The relationship between unwanted sexual experiences, psychological well-being, substance abuse and high-risk sexual behaviour among adolescents

By

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TABLE OF CONTENTS

LIST OF TABLES AND DIAGRAMS

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SUMMARY

The interaction between unwanted sexual experiences during childhood and an adolescent's psychological well-being, use of substances and involvement in high-risk sexual behaviour was explored in this study.

Unwanted childhood sexual experiences, such as sexual abuse, are major societal concerns and have been widely researched. However, much of the research was done using individuals presenting for help with the effects of this trauma. This excludes those individuals who experienced sexual abuse, but did not suffer any visible consequences as a result. Previous research therefore presents half a picture. South African literature on this phenomenon is also limited. As a result, this study looks at childhood sexual abuse or unwanted childhood sexual experiences within a South African context using a sample from the general population in order to obtain a more accurate picture.

The Cognitive Behavioural Theory and the Theory of Reasoned Action will be used to attempt to explain how exposure to unwanted sexual experiences may contribute to certain psychological, emotional and behavioural outcomes. The Cognitive Behavioural Theory postulates that there is a relationship between an individual's thoughts or cognitions and their emotions and behaviour. Cognitions are formed through the individual's previous experiences and are the basis upon which the individual will act in future experiences. The Theory of Reasoned Action states that it is not only one's own attitudes and beliefs that influence one's behaviour, but also the perceived attitudes of others around oneself. By incorporating these two theories into the study, one can hypothesise why, and how, certain effects may or may not result in sexually abused individuals.

From previous research, it can be concluded that childhood sexual abuse can lead to poor psychological well-being, increased participation in the use/abuse of substances and increased involvement in high-risk sexual behaviour. By

using a general sample of the population (a sample that includes both sexually abused and non-sexually abused individuals) this study attempted to investigate interactions between these four variables and explore factors that interfere with or promote the relationship between these variables.

It appears that there is, in fact, an interaction between the four variables. There is a positive relationship between unwanted sexual experience and adolescent substance-use behaviour, specifically drug abuse and between unwanted sexual experience and adolescent high-risk sexual behaviour. No relationship was found between unwanted sexual experience and psychological well-being.

If and how these variables interact is dependent on the specific individual. It is problematic to assume that each individual reacts to a trauma, such as unwanted sex, in the same way. Other factors, such as the details around the abuse as well as the previous experiences and functioning of the child, need to be considered.

CHAPTER ONE

INTRODUCTION

1.1 Motivation for the Study

Unwanted sexual experience during childhood, such as sexual abuse, is a phenomenon which affects both males and females of every age, class, race and culture (Collings, 2002). Child sexual abuse has been defined by individuals and organisations, and is a term that most people use to describe sexual behaviour that is forced upon a child. However, these definitions are often limited in that they discuss the specific behaviours that warrant the use of the term 'sexual abuse'. The child's perception of the behaviour is not acknowledged. The term 'unwanted sexual experience' is therefore broader than this in that it covers all acts included in sexual abuse, but also takes the child's subjective experience into account, and includes 'sexual' behaviours that the child feels are unwanted, whether it be done by an adult or a younger person. For the purpose of this study, the two terms will be used interchangeably and will encompass all behaviours included in the term 'sexual abuse', as well as any sexual behaviour perceived as unwanted by the child.

A wide variety of research has been conducted internationally on the effect that these experiences have on an individual later in life. However, most of the research was done retrospectively and the samples used were gathered from those individuals presenting for help with the effects of the abuse, or presenting with certain difficulties, which, in fact, may not have been a result of the abuse (Gokaldas, 1998). This presents problems, as individuals who had been sexually abused but did not present with difficulties were not included in the research. As a result, the samples are biased. Previous research compares the characteristics of abused individuals presenting for help with those of non-abused individuals and, as a result, most of the

research implies a causal relationship between childhood sexual abuse and the effects it has on the individual later in life. However, there is not necessarily a causal relationship. It is therefore necessary to conduct research on unwanted childhood sexual experiences using a sample of the general population, and looking at the interaction between several factors as opposed to cause and effect relationships. Studying the influence this phenomenon has on children later in life may increase awareness into the severity of childhood sexual abuse, or may indicate that it does not have such a devastating effect as currently believed.

The study focuses on the long-term affects of childhood sexual abuse, such as the effects that are experienced during adolescence. Adolescence is a difficult developmental period. Individuals in this stage are faced with the need for more independence and many choices as to how they will gain this independence. It is also a stage when peer pressure can become a powerful determinant in an adolescent's behaviour, and parental and societal beliefs are questioned. During this stage, the adolescent is often exposed to new experiences, such as sexual experiences and experiences with substances (Ferrera, 2002). While striving for independence, the adolescent may find that he/she needs to make choices about his/her behaviour with respect to these factors.

When children are exposed to unwanted sexual experiences or sexual abuse, they are violated and may have difficulty understanding or integrating the experience. If they do not have the resources to work through the feelings, which can be associated with this type of experience, psychological difficulties can ensue (Briere, 1992). Due to the fact that adolescence can already be a confusing time for the individual, psychological difficulties persisting into this developmental period may affect the behavioural choices the individual makes. This could lead to participation in dangerous behaviours, and two areas in which this may occur are sexual behaviour and abuse of substances (Ferrera, 2002). As a result, it is necessary to look not only at the psychological effects of childhood sexual abuse, but also at the behavioural

effects such as involvement in substance-use behaviour and high-risk sexual behaviour.

1.1.1 Child Sexual Abuse within South Africa

Sexual abuse is a major social problem in South Africa. For decades it was concealed by ignorance and indifference and yet, despite increasing attention, it still remains shrouded in secrecy and denial and is considered a taboo of society. A large body of literature has been developed on this issue in the last twenty years. However, much of the research conducted in South Africa has attempted to emulate research emerging from the European-American socio-environment, thereby assuming that findings of such studies are universal and generalisable to the diverse cultural context of South Africa. This assumption is problematic, in that paradigms that form the basis of foreign research are not necessarily appropriate within the South African context (Gokaldas, 1998).

As a result, conducting research on the experience of unwanted sexual behaviour, such as childhood sexual abuse, within a South African context is essential.

Childhood sexual abuse is a growing concern. Reports indicate that the number of children sexually abused each year in South Africa has more than doubled over the past two decades (Collings, 2002). Collings (2002) states that reports also indicate that there appear to be some unusual characteristics of abuse in this country, such as an especially rapid increase in the number of males that are sexually abused (a 45,8% increase over a 10 year period as opposed to a 31% increase of abuse in the female population). There also seems to be an increased risk of abuse by professionals. It was found that 25% of perpetrators are professional people, 30% of these professional people being teachers and 17% being doctors. This was excessively higher than the percentage of professional offenders in the United States. An increased risk of abuse by multiple offenders was also seen in that ten per cent of abuse incidents involve multiple offenders. This is compared to the

statistics of the United States in which only 2,6% involve multiple offenders (Collings, 2002). There is an ongoing debate as to whether there has been a real increase in childhood sexual abuse or whether reporting rates have increased due to a heightened level of awareness. For various reasons it is difficult to determine the actual prevalence of childhood sexual abuse within South Africa (Townsend & Dawes, 2004) but, currently, it is believed that about one child in eight is sexually abused (Davel, 2000). However, several factors influence the ability to determine an exact prevalence, and the most prominent of these factors is the definition of child sexual abuse.

Currently, there is no single definition of child sexual abuse that is used consistently by all organisations. The problem with formulating a concrete definition stems from a number of factors. One of the primary problems with the definition lies in the fact that 'sexual' as a term is often assumed to be an act of sexual intercourse. This is, in fact, far from the truth since much of child sexual abuse involves acts that would be regarded as subtle in comparison to intercourse. Sexual abuse of children often constitutes touching the child or asking the child to touch themselves, exposing the child to pornographic material, requiring the child to look at parts of the body, sexual acts or any other material which is arousing to oneself (Gokaldas, 1998). Muller (1998) describes childhood sexual abuse as the involvement of dependent, developmentally immature children and adolescents in sexual activities that the child does not fully comprehend, is unable to give informed consent to and which violates the normal taboos of society. A common definition used in South African law is, "sexual abuse refers to acts of a sexual nature, inappropriately perpetrated by adults (or other children) upon children" (Davel, 2000, p. 362). A child is considered any person under the age of 18 (Davel, 2000).

This difficulty with developing a single, consistently used definition creates problems as organisations will neglect to report certain cases for the simple fact that they do not fall within the limits of what they class as sexual abuse. A common example of this is that there are, in fact, two types of sexual abuse: contact sexual abuse and non-contact sexual abuse.

- Contact sexual abuse involves any form of physical contact during the commissioning of a sexually abusive act, such as penetration, which includes penile, digital and object penetration of the vagina, mouth or anus. It also involves non-penetration, which includes fondling of sexual parts of the child's body, sexual kissing or the child touching the sexual parts of another person's body.

- Non-contact sexual abuse includes exhibitionism, voyeurism and exposing the child to sexual content such as pornography (Dawes, Borel-Saladin & Parker, 2004).

Many individuals, as well as organisations, will avoid reporting non-contact sexual abuse, as it does not fall under their definition of sexual abuse (Dawes, Borel-Saladin & Parker, 2004).

For the purpose of this study, sexual abuse and unwanted sexual experiences will be used interchangeably and will include the definitions of contact sexual abuse and non-contact sexual abuse, as well as any other sexual behaviour experienced as unwanted by the child. Unwanted childhood sexual experiences would therefore include all behaviour of a sexual kind in which a child is involved, including behaviour between adults and children or between children and other children experienced by the *child* as unwanted sexual experience.

1.1.2 How the South African Context Contributes to Child Sexual Abuse

There is no single causative factor for childhood sexual abuse, but rather multiple factors have been identified. It is important to take these factors into account as they can aid in explaining how the South African context contributes to the high incidence of childhood sexual abuse. Becker and Kaplan's model (Becker, 1994) proposes that sexual abuse results from a combination of socio-cultural and economic contexts, interpersonal contexts and individual characteristics. Individual characteristics refer to the

characteristics of the perpetrator and may include poor impulse control, low self-esteem, a lack of empathy for victims and/or sexual dysfunction. Interpersonal contexts may include domestic violence, poor attachment patterns and victim-perpetrator relationships. Within South Africa there are also certain socio-cultural and economic factors that may contribute to the high incidence of childhood sexual abuse.

The first of these factors that may contribute to childhood sexual abuse is patriarchy or male dominance which is present in some groups. South Africa is a largely patriarchal society and young children are socialised into a set of unequal gender and power relations that creates a culture of male sexual entitlement. Some males develop with the belief that they have a right to enforce their power on those less powerful, namely woman and children, and this may be done through different forms of abuse, including sexual abuse. This is a feminist viewpoint and although it may play a contributory role in explaining the incidence of sexual abuse in South Africa, it is important to note that not all males use abuse to enforce their power. Another problem with this viewpoint is that is does not explain the reason for sexual abuse committed by females (Townsend & Dawes, 2004).

Gender socialisation and child rearing are also important factors in explaining possible contributors to childhood sexual abuse. Within many South African cultures, children are brought up to obey their seniors unquestioningly and to follow the old rule of “children should be seen and not heard”. This may influence the incidence of abuse as the children will do as told, such as participate in sexual acts with a senior, and remain silent about it. It is therefore possible that certain socialisation mechanisms may render children vulnerable to sexual abuse (Townsend & Dawes, 2004).

Rapid social change within South Africa has led to a breakdown of traditional culture, occasioned by such factors as inter-ethnic marriage, urban migration and other social and economic forces. These factors are believed to have an impact on the increase in child sexual abuse in the country. Immigrant and urbanising families face unique problems that may potentially lead to child

maltreatment. Through formal schooling, immigrant children, as well as indigenous children, acquire more knowledge of the new environment than their parents, and become less compliant and obedient, providing greater opportunities for parent-child conflict. A move from rural to urban areas may isolate families from kin and social networks, thereby decreasing the likelihood that parent-child conflict can be diminished before it escalates to child maltreatment (Korbin, 1991).

Another explanation is that of social fragmentation. This view suggests that child sexual abuse is due to the increasing isolation of individuals and families from a sense of community, which results from increased mobility and the disintegration of neighbourhoods, communities and kin networks. This isolation deprives people of socially sanctioned forms of support and intimacy so instead they turn to forms that are taboo. In other words, the sexual attachments that would normally develop outside a family occur within a family (Lalor, 2004). On the flip side, child sexual abuse which does not occur within the family but rather between child and a non-family member can be exacerbated by the migrant labour system. Many parents in this country work as migrant labourers, either in other provinces or in places far from their homes. This leads to a lack of bonding between parents and children, a lack of supervision of children and, due to poor child care facilities, many children are left at home alone during the week or left with nannies or grandparents who may not give them proper care. This leaves them vulnerable to sexual abuse from opportunistic predators (Madu, 2003).

Although the aforementioned factors are believed to have an influence on the prevalence of child sexual abuse, the most prominent factors contributing to the prevalence within South Africa is that of poverty, unemployment and overcrowding. It is important to recognise that studies have indicated that child sexual abuse happens among all class groups and all racial categories (Collings, 2002). However, these socio-economic factors play a role in increasing the child's vulnerability to sexual abuse. Unemployment is a major problem within South Africa and may contribute to child sexual abuse for several reasons: those who are unemployed simply have more time on their

hands, and therefore, a greater opportunity to approach their victims; poverty stems from unemployment and children from poverty stricken homes may become involved in sex work in order to help support the family by paying the rent, buying food and paying for schooling; and finally, poverty may result in overcrowding of homes which limits the possibility of separation between sexualised adults and the children as co-sleeping (parents and children sleeping in the same bed) is often necessary and may provide additional opportunities for sexual abuse. One must, however, be aware that not all individuals exposed to unemployment, poverty and overcrowding resort to sexually abusing children. These factors merely facilitate in increasing the prevalence of sexual abuse in South Africa (Townsend & Dawes, 2004).

Cultural factors have also been associated with the high prevalence of sexual abuse in South Africa. Many cultures persist with traditions which are believed to be sexually abusive toward children. An example of this is virginity testing which is practised within the Zulu and Xhosa culture, where female children are inspected in order to determine whether they are virgins. This is done prior to marriage to determine the amount of labola. Although it is seen as an essential practice within the culture, many have argued that these young girls' exposure to and inspection by their seniors is a violation of their rights and, in fact, a form of child sexual abuse (Jewkes, 2004).

The so-called 'virgin-cleansing myth' suggests that having sexual intercourse with a virgin will cleanse the perpetrator of HIV or other sexually transmitted diseases and, as a result, can also contribute to the incidence of child sexual abuse (Lema, 1997). It is also believed that some traditional healers advise clients seeking success in farming, business, gambling or other monetary affairs to secure this success by having sex with a very young girl, often the client's own daughter. It is often the man's wife who prepares the daughter for sexual intercourse with her father (Meursing, Vos, Coutinho, Moyo, Mpofu, Oneko, Mundy, Dube, Mahlangu & Sibindi, 1995). Studies have indicated that these myths are still believed and practised, and could play an influential role in the number of children sexually abused, as well as the prevalence of HIV infected individuals (Jewkes, 2004).

1.1.3 Child Sexual Abuse and the Three Chosen Variables

Sexual abuse during childhood may affect an individual's psychological well-being as well as their involvement in certain behaviours, such as the abuse of substances and participation in high-risk sexual behaviour.

