Child Abuse & Neglect

Its Forms, Causes and Consequences

In

The Kingdom of Saudi Arabia

Ali Hassan Al-Zahrani

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"I think about it frequently. An experience I wish I could forget. It's not on my mind 24 hours a day, but always at the back of my mind"

(Waterhouse, 1993)

"It will never go away. It's like a never-ending story. It still worries me"

(Waterhouse, 1993)

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Declaration

I, Ali Hassan Al-Zahrani, declare that the work contained in this thesis is my own.

Signed:

Date: April 2003

PhD
University of Edinburgh
2004

Dedication

My heartfelt thanks to my parents the most generous beings on the planet for their personal, and spiritual support.

I would particularly like to thank my wife for all her help, patience, and support throughout the construction of this thesis. This thesis is a gift to my children; Riyadh, Riyan, Arwa, Rami, and Ahmed.

Abstract

Despite the significant contributions that have been made to the understanding of child abuse, there is still considerable public concern about it, particularly regarding its forms, causes, and prevalence (Waterhouse, 1993). As far as the researcher knows, many people in Saudi Arabia still do not know the difference between the disciplining and punishment of a child.

It is understood that child abuse is a very sensitive topic, not only in Saudi Arabia but all over the world. Maybe that is why only 39 cases of child abuse have been seen in Saudi Paediatric clinics during the last decade. In fact, in Saudi Arabia, we have no idea of the extent of child abuse, its causes or consequences. In the light of this situation, I decided on three main aims for this thesis. The first was to ascertain the reasons for child abuse in the society of Saudi Arabia. To this end I selected various epidemiological factors (e.g. parent's ages, parent's occupations, parent's education, parent's income, parent's residence, number of siblings in the family, marital problems, and the client's age). It was found that income, the number of siblings, the father's level of education, the mother's level of education, the father's age, and the mother's age are significant factors affecting the level of all form of child abuse (emotional, physical and sexual), and emotional neglect.

The second aim of this study was to identify the types of child abuse that are the most common in Saudi Arabia. Child emotional neglect (26.6%) was found to be the most prevalent (27.3% among households, and 24.3% among students). The second most prevalent was child emotional abuse (22.8% overall with 21.1% among students, and 23.4% among households). The third was child sexual abuse (22.7% overall, with 27.2% among students, and 14.7% among households). The fourth was child physical neglect (18.4% overall, with 21.1% among students and 13.5% among households). The fifth was child physical abuse (12.2% overall, with 12.3% among students, and 12.2% among households. And the last was medical neglect (9.4% overall, with 6.6% among students, and 14.5% among households).

29.4% of the sample said that they had received physical abuse from their father, while the second most common origin of the abuser was from among the victims siblings (18.5%), then relatives (11.6%), then mothers (8.3%), then friends (5.5%) and finally teachers (3.4%). 40.4% of the victims of physical abuse said they had been abused when aged between 11-15 years old, while (32.2%) said that they had been abused between the ages of 6-10, while the third group said that they were aged above 16 years old at the time of abuse.

Fathers were the most common perpetrators of emotional abuse (14.4%) followed by siblings (12.1%) and then other relatives (11.8%). Mothers

were the fourth most common perpetrators of emotional abuse. 27% of clients were emotionally abused when aged 11-15 years old, 19.2% at 6-10 years old, and 12% at above 16 years old and 2.3% at under five years old. On close examination of both physical and emotional abusers, we see a similarity between them. For example; fathers were the most likely to be the perpetrator in both categories, followed by siblings then relatives. The majority of victims in both categories said that they had been abused when aged between 11-15 years old, with 6-10 being the next most likely age range for abuse to occur, followed by those 16 or older, again in both categories. Also, less than 5% of clients received emotional or physical abuse while aged under five years old. This in fact gave an indication that emotional abuse could happen as a consequence of physical abuse. In other words, physical abuse can be, and is, accompanied by emotional abuse.

With regards to child sexual abuse, 23% of victims were aged between 6-10 at the time of abuse. Surprisingly, 12.8% of clients said that they had faced sexual child abuse while aged above 16 years old and just 3.2% when aged under 5 years old. This time, both the father and mother were the least likely perpetrators (1%). Relatives were the most likely to be perpetrators of sexual abuse (16.6%), then friends (12.3%), then siblings (4.8%), and then teachers (2.1%).

The third aim of the study was to examine a number of key issues

regarding the sequelae of the experience of abuse. Analyses showed that there is an association between all forms of child abuse (sexual, physical, emotional), emotional neglect and the following psychological problems; low self-esteem; aggression; psychological distress; and impulsiveness. More specifically, when the victim had received any of those forms of child abuse and neglect to a severe degree, they manifested a correspondingly severe degree of low self-esteem, aggression, psychological distress, and impulsiveness.

In this study I attempted to create cluster groups. It was found that if a child faces all forms of child abuse (sexual, physical, emotional abuse) together with one form of neglect (emotional neglect), and where this is accompanied by various epidemiological factors such as a low level of parental education, a young mother, and six or more siblings, then the outcome psychological problems are self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress. In other words, sexual, physical and emotional abuse and emotional neglect together with a low level of parental education, a young mother, and six or more siblings, is associated with self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress. However, if sexual abuse alone is accompanied by various epidemiological factors such as young parents, an unemployed father, and siblings numbering six or more,

then it associated with the following psychological problems; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression and psychological distress. If child abuse (sexual, physical and emotional), and emotional neglect happen without additional epidemiological factors, then the associated psychological problems are; low self-esteem; aggression; impulsiveness; and psychological distress.

In conclusion, this study can be considered to be the first Saudi Arabian nationwide study of child abuse. It is intended to give a brief overview, and to open up the door for other researchers by breaking the taboo that surrounds the issue of child abuse in Saudi Arabia. It is also intended to give an indication to the government, to parents, to professionals, to teachers, and to society as whole that child abuse in Saudi Arabia is a real issue that is affecting our children now and therefore will have repercussions for the nation in the future.

List Of Tables

List of Figures

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Ali H. Al-Zahrani

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Contents

Chapter 1. Introduction

1.1 Background

One unassuming fact is true of all of us- we have all been children. Each of us has completed the journey from newborn to young adult and perhaps beyond (Kendall, 2000). Childhood is an image that advertisers use to represent carefree innocence (Fruitage et al, 1998); and the realisation of this depends on the relationship that is built up between the child and its parents or guardians. This normally starts from childbirth, and if it is a good, positive relationship it will be reflected in the nature of the child. This early affective bond is usually called *parent-infant bonding* (Lee, 1978).

Growing up in the world can be challenging for children, who typically struggle with the desire for independence, physical changes, and questions about the future and the world around them (Edwards-Sutton, 1995). Nowadays, many children are hit, smacked, or slapped on a daily basis by parents who do not consider these actions to be abusive. Yet thousands of children experience violence on a regular basis, and their lives are irretrievably altered as a result (Fruitage et al., 1998). Year by year, in our increasingly open societies, the statisticians cite figures which show that there is more abuse, more physical violence, more neglect and more sexual exploitation (Jay & Doganis, 1987). Unfortunately, in some countries parents punish their children without realising that this could affect them in adulthood. Some parents still believe that this is an effective way to discipline their children. Various Arabic media especially TV

programs, and in particular serials, still contain negative examples of disciplining children.

Child abuse is in fact a worldwide phenomenon and has become a major concern in many countries throughout the world (Eastman, 1994). Child abusers are found mostly in the ranks of the unemployed, the blue-collar worker, the white-collar worker, and some other professionals. They come from almost all known societies such as Protestants, Catholics, Jews, Baptists, Moslems, as well as atheists (Pelton, 1985 p.23). In America, abuse and neglect have become one of the biggest threats to the lives of infants and small children (U.S. Advisory Board on Child Abuse and Neglect, 1995). In the U.S.A., the incidence of all forms of child abuse increased by 50% from 30 per 1000 children to 45 per 1000 between 1985 and 1992 (Kattan, 1998). Approximately 2.9 million children were identified and/or reported as victims of child abuse and neglect throughout the United States (Baladerian, 1994). The National Centre on Child Abuse and Neglect in Washington, D.C., has estimated that one million children are maltreated each year. Wang & Harding (1999) found that 42% of children died from neglect, 52% died from abuse, while 5% died as a result of multiple forms of maltreatment, in 26 states between 1996 and 1998. Between 2000 and 4000 deaths occur annually in the U.S. and are caused by child abuse and neglect (Elkerdany et al., 1998). According to the U.S. Advisory on Child Abuse and Neglect, deaths from abuse and

neglect of children aged 4 and under outnumber those from falls, choking on food, suffocation, drowning, residential fires, and motor vehicle accidents. In Britain, smacking children has been acceptable for some time (McClure & Choonara, 1992). A British survey has shown that each year at least one child per 1000 under the age of 4 years suffers severe physical abuse (Meadow, 1993). The BBC national poll carried out for the Child watch programme in October 1986 concluded that over 4 million adults in Britain had suffered some form of abuse as children (The Violence Against Children Study Group, 1990). In Saudi Arabia, until the 1990s, cases of child abuse and neglect went unpublished by medical professionals (Al-Aissa, 1998). The problem has only recently begun to receive attention among people of all educational levels, socio-economic status, and religious denomination. Indeed this is a most complex issue, not only for researchers, but also for society as a whole to come to terms with (Hopper, 1998). Nobody likes to hear the term 'child abuse', particularly among strict conservative societies because when one refers to 'child abuse' the first impression is usually that it is sexual abuse that is being addressed. As we know, sexual relations between parents and children in Saudi Arabia are totally unacceptable. It is considered to be sinful and for this reason is prohibited (Haditono, 1981). However, some parents consider the child to be property, and as such feel free to do what they like with children while the law is powerless to stop them.

