannot-stand-it-itis, demands* and *damning oneself and others* create difficulties in the person's life. It can contribute to psychological disturbances (Ellis & MacLean, as cited in Neukrug, 2011). The two types of

disturbances, as described by Froggatt (2005), are Ego disturbance and Discomfort disturbance. These two terms usually go together, although one is usually dominant.

Ego disturbance occurs when one persistently holds irrational beliefs about the 'self' as a result of negative self-evaluation. For example, 'I must do well to get approval from my friends. If I fail, it will prove that I am not good.'

Discomfort disturbance: The person feels his or her comfort zone is threatened because of demands made by others and about the world. Statements like, 'My parents must treat me well.'

Ellis (2003) maintained that these two forms of disturbances create *ego anxiety*. Thus, the individual becomes anxious because of the belief that his/her personal worth is threatened and further leads to avoidance of situations where he/she perceives fear and disapproval from others. A person exhibiting ego anxiety looks up to others for acceptance and approval and is unable to show assertiveness due to fear of what others may think.

Discomfort anxiety is emotional tension that results when one avoids an event or circumstance that is seen as too hard to bear or too challenging to overcome. For example, when one worries about an impending presentation and makes comments like, "I would look awful in front of my course mates; it would be a difficult thing to do", the apprehension could make the individual perform abysmally.

Ego anxiety occurs when one feels that his or her 'self' or personal worth is threatened when he perceives his actions would not be approved of by others. Thus, the person looks to other people for acceptance or effectiveness (Ellis, 1980).

Secondary disturbance occurs when one feels guilty for having a problem. For instance, a person suffering from stigmatisation feels disturbed for having anxiety-related problems. A child may become dejected because he/she is not overcoming their problems as quickly as it should be.

Short-range enjoyment – this type of maladaptive behaviour results from seeking immediate pleasure. The child tries to avoid pain by resulting in things that give immediate pleasure by;

i. ***Avoidance of events and circumstances*** – people try to avoid situations they perceived as 'too hard' or 'too difficult' to overcome.

ii. ***Procrastination*** – putting off difficult tasks or unpleasant situations.

iii. ***Negativity and complaining*** – becoming distressed over small hindrances and setbacks, over-concerned with unfairness, and prone to making comparisons between one's own and others' circumstances.

The Process of Therapy

There are different levels of change. Superficial level of change occurs when the individual alters the body chemistry through exercise, diet, or medication. Superficial change can also occur by avoidance of the situations, or by changing one's inferences about the situation. All these changes make one feel less anxious and help to cope with the situation but for a while. Ellis believed in superficial change but stressed more about the use of practical techniques to modify the individual's core beliefs. The practical techniques help to achieve fundamental and more lasting change (Froggatt, 2005).

Therapeutic relationship – Engage the client

An intense relationship between therapist and client is not required. However, the counsellor is to accept all clients and teach them to accept others

and themselves unconditionally. Ellis places much emphasis on accepting rather than empathy. Ellis maintained that the therapist could give empathy if they wish, but they should do it with extreme caution. According to Ellis (1980), the therapist's expression of empathy makes the clients think that they are good people because the therapist approves of or loves them. Instead, Ellis builds rapport with his clients by showing them that he has great faith in their ability to change themselves and that he has the tools to help them do this.

The relationship between the REBT counsellor and the client is egalitarian. Thus, there is equality between the two parties. The counsellor does not present himself as an authority figure to the client.

Counsellor's role

The REBT therapist takes on the role of a teacher. The therapist actively teaches the client how to identify irrational and self-defeating beliefs that are causing their behaviour. The REBT counsellor is to reveal the mustabatory statements and disputes them with techniques that are categorised into cognitive, emotive, and behavioural (Corey, 2009). Rational emotive behaviour therapists often use self-disclosure. They share their own imperfect beliefs and values with the client. Doing this communicates to the client that the counsellor is not perfect in all aspects. The therapist must observe any secondary disturbances or anxieties about the interview, while demonstrating to the client that change is possible, even at an early stage of the therapy (Froggatt, 2005).

There are objectives in REBT that the therapist works to achieve in counselling. One objective is to teach the clients that they have the choice to make themselves feel either comfortable or miserable when faced with

unpleasant situations (Ellis, 2003). They also use the ABCDE's model of personality to assist the individual in minimizing and solving emotional disturbances by decreasing self-defeating behaviours (Sharf, 2015). These goals shape the roles of the therapist, client, and the therapeutic relationship.

1. *Assess the problem, person, and situation*: the therapist could begin by assessing the client's view of what is wrong with them, followed by how the client feels about having this problem. After which the therapist determines the presence of any related clinical disorders, obtains as much as possible, any history about the client's issue, and assesses the severity of the problem (Froggatt, 2005).
2. *Prepare the client for therapy*: Froggatt (2005) opined that both the therapist and the client have to clarify the treatment goals in concrete and specific terms. The therapist then takes the clients through the basics of REBT and the approaches to be used.
3. *Implement the treatment programme*: the next stage of therapy is for both parties to implement the treatment (Froggatt, 2005). At this stage, rational analysis is carried out. Thus, specific episodes where the target problem(s) occur should be analysed, and the therapist also ascertains information about the client's beliefs and changes them when necessary. The therapist develops and applies REBT strategies and techniques to reduce or modify ways of behaving.
4. *Evaluate the progress*: Froggatt (2005) proposes that the REBT therapist checks for improvements in the client's target problem(s) towards the end of the treatment. It is essential to find out if these changes are due to the intervention or other external factors.

5. *Prepare the client for termination*: psychological treatment for a client can come to closure for many reasons. When it becomes necessary to terminate treatment, the therapist must do so with an open-door policy after preparing the client to cope with setbacks and relapse. That is making it clear to the client to ask for help if needed in the future and be able to identify any irrational beliefs.

Client's Role

The role of the client is to accept their beliefs as the primary cause of their distress and then learn to apply logical thought. They are to actively work outside the therapy session to help to ameliorate the problem and to maintain the new and rational belief (Corey, 2009).

Counselling Techniques

The goal of therapy is to guide the client to develop constructive and confident images of him or herself, instead of just removing the symptoms of dysfunctional behaviours (Engler, 2014). Therefore, he believes in using techniques to dispute his client's irrational thoughts to achieve self-worth. According to Sharf (2015), the core of the REBT is to apply the A-B-C-D-E model to deal with maladaptive behaviours. The REBT practitioners are of the view that when irrational beliefs have been rationally disputed (D), the client can experience a new Effect (E). These irrational beliefs are rooted in the core values of irrational beliefs. A-B-C-D-E therapeutic approach is introduced at an early stage of the therapy. The therapist helps the clients to identify the irrational beliefs (B). The REBT therapist goes ahead to teach them that the irrational beliefs are the cause of the psychological distress (C) and not the actual event or what they perceived to have happened (A) (Neukrug 2011).

The therapist actively disputes (D) the client's irrational beliefs. The disputation of irrational belief is done by detecting irrational beliefs, discriminating irrational from rational beliefs, and debating irrational beliefs. Clients go over a particular "must," "should," or "ought" until they no longer hold that irrational belief, or at least until it is diminished in strength (E) (Corey, 2009). According to Neukrug (2011), the disputation of irrational beliefs can be in the form of cognitive, behaviour, or emotion.

Cognitive disputation methods

Cognitive homework: this strategy is to give the client work to do outside the counselling sessions. This form of assignments entreat the client to perform an activity such as positive self-talk, reading, listening to or watching related material that facilitate the disputation or the treatment process (Sharf, 2015).

Coping self-statements: the self-talk involves challenging the client to substitute the negative thinking to positive and frequently make these positive pronunciations to him or herself. These self-talks shape one's thoughts and emotions because the REBT assumes an overlapping and interrelated process of emotion, thinking, and social. In counselling, the REBT therapist effectively disputes the beliefs which will minimise the consequences (Engler, 2014).

Psycho-educational methods: REBT counsellor introduces its clients to various educational materials and other self-help books related to their problems. For instance, a client can listen to audio-tapes on self-esteem, which can educate him on its causes and effects (Sharf, 2015).

Teaching others the REBT techniques: the REBT therapist puts premium on encouraging their clients to teach others the principles of REBT (Corey, 2009). This process aids clients to point out the irrational beliefs of their friends, and persuade them to replace the negative beliefs with rational thinking (Engler, 2014). According to Sharf (2015), Ellis believed that teaching others helps the client to learn more effective ways of disputing his or her problems.

Problem-solving skills: the REBT proposes that clients can expand their choices of capabilities and goals on their rational thoughts, feelings, and actions. The problem solving strategy is to help clients to figure out and arrive at viable options by dealing with their emotional problems about life's issues (Engler, 2014).

Emotive techniques

Rational emotive imagery: this skill involves clients imagining their feelings when the event first occurred. The clients are made to maintain these negative images and are encouraged to work on changing the unhealthy feelings attached to the experiences (Ellis, 2000). As the REBT therapist disputes these negative feelings about adversities, clients gain a better chance of changing their dysfunctional beliefs about the situation.

Using humour: the REBT assumes also that emotional disturbances often result from being extremely critical of oneself. Subsequently, the therapist uses humour to let their clients know that the issue might be ridiculous and not as serious as they thought initially (Neukrug, 2011). The intention is not to belittle the client's problem rather, to discourage them from wallowing in the problem. According to Neukrug, Ellis was noted for using humorous songs,

and he encouraged people to sing to themselves or in groups when they feel depressed or anxious.

Role-playing: the role play is use to cause behavioural, emotive and cognitive changes in the client (Ellis as cited in Sharf, 2015). Either the clients, therapist or both are encouraged to role play their past experiences causing the pain or how they would want to live their lives.

Shame-attacking exercises: like the role play, clients are made to perform an activity directly related to issues that disgust them or others. Clients sometimes are ashamed to do certain activities in their life, partly as a result of negative past experience, or meet others disapproval. The purpose of this strategy is to help the clients to feel unashamed while acknowledging that people's criticism might not be as powerful or be accepted by others (Ellis, 2000) .

Behavioural techniques

Skills training: like problem solving skills, the REBT therapist teaches clients some abilities such as assertiveness training and communication skills. This training is to help clients develop social skills for effective living (Corey, 2009).

Reinforcements and penalties: this strategy uses rewards and punishment based on the client's goals. Reinforcement strategies such as tokens and praises are used when a client is able to attain a set goal and vice versa Reinforcement is where the client is praised or appreciated for achieving a goal. The counsellor encourages the client to reward himself for being able to overcome his illogical thoughts. With punishment, the client denies himself certain privileges for unaccomplished targets or tasks (Sharf, 2015).

Although Ellis categorised his strategies into behavioural, emotional, and cognitive, in practice, some of them may coincide or overlap. For instance, assignments, humour, and imagery can be cognitive, emotive, or behavioural techniques (Corey, 2009). These techniques used by the REBT counsellors help their clients to gain insight into their problems and change irrational thinking to healthy feelings.

Concluding Comment

Literature has revealed some limitations of REBT, such as the application of Ellis' A-B-C model for identifying and disputing irrational beliefs (Sharf, 2015). Sharf further explained that the formula fails to address deep underlying problems of the client. Ellis (2000) also recounted that empathy is necessary in counselling but does not place much emphasis on it. According to him, empathy makes the victim assume that the therapist accepts all his irrational beliefs, and this does not help in healing the victim. The limited empathy and much emphasis on disputing dysfunctional beliefs tend to place some limitations on the therapy. These principles of REBT do not allow victims much space to reveal their feelings during sessions, even when it emerges (Corey, 2009). Therapists ignore other possible causes of psychological problems and limit themselves to only illogical thoughts as the causes of victim's problems. Too much rationality of the REBT process does not sufficiently deal with emotions (Sharf).

The personal characteristics of the REBT therapist provide another area of concern. A therapist who does not possess the teaching and directing qualities might not be able to practice this theory (Engler, 2014).

Despite these limitations in REBT, Cohen and Mannarino (1996) and Deblinger, Stauffer and Steer (2001) believed that it is one of the best approaches to treat psychological impacts on CSA victims. They revealed that Cognitive Behavioural Theory, which REBT is a type, is the best approach to treat CSA. Stein (2011) reiterated that victims of CSA have erroneous cognitions and as such, REBT is the best therapy to dispute the irrational beliefs of self-defeating talks. David, Szentagotai, Eva, and Macavei (2005) conducted a meta-analysis of the effectiveness of REBT and correlated higher numbers of REBT sessions with better outcomes and a more significant effect size.

In the same way, REBT therapists can examine irrational beliefs and apply the cognitive, emotional, and behaviour techniques to restructure their thinking pattern irrespective of the person's characteristics (Sharf, 2015). According to Wolfe and Naimark (as cited in Sharf, 2015), the theory can help both male and female victims of CSA to challenge their illogical beliefs through emotional, behavioural, and cognitive techniques. These techniques could help victims to accept themselves and stand up for their rights (Sharf) , it is the individual who sustains his or her unique way of thinking (Sharf, 2015). The CSA victims are likely to define themselves as evil or worthwhile, depending on how others react towards them. Those who feel worthless about themselves care too much about what others say about them. Nevertheless, if the reaction is positive, there is healthy emotional behaviour. The researcher believes that the REBT theory would help dispute the Four-factor model of CSA by teaching them to replace these irrational thoughts with a healthier one.

Individual Psychology (IP) by Alfred Adler

Alfred Adler described his childhood as a physically weak and unattractive person who was jealous of his older brother. Nevertheless, not all these negatives deterred him from living; he was determined to defy any negative predictions and overcame his deficiencies (Neukrug, 2011).

Adler was a crucial member in the development of the Psychoanalytic Society and the President of Vienna's Psychoanalysis Society (Neukrug, 2011). Adler later began to question some basic tenets of Freud's psychoanalysis, such as the sex drive. To Adler, other social issues such as education, politics, gender roles, poverty, and others are very critical in human development (Neukrug). In the year 1911, Adler and others left Vienna's Psychoanalytic Society after his controversial presentation on what he called The Masculine Protest. In that presentation, Adler, instead of focusing on biological and psychological factors and their influence on excessively masculine behaviours, instead spoke on the power of culture and socialisation (Sommers-Flanagan & Sommers-Flanagan, 2004).

Adler (1998) claimed that placing excessive value on masculinity created either passive or unwarranted aggressive behaviours in men. Alternatively, women who dressed and acted as men were not suffering from penis envy, but a social-psychological condition (Sommers-Flanagan & Sommers-Flanagan, 2004). He therefore developed the IP on the premise that all humans should seek superiority and also support the women's rights movement (Ansbacher & Ansbacher, as cited in Sharf, 2015). Adler abandoned Freud's fundamental theories because he believed Freud was excessively narrow in his emphasis on biological and instinctual

determination. According to Corey (2009), Adler assumed behaviour to be purposeful, goal-directed and consciousness, more than unconsciousness. He also thought that personal development is based on the feeling of inadequacy and not on sexuality.

Adler was popularly known among his colleagues as an early feminist to point out the myth of masculine superiority (Bitter, Robertson, Healey & Jones Cole, 2009). His passion on feminism led him to write extensively on gender issues, with a significant part on the myth of women's inferiority, among others.

Basic Assumptions

Adler based his theoretical system on the Latin word 'individuum.' This Latin word means complete, whole, and indivisible (Parrott, as cited in Sommers-Flanagan & Sommers-Flanagan, 2004). Adler believed that people could only be understood as integrated and complete beings. According to Adler, human beings are the creators of their own lives. People's unique style of living is an expression of their goals rather than merely being shaped by childhood experiences (Neukrug, 2011). He assumed that a person's perception of past events has a continuing influence on the present and the future. History itself in therapy is not significant. This view also espouses the purposeful nature of the behaviour, emphasizing that where we are striving to go is more important than where we have come from (Corey, 2009). It is not necessary to wallow in history as a source of information to encourage the client. The primary reason to spend time gathering the client's detailed history is to understand its impact on the present and the future (Sommers-Flanagan & Sommers-Flanagan).

Adler does not believe in the innate goodness or innate destructiveness of humans. Human strive for excellence and completeness, which means "Vollkommenheit" (Sommers-Flanagan & Sommers-Flanagan, 2004).

View of Human Nature

Adler (as cited in Neukrug, 2011) is of the view that the individual begins to form an approach in the first six years of living. Subsequently, the memories of those experiences at that age are critical factors in the development of one's private logic and subjective final goal. A person's fictional vision shapes the goals of life, which becomes the source of motivation for that person. These memory pictures remain relatively constant throughout life. Adler described these as internal sources of one's values, beliefs, goals, and interests. Adler saw that every individual is born with innate capabilities and is aware of his or her limitations but can interpret, influence, and create events. Genetics and heredity are not as important as what one chooses to do with the abilities and limitations a person possesses. Each person can strive to make up for the inferiority felt in childhood (Corey, 2009).

Adler saw inferiority feelings as a normal condition and a wellspring of creativity, rather than a sign of weakness or abnormality. Adler (1998) maintained that inferiority feelings motivate one to strive for mastery, superiority, success, and completion. Human beings strive for perfection by moving forward to make themselves complete and to fulfill their correct drive. If this process is smooth, it brings out the person's uniqueness and natural creativity; creates connection and cooperation with others, and promotes meaningfulness in life. Adler maintained that it is essential to understand

people within the systems in which they live. Adlerian is therefore of the view that individuals could become whatever they want to be (Corey, 2009).

Essential Concepts in Individual Psychology

Holistic and existentialist core

Adler's theory places emphasis on the individual. Unlike Freud, Adler stressed that people could be better understood as integrated individuals and not assume that all humans have the same source of anxiety or challenges (Corey, 2009). To Adler, the individual has countless motivating factors such as needs for power, security, self-esteem, and achievement besides gratification. Individual psychology is a wholistic theory that takes each person as a unified entity. Human beings are a collection of symptoms where psychic structures (id, ego, superego) struggle together with each other (Neukrug, 2011). He was more concerned with how the individual uses body and mind in the pursuit of goals. He believed the whole person made decisions for which he or she was entirely responsible. Thus, Adler emphasised the unity of thinking, feeling, acting, attitudes, values, the conscious mind, and the unconscious mind (Mosak & Maniacci, 2008).

In Adlerian theory, personal choice is critical in behaviour change. The concept of existentialism (phenomenology) is a central assumption of individual psychology (Sommers-Flanagan & Sommers-Flanagan, 2004). Existentialism deals with dilemmas of existence such as freedom, choice, responsibility, and meaning of life. Neukrug (2011) explained that freedom of choice also includes responsibility for one's actions and inactions.

Feeling of inferiority and striving for superiority

It is the pervasive feeling that one's abilities and characteristics are inferior to others. Adler described the feeling of inferiority as a motivational drive for one to achieve and attain the goal of life, rather than a negative factor in life. For instance, a person who feels less intelligent and attractive will strive for competence in order to cope with the feelings of helplessness (Corey, 2009). At the same time, feelings serve as a driving force to work on one's inadequacies to achieve something of worth. People who demonstrate superiority complex are self-centred and arrogant. The striving for superiority or competence is a natural and fundamental motivation of individuals, whereas the superiority complex is not (Sharf, 2015).

Striving for superiority also does not necessarily mean being superior to others. Instead, it means moving from a perceived lower or unfavourable level to a perceived, more satisfying life (Corey, 2009). The unique ways in which people strive for competence is what constitutes individuality and the goal that contributes to the development of the human community (Corey). Adler explained the superiority feeling as inflating one's self-worth to overcome his inferiority feelings. Complexes on the other hand, are negative attitudes that subdue oneself and others (Sharf, 2015).

Soft determinism

From his perspective, behaviour is a combination of several factors, and the individual has the freedom to choose from these behavioural options. He believed that the individual is responsible for his or her behaviour but cannot be blamed for the misdeeds. Since the person may not entirely

understand or be aware of the potential outcome of his actions (Sommers-Flanagan & Sommers-Flanagan, 2004).

Social interest and community feeling

Adler (2012) viewed human beings as social beings which is paramount in human development. Adler placed much emphasis on understanding the individual within the context of the family constellation. Community feelings occur when the individual is aware of being a member of the human community by experiencing a deep sense of connection to others. The German word for social interest, "Gemeinschaftsgefühl", is described as a community feeling in action. It is a sharing of a sense of communion with others (Sharf, 2015).

Private logic and common sense

Private logic involves one's convictions and beliefs that get in the way of social interest and that do not facilitate belongings (Carlson, Watts & Maniacci, 2006). Clients' problems arise because the conclusions based on their private logic often do not conform to the requirements of social living. The core of the therapy is for clients to discover and learn to correct their basic mistakes associated with their coping skills (Corey, 2009).

Lifestyle: the early cognitive map

This concept explains how the individual creates his or her world, sets and achieves targets through the rules they have created. The individual's lifestyle includes the person's way of thinking, acting, feelings, and striving toward goals. It can be conscious or unconscious (Mosak & Maniacci, 2008). Adler believed that the individual's lifestyle is in continuity. That is the past, present and future are intertwined. This continuity means that one's

future is a strong influence on the present behaviour or early childhood experience (Sommers-Flanagan & Sommers-Flanagan, 2004). Therefore any negative beliefs or basic mistakes people hold about the self, world, and others could cause emotional pain and distress (Sharf, 2015). However, these faulty assumptions could be modified in life. Human beings have the chance to reframe childhood experiences, and consciously create a new style of life (Sommers-Flanagan & Sommers-Flanagan).

Birth order

The birth order in Adlerian therapy can be described in terms of the relationship between the child and his or her other siblings. Adler believed that each child is born into a different psychological situation. Birth order in individual psychology does not really mean the physical birth position, rather, the psychological birth position of the individual among members of the family. For instance, if the second child has a stronger will-power than the first child, the second child may assume the role of a first-born. This psychological birth position and the reaction of parents to the child could influence how a person relates to society (Sharf, 2015).

Striving with purpose

One of the main tenets in individual psychology is that humans can actively shape themselves and the environment. That is, humans have a sense of purpose and a choice towards life and not passive recipients of their biological traits or reactors to the external environment (Carlson & Englar-Carlson, 2008). Adlerian therapy proposes that one's attitude may serve as the driving force in the individual's lifestyle, as such, behaviour could be analysed for its purpose. Therefore, when an individual's view of life is distorted, the

thinking becomes faulty, which may lead to destructive emotions and inappropriate behaviours (Carlson & Englar-Carlson). It is important to note that Adlerian therapists do not aggressively interrogate clients, instead, show much interest in the client's purpose of behaviour in therapy (Sommers-Flanagan & Sommers-Flanagan, 2004).

Task of Life

In the world of Adler, humans are social beings and must be considered within the context of their relationship with the broader community. Adler initially proposed three main tasks that run through the life of every individual; work/occupation, friendship, and love/intimacy. Years later, Adlerian theorists included spiritual tasks of life, parenting, and the family (Dinkmeyer, Dinkmeyer & Sperry, 1987). There are six tasks of life that everyone must participate in on a day to day basis, whether they have healthy or unhealthy mental health (Carlson & Englar-Carlson, 2008).

Work/occupation task: The /work/occupation task is how one uses the skills and strength to make a living and contribute to the welfare of the community. It can also include household chores and voluntary work as part of a person's regular responsibility and obligations. Dreikurs (1967) maintains that the age at which different people begin to work varies. In most cases, girls start doing household chores earlier than boys. He maintains that how one carries out his or her responsibilities has a direct influence on the occupational task. For instance, a child who is fond of evading his or her chores has difficulty in achieving an occupational task.

Another factor that is closely related to the occupational task is the individual's level of prestige. A person's feeling of inferiority tends to affect

his/her attitude toward society; the higher the feeling of inferiority, the higher the will to deal with it. He or she tends to think of his/her work less as a useful contribution to the community than a circumstance that helps or hinders him in his struggle for prestige (Hesiserman, 2013).

Social relationships/friendships: The social relationship focuses on how people relate to each other in society and how they contribute to society. In this task, human beings need to develop deep and lasting relationships. This task is what defines and sustains one's membership in the human race (Hawes & Blanchard, as cited in Levan, 2010). Heiserman (2013) suggested that when one exaggerates or pretends in a social relationship, the more likely he is to conceal his genuine feeling. For instance, a victim of child sexual abuse (CSA) might not enjoy the social relationship to the fullest. Because CSA occurs among the human race and is usually perpetrated by acquaintances/friends/relatives, it creates in the individual a feeling of distrust, anger, and many more. These negative emotions create in the victim the need for protection. They, therefore, try to empower themselves by controlling their environment. This obsession can create a lack of interest in social activities and lead to difficulty in social adjustment (Waters, Westermeyer, Gralewski, Schneider & Warkentin, 2008)

Intimate relationships/love: The intimate relationship/love task comprises the marital/long term relationship. Love task involves a very close relationship between two people and tends to test one's cooperation. According to Dreikurs (1967), one's lack of social interest can influence the intimate relationship task. Victims of child sexual abuse tend to have a fundamental mistrust of others, causing them to avoid intimacy with everyone, which can

include their partners and children. The love and sex task refers to the intimate relationships that an individual engages in with a partner. Without quality interaction with others, the social task is often left unfulfilled and a vast hole is created. The love task can overcome the distance that is likely to be preserved by other tasks such as occupational, social, or spiritual.

Parenting: The task of love/relationship is closely related parenting. Parenting task is the charge to guide, provide, protect, and help another individual or a child who is under one's care. The child can either be biological or not biological. This type of task can be affected by several factors. Levan (2010) cited the history of CSA as one of the factors. They found that CSA was associated with emotionally disturbed parenting. Dilillo and Damashek (2003) added that CSA could impair a parent's mental functioning, which can affect their parenting style and result in poor development for their children.

Spirituality task: The spiritual task deals with a person's belief systems and the meaning of existence. The developing child leads a meaningful life by relating with other members in the community, god, the universe as well as the life after death (Sharf, 2015). How the individual deals with all this spirituality is a function of lifestyle (Sommers-Flanagan & Sommers-Flanagan, 2004). A sexually abused child may struggle with this task and question the love of God for him or her (Levan, 2010).

Self task: Adler maintained how crucial it is for each individual to know the self, understand his worth, and how to get along with others. Human beings are exposed to different life events, and each of these affects the self differently (Corey, 2009). These events influence our decision, perception, and worldview. These factors, in turn, direct our coping strategies,

interpretations, and reaction to issues. Hence, a single act of sexual abuse in a child's life can interfere with all aspects of his life. This interference sometimes is demonstrated through feelings of inferiority, powerlessness, and incompetence (Levan, 2010).

The life task influences each individual differently. Hence, a person's mental health is dependent upon the feeling of working toward a satisfying and meaningful solution to all of the tasks of life (Hawes & Blanchard, as cited in Levan, 2010).

Therapeutic Process in Individual Psychology

Adlerian therapy employs a collaborative or mutual relationship between the counsellor and the client. The goal is to develop the client's sense of belonging and understand their unique lifestyle. This goal is achieved by increasing the client's self-awareness, challenging, and modifying his or her fundamental premises, life goals, and basic concepts (Dreikurs, 1967). Adlerian therapy is skewed to the growth model and not the sickness model of personality. The reason is that they do not view their clients as sick people who require a cure. They believe that the pathological view of clients creates discouragements, which brings them to therapy.

Dreikurs (1967) categorised the therapeutic process into four main phases. These phases overlap and provide a means of understanding the Adlerian psychotherapy and counselling process. It is necessary to note that the therapists do not rigidly follow the phases progressively. These phases are relationship, assessment, and analysis of the client's lifestyle, interpretation and insight, and re-orientation and re-education (Sharf, 2015).

Phase 1: Therapeutic relationship

According to Corey (2009), the therapeutic relationship is based on a sense of deep caring, involvement, friendship, listening, responding, demonstrating and respect for clients. The relationship also includes instilling hope and faith in the person's strengths as well as his or her problems. For this to occur, the therapist must listen attentively and pay attention to the client's facial expressions and other gestures. Adler emphasised a deep positive relationship building between the therapists and the clients. The relationship is egalitarian. Both the therapist and the client assume equal status. The therapist and client collaborate during sessions, but the therapist takes on a teaching role and actively takes steps to enhance the collaboration and communicate interest in the client (Sharf, 2015).