- The term psychological well-being is equivalent to that of mental health or psychological health. It is defined as a complex and interrelated tapestry of several components, including self-regard, independence, problem-solving, assertiveness, stress tolerance, self-actualisation, happiness, reality-testing, interpersonal relationships, flexibility, and social responsibility (Bar-On, 1988). For the purpose of this study we will focus on three of these components, namely self-regard, happiness and interpersonal relationships. Many factors may affect an individual's mental health, including childhood sexual abuse. Investigating the relationship between these two concepts will provide mental health professionals with a better understanding of how sexual abuse impacts on a person's psychological well-being.

- Substance abuse is defined as "a maladaptive pattern of substance use leading to a clinically significant impairment or distress, manifested by one or more of the following symptoms within a 12-month period: recurrent substance use in situations that cause physical danger to the user, recurrent substance use in the face of obvious impairment in school or work situations, recurrent substance use despite resulting legal problems or recurrent substance use despite social or interpersonal problems". The use of any type or amount of substance, by an individual, before the age of 18 is considered substance abuse (Sadock & Sadock, 2003, p. 1287). The abuse of substances is increasing rapidly in the South African adolescent population. South African individuals are using substances at an increasingly younger age and more frequently than in previous years (Radzick, Freeman & MacKenzie, 1999). Substance use possibly acts as a coping mechanism for dealing with abuse-related psychological distress.

Due to this, individuals may be unable to halt their use of substances until alternative skills for dealing with trauma-related memories and cognitions have been put in place. Many clinicians believe that the use of substances must be arrested before other syndromes can be effectively treated. Others realise that the requirement of abstinence may be inappropriate for such patients and may in fact lead to treatment avoidance. Being aware of the impact childhood sexual abuse may have on the use of substances, as well as the psychological processes underlying their need for these substances is essential. This knowledge may aid professionals in providing a more effective treatment programme that integrates treatment of substance use together with treatment of symptoms of child sexual abuse (Freeman, Collier & Parillo, 2002).

- It is no secret that HIV/AIDS in South Africa is a serious and accelerating problem, and the female population is now recognised as one of the fastest growing groups of HIV/AIDS patients worldwide (Batten, Follette & Aban, 2001). One of the many factors contributing to the increase of HIV-infected persons is the high-risk sexual behaviour that individuals engage in, such as sexual intercourse with various partners and having unprotected sex (Batten, Follette & Aban, 2001). Research has indicated that childhood sexual abuse is one of the many factors predisposing this behaviour. It has also been indicated that these individuals are less likely to change their sexual behaviour as a result of information provided about HIV/AIDS risks (Batten, Follette & Aban, 2001). Mental health professionals, therefore, need to be made aware of the possible link between the psychological effects of child sexual abuse and the involvement in high-risk sexual behaviour. By focusing on the core issue of abuse and dealing with the psychological effects emerging from the abuse, it is possible to prevent or treat the high-risk sexual behaviour of the individual (Kalichman, Gore-Felton, Benotch, Cage & Rompa, 2004).

1.2 Summary

The need for research on childhood sexual abuse in a South African context has been demonstrated, as have the reasons for analysing the relationships between childhood sexual abuse, psychological well-being, substance use/abuse and high-risk sexual behaviour in adolescents. The following chapters will discuss the theoretical framework used when looking at the relationship between these variables, the available literature on the four variables, methods of collecting data in order to study the relationships between these constructs and finally, the results obtained from analysing the data. The study will conclude with a discussion on how these four variables are associated with each other and a conclusion in terms of whether there is, in fact, a relationship between unwanted sexual experiences during childhood and the psychological well-being, substance-use behaviour and sexual behaviour of adolescents.

CHAPTER TWO

THEORETICAL FRAMEWORK

Literature indicates that unwanted sexual experience during childhood affects an individual's psychological well-being and behaviour both at the time of the incident, as well as later in his/her life (see chapter 3). The cognitive-behavioural theory provides a framework for explaining how and why these past experiences influence the individual's feelings and behaviour later in life. However, it is not only past experience that impacts on an individual's behaviour, but also the attitudes of others. An individual may be influenced to behave in a certain way as that is what is accepted by those around him/her. This can be further explained by the theory of reasoned action. These two theories can therefore be used simultaneously to explain how certain emotions and behaviours may result from a traumatic experience, such as sexual abuse. This study will attempt to determine whether unwanted sexual experience during childhood influences the psychological well-being, substance-use behaviour and sexual behaviour of an individual. If the research determines that it, in fact, does impact on these variables, these two theories can be used to explain how this occurs.

2.1. Cognitive Behavioural Theory

The Cognitive Behavioural Theory will be used to understand interactions between the variables being measured in the study, namely unwanted sexual experience during childhood, psychological well-being, substance-use behaviour and sexual behaviour. This theory looks at the relationship between an individual's thoughts or cognitions and the person's behaviour. This therapeutic mode is based on the assumption that emotions and behaviour are largely determined by the way in which the individuals structure their world. Cognitions are based on attitudes or assumptions - called schemata - which are formed through the individual's previous experiences. These cognitions are then the basis upon which the individual will act in future

experiences (Ronen, 1998). In other words, when an individual encounters a situation, their beliefs or cognitions are the mediating factors which will determine how the person feels about, and responds to the situation. People that seek counselling for difficulties they are experiencing, describe these difficulties in terms of how they are feeling (e.g. depressed) or the situation with which they are unable to cope. However, both these aspects can be described by looking at the way the person thinks about the situation. It is, therefore, not the actual event that produces the bad feelings or difficulty in coping but rather the way the event is appraised or thought about. When people hold unrealistic and negative beliefs about themselves or their experiences, an emotional upset will result and they will behave in accordance with these beliefs (Trower, Casey & Dryden, 1995).

Victims of child sexual abuse may develop negative beliefs and attitudes (cognitions) about the world and about themselves. This is largely dependent on how they interpret the abusive events. They may view the world as an unsafe place and see themselves as worthless. As a result of these cognitions, their emotional well-being and behaviour may be negatively affected. As already mentioned, psychological well-being consists of several components, including positive self-regard, independence, assertiveness, the ability to cope with stress, self-actualisation, happiness, good social relations, good reality-testing and effective problem-solving (Bar-On, 1988). Early trauma such as sexual abuse can impact on the healthy development of these components and, as a result, the individual may form negative beliefs about themselves. These individuals believe that they are worthless and that they are to blame for the abuse. They see little hope for the future and believe that the world cannot be trusted to keep them safe. These beliefs can negatively affect their psychological well-being as they develop negative emotions as a result of these beliefs (Briere, 1992).

Beliefs formed by victims of child sexual abuse not only affect their emotions, but can also have an impact on their behaviour. These individuals may feel the need to self-medicate in order to deal with the negative emotions they are experiencing and, as a result, become users and abusers of various

substances. Their beliefs that they are worthless and unlovable may lead to feelings of isolation and a profound sense of loneliness and alienation from others. In their desperate need to belong, they may associate with the most readily available form of social support, the drug-using party people. Their need to belong can influence them to conform to the ways of the group and their psychological characteristics may increase the risk of being influenced (Evans & Sullivan, 1995).

Sexual behaviour may also be affected by the beliefs formed by victims of childhood sexual abuse. They have learnt (and formed beliefs) at an early age that one of the ways of gaining intimacy, nurturance and interpersonal closeness is sexual availability. They may, therefore, enter into sexual encounters in search of closeness and nurturance, but sustained intimacy may lead to fearfulness of becoming vulnerable and being exploited and abandoned, which may also be a belief formed early in life. These feelings may cause them to leave and seek another sexual partner. They may have also formed a belief that the only way to gain the things they need, is to trade for them with sex. This belief may continue later in life, resulting in transactional sex (Briere, 1992).

Although there seem to be many severe consequences associated with childhood sexual abuse, it is important to keep in mind the possibility that all sexually abused individuals may not react to the abuse in the same way. It is also important to remember the possibility that certain individuals may not suffer any serious consequences at all. There are many variables which affect how an individual will construct the experience in their mind and will, in turn, respond to and deal with being sexually abused:

- Initially, it is the actual event which may influence whether or not there are later consequences and how severe they will be.

- The age of the child during the period of the abuse is important. Younger children are more likely to experience negative effects after the abuse, as

they are mentally and emotionally too immature to understand the act of the abuse, and they develop distorted cognitions more easily. They are also more susceptible to being influenced by their seniors whom they see as wise and all-knowing and the child may, therefore, take the blame of the abuse onto themself. This can lead to feelings of guilt which has more serious consequences in terms of the individual's psychological well-being.

- The type, severity, frequency and length of abuse are thought to play a big role in the effect the abuse will have on the child.

- Contact sexual abuse is believed to have a more negative effect on the child than non-contact sexual abuse, as stronger cognitions are formed about the experience.

- Within contact sexual abuse, the severity of the abuse can differ. In instances where the child is severely hurt physically, especially on many occasions and for a long period of time, the result is that the child will generally suffer more trauma from the abuse and more psychological difficulties later in life.

- Finally, the perpetrator is an important factor in how the child reacts to the abuse. Generally, when the perpetrator is in an intimate relationship with the child, such as a parent, family member, teacher, neighbour or other adult responsible for the care of the child, the abuse may have a more negative effect on the child than when the perpetrator is unknown to him/her. This is often due to the fact that the child has trust in this person to care for him/her, and this trust is then shattered, leaving the child with a belief that the world is unsafe (Richter & Higson-Smith, 2004). On the other hand, an attack by a stranger may be more traumatic. When the perpetrator is known to the child and there may be an element of trust between the child and the perpetrator, this may create an illusion of safety for the child. If the perpetrator is unknown to the child, this perceived

safety is missing and the child may feel afraid and traumatised at the time of the abuse.

In short, the factors contributing to the way the child experiences the abuse, and the resulting cognitions formed around the abuse, will play a role in the effect the abuse has on the child.

Several factors post the abuse will also influence the effect that the abuse has on the child. The first is the child's disclosure of the event. Many children live with the knowledge of the abuse and do not receive help or support from someone they can trust. They are often afraid to disclose the abuse as they have been threatened by the perpetrator, believe they are responsible for the abuse or fear that disclosure will lead to the perpetrator being put in jail. This creates anxiety in the instance where the perpetrator is a parental figure or the breadwinner, as the child feels that he/she will be responsible for financial suffering in the family. If the child is able to disclose the details of the abuse, it is essential that he/she receives support from those to whom the abused individual discloses the information. Children who feel they are not believed or that they are blamed for the abuse may feel unsupported and abandoned. Support from family members or other intimate individuals in the child's life can help the child develop appropriate beliefs about the experience and therefore reduce the negative effects the sexual abuse can have on the child later in life (Richter & Higson-Smith, 2004).

If one considers child sexual abuse from a cognitive-behavioral perspective, one would assume that cognitive restructuring later in life can benefit the individual by replacing dysfunctional beliefs with more realistic functional beliefs. This, in turn, would alter any dysfunctional behaviour the individual engages in. Several studies investigate the cognitions or beliefs associated with childhood sexual abuse and the benefits of cognitive restructuring.

A study by Briere (1992) indicated that survivors of childhood sexual abuse frequently have cognitions related to negative self-evaluations, hopelessness, helplessness and guilt. They also tend to have maladaptive beliefs/schemas

related to mistrust, vulnerability, incompetence, intimacy, power and safety (McCann & Pearlman, 1990). Wenninger and Ehlers (1998) conducted a study on 43 child sexual abuse survivors and assessed their attributional styles and dysfunctional beliefs. It was found that child sexual abuse survivors have a relatively stable negative attributional style and attributed negative events in their lives to internal, stable and global causes. In a study by Waller and Smith (1994) it was found that women with a history of childhood sexual abuse, who experienced a psychological disorder, had significantly greater levels of self denigratory beliefs and information-processing bias than women with a psychological disorder but who had no history of childhood sexual abuse.

Several studies explored the effectiveness of cognitive-behaviour therapy for survivors of childhood sexual abuse. Gazan (1986) conducted a treatment programme for five adult females who experienced childhood sexual abuse and were experiencing abuse-related sexual dysfunction. Cognitive restructuring was conducted and included education, reattribution, distancing and logical analysis. The results indicated that the cognitive restructuring improved these women's self-reported sexual functioning and was successful in modifying their beliefs about their roles in and responsibility for the sexual victimisation.

Another study, by Jehu (1989), was conducted on 51 women that had been sexually abused before the age of 10 and who were subsequently in treatment for psychosocial problems. Cognitive techniques were used to change the distorted thinking of the participants and, in this way, reduce their symptoms, which included depressive episodes, feelings of guilt and low self-esteem. Techniques such as reattribution, distancing, decatastrophising, logical analysis and education were used. Results showed that the cognitive restructuring significantly reduced the participants' distorted beliefs, and improved the survivors' disturbed moods.

Smucker, Dancu, Foa and Niederee (1995) conducted a study focusing on the effectiveness of imagery rescripting for adult survivors of childhood sexual

abuse, suffering from post-traumatic stress disorder (PTSD). They highlight the fact that positive schemas of the survivor are often replaced by maladaptive schemas/beliefs such as profound mistrust, passivity, helplessness, powerlessness, guilt and degrading self-perceptions. These beliefs indicate the likelihood that fundamental assumptions were distorted and maladaptive schemas created. The results indicated a notable change in the participants' maladaptive abuse-related beliefs and none of the participants met the criteria for PTSD post-treatment or at three month follow up or a six month follow up.

Finally, Rieckert and Moller (2000) investigated the effectiveness of cognitive restructuring based on rational-emotive therapy in a sample of 40 female adult survivors of childhood sexual abuse. Results indicated significant reductions in depression, state anxiety, anger, guilt and significant improvement in self-esteem.

It is evident that childhood sexual abuse can affect the individual's beliefs/schemas and that these cognitions, in turn, may contribute to dysfunctional emotions and behaviour. Cognitive restructuring seems effective in modifying these dysfunctional beliefs and thereby reducing psychological distress and dysfunctional behaviour. The cognitive theory can therefore be used to understand the impact of unwanted childhood sexual experiences on the psychological development of a person.

2.2. Theory of Reasoned Action

It is not only one's own attitudes and beliefs that influence one's behaviours but also the perceived attitudes of others around oneself. This theory was proposed by Ajzen and Fishbein (1980) and suggests that a person's decision about whether or not to engage in a particular behaviour is the result of a rational process that is directed toward a goal and that follows a logical sequence (Baron & Byrne, 2003). Although an individual's behaviour does

not always seem rational and may not be entirely explained by this theory, it does provide us with a basis for possibly explaining how, and why, certain individuals reach the decisions and engage in the behaviour that they do. According to Ajzen and Fishbein (1980), three factors play a role in determining whether or not an individual will carry out a certain behaviour. These are: Their attitude toward a behaviour, the subjective norms and the perceived behavioural control. The individual's attitude toward a behaviour is dependent on their own beliefs and cognitions about the behaviour, as is their perceived behavioural control. Therefore, if an individual believes that the behaviour will yield a positive consequence, and if they believe that they have the ability to perform the behaviour, their intentions to carry out the action will be strong. However, the attitudes of others are also taken into account in this theory. An individual's decision on whether or not to participate in a certain behaviour is strongly dependent on whether he/she perceive *others* around them to approve or disapprove of the behaviour. Therefore, individuals engaging in sexual behaviour or the use of substances are not only influenced by their own beliefs and cognitions, but also by the subjective norms they believe others to have (Baron & Byrne, 2003). Individuals who have experienced childhood sexual abuse possibly have an attitude toward sexual behaviour and substance abuse that is different to others, as they may feel the behaviours provide a relief or resolution to the psychological difficulties they may be experiencing as a result of the abuse. This alone may affect their behaviour. However, if they perceive their peers to approve of the behaviour, it may enforce their willingness to engage in this behaviour. The balance between self-perceptions and the perceptions of others is dependent on the context. If self-perceptions are strong, the individual may not need the approval of others, but in the case where the individual is unsure of the behaviour, the perceptions of others may be the factor that swings their decision in one direction or the other.