In Saudi Arabia nearly every month local newspapers report at least one incident of child physical abuse. Indeed several tragic stories have been published in the past few months. A double tragedy was reported in a local newspaper *Alwatan,* on 30th of April 2002, under the title "Citizen set fire to his five children in order to retaliate against their mum". He used a belt on all five children and set fire to two, but fortunately their neighbours heard their mother's cries, whereupon they broke in and intervened to save the other children. It is difficult to comprehend that this father intended to upset his wife by killing his own children. Had there been a strong legal deterrent in place, this tragedy might not have occurred. Child abuse does not only occur in the home but is also quite visible in schools. A report published in 1996 by educational affairs directorate in Riyadh Region that belongs to Saudi Ministry of Education estimated that in a school in Riyadh region 7198 children are beaten per year by the head teacher for reasons such as lateness or failure to complete homework. The children were beaten on the feet or the back (Al-Saud, 2000). Another report published in 1997 shows that one of the teachers had beaten students so severely with a hard object that bruises were evident. He also verbally abused them emotionally by using terms such as 'lazy', 'stupid', and 'ugly' (Al-Saud. 2000). In one report, which was published in 2000, it was estimated that in one school the head teacher slapped the faces of the pupils 1800 times per year, meaning that three children are slapped every

day. The head teacher banged students into walls, pinched them violently, and slapped their faces. It also estimated that a head teacher in another school had beaten approximately 7500 students on their feet in one year (p 80). At the present time child abuse in Saudi Arabia is not clearly diagnosable, and as such doctors dealing with cases of sexual abuse or other types of abuse do not know how to deal with and manage such cases (Al-Ayed et al., 1998). If parents bring a child to a hospital with a medical problem, the physicians or paediatricians may have difficulty deciding whether it resulted from an accident, disease or inflicted injury (Bourne & Newberger, 1979). The reason for this is that there is no structured national system to deal with cases of child abuse and doctors do not have the special training necessary (Kattan et al., 1995). Though some of them know how to deal with it due to their having come from abroad, they generally do not wish to draw attention to it for many reasons, the most important one being the inherent conservatism of the Saudi society.

Usually, child abuse occurs between the ages of three months and 16 years and is perpetrated by a person or people known to the victim (Valman, 1987). Valman states that about 80% of the children who are sexually abused are abused by the father, stepfather, male relation or other co-habitee of the mother. In general, the child victims of abuse and neglect have a relatively young average age of 7.4 years, however, the

highest rate of physical injury is found among older children of 12-17 years of age (Wolf, 1987).

In many cases the causes of child abuse stem from the background and upbringing of the abusing parents. A survey by Gil (1979) found that 11 % of parents who abuse their children were themselves victims of abuse during their childhood. Also, the risk of abuse was found to increase in cases of premarital conception, teenage marriage, unwanted pregnancy, as well as in those families encountering social isolation and financial difficulties (Kattan, 1998). 33% of mothers in the National Society for the Prevention of Cruelty to Children (NSPCC) sample were aged less than 20 at the time of birth. A mother who is very young when she gives birth to a child may not know how to bring the child up adequately (Gillham, 1994). Small family size was a particular precipitator of child abuse. In the working class NSPCC sample 85% of the abused children came from one or two-child families (Frude, 1980). In various cultures problems with the marriage may lead to child abuse. For instance, the marriage may have been between two young people from disturbed homes who married for the wrong reasons, perhaps because they wanted to leave home or were in need of affection (Elkerdany, 1998). He added that some people mistakenly believe that a pregnancy will help to reverse instability in a relationship, but the child may be difficult to rear. The parents of physically abused children are more likely to be single, unemployed, of low socio-

economic status, and to have low levels of education (Gillham, 1994).

Many researchers have found the effects of child abuse to manifest not only in adulthood but also in middle childhood. O`Hagan & Dillenburger (1995) found evidence of a relationship between domestic violence and child abuse. In February 1993 a 2 year-old boy was brutally murdered by two 10 year-old boys. They were later described as victims of emotional and actual neglect and family breakdown (p.103).

The selection of this topic is the product of my experience in the psychiatric clinics and mental health hospitals in several regions of Saudi Arabia. In spite of the fact that cases of child abuse are presented to my colleagues and myself from time to time, the prevalence of child abuse in Saudi Arabia is unknown. An unpublished report issued by King Fahad National Guard Hospital (1997) indicated that 21% of children that visited the hospital in 1995 had been abused. This study becomes still more relevant when we are aware that according to a report published by the Saudi Ministry of Planning (1992), 49.23% of the Saudi population are under the age of 14.

The aim of this research is to explain the effects of abuse, how the victims feel to have been abused, to explore his or her emotional states as an adult and the factors that contribute to child abuse. It is hoped that this is a positive step towards dealing with the past and creating a new life for victims and for their children in the future (Gannon, 1989).

1.2 Historical Context of Child Abuse:

Child abuse is a phenomenon that came to light in the early 1960s in the USA, with the UK following soon after (Cooper, 1993). The medical community began to note systematically the harming of children by their parents (Gelles & Cornell, 1983). Radiologists noted fractured bones associated with head injuries in infants and speculated that the injuries might have been inflicted by parents or by other people responsible for the children's care (Gelles & Cornell, 1983). However, it was an article that appeared in the Journal of the American Medical Association in 1962 by Professor C. Henry Kempe, a child psychiatrist, and his colleagues in which they used a new term, namely, '*Battered Child Syndrome*' (Gelles & Cornell, 1983), that was one of the key pieces of research.

The child-welfare movement began in the US during the middle and late 19th century when the exploitation of children and adults during the Industrial Revolution gave rise to undeniable signs of childhood suffering; homeless and starving children wandered the streets (Gelles & Cornell, 1983 p45) and there have since been many books and articles published dealing with child abuse. ' A Guide to the Practical Physician', published in 1684, has a section on children entitled, 'The Regiment of Children' in which the author states that some mothers could not or would not care for their own babies (Lynch, 1985). The first book on child rearing was published in 1923 entitled '*Advice to young Mothers on the Physical*

Education of Children', and then *the ABC of 1 to 7'* was first published in the BMJ in 1981 (Valman, 1987; Lynch, 1985). Perhaps in the past child abuse was not readily recognised and, therefore, had a tendency to be ignored. However, when we go back to the 4th Century AD we find that children then faced problems with their relatives and their societies. Maher (1987) has divided historical responses to children into the following modalities:

- **Infanticide Mode*: (antiquity to 4th century AD)***

In this period, female children were totally expendable with the result that daughters were rarely reared in ancient Greece-of 600 families, from the 2nd Century inscriptions at Delphi, only one per cent of the population raised two daughters.

- **Abandonment Mode*: (4th to 13th century)***

In medieval religion, children were just about perceived as having souls, but primitive processes at work in their parents meant that children were feared and hated. Physical abandonment in nunneries and foster families; swapping of children between households so that they could be used as servants; and neglect of children's emotional needs, seemed to characterise this period. Regular beating of children was still seen to be necessary, because of their perceived inherent wickedness.

- **Ambivalent Mode*: (14th to 17th Century)***

This period seems to show early attempts to develop the relationship

between children and parents. There was a proliferation of child instruction manuals, where the predominant notion in child development was of 'moulding' the child, both physically and emotionally, into a parental likeness. Ambivalence accompanied this attempt to mould the child, probably because of the concurrent perception that the child's needs were different from those of the adult.

- **Intrusive Mode*: (18th century)***

In this period there is more parental encroachment into the child's domain -curbing its anger, its mind and its will. Parents in this period punished the child, that is, they would strike it but generally refrained from whipping. The child was seen in a less threatening light, and the sciences of paediatrics and child health were born.

- **Socialization Mode*: (19th to 20th century)***

In this mode the guiding of children towards socially acceptable patterns of behaviour was developed. Freud's structural theory, Skinners behaviourism and the whole plethora of psychodynamic, cognitive and family therapies sprang up during this period. Even today, this socialising mode of child rearing is probably the most commonly held model in Western society, and lastly:

- **Helping Mode*: (mid-20th century)***

This is best described as being based on a philosophy of `child knows best`; and parents should be available to respond to the child's wishes, to

empathise with the child, never disciplining the child. Much of this helping mode seems to put the parent in the role of therapist to the child. This approach could deprive the child of an appropriate parenting experience, and also, runs the risk of putting the child in the new role of 'patient'. A Co-operative approach between parent and child is possible in child rearing, and this in itself makes hopeful reading after the preceding catalogue of child abuse (p. 9-11).

Summary of Maher's modalities

From the 4th AD to the 13th Century children were totally expendable, particularly females - only one per cent of the population raised two daughters. Children at that time were used as servants and were totally neglected emotionally. From 14th to 18th Century, the relation between parents and children was slightly improved. Parents in this period still punished the child, but generally refrained from harsher extremes such as whipping. The child was seen in a less threatening light, and the sciences of paediatrics and child health-care were born. The real improvement took place in the 19th and 20th Centuries, when psychological theories such as Freud's structural theory, Skinners behaviourism and the whole plethora of psychodynamic, cognitive and family therapies sprang up.

The best period for children in Western society began in the mid-20th century where a co-operative relationship between parents and children that had never previously existed started to take hold.

1.3 Background to Saudi Arabia

1.3.1 Historical and Cultural Background:

The origins of the contemporary Saudi state lie in the early eighteenth century when the crucial relationship between Sheikh Mohammed Ibn Abd al-Wahhab and Imam Mohammed Ibn Saud was established (Niblock, 1982). But in 1814 the Ottoman government crushed Al-Saud and they were subsequently driven from *Najd*, now part of the Riyadh Region and took up temporary residence in Kuwait (Niblock, 1982). In 1902 Abd al-Aziz in leading the capture of Riyadh, initiated events that led to the unification of the warring tribes (Niblock, 1982). A major factor in the success of Abd al-Aziz was his propagation of the doctrines of the puritanical Wahhabi sect of the Sunni branch of Islam after much fighting and extensive missionary work (Young, 1983). When the situation settled down and life started to return to normal, he began the construction of a new country. The name he chose for it was Saudi Arabia (*Arabic*: *al -Mamlaka al -Arabiya al -Saudiy-aTrans*: The Kingdom of the Arabs of the House of Saud) (Nyrop, 1984).

The kingdom of Saudi Arabia encompasses about four-fifths of the Arabian Peninsula (Al-Farsy, 1979), and demanded attention as the location of the two holiest sites of Islam- Mecca and Medina (Nyrop, 1984). Saudi Arabia was founded as a religious state, and the total population of Saudi Arabia is Muslim. As such, the king of Saudi Arabia

and his brothers have a close relationship with the Sheikhs and the *Ulama*, the religious scholars (Khodair, 1992).

In 1951 there were a handful of Europeans and other foreigners working in Saudi, but this has now increased to more than 5 millions (Ministry of Planning, 1992). The majority of them are from United State of America, Europe, Asia, and Africa (Nyrop, 1984). Nyrop (1984) states that in the 1970s 26% of the population lived in urban centres, and by 1984 over 70% did so.