Additionally, the Adlerian therapist tries to understand the client, goals for therapy, and ensures a mutual relationship with the client. Corey (2009) postulated that progress in therapy is possible only when the therapist aligns him or herself with the client's goals. Where the goals of the therapist and the client are not aligned, the therapist educates and encourages the client about appropriate goals. For an effective counselling process, the IP therapist must deal with the personal issues the client recognises as significant and is willing to explore and change (Sharf, 2015).

Like the solution-focused approach, Adler's theory also focuses on the positives and strengths of the client, with little attention to the problem. This is not to say that talking about problems and difficulties is avoided. Instead, the therapist initially focuses on the person, not the problem. Counsellors help clients become aware of their strengths and potentials rather than dealing

continually with their challenges. Though therapy goes beyond a therapeutic relationship, respect and value for the client is an essential part of the change process (Bitter, Christensen, Hawes, & Nicoll, as cited in Sommers-Flanagan & Sommers-Flanagan, 2004). Successful therapy and the other phases largely depend on the therapeutic relationship that exists between them.

Phase 2: Assessment and analysis of the client's lifestyle.

The second phase of Adlerian counselling aims to get a deeper understanding of an individual's lifestyle. During this assessment phase, the focus is on the individual's social and cultural context. Adlerian practitioners allow salient cultural identity concepts to emerge in the therapy process, and these issues are then addressed (Carlson & Englar-Carlson, 2008). This assessment phase proceeds from two interview forms: the subjective and objective interviews (Corey, 2009).

The subjective interview is where the client is allowed to express himself or herself freely. Through active listening and empathic understanding, the therapist encourages the client to tell his story as wholly as possible (Carlson & Englar-Carlson, 2008). It is usual for the therapist at the beginning of the session to be bored with the client's winding and lengthy narration, however, the therapist should not stop the client from expressing himself. The therapist needs to develop an interest in the client's story and encourage them to speak freely. The narrative will give the therapist clues to the client's lifestyle, coping styles, and the client's concerns (Corey, 2009).

The objective interview also seeks to discover information about the history behind the client's challenges. The lifestyle assessment should develop a holistic narrative of a person's life (Sharf, 2015). The therapist should focus

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on making sense of the client's coping strategies, uncover its interpretations as well as the logic involved. Information may include medical, social, reasons the client chose therapy at this time, coping skills, and lifestyle assessment (Corey, 2009). The strategies used at this stage involve family constellations, the question, earliest collection, and dream analysis (Sommers-Flanagan & Sommers-Flanagan, 2004). Adlerian therapists operate on the assumption that it is the interpretations people develop about themselves, others, the world, and life that govern what they do.

The family constellation: A family constellation interview is an approach that is used to obtain pertinent information about the client's childhood experiences that shaped the lifestyle (Carlson & Englar-Carlson, 2008). Information on family constellations should include descriptions of each family member, how they interact with one another, and how the client views each of them. Adler suggested that it is through the family constellation that each person forms his or her unique view of self, others, and life (Neukrug, 2011). Factors such as cultural and familial values, gender-role expectations, and the nature of interpersonal relationships are all influenced by a child's observation of the interactional patterns within the family (Corey, 2009). Hence, parental values, disciplinary measures, and relationships with children are essential information for Adlerian. Also, information about how the parents got along with each other and how this relationship may have changed at various points in time may be valuable information (Sharf, 2015).

Adler also considered birth order to be a strong predictor of lifestyle. He emphasised that every individual within the family is born into a different

family; this is because, with the addition of a new family member, the family dynamics always change (Sommers-Flanagan & Sommers-Flanagan, 2004).

The question: This strategy is used by the therapist to get more information on issues the client may be avoiding and also to determine the reasons and the purpose of the client's actions. The question is a straightforward method for determining if the client is obtaining special treatment or secondary gain for having the problem(s) (Corey, 2009). After asking the question, the individual psychology practitioner listens carefully for activities or relationships that the client might resume should his or her problems be resolved. The Adlerian therapist asks, "The Questions," like, "How different would your life be if you were well?" Alternatively, "What would you be doing in your life if you no longer had these challenges?" (Carlson & Englar-Carlson, 2008).

***Early recollections*:** They are the memories of past messages that are still active in the client's present life. The application of early recollection becomes effective when it is specific, connected with the clients and has a bearing on the present issue. According to Sommers-Flanagan and Sommers-Flanagan (2004), if the memory is not related to the current issue, then there is no purpose for the client to remember it. Adler believed that more recent memories could be useful, yet, older incidences at age 4 or 5, can be helpful. They occur near the beginning of the time when the lifestyle is forming (Sharf, 2015).

Sommers-Flanagan and Sommers-Flanagan (2004, pp. 94) adapted the following items as a checklist to determine the usefulness of the memory:

1. Is the individual active or passive?
2. Is he or she an observer or a participant?

3. Is he or she giving or taking?
4. Does he or she go forth or withdraw?
5. Is he or she alone or with others?
6. Is his or her concern with people, things, or ideas [or animals]?
7. What relationship does he or she place himself or herself in with others? Inferior? Superior?
8. What emotion does he or she use?
9. Are details and colour mentioned?
10. Do stereotypes of authorities, subordinates, men, women, old, young, reveal themselves?

After assessing these themes, the therapist then prepares a report that will capture the essence of the victim's event. The report should highlight the significant events that are related to the issues being discussed.

Dreams: An Adlerian therapist can make use of dream analysis. The therapist encourages the clients to relate mostly to their childhood or sometimes recurrent dreams. Adler defined the dream as a means adopted by the individual to solve immediate life problems and can also be an expression of self-deception (Corey, 2009). He explained that thoughts and feelings in the form of a dream allow individuals to distance themselves from their thoughts and feelings (Sharf, 2015). Consequently, people who are bold enough to confront their fears and deal with their misgivings during day time, have their goals in congruence with reality. Such people, according to Adler, have fewer or no dreams. Alternatively, that individual may intentionally not remember his or her dreams. This intentional forgetfulness may be an indication of the

individual's unpreparedness to change maladaptive behaviour (Adler, as cited in Sommers-Flanagan & Sommers-Flanagan, 2004).

Adler explained dreams as purposeful, and often indicate an individual's lifestyle, determine his fear for the future and his likes. Throughout therapy, clients are encouraged to narrate their dreams to the therapist (Sharf, 2015). Adler does not have fixed meanings or interpretations of dreams. Adler was of the view that human beings are unique and so are their dreams. Therefore, to understand one's dreams, one must know the individual dreamer because dreams and the dreamer are viewed as unique and connected (Carlson & Englar-Carlson, 2008). The solution is to understand the meaning of the dream within the context of the person's lifestyle and then help him to approach and successfully address the thoughts and feelings in his waking life.

A summary of all the different assessments is drawn for each client, and they are then analysed. Afterward, the counsellor discusses the specifics with the client. Through this, therapists can identify some of the client's basic mistakes in life. Some of the basic mistakes a counsellor is likely to get after the summary are; (Mosak & Maniacci, 2008; Mosak, 1995)

1. Overgeneralisations: "There is no fairness in the world." or "I am always the one who has to take care of everything."
2. False or impossible goals of security: "I must please everyone if I am to feel loved." "I have to be the boss to be acceptable, or others should always take care of my needs."
3. Misperceptions of life and life's demands: "Life is so very difficult for me." "The world is against me."

4. Denial of one's basic worth: "I am stupid, so why would anyone want anything to do with me?" "No one could ever love me."
5. Faulty values: "I must get to the top, regardless of who gets hurt in the process."

Phase 3: Insight and interpretation

The summaries are analysed to get insight into the client's family dynamics, early recollections, dreams, and basic mistakes (Sharf, 2015). Adlerian therapists interpret the findings of the assessment as an avenue for promoting self-understanding and insight. Insight refers to an understanding of the motivations that operate in a client's life. Self-understanding is only possible when hidden purposes and goals of behaviour are made conscious. Adlerian considers insight as a particular form of awareness that facilitates a meaningful understanding of the therapeutic relationship and acts as a foundation for change (Corey, 2009). Interpretation deals with clients' underlying motives for behaving the way they do in the here and now. The interpretations of the assessment are aimed at creating awareness of one's direction and goals in life. Therefore, they are done in connection with the client's goals and purposes and not to the psychological conditions. He believed that interpreting psychological conditions does not promote change. Instead, it makes the client feel insecure or inferior. The interpretation intends to demonstrate further the course of maladaptive lifestyle (Dreikurs, 1967).

Phase 4: Re-orientation and re-education

Corey (2009) referred to this phase of the therapeutic process as the action-oriented phase. It is the stage where insights are put into action. After

the summary of the detailed information, the therapist adapts the techniques suitable for the needs of the client. Adlerian therapists are not interested in temporal behavioural change, rather a transformation outside the walls of therapy (Sharf, 2015). They then focus on re-education through teaching, guiding, provision of information, and offer encouragement to clients who are discouraged.

Future autobiography: This strategy is used to reshape and redirect the client's future. It can be in oral, pictorial, or written form (Corey, 2009). The client gives a detailed or sketchy view of how he or she sees his or her future. By this, the client can identify the client's fear and what is inhibiting or facilitating him or her from living a satisfying life. This technique works best after the counsellor has gathered enough information about the client's past and lifestyle (Sommers-Flanagan & Sommers-Flanagan, 2004). The past and lifestyle data aid the therapist in understanding the client's fundamental beliefs better. The data helps the therapist to coach the client well to write a realistic future autobiography.

Acting "as If": This technique is useful for victims who are afraid to live a certain kind of life for fear of failing. This technique offers the client permission to see how it feels to try on new ways of behaving (Carlson & Englar-Carlson, 2008). The therapist encourages the client to act or role plays the desired behaviour he or she wishes to be but has been avoiding. When the client successfully acts that desired behaviour, the therapist then encourages the individual to maintain the new behaviour for the rest of the day's session and beyond. By consistently engaging in these adaptive ways and talking about them in therapy, the client gains new perspectives of life, and the

motivation for behaving differently with little or no fear (Sommers-Flanagan & Sommers-Flanagan, 2004)

Soup-spitting technique: Like acting as if, this technique is appropriate for clients who frequently avoid or evade demands and responsibilities associated with basic life tasks. Instead of role-playing, the therapist pushes the client to realise the excuses for deferring behavioural change are not valid (Sommers-Flanagan & Sommers-Flanagan, 2004). He muddies the client's reasons for not trying to face that particular life task or responsibility. The concept of spitting in the client's soup is a metaphor for spoiling the client's use of a particular avoidance or neurotic strategy. This technique works best where the therapist has been able to create a friendly therapeutic relationship with the client (Sommers-Flanagan & Sommers-Flanagan).

Encouragement: Encouragement is the most basic and vital component in Individual Psychology. It runs through all the four phases of therapy and all the various techniques discussed already (Dreikurs, 1967). Corey (2009) describes it more as a fundamental attitude rather than a technique. Encouragement is understood to have therapeutic qualities. Clients become motivated when the therapist shows interest in their potential and believes in their capabilities. Adlerian therapists believe that people who assess counselling are all discouraged in some way (Hands, 2019). The use of encouragement facilitates positive change and attainment of goals. Encouragement is when the therapist pushes the client to take responsibility, to move on in life, charging him to accomplish the set goals while acknowledging the difficulties in the process accomplishment (Corey, 2009).

Adlerian therapists have variously defined encouragement. Dreikurs, Gunwald, and Pepper (as cited in Yang, Milliren & Blagen, 2009) defined as a method used to increase clients for self-evaluation. Dinkmeyer and Losoncy (as cited in Corey, 2009) stated that comments foster effort, improvement, acceptance, faith, or confidence in a client. Sweeney (2009) added that intervention tools are use to support and enhance the positive attributes. In effect, encouragement is a set of skills, process, outcome, or attitude, that facilitates change in discouraged clients to overcome feelings of inferiority. Adlerian encouragement is not used for the sake of encouragement itself, but rather within the context of client problems. That is, the ultimate goal of encouragement is to assist individuals in using their courage to take responsibility for their problems (Ansbacher & Ansbacher, as cited in Hands, 2019).

In sum, Adler believed that though the experiences of the past shape the individual's lifestyle, these faulty interpretations could be changed. A victim's private logic may be formed with the experiences of sexual abuse. which may be the cause of maladaptive behaviour. However, it is possible to change these basic mistakes. Adler believed that change could occur at any point in a person's life. Changing the inferiority feelings by encouraging can prevent maladaptive behaviours (Neukrug, 2011).

Bioecological System Theory of Child Development by Urie Bronfenbrenner

Choate (2012) described trauma as a complex interaction between the individual and the environment. Several systems that either directly or indirectly affect the individual can influence life experiences. Urie

Bronfenbrenner developed the Ecological system theory of human development in the 1970s. The theory evolved between the years 1973–2005. The first wave (1973-1979), called the Ecological Model/Approach, brought with it the first four interrelated layers. He highlighted the environment and divided the individual's environment into nested and interrelated systems. Phase two also emphasised that the individual plays an active role in his or her development. Bronfenbrenner (2005) used complex layers to look at human development within the context of the system of relationships that form the person's environment. The individual is nested within larger systems that affect development. Therefore, any change or conflict in any one of the layers will have a ripple effect on the other layers (Paquette & Ryan, 2001). He believed that human development is through multiple processes of different yet interrelated layers, namely, microsystem, mesosystem, exosystem, macrosystem and the chronosystem.

Microsystem: The microsystem is the system closest to the person and the one in which the growing child has direct contact. In the ecological model, the microsystem is the smallest and the first of the layers. It is the most immediate surroundings of the individual (Paquette & Ryan, 2001). The child actively participates in the environment. Examples are the home, peer, school, the church, or any association within which the child is active. This layer is the live setting that contains the developing person where there could be elements like the parents, peers, siblings in the home. Interaction within this layer is bi-directional (Bronfenbrenner, 1999). For instance, the child directly or indirectly shares some behaviours and values with the siblings as they interact. Alternatively, the siblings also copy some of the child's behaviour. Roundly

(2018) explains this stage as the most influential level of the ecological systems theory.

Mesosystem: The mesosystem is the second layer in the nested system and depicts the interrelatedness of the microsystems. It is the interaction between two or more of the microsystems of the child. The effect on the child can be detrimental if the different microsystems are working against one another. A positive interaction between a parent and the child's peers can influence the child's sexual relationship (Paquette & Ryan, 2001).

Exosystem: The exosystem also involves decisions that have a bearing on the person. However, the child had no direct participation in the decision-making process (Berk, 2008). Unlike the mesosystem where the interaction is between two or more microsystems, the exosystem is between the elements in the microsystem and other systems in which the child has no participation — for instance, the work conditions of a parent. The child feels the positive or negative force from the parent's decisions at the workplace. A parent whose work takes him away from home for an extended period can affect the relationship with the child (Roundly, 2018).

Macrosystem: The fourth and outermost layer in the ecological model encompasses the institutional systems of culture, religion, social, economic, educational, and legal systems (Bronfenbrenner as cited in Coscioni, do Nascimento, Rosa & Koller, 2018). This layer defines a more extensive social system in which the child does not function actively, but has a substantial effect on the child. The effects of these principles, defined by the macrosystem, influence the interactions of all other layers (Berk, 2008). For example, if the culture of a society is liberal on matters of abuse, that society

is less likely to provide resources to help sexually abused children. The parents' ability to protect their children's welfare is likely to be affected.

Bronfenbrenner's assertion was, however, criticised for using people who did not belong to a specific context. This paved the way for the second phase in the theory to include the chronosystem and the concept of time (Berk, 2008). Between the period of 1980-1993, he developed the second wave, called Ecological Paradigm. Four different models (Social Address, Person-Context, Process-Context, and Person-Process-Context) were added to the concepts in phase one (Bronfenbrenner, 1999). The model emphasised the active aspect of the person in the environment, the effects of time, and the processes of development (Bronfenbrenner, 1994).

Chronosystem: Bronfenbrenner regarded this system as the most crucial element of the ecological model. This system focuses on the interaction between the various systems and how they affect the individual over time (Ashiabi & O'Neal, 2015). This model measures an individual's development, which include all the events and interactions that happened during the child's life and across generations. Elements within this system can include internal factors that occur within the individual (Berk, 2008). It may include a change in family structure, patient's employment, recession, or pandemic. This system focuses on the interaction between the various systems and how they affect one another over time (Bronfenbrener & Ceci, 1994). As children get old, they may react differently to environmental changes.

He finally renamed it bioecological systems theory to highlight the interactions between heredity and environment (Rosa & Tudge, 2013). Several modifications were added to the first and the second waves. The bioecological

dimension is to recognise the structural and the functional levels of people, including biological, cognitive, emotional, and behavioural aspects of human development (Coscioni et al., 2018). It is also characterised by the formulation of the Process-Person-Context-Time concerning human development (Bronfenbrenner & Evans, 2000).

The first element in the bioecological model is the Process, also referred to as the Proximal Process. It encompasses a specific form of interaction between the individual and his environment, which operates over time (Berk, 2008). He considered this element as the underlying mechanism of an individual's development, which occupies a central part of the model (Bronfenbrenner, 1994). He outlined two main principles in the proximal processes. In the first principle he believed that five activities must take place in the life of the developing person:

> Especially in its early phases, but also throughout the life course, human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate external environment. The interaction must occur on a fairly regular basis over extended periods for the proximal

process to be effective. Such enduring forms of interaction in the immediate environment are referred to as proximal processes. Examples of enduring patterns of the proximal process are found in feeding or comforting a baby, playing with a young child, child-child activities, group or solitary play, reading, learning new skills, athletic activities, problem solving, caring for

others in distress, making plans, performing complex tasks, and acquiring new knowledge and know-how. (Bronfenbrenner & 2006, pp. 797).

Building on this preposition, interactive process overtime helps to shape the developing child in areas such as capabilities, skills, interest, and knowledge. This proposition implies that a positive interaction between and among the person's biological make-up and the elements in the immediate external environment is likely to generate a healthy person and vice versa (Bronfenbrenner, 1994). He further suggested that children learn and understand the world through playing with others or reading.

To quote the words of Bronfenbrenner and Morris (2006, pp. 798) again, the second preposition of the proximal process is;

> The form, power, content, and direction of the proximal processes affecting development vary systematically as a joint function of the characteristics of the developing person, the environment - both immediate and more remote - in which the processes are taking place, the nature of the developmental outcomes under consideration, and the social continuities and changes occurring over time through the life course and the historical period during which the person has lived.

According to Coscioni et al., (2018), these elements may be about the individual's immediate environment or changes occurring over time through the life course and the historical period during which the person has lived. However, the influence of these processes on human development varies from person to person.

Person, in the bioecological model, was established to indicate the role of the individual and their characteristics in social interactions and their

individual development. These characteristics include age, sex, gender, physical or mental health, and others. These visible characteristics of the person are readily measurable over time. Bronfenbrenner and Ceci (1994) proposed three types of personal characteristics that can shape one's development. Bronfenbrenner identified characteristics, such as age or gender, and other features visible to the outside world that act as the stimulus to development.

Similarly, mental and emotional features that are not easily recognised by others are also required for the proximal process. Examples of these overt resources, experiences, intelligence, ability, experience, knowledge, skill, and education are useful at a given stage of development. Also, forced characteristics to invite or discourage reactions from the social environment that can foster or disrupt the operation of proximal processes. It is essential to note that individual qualities such as the drive to succeed, and resilience in the face of obstacles are different even for people with the same amount and access to resources.

The context in the bioecological model is made up of the nested system. The already established five systems – microsystem, mesosystem, exosystem, macrosystem, and the chronosystem formed the basis for the context of the person. The interaction between these systems influences the development of the child. This influence could be either positive or negative, depending on the nature of the child's relationships.

One most essential element developed by Bronfenbrenner in the bioecological model is Time. Bronfenbrenner proposed that the interactions among the systems and the biological characteristics of the child occur on a

measurable and chronological scale. Time in this sense can influence interactions within both a person's lifespan and across generations. Three successive primary levels of time have been described (Bronfenbrenner & Ceci, 1994). Microtime relates to continuity versus discontinuity in the current occurrences of proximal processes. That is, the immediate interactions the developing child is involved in. That is the moment of the actions. Mesotime refers to the periods of the occurrences that are stretched over a broader time interval. The interaction happened within the person's immediate environment and lifespan. However, it extends beyond the moment of the action even for days and weeks. Macro-time is about the changes and activities in the child's larger society that can affect the process and outcomes of development. It focuses on both within and across generations of human development over the life course.

The bioecological model of human development focuses on the age periods of childhood and adolescence and its applications to policies that enhance human's development. Behaviours that emerged during the early stage of development continue throughout life. A person's interactions and engagements with others could arouse both positive and negative emotions such as love, sorrow, and boredom, at different degrees (Bronfenbrenner & Morris, 1998). Such positive and negative development settled in the past can shape the course of development in the future. Equally, the interactions among the biological factors, microsystem, mesosystem, exosystem, and the macrosystem have impacts on the child's development. Since the layers are interrelated, any change in any of these layers can influence the mental health of the child.

Therefore, CSA tends to increase when a vulnerable person finds him or herself within a society that seems to encourage it. Such a victim becomes psychologically traumatised because the society lacks the resources and the will to protect the child (Bronfenbrenner, 1994). When parents or caregivers also appear to be unapproachable, the victim is more likely not to disclose the incident to them for fear of shame and blame. The child may then try to handle it on his own and adopt coping mechanisms like avoidance and detachment to deal with the situation. According to Bronfenbrenner (1999), the use of avoidant coping strategies is related to increased mental problems. Mental problems occur when the individual attempts to avoid memories and feelings associated with the abuse rather than to process them actively. The concept of this theory could suitably explain the social and biological characteristics of victims of CSA and their psychological impacts.

Four-factor Model of Psychological Impact of CSA

Finkelhor and Browne (1985) developed the Traumagenic Dynamics (four-factor model of CSA) to synthesise all the criteria of PTSD and other theories of trauma. The uniqueness of this trauma theory is that it considers associated conditions before, during, and after the abuse (Van der Merwe, 2009). The model offers a much broader explanation of the range of similar effects with different behavioural manifestations. According to the model, the trauma alters the victim's cognitive and emotional orientation about him/herself, others, and the world. The dynamic examines the impact of sexual abuse under four main trauma-causing factors (Finkelhor, 1987). These Four-factor model (sexualisation, betrayal, stigmatisation and powerlessness) are explained below:

Sexualisation: Sexualisation refers to how sexuality is shaped, often in an inappropriate and dysfunctional manner, by several processes. The sexuality of the victim is shaped and distorted by sexual abuse. It occurs when part of the child's body is overly 'praised' or 'exhorted' or when the child associates frightening memories and events with sexual activity (Makhija, 2014). This dynamic represents the consequence of a process by which children's sexual feelings and attitudes become distorted in response to abuse. The process leads to the manifestation of sexuality that is developmentally inappropriate (McCallum, Peterson & Mueller, 2012).

Makhija (2014) illustrated that the degree of sexualisation varies with sexual abuse experiences. Experiences, where a child is lured or enticed to participate in sexual activity, can be associated with misconceptions about sex. Alternatively, if force was used, the child is likely to develop fear or frightening memories associated with sex. Additionally, a child who does not fully comprehend the implications of the sexual activity is more likely to experience a higher degree of sexualisation than a child at a developmental level or age (Finkelhor & Browne, 1985). Also, a child who was rewarded for the sexual activity will most likely develop maladaptive scripts for sexual behaviour. Some behaviours linked to sexualisation are; frightening memories of sexual activities, manipulating others for sexual gratification (McCallum et al., 2012), heightened awareness, and negative beliefs on sexual issues (Finkelhor & Browne, 1985).

Betrayal: Betrayal is the loss of trust in either the perpetrator who shattered the relationship and other adults who are perceived by the victim as not giving protection from being abused. According to Finkelhor and Browne (1985), a

child who does not get support upon disclosure of sexual abuse incidence has a higher chance of feeling betrayed. The basis of betrayal can be when a child realises that a trusted person had sexually abused him (Makhija, 2014). Similarly, anyone who blatantly or indirectly denies adequate protection to the child or does not believe the child upon disclosure reinforces betrayal. Additionally, it can be as a result of a change in one's attitude towards the victim (Finkelhor & Browne). Indeed, a child who previously had a secured bond with the parents/caregiver can suddenly develop a distrust for caregivers and others, negative social attitudes, or negative self-esteem. The provocation of betrayal could delay or begin right after sexual abuse. Its degree largely depends on the relationship between the victim and the perpetrator and how much the victim feels he or she has been betrayed. Betrayal may be much worse in the case of an abusive relationship that started in an affectionate and nurturing way than in one in which there was suspicious behaviour from the onset. These factors can further traumatise and make the victim feel he or she is responsible for the pain (Makhija).

The long-term effect of this factor can be devastating for the victim (Boyd, 2011). Typical of these are guilt, rage, denial, or distrust for others (Cantón-Cortés, Cortés & Cantón, 2012). Another characteristic associated with betrayal is that the victims may anxiously seek for relationships with others, which may sometimes be against societal norms. This kind of limitation in a relationship may lead to excessive alertness in interpersonal relationships. It may also serve as a hindrance to creating a mutually satisfying relationship with others (Van der Merwe, 2009).

Stigmatisation: This factor relates to the shame associated with CSA. Messages overtly or covertly communicated during and after sexual abuse of the child could serve as sources of stigmatisation. These messages can come from the abuser blaming the child for being the cause of the sexual abuse (Makhija, 2014). The perception is reinforced by the perpetrator's manipulative words/actions; social negative attitudes towards victims; or describing the child as evil or being responsible for the abuse (Collin-Vézina et al., 2013). In some cases, the pressure from people to keep the sexual abuse secret, being treated as an outcast or unworthy or differently, can increase the victim's sense of stigma. The pressure may come from either the abuser or other people. In this regard, non-abusive parents, professionals, and others can directly or indirectly communicate stigmatisation (Makhija).

Stigmatisation can occur in various degrees. The level of stigmatisation tends to be higher for a victim who was blamed, insulted, or rejected than the one who got support. Similarly, younger children with little knowledge of social attitudes may have little stigmatisation than the older ones (Finkelhor & Browne, 1987). Primarily these include feelings of badness, worthlessness, shamefulness, and guilt. Loss of status, isolation, self-destructive behaviour (Kennedy & Prock, 2016), suspicion of people's behaviour, a false sense of being different, and low self-esteem (Finkelhor & Browne, 1985) are some of the manifestations.

Powerlessness: The fourth factor, powerlessness, refers to the process whereby a victim's sense of control and desires are thrashed (Finkelhor & Browne, 1985). It is reinforced if the child is consistently unable to make another person understand or believe what has happened to him or her. This

effect is intensified by the victim's inability to alter the situation despite an imminent threat of harm and the violation of personal space (Finkelhor & Browne, 1987). CSA creates a shattered self-image when there is a sense of helplessness, vulnerability, and inability to explain the abuse clearly to be understood and believed. Powerlessness could lead to loss of will-power. An individual who feels powerless may attempt running away from home (Kennedy & Prock, 2016).

Conceptual Framework

This section discussed the scope of the CSA, namely - definitional issues, the spectrum of CSA, and the assessment of CSA. It also looked at the techniques employed in the group counselling, the therapeutic relationship, and the task or the roles of the counsellor in both the individual and group counselling. The last part in this section looked at a self-designed hypothetical framework guiding the study.

Scope of CSA

CSA is one of the most repulsive crimes in the world (Goldstein, 1999). It is harmful to the healthy development of the victim. Researchers have not reached a universally agreed definition for this type of crime. Such variation in definitions has an impact on dealing with CSA (Bagley & King, 2004). Different researchers, organisations, and clinicians have diverse definitions for CSA.