Having said that, it is important to note that individuals may participate in certain behaviours - even when they disagree with the behaviour and feel that others disagree with it. It is therefore apparent that other factors play a role in an individual's decision to engage in a particular behaviour. There are a

multitude of factors which may be influential in this regard, ranging from an individual's psychological characteristics, to an individual's unconscious motives and to the norms of society. The relationship between child sexual abuse and the maladaptive behaviour that may occur is therefore not a simplistic, linear relationship. One must therefore consider all these aspects when attempting to explain an individual's behaviour. This is problematic as it is impossible to analyse, in depth, all these factors for each participant in this study. Therefore, for the purpose of this study, we will focus on the psychological characteristics of the individual, specifically their well-being, the individual's beliefs about certain behaviours, and their perception of the beliefs their parents and friends hold of the behaviours. This will be expanded on in the following chapter.

CHAPTER THREE

LITERATURE REVIEW

The purpose of this chapter is to discuss available literature around the four variables, namely unwanted sexual experience, psychological well-being, substance abuse and high-risk sexual behaviour. The term 'unwanted sexual experience' was constructed specifically for this study. It encompasses all behaviours included in the term 'sexual abuse', as well as any other sexual behaviours perceived as unwanted by the child. Due to the fact that there is no literature available on 'unwanted sexual experience', the literature will focus on the effects of sexual abuse, specifically contact sexual abuse. This will provide us with an idea of the effects that may result from unwanted sexual experiences. It is important to note that the individual may be influenced by the experience to a greater or lesser degree, depending on the type, severity and frequency of the experience.

3.1. Relationship between Unwanted Childhood Sexual Experiences and Psychological Well-Being

Sexually abused children often experience significant psychological distress and dysfunction. This traumatisation occurs at a most critical time of their lives - when assumptions about self, others and the world are formed, and when their own coping skills are being formed. They, therefore, do not have the capacity to interpret and understand what happened to them and, as a result, such psychological trauma may impact severely on their subsequent psychological and social maturation. Studies of the psychological effects must therefore focus not only on the immediate effect but also on the subsequent interference with normal development in the long term (Briere, 1992).

3.1.1 Psychological Well-Being

Psychological well-being is a complex and interrelated tapestry of several components. A psychologically healthy individual is one who (most of the time and in most situations) has positive self-regard, is independent, is assertive, can withstand and cope well with stress, is self-actualising, is relatively happy, can engage in mutually satisfying social relations, has good reality testing and can problem-solve effectively. The healthier an individual, the greater the degree of these factors. However, very high or very low degrees of one or more of these factors can also be associated with pathological conditions (Bar-On, 1988). Early trauma, such as sexual abuse, may impact on the healthy development of some of these components that can, in turn, contribute to the development of a pathology or mental illness (Briere, 1992).

3.1.2 Psychological Well-Being and Childhood Sexual Abuse

Extensive research has been conducted internationally on the development of mental illness following childhood sexual abuse. There seems to be a variety of mental and emotional and behavioural difficulties that occur both at the time of the abuse, as well as later in life. The abused individual can develop assumptions (cognitions) about the world and self-perceptions based on the trauma they endured. Due to these assumptions, they may overestimate the danger the world represents and underestimate their own self-efficacy and self-worth. This can result in feelings of guilt, a low self-esteem and self-blame. There are often feelings of betrayal linked to the abuse, and feelings of powerlessness, hopelessness for the future and helplessness are common (Briere, 1992). Indirectly, suicidal behaviour may be linked to sexual abuse through hopelessness. Suicidal behaviour includes suicide ideation, making threats and plans, deliberate self-harm and suicide attempts (Bergen, Martin, Richardson, Allison & Roeger, 2003). Other difficulties may include high levels of depression and anxiety, psychosomatic complaints, flashbacks, intrusive memories, emotional numbing, emotional detachment, interpersonal

difficulties such as isolation, difficulty sustaining relationships and difficulty trusting others (Evans & Sullivan, 1995). Other than these difficulties, survivors of childhood sexual abuse sometimes qualify for a variety of diagnoses, including Major Depression, a variety of anxiety disorders, personality disorders and attention deficit disorder (Evans & Sullivan, 1995). Post-traumatic stress disorder has been a focus of research with respect to childhood sexual abuse, and is believed to be an increased risk for individuals who have experienced this trauma in their early years (Hanson, Saunders, Kilpatrick, Resnick, Crouch & Duncan, 2001). Due to the variety of symptoms and problems survivors of childhood sexual abuse may experience, experts have been unable to define a common 'survivor syndrome' associated with this trauma (Evans & Sullivan, 1995).

3.1.3 Discourses of Childhood Sexual Abuse

Although much emphasis has been placed on the possible psychological outcomes of childhood sexual abuse, it is important to take into account the fact that not all victims of childhood sexual abuse experience these negative effects. In the previous chapter, factors that may reduce the negative effects of the abuse were briefly mentioned. These included the child's willingness to disclose the abuse to a trusted adult, knowing that he/she will be believed and not blamed, as well as the amount of support received from caregivers and family members. The period after the abuse is an extremely sensitive time for the abused child and being guided through it by individuals whom the child trusts and feels loved by, can enable the child to develop almost unscathed by the abuse (Richter & Higson-Smith, 2004). However, the support network and social circle of the child may, in fact, have an adverse effect on the sexually abused child. Society in itself has generated several discourses around the act of sexual abuse. In some instances, these discourses can possibly serve to perpetuate the negative impacts on an abused child. Armon-Jones (1985) and Harre (1986) conducted studies on the social construction of emotions surrounding childhood sexual abuse. These studies suggest that the widespread notion of negligent irresponsibility or, in laymen's terms, "people

get what they deserve", can play a part in the emotional response of the victim to the abuse - both at the time of the trauma as well as in later years. This in itself may contribute to the child being unwilling to disclose the abuse for fear that others in society will in turn blame them for the abuse. If the child is able to bypass this discourse and disclose the event of the abuse, other discourses may become instrumental. The child exposed to sexual abuse is often considered a victim by society. They may then fall into the role of being damaged and needing protection and 'help'. They may be stigmatised by the rest of society and, as a result, the abuse is kept as quiet as possible and the child begins to realise how 'bad' the event in fact is. They may constantly be told not to share the experience with anyone and may hear whisperings of concern between their loved ones. The abuse is sometimes covered up as much as possible and the child interprets this as the abuse being something that is shameful. The perpetrator is possibly spoken about with anger and hate. If this person is someone the child knows and trusts, there may be feelings of guilt and confusion and, no matter who the perpetrator is, these words of anger can serve to enhance the negative feelings the child is developing about the abuse. The child is often whisked off to receive counselling or other forms of help and may be treated as though they have a problem. All these social constructs around the abuse can be perpetuators of the negativity the child may develop around the abuse and may lead into psychological problems later in the child's life (Levett, 1987).

The notion that some children may be unaffected by childhood sexual abuse is not popular. If disturbances in the child are not evident, the belief is that these negative effects will emerge later in life in response to some trigger (Finkelhor, 1984). Due to the fact that, at the time of the sexual abuse, the child is made aware of the negativity surrounding this event, it becomes a significant trauma in the mind of the child. Any psychological difficulties experienced later in life might then be linked back to the abuse, which is then considered to be the predisposing factor. Although there is no doubt that childhood sexual abuse may contribute to long-term consequences, determining a direct cause-effect relationship is almost impossible. This is due to the many intervening variables present in the individual's life before, during

as well as after the abuse. Factors during the abuse that may lead to more negative symptomology later in the child's life have been discussed previously and include the type, severity, frequency and length of abuse, the age of the child during the abuse and the relationship of the perpetrator to the child. Intervening variables occurring before the abuse include any predispositions the child may have for developing psychological difficulties such as early parental care, genetic predispositions and unsuccessful conquering of developmental milestones. Finally, any event after the abuse which is experienced as significant by the individual may play a role in the development of psychological difficulties - whether the individual had been abused or not (Levett, 1987). In short, the psychological development of an individual is such a complex process that it would be negligent to assume that childhood sexual abuse directly, and in all instances, contributes to psychological distress and dysfunction without considering other factors present in the individual's life. Having said this, and after consideration of the impact societal discourses around sexual abuse may have on the abused individual, it is still important to acknowledge that a significant amount of research has indicated that in many instances, childhood sexual abuse does have a negative impact on the individual's psychological well-being. In this study, this relationship will be investigated.

3.2. Relationship between Unwanted Childhood Sexual Experiences and Substance Use

The use of substances in adolescents has increased rapidly in the past 30 years. This is of great concern because of the negative consequences of substance abuse and dependence, such as involvement in crime and other antisocial activities, impairment in academic and occupational performance, as well as an increased risk of suicide, accidents, contagious diseases and psychological distress (Barlow & Durand, 2002). As a result, substance abuse is viewed by many health and law enforcement professionals as one of the biggest problems facing South Africa today (Barlow & Durand, 2002).

According to Edmonds (1996), as many as 80% of high school pupils in some areas have experimented with psychoactive chemicals at least once in their high school career. Given the fact that 10 – 15% of these individuals can develop dependency, it is quite possible that up to 10 out of every 100 high school pupils are at risk of developing substance dependency (Francis, 1994).

3.2.1 Factors Contributing to Substance Use/Abuse

Substance abuse is a complex condition with multiple factors contributing to its development and maintenance (Schinke, Botvin & Orlandi, 1991). This condition has already been defined. However, in persons under the age of 18 the use of substances is defined as abuse even if the criteria in the DSM-IV are not met (Sadock & Sadock, 2003). Research done by the Molecular Neurobiology Laboratory of the National Institute on Drug Abuse in the USA, suggests that addiction rests on a foundation of 30% genetic predisposition and 70% environmental factors (Doweiko, 1996). Another dimension of this interactive model looks at the etiological role of interpersonal and intrapersonal factors. The most important interpersonal factors discussed in literature include peer groups, specifically the need to be accepted, parental and family factors such as modelling, conflict and support, and environmental factors such as a lack of stimulating activities. Many adolescents are insecure and exhibit an overwhelming need for approval and acceptance by a peer group. During this time, the peer group becomes increasingly significant relative to the family as a socialising context. Adolescents comply with peer standards to achieve status and identity within a peer group, which can be a critical factor preceding experimentation with substances. An individual seeking approval and acceptance from a drug using peer group may in turn initiate their own use of substances in order to feel a part of the group. The group, therefore, helps to shape adolescents' attitudes and beliefs about drugs as well as forming the rationales that adolescents use to explain and excuse drug use (Sartor, 1990). This provides evidence for the theory of reasoned action. The individual has the opportunity to use substances as they are readily available from his/her peers, believes that the behaviour will yield a

positive consequence (they will be accepted by the peer group) and the use of drugs is approved of by those around them, namely their peers.

Parent- and family-related factors impact significantly on the etiology of substance use in adolescents. The most influential of these factors is that of parent modelling. Parents who abuse drugs and alcohol give their adolescents the impression that these substances are part of the adult world, and it is therefore understandable that the adolescent would identify with these norms and conduct. In this way, families pass the pathology from one generation to the next (Sartor, 1990). Other factors also play a role, such as conflict in the family and lack of support from family members. These factors leave the adolescent feeling alone and angry with his/her home environment and steer them toward an accessible group of peers, which is often the drug using group (Terblanche, 1999).

Finally, in terms of environmental factors, there are three major areas that contribute to adolescent substance use. Again the theory of reasoned action is clearly portrayed here. In the social environment, there is a fair amount of exposure to, and relatively limited discrimination against, the use of substances, especially alcohol and 'soft drugs'. This creates a 'drug-friendly' environment which could entice many adolescents (Rocha-Silva, 1998). Secondly, as already mentioned, the ease of obtaining drugs in our society may contribute to the maintenance of the drug culture and allow those attempting to use drugs for the first time easy access to the substance of choice (Wilson, 1991). Thirdly, one of the most underrated pressures in our society is that of boredom. It is a major cause of distress, hopelessness and depression in adolescents. This boredom is often associated with under-stimulation in school settings and neighbourhoods, which leaves the individual feeling frustrated and discontent. The use of drugs, therefore, occur most often during leisure time. If leisure activities fail to satisfy the adolescent's need for optimal arousal, boredom results and drug abuse may be an alternative to lessen this negative state (Pillay, 1993).

Intrapersonal factors that play a role in adolescent substance abuse can include personality traits, negative emotions, emotional pain, reward potential and self-appraisal. In terms of personality traits, most literature points to extraversion as a contributor to substance abuse. Extraversion manifests itself in the need for excitement and stimulation. Substance abusers are more likely to be sensation seekers and have a low tolerance for repetitious experience, and thus seek thrills and adventures. It is therefore not surprising that many substance abusers present with an extrovert personality (Francis, 1994). Another personality trait correlated with substance abuse is neuroticism which includes negative feelings, especially expecting the worst about themselves and their environment. The use of substances may develop in order to gain relief from the negative emotions associated with this personality trait (Pillay, 2000).

Negative emotions such as depressive features (feelings of rejection, low self-esteem, hopelessness, and a sense of failure), anxiety, tension and confusion increase the chances of the individual using substances in order to escape these negative emotions. He/she uses alcohol and illegal substances in order to self-medicate. However, after using drugs for many years for the relief from emotional pain, the individual can often continue using the drugs from force of habit and to prevent unpleasant withdrawal symptoms (Barlow & Durand, 2002).

Finally, self-appraisal and reward potential play a role in the possibility of an adolescent turning to the use of drugs. If an adolescent is uncertain about his/her own values, goals and priorities regarding the use of alcohol and drugs, the risk for substance abuse increases. This is especially true when the individual perceives him-/herself to be inadequate and uses the substances in order to camouflage perceived inadequacies and give them courage to master their inhibitions and shyness (Chetty, 2000). Risk increases after the first attempt of drug use. One of the basic principles of behavioural psychology is that if something increases the individual's sense of pleasure or decreases the individual's discomfort, the person is likely to repeat the behaviour. It is

therefore understandable that the pleasurable effect of the substance can create a pattern of functioning in which the drug-taking behaviour is strengthened every time the positive effects of the substance is experienced (Prochaska & Norcross, 1999).

Schinke et al. (1991) discuss several factors similar to those described above that may contribute to the cause or origin of substance use in individuals. Other than those already mentioned, they also include the following factors:

- Developmental factors - involving oneself in risk-taking behaviour in order to develop a sense of autonomy, independence and personal identity separate from parents.
- Cognitive factors - adolescents' thought patterns become more abstract and hypothetical as they develop, enabling them to accept deviations from established rules and recognise the frequently irrational and inconsistent nature of adult behaviour.
- Media - messages promoted by the media on the lifestyle of substances users (popularity, success, sex appeal, and fun) are powerful sources of influence for the already influential adolescent.