The exact size of Saudi Arabia remains unknown, because it possesses more undefined than defined boundaries, the Saudi government estimates it at 2,217,949 square kilometres (Nyrop, 1984). It has a desert climate characterised by extreme heat during the day, an abrupt drop in temperature at night and a slight and erratic fall rain (Nyrop, 1984).

The population of Saudi Arabia according to the latest official report, issued in 1992, was 19,895,232, 14,872,804 Saudis and 5,022,428 non-Saudis, half or more of whom (9,927,372) were under the age of 19 (Ministry of Planning, 1992; Al-Farsy, 1990). Quarter of the population (5,193,149) live in the Mecca Region, which includes the three major cities of Jeddah, Mecca, and Taif. The second most populous area is the Riyadh Region (4,485,028), while the third is the Eastern Region (2,886,661) (Ministry of Planning, 1992).

The extended family is the basis of society in Arab social life, and is

typically composed of a couple, their unmarried offspring, their married sons and daughters-in-law, and their sons' children (Nyrop, 1984).

Saudi is the third largest producer of oil after Russia and America, but has the largest production capacity in the world (Nyrop, 1984).

1.3.2 Religious Background:

The Prophet Mohammed began to preach Islam in Mecca in 622 AD. He and a group of his followers were invited to the town of *Yathrib,* later known as Medina, meaning 'the city of the religion', because it was the centre of his activities (Khodair, 1992). The migration or *Hegira*, marks the beginning of the Islamic era; the Muslim calendar, based on the lunar year begins in AD 622. Mohammed continued his preaching in Medina, eventually defeated his opponents, returned in triumph to Mecca, and consolidated both the temporal and spiritual leadership of Arabia before his death in 632 (Nyrop, 1984).

Islam means submission to God, and he who submits is a Muslim. When a person becomes a Muslim he or she should perform the five pillars of the Islam as follows:

Al Shahada (testimony): i.e. stating that, "There is no god but God (Allah), and Mohammed is his Prophet".

Al Salah (Prayer) Each Muslim is required to pray five times daily in a prescribed manner and at a specific time.

Al Siyam (Fasting): This entails complete abstention from food, drink, and sex from sunrise until sunset during the month of Ramadan.

Al Zakah (Almsgiving): That is almsgiving to those who deserve it, each Moslem who is able should give a certain percentage of his annual income, either in money or in kind to the poor and the indigent.

Al Hajj (the Pilgrimage): All Muslims should, at least once in their life, if possible, perform the journey to Mecca (Khodair, 1992).

As mentioned before, in 1744 a crucial relationship was established between Mohammed Ibn Abd al-Wahhab, a religious scholar and Mohammed Ibn Saud (Niblock, 1982). Together they determined to embark on a campaign to spread Mohammed Ibn Abd al-Wahhab's message of *tawhid,* the unity of God (Niblock, 1982). The message of Ibn Abd al-Wahhab was essentially that Islam had been corrupted and that a return to the pristine conditions of the early days of the Islamic community was necessary (Hopwood, 1982).

1.3.3 The Role of Women:

Allah says in the holy Qur'ân:

> ***"They are a libaas {protection} for you and you are the same for them".***

And further:

> ***"And among His signs is this, that He created for you wives from among yourselves, that you may find repose in them, and He has put***

between you affection and mercy."
al-Rum 21.

These Quranic verses describe how men and women should come together, protect one another, and beautify one another. It is stipulated that each has to support, work and act on behalf of the other (Al-Sadlaan, 1996). This is in fact the prescription of Islam with regards to the treatment of women. However, the reality in some Arab communities is that boys are regarded as an asset to the family whereas girls are regarded as a liability (Sharabi, 1977). Arab traditions emphasise submissiveness and dependency as important feminine attributes in the upbringing of girls, and the idea that the function of the women is to produce and care for children is widely held particularly in the rural areas and among the Bedouins (El-Islam, 1984). However, in Saudi Arabia, the number of educated women is rising rapidly and these educated women are challenging the traditional limitation of their role in marriage and mothering (Khodair, 1992). Needless to say, they are facing many obstacles. Finding a suitable job on completion of their studies may well necessitate moving to another town. However, they are not permitted to drive or leave town without an escort. Some families have overcome this problem by providing a chauffeur driven car, but many are unable to do so (Shirley, 1982).

Women in Saudi are generally not permitted to work with men; they have separate schools, universities, banks, libraries, and hospitals. It is true that they can work with men in some hospitals, particularly the largest ones,

such as the military hospitals.

Separation of the sexes does not lead to the radical isolation of women from public life. For necessities, they can contact men via the Internet, e-mail, and telephone. For social affairs, women can visit each other at home or in the shops, clubs, cafés, and restaurants provided for them.

1.4 Child Rights

The child shall enjoy special protection and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity" (Castle, 1978).

The phrase 'children's rights' includes the right to vote, to work, to own property, to travel, to choose one's guardian, to receive a guaranteed income, to assume legal and financial responsibilities, to control one's learning, to use drugs and to drive, to adequate food, clothing and medical care, to appropriate education and training, and protection against exploitation, cruelty and neglect (Franklin, 1986 p12). It is important to make sure that children should have all of these rights, because they are in a special period, a period of vulnerability. Therefore violence toward children should be considered to be a very serious issue, and should become a focal point of substantial public and governmental attention (Elkerdany et al., 1998).

As it stands, the debate on children's rights has focused on the differences

between the liberationists and the projectionists or paternalists. The liberationists favour extending a number of rights, hitherto held exclusively by adults, to children (The Violence against Children Study Group, 1990, p23). The process would ensure that children are able to exercise control over their environments, make decisions about what they want, and have autonomous control over various facets of their lives (The Violence against Children Study Group, 1990, p23). Projectionists or paternalists favour restricting children's lives in some areas while compelling them to do other things, all of which are seen as being in their best interests (The Violence against Children Study Group, 1990 p23). However, it is clear that contemporary parents disagree about children's rights and appropriate discipline (Arnold, 1990).

The Scandinavian countries have been in the forefront to abolish corporal punishment in all state schools. In 1987 the UK became the last European country to do so (Creighton & Russell, 1995). In Scotland, in 1992, the Scottish Law Commission recommended that it should be an offence in both criminal and civil proceedings for a person to hit a child (Scottish Law Commission, 1992).

1.4.1 In the UN

In 1959 the United Nations Declaration of the Rights of the Child stated, "The child shall be protected from all forms of neglect, cruelty and exploitation" (U.N, 1959). On November 1989 United Nations Declaration

of the Rights of the Child sought to establish a set of principles, which should be reflected in the provision made for the world's children. These include the following:

The State's obligation to protect children from all forms of maltreatment perpetrated by parents or others responsible for their children, and to undertake treatment and preventative programmes in this regard.

- ***Protection of privacy***

The right to protection from interference with privacy, family, home and correspondence, and from libel/slander.

- ***Protection of children without families***

The state's obligation to provide special protection for children deprived of their family environment and to ensure that appropriate alternative family care or institutional placement is made available to them, taken into account the child's cultural background.

- ***Sexual exploitation***

The child's right to protection from sexual exploitation and abuse, including prostitution and involvement in pornography.

- ***Drugs abuse***

The child's right to protection from the use of narcotic and psychotropic drugs and from being involved in their production or distribution.

- ***Health and health Services***

The right to the highest level of health possible and to access to health

and medical services, with special emphasis on primary and preventive health care, public health education and the diminution of infant mortality. The state's obligation to work towards the abolition of harmful traditional practice. Emphasis is laid on the need for international co-operation to ensure this right.

- ***Education***

The child's right to education, and the State's duty to insure that primary education at least is made free and compulsory.

- ***Child labour***

The State's obligation to protect children from engaging in work that constitutes a threat to their health, education or development, to set minimum ages for employment, and to regulate conditions of employment.

- ***Sale, trafficking and abduction***

The State's obligation to make every effort to prevent the sale, trafficking, and abduction of children.

- ***Torture and deprivation of liberty***

The prohibition of torture, cruel treatment or punishment, capital punishment, life imprisonment, and unlawful arrest or deprivation of liberty. The principles of appropriate treatment, separation from detained adults, contact with family and access to legal and other assistance.

- ***Adoption***

In countries where adoption is recognised and/ or allowed, it shall only be

carried out in the best interests of the child, with all necessary safeguards for a given child and authorization by the competent authorities.

- ***Refugee children***

Special protection to be granted to children who are refugees or seeking refugee status, and the State's obligation to co-operate with competent organizations providing such protection and assistance.

- ***Handicapped children***

The right of handicapped children to special care, education and training designed to help them to achieve greatest possible self-reliance and to lead a full and active life in society.

- ***Children of minorities or indigenous population***

The right of children of minority communities and indigenous populations to enjoy their own culture and to practice their own religion and language.

- ***Separation from parents***

The child's right to live with his/her parents unless this is deemed incompatible with his/her best interests; the right to maintain contact with both parents if separated from one or both; the duties of States in cases where such separation results from State action.

- ***Parental responsibilities***

The principle that both parents have joint primary responsibility for bringing up their children and that the State should support them in this task.

- ***Name and nationality***

The right to have a name from birth and to be granted a nationality (Tisdall, 1997 p160).

- ***Preservation of identity***

The state's obligation to protect and, if necessary re-establish the basic aspects of a child's identity (name, nationality, and family ties).

- ***The child's opinion***

The child's right to express an opinion and to have that opinion taken into account, in any matter or procedure affecting the child.

- ***Freedom of expression***

The child's right to obtain and make known information, and to express his or her views, unless this would violate the right of others.

- ***Freedom of thought, conscience and religion***

The child's right to freedom of thought, conscience and religion, subject to appropriate parental guidance and nation law.

- ***Freedom of association***

The right of children to meet with others and to join or set up associations, unless the fact of doing do violates the rights of others.

- ***Access to appropriate information***

The role of the media in disseminating information to children that is consistent with moral well-being and knowledge and understanding among people, and respects the child's cultural background. The State is

to take measures to encourage this and to protect children from harmful materials.

- ***Social security***

The right of children to benefit from social security.

- ***Leisure recreation and cultural activities***

The right of children to leisure, play and participation cultural and artistic activities.

- ***Best interests of the child***

All actions concerning the child should take full account of his or her best interest. The State is to provide adequate care when parents or others responsible fail to do so.

- ***Parental guidance and the child's evolving capabilities***

The State's duty to respect the rights and responsibilities of parents and the wider family to provide guidance appropriate to the child's evolving capacities.