The UN Convention on the Right of the Child (2011) defined CSA as any sexual activity by either an adult or child who uses threats and power to have a sexual relationship with another child. This definition states that CSA excludes sexual activities between children older than the legal age limit. The

World Health Organisation (1999) defined CSA as a sexual encounter between a child who is not developmentally prepared, cannot give consent, or that contradicts societal norms or laws. CSA occurs when an adult of power, for his or her sexual gratification, engages a child in any kind of sexual behaviour to which the child is unable to give consent (Sanderson, 2006).

Glaser and Frosh (1993) also described CSA as a social phenomenon practiced on children. They further explained that child sexual relationships could be abusive depending on the sexual regulations of a particular society. While Glaser and Frosh's definition is based on societal regulations, Finkelhor (1994) based his on the age difference between the abuser and the victim. Finkelhor clarified that a sexual encounter between children under 13 years with an older person(s) with the age difference of at least five years. Equally, a sexual relationship between children of 13 – 16 years and another person(s) with the age difference of at least ten years older, is considered as sexual abuse.

Although there are different views with regards to the definitions of CSA as explained, each brings out three main issues – age, power, and sexual activities. Glaser and Frosh (1993) postulated that a useful definition of CSA must combine the definition of a child, sexual, and the power relationship that pertains between the abuser and the victim. Any robust definition of CSA must be able to define these terms, including abuse (Sanderson, 2006).

Age, in this sense, refers to the age of consent. Usually, researchers use the state's legal definition of age of consent, which is mostly the chronological age, to define the limits of abuse. For instance, the United Kingdom (UK) places its legal age of consent to be anyone under the age of 18 years.

However, consideration is given to persons above 18 years of age whose mental age is less. In law, these people are not seen as children because their chronological age is above 18 years. However, they are unable to give informed consent, making them more vulnerable to CSA (Sanderson, 2006). The constitution of Ghana, like the UK, recognises a person below the age of 18 years as a child (Children's Act, 1998). Finkelhor (1987) placed the age below 13 years or between 13 – 16, depending on the age gap between the victim and the abuser.

Another critical concept in CSA is the term sexual. It is crucial to define sex in order to determine what is sexual and non-sexual abuse. The determination of which is heavily influenced by the culture or the community. Different people have ascribed diverse reasons as to why they engage children in various sexual behaviours. To such communities, sexual relationships with a child are not abusive but regarded as standard. Some communities in some African countries believe the antidote to AIDs (Acquired Immuno-Deficiency syndrome) is to have sexual intercourse with a child who is a virgin. This type of sexual relationship is seen by these people to be a sacrificial purpose (Sanderson, 2006). According to deMause (2002), incest is acceptable among some cultures in India and Japan. The Baiga in India, for instance, encourages marriage between fathers and daughters, mothers and sons, siblings and grandparents, and grandchildren. The children are encouraged to participate in sexual activity with their parents or maybe 'lent' to other members of the extended household for sexual purposes. It is normal in India and China for a child to be masturbated. They masturbate for the boys to have an enlarged penis and to make the girls sleep well. Bagley and King (2004) explained that

though incest is a taboo, it is not considered as CSA, because its violation is based on blood ties and not on trust or authority. Child marriages in some parts of India, Egypt, China, Japan, and Ghana are acceptable, though, legally condoned in these countries.

Regrettably, some children are sold into prostitution for reasons as poverty. In some communities in Ghana and Togo, girls may be sold to become temple maidens to provide sexual services to temple worshippers (Mackay & Fesenmaier, 2000). Egypt, Sudan, Eritrea, Ethiopia, Sierra Leone, Mali, Nigeria, Chad, Kenya, Senegal, Yemen, Ghana, Cameroon, Niger, Tanzania and many other African countries still subject the girls to Female Genital Mutilation (FGM) (Gender, Human Rights and Culture Branch, Technical Division, UNFPA, 2008). These practices are defined not as CSA but as initiation rites with definite religious and cultural meanings. Glaser and Frosh (1993) see sexual to include any activity that brings gratification to the partner. The Ghana Criminal Code (1960) defines sexual (defilement/rape) as unnatural and natural carnal knowledge of a person. The lack of agreement in the term sexual also makes it challenging to reach a universal definition of CSA and to establish its exact prevalence rate.

A third issue which is of concern when defining CSA is the issue of power or abuse (Sanderson, 2006; Glaser & Frosh, 1993). Glaser and Frosh theorised that at the centre of any form of abuse is the exploitation of a power differential, which may be explicit or subtle. Explicit is a form of power exploitation that is direct or usually involves a stranger, unlike subtle exploitation, the abuser plays on the dependency or innocence of the child. Power in CSA does not necessarily mean that the child is under the care of the

abuser. Besides, children's dependence on adults is one of the factors that define them as children. Therefore, any sexual activity between these two parties is an exploitation of power and abuse.

The inconsistencies in these three terms contribute to the lack of universal definition for CSA. It makes it murky to establish parameters for CSA. With consideration to the difficulties enumerated on the definition of the concept, the researcher came up with a working definition for CSA. CSA in this study means any single sexual activity or series of sexual activities with a child between 12 - 17 years. This sexual intercourse or relationship can occur between children or peers below 18 years. Likewise, the relationship can also happen between an adult and a child with or without the child's consent. It includes all the spectrum of sexual assault, harassment, and sexual crime against a child.

Sanderson (2006) grouped the spectrum of CSA under two broad categories – contact and non-physical sexual behaviours. In CSA, the victim can either have a physical or no physical contact with the abuser. The non-physical contact is where the abuser and the victim do not have any form of physical contact. However, the abuser becomes sexually satisfied or aroused via his or her reactions to the child. These sexual activities could be verbal or through gestures. Verbal sexual harassment such as derogatory remarks about a child's body, and requests for sexual favours (Heiberg, 2005) are some examples of non-physical contact of CSA. Ferguson and Hartley (2009) explained sexual gestures as behaviours that visibly communicate sexual messages to a child. Also, when one through the media or any means displays sexual materials intended to seek sexual arousal. Examples are when a person

forces or lures a child to watch explicit sexual videos or pictures, sexting, or exposes his or her genitalia to a child. Non-contact forms of sexual abuse are often a prelude to contact sexual abuse.

The physical contact form of CSA also occurs when some part(s) of the abuser's body physically connects with that of the victim. The abuser sensually touches the victim to gain sexual gratification. The touch can be bi-directional or one way. Bi-direction touch means both the abuser and the victim touch each other, directly or through clothing (Sanderson, 2006). It can be in the form of touching, rubbing, caressing, fondling, or tickling the genitals, breasts, or inner thighs (Gandari & Chihambakwe, 2010). Physical contact sexual abuse can also involve oral sexual activities, such as sucking of breasts or tongue kissing and oral-genital. It can also be the penetration of objects or body parts into the genitals or anus (Collin-Vézina, Daigneault, Hébert, 2013).

Although the statutes in every state define what constitutes CSA in that particular country, there is a difficulty when it comes to determining how sexual action becomes abusive or not. Righthand and Welch (2001) proposed a common ground. They recommended that the "intent" of the adult's sexual behaviour and its effect on the victim might differentiate between sexual and non-sexual abuse. The intent in CSA implies the abuser's action is geared towards sexual gratification. Sanderson (2006) reiterated that the intent of the abuser's action could be determined through a comprehensive assessment of the victim/child.

Assessment of CSA Victims

For any person to effectively handle cases of CSA, it is essential to establish the authenticity or otherwise of it (Sanderson, 2006). In many instances, obvious physical, medical, or psychological symptoms may not be available to prove the truth. In this regard, the legitimacy of the abuse largely depends on the narrations of either the child's or the families' or both parties. Most importantly, the counsellor must be able to get quality and enough information to substantiate the abuse. The National Institute of Child Health and Human Development Protocol (NICHD) can assist counsellors to understand how children's testimony can become useful and accurate as possible (Rooy et al., 2015).

The NICHD protocol is an interview guideline used with children suspected to have been sexually or physically abused. The protocol aimed at improving the quality of information from children. The NICHD interview protocol has three phases: introductory, rapport-building, and substantive or free recall (Baugerud & Johnson, 2017). The first phase of the conversation between the counsellor(s) and the child is the introductory stage. This phase is for self introduction and establishing ground rules for the interview. The interviewer/counsellor introduces him/herself to the child and clarifies the tasks and expectations for each party. The interviewer assures the child that he or she can say, "I do not remember" or "I do not understand" or he or she can correct the interviewer/counsellor when appropriate. The counsellor mainly talks about unrelated issues and encourages the child to talk freely and tell the truth. The idea is to encourage the child to be comfortable and develop rapport (Lamb et al., as cited in Baugerud & Johnson, 2017, pp. 127).

The rapport building stage, which is the second phase, is to create a relaxed and supportive environment for children to describe the incident in detail. As they talk about other issues of life, the counsellor identifies specific details/events in the information given by the child. The counsellor uses a series of prompts to identify the targeted events. As the conversation continues, the counsellor carefully and increasingly encourages children to recall the incident and talk about it (Harris, 2010).

The third phase deals with targeted issues. The interviewer prompts the child to indicate how many times the incident has occurred to him/her and then proceeds to secure incident-specific information. Open-ended questions/statements, such as "Then what happened?"; "earlier you mentioned a person …"; and "… tell me everything about that." If crucial details are still missing, closed-ended questions are also useful in eliciting more information (Baugerud & Johnson, 2007, pp. 129).

Faller and Everson (2014) also described three criteria that are useful to establish the authenticity of CSA. They outlined three general categories of information that should be assessed in the child's statements:

1. **Description of sexual abuse:** the therapist allows the victim to describe the incidence of the abuse. This description can be either verbal or acting the scene. The interviewer looks for clues such as the child's knowledge of sexual activities that are beyond the developmental age, account consistent with a child's perspective, and an explicit description of the sexual acts (Faller & Everson, 2014).
2. **Information about the context of the sexual abuse**: Faller and Everson (2014) further explained that the interviewer looks for more

and peculiar details in the child's narration. The child must be considered to have provided sufficient contextual material if she/he gave at least three of the contextual information. This information may include but not limited to;

i. where, and when the sexual abuse happened,
ii. where other family members might be when the abuse was on-going,
iii. what the abuser might have said to the child before, during and after the incidence,
iv. description of dresses both the victim and the abuser were wearing,
v. part of the clothing removed in the process
vi. frequency and duration of the abuse,
vii. whether the offender said anything about telling or not telling,
viii. whether the child told anyone, and if so, who did the child tell and that person's response?

It is important to note that a child who might have experienced the abuse more than once, especially younger ones, may not remember details about all incidents. In this case, the child may give confusing and inconsistent information. This problem may occur when pre-school children are interviewed by different people or at different times. It is best to ask the child to tell you about the last time in order to obtain contextual information.

3. **Emotional reaction consistent with the behaviour being described:**

The criteria relate to the child's functioning and the circumstances of

the interview. How the child displays his or her emotions should be consistent with the behaviour he or she is narrating. Children may have a variety of emotional reactions to sexual abuse, depending on the characteristics of the child and the abuse. Some common emotional reactions associated with child abuse are reluctance to disclose, embarrassment, anger, anxiety, disgust, depression, fear, and sexual arousal. Meanwhile, Faller (1990) indicated that victims usually express little or no emotion during the interview. Reasons for no emotions were repression, when the abuse happened, not upset about the abuse, and the number of abuses suffered. It is, therefore, important that the therapist appreciate that a child's inability to describe sexual abuse does not mean it did not happen. Faller admonished that the interviewer enquires about the authenticity of the victim's story from another person when there is more evidence of false allegations.

Peterson (as cited in Goldstein, 1999) cautioned that the interviewer gets a history of child maltreatment from a parent who excessively fidgets or shows extreme hostility. Parents sometimes demonstrate grief, fear, sorrow, shame, denial, regret, and anger because of the abuse of their children. Some non-offending parents sometimes feel responsible for the abuse because they could not adequately protect the children (Goldstein). It is crucial to examine the child's relationship with other children, siblings, and parents. The counsellor must help such parents to heal and adjust to the situation. Then enlist the parent's support for the child to share in the child's unique feelings.

Grooming in CSA

Grooming is a method used by sexual abusers to trap their victims. The strategy involves building a relationship with the child as well as significant others in the child's life. The grooming stage serves as a preparatory process for the abusers of CSA (Elliot, 2015). Usually, the process involves building a trusting relationship with the child and or other members of the family. Groth and Burgess (as cited in Burgess & Hartman, 2018) introduced two dimensions of grooming – pressured sexual and forced sexual contacts. They explained the pressured sexual contacts as manipulation with no physical force. The abuser usually uses persuasion, tokens, attention, and money to advance a willing sexual relationship, and sexual control over the victim. In extreme cases, abusers may use threats and physical force to assault or abuse a child sexually (Pollack & MacIver, 2015). The forced sexual contact is the application of intimidation, verbal or physical force, to break the victim's resistance or self-will.

Though CSA can happen abruptly, it is mostly premeditated. In most cases, the abuser knew the victim for a significant period of time before the first sexual abuse incidence (Smallbone, n.d). This cycle of the process allows the abuser to groom the child into accepting sexual advances strategically (Olson, Daggs, Ellevold & Rogers, 2007). Some of these behaviours may often appear ambiguous both to the victim and others who may observe it. Smallbone added that the abuser may sometimes unconsciously be given these sexual motivations until late in the process, or after the sexual abuse had occurred. However, grooming becomes conscious and deliberate after the first incidence. Van der Merwe (2009) asserted that pre-trauma events, which

include the grooming strategies, are necessary for devising intervention strategies for CSA victims. They inform the therapist on certain critical elements needed to be included in the treatments.

The grooming process

Varied literature on sexual abuse of children have outlined different grooming processes. There are grooming processes related to cybersex exploitation (O'Connell, 2003; & Webster et al., 2012). Other theories call for direct interaction with the abuser in order to learn their characteristics and the stages they used. For instance, Marshall and Barbaree's Integrated Theory (as cited in Elliot, 2015) proposed that personal characteristics developed at an early age leave abusers unprepared to understand and deal with hormonal changes. Subsequently, they employ inappropriate means to satisfy their hormonal and sexual needs . This peculiar developmental defect about the CSA abusers could neither have been known nor identified by the victims. The abusers were not directly involved in this study. The focus of this research was on the victims. Hence, the narrations of the victims were used to establish how they were groomed for sexual abuse.

Grooming the environment and significant others

The sexual grooming of children begins with identifying the potential victim. Abusers often look for certain characteristics, such as perceived vulnerability, attractiveness, or ease of access (Mooney & Ost, 2013; van Dam, 2001). They look for how vulnerable the child is and approach them through various means. Abusers of CSA use indicators like a child with poor relationship with parents and friends (Berliner & Conte, 1990), or a child who had already been victimised (Leberg, 1997), single-parent families to gain this

status (Elliott, Browne & Kilcoyne, 1995). Younger children, especially those with less protection due to the absence of parent(s), may also be targets of CSA abusers.

One other crucial behaviour abusers put up is to be influential within the community and in the child's personal life (van Dam, 2001). After identifying their potential victims, they try their best to penetrate the child's immediate environment. Though their target is the child, they as well connect themselves to significant others in the life of the child. They integrate at places where they are likely to meet children and gain the trust of others, such as parents, siblings, friends, and teachers. Likewise, they can become the child's friend so they could be alone with the child most often. Elliot (2015) warned that the aim of this acting on the side of the abuser is to increase potentiality. He explained potentiality as creating and maintaining a suitable environment to facilitate desensitisation.

Gaining access to the potential victim

The second stage for the abuser is to have access to the targeted child. Elliott et al. (1995) proposed that extra-familial and Intra-familial abusers may employ different strategies to gain access to the child. Extra-familial abusers who may not readily have access initiate contact with their potential victims. They often seek out situations where victims will be available, such as going to schools, church or running errands, and strike communication. Young people who abuse children in sexual activities also try to create avenues to be alone with the victim most of the time. They create reasons to walk the potential victims to the house or take them on outings (Craven, Brown & Gilchrist, 2006), offering a ride or invitations (Mooney & Ost, 2013).

Intra-familial abusers already have an established relationship with the victim and can quickly gain access to their victims (Craven et al., 2006). However, because of their harmful intentions, they also groom their potential victims. This type of abusers usually creates opportunities to have more time alone with the potential victim. They isolate the victim from their non-abusing parents, siblings, and the outside world. In most cases, they try to brand the non-offending parents as evil. They portray themselves as the only good people in their potential victim's life. They act as the child's confidant and meet the needs of the child (Leberg, 1997).

Gaining the trust of the child and significant others

The third process of the grooming, as described by Winter and Jeglic (2016) as the "emotional recruiting of the victim." They further explained this stage to be the central role in the grooming process. It is the stage where the potential abuser cultivates a relationship, trust, and cooperation with the potential victim and significant others in the child's life, which is intended for the abuse (Craven et al., 2006). This process is facilitated by helping the child, as well as giving of gifts, incentives and attention based on the characteristics of the child (McAlinden, as cited in Winters & Jeglic, 2016).

Callahan (2004) outlined three forms of incentives. The financial incentives are in the form of material rewards, which the recipient/victim anticipates for acting in a particular way. He named the second as moral incentives. This kind of incentive is meant to appeal to the recipient's sense of worth. The giver presents a particular action as right. Alternatively, he portrays to the recipient that failure to act in a certain way may lead to a negative perception from others. The third is coercive incentives. In this case,

the recipient is made to believe that failure to behave in specific ways will attract punishment from the giver. Abusers impress on the victims with some of these incentives to get what they want.

The potential abuser positions him or herself as a confidant and assumes a non-threatening relationship. These behaviours intend to give the impression that a loving relationship could exist between them (Mooney & Ost, 2013). The aim is to gain the trust of the child and people around to be able to manipulate the child into participating in sexual abuse.

Desensitising the child to touch.

This stage is where the abusers eventually implement their actions. They would begin at an increasing rate to touch the sensitive parts of the child if they had not started already. According to Winters and Jeglic (2016), touching or gestures usually happen innocently and then increase. The touch and gestures could be physical touch or non-physical touch.

Maintenance of secrecy of the abuse incidence

As the abusers conceived the idea to abuse someone sexually, they plan along with it how to keep their activities secret from others. This stage is subtly embedded in all the other stages of the grooming. They isolate the child from others so the child would not have anyone to disclose the incidence to (Warner, 2000).

Strategies like threats, unbelief, gifts, or extra privileges are also used by the abusers (Berliner & Conte, 1990). They sometimes pick up fights with other family members or close ones to reinforce their threats. van Dam (2001) suggested that abusers might make the victim feel responsible for sexual abuse. They often employ this blame game mainly when the victim was made

to take an active role in the process. They make the child performs the sexual acts on the adult or compelled to do it on another child. The blame game compels the victims to keep the incidence of sexual abuse secret. The victim keeps the incident to him or herself because he or she feels bad about it and that no one will believe them (Warner, 2000).

The feeling of responsibility, betrayal, and guilt are all part of the process of keeping their sexual abuse incidence secretive. These feelings burden the victim and put much pressure on the child not to disclose the sexual abuse. The child feels he or she did not want the sexual relationship, while at the same time thinking that the body reacted to the sexual stimulation. This state of confusion further makes the child sink into self-betrayal. The victim might interpret these feelings as evidence of enjoying themselves sexually (Warner, 2000), which may affect psychological development.

Grooming behaviours

Berliner and Conte (1990) described two main types of grooming behaviours - physical and psychological. Physical grooming involves the gradual sexualisation of the relationship between the abuser and the victim. Psychological grooming is used to facilitate and achieve increased sexualisation. The abuser builds the child's trust (van Dam, 2001), makes him or her feel good, and then starts to violate boundaries.

Examples of grooming behaviours of abusers are; intentionally barging in when the child is undressed, or getting dressed. The abuser can also expose his or her nakedness to the child. Gradually soothing the victim's body under cloth usually begins with non-sexual touching. A conversation may border on

sexual themes or other topics while touching the child sexually (Leberg, 1997).

Pollack and MacIver (2015, pp. 166) outlined the following as some of the grooming behaviours abusers of CSA exhibit;

1. seem to be overly interested in the child,
2. gives special privileges to the child,
3. frequently initiates/creates opportunities to be alone with a child,
4. teasing a child about breast/genital,
5. excessively caters for the interest of the child,
6. displays favouritism towards one child in the family,
7. discusses and shows sexually explicit themes and images to the child, or
8. plays games that include touching of the genitalia.

These processes and behaviours are not mutually exclusive. Each victim of sexual abuse is groomed differently. Some may experience all these stages, either systematically or not. While, others may not be premeditated (Craven et al., 2006). Their integration into society is well organised and very instrumental that others could hardly suspect their motives. Even if sexual abuse eventually happens, they would be believed by the community instead of the victim's story. All these preparations are done to get access to the potential victim and eventually sexually abuse the child.

Group Counselling

Group counselling involves more than a participant. Due to the sensitivity of CSA, one needs to strategise carefully before bringing different victims of CSA into a group (van Loon & Kralik, 2008). It is essential that the

therapist has individual interviews with each member before forming the groups. This stage helps to foster connection between the therapist and the members. The connection among members and the group leader is crucial in sustaining the life of the group. The group discussion also allows members to share their experiences on the abuse. Yalom's group psychotherapy is one of the techniques in establishing and sustaining the sanity of group counselling (Yalom & Leszcz, 2005).

Therapeutic relationship

Yalom believes in establishing a positive relationship between the therapist and the clients or members of the group. The relationship must be built on acceptance, genuineness, and empathy, which the therapist must never compromise on. According to Yalom, no technical consideration takes precedence over these factors in therapy. The techniques in therapy are much useful when paralleled with acceptance and therapist-client relationships (Yalom & Leszcz, 2005).

The therapist's role is to create the machinery of therapy, set it in motion, and keep operating with maximum effectiveness. Yalom groups the fundamental task of the group therapist as follows:

1. ***Creation and maintenance of the group:*** the leader is responsible for creating and convening the group. Before group meeting commences, the therapist must have considerable time on the selection and preparation of the group members. The therapist acts as the initial deter, group unifier, setting time, and place for the meetings. At the beginning of the group meetings, most of the members may be new to each other. Hence, as the unifying force of the group, the therapist is to

create the therapist-client and members' alliances. Once the group meeting begins, he ensures that member attrition is avoided.

2. ***Building a group culture:*** in group therapy, the group also serves as an agent of change. Therefore, one of the major tasks of the therapist is to shape the group into a therapeutic social system. There also must be rules or norms to guide the interaction of the group members. The therapist can present to members a list of behaviours and ask members to indicate which are appropriate and inappropriate for the group or ask them to write down the rules for the group. The therapist has to create a group culture that will maximise effective group interaction. This interaction among members sets the therapeutic factors into motion and exert high therapeutic strength. Members are to be encouraged to communicate freely, be honest, active, non-judgmental, communicate acceptance, and do self-disclosure.
3. ***The principle of here-and-now***: it is the task of the group therapist to recognise and understand the immediate events of the group. These events take precedence over the past and the current ones outside life. If the group is to be effective, it must also be self- reflective, thus, examining the here-and-now behaviour that has just happened. It is the responsibility of the therapist to direct the group from disruptive materials and focus on building a healthy relationship with one another. Recognising this facilitates cohesiveness, recovery, self-disclosure, feedback, and other therapeutic factors necessary for the growth of the group.

Group counselling for children with similar challenges is an effective way of treating CSA victims. It helps other members to realise that they are not the only ones with such challenges. The group discussions help other members to learn specific ideas that could not have emerged during individual counselling from their peers. Using these strategies to organise meetings facilitate treatments of the psychological impacts of CSA on the victims.

Conceptual Framework

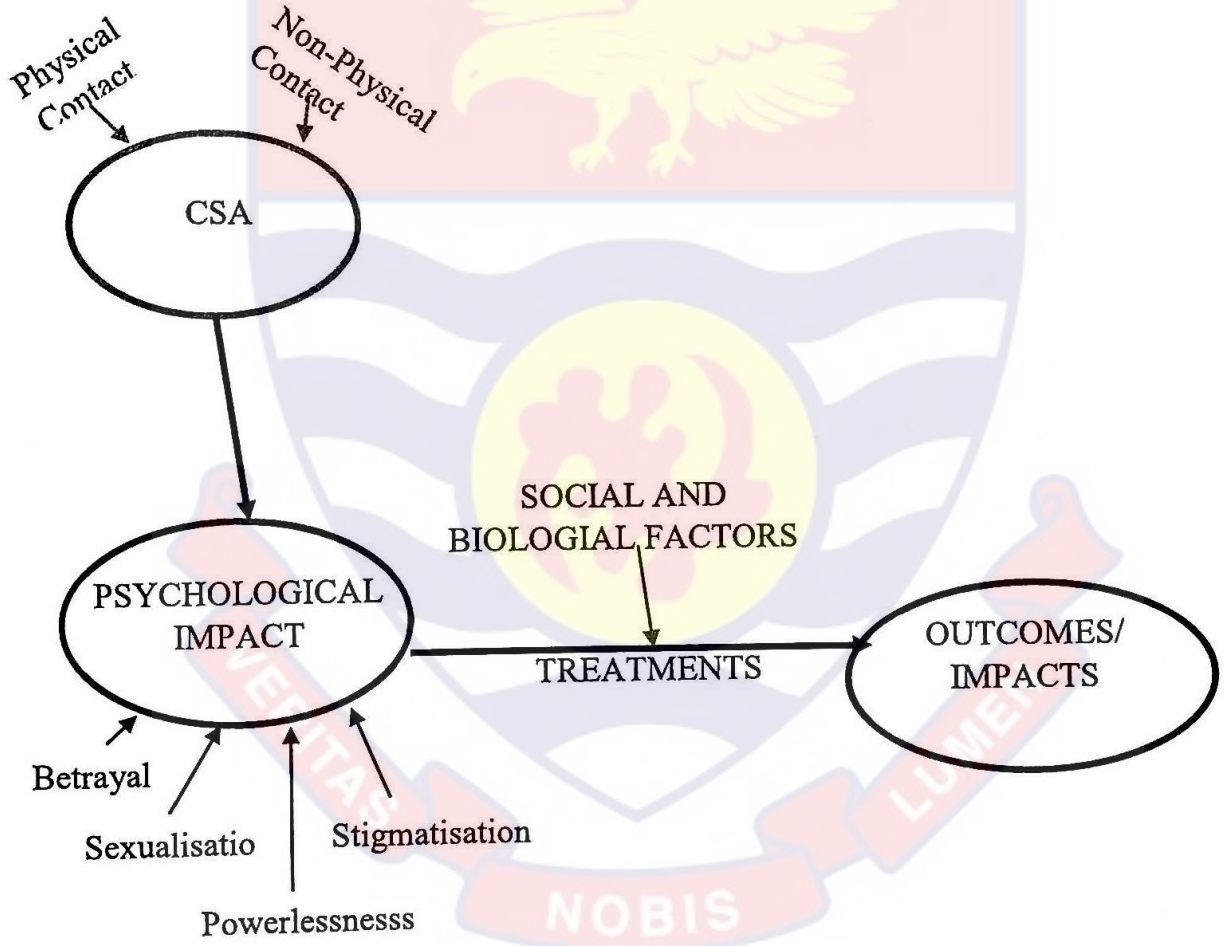

Figure 1: A Self-designed framework for psychological impacts and treatments of CSA on the victim

The diagram depicts the effect of therapy on the Four-factor model of psychological impacts on CSA victims. It shows that when a child of 12 – 17 years experiences sexual abuse, whether physical or non-physical contact, he or she may suffer psychological impact. The discomfort can either be some or

all of the Four-factor model of the psychological impacts of CSA. These impacts are sexualisation, powerlessness, stigmatisation, and betrayal. The line joining the two different impacts indicate that age, gender and family background could influence the outcomes of treatments. One assumption guiding this study is that the one-on-one interviews and the group psychotherapies would help to alleviate the Four-factor models on the CSA victims, which will help the CSA victims live a more satisfying life.