3.2.2 Substance Use/Abuse and Childhood Sexual Abuse

Kendler, Bulik, Silberg, Hettema, Myers, and Prescott (2000) state that several studies indicate that survivors of childhood sexual abuse are at greater risk of developing substance abuse disorders than the general population. This research indicates that certain of the factors mentioned previously hold more weight than others when it comes to attempting to explain why sexually abused adolescents turn to the abuse of substances.

Ballon, Courbasson and Smith (2001) conducted research using 287 male and female youths (age 14 to 24 years) presenting for help with substance-use problems. They focused on those individuals who had been sexually abused and investigated whether they rely on substances in order to cope

with the sexual abuse they had endured as children. The research was done using a semi-structured interview focusing on substance use, history of previous sexual abuse and coping strategies. Of the 287 individuals, 72 had experienced sexual abuse during childhood. The results indicated that substances were generally used as self-medication. The abused individuals expressed that they experienced intense negative feelings including depression, fear, guilt, shame, hopelessness, helplessness, anger and resentment as a result of the abuse and turned to the use of substances to help numb these feelings.

Another factor which may contribute to the use of substances by victims of childhood sexual abuse is a combination of psychological characteristics and peer pressure. Many survivors of childhood sexual abuse often feel a profound sense of loneliness and alienation from others. Some of these individuals, in their desperate need to belong, are willing to join with any form of social support, which often leads them to the drug-using party-people. Their need to belong may influence them to conform to the ways of the group and their psychological characteristics may increase the risk of being influenced (Evans & Sullivan, 1995). A study by Freeman, Collier and Parillo (2002) indicates that individuals who are sexually abused during childhood are more likely to run away from home during adolescence. These individuals may form deviant peer associations on the streets, which contributes to the substantially higher rates of alcohol and illicit drug use among runaway youth in comparison to non-runaway youth. Furthermore, the need to survive on the streets may lead to more serious offences such as the trading of drugs and becoming involved with drug dealers, which enables these individuals to access substances more readily (Freeman, et al., 2002)

Extensive research has indicated that individuals experiencing childhood sexual abuse are at an increased risk for developing substance use disorders, even when background familial factors were controlled (Bulik, Prescott & Kendler, 2001). However, one must still keep these familial factors in mind as research data has indicated that there is a high correlation between parents

with a substance-abuse disorder and physical and sexual abuse directed toward their children. Survivors may, therefore, have a genetic vulnerability to developing chemical dependency or it may be due to familial modelling, other interpersonal factors or intrapersonal factors. The combination of factors involved must therefore always be kept in mind (Evans & Sullivan, 1995).

3.2.3 Substance Use/Abuse and Psychological Factors

It is important to note that the use of substances does not necessarily indicate a substance-use disorder. Many individuals use substances as self-medication in order to numb the psychological pain they are experiencing yet the use of the substances may not escalate to the point where the individual's functioning is seriously impaired. There is conflicting evidence as to whether there is an association between childhood sexual abuse and substance-use disorders; or whether the association is rather between childhood sexual abuse and psychiatric disorders with substance abuse being secondary to this. The majority of research indicates that psychological effects develop initially and that the individual uses substances in order to cope with these effects (Freeman, et al., 2002). This is not necessarily always the case. Literature indicates that certain sexually abused individuals may deal with the psychological effects of the abuse in different, healthier ways. Those individuals who have a positive appraisal of family support and social support systems often develop a well of strength and resilience. They are then able to cope with the feelings associated with the abuse without the need to self-medicate. On the other hand, individuals, who view themselves as being alone, may turn to alternate ways of coping with the challenges they face, and this often includes escaping their feelings with the use of substances (Pretorius, 2002).

3.3 Relationship between Unwanted Childhood Sexual Experiences and High-risk Sexual Behaviour

Adolescence is a time when individuals come into their own sexuality. Experimentation with intimate relationships and sexual partners is a normal part of development in preparation for adulthood. Sexual interaction is therefore not only accepted amongst adolescents, but also encouraged. For many decades, sexuality was not openly discussed, but in recent times it has become a more accepted topic (Ferrera, 2002). Adolescents are engaging in sexual practices at a younger age and with a higher frequency. This provides a society, and especially an adolescent population in which sexual activity is part of the norm. For several reasons, which will be discussed in the following section, sexually abused individuals tend to participate in more high-risk sexual behaviour. In terms of the theory of reasoned action, this provides sexually abused individuals with an environment where their high-risk sexual behaviour is not discriminated against. This may encourage them to initially engage in this behaviour, as well as allow them to continue with this behaviour in an accepting society (Ferrera, 2002).

3.3.1 Sexual Behaviour and Childhood Sexual Abuse

An area of interest with respect to childhood sexual abuse, is the effect this trauma has on the individual's sexual behaviour later in life. Batten et al. (2001) describe two extremes of sexual behaviour that may develop following sexual abuse:

- The first is experiential avoidance of sexual situations. The individual is unwilling to experience negatively evaluated events such as thoughts, feelings or memories associated with the abuse, and therefore avoids situations in which these events would be experienced. The victim often associates the arousal state leading to sexual activity with anxiety and tension. A problem develops with physical touching which forms a barrier

against any sexual activity. The individual often also experiences an inability to love as when the abuse was perpetrated by a caretaker, love has been associated with the accompanying emotion of betrayal. This may contribute, in some cases, to difficulties forming and sustaining intimate relationships and may cause him/her to avoid any form of sexual contact (Hollin & Howells, 1992).

- More prevalent seems to be the opposite extreme of sexual behaviour. Most research suggests that victims of childhood sexual abuse are more likely to engage in a number of high-risk sexual behaviours beginning in adolescence (Batten, et al., 2001). These individuals are more likely to have initiated sexual behaviour at an earlier age, report less condom use, choose riskier partners, are more likely to have multiple partners, and are more likely to engage in prostitution (Batten, et al., 2001). Victims of childhood sexual abuse tend to display age-inappropriate sexual behaviour. They have learnt at an early age that one of the ways of gaining desperately needed interpersonal closeness and nurturance is sexual availability. They, therefore, enter into sexual encounters in search of this, but sustained intimacy leads to fearfulness of becoming vulnerable and being exploited and abandoned which causes them to leave and seek another sexual partner. Another explanation for the multiple sexual partners is the use of sex for distraction, excitement and avoidance of emptiness. Sexual activity has been found to have the ability to temporarily soothe or dispel chronic abuse-related dysphoria. Inappropriate or excessive sexual activity is therefore used as a coping mechanism to modulate the painful internal experience (Briere, 1992).

3.3.2 Sexual Behaviour and Psychological Factors

Prostitution is the most obvious example of sexual adversariality assumed by some childhood sexual abuse victims. Researchers such as Goldstein (1987) and Bagley and King (1990) are of the opinion that the increase in juvenile crimes such as prostitution may be attributed to sexual abuse during

childhood. Prostitution involves the delivery of sexual stimulation and gratification for profit (Bartollas & Dinitz, 1989). According to Doyle (1994), prostitution can be characterised by three major traits namely, pecuniary (gain), indifference or frigidity and non-selectiveness with respect to the client. In other words, prostitution encompasses the exchange of a sexual deed with the motivation of monetary gain or some other form of remuneration in the absence of any emotional involvement. There seem to be two distinct concepts around the reasons an individual may enter into prostitution, namely susceptibility and exposure.

Susceptibility refers to psychological traits such as feelings of worthlessness, loneliness and fear of intimacy, to name just a few (Bartek, Krebs & Taylor, 1993). A sexually abused individual often believes that he/she can only be accepted by others on sexual terms. The individual was raised in an environment where sex was expected from them and they were expected to engage in these sexual acts in order to be accepted and 'loved' by the abuser. He/she therefore develops beliefs (schemas) that in order to be liked or accepted by others, he/she must provide sexually to others. This makes it difficult to sustain an intimate relationship with a single individual as the abused individual may constantly seek attention and affection from others by offering sexual affiliation. His /her feelings of worthlessness and loneliness will further contribute to the need to be accepted by others, but fear of intimacy and abandonment will prevent the individual from maintaining a relationship in which he/she is accepted. This can result in promiscuity. If the possibility arises for the individual to receive money for sexual favours, he/she may be drawn into the world of prostitution; a place where he/she can develop a sense of worth in his/her own mind, yet at the same time maintain an emotional distance from his/her sexual partners (Doyle, 1994).

Exposure refers to the experience of a traumatic event such as child sexual abuse. A child exposed to sexual behaviours, and therefore premature sexual learning, undergoes what Hollin and Howells (1992) refers to as traumatic sexualisation. Ideas around sexual morality and appropriate sexual conduct become distorted, enabling the child to behave in a sexual way which is

incongruent to his/her level of sexual development. The schemas or beliefs of the child determine his/her behaviour, and distortions in these schemas can lead to distortions in behaviour. The individual may then engage in sexual behaviour at an earlier age than non-sexually abused individuals and may, as described above, engage in sexual behaviour with multiple partners due to his/her psychological traits. Often these sexual acts are unfulfilling and elicit self-critical thinking and associated feelings of shame, guilt and low self-esteem. Despite this, the individual continues to engage in these sexual acts. This is possibly explained by the theory that sexually abused individuals engage in excessive sexual acts in order to re-enact the original child sexual abuse experience (Gold & Seifer, 2002). It is therefore an unwitting attempt to master the trauma of the abuse and gain a sense of 'triumph over tragedy' as this time the victim chooses rather than submits. However, the resolution is never met and so the cycle continues (Schwartz & Galperin, 2002). Because of their developmental immaturity, these individuals are often unaware of the safety risks involved in sexual behaviour, and may omit using any type of protection such as condoms. Those children who received a reward for sexual activity learn that sex is a tool for manipulation. Many of them were bribed by the abuser and provided with luxuries and necessities in exchange for sex. They concluded from this that the only way to gain the things they need is to trade for them and this transaction is centred around sex from a young age and continued to be centred around sex later in life, thus resulting in transactional sex or prostitution (Briere, 1992).

3.3.3 Sexual Behaviour and HIV/AIDS

The excessive or inappropriate sexual behaviour mentioned above is not only a problem in itself but often has secondary implications. The main concern for South African individuals participating in high-risk sexual behaviour is that of contracting a sexually transmitted disease such as HIV/AIDS. Research indicates that victims of childhood sexual abuse are at an increased risk for contracting HIV due to the sexual behaviour they exhibit later in life (Hobfoll, Bansal, Schurg, Young, Pierce & Johnson, 2002). Seven constructs have

consistent support in literature as an outcome of childhood sexual abuse and a predictor of HIV risk behaviour. Individuals who have been sexually abused in their childhood often present with a low self-esteem, lack of psychosocial well-being, low optimism concerning the future, poor psychosexual functioning, use of avoidant coping strategies (drugs or alcohol), little belief in their ability to control a situation, submissiveness and passivity toward male gender and fear of anger from a sexual partner (Quina, Morokoff, Harlow & Zurbriggen, 2004). These factors increase the risk of the individuals contracting HIV, as they often believe they are worthless and that there is no hope for their future. They will engage in sexual behaviour that may prove to be harmful as they feel they have nothing to lose. The lack of belief in themselves, their worth, and in their ability to control certain situations will often prevent the individual from insisting on the use of protection during sexual intercourse, as will their passive attitudes toward men and their fear of angering their partner. Sexually abused individuals therefore develop beliefs and attitudes toward themselves and toward sexual activity, which persists into adulthood causing them to engage in high-risk sexual behaviour which in turn may lead to them becoming infected with HIV (Quina, Morokoff, Harlow & Zurbriggen, 2004).

3.3.4 Sexual Behaviour and Substance Use/Abuse

It is by now apparent that psychological processes underlie the sexual behaviour developed later in life. Feelings associated with the abuse, and beliefs that develop about the self and relationships after the abuse, often determine the sexual behaviour of the individual. It could therefore be said that high-risk sexual behaviour develops secondary to the psychological processes involved in the experience of sexual abuse, and that cognitions related to the abuse influence the individuals' behaviour later in life. This is similar to the finding of the effect that sexual abuse has on the use and abuse of substances. What is interesting is that the use of substances may also play a role in the involvement of high-risk sexual behaviour. Survivors of sexual abuse often self-medicate with alcohol and drugs in order to numb the

emotional effects of the abuse. Substances affect one's judgement, behavioural disinhibition and motivation for self-protection and, as a result, there is evidence that individuals report engaging in more high-risk sexual behaviour while under the influence of substances (Kalichman, Kelly & Rompa, 1997).

3.4 Summary

It is apparent from the literature that childhood sexual abuse may have many effects on an individual's psychological functioning, as well as their behaviour later in life. The cognitive behavioural theory explains this in terms of the fact that, during the abuse, the individual forms beliefs about the world and about themselves, and these cognitions then determine the emotions and behaviour of the individual. The attitude of the individual and the attitude of others toward the behaviour also play a role in determining future behaviour of the individual. It is also apparent from the literature that the three variables discussed, namely, psychological well-being, substance use and engagement in high-risk sexual behaviour are, in fact, related to each other and to child sexual abuse in a complex manner as opposed to in a linear fashion. It seems as though the cognitions formed during abuse lead to psychological effects, and that the cognitions formed during abuse, as well as the resulting psychological effects, play a role in determining whether an individual will engage in the use of substances and high-risk sexual behaviour. Substance abuse also seems to affect the probability of engaging in high-risk sexual behaviour. This behaviour may contribute to emotional difficulties which could increase the chances of substance use. In short, it is apparent that many relationships may exist between the four variables. This research will allow us to determine which relationships are significant for this group of adolescents.

CHAPTER FOUR

METHODOLOGY

In this chapter the methodology used to investigate the relationship between unwanted childhood sexual experiences and the three other variables will be discussed. The participants of the study will be described, as well as the methods for collecting and analysing the data.

4.1 Goal of the Research

This research intends to determine whether there is a relationship between unwanted sexual experiences during childhood and psychological well-being, the use of substances and involvement in high-risk sexual behaviour in adolescents. To investigate the relationships, the following hypotheses were formed:

Hypothesis 1: There is a relationship between unwanted childhood sexual experiences, adolescent psychological well-being, substance-use behaviour and high-risk sexual behaviour.

Hypothesis 2: Adolescents who were involved in unwanted childhood sexual experiences tend to have a lower psychological well-being than adolescents who were not involved in unwanted childhood sexual experiences.

Hypothesis 3: Adolescents who were involved in unwanted childhood sexual experiences have a greater likelihood of using/abusing substances than those who were not involved in unwanted childhood sexual experiences.

Hypothesis 4: Adolescents who were involved in unwanted childhood sexual experiences have a greater likelihood of engaging in high-risk sexual

behaviour than those who were not involved in unwanted childhood sexual experiences.

4.2 Sample

The participants in this study consist of adolescents that attend secondary schools in the Tshwane area. The Gauteng Department of Education identified 12 schools as representative of the population distribution of the area to participate in the project. The participants include white, black, Indian and coloured males and females in grades 8 to 12. It was agreed with the principals of the schools that the disruption of classes would be limited. It was therefore decided to use one class from each grade at each school and not a strictly randomly selected sample of individuals. The class in each grade was randomly chosen.

In this study 1 918 adolescents participated. Of these individuals, 54% were male and 46% female. The participants were from three different language groups. Three per cent of the participants spoke English as a home language, 7% spoke Afrikaans and 90% spoke an African language. The ethnicity of the participants can be determined by the language spoken: those speaking English were Indian individuals, those speaking Afrikaans were white and coloured individuals and those speaking an African language were black individuals. The participants ranged from 13 to 19 years in age and were chosen from grades 8 to 12 (see Tables 1 and 2 for distribution of age and grade). Grade 12 learners were discouraged to take part in the evaluation as it was their final school year and they were, therefore, encouraged to rather focus their attention on their studies.