- ***Armed conflicts***

The obligation of States to respect and ensure respect for humanitarian law as it applies to children. The principle that no child under 15 take a direct part in hostilities or be recruited into the armed forces, and that all children affected by armed conflict benefit from protection and care.

- ***Rehabilitative care***

The State's obligation to ensure that child victims of armed conflicts,

torture, neglect, maltreatment or exploitation receive appropriate treatment for their recovery and social reintegration.

- ***Implement of right***

The State's obligation to translate the right in the convention into reality.

- ***Non-discrimination***

The principle that all rights apply to all children without exception, and the State's obligation to protect children from any form of discrimination.

The UN emphasized that all rights guaranteed by the Convention must be available to all children without discrimination of any kind. The State must not violate any right and must take positive action to promote them all (Tisdall, 1997 p160).

1.4.2 In Islam

A Muslim recognizes that a child has certain rights over his parents that he must fulfil. Furthermore, there are some manners and etiquette that must be followed between the two. Some of the rights on the part of the parents are choosing a good name for their child, to sacrifice an *Aqiqah* "A feast is held in the honour of the new born child". The feast would normally consist of two sheep to be killed for a boy and one for a girl. On the seventh day, the child might be circumcised, Parents have to be merciful, and gentle with the child, they have to provide him/her with adequate food and clothing, they have to bring him/her up in a proper way, being concerned with his/her cultural and social upbringing, teaching him/her about Islam

and training him/her to fulfil the obligatory and recommended aspects of Islam as well as other related manners (Al-Jazâiri, 1998). This continues until the child gets married regardless of his or her age, at which time s/he will give her or his choice to stay under his guardianship or to move off on his or her own. These are all based on the following evidences from the *Qur'ân* and *Sunnah* (Petitions of the Prophet Muhammad).

Allâh says in the Qur'ân:

> ***"The mothers shall give suck to their children for two whole years, (that is) for those (parents) who desire to complete the term of suckling, but the father of the child shall bear the cost of the mother's food and clothing on a reasonable basis"*** ***Al-Bakhrah 233.***

The meaning of the first part of this verse is that a mother should breast-feed her child for two years.

And says:

> ***"And kill not your children for fear of poverty"*** ***Israa 31.***

And says:

> ***"Wealth and sons are allurements of the life of this world"*** ***Al-Kahf 46***

Also says:

> ***"And when the news of (the birth of) a female (child) is brought to any of them, his face becomes dark, and he is filled with inward grief! He hides himself from the people because of the evil of that whereof he***

has been inform.
Shall he keep her with dishonour or bury her in the earth? Certainly, evil is their decision".

The verses above give an indication of the attitudes prevalent in the Arabic peninsula before Islam. However, the teachings of Islam began to work against infanticide and intentionally inflicted injuries, considering them to be capital offences that necessitate the punishment of the assailants (Al-Eissa, 1998).

It is stipulated in the Qur'ân that the Muslim must follow the example of the Prophet Muhammad. In *Surah of An-Nisa*, verse 80:

"He who obeys the Messenger has indeed obeyed Allah, but he who turns away, then we have not sent you (O Muhammad) as a watcher over them".

And also, in *Surah of Al-Ahzab*, verse 21:

"Indeed in the Messenger of Allah (Muhammad) you have a good example to follow for him who hopes for (the meeting with) Allah and the last Day, and remembers Allah much".

Therefore Prophet Mohammed (peace be upon him) affirmed in his sayings that children should be well-treated, fed, educated and gently disciplined in order to create a moral society on earth (Al-Eissa, 1998). The Prophet himself showed considerable affection towards children; below are some of his sayings in this regard:

His tenderness towards children:

> ***Narrated Abu Qatada: The prophet came out towards us, while carrying Umamah, the daughter of Abi Al-As (his grand-daughter) over his shoulder. He prayed, and when he wanted to bow, he put her down, and when he stood up, he lifted her up (Khan, 1983 p18).***

The prayer is a time of concentration and meditation in the life of the Muslim, and it is generally disliked that it be disrupted in any way. However, in spite of that, the Prophet Muhammad prayed with a daughter of one of his companions over his shoulder. He did not punish or neglect her, in order to give a good example to parents and guardians.

Further Hadiths that illustrate his attitude towards children are:

> ***Narrated Usama bin Zaid: Allah's Messenger used to put me on (one of) his thighs and put Al-Hassan bin Ali on his other thigh, and then embrace us and say, "O Allah! Please be Merciful to them, as I am merciful to them" (Khan, 1994 p 955).***

Another on Narrated by Aisha:

> ***A Bedouin came to the Prophet and said. " You (people) kiss the boys! We do not kiss them." The Prophet said, "I cannot put mercy in your heart after Allah has taken it away". (Khan, 1994 p 954).***

A Hadith illustrating his stipulation to refrain from neglecting female children:

> ***Narrated Aisha, the wife of the prophet: A lady along with her two daughters came to me asking me (for some alms), but she found nothing with me except one date which I gave to her and she divided it between her two daughters, and she then she got up and went away. Then the prophet came in and I informed him about this story. He said, "Whoever is in charge of (put to test by) these daughters and treats them generously, then they will act as a shield for him from the (Hell) Fire" (Khan, 1983 p 18).***

His condemnation of infanticide:

> ***Narrated Abdullah: I said ' O Allah's Apostle! Which sin is the greatest? " He said, "To set up a rival unto Allah, though He Alone created you. I said, "What next? " He said, to kill your son lest he should share your food with you. " I further asked, " What next? " He said, " To commit illegal sexual intercourse with the wife of your neighbour" (Khan, 1983 p 20; Khan, 1994).***

The prophet Mohammed (peace be upon him) said to those of his companions and followers who had daughters:

> ***"Whosever has a daughter and he does not bury her alive, does not insult her, and does not favour his***

son over her, God will enter him into Paradise."

The Hadith has a similar theme

" The person who brings up two baby daughters will, after his death, enter paradise with me just as these two fingers of mine are close to each other (Hasan, 1998).

In 1984 the Ministers of social affairs from the Arabic nations had a meeting to discuss children's rights. By the end of their meeting they published what was later named 'An Arabic Charter of Children's Rights which includes the following articles:

- Children must have access to free education.
- The parent or guardian must care for children in their charge, and allow them to grow up in safety.
- The parent or guardian must support their children socially.
- The parent or guardian must protect them from exploitation.
- The parent or guardian must provide them with social security.
- The parent or guardian must teach them how to love others (Al-Jeshi, 1996 p149).

In 1990, the Arabian Gulf States, which include six countries (namely the United Arab Emirates, Qatar, Kuwait, Oman, Bahrain and Saudi Arabia) held a meeting to discuss children's rights. They emphasised respect for the World's Childhood Agreement, while giving each State scope to find

the best way of applying it practically (Al-Jeshi, 1996). In Kuwait for instance, if the parent or guardian refused to do his or her duty in providing for their children's needs particularly if the child was under 14 years of age, then Article 167 allows the government to jail them for a maximum 10 years, or heavy a fine of 10,000 DK (the equivalent of £20,000) or both fine according to the decision of the court (Al-Eissa, 1999). In Saudi Arabia there is in fact widespread debate about how to educate parents progressively or deter them with punishment. Some academics hold the opinion that education by punishment would have negative consequences (Abdulaziz, 1997). On the other hand, religious scholars have drawn attention to the necessity of corporal punishment in certain situations, citing the following Prophetic Hadith as evidence:

> ***"Teach the child to pray at the age of seven and beat them if they don't do it at the age of ten" (Abu Dawud, 1989).***

However, various renowned religious scholars including Sheikh Muhammad Al-Othimeen give an explanation of this Hadith. He states, "The majority of children will listen to their parents if they use nice words with them, that is why the Prophet Muhammad gave parents three years in which to teach them, which is enough for a normal child. With others one needs to raise one's voice to make them listen, while others still will not listen without being beaten, which I believe are in the minority." He adds,

to paraphrase, that if one wishes to use physical force in order to teach them to pray when they reach the age of 10, that there are many points that one must consider before doing so:

① Beating should be used exclusively to educate and improve the child's behaviour.

② Beating should be carried out by hand, to a maximum of 10 blows, without inducing bruising.

③ Beating must avoid the face and areas where it could result in physical damage.

④ Beating should not be administered in retaliation (Al-Hudaithy, 1988). However, the fact remains that in Saudi Arabia there is no clear regulation specifically regarding the relationship between children and their parents (Al-Saud, 2000).

Summary of findings

Children in fact faced problems with their relatives and their societies in the 4th Century AD. Perhaps, in the past child abuse was not readily recognised and, therefore, had a tendency to be ignored. Child abuse came to light in the early 1960s in the USA, with the UK following soon after. Radiologists noted fractured bones associated with injuries in infants and speculated that the injuries might have been inflicted by parents or other people responsible for the children's care. However, it was an article that appeared in the Journal of the American Medical Association in 1962

by Professor C. Henry Kempe, child psychiatrist, and his colleagues in which they used a new term, namely, '*Battered Child Syndrome*.

In Saudi Arabia, until the 1990s, cases of child abuse and neglect went unpublished by medical professionals. A report published in 1996 by the Saudi Ministry of Education estimated that in a school in the Riyadh region 7198 children were beaten per year by the head teacher. Another head teacher hit students against walls, pinched them violently, and slapped their faces. Another report estimated that a head teacher in another school had beaten approximately 7500 students on their feet in one year. All that happened because for reasons such as lateness or failure to complete homework.

In 1959 the United Nations Declaration of the Rights of the Child stated, "The child shall be protected from all forms of neglect, cruelty and exploitation". The teachings of Islam began to work against infanticide and intentionally inflicted injuries, considering them to be capital offences that necessitate the punishment of the assailants. A Muslim recognizes that a child has rights over his parents that he must fulfil. Furthermore, there are some manners and etiquette that must be followed between the two. These are to be found in the parents choosing a good name for their child, to sacrifice an *Aqiqah* for their child on the seventh day, circumcising the child, having mercy and gentleness with the child, providing food and

clothing for the child, bringing him/her up in a proper way, being concerned with his/her cultural and social upbringing, teaching him/her about Islam and training him/her to fulfil the obligatory and recommended aspects as well as other manners. This continues until the child gets married off regardless his or her age, at which time s/he will give her or his choice to stay under his guardianship or to move off on his or her own. These are all based on evidence from the *Qur'ân* and *Sunnah.*

Chapter 2
Child Abuse & Neglect

Introduction

Child abuse is a controversial topic not just in Saudi Arabia but also in many countries, societies, and cultures, including the industrialised nations. As a result, many cases of child abuse are not reported to the local authorities, and as such, the prevalence of child abuse is unknown across the world. Although many cases go unreported, the number of reported cases of child abuse is increasing throughout the world. Take for instance America, where cases of child abuse increased by more than 1500 (125 per year) between 1980 and 1991 (see table 1).