Empirical Framework

Although CSA occurs in almost every country, across all ages and socio-economic classes, its exact magnitude cannot be determined. Reasons such as cooperating with the perpetrators, shame, and social silence (van Loon & Kralik, 2008) deter CSA victims and their families from reporting its incidence. Diverse views on the determinants of CSA across cultures, even within the same country (Goldstein, 1999) add to why CSA estimates vary widely. Notwithstanding the challenge in the estimates, researchers, clinicians and other groups of people have made efforts to get reliable and comparable data of CSA. This section mainly deals with the empirical evidence of the prevalence of CSA and its impacts on the victims.

Characteristics of CSA Victims

Different research have varied findings on the link between CSA and the victim's biological and social factors. Coopersmith (1967), for instance, discovered that there was no significant correlation with factors such as education, geographic location, social class, and parents' occupation with CSA. On the contrary, some researchers revealed a significant relationship between the child and the adults was discovered.

Esposito and Field (2016) alluded that childhood sexual abuse is a 'gendered' issue. They reiterated that gender influences the risk and the likelihood of a person to be abused. Sanderson (2006) echoed that globally females tend to be sexually abused more than males. Ullman and Filipas (2005) examined gender differences in sexual abuse victims among 733 students. In the study, female students reported much severity of CSA. A study by Chen and Chen (2005) to ascertain information from the parents of Grade 3 pupils in Fuxin City, China, on the prevention of CSA indicated that boys could also be sexually abused. Berliner (2011) found that girls are at higher risk of being sexually abused than boys.

Several researchers have affirmed this assertion. deMause (2002) also found a prevalence rate of CSA in the USA used to be 60% among females and 45% of males. Collin-Vezina et al. (2013) affirmed that CSA is a significant issue that affects more than one out of five females and one in ten males globally. In 2016, Platt, Back, Hauschild and Guedert (2018) information gathered from the Brazilian Case Registry Database rated girls to be more sexually abused than boys. However, boys are more likely to face repeated sexual abuse than girls. Esposito and Field (2016) further revealed in their study among Australians that one in three girls and one in seven boys experience some form of child sexual abuse. In Ghana, the majority (68.4%) of the respondents expressed that boys and girls are sexually abused (Sika-Bright & Nnorom, 2013). Agu et al. (2018) found among 655 respondents (children, parents, and headteachers) that 92% of the victims of CSA were females.

Finkelhor (1994) asserted that age is a significant factor in sexual abuse. He believed that children of all ages are at risk of CSA. Agu et al. (2018) revealed that boys are at higher risk of being sexually abused than girls before the age of 16 years. In the same way, the rate of sexual abuse among females at age 16 years and older increases more than boys. The U.S. Department of Health and Human Services (as cited in Putnam, 2003) reported that approximately 35.9% of the victims were 12 years and older. Additionally, Bagley and King (2014) exposed that 81% of the victims used in their study were sexually abused before puberty. Sawyer, et al., (2004) also revealed that the average age of onset of abuse was 8.56 years. The modal age of the victims of CSA in Ghana was 14 years (Agu, et al., 2018). The researchers further explained that about 26% of the respondents were defiled before 11 to 15 years, while 11% first experienced a sexual encounter at 16 years and beyond.

Concerning the social factors, Essabar et al., (2015), observed that CSA could occur as a result of impairments in the family system. Sedlak's (1997) study on the incidence of child abuse found a connection between family structure and age of onset of CSA. Finkelhor (1993) also acknowledged that family constellation, particularly the absence of one or both parents, is associated with increased risk of child sexual abuse. For instance, older children from father-only families were at increased risk of sexual abuse (Sedlak). The presence of a non-related figure such as a stepfather is a high probability of sexual abuse for the children, especially girls (Finkelhor).

Berliner (2011) identified that both boys and girls who have lived without one of their natural parents are at increased risk. Black, Heyman and

Smith-Slep (2001) added that children who live with only one or none of their biological parents have an increased rate of abuse. Majority (79.3%) of the school children within the Cape Coast Metropolis agreed that children from reputable homes can also be sexually abused (Sika-Bright & Nnorom, 2013). Sedlak, et al., (2010) confirmed that the absence of biological parents put a child ten times more for sexual abuse than their presence. Essabar et al., (2015) also observed that 17% of the CSA victims were from families with either one parent or both parents' absence, and 8% also had a stepfather in the home. Children who live with a single parent that has a live-in partner were 20 times more likely to be victims of sexual abuse than children living with both biological parents (Sedlack et al.). In the Cape Coast Metropolis, Ghana, some children agreed that CSA could occur when the children are alone (81.2%), outside their homes (80.1%) and at night (84%) (Sika-Bright & Nnorom, 2013).

Types of CSA

The extent of the effect of CSA on the victim largely depends on the type of sexual act meted out to the child. Victims encounter both non-physical contact and physical contact sexual abuse in and outside the school. Kempe (as cited in Bagley & King, 2004) outlined CSA examples like rape, pornographic material, sexual gestures, verbal sexual comments, and unwelcome cell phone messages. These types of sexual activities can be categorised into those involving actual physical contact with the bodies of the abuser and abused, such as kissing, touching breasts, sexual intercourse. Children of all ages and from all manner of homes are intimidated to have sexual intercourse, kissed, and shown pornographic, by their abusers. Their

abusers play with the victim's buttocks, breasts, genitals, and other sensitive parts (Shakeshaft, 2002).

Essaber, et al., (2019) noted a spectrum of sexual abuse types which range from non-physical contact forms to contact forms of abuse. The results revealed that 64% of victims were sodomised, 18% were subjected to fondling, and 10% of cases had oral-genital intercourse. There was also 8% of victim's exposure to pornographic materials, pulling of clothes, touching, and pinching (Agu, et al., 2018). On whether it is good for an adult to fondle, caress or kiss a child, (25%) of the children in some selected basic schools in Cape Coast Metropolis, Ghana believed that it is good to be kissed, caressed and fondled by an adult (Sika-Bright & Nnorom, 2013).

Similarly, Awusabo-Asare, Biddlecom, Kumi-Kyereme, and Patterson (2006) found that 12% of females and 5% of males' respondents were threatened to have sexual intercourse. Twenty-seven people representing 41% of the respondents experienced intercourse (vaginal, anal, and/or oral sex), and 34% of the respondents experienced fondling, digital penetration, exposure to pornography, or genital exposure (Sawyer, et al., 2004).

There was consensus from all participants (learners, teachers, and educational psychologists) that victims of sexual abuse experience both contact and non-contact forms of sexual abuse. The most common form of sexual abuse, however, was the physical contact (Simuforasa, 2015).

Characteristics of Perpetrators of CSA

Abusers of CSA leave unwelcome sexual memories in the mind of their victims. Although studies on CSA mostly focus on the males' perpetrators, Content (2005), Craissati, McClurg, and Browne, (2002), Denov,

(2004), Glasser, Campbell, Glasser, Leitch and Fareli, (2001) and Tozdan, Briken, and Dekker, (2019), found that females also engage in sexually abusive behaviour with children. Common characteristics in all the perpetrators are that they have more authority, physical and social power than the victim. These perpetrators could be anybody; child, adult, man, woman, of diverse ages, occupation, education, income level, or marital status. They may be biological, foster parents, or other family members.

FInkelhor (1994) reiterated that persons who sexually abuse boys might be intra-family perpetrators. This type of abuse can continue over a more extended period than sexual abuse outside the family (Finkelhor, 1994). According to Schachter, Stalker, Teram, Lasiuk and Danilkewich (2009), unlike physical abuse of children, non-parental relatives constituted the largest group of perpetrators (35%) of child sexual abuse. They further mentioned the child's friend/peer (15%), stepfather (13%), biological father (9%), other acquaintances (9%), parent's boyfriend/girlfriend (5%), and biological mother (5%) as some perpetrators of CSA. Majority (54.3%) of the respondents in a study conducted in the Cape Coast Metropolis, Ghana confirms that perpetrators of CSA could also be family members (Sika-Bright & Nnorom, 2013). The victims in another study in Ghana categorised child sexual abusers as boy/girl friend (37.7%); school mates (28.3%); relatives (15.1%); teachers (5.7%); parents (3.8%); school officials and strangers (3.8%) (Agu et al., 2018). Strangers make up the smallest group of perpetrators. Douglas and Finkelhor (2015) rated strangers as a group with the least number of offenders in their factsheet on childhood sex abuse. Pastors have also been found to be perpetrators of CSA (Firestone, Moulden & Wexler, 2009).

Principal perpetrators of the first incident were again primarily known to the respondents and were primarily intimate partners and neighbours (Mwangi et al., 2015). The abusers were mostly friends, classmates, and neighbours for girls and boys victims. The perpetrators of the first incident of unwanted sexual touching were mainly people known to the respondent. Eleven percent (11%) of the victims of CSA in Ghana cried that the act was forced.

CSA and Four-Factor Model

The psychological consequences of CSA have been affirmed by several researchers around the world (Osei, 2016; Resnick, Acierno, Holmes, Kilpatrick & Jager, 1999). According to the American Medical Association (2005), 20% of all victims develop serious long-term psychological problems, which take the form of nightmares, flashbacks, anxiety over sex, and PTSD. Essabar et al. (2015) observed that about 22% of victims of CSA used in their study were asymptomatic. Meanwhile, they identified diverse psychological challenges with CSA victims. These include fear, anxiety, irritability, sleep disturbances, social problems, and inappropriate sexualised behaviour. Cobia et. al. (as cited in Rooy et al., 2015) reported that many victims of CSA who suffered PTSD mostly had challenges with interpersonal, personal adjustment, and social isolation. They further cited relationship problems stemming from feelings of worthlessness, excessive guilt, a heightened level of alertness to the possibility of danger, and an inability to experience relaxation. Victims employ vigilance as a primal survival strategy, and therefore invaluable to the victim (Barber, 2012). Forde (2004) also asserted that girls with a history of CSA in some parts of Cape Coast suffered

developmental challenges, such as low self-esteem, betrayed, vulnerability (Muhammed, 2014).

Finkelhor (1994) maintained that intra-family abuse had more severe and lasting consequences. CSA is associated with greater traumatic sexualisation (Matorin & Lynn, 1998) and greater powerlessness (Bolger & Patterson, 2001). Cantón-Cortés, Cortés and Cantón (2012) reiterated that the dynamic most strongly related to psychological adjustment is powerlessness. Betrayal was the least predictive dynamic. (Senn, Carey and Coury-Doniger (2011) revealed that sexualisation and powerlessness were greater among female victims of CSA as compared to non-CSA females. Many of the female victims described an aversion to sexual activity, because of the forceful way they were first introduced to sex (Senn, Carey & Coury-Doniger, 2013).

Makhija (2014) used the Four-factor model to examine how the symptoms of childhood sexual abuse (CSA) are related to the attitudes of female adolescents' interpersonal relationships. The study was among females in the age range of 13-18 years with a history of CSA who had reported to the Regional Diagnostic and Treatment Center (RDTC) in Newark. The results linked severe sexual abuse to high degrees of betrayal, powerlessness, and stigmatisation, but no significant support between severity and prediction of sexualisation.

Researchers such as Feiring et al. (2009), Finkelhor and Browne (1985), and McCallum, et al. (2012) have enumerated many characteristics that describe each of the factors of the psychological impact of CSA.

Sexualisation

Finkelhor and Browne (1985)

Sexual preoccupations

Knowledge of sex that is inappropriate to their age

Compulsive sex play

Flashbacks

Heightened awareness of sexual issues

Confusion about sexual identity/norms

Fear, anger, sense of powerlessness

Love and caregiving/getting

Avoidance

McCallum et al. (2012)

Daydreaming about sex

Preoccupation with sexual thoughts

Stigmatisation

Finkelhor and Browne (1985)

Feelings of isolation

Self -destructive behaviours

Sense of Guilt/shame

Low self-esteem

Feelings of rejection

Sense of differentness from others

Feiring et al. (2009)

Feelings of dirty about the self

Becomes extremely careful

Guilty or self-blame

Stigmatised

Tendencies to running away

Betrayal

Finkelhor and Browne (1985)

Intensed need for trust and security

Extreme need for dependency

Suspect the trustworthiness of others

Hostility and anger

Desperately look for affirmation in relationship

Isolation

Impaired ability to form a closed relationship

Sudden change in the attachment to primary caregivers

Powerlessness

Finkelhor and Browne (1985)

Fear and anxiety

Nightmares

Hypervigilance

Impaired sense of efficacy

Running away

Powerless to defend themselves against others who are manipulating them

Desire to dominate others, especially, male victims

The above observable behaviours of the psychological impacts of CSA have also been empirically supported by research. In the United Kingdom, for instance, an estimated number of 50 children run away from home before age

16 due to abuse (Safe on the Streets Research Team, 1999). Wise (1990) warned that people with CSA often engage in self-mutilating behaviours than those with no history of CSA. These findings on self-injury had been supported by Yeo and Yeo (1993). They asserted that patients with history of childhood sexual abuse were prone to risk of repeated self-injury. Klonsky and Moyer (2008) also revealed that some CSA victims engaged in self-injurious behaviours.

Finkelhor and Browne (1985) believed shame as a result of CSA is an essential feature that influences social and emotional adjustment. The feeling of shame is a personal attack on the self and instills a sense of dejection and defeat. Continual engagement of CSA victims in the sense of shame can trigger low self-worth (Negrao, Bonanno, Noll, Putnam & Trickett, 2005). Rosenthal, Hall, Palm, Batten and Follette (2005) revealed that persons with an elevated sense of shame were more likely to have increased PTSD and that chronic shame is likely to impede its treatments. Wohab and Akhter (2010) added that the experience of being sexually abused in childhood predisposes one to be distressed, isolated, sad, and sexually uncontrolled. These characteristics may prevail throughout their whole life and affect other aspects of their lives.

CSA and Treatment

The Four-factor model has been applied by researchers on the treatment of diverse areas of human development (Scott, 1992). Walsh, Fortier and DiLillo (2010) studied coping strategies to mediate CSA impact. The results of their study suggested that cognitive variables are critical in the recovery process. Vigilance becomes a valuable survival strategy for CSA

victims, as a way of protecting themselves against future occurrences (Barber, 2012). Dufour and Nadeau (2001) also found that observable behaviours of stigmatisation formed about 65% of the symptoms.

Trask, Walsh, and Dilillo (2011), ascertained a substantial effect of treatments in studies that involved only the victims of CSA than studies with both the caregivers and the victims. They further revealed from the meta-analysis of 16 studies that longer durations of treatments were associated with more significant treatment. Prolonged exposure of therapies was effective for symptoms of PTSD, depression, dysfunctional sexual behaviours, dissociation, and nervousness (Resick, Nishith & Griffin, 2003). Another study on the effectiveness of REBT in the treatment of victims of childhood sexual abuse after 10 weekly sessions of group therapy indicated significant reductions in depression, anxiety, anger, State guilt, and low self-esteem (Rieckert & Möller, 2000).

Conclusion

In conclusion, the therapies described in this work have different ideologies and techniques. Each has assumptions that uniquely apply to the treatment of the Four-factor model of psychological impacts of CSA. REBT, for instance, proposes a cognitive-behaviour-emotive way of how human beings feel, think, and behave. It applies the cognitive behavioural theories approach, which states that the way human beings think about themselves and the world is based on their own emotions and behaviours. Thus, behaviour and feelings are primarily based on what we think, feel, or believe about situations and not the situations themselves. The REBT further proposes that a person's biological make-up and environment can influence the belief system and way

of life. These set some limitations on the extent to which the REBT therapist imparts a change in a victim of CSA, and these changes can occur at different levels. REBT therapist accepts that any of the superficial changes may sometimes be a more realistic option for some CSA victims but aims at the fundamental change wherever possible (Froggatt, 2005).

The REBT sees human beings to be fallible and tend towards rational and irrational thinking. The underlying assumption of this therapy is that unfortunate circumstance itself does not disturb a person but the irrational belief the individual constructs about the situation. It is the irrational thinking that leads to distress, and not the activating event itself (Neukrug, 2011). For instance, an event, in this case, CSA itself does not cause the child to be traumatised. Instead, the irrational belief the victim holds about the sexual abuse that is causing the maladaptive behaviours like hypervigilance.

The therapist shows the child that he/she has a choice to live a healthy life with different cognitive, behaviour and emotive techniques. Therefore, the work of the REBT therapist is to dispute the victim's irrational thinking about sexual abuse and not to focus on sexual abuse.

Adlerian, on the other hand, believes that as the individual develops from childhood, they draw conclusions about life and people based upon their experiences and interactions as children and their interpretations of those experiences. The individual creates their style of life to achieve a sense of superiority. The individual lifestyles have to embrace both self-interest and community interest to achieve a healthy interaction. Despite the environmental influences on behaviour, the environment does not determine human nature. The psychological distress can, however, be changed through the application

of techniques such as early recollection, dream analysis, future autobiography, and acting as if. For instance, sexually abused children could perceive the world to be a wicked place that can cause emotional pain and distress. Such a child is likely to carry this idea throughout his/her life.

Adlerian therapy recognises that it is the immature goals people set for themselves and negative lifestyle orientation that create psychological distress. Adlerian's approach to psychotherapy is a wholistic, total person. Therefore, psychotherapy should incorporate cognitive, emotional, and lifestyle elements. Personalised treatment is done based on the individual lifestyle assessment at the initial interview to understand the individual better. Adlerian therapy is based on helping people gain insight into their behaviours, through a process-oriented program of therapy (Maniacci as cited in Rooy et al., 2015).

Another dominant theory used in this study is the bioecological theory developed by Bronfenbrenner. The basis of the theory is on how individual development is influenced by multiple systems levels such as family, institutions, community, and culture. These factors are critical in understanding how adverse social reactions of CSA exacerbate the trauma of the victim. Studies, for instance, by Campbell, Dworkin and Cabral, (2009) and Ullman (2010) have shown that the effects of these therapies might be influenced by the biological and social factors of the CSA victim. The way the child was groomed for sexual abuse could also affect his or her mental health.

Some incidents of sexual abuse could be premeditated others were not. Each abuser employs different strategies to capture their potential victim. Some use aggressive means, while others use false love. They even sometimes try to create a barrier between the child and significant others in the child's

life. In each case, the victim could adversely be affected and extend to other aspects of life.

Children with history of sexual abuse may or may not be asymptomatic. Those who show symptoms may exhibit them through diverse avenues. Finkelhor and Browne (1987) developed a model to explain the cause and the effect of abuse. They grouped several negative observable behaviours into four factors. According to them, what makes this model unique to CSA is that a victim may exhibit all the factors, unlike the other forms of child abuse where a victim does not demonstrate all the factors.

Chapter Summary

Chapter 2 - review of related literature discussed the main concepts in this study. It looked at the primary forms of CSA, grooming, strategies and behaviours, the content of group therapy, and the psychological impact of CSA. This Chapter also discussed the tenets of REBT, which is useful in disputing clients' irrational beliefs (B) and replacing them with new effective behaviour and feelings. Also, IP, which considers individual uniqueness as necessary in therapy was reviewed. Bronfenbrenner's bioecological system of human development maintains that the interplay between the environment and biological characteristics influence the child's development was also discussed. This theory showed how CSA affects the victim. The chapter also looked at some studies on CSA. A framework was designed to depict how all these elements could be brought together to influence the psychological well-being of victims of CSA.

CHAPTER THREE

RESEARCH METHOD

Introduction

The primary purpose of the study was to adapt the techniques of Rational Emotive Behaviour Therapy (REBT) and Individual Psychology (IP) to treat the psychological impact of CSA victims. The chapter begins with a discussion on the research paradigm, design, and the study area. The Chapter also looked at the population, sampling procedure, and ethical consideration. The data collection instruments, their psychometric properties, data collection procedure as well as the analysis of the research questions and the hypotheses were discussed.

Research Paradigm

The approach employed in this study was mixed-method. Mixed-method research allows a researcher to collect, analyse data, and draw inferences using both quantitative and qualitative approaches in a single study (Tashakkori & Creswell, 2007). For instance, the naturalists are of the view that the appropriate method of inquiry is the use of qualitative or narrative (Polit & Beck, 2004). The positivists, on the other hand, hold that data can be meaningful through the application of numbers with statistical analysis (quantitative). These two approaches separately would not be satisfactory for this kind of study. For that reason, the mixed study method was best suited for this study.

Research Design

The type of mixed-method design used in this study was the embedded experimental method or the concurrent nested mixed-method (Creswell & Plano, 2011). It is the type of mixed study which applies different methods, but one set of data supports another data type. For an extensive and in-depth understanding of the participants' lived experiences and the application of the treatment strategies, the qualitative approach was subsumed into the quantitative approach. The results would have been non-exhaustive without the techniques from both the quantitative and the qualitative approaches. Among the quantitative approaches, the most appropriate one for this study was the Pre-test-post-test Quasi-Experimental Research Design because of the use of intact groups in the current study. The purpose was to test for the effectiveness of intervention (REBT and IP) methods for the victims of CSA in basic schools.

The random assignment of the participants into the three experimental groups was not possible. Any attempt to randomly assign the subjects would have disrupted the schools' activities. Therefore, intact groups were used. To mitigate the adverse effect of the intact groups, each school selected to represent the experimental groups was far apart from each other. To further strengthen the result of the study, equivalent groups and appropriate data analysis tools were used. Gay, Mills and Airasian (2009), warned that if randomisation is not possible, the best approach is the quasi-experimental design as it provides adequate control of threat to validity.

The qualitative approach served as secondary data for the substantive survey. The interview described the subjective reality of the CSA victims and

described how their victims entrapped them. It further provided detailed information and clarification on any of the other items listed on the questionnaire (Glesne, 2005; Patton, 2006).

Study Area

History has it that the Central Region was originally part of the Western Region of Ghana. In the year 1970, it was carved out as a separate region. It shares boundaries with Ashanti on the north, Western on the west, and Greater Accra on the east. The southern part of the Central Region is the Gulf of Guinea. The Region is also adorned with a wealth of beaches, forts, castles, and vibrant festivals. The World Heritage Foundation under UNESCO has identified some of these forts and castles as World Heritage Monuments (UNESCO, as cited in Boakye, 2009).

The region houses about 8.9% of the nation's population. As per the 2010 population census, 309, 621 children between 12-17 years were married in the Region. The same report showed about 0.7% and 2.7% of the population, ranging from 12-14 years and 15-19 years respectively, were in consensual sexual relationships. It further revealed that about 2% of the population had teenagers of 15-19 years as the heads of the household. The statistics indicated that the population of the Central Region is quite youthful (Ghana Statistical Service, 2012). The Cape Coast Metropolis forms about 7.7% of the Region's total population as at 2010. The Metropolis once served as the centre for the spread of European culture, civilisation, and secondary education to the other parts of the country (Ghana Statistical Service, 2014).

Many families living below the national poverty line, lack of schooling among the children, and early marriages were some challenges faced by the

Metropolis. There were also the issue of children not living with their biological parents (Ghana Statistical Service, 2014). However, both parents may be alive and healthy. Many of the children also came from single-parent families, which were usually headed by mothers. The poverty level makes catering for children's needs difficult and sometimes impossible. Consequently, children are often required to work to contribute to the family's upkeep and cater for themselves and other dependents. All of these factors make children vulnerable to various forms of abuse (Government of Ghana/UNICEF, 2013).

The 2010 population census affirmed that the children were vulnerable to various forms of sexual activities. The census revealed that commercial sexual exploitation of children is very rampant (Ghana Statistical Service, 2012). Additionally, the Government of Ghana/UNICEF (2016) reported that 59.3% of children were engaged in exchanging sex for money and other favours. There was a 42.9% rise in the defilement cases between 2015 and 2016. In 2016 alone, the Domestic Violence and Victims' Support Unit (DOVVSU) of the Central Region recorded 273 defilement cases. Cases of rape also increased from 38 in 2015 to 56 in 2016 (Cases of defilement, rape increase in Central Region, 2017).

Similarly, the office reported a 28% increase in sexual abuse among female victims younger than 16 years. Alternatively, adult abusers of sexual relationships rose by almost 26% in 2017 (Cases of defilement, rape increase in Central Region, 2017).

In recent times, the Central Region has come under the severe attack of CSA in the media. The media reported a case of defilement which involved

a 4-year-old victim in a village within the Central Region (GhanaWeb, 2017, October). In another report, four men were arrested for sexually assaulting two girls. The men abducted the two girls and took turns to have sex with them for one week (Abbey, 2020).

Population

The target population for the study was the victims of CSA in the Cape Coast Metropolis, Central Region. It included in-school boys and girls in the age range of 12-17. The accessible population was the respondents in Junior High (JHS) levels 1 and 2 in the three selected primary schools in Cape Coast. Each of the selected three schools was represented by the name of a therapy to fully conceal the identity of the CSA victims used in the study. School children served as the respondents because they also experience CSA but their opinions are mostly ignored. The children also were reluctant to confide in their guardians (Sika-Bright & Nnorom, 2013). This complements the report of Boakye (2009), London, Bruck, Ceci and Shuman (2005), McElvaney (2019), and Sanderson (2006) that victims of CSA and their dependents usually do not report to appropriate office such as DOVVSU, and the hospitals, denying themselves of therapy. Subsequently, the study was carried out in some selected basic schools in the Cape Coast Metropolis.

There were a total of 378 students from all the three selected schools (Cape Coast Metro of Education, 2018). However, not all the students were available in the schools at the time of the data collection. Table 1 depicts the three selected schools, which are replaced with the names of the treatment groups, and their respective enrolment for JHS 1 and 2 levels based on gender.

Table 1- Gender Distribution of Students from all the Three Schools

School/Groups	Control		IP		REBT	
Gender	Boys	Girls	Boys	Girls	Boys	Girls
JHS 1	29	29	24	41	38	43
JHS 2	25	24	26	11	48	40
Total	54	53	50	52	86	83

Source: Cape Coast Metro of Education (2018)

Sampling Procedure

The multi-staged sampling procedure was used to select the sample size. The purpose of the study was to use two therapies and a control group to alleviate the psychological pain of CSA victims. Randomization of the subjects would have disrupted the activities of the school, hence intact groups were used. Three schools were randomly selected, where a school served as one experimental group for the study. The simple random sampling method was used to select the three schools from 61 basic schools within the Cape Coast Metro of Education in the Central Region of Ghana (Cape Coast Metro of Education, 2018). Each school had an equal chance of been selected for the study.

Using the lottery method, the researcher coded the names of the 61 schools with their initials, put all of them in a box and blindly selected three coded papers, one at a time. A selected school was marked and then put back into the box. This process continued until three schools were selected (Cohen, Manion, & Morrison, 2005). Statistics from the Cape Coast Metro of Education (2018) gave a total number of students as 378 in all the three selected schools. However, only 286 students were available in the schools at

the time of the data collection. Hence the sample size for the quantitative data was 286 students.

The purposive sampling procedure was then used to select the participants for the experiment. The sampling was purposively done because not all the students from the selected schools had a history of child sexual abuse. Two major selection criteria were used to qualify a student to be part of the experimental groups. A respondent must have had at least one sexual act. This criterion is in line with Sanderson's (2006) assertion that a single sexual activity with a child is tantamount to sexual abuse. The second criterion is that in addition to the sexual act(s), the individual's State of Mind should be Somehow and above, ie. a score between 61 – 100 (Section C, Appendix C). One hundred and forty nine respondents from all the three schools met these criteria after the administration and the analysis of the questionnaire.

However, only 47 of them willingly accepted the invitation for the individual interview. For quasi-experimental studies, Gay et al. (2009) endorsed equivalent groups to ease the adverse effect of the intact groups. Yalom and Leszcz (2006) also recommended that effective group counselling should be between five to ten members. The stratefied sampling procedure was adopted to get the appropriate group size and gender representations in each of the groups.