Table 1: Table Indicating the Age Distribution of the Participants

13 years	14 years	15 years	16 years	17 years	18 years	19 years
1%	13%	18%	23%	22%	19%	4%

Table 2: Table Indicating the Grade Distribution of the Participants

Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
19%	21%	27%	31%	2%

4.3 Instruments for Data Gathering

A self-report questionnaire was administered to the participants. The questionnaire included questions that would provide biographic data of the individuals, questions pertaining to the four constructs relevant for this research, and questions providing us with information on what the participants' beliefs were about the attitudes of others with regard to the four constructs (See Appendix A). The questions pertaining to the four constructs are explained further:

- The presence or absence of unwanted sexual experience during childhood was determined by a question relating to whether or not the individual has ever experienced sex against his/her will. The question was answered on a scale: 'Yes', 'No' or 'Don't know' and interpreted on the nominal scale. There is no indication in this question as to when this happened, how serious it was and what the impact was. The term 'sex' was not defined to the participants and as a result, their answers may include any sexual experience they perceive as unwanted.

- Psychological well-being was measured with a series of 22 questions pertaining to aspects of Bar-On's Psychological well-being instrument namely self-regard, happiness and interpersonal relationships (Bar-On, 1988). The questions centred around the general mood of the individual, how the individual experiences him-/herself, how he/she perceives others to be experiencing him/her and how he/she deals with certain interactions with others. The questions are answered on a three point scale 'Agree', 'disagree' or 'In-between' and calculated in terms of a total score on the interval scale. A factor analysis was done on the 22 questions using the data of 1 918 learners. It was decided to use the 22 items as a single factor. The Cronbach Alpha reliability score was 0,76 for the scale which is considered relatively high (Howell, 1997). There is therefore an internal consistency between the items used. The following questions were answered in order to determine the psychological well-being of the individual:

    - "I do not feel good about myself"
    - "It is hard for me to accept the way I am"
    - "It is hard for me to enjoy my life"
    - "I feel lonely even when I am with people"
    - "I cannot concentrate when doing schoolwork"
    - "I feel life is not worth living"
    - "It feels impossible to deal with the problems I have"
    - "I enjoy the things I do"
    - "I really do not know what I am good at"

- "I feel shy and unsure of myself when I am with other people"
- "I cry every night"
- "I trust in myself and in my own abilities"
- "I worry about many things"
- "People do not understand me"
- "I have a feeling that something is wrong with me"
- "I would like to change many things about myself to like myself more"
- "I feel sure of myself in most situations"
- "I do not believe people who say nice things about me"
- "I think I am a good person"
- "I have a good idea of what I want to do with my life"
- "I know how to deal with upsetting problems"
- "My classmates like me the way I am"

- Use or abuse of substances is determined by questions pertaining to the type of substances used in the past month prior to the research. The questions answered were:
  - "Did you drink alcohol during the past 30 days - more than just a sip?"

- "Did you drink five or more drinks with alcohol on one day during the past 30 days?"
- "Have you used drugs such as dagga (zol), cocaine, crack, mandrax (white pipe) or LSD during the past 30 days?"

These questions were answered on a nominal scale: 'Yes', 'No' or 'Don't know'.

- High-risk sexual behaviour is assessed by questions pertaining to the involvement in sexual behaviour in the past three months and the degree to which safe sex is practised. The questions answered were:

  - "Have you ever had a sexual relationship?"
  - "Did you have sexual intercourse during the past three months?"
  - "Did you have sexual intercourse with more than one partner during the past three months?"
  - "Did you use a condom every time when having sex during the past three months?"

These questions were taken from the World Health Organisation (WHO) research package (1990) as appropriate self-report questions to assess high risk for contracting HIV/AIDS. These questions are answered on a nominal scale: 'Yes', 'No' or 'Don't know'. Again this is a self-reported questionnaire and reflects the subjective experience of the individual with regard to their intimate behaviour.

Due to the fact that the questionnaire is based on self-report, we need to take note of the possibility of gaining data which may be inaccurate due to different understandings, knowledge, beliefs and perspectives of the participants regarding the material in question, especially regarding intimate behaviour. Certain individuals may understand the terms 'sexual relationships' and

'sexual intercourse' differently to others, and differently to how it was intended to be perceived. We must also be aware that self-report data may lead to inaccurate results as participants may answer untruthfully for several reasons such as fear of exposure of their answers, attempting to provide the answer they believe is wanted, or a lack of understanding of what is meant by the question. These issues must be taken into account when analysing the data to prevent producing results that are biased (Catania, Gibson, Chitwood, & Coats, 1990).

4.4 Procedure of Data Gathering

The questionnaire was administered to adolescents in a school context in 12 schools. Permission to conduct the research was obtained from the Department of Education, as well as the school principals and guidance teachers in each school. Due to the fact that almost all the participants were below the age of 18, the research was explained to the parents of the subjects at a parent's meeting and parents could withdraw their children from the research. Arrangements were made to implement the questionnaire in each school. A research assistant administered the questionnaire in a class situation with the teacher present. The purpose of the study was explained to the participants by the research assistant and they were informed that participation in the research was voluntary, as well as anonymous. They were also given the option to withdraw from the research at any time. No names of participants were recorded, and any personal or revealing information was kept confidential. The majority of the individuals were fluent in English but for those who were not, the research assistant could translate the questions and attend to any queries regarding the questionnaire. After completing the questionnaire, the learners placed their answers in a sealed box to be opened at the university. Those learners who felt that they needed the assistance of someone to talk to could write their names and telephone numbers on the back of the questionnaire. Counselling students contacted them to provide the needed help or to refer them to appropriate helping facilities.

4.5 Research Design and Analysis

In this sample, 18% of the learners indicated that they had experienced sex against their will. The test results of these learners and those who did not indicate sex against their will was related in a post hoc quasi-experimental design (Neuman, 2000). Using a post hoc quasi-experimental design implies that there is no control over other variables that impact on a person's life. Quasi-experimental designs help researchers test for causal relationships in a variety of situations where the classical experimental design is difficult or inappropriate. In general, as in this case, the researcher has less control over the independent variable than in the classical design (Neuman, 2000).

The characteristics of respondents who indicated that they had sex against their will was investigated through descriptive statistics and related to those who did not have sex against their will. The characteristics of respondents who use substances and participate in high-risk sexual behaviour were also investigated in this way and compared to those who do not use substances or participate in high-risk sexual behaviour. The research also investigated, through descriptive statistics, the peer and parental beliefs and how these differ in individuals who use substances and partake in sexual behaviour as opposed to those who do not.

In order to test the hypothesis which states that there is a relationship between unwanted childhood sexual experiences, substance-use behaviour and involvement in high-risk sexual behaviour in adolescents, a bivariate statistical analysis was done using pairs of variables. This shows the statistical relationship between two variables (Neuman, 2000). Specifically the chi-square test was used which measures the strength of the association between variables. In this research, a p-value of smaller than 0,05 will be regarded as significant. Because of the large sample size, normal statistics may show significant differences while the effect of the difference in the mean

score is small. By calculating effect size this can be corrected (Cohen, 1988). The effect size is therefore also investigated in order to indicate the practical significance of the association. The significant values are as follows:

When the c-value is:	< 0.3	Small effect
	0.3 – 0.8	Medium effect
	> 0.8	Large effect

The association between the following variables were measured:

- unwanted childhood sexual experiences and the use/abuse of substances in adolescents
- unwanted childhood sexual experiences and high-risk sexual behaviour in adolescents
- the use/abuse of substances in adolescents and high-risk sexual behaviour in adolescents.

Psychological well-being was not included in the bivariate analysis due to it being measured on an interval scale. It was therefore investigated using analysis of variance. This analysis was done to investigate the interaction between the four variables, namely unwanted childhood sexual experiences, psychological well-being, use/abuse of substances in adolescents and sexual behaviour in adolescents.

In the interpretation, care will be taken in concluding a linear or causal relationship. No information is available about the incidence/s of abuse, how serious it was and what the impact was. This is also a post-hoc study and there is no control over other variables that impact on a person's life. Conclusions can therefore only be made about relationships that may exist and no causal relationship can be assumed.

In the next chapter the results of the study will be given.

CHAPTER FIVE

RESULTS

In this chapter, the results of the study will be given by initially providing frequencies and biographics concerning unwanted sexual experience, substance use/abuse and sexual behaviour. Relationships between these variables will then be explored by analysing the interaction between pairs of the variables. Finally the interaction between these three variables and psychological well-being will be discussed.

5.1 Unwanted Sexual Experience

Of the 1 918 individuals participating in completion of the questionnaire, 18% responded yes to the question, “have you ever experienced sex against your will”, 74% of participants responded no to this question and 8% responded to this question with “I don’t know”. The percentage of those responding with “I don’t know” can be explained by several factors. The meaning of ‘sex’ was not explained to the participants prior to completion of the question. Due to this, it is possible that certain of the participants were unsure of what is meant by this question. It is also possible that, although it was explained that the questionnaire is anonymous, certain individuals may have been reluctant to disclose their abuse and therefore avoided answering the question honestly.

5.1.1 Unwanted Sexual Experience and Biographic Data

There is a significant association between unwanted sexual experience and gender ($p < 0,0001$). Of the individuals participating in the study, 12% of the males and 20% of the females claimed to have experienced sex against their will. The individuals who had unwanted sexual experiences were not in a specific age group, since there is no significant association between age and

sexual abuse (p = 0,53). It is also apparent that sexual abuse is not confined to a single ethnic group as there is no significant association between sexual abuse and language spoken (p = 0,82). It therefore seems that sexual abuse has no boundaries when it comes to age or race of an individual.

5.2 Substance Use and Abuse

Of the individuals participating in the research, 31% admitted to using alcohol in the past 30 days and 23% admitted to binge drinking in the past 30 days (having five or more alcoholic drinks in one day). Some (11%) of the respondents admitted to using drugs such as dagga, cocaine, crack, mandrax or LSD in the past 30 days.

5.2.1 Substance Use and Abuse and Biographic Data

Of the individuals in the sample, 41% of the males and 23% of the females use alcohol. There is a significant association between gender and the use of alcohol (p < 0,0001). There is also a significant association between age and the use of alcohol (p < 0,0001). As the age of the individual increases from 13 to 19 years, so the likelihood of them using alcohol increased. It is also evident from the data that the ethnic group mostly using alcohol are white, coloured and black individuals: 32% of the African and 36% of the white and coloured participants were using alcohol compared to only 23% of the Indian individuals. There is a significant association between alcohol use and racial group (p < 0,05).

There is a significant association between gender and the use of drugs (p < 0,0001). Of the participants in the study, 15% of the males use drugs and 3% of the females. There is also a significant association between age and the use of drugs (p < 0,0001). As with alcohol, it seems that as the age of the individual increases from 13 to 19, so the likelihood of them using drugs

increases too. However, unlike with alcohol, there is no significant difference between racial group and the use of drugs. About eight per cent of each racial group participating, was found to be using drugs.

5.2.2 Drug Abuse, Alcohol Abuse and Unwanted Sexual Experience

A bivariate statistical analysis was done, using the chi-square test specifically, in order to measure the statistical relationship between unwanted sexual experience and the use of alcohol. No significant association was found. Of those individuals that claimed to have had sex against their will, 43% reported alcohol use. Of the individuals not having had sex against their will, 36% reported alcohol use. These differences are not statistically significant. This indicates that unwanted sexual experience is not necessarily a precursor for alcohol use.

Neither was an association found between unwanted sexual experience and the abuse of alcohol. Alcohol use is considered abuse if the individuals drank five or more alcoholic drinks on one day during the past 30 days. Of the individuals admitting to having had sex against their will, 27% abuse alcohol, as opposed to those who have not had sex against their will, where 22% abuse alcohol. These differences are not significant, which again indicates that sexual abuse may not influence whether an individual abuses alcohol later in life. It is, however, important to investigate whether the 27% of individuals exposed to unwanted sexual experiences, that do abuse alcohol, do so in reaction to the sexual experience.

A significant relationship was found between unwanted sexual experience and the abuse of drugs ($p < 0,05$). Of the individuals reporting unwanted sexual experience, 16% abuse drugs compared to ten per cent not having had an unwanted sexual experience. On the reverse side, of all the individuals using drugs, 22% admitted to sex against their will, whereas of those not using drugs, only 15% admitted to sex against their will. These differences are statistically significant. This indicates the possibility that unwanted sexual

experience may be associated with later use of drugs, although the frequencies are relatively low. We are aware of the fact that this is not a linear relationship and other factors can come into play to determine how the individual is affected and deals with the sexual experience.

5.2.3 Substance-Use Behaviour and Unwanted Sexual Experience

The above information looked at the interaction between unwanted sexual experience and the use of alcohol or drugs separately. It may be beneficial to group the latter variables together in order to determine the substance-use behaviour of an individual that has experienced sex against their will. Two questions from the questionnaire were used in order to create the new variable of 'substance-use behaviour'. The questions were:

- "Did you drink alcohol in the past 30 days - more than just a sip?"
- "Have you used drugs such as dagga (zol), cocaine, crack, mandrax (white pipe), LSD during the past 30 days?"

The different combinations of answers to these questions were used in order to divide the substance-use behaviour of the individual into alcohol only, drugs only, both drugs and alcohol, or no substances. For example:

- If the individuals answered 'yes' to drinking alcohol in the past 30 days but 'no' to using drugs in the past 30 days, they fall into the **alcohol only** group.

- If the individuals answered 'yes' to drinking alcohol in the past 30 days and 'yes' to using drugs in the past 30 days, they fall into the **both drugs and alcohol** group.

- If the individuals answered 'no' to drinking alcohol in the past 30 days and 'yes' to using drugs in the past 30 days, they fall into the **drugs only** group.
- If the individuals answered 'no' to drinking alcohol in the past 30 days and 'no' to using drugs in the past 30 days, they fall into the **no substances** group.

Those individuals who did not answer one or both of the questions were excluded from the sample. As a result the sample size, used when looking at the substance-use behaviour of individuals, is smaller than the total sample size. In this case, almost 50% of the total sample is missing. This affects the percentages largely, which will then differ from those previously given. Only data of half of the sample (N = 968) is used in this calculation.

In the following tables (Tables 3 and 4) the interaction between unwanted sex and substance-use behaviour (i.e. alcohol use, drug use, use of both alcohol and drugs and the use of neither drugs nor alcohol) was investigated. The association between unwanted sex and substance-use behaviour is not significant ($p > 0,1$). As is apparent from the table, of the individuals who have been involved in unwanted sexual experiences, 34% use alcohol, 3% use drugs, 13% use both alcohol and drugs and 50% use neither alcohol nor drugs. Almost the same pattern can be seen for those who were not involved in unwanted sexual experiences. Unwanted sexual experience does therefore not seem to play a major role in the use of substances. However, when looking at drug abuse on its own, there is a significant relationship (see section 5.2.2).