Table (1) Shows cases of child abuse in the USA increased by more than 1500 between 1980 and 1991.

Cases of Child Abuse	Year
1154	1980
1225	1981
1262	1982
1477	1983
1727	1984
1928	1985
2086	1986
2178	1987
2243	1988
2411	1989
2508	1990
2694	1991

Source: Ginsberg, 1995.

The definition of child abuse has changed over time, as has the attitude of societies toward children and their relationship with their parents (Arnold,

1990). Giovannoni & Becerra (1979) were of the opinion that there were no adequate definitions of abuse that could be operationalized by professionals. Child abuse and neglect are matters of social definition and that the problems that inhere in the establishment of those definitions ultimately rest on value decisions (Giovannoni & Becerra,1979). The definition of child abuse varies from country to country (Mouzakitis & Varghese, 1985), from state to state, courtroom-to-courtroom, professional-to-professional, and physician-to-physician (Morris et al, 1985). The federal Child Abuse Prevention and Treatment Act of 1974 defined child abuse and neglect as:

> ***The physical or mental injury, sexual abuse or exploitation, neglectful treatment, or maltreatment of a child under the age of eighteen, or the age specified by the child protection law of the state in question, by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary (Arnold, 1990 p269).***

Child abuse in fact takes many forms that do not always adhere to easy definition (Gannon, 1989). Of course there are different types of child abuse and neglect, but this study focuses on three forms of child abuse; emotional; physical; and sexual, and three forms of neglect; emotional;

physical; and medical. It is intended to give more detail in relation to definition, categories, types, indicators, and prevalence.

2.1 Child Neglect

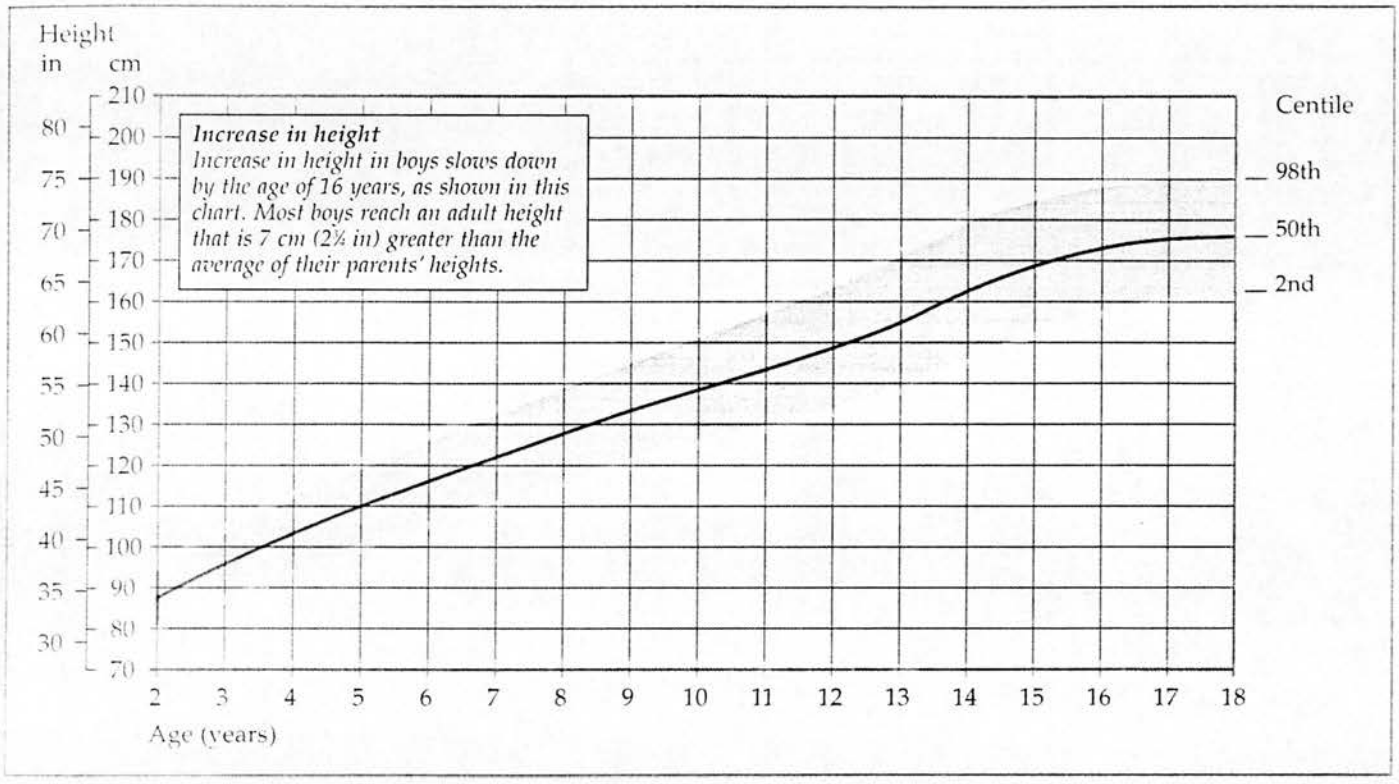
Although children have been abused and neglected for centuries, the recognition of maltreatment as a social problem is relatively recent (Briere et al, 1996). Neglect is the most common and occasionally leads to abuse (Bourne & Newberger, 1978). The main question here is, why the children who are neglected are more likely to be victims of other forms of abuse. Some researchers answer this question by asserting that failure to meet the needs of children in any area of their development will cause emotional damage (Beaver et al, 2002). It was thought mistakenly that neglect did not affect children, but in fact a child may starve to death because of the deliberate action of neglect by parents (Gelles & Cornell, 1983).

The syndrome known as 'failure to thrive' has been associated with the neglect of children (Gelles & Cornell, 1983). Growth failure or failure to thrive often accompanies child abuse (Lynch, 1982). Failure to thrive describes children who fail to grow normally for no biological reason (Beaver et al, 2002). It has been estimated that on average 5% to 10% of an inner city population fail to thrive before the weaning period, but many undiagnosed children may be experiencing failure to thrive (Skuse 1985; Hobbs et al, 1999; Kessler, 1999; Sherry, 1999). Children with histories of failure to thrive as infants may exhibit continued growth failure (Skuse, et al, 1994); developmental delay (Field, 1984); behavioural problems

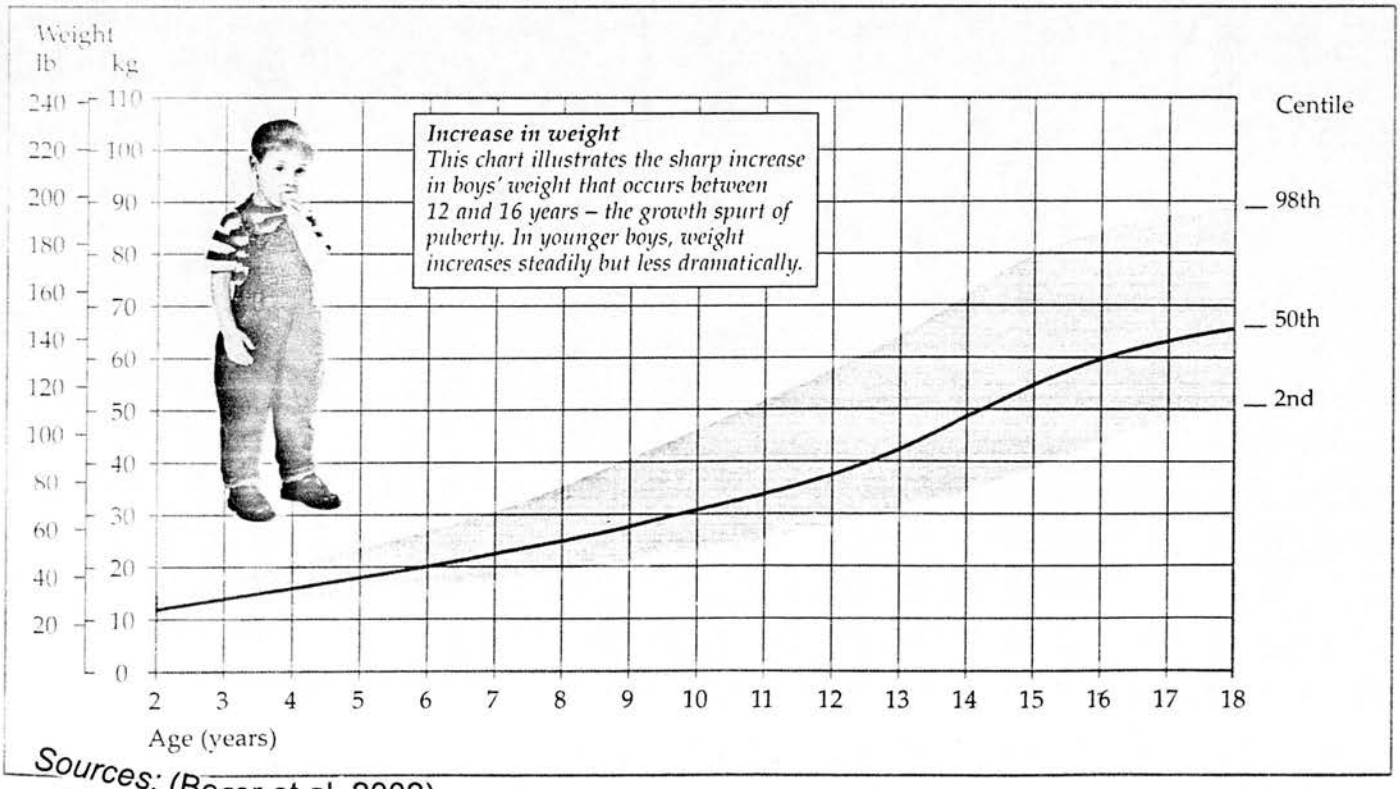
(Drotar & Sturm, 1992); depressed immunologic resistance (Bithoney & Newberger, 1987); cognitive/academic deficits (Singer & Fagan, 1984; Drotar & Sturm, 1988); and developmental retardation including motor, language, intellectual, social and behavioural components well into young adulthood (Wilson & James, 2002). In addition, there is a higher rate of behavioural disturbances (27-48%) among school-aged children with a history of failure to thrive in infancy, as judged by clinicians and teachers (Elmer, Gregg, & Ellison, 1969; Glaser, Heagerty, Bullard, & Pivchik, 1968; Hufton & Oates, 1977). The consequence for children who fail to thrive for non-organic reasons are better understood now (Hobbs et al. 1999). It is important to distinguish between children who fail to thrive for organic and those who do so for non-organic reasons. Some children are small because their parents are small; others have a medical condition causing lack of growth (Beaver et al, 2002). In many countries there is a quick-reference guide in use that identifies the normal growth margins for a child (see charts 2, 3). Any child falling out with these margins should be admitted to hospital for investigation (Beaver et al, 2002).