There were 17 respondents from the REBT school, nine females and eight males. Cohen et al. (2005) clarified that the researcher's discretion could serve as a criteria to determine the size of each stratum. Subsequently, a proportion of 55% and 45% were respectively selected from the gender to represent the group. After the presentation on CSA and the interview, eight

victims were selected for the treatment. Of the 19 respondents who accepted the invitation in the IP school, three did not want to participate. Eight females and eight males remained after the individual interview, from which 50% was selected to represent each gender. Eleven respondents comprising six females and 5 males were interviewed from the school allotted the control group. After this process, there remained eight victims in each group, making a total of 24 members.

The researcher considered a sample size of 24 appropriate for the study because it was in line with what authorities such as Yalom and Leszcz (2006) have recommended. They asserted that too big or small size is usually not effective. Moreover, Borg and Gall (as cited in Cohen et al., 2007) advised that experimental research requires a sample size of no fewer than 15 cases. Table 2 summarises the multi-stage sampling procedure used to arrive at the sample size of 24 (eight members in each of the three experimental groups.

Table 2 - Tabular Description of the Sampling Procedure and the Technique

Sampling Technique	Sampling Stage	Size
Simple Random Sampling (Lottery Method)	Accessible Population	Three Schools (286 respondents)
Purposive Sampling Method	Sample size (experiment)	24 (8 members in each experimental group)
Stratified Sampling Method	Gender	4 boys and 4 females in each experimental groups

Source: Field Survey (2019)

Data Collection Instruments

The four data collection instruments used in the study were all adapted from the major theories used in the current study. These were the pre-test survey and interview guide; and post-test survey and interview guide. The pre-test survey (Child Sexual Abuse Inventory, CSA-I) had a total of 35 items spread under three main sections. Section A – Demographic Section had three items. These items were the respondent's age, gender and family background.

The Section B – Sexual Abuse Acts had six physical contact and six non-physical contact types of sexual activities. The items for both the physical and non-physical contact activities were carefully selected from the list of sexual behaviours enumerated by Sanderson (2006). Researchers such as Essaber et al. (2019), Sawyer et al. (2004) and Shakeshaft (2002) have also found these behaviours as some sexual activities that have been experienced by victims of CSA. The respondents were to select from all the 12 sexual acts that applied to them. These were Yes/No statements. Even a Yes response indicated that the respondents had endured that particular sexual activity. Sanderson proposed that a single incidence of sexual activity with a child infers sexual abuse. More than one implies multiple sexual abuse activities.

The third Section – State of Mind, measured the four factors of psychological impact on CSA victims. There were four main constructs within this section, namely, sexualisation, betrayal, stigmatisation and powerlessness as developed by Finkelhor and Browne (1987). Finkelhor and Browne (1985) categorised the psychological impact of CSA under four major factors and enumerated several corresponding behaviours for each of them. The four constructs and their observable behaviours in the questionnaire were adapted

from Finkelhor and Browne's (1985) model of assessing the state of mind of victims of abuse. Barber (2012), Makhija (2014), and McCallum et al. (2012) confirmed tthese variables occurring as consequences of sexual abuse on the victims.

Each of the constructs had five observable behaviours that measured that particular factor, making a total of items 20 in this section. There were a mixture of positive and negative items (Appendix C). This section used a five-point likert-type scale – Not at all, Little, Somehow, Much and Very Much, with numerical values ranging from 1 – 5, respectively. The respondents were required to tick (√) one scale for each observable behaviour for all the 20 items. The total responses between 1 – 40 indicated no or little psychological distress, 41 – 60 means mild, 61 – 80 represented moderate, and 81 – 100 indicated severe psychological distress of the victim. The cut-off point for the severity of the psychological symptom was "Somehow" (Section C, Appendix C) for each of the four factors, a total scale between 61 – 80. All those who selected "Not at all" and "Little" for all items were ignored after the screening stage, even if there was a definite "Yes" response for the sexual abuse act (Section B, Appendix C). The respondents who had 61 or more scores and had a "Yes" response to the childhood sexual activity were selected for the interview and treatment.

The pre-test interview guide contained seven items, two on the victim's data, and five on the abuser's identity and the grooming strategies used (Appendix D). These five items were adapted from the proposed guide by Faller and Everson (2014). The guide recommended that at least three contextual information should be confirmed by the victim. The interview was

to get further details of the sexual abuse experiences of the 24 selected participants and to substantiate their information provided on the questionnaire.

The two pre-test instruments described above were modified for the post-test. In the post-test questionnaire, only Section C - State of Mind, comprising 20 items was used. Since their demographic data and CSA situation had already been established, Sections A and B were omitted. Regarding the post-test interview guide, three items were formulated to assess the psychological state of the participants after the treatment.

Trustworthiness of the qualitative data

The study adapted the trustworthiness benchmarks developed by Lincoln and Guba (1985). Shenton (2004) suggested that credibility could be achieved through the application of data collection and analysis procedures used in previous projects. Consequently, the interview questions were developed from Faller and Everson (2014) proposed guide for assessing CSA victims. Then again, the thematic analysis used to analyse the qualitative data in this study had been largely used by other related studies (Kerr & Beech, 2015; Sultan, Khawaja & Kousir, 2016).

To further strengthen the credibility, the study ensured that a prolonged engagement between the researcher and the participants was attained (Nowell, Norris, White & Moules, 2017). There was a powerpoint presentation to enlighten the respondents on the CSA. This presentation created a relationship between the researcher and the participants and paved the way to share their experiences. The nature of the interview being in-depth also enhanced the credibility of the study. The one on one interview between the therapists and

the participants before the group discussions also helped to establish rapport with the members. Group members were also assured of confidentiality which encouraged them to be open as possible from the onset of the data collection.

Shenton, (2004) further recommended that triangulation could be used to achieve credibility of qualitative research. For this reason, the individual interviews, focus group discussions, and some amount of observation were employed in the data collection. The researcher had a peer debriefing with the two therapists and the research assistant. The comments from the peer scrutiny were discussed with my supervisors. These meetings drew my attention to some mistakes in the interview guide, analysis and the final report, which were rectified.

Validity and reliability of the instruments

Using Cronbach's alpha, the psychometric properties of the various sections of the questionnaires were ascertained. Section B – Sexual Abuse Acts with 12 items had reliability of $\alpha = 0.766$. The reliability values for the various constructs in Section C were; Sexualisation ($\alpha = 0.772$), Betrayal ($\alpha = 0.764$), Stigmatisation ($\alpha = 0.754$) and Powerlessness ($\alpha = 0.791$), had a total of ($\alpha = .769$). The reliability of the survey was adversely affected by reverse coding of the positive items (observable behaviours) in this study (Dimitrov, 2012). Notwithstanding the total reliability of the 35 items ($\alpha = 0.769$), the results of the study are genuine, accurate, and reliable. Both the pre-test and the post-test interview guide were also valid and had an element of trustworthiness.

Validity is the degree to which an instrument measures and functions what is supposed. To establish this, the variables in the study were adequately

tested and represented in the different instruments used (Cohen et. al., 2005). The researcher's supervisors and other experts checked for the content validity of the items and the necessary corrections were effected to reflect the purpose of the study.

Pilot Testing

The pilot testing of the instrument was done mainly to check for its reliability and to correct any ambiguous items. Through the pilot testing, the researcher was confident of meeting CSA victims with psychological impacts from the schools. In view of this, adolescents' students were used for the pilot testing. The respondents shared similar characteristics such as the ages and the gender with the respondents used in the main study.

The pre-test questionnaire was pilot tested in Ankaful M/A, St Lawrence Catholic' A', Wesley Girls, Pedu M/A 'A' and Akokokrom Basic schools. A total of 50 students were randomly selected from these basic schools, all in the Central Region, to assess the reliability of the questionnaire. Browne (1995), emphasised that in any type of research, respondents above 30 may be appropriate for the pilot test. It took an average of 40 minutes to answer the original 36 items on the pre-test questionnaire (CSA-I), and they were collected on the same day.

Ambiguous statements such as "I easily become angry" were rephrased to "I get angry when I think of the abuser. Also an item like, "I worry" was changed to, "I worry about the abuse most of the time." After the analysis and face-value assessment of the responded instrument, one item in Section A, 'where do you stay?' was omitted from the final questionnaire. It was found to

be irrelevant. This reduced the items from 36 to 35 for data collection in the main study.

Ethical Consideration

The accepted proposal was sent to the University of Cape Coast's Institutional Review Board to obtain Ethical Clearance (Appendix B). This letter indicated to the participants the purpose and nature of the study, as well as their rights. It also spelled out other stringent ethical research standards that must be followed.

Studies of this kind come with peculiar ethical challenges, such as the vulnerability of the children, confidentiality, uncertainty about their safety, and how much information they can give. To deal with the vulnerability of the children, adults participating were significant. During the individual interviews, the participants gave names of trusted parents/adults who could provide consent for them. These children, however, did not want their parents to know about their sexual abuse experience. This apprehension was partly because of their parent's reaction at the time of the first disclosure of sexual abuse. The participants were rather more comfortable with some teachers and the school counsellors due to trust and affability. Ideally, parents of an abused child could give consent for research of this nature. However, where parents' involvement is perceived inimical by the child, researcher, or both parties, to the child's life, another close adult of the child could step in for the purpose (Council of International Organisations of Medical Sciences (CIOMS), 2016). Consequently, the children chose trusted teachers in the school to provide informed consent. These teachers led the research team to the parents of the 24

participants to inform them about an on-going school's programmes. The parents consented and agreed to release their children after school.

Other stringent ethical standards observed included the safety of the participants. No child was forced to participate in the study. The participants were given a chance to decide on whether to participate in the research or not. They were at liberty to exit the study at any point. Those who were not willing to continue, irrespective of their score, were withdrawn from the study. They were not coerced into anything they did not wish to do. They were also advised on their rights. Helplines (supervisors' and the researcher's phone numbers) were made available to the participants to call at any time, should the intervention process become distressing to them. The researcher used age-appropriate language and involved the children in all the decision-making processes.

To further protect the participants, the names of the schools were replaced with the names of the therapies. Code names used during the entire period of the treatment were given to both the participants and the counsellor(s) to conceal their identity. Only the researcher and the counsellor(s) were privy to their real identity. The researcher could not use the privileged information to disgrace a child or divulge to a third person, without the child's consent. The proof protection, understanding and trust from the research team strengthened the therapeutic relationship, which is necessary in counselling.

Data Collection Procedures

Aside from the designing of the data collection instruments, other things were also prepared before the actual data collection exercise. Three

field assistants, two counsellors, and a research assistant were trained for a day, to help in the data collection process. They went through the purpose of the study and their responsibilities. Some of the areas discussed during this training were the rights of the participants, consent seeking from the participant's parents, confidentiality, and the strategies in the two different therapies. These field assistants were necessary because Faller (1990) asserted that it is necessary to use multiple therapists in sensitive issues. Faller further specified that the co-therapy enhances a researcher's ability to efficiently and independently affect therapeutic change without personal influence.

The two counsellors were Ph.D. (Guidance and Counselling) students who are practitioners. They led the treatments in both groups - one for the REBT group and the other for the IP group. They also helped in the administration of the survey. The research assistant was a Master's student (Special Education), UCC, who also assisted with the administration of the instruments. The data collection procedure was in three phases:

Phase 1 - Permission-seeking and screening

Letters of introduction (Appendix A) and ethical clearance (Appendix B) obtained from UCC were sent to the heads of the three participating schools. The researcher also discussed the purpose and the nature of the research with the various headteachers, and they were willing to allow their students to participate.

The research team went to the schools on the scheduled dates. In each school, the researcher held about 30 minutes power-point presentations on child sexual abuse. The presentation on CSA was necessary since children are

uncomfortable to disclose their CSA experiences. It eased up the pressure to share their experiences, knowing there was help for them.

The presentations focused on the meaning of CSA, causes, forms, nature of abusers, signs and effects of CSA for all the students in the JHS 1 and 2 levels. The presentation aroused the interest of the students and motivated them to ask questions or confusion about sexual abuse. These questions were addressed accordingly. Some expressed how the thought of the abuse frightened them. Afterward, the pre-test questionnaires (CSA-I) were given to all the students in the room to respond. The research team also attached a piece of paper to each questionnaire for the respondents to write their names. The field assistants went round to collect the papers and the questionnaires. Each piece of paper was securely attached to the respondent's questionnaire and later was sought out. These pieces of papers were for easy identification of the abused children and their continued participation.

The sorting of the questionnaires into abused, non-abused, asymptomatic, and symptomatic lasted for about two days. This process was achieved based on the two primary selection criteria. The respondent must at least have one sexual act. The other criterion was that, in addition to the sexual acts, should have the State of Mind be somehow and above, ie., a score between 61 – 100 (Section C, Appendix C). The respondents who had 61 or more scores and had a "Yes" response to the childhood sexual activity were selected for the interview and treatment. After this sorting process, the research team went back to the schools to meet the respondents who met the criteria for the individual interview. The victims' statements were considered as true and genuine; for respondents' comments after the presentation and

during the individual interviews revealed some emotions, such as reluctance, embarrassment, anger, anxiety, disgust, and depression that were consistent with the narration (Faller & Everson, 2014). Moreover, their knowledge of sexual activities was beyond their developmental age (Faller & Everson). The team obtained informed consent from the parents of the respondents who responded to the invitation and were willing to participate.

Phase 2 - Anxiety reduction and group intervention

These selected participants in the three experimental groups went through individual sessions (*session 1*) with support from the counsellor assigned to the group. This individual counselling helped us to explain the procedures to the victims, encouraged them to participate fully, assured them of confidentiality, and gave sufficient information concerning the study. The individual sessions again helped to reduce their level of anxiety and build a therapeutic relationship between the therapist and the victims (Anderson & Mayes, 1982).

During the individual counselling, Code names were given to both the victims and the counsellor(s) to conceal their identity. It was the code names that were used during the entire period of the treatment. The inventories and other documents about the victims were secured, even from the school counsellors who helped in organising the students. Only the researcher and the other counsellor were privy to their real identity.

The second stage of phase two was for group interventions. After the first session (anxiety reduction and relationship building), the remaining seven sessions were used for REBT and IP group meetings in their respective schools. The first group meeting continued the relationship building and

ground rules in both groups (*session 2*). The members introduced themselves to one another, though some were already classmates. Because the school authorities chose the meeting time and place, the counsellor only informed them about it, which they agreed. The counsellor explained to the members the importance of the group meetings. Group participation is often more empowering than individual therapy for victims of CSA. The therapeutic group is necessary for the feelings of the safety of the participants. It also encourages the use of personal power (Gans & Weber, 2000). Each member was given a chance to ask a question and expressed his or her fears. The counsellors then asked them to set some group rules to protect the members of the groups. Some of the ground rules are as follows:

1. no discussion on the study outside the group meetings,
2. respect for each. This rule was essential to the members because they were not from the class and levels,
3. avoid the use of abusive words
4. no teasing
5. not to talk to friends or mates who are not part of the meetings about the sessions.

The counsellor(s) on their part added these three rules which were also agreed on by the members:

1. be active members of the group
2. do all assignments given
3. a member leaves the group when he or she discusses another member's issues with someone else.

Details of the therapies in the various groups (schools)

The members and the counsellor in the two therapy groups agreed to meet after school hours for one hour each day. The following is a summary of a proposed itinerary in each of the therapies:

Session 3 – Explained the REBT process and techniques to the participants.

The counsellor took the members through the process of the REBT procedures. According to Ellis (2000), the counsellor must teach the client the ABC model. The counsellor explained the A is the activating event, which is the CSA. He further explained that the B in Ellis' model is irrational beliefs. The irrational beliefs are the observable behaviours for the Four-factor model of the psychological impacts of CSA. Some of the irrational beliefs were; 'my friends are more attractive than me,' and 'my parents do not care for me because of the sexual abuse.' He also taught them the C in the REBT. He explained that C means the consequences of such irrational beliefs, such as running away from their abusers. He further explained that it is not the A (sexual abuse) that was making them run away from their abusers. Instead, it is the erroneous belief they had entertained about the sexual abuse that was making them behaved that way. Hence the purpose of the group meetings was for him to support (D – Dispute) them to overcome the challenges (E – Effective living).

Session 4: Negative self-verbalisation/ coping statements.

The victims were guided to identify some of their irrational thoughts. They mentioned some as 'my parents must understand my abuse experience,' and 'I do not have any friend because I am not beautiful.' The REBT counsellor

explained how continuous verbalisation of these negative statements could affect their lives.

Session 5: Rational emotive imagery.

The victims in the REBT group were made to picture their first encounters with their perpetrators. These clients were made to maintain these negative images and were stimulated to work on changing the unhealthy feelings attached to the experiences (Ellis, 2000). The counsellor helped them to understand these feelings and beliefs. Afterwards, the dysfunctional beliefs were disputed.

Session 6: Shame attacking.

The victims were taught to confront their fears. The counsellor challenged the members to do what they could not do previously as a result of sexual abuse.

Session 7: Problem-solving skills.

This session was aimed at helping the victims to overcome their daydreaming about the CSA. It was to teach them self-control measures that will aid in bringing their minds back in class when they begin to daydream.

Session 8: Assertiveness training

The counsellor explained to them how to identify their unique qualities and use them for their benefits. They were guided to identify some of the strength they possessed. This last session was also used to prepare the members for the termination of the treatment. The members were encouraged to call the therapist or the researcher whenever necessary.

The following gives details of the activities in the IP group meetings:

Session 3: Therapeutic relationship.

This session followed off from the anxiety reduction and the relationship-building session. In session three of the IP group, the counsellor also continued with the relationship building because it is the first phase of Adlerian therapy. Adler's therapeutic relationship is based on friendship, mutual respect, and instilling hope in the victims. For this to occur, the therapist must listen attentively and pay attention to the client's facial expressions and other gestures.

Session 4: Assessment and analysis of victim's lifestyle.

This phase revealed that most of the victims felt that their abusers were right to have done that to them. There were three categories of CSA victims in the IP group. However, each of these groups met the criteria and had some form and level of psychological distress. The first category was those who were worried about the abuse initially but later felt that once it had happened, it was okay to continue the sexual relationship. The second classification on the other hand, was thinking of how to stop the sexual relationship but was afraid of disapproving comments from their friends. The third category was those who were ashamed of the sexual abuse experience and felt terrible about themselves.

Session 5: Insight and interpretation.

From the assessment and analysis of the victim's life, the counsellor got to understand their motivation for being in the group. The question was raised, 'how would you have lived your life if you had not first experienced the sexual abuse?'. Some of the answers were: '... wait till marriage', '... not to have

engaged in this sexual relationship', '… focused on my studies'. Some of them also mentioned that they would have had good results because they usually daydream about it in class. The thought takes their minds off their studies most of the time.

Session 6: Reorientation and re-education (future autobiography)

Adler described this stage as the action-oriented phase. The members were encouraged to set new and positive goals in life. The first category of victims in the group got to understand that their goals in life were faulty and agreed to change them. In contrast, the second and third categories of the victims were encouraged to accept the situation and embrace positive change.

Session 7: Reorientation and re-education (Acting "as If").

To further encourage them to focus on their potential and strengths, they were tasked to act like what they wished to be. Most of the victims were involved in football. The school was vibrant in training their students to participate in the football club established by the school, in collaboration with an NGO. The football was one of the potentials identified, and they were encouraged to channel their energies to it. Those who were not interested in football concentrated on what will help them achieve their goals in life. They were happy doing that. This strategy offered them the zeal to see how it feels to be what they wished to be in the future. Therefore, they were encouraged to maintain the new desired behaviour to achieve their new goals in life.

Session 8: Reorientation and re-education (soup-spitting).

Soup-spitting is a confrontation skill used by the counsellor to prove to the participants that the excuses were just something they made up to avoid living a responsible life. The members made illogical statements like it is a

'boys-boys' thing. "Everybody does it. So, it is okay for me." "I cannot stop myself from seeing her. But I want to stop it because it disturbs me a lot." They were comfortable with these excuses and preferred to procrastinate stopping that particular lifestyle they enjoy yet knew it was not suitable for their healthy development. The counsellor used a soup-spitting strategy to make the victims realise that their excuses were not worthy.

After learning a new positive behaviour, the therapists duly prepared the members for the termination of the group meetings. The members were also encouraged to contact the counsellors or the researcher if need be.

Phase 3: Follow up and post-test

The last phase of the treatment was used for follow-up and the administration of the post-test. The three-week interval was to ensure that the change was permanent, teachers and school counsellors attested to the positive change among the members in the two treatment groups. During the follow-up, the researcher presented the field notes written by the two therapies to the respective member. This debriefing was to further ensure the credibility of the data (Lincoln & Guba, 1985). The process was followed up with the individual post-test interview and the questionnaire to assess their state of mind after the treatments. The research had one individual session with the members in the control group after the post-test. They were, however, informed to call for further sessions whenever they feel the need.

Data Processing and Analysis

To answer the research questions and test the hypotheses, the following statistical methods were applied to analyse the data collected:

For research question one, there were 12 (six physical and six non-physical contact sexual behaviours) multiple response items (Appendix C). A frequency count was calculated for the items before running the frequencies and percentages. Research question two was to find out which of the four factors was predominant among the victims of CSA. The means and standard deviation were calculated for all the Four-factor models.

Research question three was qualitative. The principles of thematic analysis were adapted to examine the 24 participants' responses. This approach could be modified (Braun & Clarke as cited in Nowell et. al., 2017) to produce a clear and organised report (King as by Nowell et al.) for the study. The first step in the thematic analysis was to familiarise oneself with the qualitative data collected (Nowell et al.). The participants did not agree for the researcher and assistants to tape record the sessions. The team therefore resorted to notes taken during the one-on-one interview and throughout the group meetings. All field notes were compiled by the therapists at the end of the last treatment sessions. Pseudonyms for each participant were developed to identify their respective narrations. The themes for the various sessions were used to organise the data and were secured in a safe.

The second step was to develop initial codes. The themes were generated manually and later were given a colleague to do peer debriefing (Côté & Turgeon as cited in Nowell et al., 2017). Coding is the process of labelling data into various segments. The initial phase of the coding was to do a line-by-line assessment of each victim's narrations. In so doing, similar words, expressions, and ideas in the narrations were marked. The third step of thematic analysis was to search for themes (Lincoln & Guba, 1985). The

coding was to summarise the marked expressions into the same categories based on prior findings by other researchers. Similar expressions were brought together to form major and sub-theme themes. Afterwards, coherence in the developed themes and all the necessary corrections were made (Nowell et al., 2017). Any redundant theme was either discarded and/or combined with related ones. Further modifications in the themes as well as debriefing continued to reflect the exact experiences of the victims. Finally, the major themes and the various divisions were tabulated and a concise report was written, with direct quotes from some participants.

Hypothesis one was to compare the mean difference and the experimental effects among the three experimental groups. The Kruskal Wallis test was selected to analyse the quantitative data for the hypothesis. The result was supplemented by qualitative data. Thematic analysis was used to derive the themes from the victims' narrations. The techniques helped to code the victims' expressions into various themes. This approach was selected to analysis the lived experiences of the participants because of its flexibility (Braun & Clarke, as cited in Nowell et al, 2017). These different data were analysed separately in the result section and were converged in the discussion of the results. This method of analysis is appropriate because it was equally effective in the research by Mizrahi, Rosenthal, & Ivery, 2001; Sieber et al., (as cited in Cresswell & Plano, 2011).

Hypothesis two was intended to rank the Four-factor model of CSA to ascertain which one had the highest interaction with the two therapies. As stated by Field (2009), Friedman ANOVA is used for testing differences between more than two conditions with the same participants.

Chi-square test of independence was used to analyse the data for Hypotheses three and four. Since this type of test uses categorical data, it was necessary to categorise the continuous data (Field, 2009). With hypothesis three, the Chi-square helped me to assess the association between age and gender of participants and the effect of the groups. The ages were categorised into 12 – 14 as early adolescents and 15 - 17 years as middle adolescents. The difference between the pre-test and the post-test scores, that is the effect, were categorised into two; from negative to three were labelled as low and four and five were graded as elevated effect. Concerning the family background (hypothesis four), the various dimensions were categorised into two groups – Biological and Non-biological parents. Those victims who indicated that they stayed with both parents, mother alone, or father alone were brought together to form the biological parents. Moreover, all the remaining living conditions (siblings, friends, aunties, uncles, and self-care) were brought under one umbrella to be the non-biological parents.

Chapter Summary

In sum, the chapter discussed all the elements that made up the methodology of the research. Specifically, the Chapter discussed the research design, study area, population, sample, and sampling procedure. The data collection instruments and data collection procedures were described in detail. The description included reliability. The chapter also discussed how the data collected were analysed. The next chapter looked at the detailed discussion of the analysis of the data collected.

CHAPTER FOUR

RESULTS AND DISCUSSION

Introduction

The primary purpose of the study was to apply the strategies of Rational Emotive Behavioural Therapy and Individual Psychology to treat the four factors of the psychological impact on sexually abused children in the Cape Coast Metropolis. Questionnaires were administered to screen 24 participants from a sample of 286 students. The results from both the survey and the interview have been analysed and discussed under three main sections. The first section presented the demographic data on the 286 survey respondents. This section ended with a composition of the 24 experimental participants. The 24 participants were involved in the experimental study, comprising eight members in each of the groups. Then the interview guide was used as an additional instrument to elicit more information from the 24 participants. The results of the demographic data were presented in percentages, frequencies, and charts.

The second section focused on the analysis and the interpretation of the findings of the survey (286) and experimental groups (24). For confidentiality and anonymity, the names of the schools have been replaced with the experimental groups (REBT, IP, and Control). The results of research questions one and two were presented in percentages, frequencies, means, and standard deviations. The thematic analysis was used to analyse the interviews to answer research question three. The thematic analysis supplemented

Kruskal Wallis test for hypothesis one. Friedman's ANOVA was used to analyse data to test for hypothesis two. Chi-square was also employed to analyse the data for the hypotheses three and four. The last section mainly focused on the discussion of the findings on the research questions and the hypotheses. The data were collected from three schools within the Cape Coast Metropolis. However, the random assignment of the participants could not be possible. Hence, the results could not be generalised to other sexually abused children outside this range.

Section 1 – Description of Participants' Bio-Data

The background information on the demographic characteristics of all the respondents is presented in this section. It centred on their enrolment in the schools, age, gender, family background, and sexual abuse cases (Appendix C).

Table 3 illustrates a frequency distribution of how many students were in each of the groups/schools. The first column lists the names of the groups which represent a school used in the study. The frequency category displays the frequency of students' enrolment in the participating schools. With no preference or criteria, each school was assigned a treatment group; REBT to one school, IP to another, and Control to the third school. As at the time of data collection, there were 127, 82, and 77 students in the various participating schools assigned the REBT, IP, and the control groups, respectively. These frequencies were converted to percentages in the percent column (44.4%, 28.7%, and 26.9%), respectively.

Table 3- Distribution of Participating Schools

Groups/School	Frequency	%
REBT 'School'	127	44.4
IP 'School'	82	28.7
Control 'School'	77	26.9
Total	286	100.0

Source: Field survey (2019)

Table 3 further reveals a total of 286 students in all three schools/groups. The school with the highest number of respondents had 127 enrolments, and this represented the REBT group.

Table 4 shows the age of the 286 participants. They ranged from 12 - 17 years. The frequency for the ages was converted to percentages.

Table 4- Distribution of Respondents by Age

Age	Frequency	%
12	19	6.60
13	81	28.32
14	87	30.42
15	49	17.13
16	27	9.40
17	23	8.00
Total	286	100.0

Source: Field survey, (2019)

The age distribution of the respondents, as shown in Table 4, revealed that most students were within 14 (87, 30.4%) years of age, with 17 (23, 8.0%) years having the least representation. Among all the respondents used in the survey, children aged 12 years were the least in all the three schools.