Table 3: Statistics for Table of Substance-Use Behaviour by Unwanted Sex

Statistic	DF	Value	Probability
Chi-square	6	10,2786	0,1134
Effect Size		0,1025	

Table 4: Table of Substance-Use Behaviour by Unwanted Sex (N = 968)

Substance Use Behaviour **Unwanted sex**

Frequency Percent Row Pct Col Pct	Yes	No	Don't Know	Total
Alcohol	53 5,48 16,61 34,19	242 25,00 75,86 32,88	24 2,48 7,52 31,17	**319** **32,95**
Drugs	4 0,41 20,00 2,58	15 1,55 75,00 2,04	1 0,10 5,00 1,30	**20** **2,07**
Both	20 2,07 22,99 12,90	55 5,68 63,22 7,47	12 1,24 13,79 15,58	**87** **8,99**
None	78 8,06 14,39 50,32	424 43,80 78,23 57,61	40 4,13 7,38 51,95	**542** **55,99**
Total	**155** **16,01**	**736** **76,03**	**77** **7,95**	**968** **100,00**

5.2.4 Substance Abuse and Social Approval

There is a significant association between whether an individual drinks alcohol and whether or not their friends drink alcohol ($p < 0,0001$) (Table 5). Of those individuals who drink alcohol, 87% have friends who also drink alcohol. Those who do not drink alcohol have a greater proportion of friends who also do not drink and a small proportion of friends who do drink. It therefore seems that the more alcohol-drinking friends an individual has, the greater the likelihood that they too will drink alcohol.

Table 5: Table of Participants' Use of Alcohol by Friends' Use of Alcohol

Participants' Use of Alcohol	Friends' Use of Alcohol: None	Most	Total
Percent Row Pct Col Pct			
Yes	4,14 13,31 12,01	26,99 86,69 44,89	**31,13**
No	30,37 44,10 87,99	38,49 55,90 55,11	**68,87**
Total	**34,51**	**65,48**	**100,00**

When looking at the relationship between whether an individual uses drugs and whether or not they have friends who use drugs (Table 6), a significant association was found ($p < 0,0001$). Of those individuals who use drugs, 75% have friends who also use drugs. Those who do not use drugs have a greater proportion of friends who also do not use drugs (81%). It therefore seems that

the more drug-using friends an individual has, the greater the likelihood that they too will use drugs.

Table 6: Table of Participants' Use of Drugs by Friends' Use of Drugs

Participants' Use of Drugs	Friends' Use of Drugs		
Percent Row Pct Col Pct	**None**	**Most**	**Total**
Yes	2,02 25,48 2,64	6,59 74,52 33,64	**8,61**
No	74,38 81,38 97,36	17,01 18,62 66,36	**91,39**
Total	**76,40**	**23,60**	**100,00**

When looking at the relationship between whether an individual would get into trouble with their caretakers for using alcohol or drugs and whether or not they in fact drink alcohol or use drugs, a significant association was found in both cases ($p < 0,0001$). This suggests that if an individual believes his/her caretakers will disapprove of the behaviour, this may reduce the chance of him/her in fact taking part in the behaviour. The attitude of the caretaker therefore plays a significant role in the behaviour of the individual.

5.3 Sexual Behaviour

In this sample of adolescents, 41% reported having had a sexual relationship while 57% had not had a sexual relationship (2% were unsure). Of the individuals participating in the study, 28% had sexual intercourse in the **three months prior** to the study, 62% did not and 10% were unsure.

High-risk sexual activity can be divided into two variables, namely sex with multiple partners and the use, and/or lack thereof, of condoms. Of the individuals who reported having sexual intercourse in the past three months, 38% had sexual intercourse with multiple partners in these three months. In terms of condom use, 67% of the participants who reported having sexual intercourse in the past three months used condoms every time they had sex.

5.3.1 Sexual Behaviour and Biographic Data

There is a significant association between having had a sexual relationship and gender ($p < 0,0001$). Of the males participating in the study, 51% had had a sexual relationship compared to 33% of the females. A significant relationship was found between having a sexual relationship and age ($p < 0,0001$). It seems that older adolescents are more sexually experienced. Sexual experience is also significantly associated with racial group ($p < 0,0001$). More black adolescents reported having had sexual relationships (44%) as opposed to only 32% of the white and coloured participants and 17% of the Indian participants.

There is a significant association between having multiple sexual partners and gender ($p < 0,01$). In the total sample, 14% of the male participants and eight per cent of the female participants had multiple sexual partners. There is no significant association between gender and the use of condoms.

There is a significant association between age and multiple sexual partners ($p = 0,0003$) as older adolescents tend to have more sexual partners. There is also a significant association between age and the use of condoms ($p = 0,001$), as older adolescents are more likely to use condoms. However, due to the fact that age is significantly associated with an individual having a sexual relationship, it would make sense that younger individuals do not have multiple partners or use condoms, as they are not engaging in sexual relationships at all. It is also important to note that although more individuals have sex with multiple partners the older they get, they also use condoms more, so it is debatable whether this is classified as safe sex as opposed to high-risk sexual behaviour. Of the individuals engaging in sexual intercourse with multiple partners, 65% used condoms on each sexual encounter. Therefore, although some individuals engage in high-risk sexual behaviour in terms of the number of sexual partners they have, two-thirds of them take some precautions in order to ensure that their behaviour is safe. However, there is still the one third of these individuals that take no precautions and their behaviour is classified as totally high-risk sexual behaviour.

Finally, there is no significant association between racial group and involvement with multiple sexual partners, or between racial group and condom use during sex. Therefore race does not seem to play a role in high-risk sexual behaviour.

5.3.2 Sexual Behaviour and Unwanted Sexual Experience

It was found that there is a significant association between the sexual practices of individuals and past unwanted sexual experience ($p < 0,0001$). Adolescents who reported unwanted sexual experiences were more likely to have had a sexual relationship than those who had not reported these experiences (78% vs 62%).

When comparing past unwanted sexual experiences with engagement in risky sexual behaviour (having multiple sexual partners and refraining from using a

condom during sexual intercourse), there is a significant association. It was found that 23% of the individuals exposed to these experiences engage in sexual intercourse with multiple partners, opposed to only 10% of non-sexually abused individuals and 43% of sexually abused individuals do not use condoms during sexual intercourse opposed to 38% of non-sexually abused individuals. Due to the fact that these differences are significant, there seems to be evidence that those who have been exposed to unwanted sexual experiences may engage in high-risk sexual behaviour.

5.3.3 Risky Sexual Behaviour and Unwanted Sexual Experience

The above analysis looked at aspects of sexual behaviour, namely having a sexual relationship, sexual intercourse with multiple partners, and the use of condoms during sexual intercourse, separately. Although this information is useful, it would also be beneficial to group these three variables together and thereby look at the interaction between unwanted sexual experience and what we can then call risky sexual behaviour (Table 7). In this way, we can identify the type of sexual behaviour an abused individual may participate in as opposed to looking at parts of their behaviour. Three questions from the questionnaire were used in order to create the new variable of 'Sexual behaviour'. The questions were:

- "Have you ever had a sexual relationship?"
- "Did you have sexual intercourse with more than one partner during the past three months?"
- "Did you use a condom every time when having sex during the past three months?"

The different combinations of answers to these questions were used in order to divide the sexual behaviour of the individual into safe sexual behaviour, risky sexual behaviour and no sexual behaviour. For example:

- If the individuals answered ‘yes’ to having a sexual relationship, ‘yes’ to multiple sexual partners and ‘no’ to the use of condoms, their behaviour is classified as **Risky**.

- If the individuals answered ‘yes’ to having a sexual relationship, ‘yes’ to multiple sexual partners and ‘yes’ to the use of condoms, their behaviour is classified as **Safe**.

- If the individuals answered ‘yes’ to having a sexual relationship, ‘no’ to multiple sexual partners and ‘yes’ to the use of condoms, their behaviour is classified as **Safe.**

- If the individuals answered ‘yes’ to having a sexual relationship, ‘no’ to multiple sexual partners and ‘no’ to the use of condoms, their behaviour is classified as **Risky**.

- If the individuals answered ‘no’ to having a sexual relationship they were placed in the **no sexual behaviour** group.

Those individuals who did not answer one or more of the questions were excluded from the sample. As a result the sample size used, when looking at the sexual behaviour of individuals, is smaller than the total sample size. In this case, almost 50% of the total sample is missing and a sample size of 968 was used. This affects the percentages which will then differ from those previously given. Results are thus only available for a part of the sample where no missing values were found.

The following is a table of unwanted sex and sexual behaviour:

Table 7: Table of Sexual Behaviour by Unwanted Sex

(N = 968)

Sexual Behaviour	Unwanted Sex			
Frequency **Percent** **Row Pct** **Col Pct**	**Yes**	**No**	**Don't Know**	**Total**
Safe Sex	70 7,23 17,37 45,16	295 30,48 73,20 40,08	38 3,93 9,43 49,35	**403** **41,63**
Risky Sex	57 5,89 22,89 36,77	182 18,80 73,09 24,73	10 1,03 4,02 12,99	**249** **25,72**
No Sex	28 2,89 8,86 18,06	259 26,76 81,96 35,19	29 3,00 9,18 37,66	**316** **32,64**
Total	**155** **16,01**	**736** **76,03**	**77** **7,95**	**968** **100,00**

Table 8: Statistics for Table of Sexual Behaviour by Unwanted Sex

Statistic	DF	Value	Probability
Chi-square	4	26,6367	< 0,0001
Effect Size		0,1636	

There is a significant association between unwanted sex and risky sexual behaviour ($p < 0,0001$). The association may however not be of practical significance because of the small effect size (0,1636). Having said this, there are several conclusions one can draw from the table. Of the individuals who have had sex against their will, 45% engage in safe sexual behaviour, 37% engage in risky sexual behaviour and only 18% do not engage in sexual behaviour. This is in contrast to those individuals who have not had sex against their will in which 40% engage in safe sexual behaviour, 25% engage in risky sexual behaviour and 35% engage in no sexual behaviour. These differences are significant and indicate that an individual who has experienced unwanted sex is more likely to engage in risky sexual behaviour than an individual who has not experienced unwanted sex or sexual abuse.

5.3.4 Sexual Behaviour and Social Approval

When looking at the relationship between whether an individual feels pressured by their friends to have sex and whether or not they have had sexual intercourse in the three months prior to the study, we find that there is a significant association ($p < 0,05$). This indicates that peer pressure plays a role in the individual's sexual behaviour. It is also important to determine whether peer pressure and the attitude of society impact on whether an individual engages in high-risk sexual behaviour. There is a significant association between whether an individual believes that their friends practise safe sex and their engagement in high-risk sexual behaviour in terms of using a condom during sexual intercourse ($p < 0,0001$). This indicates that if an individual's friends practise safe sex, they are more likely to do so.

5.3.5 Sexual Behaviour and Substances

There is a significant association between whether an individual abuses alcohol or not and their sexual behaviour ($p < 0,0001$) (Table 9). Of the individuals who had abused alcohol (had five or more drinks with alcohol on

one day) in the 30 days prior to the testing, 41% had had sexual intercourse in the three months prior to the testing. Of the individuals who had not abused alcohol in the 30 days prior to the testing, only 24% had had sexual intercourse during this time. This indicates that the abuse of alcohol may be associated with sexual intercourse.

Table 9: Table of Sexual Activity by Alcohol Abuse

Sex in Past 3 Months	Alcohol Abuse		
Percent Row Pct Col Pct	**Yes**	**No**	**Total**
Yes	9,31 33,43 40,66	18,54 66,57 24,05	**27,85**
No	11,07 17,69 48,35	51,51 82,31 66,81	**62,58**
Don't Know	2,52 26,32 10,99	7,05 73,68 9,14	**9,56**
Total	**22,90**	**77,10**	**100,00**

It is also important to look at whether the abuse of alcohol is related to the likelihood of having high-risk sexual intercourse. The chi-square test was used to determine the significance and it was found that there is a significant relationship ($p < 0,0001$) between abusing alcohol in the past 30 days and having sex with multiple partners in the past three months. Of the individuals who did abuse alcohol, 21% had sexual intercourse with multiple partners, as opposed to only nine per cent of those who did not abuse alcohol. This difference is significant and indicates that the abuse of alcohol may be related to increased high-risk sexual behaviour.

There is not a significant association between alcohol abuse in the past 30 days and condom use when having sex during the past three months. Therefore, although the abuse of alcohol is related to the level of sexual activity and the number of sexual partners, it is not related to the use of condoms by the individual.

There is a significant association between the use of drugs and sexual behaviour ($p < 0,05$) (Table 10). Of the individuals who used drugs in the past 30 days, 37% had had sexual intercourse in the past three months compared to the individuals who had not used drugs in the past 30 days, where only 27% had had sexual intercourse during this time. These differences are significant and indicate that the abuse of drugs may be associated with participation in sexual intercourse.

Table 10: Table of Sexual Activity by Drug Abuse

Sex in Past 3 Months	Drug Abuse		
Percent Row Pct Col Pct	**Yes**	**No**	**Total**
Yes	4,19 14,93 36,76	23,87 85,07 26,94	**28,06**
No	5,78 9,26 50,74	56,62 90,74 63,89	**62,40**
Don't Know	1,42 14,91 12,50	8,12 85,09 9,17	**9,55**
Total	**11,39**	**88,61**	**100,00**

There is a significant association ($p < 0,0001$) between drug use in the past 30 days and sexual intercourse with multiple partners during the past three months. Of those individuals who did use drugs within the past 30 days, 25% had sexual intercourse with multiple partners as opposed to only 10% of those who did not use drugs in this time. Again, however, there is not a significant association between drug use and condom use. It can be concluded that although the use of drugs may be related to high-risk sexual behaviour in terms of the number of sexual partners an individual may have, it is not related to the use of condoms.

5.3.6 Risky Sexual Behaviour and Substance-Use Behaviour

Although we have looked at the separate effects of drugs and alcohol on different aspects of high-risk sexual behaviour, in this section the focus will be on the interaction between substance-use behaviour in general (the concept described in section 5.2.3) and risky sexual behaviour in general (the concept described in section 5.3.3). The two created variables (substance-use behaviour and risky sexual behaviour) are used in this analysis and the chi-square test allows us to determine the association between these two variables. The following table (Table 11) indicates the interaction between substance-use behaviour (namely use of alcohol, use of drugs, use of both alcohol and drugs or use of neither alcohol nor drugs) and sexual behaviour (namely safe sexual behaviour, risky sexual behaviour or no sexual behaviour). Note that a smaller sample size is used in this analysis due to cumulative missing values on the combination of variables.

There is a significant association between substance-use behaviour and sexual behaviour ($p < 0,0001$). The association may however not be of practical significance because of the small effect size (0,2105). From the table it is apparent that those individuals using substances are more likely to engage in some type of sexual behaviour, whether it is risky or safe. Of the individuals engaging in high-risk sexual behaviour, most did not use any substances (47%) but a large number used alcohol (39%) and very few used

drugs (2%) or both (12%). Those engaging in safe sexual behaviour showed a similar pattern whereas for those who did not engage in any sexual behaviour, most did not use any substances (71%), a few used alcohol (23%) and an insignificant number used drugs (1%) or both (5%). It is apparent from the table that the use of a substance, whether it be alcohol, drugs or both, increases the likelihood of engaging in some type of sexual behaviour, safe or risky.