Chart (2)

BOYS' HEIGHT FROM 2 TO 18 YEARS



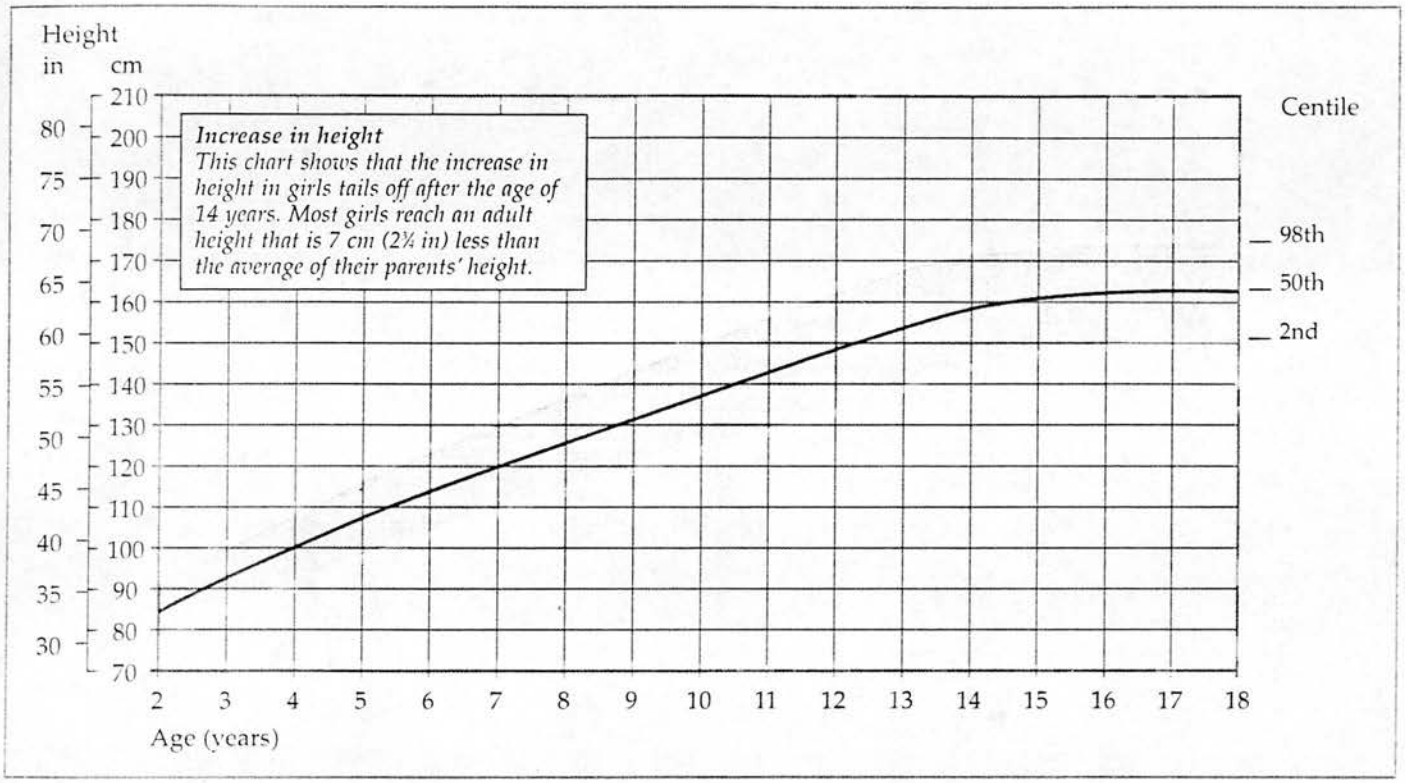
BOYS' WEIGHT FROM 2 TO 18 YEARS



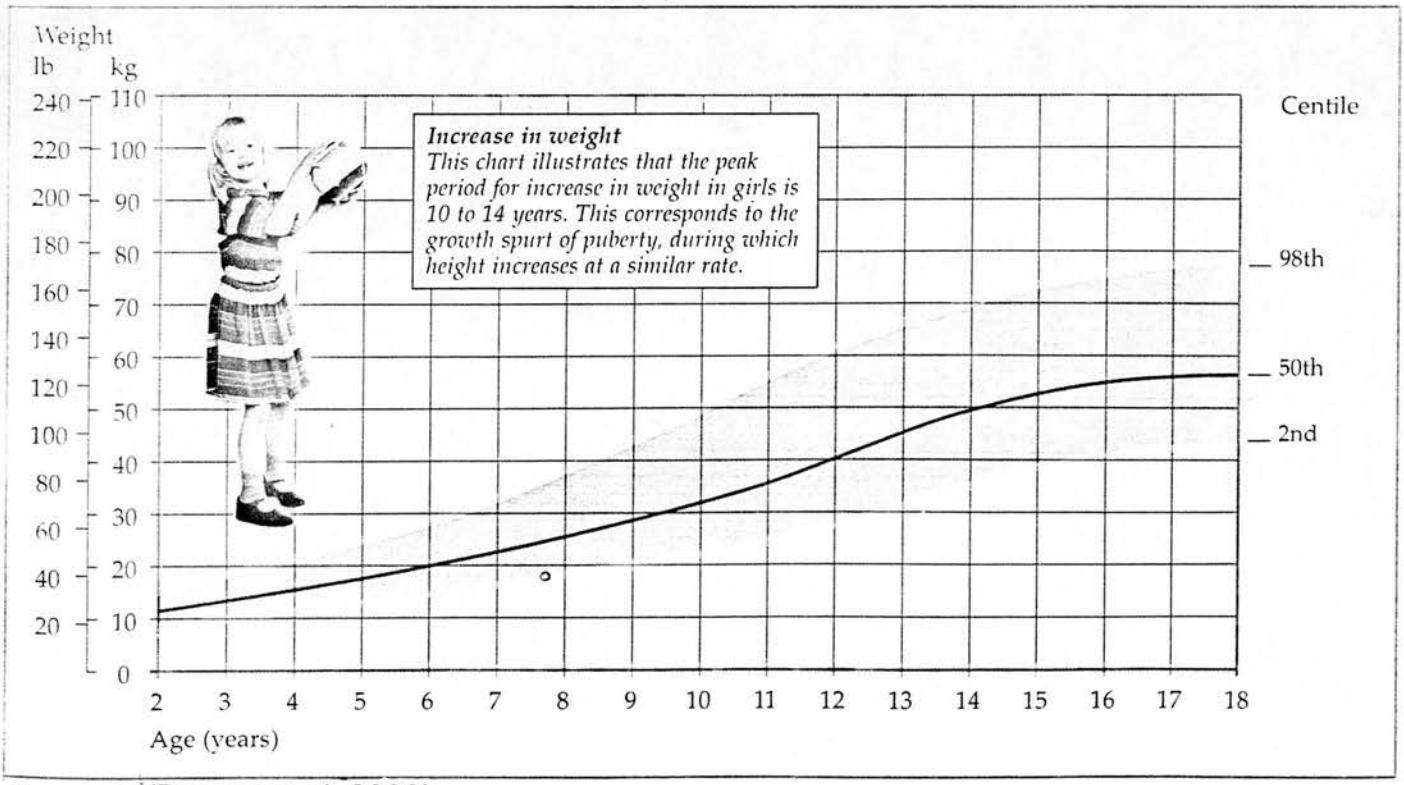
Sources: (Beaer et al, 2002).

Chart (3)

GIRLS' HEIGHT FROM 2 TO 18 YEARS



GIRLS' WEIGHT FROM 2 TO 18 YEARS



Sources: (Beaver et al, 2002).

2.1.1 Definition

Neglect means many things to many people. Definitions may very depending on whether one takes a legal, medical, psychological, social service, or lay perspective (Briere et al, 1996). Neglect and emotional abuse are more difficult to define (Brassard et al, 1987). There is no standardised definition of child abuse or child neglect that has been developed by researchers and accepted by welfare professional (Parton, 1985).

There is a common definition of neglect as "failing to provide the love, care, food, or physical circumstances that will allow a child to grow and develop normally" (Meadow, 1993).

2.1.2 Types of neglect

There are several types of neglect have been identified, including the following:

2.1.2.1 Emotional neglect

In many cases, this type of neglect is more difficult to document or substantiate because of the absence of clear physical evidence and the fact that it goes on quietly in the privacy of the home, often beginning when children are too young to speak out or even know that they are not receiving appropriate care (Egeland & Erickson, 1987). Emotional neglect included, for example, allowing a child to use alcohol or drugs, allowing a

child to witness chronic or severe spousal abuse, and encouraging a child to engage in delinquent behaviour (Meadow, 1993).

2.1.2.2 Physical neglect

This is the most widely recognized and commonly identified from of neglect. It includes failure to protect children from harm or danger and failure to provide for the child's basic physical needs, including adequate food, shelter, clothing, warmth, sleep, rest, fresh air, and exercise, and leaving young children alone and unsupervised (Beaver et al, 2002).

2.1.2.3 Educational neglect

Educational neglect includes the refusal to enrol a child in school or permitting a child to miss school frequently (Meadow, 1993; Egeland, 1996).

2.1.2.4 Intellectual neglect

Intellectual neglect includes refusing or failing to give children adequate stimulation, new experiences, appropriate responsibility, encouragement, and opportunity for appropriate independence (Beaver et al, 2002).

2.1.2.5 Medical Neglect

This refers to care-givers' failure to provide prescribed medical treatment for their children, including required immunizations, prescribed medication, recommended surgery, or other intervention in cases of serious disease or injury (Briere et al, 1996).