Table 5 is a frequency distribution for the gender used in the study. The frequency and percent columns show that the females formed 55.6%, while the males were 44.4% of the respondents.

Table 5 - Distribution of Respondents by Gender

Gender	Frequency	%
Male	127	44.4
Female	159	55.6
Total	286	100.0

Source: Field survey (2019)

From Table 5, the majority of the respondents used in the study in all three schools were females.

Table 6 demonstrates the distribution of the respondents' family background at the time of the data collection.

Table 6 - Distribution of Respondents' Family Background

Type of Home	Frequency	%
Both parents	143	50.0
Mother alone	94	32.9
Father alone	17	5.9
Step-parents	14	4.9
Uncle	1	0.3
Aunty	5	1.7
Sister	3	1.0
Grandparent	6	2.1
Friend	2	0.7
Stay alone (Self-care)	1	0.3
Total	286	100.0

Source: Field survey (2019)

The frequency column in Table 6 shows that amongst the 286 respondents, 143 (50.0%) lived with both parents. From the analysis, 6 (2.0%)

children were staying with grandparents, 5 (1.7%) with Aunty, 3 (1.0%) with Sister, 2 (0.7%) with Friend, and 1 (0.3%) with Uncle. The table also exhibits that one person stayed alone, with little or no parent's supervision.

Table 7 presents the distribution of childhood sexual abuse cases of the respondents. The table was generated from the frequency counts of the multiple responses on the various forms of sexual acts (Appendix C). The first column represents the respondents' sexual abuse experiences. "No" represents respondents with no history of sexual abuse. "Yes" indicates that the respondent had experienced either one or more of the forms of the sexual act(s). The second column shows the frequency of sexual abuse.

Table 7 - Distribution of CSA Cases

Occurrence of CSA	Frequency	%
No	154	53.8
Yes	132	46.2
Total	286	100.00

Source: Field survey (2019)

The frequencies in Table 7 specify that 132 (46.2%) had experienced at least one sexual abuse act, and 154 (53.8%) had no history of CSA. Though Table 7 shows that most of the respondents had no history of CSA, the difference between these two groups of respondents is not much. The number of CSA victims revealed in this study is quite alarming.

Table 8 gives a description of the prevalence of sexual abuse cases with gender. Table 8 follows on from Table 7. It compares the number of sexual abuses and non-abuse case to respondents' gender.

Table 8 - Gender Distribution of CSA and Non-CSA Cases (N=286)

Gender	Abused (Yes)		Not Abused	
	Frequency	%	Frequency	%
Male	53	40.15	74	48.05
Female	79	59.85	80	51.95
Total	132	100.00	154	100.00

Source: Field survey (2019)

Table 8 shows that out of the total 132 respondents with the history of CSA, 79 were females, whereas 53 were males. It shows that more female respondents were sexually abused than male respondents in all three schools. A total of 154 children comprising 74 males and 80 females, however, reported not ever abused in the schools.

Having displayed the demographic data for the 286 respondents, the second part of this section presents the results of the demographic data on the 24 participants used in the experiment. Except for figure 2, all the other data were collected quantitatively.

Figure 2 presents a histogram of the numerical values of the variables (age of the 8 participants in each of the experimental groups). On the horizontal axis is the various experimental groups – Rational Emotive Behaviour Therapy, Individual Psychology, and Control. The vertical axis is the frequency of ages.

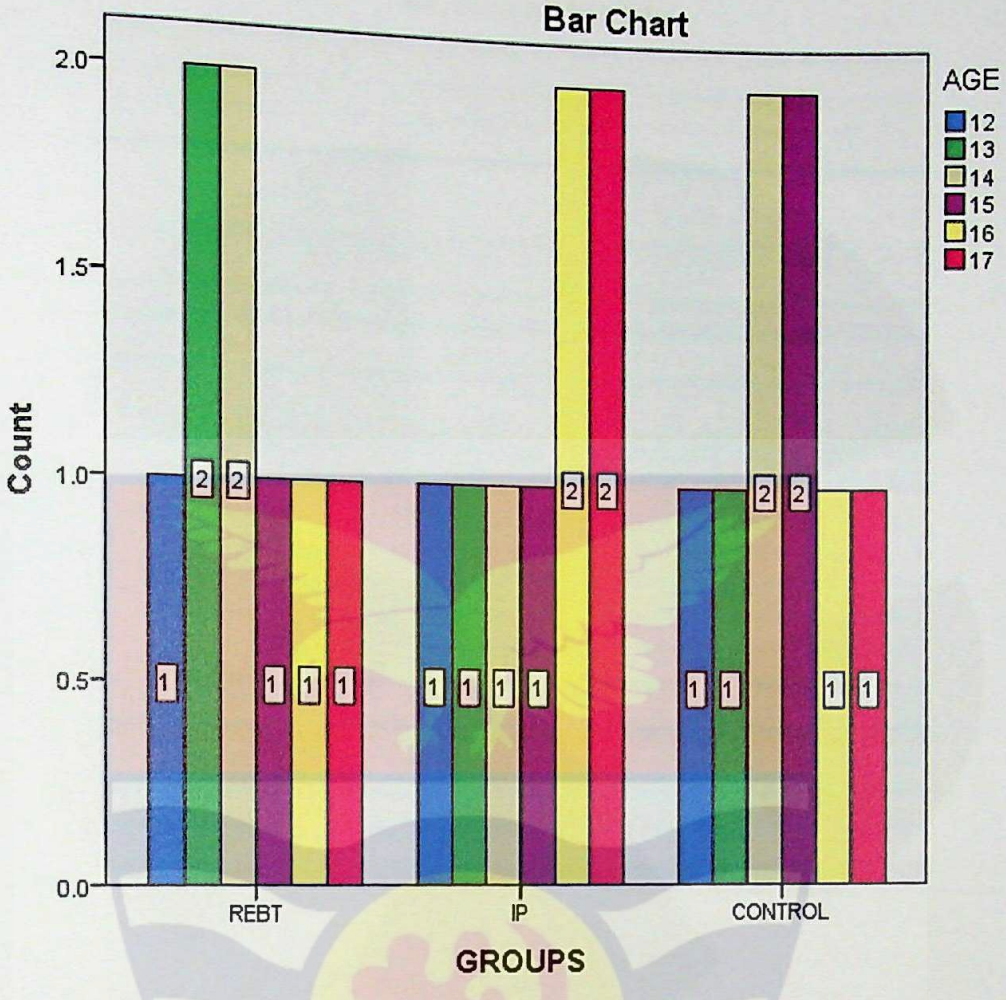

Figure 2: Bar chart distribution of age of 24 participants in the experimental study
Source: Field survey (2019)

There were varied representations of people from each of the adolescent's age groups from 12 - 17 in the three groups. Each bar represents a particular age of the CSA victims in that experimental group. The ages 12, 13, 14, 15, 16, and 17 were presented by the colours - blue, green, brown, purple, yellow, and red, respectively. The median ages for the REBT were 14 and 13 years, that of the IP group were 16 and 17 years, and the Control group were 15 and 16 years, each having two representations. The remaining ages were one for each age category. These victims were selected from the respondent whose questionnaire indicated psychological distress and willingly attended the interview.

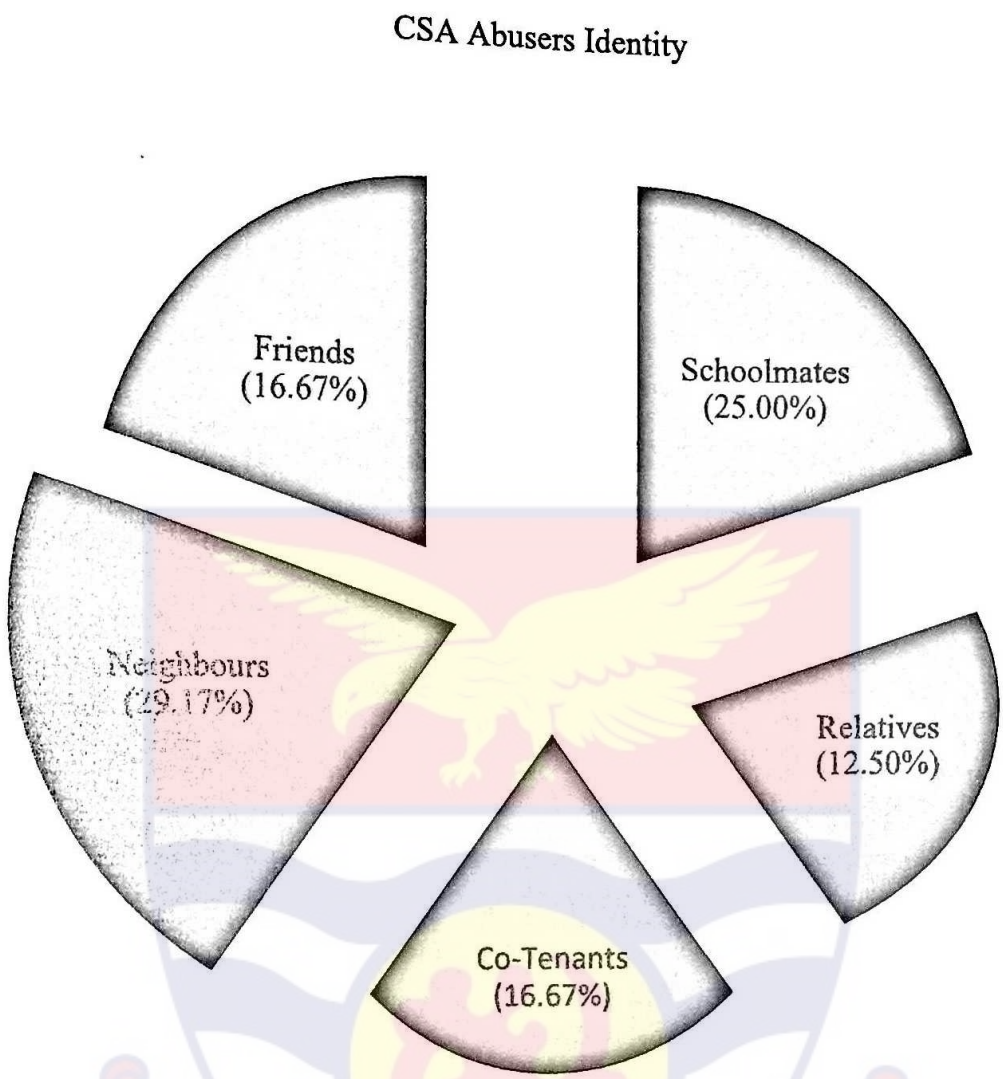

Figure 3: Pie chart distribution of the identity of CSA perpetrators
Source: Field survey (2019)

The pie chart shows that neighbours (29.2%) mostly abused the children used in the study. This was followed by school-mates (25.0%), co-tenants and friends both had (16.7%) whereas relatives were (12.5%).

Figure 4 presents the distribution of the persons victims usually disclose their sexual abuse experiences. The numerical values were displayed in percentages.

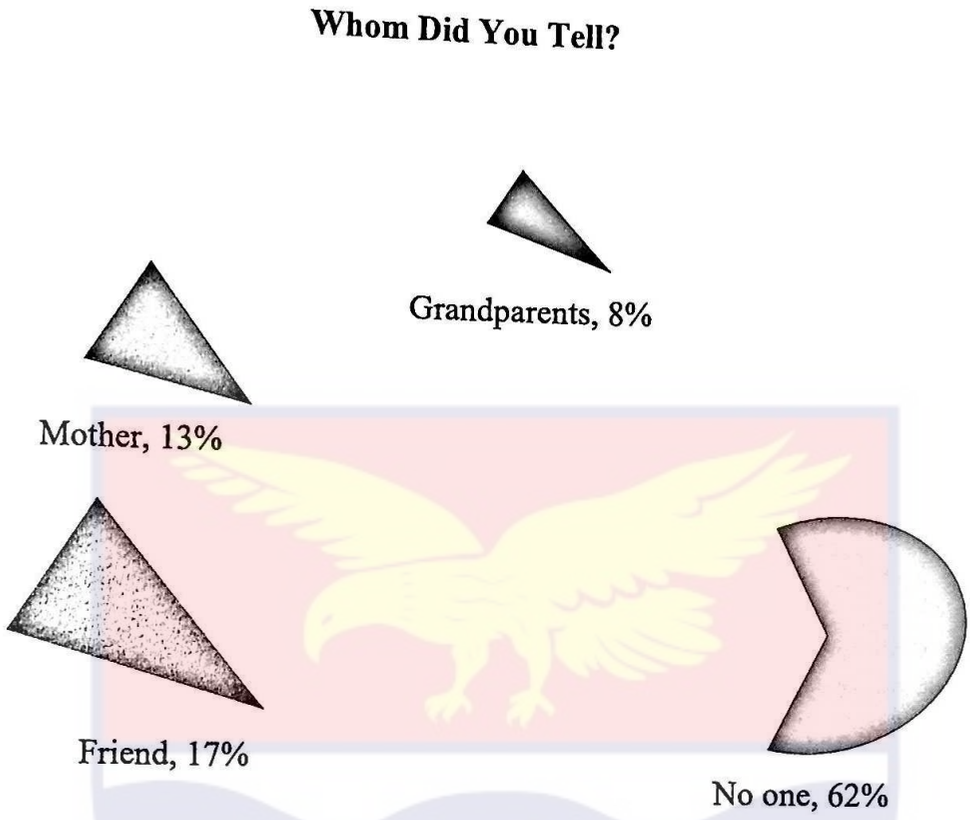

Figure 4: Pie chart distribution of the persons CSA victims disclosed the abuse.
Source: Field survey (2019).

From the diagram and the percentages, victims mostly do not disclose the incidence of the abuse to anyone. Sixty-two percent (62%) of the respondents had not informed anyone about their experience of CSA.

Section 2: Analysis and Interpretation of Data Collected

This section displays the results and the interpretations of the three research questions and four hypotheses.

Research Question 1: Which types of CSA are perpetuated in the Cape Coast Metropolis?

Table 9 is a descriptive statistic of the non-physical contact form of CSA in descending order. The second column lists the six non-physical contact sexual activities the respondents had experienced. In all, there were

287 counts spread under the six various themes. The frequency was converted to percentages under the percent column.

Table 9 - Distribution of Non-Physical Contact Forms of CSA

Non-contact	Frequency	%	Rank
Told me to kiss him/her	69	24.00	1st
Encouraged me to have sex with someone	59	20.60	2nd
Said I have beautiful buttocks/breast	54	18.80	3rd
Watched pornographic movies with me	51	17.80	4th
Told me to play with the penis/vagina/breast	28	9.80	5th
Told me to remove my dress and looked at my nakedness	26	9.10	6th
Total	287	100.00	

Source: Field survey (2019).

The frequency shows the non-physical contact sexual behaviours the respondents had experienced. From the list of the sexual behaviours, 'Told me to kiss him/her' had the highest responses, representing 24.00% of the 287 responses. This indicates their perpetrators requested a kiss(s) from them. Fifty-nine responses, which formed 20.60%, revealed that a significant person in their lives 'encouraged them to have sex with another person.' 'Told me to remove my dress' had the lowest, which is 26 and it represented 9.10% of the total counts of the non-contact physical form of CSA.

Table 9 further reveals that 54 (18.80%) of the responses were on verbal comments of a sexual nature about their breasts/buttocks, whereas 51 (17.80%) had to watch pornographic pictures/movies. Meanwhile, 26 (9.80%) victims were asked to fondle their perpetrator's penis/breasts/vagina.

Table 10 is also on the type, but on the contact physical forms of CSA the victims had experienced. The second column lists the variables (physical

contact). The count column shows the numerical values of six examples of the physical contact form of CSA in descending order.

Table 10 - Distribution of Physical Contact forms of CSA

Physical Contact	Frequency	%	Rank
Inserted his penis in my vagina	50	34.70	1st
Kissed me	41	28.50	2nd
Played with my breasts/buttocks (fondling)	26	18.10	3rd
Inserted his/her finger or objects in my vagina	18	12.50	4th
Inserted his penis in my anus	8	5.60	5th
Inserted his penis in my mouth	1	0.70	6th
Total	144	100.0	

Source: Field survey (2019)

The respondents indicated that penile-vaginal intercourse (inserted his penis in my vagina) was the type they experienced more; that is, 50 counts representing 34.70% of the total responses. The next highest sexual activity was 'Kissed me' with 41 (28.50%), followed by fondling (26, 18.10%), and insertion of objects in the victim's vagina (18, 12.50%). Table 10 also depicts 8 (5.60%) counts of anal sex and oral sex (1, 0.70%).

Research Question 2: What factors of psychological impacts do CSA victims experience in the Cape Coast Metropolis?

Table 11 shows the descriptive statistics of the psychological impacts of CSA per factor. The N column represents the total number of students exhibiting a specific psychological impact of CSA.

Table 11 - Descriptive Statistics of the Four-Factor Model of the Psychological Impact on CSA Victims

Psychological Impact	N	Mean	Std. Dev.
Sexualisation	128	2.14	1.31
Betrayal	126	1.90	1.05
Stigmatisation	123	1.94	1.20
Powerlessness	121	2.11	1.23

Source: Field survey (2019)

Sexualisation (M=2.14, SD=1.31) and powerlessness (M=2.11, SD=1.23) showed the highest mean number of characteristics of the CSA factor exhibited by the students. Comparatively, the mean number of characteristics of CSA factors exhibited by the students was lower in stigmatisation (M=1.94, SD=1.20) and betrayal (M=1.90, 1.20). The standard deviation increases with an increase in the mean number of CSA factor characteristics exhibited by the victims.

Turning on to the observable behaviours per factor, the researcher generated a means and standard deviations table for each of the factors. There were five observable behaviours that measured each of the four factors of the psychological impacts of CSA.

Tables 12 to 15 illustrate the means and standard deviations of the observable behaviours per the factors of the psychological impacts of CSA. The first column lists the various observable behaviours for each of the factors used in the study. The second and third columns list the means and standard deviations for these observable behaviours.

Table 12 - Distribution of Five Observable Behaviours for Sexualisation

Observable Behaviours	Mean	St. Dev.	Rank
I still remember the abuse as if it is happening again	4.21	1.22	1st
I avoid items that remind me of the abuse	3.71	1.63	2nd
I daydream of the sexual abuse when someone touches me	2.79	1.64	4th
I avoid places associated with the abuse	3.04	1.60	3rd
I am able to play with my friends without acting sexy	2.58	1.76	5th

Source: Field survey (2019).

Table 12 displayed that the highest observable behaviour demonstrated by the victims was having memories about the incidence of sexual abuse. This behaviour was followed on by 'avoidance of items that remind the victims of sexual abuse. These behaviours had their corresponding standard deviations as low, indicating that most of the numbers were close to the average.

Table 13 is a list of five items that measured the element of betrayal in the psychological impact the victims suffered. There were four negative items and a single positive item.

Table 13 - Means and Standard Deviations of the Observable Behaviours for Betrayal

Observable Behaviours	Mean	St. Dev.	Rank
I think my parents understand how I feel about the abuse	4.29	1.37	1st
I think about the sexual abuse when I am ignored	2.83	1.71	2nd
I easily get angry with people when I remember the abuse	2.00	1.67	3rd
I am not sure my guardians/parents care for me.	1.54	1.35	4th
My guardians/parents like my siblings more than me	1.21	0.59	5th

Source: Field survey (2019).

Table 13 revealed that the CSA victims believed that their parents understood their feelings about their abuse. The observable behaviour with the second-highest means is 'I think about sexual abuse when I am ignored' with a standard deviation of 1.71. Alternatively, 'My guardians/parents like my siblings more than me' had the least means with a deviation of 0.59.

Table 14 presents the means and standard deviations for observable behaviours for Stigmatisation.

Table 14 - Distribution of Observable Behaviours for Stigmatisation

Observable Behaviours	**Means**	**St. Dev.**	**Rank**
I am ashamed of myself because of the sexual abuse	2.71	1.72	1st
I think my friends still enjoy my company even after the abuse	2.38	1.66	2nd
I like to be alone most of the time when I think about the abuse	1.63	0.82	3rd
My friends are more attractive than me	1.75	1.51	4th
I like to cut myself when I am reminded of the abuse	1.34	1.23	5th

Source: Field survey (2019).

From Table 14, the behaviour that was mostly exhibited by the respondents with the history of CSA was, "I am ashamed of myself because of

the sexual abuse." This behaviour was closely followed by, "I think my friends still enjoy my company even after the sexual abuse. Self-mutilating behaviour seemed to be low among the CSA victims used in the study.

Table 15 is an outline of the four negative and one positive observable behaviours listed under powerlessness.

Table 15 - Means and Standard Deviations of Five Observable Behaviours of Powerlessness

Observable Behaviours	Means	St. Dev.	Rank
I worry about the abuse	3.38	1.66	1st
I have lost interest in school	3.29	1.68	2nd
I find it difficult to sleep when I remember the abuse	2.38	1.74	3rd
I wish to run away whenever I see the abuser	2.33	1.58	4th
I am comfortable to ask for what I need	1.75	1.51	5th

Source: Field survey (2019).

Table 15 displays that most victims of CSA worry about the incidence. Also, victims indicated that they had lost interest in school because of sexual abuse. However, the respondent(s) is '..comfortable to ask for what I need' run least among the behaviours demonstrated by the victims.

Relating Tables 11-15, it can be said that sexualisation and powerlessness were highest on means. This result indicates that on a whole, the respondents mostly exhibited these two factors of psychological impacts of CSA. With reference to the observable behaviours, the victims frequently had flashbacks of the sexual abuse experience(s).

Research Question 3: How do child sexual abusers in the Cape Coast Metropolis groom their victims?

The 24 members in the three experimental groups narrated the strategies their abusers used to trap them. Pseudonyms were assigned to the

raw data to represent the individual victims. The narrations correspond to the individual victims. Initials of the three experimental groups are attached to the pseudonyms, for instance, CG Control Group, IPG – Individual Psychology Group, and REBTG – Rational Emotive Behavioural Therapy Group. This identification is to help classify the participant's experimental group during the treatment. Their responses have been translated carefully without changing the original meaning of the narrations. The stories narrated by both males and female victims of CSA have been analysed to answer this qualitative research question.

Two major themes: Enticement and Aggression emerged from the victims' response to the interview question, 'What happened between you and the abuser?' (Appendix D). Table 16 illustrates the four sub-themes – 'Playfulness,' 'Deception,' 'Seduction,' and 'Teasing' and two sub-themes – 'Drugging' and 'Bullying' developed from the two major themes, respectively.

Table 16 - Emergent Themes and Sub-Themes of Strategies of CSA Abusers

Themes	Sub-Themes	Frequency	%	Rank
Enticement	Playfulness	10	41.17	1st
	Deception	5	20.82	2nd
	Teasing	4	16.67	3rd
	Seduction	3	12.50	4th
Aggression	Drugging	1	4.17	5th
	Bullying	1	4.17	6th
Total		24	100.00	

Source: Field survey (2019)

From the narrations, three participants explained how their abusers seduced them into sexual activities, as shown in Table 16. One of them narrated how a university student deliberately Enticed him.

> She sent me one day to buy something from the Science market for her. When I returned, she had changed her dress. She was wearing a nightie. When I gave the things to her, she told me to wait for her because she had something for me. She said I should sit on her bed. Then she started watching 'porno,' and she encouraged me to watch too. She started talking about the movie (porno). By the time I realised she was having sex with me (Enoch, CG).

In Seduction, the abuser carefully hatches the plan to entice their victims to engage in the sexual relationship. Another victim reiterated, "*she used to say that I am her boyfriend. Anytime we were together, she will try to touch me even when friends were around. I did not like it, but I was enjoying it*" (Abubakr, IPG).

Abusers who use seduction are not usually shy and might cling themselves to the immediate family members of their victims to conceal their motive. For instance, Abubakr IPG told us that his abuser complained to his father when he stopped talking to her. The father unknowingly told his son to speak to the girl since they were friends.

Playfulness was the most common element in the victims' narratives. Out of the 24 participants, ten mentioned how the abusers managed to get them as if they were playing with them. "*He jokingly told me to kiss him*" (Mensima, REBTG). The majority of the victims alluded that their male counterparts in school use such sexual comments and other physical touches as playing with their buttocks and breasts. They did this as a way to drive them away from the classrooms after school hours so that they could lock up. Some of their classmates also brought phones to school and asked them to watch

pornographic materials with them during break time or when there was no teacher in the class.

The Deception was the second-highest sub-theme under grooming. This assertion is not to conclude that siblings who sleep together on the same bed sexually abuse each other. Nonetheless, an innocent girl found herself in this condition. "*I used to sleep by my brother on the same, but sometimes when he thought I was sleeping, he would touch my breasts and have sex with me*" (Aba, IPG). She thought they were siblings and so sleeping on the same bed could not be a problem. Little did she know her brother could take advantage of her when she was asleep. This sexual act continued until the girl informed their mother, who advised her to sleep on the floor.

Similarly, abusers who resorted to Deception might play on the innocence of the families and betray them. One such abuser used to work for the victim's grandmother, who later raped the girl when he visited the house in the absence of the grandmother (Effe, CG). Another boy who looked depressed narrated his ordeal. His story was corroborated by another victim who experienced similar sexual abuse in the hands of another abuser.

> An older woman who stayed around our house used to call me her husband when I was 9 years old. She will call me into her room, give me food to eat, and have sex with me on several occasions. She will play with my penis too. (Kojo, REBTG).

Like the seduction, some of the sexual abusers who employed deception tried to win the hearts of significant others in the child's life. They groom both the victims and their environments to facilitate their plan.

Teasing can make a make-believe story a reality. Four of the 24 participants said their friends and classmates humorously paired them with the opposite sex. They initially felt uncomfortable with this pairing and could not be where their 'partners' were. Then as the teasing continued, they began to relax their stance. At this point, they got interested in each other and became friends.

From Table 16, only one person claimed that his abuser drugged him. One of the victims used in this study realised he was sexually abused when he woke up from drug-induced-sleep. He narrated, *"I did not see it when she was doing it. I think she drugged me. I felt different when I woke up."* (Frank, CG).

Likewise, one boy explained that his abuser resorted to bullying when he refused his proposal; "*There is a boy in my class who used to bother me with sex. I denied him several times, but he kept on pushing. He even threatened to beat me when I told my parents"* (Amos, IPG). This victim, particularly, was approached by another boy, whom he alluded to be gay. He proposed love to him but refused on several occasions. Being tired of the frustrations, the victim informed his parents, who came to the school to complain. The abuser upon hearing that threatened to beat him but later gave up on him when his efforts were futile.

Overall, the abusers of the CSA victims in this study employed six different strategies. These six strategies could be grouped into two major categories – enticement and aggression. From Table 15, only two victims received compulsion or were forced. All the remaining victims were enticed in one way or another.

Hypotheses Testing

H01. There is no significant difference in the effect of REBT, IP, and Control on the psychological consequences of CSA.

The objective of this hypothesis was to test if any of the experimental groups had some effect on the participants' state of mind after its application. The means of this test revealed a rank of 18.75 for Rational Emotive Behaviour Therapy, 14.25 for Individual Psychology, and .50 for the Control Groups. The Kruskal-Wallis Test showed a significant difference in the extent to which CSA victims reacted to different treatments in the study, H (2) = 14.36, p = 0.001, η2= 0.62. The effect of the treatment accounted for 62% of variation in the extent of which victims' psychological distress was improved. Within the treatments, the effect is small but higher than the control group.

Table 17 - A multiple comparison of the REBT, IP and the Control Groups

Groups	Test Statistics	Sig
Control – IP	9.188	.027
Control – REBT	12.938	.001
REBT-IP	3.730	.857

Source: Field survey (2019)

A pairwise comparison showed Rational Emotive Behaviour Therapy (p< . 001) had a higher significant effect than the Adlerian Therapy (p = .027) group at p = .05. However, there is no significant difference between REBT and IP (p =. 857). Accordingly, the null hypothesis was rejected. Qualitative data were also analysed to buttress this finding.