Table 11: Table of Substance-Use Behaviour by Sexual Behaviour (N = 968)

Substance-Use Behaviour / Sexual Behaviour Frequency Percent Row Pct Col Pct	Safe Sex	Risky Sex	No Sex	Total
Alcohol	149 15,39 46,71 36,97	97 10,02 30,41 38,96	73 7,54 22,88 23,10	**319** **32,95**
Drugs	12 1,24 60,00 2,98	6 0,62 30,00 2,41	2 0,21 10,00 0,63	**20** **2,07**
Both	41 4,24 47,13 10,17	29 3,00 33,33 11,65	17 1,76 19,54 5,38	**87** **8,99**
None	201 20,76 37,08 49,88	117 12,09 21,59 46,99	224 23,14 41,33 70,89	**542** **55,99**
Total	**403** **41,63**	**249** **25,72**	**316** **32,64**	**968** **100,00**

Table 12: Statistics for Table of Substance-Use Behaviour by Sexual Behaviour

Statistic	DF	Value	Probability
Chi-square	6	44,8934	< 0,0001
Effect Size		0,2105	

5.4 Psychological Well-being

The psychological well-being score was compiled from the scores of the 22 questions pertaining to aspects of Bar-On's Psychological well-being instrument namely self regard, happiness and interpersonal relationships. The questions were answered on a three-point scale and calculated in terms of a total score on the interval scale. A factor analysis was done on the 22 questions using the data of 1 918 learners. It was decided to use the 22 items as a single factor. The mean psychological well-being for the group is 52 with a minimum score of 22 and a maximum score of 66. The participants scoring below this mean will therefore have a below-average psychological well-being and those scoring above this value, a higher than average psychological well-being.

An analysis of variance of psychological well-being was done to investigate the effect unwanted sexual experience, risky sexual behaviour and substance-use behaviour may have on the individual's psychological well-being as well as the interaction between all four variables (Table 13). In this analysis the combined concepts as defined in section 5.2.3 and 5.3.3 will be used to describe risky sexual behaviour and substance-use behaviour. A sample size of N = 968 was used in this analysis due to the accumulation of missing values.

Table 13: Analysis of Variance for Psychological Well-Being

Source	DF	F Value	Pr > F
Unwanted sexual experience	2	2,01	0,1342
Sexual Behaviour	2	1,28	0,2788
Sexual Behaviour * Unwanted sexual experience	4	1,62	0,1670
Substance Abuse	3	2,42	0,0646
Sexual Behaviour * Substance Abuse	6	2,06	0,0559
Unwanted sexual experience * Substance Abuse	6	0,59	0,7365
Sexual Behaviour * Unwanted sexual experience * Substance abuse	9	2,22	0,0190

5.4.1 Psychological Well-Being, Sexual Behaviour, Substance-Use Behaviour and Unwanted Sexual Experience

When all the variables are combined, there is a significant interaction between unwanted sexual experience, sexual behaviour, substance-use behaviour and psychological well-being ($p < 0,05$).

When looking at the group of individuals with a psychological well-being below average, there is a tendency toward the use of substances, mainly drugs or both drugs and alcohol, involvement in unwanted sexual experience and involvement in some type of sexual behaviour, either safe or risky. Those individuals in this group who had not been exposed to unwanted sexual experiences were involved in the use of drugs or both drugs and alcohol and sexual behaviour.

When looking at the group of individuals with an average psychological well-being, the tendency is that none of the individuals had experienced unwanted sex, most of them did not use any substances and most of them were not engaging in sexual behaviour.

Finally, when looking at the group of individuals with a psychological well-being above the average of the entire population of participants, the tendency is that most of the individuals did not use any substances, most had not experienced unwanted sex but most also participated in some type of sexual behaviour, safe or risky.

It is apparent that there is an association between the four variables but one must investigate where, amongst these four variables, the relationships lie.

5.4.2 Psychological Well-Being and Unwanted Sexual Experience

There is no significant interaction between unwanted sexual experience and an individual's psychological well-being on the 5% level of significance. This indicates that experiencing unwanted sex does not seem to affect an individual's psychological well-being.

5.4.3 Psychological Well-Being and Sexual Behaviour

There is no significant interaction between sexual behaviour of an individual and their psychological well-being. It therefore seems that an individual's sexual behaviour in terms of whether they participate in safe sexual behaviour, high-risk sexual behaviour or no sexual behaviour is not related to their level of psychological well-being.

5.4.4 Psychological Well-Being and Substance-use behaviour

The interaction between substance-use behaviour and psychological well-being is significant at the 10% level. Those individuals using drugs presented with the lowest value for psychological well-being, a value well below the mean. The individuals using both drugs and alcohol also had a psychological well-being value below the mean, but higher than for those using drugs alone.

The individuals using alcohol alone again had a psychological well-being value that was below the mean but still higher than for the individuals using drugs alone or both drugs and alcohol. Finally, those individuals who did not use any substances had a psychological well-being value slightly higher than the group mean. It therefore seems that the use of substances and the psychological well-being of an individual interact in some way. It is possible that substance use may have a negative effect on one's psychological well-being and the type of substance used also seems important in this regard. However, it is also possible that individuals with psychological difficulties and poor psychological well-being will use substances in order to deal with these difficulties. Both these interactions must be seriously considered.

5.4.5 Psychological Well-Being, Sexual Behaviour and Unwanted Sexual Experience

There is no significant interaction between unwanted sexual experience, sexual behaviour of an individual and their psychological well-being.

5.4.6 Psychological Well-Being, Sexual Behaviour and Substance-Use Behaviour

There is a significant interaction at the 10% level between sexual behaviour, substance-use behaviour and psychological well-being. Those individuals presenting with a psychological well-being score below the group mean were all found to be using some type of substance, whether it be alcohol, drugs or both. They were also more likely to engage in some type of sexual behaviour, safe or risky. However, those with a psychological well-being score equal to or above the group mean were found to use no substances but were still sexually active. It seems as though the use of substances plays a greater role in one's psychological well-being than one's sexual behaviour.

5.4.7 Psychological Well-Being, Unwanted Sexual Experience and Substance-Use Behaviour

There is no significant interaction between unwanted sexual experience, substance-use behaviour of an individual and his/her psychological well-being.

In the next chapter, these results will be discussed in terms of the hypotheses and explained according to the literature presented.

CHAPTER SIX

DISCUSSION AND CONCLUSION

The research explored whether there is a relationship between unwanted sexual experiences during childhood and psychological well-being, the use of substances and involvement in high-risk sexual behaviour in adolescents.

A summary of the general results will be presented first and then the hypotheses will be discussed.

Of a sample of 1 918 adolescents participating in the research, 18% reported past unwanted sexual experiences. This correlates with the literature which states that the prevalence rates of child sexual abuse in South Africa in the year 2000 was one in every eight children (Davel, 2000). In this study, unwanted sexual experience was significantly associated with gender but did not occur more in adolescents of a specific age or racial group.

Of the individuals participating in the study, 32% were using alcohol. The use of alcohol was more common in males than in females. The use of alcohol increased as the age of the individuals increased. It was also found that the use of alcohol was more prevalent in white, coloured and black individuals.

The prevalence rate of using drugs was lower, in that only 11% of the participants used drugs. Again, the use of drugs was more common in males than in females and increased as the age of the individuals did. Unlike with alcohol, the use of drugs is not affected by racial group.

Of the adolescents participating in the study, 41% had had a sexual relationship at some point in their life. This was more common in males than in females and the tendency to have had a sexual relationship increased as the age of the individuals did and was more common among black

adolescents. Of the participants, 28% had had sexual intercourse in the past three months. Of these individuals, 38% engaged in high-risk sexual behaviour by having sexual intercourse with multiple partners and 33% engaged in high-risk sexual behaviour by not using a condom during sexual intercourse. Male participants were more likely to have multiple sexual partners than female participants. When looking at overall high-risk sexual behaviour (i.e. having sexual intercourse at a young age, having multiple sexual partners and not using condoms), 26% of individuals participating in the study were found to fit the criteria.

6.1 Relationships between Variables

In order to test the hypotheses which state that there is a relationship between unwanted childhood sexual experiences, substance-use behaviour and involvement in high-risk sexual behaviour in adolescents, a bivariate statistical analysis was done using pairs of variables. Specifically the chi-square test was used. Psychological well-being was not included in the bivariate analysis due to it being measured on an interval scale. The relationship between all four variables was investigated using analysis of variance.

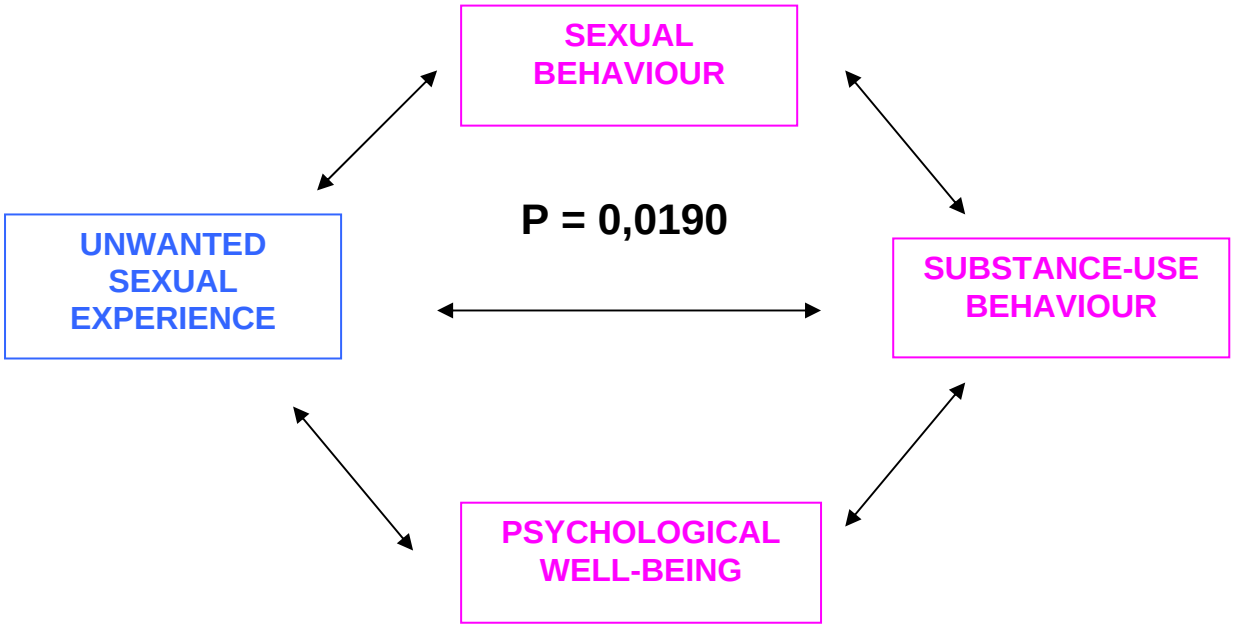
In the following section, results relating to the hypotheses will be discussed:

Hypothesis 1: There is a relationship between unwanted childhood sexual experiences, adolescent psychological well-being, substance-use behaviour and high-risk sexual behaviour.

According to the results, there is significant interaction between all four variables, namely unwanted childhood sexual experience, psychological well-being, substance use/abuse and high-risk sexual behaviour (see diagram 1). There was a tendency for individuals with low psychological well-being to have had unwanted sexual experiences, to be using either drugs or both drugs and alcohol, and to be engaging in some type of sexual behaviour,

either safe or risky. Some individuals with low psychological well-being did not have unwanted sex but were using drugs or both drugs and alcohol and engaging in sexual behaviour, safe or risky. This is therefore not a simplistic relationship and it is important to keep in mind that other factors may influence how an individual reacts to an unwanted sexual experience. For instance, it was found that peer pressure and the attitude of society seem to influence substance use and sexual behaviour of adolescents (section 5.2.4 and 5.3.4). As a result, we can acknowledge the relationships between the four variables, but need to take note of the fact that not all individuals will react in the same way to similar experiences as their social network may also influence their behaviour.

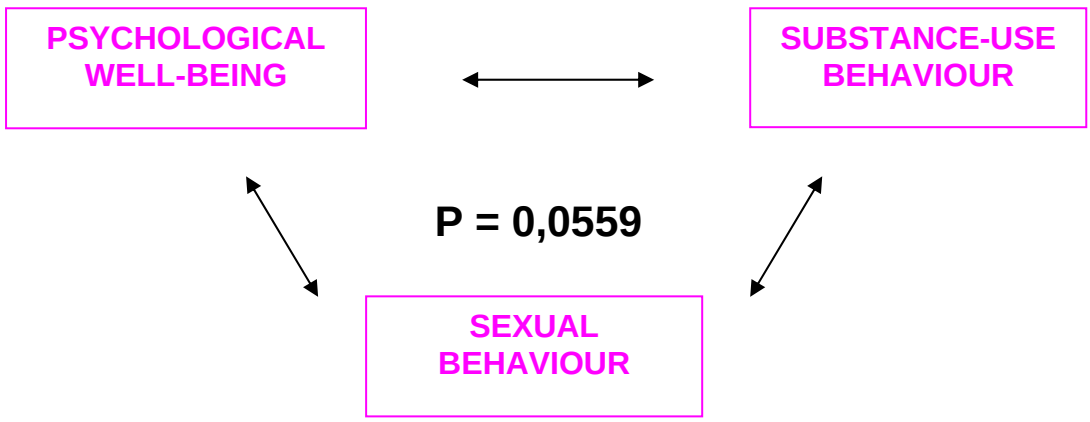
Diagram 1: The Interaction between Unwanted Sexual Experience, Psychological Well-Being, Substance-Use Behaviour and Sexual Behaviour



It has been concluded that there is a relationship between all four variables but one must investigate the relationships between pairs of these variables in order to find where the relationships lie, as well as the strength of the relationships.

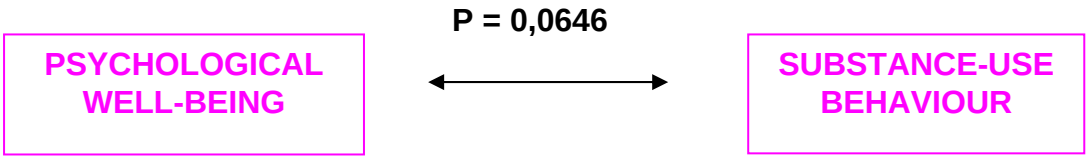
There is a significant interaction at the 10% level between sexual behaviour, substance-use behaviour and psychological well-being (see diagram 2). There was a tendency for individuals presenting with a psychological well-being score below the group mean, to use some type of substance, whether it be alcohol, drugs or both. They were also more likely to engage in some type of sexual behaviour, safe or risky. However, those with a psychological well-being score equal to or above the group mean were found to use fewer substances but were still participating in sexual behaviour. It seems as though the use of substances plays a greater role in one's psychological well-being than sexual behaviour. This may be due to the fact that, as described in the literature, sexual interaction has become more accepted among adolescents in recent decades. It is, therefore, a part of the norm and as a result, may not be as strongly linked to psychological well-being as previously believed (Ferrera, 2002). It would be beneficial, in this regard, to examine the relationship between psychological well-being and sexual behaviour as well as psychological well-being and substance-use behaviour separately.

Diagram 2: The Interaction between Psychological Well-Being, Substance-Use Behaviour and Sexual Behaviour



When investigating the relationships between pairs of variables in this interaction, it is apparent that there is no statistically significant association between psychological well-being and sexual behaviour. There is, however, a significant interaction between substance-use behaviour and psychological well-being at the 10% level (see diagram 3). There is a tendency that individuals using drugs, alcohol or both drugs and alcohol presented a psychological well-being below the group mean, whereas those individuals who did not use any substances had a higher psychological well-being score. It therefore seems that the use of substances and the psychological well-being of an individual interact in some way. Drug use especially, is associated with a lower psychological well-being. It is also possible that individuals with psychological difficulties and poor psychological well-being will use substances more in order to deal with these difficulties. This is termed self-medicating (Freeman, Collier & Parillo, 2002).