2.1.4 Indicators of neglect

Beaver et al (2002) state that the following are signs and symptoms:

- Constant hunger, voracious appetite, large abdomen, emaciation, stunted growth, obesity, failure to thrive.
- Inadequate, inappropriate clothing for the weather, very dirty, seldom laundered clothing.
- Constant ill health, untreated medical conditions, for example extensive persistent nappy rash, repeated stomach upsets, chronic diarrhoea.
- Unkempt appearance, poor personal hygiene, dull matted hair, wrinkled skin, skin folds.
- Constant tiredness or lethargy.
- Repeated accidental injury.
- Frequent lateness or non-attendance at school.
- Low self-esteem.
- Compulsive stealing or scavenging.
- Learning difficulties.
- Aggression or withdrawal.
- Poor social relationships (p.213).

2.2 Child Emotional Abuse

Emotional abuse is less likely to be recognized and reported (Newberger, 1983). There are different names for emotional abuse. It is also known as psychological abuse, psychological maltreatment, or emotional maltreatment (Al-Saud, 2000). However, O'Hagan (1993) suggested that emotional and psychological abuse may be differentiated from one another and offered the following definition; emotional abuse is sustained, repetitive, inappropriate emotional response to the child's expression of emotion and its accompanying expressive behaviour (p.28) while psychological abuse is the sustained, repetitive inappropriate behaviour which damages or substantially reduces the creative and developmental potential of crucially important mental faculties and mental processes of a child; this includes intelligence, memory, recognition, attention, language and moral development (p.33). The term emotional abuse will be used in this study.

2.2.1 Definition

As mentioned in the definition of neglect, emotional abuse and neglect are more difficult to define. Emotional abuse, characterised by persistent or severe emotional ill treatment or rejection, is likely to have several adverse effects on the emotional and behavioural development of the child (O'Hagan, 1995, p 453).

2.2.2 Types of emotional abuse

The classification of types of emotional abuse is described as follows:

- ***Rejecting***

The adult refuses to acknowledge the child's worth and the legitimacy of the child's needs.

- ***Isolating***

The adult cuts the child off from normal social experiences, prevents the child from forming friendships and makes the child believe that he or she is alone in the world.

- ***Terrorising***

The adult verbally assaults the child, creates an atmosphere of fear, bullies and frightens the child and makes the child believe that the world is hostile and unpredictable.

- ***Ignoring***

The adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development.

- ***Corrupting***

The adult mis-socialises the child, stimulates the chid to engage in destructive, antisocial behaviour, leading to problems in the child's social development (Daniel et al, 2000 p128).

2.3 Child Physical Abuse

2.3.1 Definition

Definitions vary because of their reliance on a social judgment process that seeks to integrate social-demographic details such as risk factors and safety issues with the child's physical or medical status, such as the severity of an injury (Emery, 1989). Maher (1987) states that all physically injured children under the age of 17 years, where the nature of the injury is not consistent with the account of how it occurred, or where there is definite knowledge, or a reasonable suspicion, that the injury was inflicted by any person having custody, charge, or care of the child, have been physically abused (p.24). Physical abuse entails soft tissue injury to the skin, eyes, ears, and internal organs as well as to ligaments and bones (Meadow, 1993 p.1).

2.3.2 Types of physical abuse

Physical abuse is categorised by the severity of the injuries. These categories are defined as:

- Fatal: all cases, which resulted in death.
- Serious: all fractures, head injuries, internal injuries, sever burns and ingestion of toxic substances.
- Moderate: all soft tissue injuries of a superficial nature (Maher, 1987 p25).

2.3.3 Indicators of physical abuse

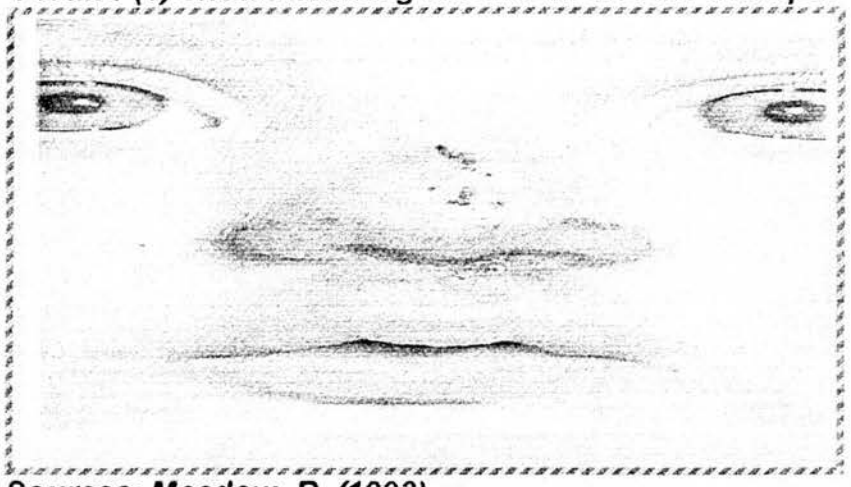
It is easy for doctors or caregivers to recognise the physical signs of child abuse if they have enough training by being alert and carefully studying every injury in early childhood (Carver, 1978). The majority of children who are physically abused suffer soft tissue injuries such as bruises and lacerations (Jones et al, 1987). The injuries are often made at different times and there is commonly a delay in reporting them (Carver, 1978). The following indicators of physical abuse provide more detail.

- ***Bruises***

Some studies show that 70% of abused children suffer soft tissue injury, such as bruises, lacerations, or weals (Beaver et al, 1999). The position of the bruising is important. Carver (1978) describe the types of bruising as follows:

- Bruising around the mouth and lips (see picture 1) and tearing of the fraenulum of the upper lip or more rarely of the tongue are important signs and the mouth should always be carefully inspected.
- Down the face of a crying child on the floor or other hard surface.
- A bruised cheek in a baby or toddler is hardly ever due to an accident.
- A black eye is very suspect since a toddler's falling on a flat surface rarely causes one.

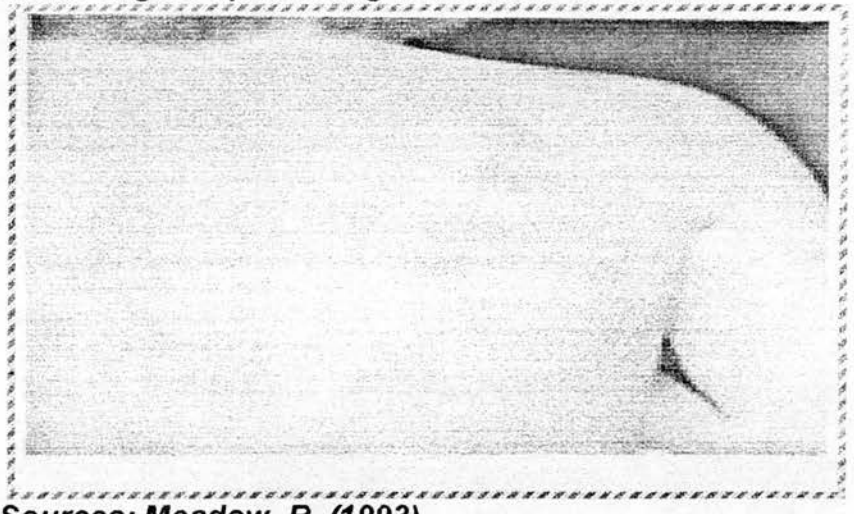
Picture (1) shows bruising around the mouth and lips.



Sources: Meadow, R. (1993).

- Finger tip bruises (see picture 2) occur on the face, usually with the thumb mark on one side and the finger marks on the other, caused by the forcible holding or pressing.

Picture (2) shows fingers tip bruising in the back of a child.

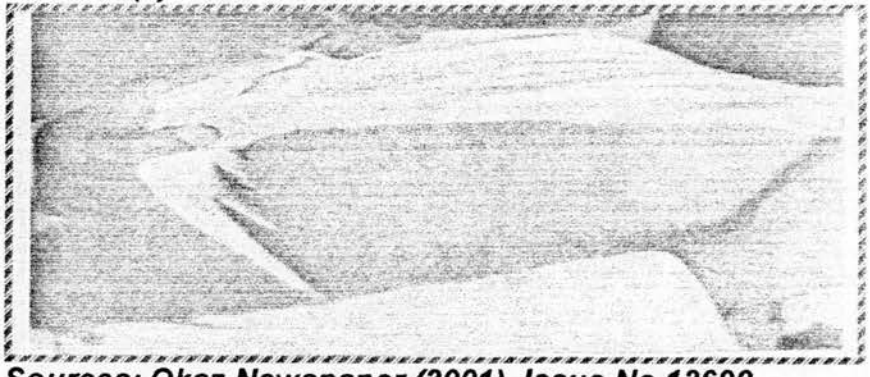


Sources: Meadow, R. (1993).

- Grasp marks occur on the limbs from the forcible holding down of the child or from grabbing him violently and sometimes from swinging him by a limb.

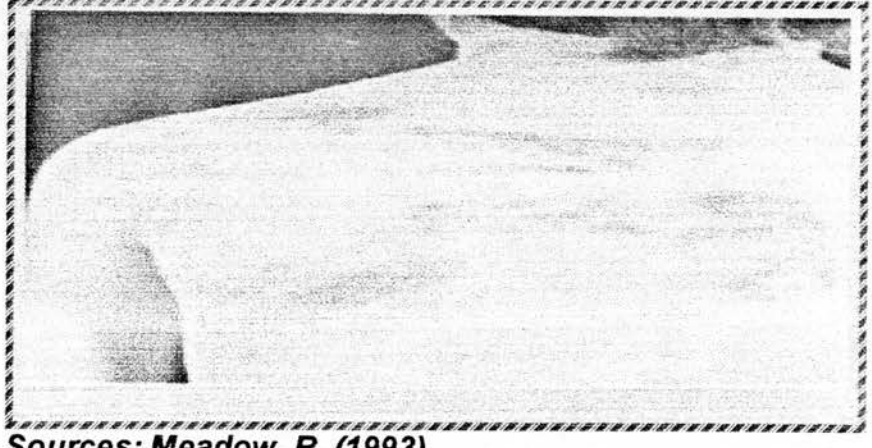
- A bite mark from the adult human is a round or oval mark and often has a gap at each side.
- An outline of the weapon used to strike the child may be seen. These are commonly fingers, fists, a stick (see picture 3), lash (see picture 4) or belt but other instruments may be used.

Picture (3) shows marks of stick in the back of child.



Sources: Okaz Newspaper (2001), Issue No 12690.

Picture (4) shows lash marks in the back of a child.



Sources: Meadow, R. (1993).