The victims' narratives were analysed into themes to support the qualitative results. Similarly, there were 100% positive responses to the question; was the treatment helpful to you? Only the 16 participants in the two

treatment groups (REBT and AT) responded to this question since the control group received delayed treatment (treatment after the post-test). All the 16 participants in the Rational Emotive Behaviour Therapy and Adlerian therapy groups admitted that the sessions were helpful to them. Table 18 displays the five themes that emerged from the participants' responses to the question, 'How has the treatment helped you to deal with the problems you faced because of the sexual abuse?' (Appendix F).

Table 18 - Emergent Themes on Benefits of the REBT and the IP Groups

Themes	Frequency	%	Rank
I think well about myself	8	50.00	1st
I stopped having bad dreams I used to have about the sexual abuse	3	18.75	2nd
I now know that sex at this age is not suitable for me	2	12.50	3rd
I am happy that I shared my problems with someone	2	12.50	4th
I feel less sad and less guilty	1	6.25	5th
Total	16	100.00	

Source: Field survey (2019)

From Table 18, majority of the CSA victims from both treatment groups showed how the therapies helped them to change their perception about themselves. The treatment also helped three of them to have better dreams in their sleep. The least emergent theme was feeling less sad and guilty about the abuse after the treatments.

Another interview question used to assess the benefits of the treatments and was administered to the members in the two treatment groups was, 'How has the treatment changed your relationship with others? (Appendix F). Table 19 outlines three emergent themes from the interview question.

Table 19 - Emergent Themes on Victims' Relationship with Other People

Themes	Frequency	%	Rank
I am able to play with my friends	6	37.50	1st
I know how to deal with my abuser	5	31.25	2nd
I understand my parents	5	31.25	2nd
Total	16	100.00	

Source: Field survey (2019)

Table 19 also revealed how the treatments helped the victims. Six of them were able to play with their friends as compared to the pre-test. They could not articulate themselves well enough because of the abuse. They initially felt less attractive and different from the others. All these negative thoughts prevented them from socialising with friends. *"I was afraid of what my friends would say about me, so I kept to myself and wanted to be alone most of the time. But after the discussions, I am gradually getting closer to people"* Mensima, REBTG).

Merging the results of both quantitative and qualitative data, the two treatment groups had better results than the control group. Hence, there was sufficient evidence to reject the null hypothesis and assume a significant difference among the three experimental groups. That is to say, REBT and AT groups had positive effects of the treatments on the participants as compared to the control group. The qualitative data analysis gives support to this

decision. The results from these two analyses were compared at the point of discussion to identify areas of convergence or agreement.

H02. There is no significant difference in the effect of therapy on each of the Four-factor model of the psychological impacts

Friedman ANOVA was conducted to test the differences in the effect of therapy among the Four-factor model (stigmatisation, betrayal, powerlessness, and sexualisation) of CSA. The analysis showed a significantly different effect of therapy on the four factors, χ^2 (3) = 16.64, p = .001, w = 0.35. Post hoc with Wilcoxon tests revealed where the differences were. Though stigmatisation was ranked third among the four factors, there was no significant interaction with therapy (Z = -1.36, p = 0.18). All the remaining factors showed a significant interaction with the effects of the therapy. There was a significant interaction between therapy and betrayal (Z = -3.42, p = 0.001), sexualisation (Z = -3.11, p = 0.002) and powerlessness (Z = -2.75, p = 0.005). A Bonferroni correction was applied. All effects were reported at α = 0.0125 (0.05/4) level of significance. The researcher concluded that there was enough evidence to accept the difference in effect.

H03. There is no significant association between gender, age, and the effect of the treatments on the CSA victims.

The χ2 test of independence was used to show the influence of biological factors of CSA victims on the effects on the treatments. For the age range, 66.7% of the early adolescent proportion had an elevated effect as compared to 33.3% of the middle adolescent at χ2 (1, 2.667, 160, p= .102. Turning to examine the relationship between gender and its influence on the treatments on the CSA victim, an equal proportion of both males and females

had little and elevated influence on treatments. Both young and middle adolescents equally had 50% for each level of effect of treatment, $\chi 2$ (2, 16) = .000, p =1.000). The general story across results is that both males and females at different age groups had different levels of effectiveness of treatments in the study. There appears to be no significant influence between biological factors on the effect of the treatments used in the study at $a = .05$.

H04. There is no significant association between social factors of the victims of CSA and the effect of treatments.

A breakdown of the chi-square showed that a 40.0% proportion of the respondents staying with biological parents received high effects. In contrast, respondents who stayed with people other than their biological parents had 60.0% for elevated and 40.0%, little effects respectively. The result appears to show similar effects of therapy between the two kinds of family. A chi-square test of independence ($\chi 2$ (2, 16) = .800, p = .371) gives evidence for the null hypothesis. Even though the family background does not influence the effect of the therapy among the population from which the sample was drawn, treatments appeared to have much influence on the victims from the non-biological parents' type of home. Based on the chi-square test of independence, there is no statistically significant association between the family background of the victim and the benefit of the treatment.

So far, the proceeding sections of the chapter focused on the analysis of the data collected and its interpretation. The following section will look at the discussion of the results of the analysis of the data.

Section 3 – Discussion of the Results of the Analysis

This section extensively discussed the results of the research question and the four hypotheses.

Types of CSA mostly Perpetrated in the Cape Coast Metropolis

The research question one addressed the first purpose of the study, which was to investigate the most prevalent forms of CSA experienced by children in the Cape Coast Metropolis, Central Region of Ghana.

The findings revealed that children experienced both contact and non-physical contact CSA. These particular results corroborate studies on the prevalence of CSA in other localities by Aboagye (2013), Awusabo-Asare, et al. (2006) and Jewkes, Sen, and Garcia-Moreno (2002). The analysis in this current study further exposed that, though the children suffer both forms, the number of responses for non –contact (287) was the most prevalent of the two.

Before interpreting the analysis of the non-physical contact form of CSA, it is necessary to look at the physical contact form of CSA. Table 10, which listed the various activities on physical contact of CSA, displayed "penile-vaginal intercourse" (50, 34.70%) as the highest. Anal and oral sex, (8, 5.10% and 1, .07%), respectively, appeared at the bottom of the ranking (Table 10). This finding substantiates prior research that children suffer these types of penetrative sex as well as penile-vaginal intercourse (Essabar et al., 2019). As shown in previous and the current study, children all over the world are exposed to varying degrees of the physical - contact form of sexual abuse. These are most often the use of the victims or perpetrator's bare hands/mouth or objects to sexually touch the sensitive parts of the victims/perpetrator (Table 10; Aboagye, 2013; Sawyer et al. 2004).

Comparatively (Tables 9 & 10), it can be seen that the respondents suffered more non-physical contact forms of sexual abuse. Among the six items detailing how the children had suffered each of the non-physical contacts, 'told me to kiss him/her' placed first (Table 9). The element of "kiss" was rated high in both contact and non-physical contact of CSA. Aboagye (2013) indicated that the kiss had the least of the responses (1, 3.30%), which is contradictory to the current findings. One possible account for the drift in kissing, that is, it being high in the present study may be the influx of social media. My observation during the data collection was that some of the students were seen with mobile phones in schools. One respondent with a pseudonym Esi commented during the interview session, *"My classmate shows us pornographic materials on the phone he brings to school."* (Esi, CG).

The researcher does not dispute the enormous benefits of social media. However, social media could also serve as a source of increasing CSA if proper education is not given. Oshri, Himelboim, Kwon, Sutton, and Mackilop (2015) reiterated that childhood sexual abuse has a link to social networks. Eder, Evans, and Parker (1995) also warned kissing to be the most frequently used gesture or action to display affection/love. This assumption is foreign to the Ghanaian culture. However, acculturation, coupled with technology, may be the contributing factor to the fastest-growing phenomenon in our part of the world. It is not surprising that "Watched pornographic movies with me" (51, 17.80%) also received high responses from the respondent.

Secondly, "encouraged me to have sex with somebody," was the second-highest for the non-physical contact type of CSA (Table 8). This

particular item adds to the existing knowledge of CSA. Prior research in this field of study was usually only on the perpetrator-victim relationship (Hilton & Mezey, 1996; & Sidebotham, 2017). However, this result expunges the notion that sexual abuse can occur only between the two parties (victims and perpetrators). It is evidenced that significant others influence adolescents' sexual life and, therefore, can contribute to the occurrence of CSA. *"My classmates wanted me to have sex with a guy who is a gay, and I didn't do it ... he threatened to beat me when he got to know I had informed my parents."* (Amos, IPG). This corroborates with ika-Bright and Nnorom (2013) study within this Metropolis that children will kiss when an adult encourages or initiates it.

The focus was on both the contact and the non-physical contact of the CSA, and the non-physical type of CSA emerged as the overarching type. The overall finding is inconsistent with prior research that found the contact form to be the most prevalent (Simuforasa, 2015). There may be several explanations in addition to acculturation and technology. The respondents understood what constituted contact and non-physical forms of CSA. Before the administration of the questionnaire, the researcher gave a talk on CSA. The presentation offered the respondents the opportunity to clarify any confusion on CSA.

Although both contact and non-contact are under-reported, the non-contacts usually go unnoticed because victims do not usually feel the psychological impacts immediately. Subsequently, do not report its occurrences (Martin & Silverstone, 2013). This finding indicates that curriculum planners and educators must incorporate the knowledge of CSA in

the syllabus (Brown, Brack & Mullis, 2008). The educators must identify such children and deal with the problems head-on. Parents cannot be left out in educating their children about CSA. Parents should ensure that their children use social media for educational and the right purposes. In effect, parents should be interested in the affairs of the friends their children make.

Four-factor Model of CSA Victims in the Cape Coast mostly Experience.

The psychological factors proposed by Finkelhor and Browne (1985) imply that the consequences of CSA can be analysed in light of four constructs – sexualisation, betrayal, stigmatisation, and powerlessness. The purpose of the research question two was to establish the fact that CSA victims experience some form of psychological distress and which of these factors are predominant. It was also to select the most prevailing observable behaviours for each of these four factors.

The analysis of the data collected found support for the part of these purposes. It corroborated the findings of clinicians who have established the link between CSA and challenges with psychological development (Sanderson, 2006). Although there is not much empirical evidence on the four factors, some of the few, whether cross-section or longitudinal, have revealed the relationship between CSA and this model at varying degrees (Duket, 2015; Olafson, 2011). For instance, Feiring et al. (2009) examined the impacts of CSA to stigmatisation and sexualisation (McCallum et al., 2012) also found a relationship between the variables.

Unlike Makhija (2014), who found the impacts of sexual abuse to be high on betrayal, powerlessness, and stigmatisation but no significant support for sexualisation, the current study found otherwise. Among the four factors

assessed in the current study, sexualisation came out as the major psychological consequences exhibited based on the responses of the CSA victims (Table 11). The high sexualisation behaviours could be attributed to the characteristics of the different respondents used in the studies. Makhija examined the four factors among females' victims of CSA between 13-18 years who had reported to a diagnostic treatment centre, New Jersey. Whereas the population for the current study was adolescent, heterogeneous groups, and were in school. A younger child who does not understand the implications of sexual relationships is more likely to experience a greater level of sexualisation than a child who understands it (Finkelhor & Browne, 1987).

The most common observable behaviours of sexualisation factor centred on issues of heightened awareness of sexual abuse (remember the sexual abuse as if it is happening to them again) and avoidance of sexual themes (Table 12). This revelation is also in line with Finkelhor and Browne's (1985) assertion that victims of CSA have flashbacks of sexual abuse. Barber (2012) also warned that CSA victims demonstrate a heightened level of alertness to the possibility of danger, unable to relax, and are overly vigilant. They usually employ these strategies to avoid further abuse.

Similarly, the majority of the findings of other research have powerlessness on top of the dimensions of the psychological distress that CSA victims mostly demonstrated. For instance, Bolger and Patterson (2001), Makhija (2014), and Senn et al. (2011) revealed that CSA has a more significant association with powerlessness. This is also true in the current study. The respondents demonstrated a greater degree of powerlessness. Perhaps, the 'Ghanaian Child Respect Syndrome' may be accounted for this

high degree. The socialisation process teaches children that all adults have the right to exercise their power under whatever circumstances. Children grow up believing that all adults are upright morally. Any attempt by the child to question the authority of the adult will label the child as bad or insolent. Children cannot assert their will power even when the adult crosses the boundary or sexually abuses the child. Sika-Bright and Nnorom (2013) also found that children within this Metropolis will agree to sexual abuse when an adult ecnourages or initiates it.

Children are supposed to be respectful. They obey without complaint, even if it is against their will. This unwritten Ghanaian norm has directly or indirectly inculcated into children by the agents of socialisation kills our sense of control and will-power (Dako-Gyeke, 2018).

Cultural values, social customs, and laws may also contribute to the high rate of powerlessness in this study. Some societal values may punish assertiveness and do not allow the smooth development of such traits (Lartey, 2019). Berk (2008) warned that values and beliefs could influence a person's interactions with the environment.

The results also revealed that CSA victims worry about sexual abuse more than the remaining four observable behaviours that measured powerlessness (Table 15). Wohab and Akhter (2010) asserted that individuals with a history of CSA often get distressed and become sad. Such a child has a high probability of running away from home (Goodall & Lumley, 2007).

Although betrayal and stigmatisation had the least means and standard deviations (Table 11), their observable behaviours are worth considering. For betrayal, most of the victims had doubts about the love and care their parents

had for them. These beliefs stem from the angle of their sexual abuse experiences. Children largely depend on parents for survival, affection, love, trust, and, ultimately, guidance. However, children with sexual abuse experience(s) require extreme dependency; desperately look for affirmation; security, and trust (Finkelhor & Browne, 1987; Watson, as cited in Aboagye, 2013). Hence, whichever way the child was groomed for sexual abuse could affect his or her relationship with others (Makhija, 2014). They develop difficulties with interpersonal and personal adjustment (Rooy et al., 2015).

Concerning stigmatisation, self-mutilating behaviours were least demonstrated by the respondents. Though on a small scale, some CSA victims engaged in behaviours which are detrimental to their development. It corroborates with prior research. For instance, Klonsky and Moyer (2008), revealed that a small number of CSA victims engaged in self-injurious behaviours. Wise (1990) and Yeo and Yeo (1993) also warned that people with history of CSA were prone to self-mutilating behaviours than those without sexual abuse experience. Alternatively, "I am ashamed of myself because of the sexual abuse" was rated high among the stigmatisation behaviours. Finkelhor and Browne (1985) believed shame as a result of CSA is an essential feature that influences social and emotional adjustment. Continual engagement of victims in the act of shame triggers low self-worth (Negrao et al., 2005). Relatedly, "see my friends to be more attractive than me," and isolation also received some attention from the victims.

To sum up the discussion on this particular research question, the researcher can state that CSA victims who experienced psychological distress were more than asymptomatic victims (Table 11). The findings dispel the

notion that the majority of children do not suffer any form of psychological trauma when they are traumatised (Essaber et. al., 2015). The possible reason for these different results may be the framework for the psychological impacts. The PTSD model, for instance, looks at DSM-IV categorisation of diagnosing the adverse reactions to a traumatic event. It organises the symptoms into re-experiencing, avoidance, negative cognition/mood, and arousal. The danger with this model is that a victim is likely not to get the appropriate diagnosis and treatment if he or she does not display sufficient symptoms to warrant the label of PTSD. It also does not consider the event before the incidence of the abuse. In effect, it is limited in the diagnosis of the psychological impact; whilst the Four-factor model wholistically considers varied aspects of the psychological impacts on the CSA victim.

The good thing about the four-factor model of psychological impact is that it brings together all the symptoms of the PTSD model and other trauma theories under four different factors (Finkelhor, 1987; Makhija, 2014). It should be noted that victims react differently to CSA and also demonstrate the four-factor model differently. Those who suffered some psychological distress demonstrated it at different levels. Others demonstrated some or all of the Four-factor model (Table 11). Some victims might have had their sense of value and worth distorted. Others demonstrated a frail sense of ability to control their lives. All these tend to influence the development of the child.

Grooming Strategies of Sexual Abusers of Children

The question explored abusers' strategies and their grooming behaviours. The thematic analysis of the qualitative data on abusers' strategies revealed two forms of grooming – enticement, and aggression (Table 16).

Groth and Burgess (as cited in Burgess & Hartman, 2018) also proposed these two types of grooming. The findings also revealed aggressive strategies as the least form of grooming employed by the abusers of the victims used in this study. A stranger sexually abused none of the participants. All the 24 participants were sexually abused by someone they knew (figure 3). There was also inter and intra-familial sexual abuse. However, the majority were inter-familial and occurred on the blind side of the victim's family or parents.

The findings highlighted some of the processes of grooming in CSA. The Abusers first formed a bond either with the victim or formed a relationship with the child's broader system. In this regard, the participants stated how their abusers used to be her mother's regular customer or lived in the community with the abuser. Once they got in contact with the child or his or her microsystem, they tried to gain the trust and respect of the victim and other family members. As stated by one victim, 'I was alone in the house when he came to look for my grandmother.' The abuser gained the child's trust because of his relationship with the grandmother. This relationship offered the perpetrator the chance to enter their house at any time. Therefore, no one suspected him of defiling the child when he entered the house in the absence of the grandmother.

The next step in the grooming process identified in this study is caring for the child. The abusers assumed a caring position, such as giving their victims food and running errands for the abuser. This technique corroborates the assertion by McAlinden (as cited in Winters & Jeglic, 2016) that the process of sexual abuse is facilitated by giving of gifts and incentives. It is done based on the peculiar needs of the potential victim. The abusers used

both financial and moral incentives to lure their victims. Then eventually, they executed their plans of having sexual relationships with the victims. The grooming processes identified in this study substantiate the process of grooming described by prior research, such as Plummer (2018).

Another concept found in this present study was that sworn secrecy was not achieved through giving of gifts and tokens alone. Instead, by the respect and the trust, the victims had for their abusers before the sexual abuse. For instance, '*I trusted him so I could not discuss with any other person or asked her.*' Also, the abuser's position within the child's microsystem facilitated the child's silence. Examples are, '*she was a university student*' and another retorted, '*she complained to my father that I do not talk to her.*'

The finding is also helpful in understanding the sexual grooming behaviours of male and female perpetrators of CSA. Older female perpetrators mostly seduced, deceived, and drugged their innocent victims. Though none of these female abusers was a family member, they assumed a position of authority under the disguise of caring for these children, such as giving them food. The majority of male abusers, on the other hand, adopted playfulness and bullying to entrap their victims. The grooming behaviours used by both male and female abusers illustrated how sexual abuse of children had been normalised in schools and the communities. Furthermore, the result demonstrated how the secrecy of CSA is indirectly facilitated by people in the child's ecological system.

Effects of Rational Emotive Behavioural Therapy, Individual Psychology and Control Groups on CSA victims

The purpose of this hypothesis was to test the effectiveness of the three experimental groups on the psychological impacts of CSA victims. It was also to compare which of these groups had the most influence on the victims. The analysis revealed a significant positive high effect of Rational Emotive Behaviour Therapy and the Individual Psychology groups. The control group, on the other hand, had a low mean rank when the pre-test and the post-test scores were compared. The results further indicated differences among the three experimental groups. The themes derived from the qualitative data on the effect of the groups all gave support for the quantitative data. Hence, the null hypothesis was rejected.

Different studies have attested to the effectiveness of Rational Emotive Behaviour Therapy and Adlerian Therapy on diverse issues confronting children. Meany-Walen (2010) used the Adlerian play-therapy for disruptive behaviours among elementary school children. Rykova (2014) compared the effectiveness of Gestalt and Adlerian therapies for disruptive behaviours. Wagner and Elliot (2014) also applied Adlerian adventure-based counselling to enhance self-esteem in school children. Turner (2016) concluded that Rational Emotive Behaviour Therapy is a valuable approach to address mental health issues in sport. The therapeutic strategies applied in this study were also adapted from Albert Ellis and Adlerian therapies. The result of the study after 8 sessions gave further support for the need for treatment for CSA victims. Compared with the control group, the members in the two treatment groups

improved in their level of psychological distress as per the baseline-data and post-test results.

Nonetheless, the Rational Emotive Behaviour Therapy group had a higher significant effect as compared to Individual Psychology. This finding substantiates the assertion by Cohen and Mannarino (1996), Deblinger et al. (2001) and Stein (2011). They opined that Rational Emotive Behaviour Therapy is the best therapy to dispute the illogical beliefs of CSA victims. It further supports the evidence that teaching victims to identify their irrational beliefs can be rewarding. The CSA victims' acceptance of their irrational beliefs, active involvement in therapy, and a combination of cognitive, behavioural, and emotive techniques can be valuable as well. It will however be premature to conclude that ignoring CSA victim's deep feelings in therapy is satisfactory due to the nature of the therapy rooms.

Similarly, understanding CSA victims' lifestyle, assessing their early recollections and family background are necessary for Adlerian therapy. The behavioural assessment and analysis helped to structure the sessions based on the psychological needs of the CSA victims. Also, the victims' capabilities to influence and create events were essential during treatment. Encouragement, which forms the core of Individual Psychology treatment, was effective in the change process. Although the victims were encouraged to strive for a healthy relationship, more empirical evidence is needed on encouragement in dealing with inferiority (Hands, 2019).

The post-test interview of the victims on the benefits of the therapies supports the quantitative results (Tables 18 and 19). The participants in both the Rational Emotive Behaviour Therapy (REBT) and Individual Psychology

(IP) therapy groups admitted that the discussions were beneficial to them. Some asserted that they did not think less of themselves any longer, and were happy to have shared their problems. Others also believed that they had learned how to deal with their abusers, and never again would they run away from them (Table 19).

The effect size for the therapeutic change was medium. In Table 14, victims showed a high level of shame. In the words of Rosenthal et al. (2005) and Feiring, Taska & Lewis (as cited in Negrao et al., (2005), persons with elevated and continual engagement sense of shame were more likely to impede treatments. This could have contributed to the minimal effect size in the effect of the treatments.

Correspondingly, the low level of change could be attributed to factors, such as the length of the intervention. Studies have shown that a prolonged number of sessions correlate with a higher effect size (David, Szentagotai, Eva & Macavei, 2005). This notwithstanding, the result of this study further illustrates that both Ellis' and Adler's therapies could be equally effective in far less than 20 sessions and more useful in alleviating the pain of the victims than no therapy. The focus of therapy should instead be on limiting time rather than limiting goals (Sharf, 2015).

Unlike the members of the Control group who had a small means, those in the two therapy groups modified their thoughts, which culminated in positive reactions (Table 18). The small mean effect of the control group members could imply that the members in the control group might have also improved in a small margin or worsen. This little improvement probably could infer that confiding in a reliable person could be helpful to the victim (William

& Nelson-Gardell, 2012). Alternatively, one could deduce that victims might have further reduced their psychological health after the pre-test. In this regard, it can be concluded that the absence of immediate therapy for victims could be dire (Bagley & King, 2004). The delay can plunge the victim into long–term psychological distress. With intervention, the possibility of a normal person actively shaping his or her environment could become a reality.

Difference in the Effect of Therapy on the Four-Factor Model of the Psychological Impacts of CSA

After the analysis of the data collected, there was an indication that therapy significantly caused a therapeutic change in the CSA victims based on the Four-factor model. Except for stigmatisation, where there was no significant difference in the effect, all the other three factors significantly interacted with the therapy. Hence, the null hypothesis was rejected.

The findings project the assumptions of the two therapies used for intervention for this study. The therapist can actively dispute one's irrational thoughts when she or he appropriately identifies the individual's cognitive distortions. Identifying the Four-factor model of the psychological impact of CSA can aid in the selection of appropriate strategies for interventions (Ellis, as cited in Neukrug, 2011). Whether a teaching or directing type of therapy, it should focus on the CSA victim's particular factor and its accompanying observable behaviours.

The differences in the interaction in the Four-factor model and effects of therapy depict victims suffer from the incidence of the sexual abuse differently. As the results of the Friedman ANOVA test showed, there was

significant interaction in the effects of the two therapies for three of the factors. As shown in Table 3, some victims were asymptomatic. At the same time, those who were symptomatic exhibited varied factors of the psychological impact (Table 11). These results attest to the credence of Finkelhor and Browne's (1985) model of psychological impact. The victims demonstrated sexualisation through behaviours, such as avoidance (C). The REBT strategy, like shame-attacking and IP's active listening, proved to be effective. Coping statements and egalitarian relationships were key in dealing with the psychological distress.

Furthermore, problem-solving skills were applied to dispute (D) victims' powerlessness. They were encouraged to focus on their potentials, strengths, and the solution and not the problem. The assertiveness training was useful in reducing self-esteem and self-destructive behaviours (stigmatisation). Encouragement, which served as the core of Adlerian therapy, proved to be a useful technique for all the factors of the psychological impact on CSA victims. The importance of empowering victims in therapy is also verified in prior research (Hands, 2019; Jessiman, Hackett, & Carpenter, 2017). The result underlines the importance of establishing interaction between these factors and therapy (E).

Subsequently, it is prudent that the treatment of CSA is structured according to the four factors, as confirmed by this result. The effectiveness of therapy largely depends on the particular factor of psychological impact the victim is experiencing. Therapy must be sensitive to the specific factor of psychological impact on the CSA victim. Since the individual's subjective cognitive map greatly determines how the individual's worldview is formed,

therapy must be sensitive to the specific factor of psychological impact on the CSA victim.

Association between Biological Factors and the Effect of Therapies on the CSA Victims

One of the objectives of the study was to examine how CSA victims' biological factors could influence the treatment of their psychological distress. It was to find if the benefits victims gained from the treatment were dependent on factors such as age and gender. A chi-square test of independence showed no significant association between bio data and effects of treatments on the CSA victim. There was not much evidence to reject the null hypothesis. The decision was to accept the notion that there is no significant association between biological factors and the effects of treatments.

The analysis revealed that both males and females had an equal number of elevated effects. This result brings to light that regardless of a victim's gender, therapy can bring about healthy psychological functioning. Both Adler and Ellis were of the view that therapy can equally be useful for both females and males. It implies that the individual's gender is not as important as what the person chooses to do with his or her abilities and limitations. The result, however, revealed that more females showed little effects of the treatments and rated higher on the moderated effects. This finding supports the principles of the theories used. Ellis maintained that the nature of irrational beliefs is often different for males and females (Ndika, Olagbaiye & Agiobu-Kemmer, 2008). Hence, each therapy had preferences of how females should be encouraged to challenge their irrational beliefs.

Concerning the relationship between age and therapy, both males and females in the early adolescence performed better than middle adolescence. Prior studies focused on general adolescence. A new dimension revealed in this current study is that the age range of the victim might influence the outcome of psychological treatment. The result presupposes that each of the categories in adolescence has its peculiar concerns. Different changes occur during early and middle adolescence. Middle adolescents can think abstractly; set long-term goals, which include sexual themes; and experience heightened peer pressure than early adolescents (Allen, 2019). Therefore, Rational Emotive Behavioural Therapy and the Adlerian therapists must equip themselves with the current trend on the various age groups. Through proper identification of the psychological needs of CSA victims, therapy will achieve practical results.

Association between Victim's Family Background and Effect of Therapy

The goal was to explore the association between the victims' family background and the effect of the treatments. From the results of the chi-square test, there was no significant association between these two variables. It appears that there were similar effects of treatment between respondents who stayed with their biological parents and those who did not, as at the time of data collection. Both groups had similar effects of the therapies. The family background of the victims did not have an apparent influence on how the victims benefited from the treatment.