Diagram 3: The Interaction between Psychological Well-Being and Substance-Use Behaviour



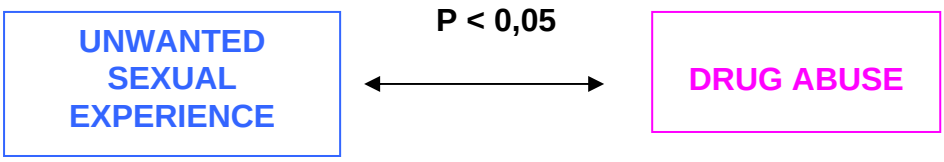
Hypothesis 2: There is a negative relationship between unwanted childhood sexual experiences and adolescent psychological well-being: Adolescents involved in unwanted childhood sexual experiences will have a lower psychological well-being than adolescents who were not involved in unwanted childhood sexual experiences.

According to the results, there is no significant interaction between unwanted sexual experience and an individual's psychological well-being on the 5% level of significance. This is in contrast to literature which states that there are a variety of mental, emotional and behavioural difficulties that occur directly following the abuse as well as later in life (Briere, 1992). It can be said that these difficulties, which have previously been researched, do not have a linear relationship with sexual abuse or unwanted sexual experience. In other words, not all victims of this trauma will react in the same way or experience the same effects. Rather, other factors can come into play and as a result, not all victims of abuse will experience negative psychological effects.

Hypothesis 3: There is a positive relationship between unwanted childhood sexual experiences and adolescent substance-use behaviour: Adolescents who were involved in unwanted childhood sexual experiences have a greater likelihood of using substances than those who were not involved in unwanted childhood sexual experiences.

According to the results, there is no significant relationship between unwanted sexual experience and overall substance-use behaviour, although there does seem to be a statistically significant positive relationship between unwanted sexual experience and adolescent drug abuse (see diagram 4). It is possible that certain individuals who experienced unwanted sex may turn to the use of drugs, but this seems to depend greatly on other factors involved. According to Freeman, Collier and Parillo (2002), a substance-abuse disorder does not develop as a direct result of sexual abuse, but rather as a result of the psychological processes involved in the experience and therefore as a means of self-medicating (Freeman, Collier & Parillo, 2002). The relationship between psychological well-being and substance-use behaviour has already been discussed. This is important to keep in mind, as some individuals may possess the resources to deal with the psychological difficulties in a healthy manner whereas others may resort to drug abuse.

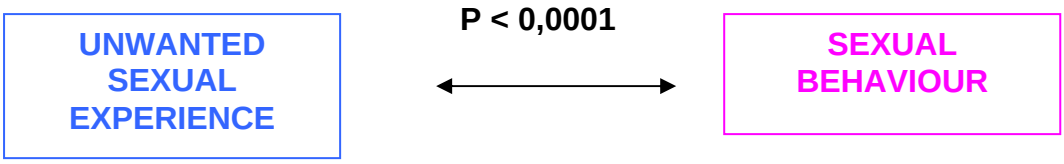
Diagram 4: The Interaction between Unwanted Sexual Experience and Drug Abuse



Hypothesis 4: There is a positive relationship between unwanted childhood sexual experiences and adolescent sexual behaviour: Adolescents who were involved in unwanted childhood sexual experiences have a greater likelihood of engaging in high-risk sexual behaviour than those who were not involved in unwanted childhood sexual experiences.

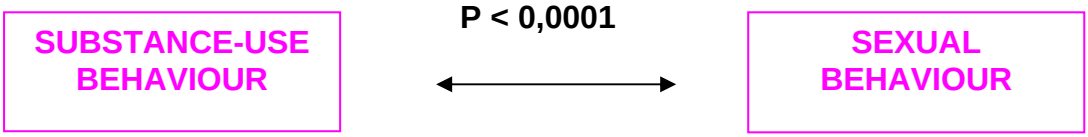
According to the results, there is a positive relationship between unwanted sexual experience and engagement in a sexual relationship ($p < 0,0001$), as well as between childhood sexual abuse and high-risk sexual behaviour (see diagram 5). Those individuals who have been involved in an unwanted sexual experience are more likely to be involved in a sexual relationship and are more likely to engage in high-risk behaviour such as sex with multiple partners. This is possibly due to the fact that the individual becomes sexualised at an earlier age and learns that one of the ways of gaining interpersonal closeness is through sexual availability. Their fear of being vulnerable and abandoned may prevent them from remaining with a single partner which results in high-risk sexual activity (Briere, 1992). It should be noted that the unwanted incident(s) could have contributed to them responding in the affirmative to the question asking if they had had a sexual relationship.

Diagram 5: The Interaction between Unwanted Sexual Experience and Sexual Behaviour



There is a positive relationship between alcohol abuse and/or drug abuse and sexual behaviour (see diagram 6). Individuals abusing some type of substance, be it alcohol or drugs, are more likely to be sexually involved and are also more likely to participate in high-risk sexual behaviour in that they often have multiple partners. This is possibly due to the fact that substances often affect one's judgement and behavioural disinhibition which may result in more high-risk sexual activity. Those individuals who do not use any substances at all are more likely to refrain from engaging in any type of sexual behaviour.

Diagram 6: The Interaction between Substance-Use Behaviour and Sexual Behaviour

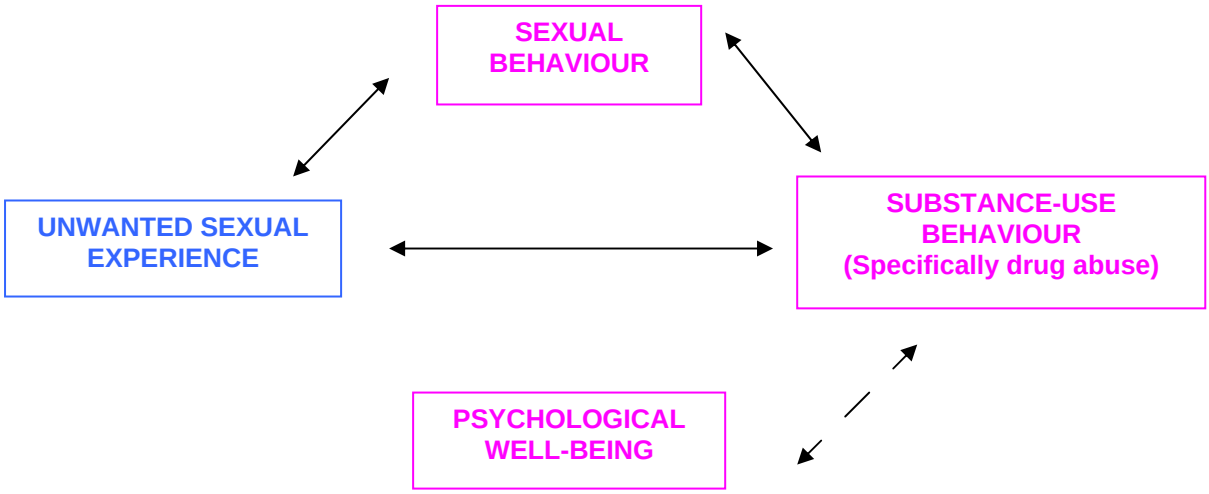


6.2 Summary

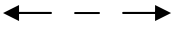
To summarise all these findings:

- There is a weak negative relationship between psychological well-being and substance-use behaviour.
- No relationship was found between psychological well-being and high-risk sexual behaviour.
- No relationship was found between psychological well-being and unwanted sexual experience.
- There is a strong positive relationship between unwanted sexual experience and adolescent substance-use behaviour, specifically drug abuse.
- There is a strong positive relationship between unwanted sexual experience and adolescent high-risk sexual behaviour.
- There is a strong positive relationship between high-risk sexual behaviour and substance-use behaviour.

Diagram 7: The Interaction between the Four Variables



Strong relationship



Weak relationship

If, and how, these variables interact is dependent on the specific individual. It is problematic to assume that each individual reacts to a trauma such as unwanted sexual experience in the same way. Other factors, such as the details around the experience as well as the individual's previous experiences and functioning, need to be considered.

6.3 Limitations of the Study

Although the research has provided some valuable information about the relationships between the variables, there are certain limitations to the study that limit the conclusions that can be drawn. The limitations of the study are mostly related to the fact that a questionnaire alone was used to gather data. Existing data from a study with another aim was used to draw conclusions about links between behaviours. Questions were therefore not tailor-made for this study, thus there are some limitations of the data.

Data was collected using a self-report questionnaire. This creates problems as the participants may not have reported accurately on some or all of the questions. Due to the fact that the questions were not explained to the participants, it is possible that certain individuals may have interpreted them differently to what was actually meant. For example, what is meant by sexual intercourse in the study may be interpreted differently by the adolescent. This would affect the data.

Due to the fact that closed questions were asked, no other information about the individuals' experiences is available. In terms of the unwanted sexual

experience, no other information is available. This is a crucial problem as one has seen that certain factors influence the way an individual may react to unwanted sex. Factors such as the age of the child during the incident, the relationship of the perpetrator to the victim, the type of sexual experience and the frequency, severity and duration of the unwanted sex may contribute to the child's perception of the experience and, as such, to long-term effects of the experience. We also have no details about the child's reaction to the unwanted sexual experience, such as whether they were able to disclose the information to a trusted individual, whether they have a good support network, or whether they received some form of help. These factors would influence how the experience affects the child later in life. In the study, we have grouped all individuals exposed to unwanted sexual experience into a single category and are therefore assuming that all individuals had the same experience and react in the same way, which we have seen is untrue.

By using a questionnaire, the respondent's behaviour is not seen in context of, for instance, their home situation, familial factors and other childhood experiences. Other factors impact on psychological and behavioural development. It is therefore problematic to assume that the noted psychological and behavioural difficulties of all the sexually abused participants are due to the abuse, as they may, in fact, be the result of many other experiences.

The questionnaire was answered in terms of a scale with the choices being either 'Yes, No, or Don't Know', or 'Agree, Disagree, or In Between'. This proved to be problematic as the participants often answered 'Don't know' or 'In Between' even to simple straight-forward questions. This indicates that the participants may have been concerned about the confidentiality of the study or may not have understood what was being asked. There were also many instances in which participants did not answer the question at all, which resulted in missing values. These many missing values in the data created problems when variables were combined. The analysis of variance was

therefore done on a much smaller sample size that could misrepresent the sample. Due to this, the data must be interpreted with caution.

Finally, the sample consisted of school-going adolescents in the Tshwane area. These results may therefore not be generalisable to the rest of the South African population, such as those individuals in rural settings or those individuals who do not attend school.

Despite the limitations, the results create an awareness of the relationships that exist between unwanted sexual experiences, psychological well-being, the abuse of substances and involvement in high-risk sexual behaviour.

Therefore, although there are a few limitations in the study that affect the conclusions that can be drawn, the study provides us with important information regarding the long-term effects that may occur following unwanted sexual experience. It would be beneficial to extend this study by adding specific questions about the unwanted sexual experience and incorporating other factors present in the individual's life.

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APPENDIX A

This is a questionnaire about you, how you feel and what you do. Please answer the questions as honestly as you can. There may be questions that make you feel uncomfortable. You may decide not to complete these questions. The information from the questionnaire will not be shared with anyone in your school.

Please use a pencil and mark the answers that apply the best to you.

Name of your school: ……..

Information about yourself					
1. Are you a MALE or a FEMALE?	MALE	FEMALE			
2. How old are you?	_____ years				
3. In what grade are you?	Grade				
4. What is the language you mostly speak at home?					
5. I feel sure of myself in most situations	YES, AGREE	IN BETWEEN	NO, DISAGREE		
6. People do not understand me	AGREE	IN BETWEEN	DISAGREE		
7. It is hard for me to enjoy my life	AGREE	IN BETWEEN	DISAGREE		
8. I know how to deal with upsetting problems	AGREE	IN BETWEEN	DISAGREE		
9. I really do not know what I am good at	AGREE	IN BETWEEN	DISAGREE		
10. I worry about many things	AGREE	IN BETWEEN	DISAGREE		
11. My classmates like me the way I am	AGREE	IN BETWEEN	DISAGREE		
12. I do not feel good about myself	AGREE	IN BETWEEN	DISAGREE		
13. I have a feeling that something is wrong with me	AGREE	IN BETWEEN	DISAGREE		
14. I feel lonely even when I am with people	AGREE	IN BETWEEN	DISAGREE		
15. I cannot concentrate when doing schoolwork	AGREE	IN BETWEEN	DISAGREE		
16. It is hard for me to accept myself the way I am	AGREE	IN BETWEEN	DISAGREE		
17. I think I am a good person	AGREE	IN BETWEEN	DISAGREE		
18. I trust in myself and my own abilities	AGREE	IN BETWEEN	DISAGREE		
19. I do not believe people who say nice things about me	AGREE	IN BETWEEN	DISAGREE		
20. I feel shy and unsure of myself when I am with other people	AGREE	IN BETWEEN	DISAGREE		
21. I would like to change many things about myself to like myself more	AGREE	IN BETWEEN	DISAGREE		
22. It feels impossible to deal with the problems I have	AGREE	IN BETWEEN	DISAGREE		
23. I feel life is not worth living	AGREE	IN BETWEEN	DISAGREE		
24. I cry every night	AGREE	IN BETWEEN	DISAGREE		
25. I enjoy the things I do	AGREE	IN BETWEEN	DISAGREE		
26. I have a good idea of what I want to do with my life	AGREE	IN BETWEEN	DISAGREE		

Information about substance use					
27. How many of your friends drink alcohol?	None	Some	Most		
28. Did you drink alcohol during the past 30 days – more than just a sip?	Yes	Sometimes	No		
29. Did you drink five or more drinks with alcohol on one day during the past 30 days?	Yes	Sometimes	No		
30. How many of your friends use drugs such as dagga (zol), cocaine, crack, mandrax (white pipe), LSD?	None	Some	Most		
31. Have you used drugs such as dagga (zol), cocaine, crack, mandrax (white pipe), LSD during the past 30 days?	Yes	Sometimes	No		
32. If your parents or caretakers find out that you were drinking alcohol or smoking dagga do you think you would get into trouble?	Yes	Sometimes	No		

Information about relationships **This section deals with aspects of your private life. The information will be kept strictly confidential.** **If you wish you need not answer the questions.**					
33 I feel pressured by my friends to have sex	AGREE	IN BETWEEN	DISAGREE		
34. My friends practice safe sex	AGREE	IN BETWEEN	DISAGREE		
35. I will refuse sex if my partner does not want to use a condom	AGREE	IN BETWEEN	DISAGREE		
36. I decide for myself what is right and what is wrong even if my friends do not agree with me	AGREE	IN BETWEEN	DISAGREE		
37. I am at risk of contracting HIV/AIDS	AGREE	IN BETWEEN	DISAGREE		
38. How many of your friends are sexually experienced?	NONE	SOME	MOST		
39. Have you ever had a sexual relationship?	YES	NO	?		
40. Did you have sexual intercourse during the past 3 months?	Yes	No	Don't know?		
41. Did you have sexual intercourse with more than one partner during the past 3 months?	Yes	No	Don't know?		
42. Did you use a condom ever time when having sex during the past 3 months?	Yes	No	Don't know?		
43. Have you ever allowed sex against your will?	Yes	No	?		

Thank you for your participation and honesty. If you wish to speak to someone about your experiences, please write your name and a contact number here or on a piece of paper and hand it to the researcher. A counsellor will then contact you soon.