It is mostly believed that family background can influence therapy (Jessiman et al., 2017), but this study found otherwise. One possible reason for this contrast is that the victims in the study did not want to involve their

families and guardians much in their decision-making process. This assertion is valid for the age group used in the study. One major feature of adolescents is that they distance themselves from their parents and cling to their peers (Allen, 2019). This result further implies that treatment should aim at making the victim accept that unrealistic societal expectations might be a source of psychological challenge, rather than using the individual's family background as a limitation to achieving success in therapy.

This result also brings to light that the therapeutic relationship with a victim is vital. Treatment might be detrimental to a victim if the therapist appears to be judgemental, not interested, and biased (Allnock, Hynes & Archibald, 2015). Irrespective of a CSA victim's family background, Rational Emotive and Behavioural and Adlerian Therapy tend to reinstate him/her to a stable psychological state of mind. Although human beings could be understood from the context of the family constellation, therapy should be unbiased. A healthy and adaptive behaviour could be learned irrespective of the kind of family from which the victim belongs. Hence, treatment could effectively be implemented in order to reduce the levels of four-factor models for CSA victims from all kinds of family backgrounds. CSA victims must be encouraged to accommodate and dispute irrational beliefs associated with the incidence of CSA and not be discriminated against on family grounds.

Summary of the Key Findings

The analyses and the discussion for both quantitative and qualitative data were presented in this chapter. The results showed a high occurrence of the non-contact physical form of CSA among the respondents for the study. The findings revealed that both females and males' victims of CSA could be

psychologically asymptomatic. While at the same time, others endured all the Four-factor model. Overall, the results of the treatments after eight sessions were effective in reducing the Four-factor model on CSA victims. The core of the intervention strategies for the two treatment groups was based on the approach of Rational Emotive Behaviour Therapy (REBT) and Individual Psychology. These strategies were effective in reducing the four factors of the psychological impacts better than the control group. Recovery through therapy does not appear to be hindered by neither the biological nor social factors of the CSA victims. The effectiveness of therapy in alleviating psychological distress depended on how well the therapist assessed the particular psychological need of the victims, rather than the victims social factors and gender.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of Study

The purpose of the study was to use the techniques of Rational Emotive Behaviour Therapy (REBT) and Individual Psychology (IP) to treat the Four-factor model of CSA victims in the Cape Coast Metropolis in Ghana. The three research questions raised centred on the forms of CSA, Four-factor model, and the grooming strategies used by the abusers. There were also four hypotheses. These focused on the effect of the three experimental groups and the factors that influenced the psychological treatments of CSA victims. These are as follows:

Research Questions

1. Which types of CSA are perpetuated in the Cape Coast Metropolis?
2. What factors of psychological impacts do CSA victims experience in the Cape Coast Metropolis?
3. How do child sexual abusers in the Cape Coast groom their victims?

Hypotheses

$H_0$1: There is no significant difference in the effect of REBT, IP, and Control on the psychological consequences of CSA.

H_A1: There is a significant difference in the effect of REBT, IP, and Control on the psychological consequences of CSA.

$H_0$2: There is no significant difference in the effect of REBT and IP on the Four-factor model of the psychological consequences of CSA.

H_A2: There is a significant difference in the effect of REBT and IP on the Four-factor model of the psychological consequences of CSA.

$H_0 3$: There is no significant association between the biological factors of the victims and the effectiveness of the treatments.

H_A3: There is a significant association between the biological factors of the victims and the effectiveness of treatments.

$H_0 4$: There is no significant association between the social factors of the victims of CSA and the effect of treatments.

H_A4: There is a significant association between the social factors of the victims of CSA and the effect of treatments.

The Chapter Two was organised under three main sections. The theoretical framework specifically discussed the tenents of the four major theories used in the study - Rational Emotive Behviour Therapy, Indivudal Psychology (Adlerian Therapy), Bioecological theory of human development and Four-factor model of CSA. The second section also looked at the two broad forms of CSA - physical contact and non-physical contact sexual activities that are perpetrated by relatives, strangers, acquaintances, or friends against the child; grooming strategies; Yalom's group counselling techniques and assessment of CSA victims. The last section of the chapter reviewed related works of other researchers.

The Chapter Three of the report discussed the procedures in embedded experimental method or the concurrent nested mixed-method used as the research design for this study. The multi-staged sampling techniques was used to select 24 CSA victims from 286 respondents from the three schools in the Metropolis. Frequencies, percentages, thematic anlysis and non-parametric

statistical strategies were also adopted to analyse the research questions and hypotheses accordingly.

Major Findings

The first research question in the study was on the forms of CSA. The analysis of the data collected revealed that the majority of the victims mostly experienced varied degrees and forms of the non-contact physical type of CSA. Non-physical contact forms, such as verbal comments on kissing, fondling their abusers' penis, breasts, and vagina, as well as being encouraged to have sexual relationships with another person, were paramount on the list of the sexual behaviours. Although victims experienced more of the non-physical CSA, some of the physical contact sexual behaviours are worth mentioning. This is so because such sexual acts ranked highest amongst the non-physical contact form of CSA. The mojority of victims who experienced the physical contact form indicated that their perpetrators had penile-vaginal, penile-anal, kissing and oral sexual intercourse with them.

The study also sought to identify which of the four factors and their observable behaviours of the psychological effects of CSA were experienced by the victims. The findings showed that respondents with a history of CSA could either be asymptomatic or suffer some form of the four elements. The findings revealed that traumagenic sexualisation was mostly expressed by the respondents. The prominent observable behaviours of this factor were memories of sexual abuse and the avoidance of the sexual themes that reminded the victims of sexual abuse. The traumagenic powerlessness also ranked second. Most victims who experienced the powerlessness expressed observable behaviour like running away whenever they saw the abuser.

The third research question was on the grooming strategies the perpetrators of CSA in the Cape Coast Metropolis employed to attract their victims. The narrations of the victims revealed that both female and male abusers employed various categories of grooming strategies, though differently. The older abusers mostly used deception, drugging, and seduction. Playfulness, teasing, and bullying were mostly employed by peers to entrap their victims. Aggression was the least of the grooming strategies used by the abusers. Both relatives and non-relatives also abused some of the respondents. No child was sexually abused by a stranger in this study. All victims were lured/convinced/led by known persons – neighbours, schoolmates, friends, co-tenants and relatives respectively.

The focus of all the four hypotheses was on the effectiveness of the experimental groups. Specifically, hypothesis one sought to compare which of the three experimental groups had the most influence on the victims. There was a significant positive high effect of Rational Emotive Behaviour Therapy (REBT) and the Individual Psychology (IP) groups, and vice versa for the control group when the pre-test and the post-test scores were compared. The finding was further supported by the narrations of the victims in all the groups. REBT had the highest positive effect on the CSA victims than the IP. Regarding hypothesis two, the results revealed that the two treatment groups had significant interaction on sexualisation, betrayal, and powerlessness, except stigmatisation. The differences in the interaction in the Four-factor model and effects of therapy depict victims suffer differently from the incidence of the sexual abuse.

The last two hypotheses sought to establish the influence of biological and social factors of the victims on the treatment of the four factors of psychological difficulties as a result of the CSA. The results revealed that these factors do not necessarily have a significant influence on the benefits a CSA victim got from therapy. Though early adolescence had better effects of the therapy as compared to the middle adolescence category, there was no difference in terms of gender. Similarly, the family background of the victims did not have an apparent influence on how the victims benefited from the treatment. The effects of treatments between respondents who stayed with their biological parents and those who did not, as at the time of data collection, were similar.

Conclusions

In the first place, REBT and the IP therapies were helpful tools in dealing with the impact on the CSA victims. REBT strategies, such as shame-attacking, coping statements, and problem-solving skills, were brief and goal-directed in disputing (D) the psychological impacts (B) associated with the incidence of CSA (A). The technique of encouragement, which formed the basis of Adlerian therapy and ran through all the four phases of therapy, was also useful. The effects of the REBT and Adlerian therapy were not dependent on the victims' biological and social factors. These two factors might not be as important in therapy as the therapeutic relationship and the strategies a therapist uses. It is necessary to note that a competent therapist understands the characteristics associated with a particular age group of the CSA victim as well as the Four-factor model of the psychological impacts on the victim.

From the results of the study, REBT and IP treatments could be successful within a specified time, when it is solution-focused and goal-centred.

It is important to note also that the respondents with the history of CSA demonstrated different levels and types of the Four-factor model of psychological impacts of CSA. Also, the Four-factor model was associated with the benefits the victims gained from the therapy. Identifying the Four-factor model of the psychological impact of CSA can aid in the selection of appropriate strategies for interventions. A wrong diagnosis might reinforce a victim's faulty beliefs. A victim may feel rejected, hurt, and feel that there is no safe relationship for him or her, including the therapist. Hence, the Four-factor model of psychological impacts of CSA can be very valuable in the healing process of the CSA victims.

As warned by Oshri et al. (2015), the respondents were innocently or unwittingly lured into sexual activities by friends via mobile phones. With regards to secrecy in CSA, it is not only gifts from the abuser that facilitated it, but the respect, trust, and the position of the abuser in the child's life aided it as well. The prevalence of the sexual activities, grooming strategies of abusers, and holding secrecy, affirm how CSA has become permissible and encouraged in schools and the communities.

Children need to be aware of the reality of CSA. The presentation on CSA to the respondents further exposed the children to the causes and effects of CSA. This information helped them to know that sexual abuse is an exploitation of personal boundaries. This enlightenment re-emphasises the need for sex education. Children's ability to identify potential perpetrators of CSA may be preventive. They should be aware that both males and females,

young and old, relatives and neighbours are potential perpetrators. The education will equip the children to understand that CSA is not a normal thing, should not be entertained, must be reported, and they should seek help as early as practicable. The results of this study attest to the fact that early intervention for CSA victims can help reduce the negative impacts associated with it. As stated earlier, the Control group members had very little mean effect of psychological impacts. The delay and absence of therapy for CSA victims may cause long–term psychological distress and developmental issues. The possibility of a CSA victim actively shaping his or her environment could become a reality and not labelled as bad when treatment is received.

The results proved that victims who experienced either physical, non-physical forms or both forms of the CSA, exhibited some or all the four factors of the psychological impacts of CSA. Recovery through therapy does not appear to be hindered by either the social factors or the gender of the CSA victims.

An observed Model of the Psychological Effect of CSA and its Treatment

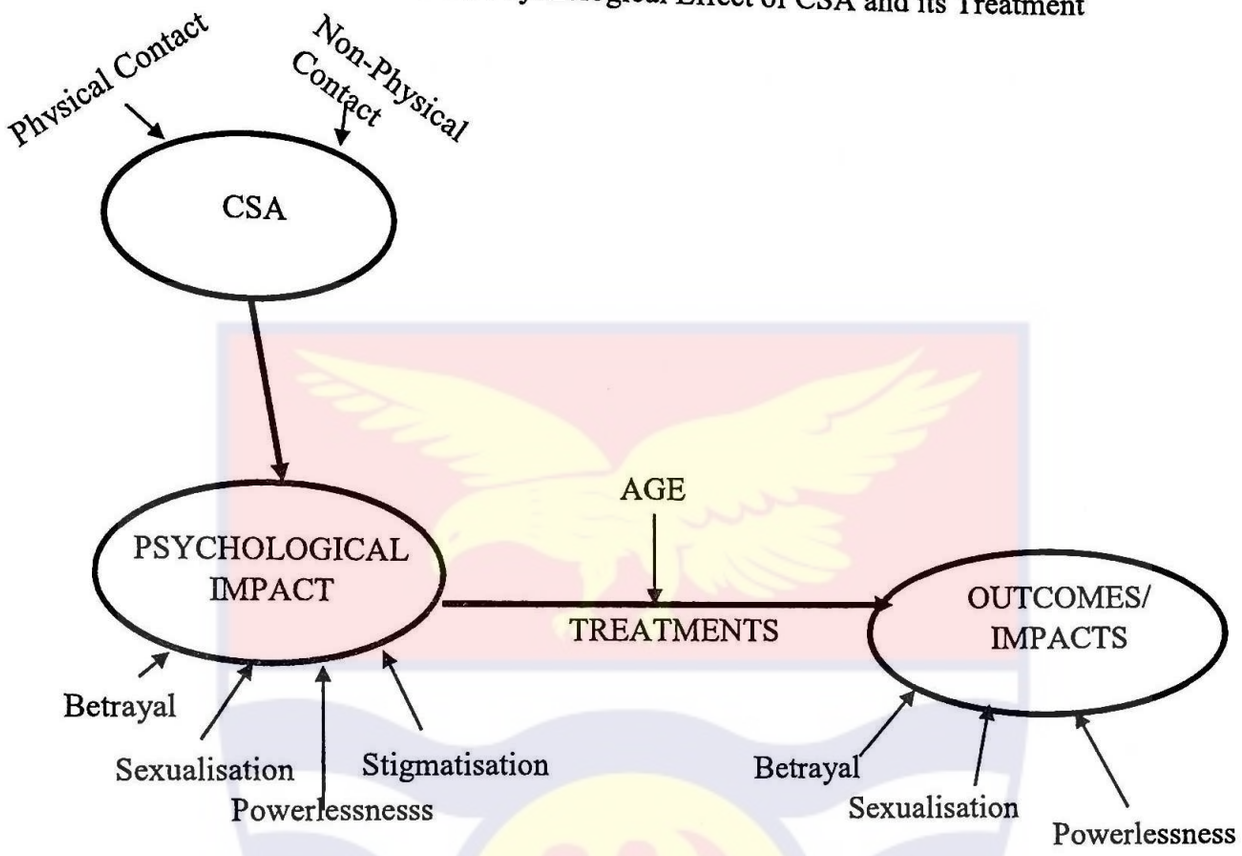

Figure 5: Observed Model of Psychological Effects of CSA and its Treatments
Source: Field Survey (2019)

The researcher assumed at the beginning of the study that biological and social factors would interact with the effect of the therapy. The biological factors comprised gender and age of the CSA victims. After the analysis of the data collected, there was no significant difference in terms of gender and the effect of the treatments. Conversely, the victims in the early adolescence had better effects of the therapy as compared to the middle adolescence category. The social factors were two variants – biological and non-biological backgrounds of the victims. It came out that victims who stayed with either their biological (both parents, mother or father) or non-biological parents (uncles, aunties, friends, grandparents, siblings, or alone) had similar effects of the therapies in both treatment groups.

In sum, the two dimensions of the social factors and gender did not influence the benefits a CSA victim got from therapy. However, the other aspect of the biological factors, age, had a significant association with the effects of the therapy.

Recommendations

Six recommendations were made based on the findings of the study:

1. School-based educational programmes on CSA, such as self-protection, prevention, and grooming strategies, could be useful in reducing the incidence of CSA. Schools' Management should institute regular seminars and workshops on CSA in schools and communities. The goal should be educating children on how and where to disclose information on CSA and seek help when necessary.
2. The REBT and Adlerian therapy were effective in dealing with dysfunctional thoughts of CSA victims. It is recommended that teachers, school counsellors and parents learn the skills of encouraging and disputing irrational beliefs which could also facilitate disclosure and behavioural changes among CSA victims.
3. REBT and IP strategies have proven to be effective in dealing with the four factors of the psychological consequences of CSA victims. It is therefore recommended that basic school counsellors and NGOs be abreast with the concept of the REBT, Individual Psychology (IP), and the Four-factor model of abuse.
4. Biological and social factors have no influence on therapy, but the Four-factor model of the psychological impact/impacts of CSA has a direct link with the effect of therapy. It is recommended that school

counsellors pay much attention to the psychological needs of the child rather than the victim's family background and gender.

5. Group counselling is very effective and time saving. It is therefore recommended that basic school counsellors acquire the skills of group counselling in order to assist victims of CSA in their school and its environments.
6. The two therapies positively enhanced the behavioural change of the CSA victims within a short period. It is recommended that there should be regular seminars and workshops for schools to be skillful in brief counselling. This will help school children who have limited time to stay in school to gain more effectiveness from counselling.

Implication for counselling

1. Since most of the victims of CSA are within the school-going age, school counsellors should have above average knowledge on the Four-factor model of the psychological impacts of CSA. The psychological impact of CSA is a grey area, and that demands a broader perspective to identify the victims. School counsellors' knowledge of the Four-factor model will provide victims with the necessary assistance. Besides, most victims informed no one about the incidence of sexual abuse, which makes the work of the school counsellor more valuable. A positive and egalitarian relationship with the school children is likely to afford the children the chance to open up to the school counsellors and seek timely psychological help.
2. No stranger sexually abused a child in this study. By implication, school guidance programmes should focus on all the categories of

abusers. Guidance services on sexual abuse should teach the children that abusers of CSA are not always strangers or old. Their siblings, peers, and trusted ones could abuse them as well.

3. The findings had powerlessness on top of the dimensions of the psychological impacts that CSA victims mostly demonstrated. The socialisation process where children are trained to be passive should be avoided and instead be encouraged to raise questions and argue their points out. School counsellors could supplement the assertiveness training children get in their various homes. This training will instil in the children the ability to drive away potential abusers of CSA and its disclosure.
4. Parents and guardians show much interest in their children's welfare. They should as well be interested in the affairs of friends their children make and develop trust in their children. Also, parents should ensure that their children use social media for educational and the right purposes. This parental bond will encourage children to disclose their experiences of CSA to parents.
5. The two therapies, REBT and Adlerian Therapy, were effective in alleviating the psychological needs of the CSA victims considering the brief nature of the treatments. Subsequently, agencies such as Domestic Violence and Victims Support Unit, Department of Social Welfare, and Non-Governmental Agencies may adapt the techniques of the therapies in their operations to provide CSA victims who might not have much time for therapy.

Contributions to knowledge

1. The critical variables in this study – CSA, intervention, and the Four-factor model of psychological impacts of CSA, are considered uncharted territory. Most impact studies on CSA used trauma theories such as the PTSD (Post Traumatic Stress Disorder) model, which is narrow. The current results have revealed how important it is to extend the psychological impacts of CSA to a broader perspective. The Four-factor model of psychological impacts of CSA victims could serve as a behavioural assessment for further intervention for the victims.
2. This study has re-established that duration for therapy should not necessarily be stretched to be effective. The results revealed that REBT and IP techniques could be equally effective in brief therapy that is far less than the established duration.
3. A new dimension of secrecy in CSA is trust, respect for the abuser, and the abuser's status within the broader community was revealed in the study.
4. The study reinforced the assertion that both males and females, young and old can sexually abuse children. However, added knowledge is in the fact that the female's older abusers used different grooming strategies from the younger ones.
5. This study revealed facts on both physical and non-physical contact forms of CSA. It came out that unlike prior research, where the majority of CSA victims experienced physical contact of CSA, this study found otherwise. Children endured more non-physical contact

forms of CSA. The non-physical contact form seems to be ignored or relegated in many studies, which seem to reinforce its occurrences.

Contribution to Policy

1. The findings of this study buttress the inclusion of sex education into the national curriculum of elementary schools. Appropriate and adequate information on grooming strategies will prevent and reduce the prevalence of CSA. Since children are more likely to disclose information to their friends, they can also serve as agents of change when proper knowledge is received. The caution, however, is that the information or the content should be aged appropriately.
2. The finding revealed that children endured more non-physical contact forms of CSA. The non-physical contact form seems to be ignored or relegated in many studies, which seem to reinforce its occurrences. Policymakers concerned with the children's welfare and parents should educate children on this form of CSA. This education will help the children to understand that other people do not have the right to touch certain parts of their bodies unnecessarily. Also, children will acknowledge the fact that some gestures and alternates are tantamount to sexual abuse and will report accordingly.

Suggestions for Further Research

1. Future research could incorporate a larger sample size of CSA victims. A large sample size could help ascertain a broader perspective on the IP's encouragement and the REBT, where deep feelings could surface. As this was a limitation of the current study, a large sample size could improve the generalisability of the findings.

2. A CSA study that could expand the social factors to include parents' socio-economic level and the child's environment (whether rural or urban) would be necessary.
3. Further work could be on school counsellors' effectiveness in dealing with the Four-factor model of the psychological impact of CSA. Since most sexual abuse cases happen among school mates, but victims and their families do not report to the police, school counsellors might serve as confidants for such vulnerable people. It will be of great help for the counsellors to be well versed in the Four-factor model to effectively and efficiently provide the necessary psychological support.

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APPENDICES

APPENDIX A

LETTER OF INTRODUCTION

UNIVERSITY OF CAPE COAST
COLLEGE OF EDUCATION STUDIES
FACULTY OF EDUCATIONAL FOUNDATIONS
DEPARTMENT OF GUIDANCE AND COUNSELLING

UNIVERSITY POST OFFICE
CAPE COAST, GHANA

Our Ref.
Your Ref: DGC/1.2/VOL.1/93

June 19, 2019

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION

We introduce to you, Justina Sarpong Akoto, a student pursuing a Ph.D Programme in Guidance and Counselling at the Department of Guidance and Counselling of the University of Cape Coast. As a requirement, she is to submit a Thesis on the topic: "*Application of REBT and IP as Counselling Strategies for Survivors of Child Sexual Abuse in the Central Region of Ghana*". We are by this letter affirming that, the information she will obtain from your institution will be solely used for academic purposes.

We would be most grateful if you could provide her the necessary assistance.

Thank you.

Rev. Fr. Dr. Anthony K. Nkyi
HEAD OF DEPARTMENT

APPENDIX B

ETHICAL CLEARANCE

UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

(Office of the Director of Research, Innovation and Consultancy)

Ms. Justina Nafsong Akoto
Department of Guidance and Counselling
University of Cape Coast

12TH SEPTEMBER, 2019

Dear Ms. Akoto

ETHICAL CLEARANCE – ID: (UCCIRBCES/2019/30)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol titled **Application of Rebt and IP as counselling strategies for survivors of child sexual abuse in the Central Region of Ghana.** This approval requires that you submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

Please note that any modification of the project must be submitted to the UCCIRB for review and approval before its implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number on all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Awuku Owusu, PhD
UCCIRB Administrator

APPENDIX C

CHILD SEXUAL ABUSE TRAUMA INVENTORY

This questionnaire is to elicit information about the incidence of Child Sexual Abuse (CSA) and its effects on the victims. It is intended for research and all information you provide would be used for that purpose. There are 3 sections in all. All information shared with me will be treated with strict confidentiality. Thank you.

SECTION A – DEMOGRAPHIC DATA

Please either **WRITE** or **TICK** where appropriate, the response to the following items:

1. Age ....
2. Gender : Male Female
3. Who do you stay with?

Both parents [ ]

Mother alone [ ]

Father alone [ ]

Step parents [ ]

Aunty [ ]

Uncle [ ]

Others, specify: .....

SECTION B – SEXUAL ABUSE ACTS

Thinking about anytime in your life, has any adult ever done any of the following things to you? Please **TICK** (√) either YES or NO for each of the actions.

	ITEM **He/she ...**	**YES**	**NO**		**ITEM** **He/she...**	**YES**	**NO**
4.	told me to play with his/her penis /vagina/breast.			10.	watched pornography movies with me.		
5.	kissed me.			11.	inserted his penis in my anus.		
6.	told me to undress before him/her.			12.	put objects/finger in my vagina.		
7.	said I have beautiful buttocks/breasts.			13.	told me to kiss him/her		
8.	encouraged me to have sex with someone.			14.	inserted his penis in my vagina.		
9.	inserted his/her finger in my mouth.			15.	played with my breast/buttocks.		
State any other experience not listed above							

SECTION C – STATE OF MIND

Below is a list of items that describe your action after the sexual abuse incidence. There is no right or wrong answer. For each of the items in the **SCALES**, please **TICK** in the box how a particular item applies to you.

	ITEMS Following the sexual abuse incidence, I...	NOT AT ALL	A LITTLE	SOME-HOW	STRONG	VERY STRONG
	SEXUALISATION					
16.	still remember the abuse as if it is happening again.					
17.	try to avoid items that remind me of the sexual abuse.					
18.	daydream of the sexual abuse when someone touches me.					
19.	avoid places that are related to the abuse.					
20.	am able to play with my friends without acting sexy					
	BETRAYAL					
21.	think my parents understand how I feel about the abuse.					
22.	think my guardians/parents like my siblings more than me.					
23.	easily get angry whenever I think of the abuse.					

24.	think about the abuse when I feel ignored					
25.	am not sure my guardians/parents care for me anymore.					
	STIGMATISATION					
26.	am ashamed of myself because of the abuse.					
27.	like to be alone whenever I think of the abuse.					
28.	find my friends are more attractive than me.					
29.	think my friends still enjoy my company.					
30.	like to cut myself when I am reminded of the abuse.					
	POWERLESSNESS					
31.	find it difficult to sleep when I remember the abuse.					
32.	worry about the abuse most of the time.					
33.	am comfortable to ask for what I need.					
34.	have lost interest in school because of the abuse.					
35.	wish to run away from the house whenever I see the abuser's face.					

THANK YOU

APPENDIX D

INTERVIEW GUIDE ON PSYCHOLOGICAL IMPACTS OF VICTIMS OF CHILD SEXUAL ABUSE

This interview is to elicit information about the incidence of Child Sexual Abuse (CSA) and its effects on the victims. It is intended for research and all information you provide would be used for that purpose. There are 3 sections in all. All information shared with me will be treated with strict confidentiality. Thank you.

1. Respondent's CODE
2. Phone no. (if any)
3. Do you know why we have met today?
4. What is your relationship with him/her?
5. What happened between the two of you?
6. Was there any force or pressure involved?
7. Have you ever told anyone about the sexual abuse and who did you tell?

APPENDIX E

POST-TEST QUESTIONNAIRE ON CHILD SEXUAL ABUSE

TRAUMA INVENTORY

This questionnaire is to elicit information about the effects of the treatments who have gone received. It is intended for research and all information you provide would be used for that purpose. All information shared with will be treated with strict confidentiality. Thank you.

STATE OF MIND

Below is a list of items that describe your action after the treatments on psychological impacts of sexual abuse experience. There is no right or wrong answer. For each of the items in the SCALES, please TICK in the box to indicate how a particular behaviour applies to you.

SN	ITEMS Following the sexual abuse incidence, I...	NOT AT ALL	A LITTLE	SOME-HOW	STRONG	VERY STRONG
	SEXUALISATION					
1.	still remember the abuse as if it is happening again.					
2.	try to avoid items that remind me of the sexual abuse.					
2.	daydream of the abuse when someone touches me.					
4.	avoid places that are related to the abuse.					
5.	am able to play with my friends without acting sexy					

BETRAYAL

6.	think my parents understand how I feel about the abuse.					
7.	think my guardians/parents like my siblings more than me.					
8.	easily get angry with people when I think of the abuse.					
9.	think about the abuse when I feel ignored					
10	am not sure my guardians/parents care for me anymore.					

STIGMATISATION

11.	am ashamed of myself because of the abuse.					
12.	like to be alone whenever I think of the abuse.					
13.	find my friends are more attractive than me.					
14.	think my friends still enjoy my company.					
15.	like to cut myself when I am reminded of the abuse.					

POWERLESSNESS

16.	find it difficult to sleep when I remember the abuse.					
17.	worry about the abuse most of the time.					
18.	am comfortable to ask for what I need.					
19.	have lost interest in school because of the abuse.					
20.	wish to run away from the house whenever I see the abuser's face.					

APPENDIX F

POST-TEST INTERVIEW GUIDE ON EFFECT OF TREATMENT ON PSYCHOLOGICAL IMPACTS ON VICTIMS OF CHILD SEXUAL ABUSE

This interview is to elicit information about the effects of the treatments on psychological impacts on victims of child sexual abuse who have gone through treatment. It is intended for research and all information you provide would be used for that purpose. All information shared with me will be treated with strict confidentiality. Thank you.

1. Was the treatment helpful to you?
2. How has the treatment helped you to deal with the problems you faced because of the sexual abuse?
3. How has the treatment changed your relationship with others?

THANK YOU