- Subcutaneous bruising produces a lump under the skin and indicates that considerable force was used.

- Pinpoint haemorrhages on the face, around the ears or anywhere on the body are particularly common indicators of abuse in babies and toddlers.
- Bizarre marking may arise because of imprinting of the skin due to pressure through coarse weave cloth, blows from the bristles of a brush or a variety of other unusual objects. The crescent shaped marks of fingernails may be seen for several hours after the neck or the limb or trunk of a baby or child has been violently grasped (p.55).

❖ ***Burns***

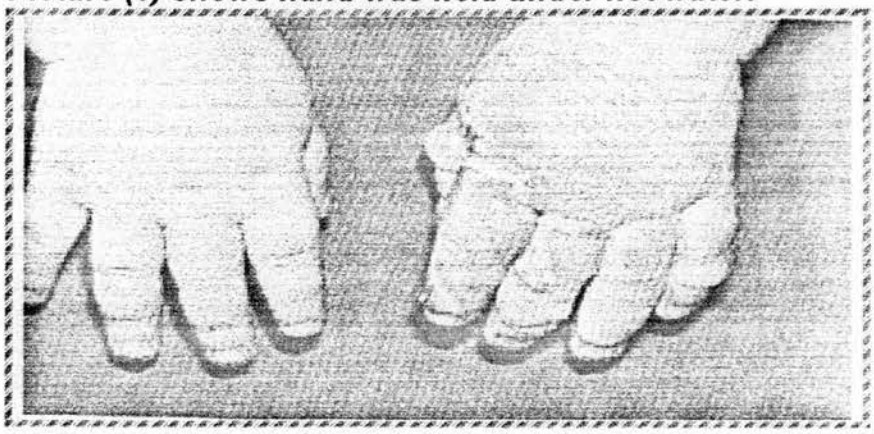
Burns and scalds are very common; around 10% of all abused children suffer burns (Jones et al., 1987). Deliberately inflicted burns and scalds are found in 10% of physically abused children, and this form of physical abuse is under-recognised and under-reported because diagnosis can be difficult (Meadow, 1993).

There are many types of thermal injury:

- Scalds: These are caused by hot water, for example, in drinks, liquid food, and baths (see picture 5).
- Contact, dry burns: Hot objects cause such burns, usually metallic, and electric fires. The injury looks like a brand mark. The burn is dry and tends to be of a uniform depth.

- Burns from flames: These are caused by fires and matches and may be identified by charring and singed hairs.

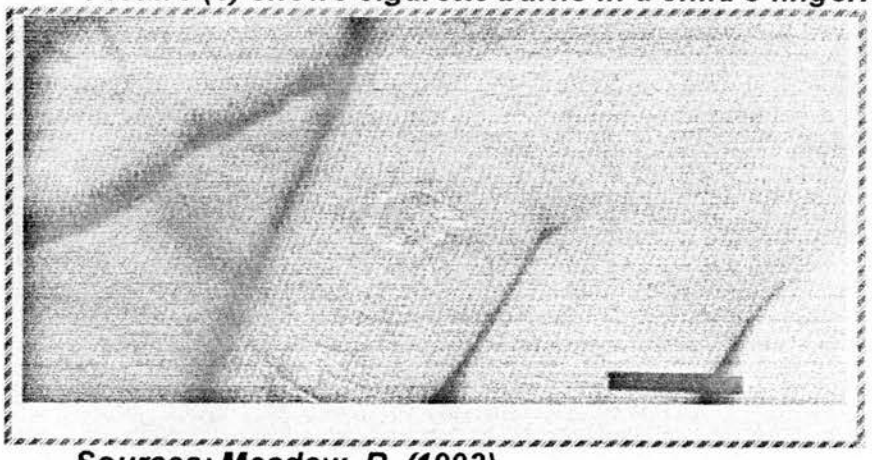
Picture (5) shows hand was held under hot water.



Sources: Meadow, R. (1993).

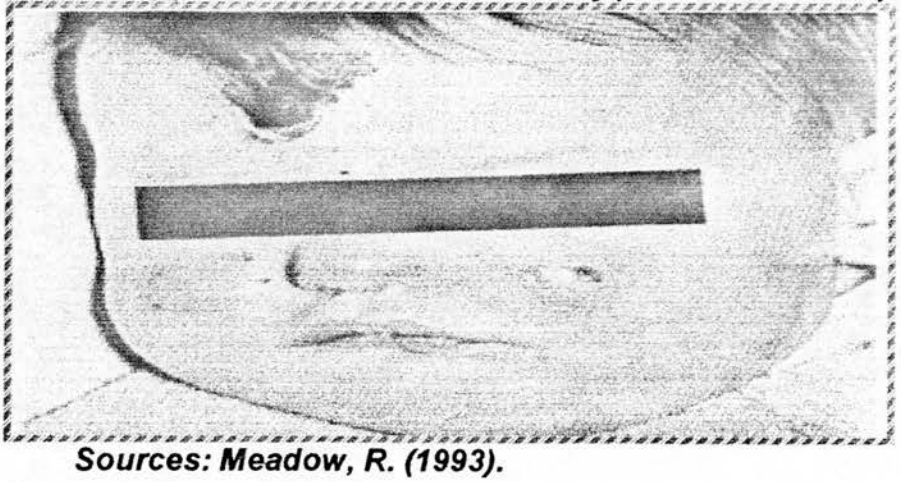
- Cigarette burns: These leave a circular mark and a tail if a cigarette was brushed against the skin. The injury may be multiple but is not particularly common (see picture 6).
- Electrical burns: These are small but deep with exit and entry points.
- Friction burns: These occur when, for example, a child is dragged across a floor (see picture 7).

Picture (6) shows cigarette burns in a child's finger.



Sources: Meadow, R. (1993).

Picture (7) shows friction burn in baby pulled across carpet.



Sources: Meadow, R. (1993).

- Bony prominences are affected and blisters are broken.
- Chemical burns: These may cause staining and scarring of the skin.
- Radiant burns: These are caused by radiant energy, for example, from a fire or the sun (Meadow, 1993 p.20).

❖ ***Fractures***

Fractures occur more commonly in children under 3 years old, in one study of physical abused more than half of the children (58%) were under 3 years old and they sustained 94% of the fractures (Meadow, 1993).

Six important patterns can be seen in fractures caused by physical abuse:

① A single fracture with multiple bruises.

② Multiple fractures in different stages of healing, possibly with no bruises or soft tissue injuries.

③ Metaphyseal-epiphyseal injuries, which are often multiple.

④ Rib fractures.

⑤ The formation of new periosteal bone.

⑥ A skull fracture in association with intracranial fracturing (Meadow, 1993 p.9).

❖ ***Head, brain and eye injuries***

Head, brain or eye injuries may indicate that a child has been swung, shaken, received a blow or been hit against a hard surface (Beaver, 1999). The result may be a small fracture or bleeding into the brain (subdural haematoma). A small outward sign of head injury accompanied by irritability, drowsiness, headache, vomiting, or head enlargement should be treated with urgency, as the outcomes can include brain damage, blindness, coma, and death (Beaver et al, 2002).

- ***Drowning***

It is now being realised that drowning is sometimes not the accident that it is reported to be, and that the child may have been drowned deliberately (Carver, 1978). Secondly, some mothers may leave a young baby in the bath unattended while they go to answer the door or telephone, and returning find the infant under the water. Thirdly, some parents punish their children by pushing their faces under water, a very cruel and frightening thing to do to a child (Carver, 1978 p59).

- ***Poisoning***

Less than 15% of the thousands of children presented to hospital because of accidental poisoning develop symptoms from the drug; death is extremely rare (Meadow, 1993). Deliberate poisoning mainly occurs in children below the age of 2½ years (Meadow, 1993). Children who have been poisoned by a parent are more likely to present in four main ways:

- The child presents as a poisoning scare in which the parent rushes the child to hospital claiming that the child has ingested the drug accidentally.
- The child presents with inexplicable symptoms and signs, usually of acute onset.
- The child presents with recurrent unexplained illnesses. These sorts of patients overlap with those for whom parents create false illnesses (Munchausen syndrome by proxy) by other means.

- The child may be moribund or dead when first seen by the doctor (Meadow, 1993 p.24).

❖ ***Laceration or Scars***

- Scratches: these may be caused by fingernails and appear as linear parallel lesions, varying somewhat in width and depth and usually deeper and wider at the beginning.
- Incisions: sometimes a clean wound or scar is seen in an odd situation often with a story that another child did it with a knife when in fact the parent inflicted it with a razor blade or other weapon (Carver, 1978 p.55).

❖ ***Internal injuries***

Children may suffer damage to the kidneys, spleen, duodenum, liver, or other internal organs as a result of a punch or kick (Jones et al., 1987). These can be present without any sign of bruising to the abdominal wall. The signs are pain, restlessness, fever, vomiting, and illness usually with other signs of injury (Carver, 1978 p.58).

❖ ***Behavioural indicators***

Some researchers who were working with abused children have described a particular attitude or facial expression adopted by abused children and labelled it frozen awareness or frozen watchfulness (Beaver et al, 2002). This describes a child who is constantly looking around, alert and aware (vigilant), while remaining physically inactive (passive), demonstrating a

lack of trust in adults. They also describe the child as: Inappropriately clinging to, or cowering from, the carer; displaying unusually withdrawn or aggressive behaviour (a change in behaviour may be particularly significant); exhibiting certain behaviours in role-play situations, including their explanation for how the injury occurred (Beaver et al, 2002).

❖ ***Additional indicators***

Physical indicators alone may be insufficient to diagnose child abuse. Beaver et al (2002) state that they should always be considered alongside other factors including the following:

- An explanation by the parent or carer that is inadequate, unsatisfactory, vague or inconsistent with the nature of the injury, considering the age or stage of the development of the child.
- An unexplained delay in seeking medical attention, or seeking treatment only when prompted by others.
- A series of minor injuries to a child, which may have satisfactory explanations.
- A history of child abuse or neglect of the child or other children in the family.
- The existence of certain parental attitudes, such as a lack of concern, remorse or guilt over an accident and

blame of others or the child for the injury (p.211).

❖ ***Other marks***

Other indicators of abuse are bites, outlines of weapons, bizarre markings, nail marks, abrasions, and a torn fraenulum (Beaver et al, 2002). Damage in a young child usually results from something being forcibly pushed into the mouth, such as a spoon, bottle or dummy (Beaver et al, 2002).

2.4 Child Sexual Abuse

The sensitive area of childhood sexual abuse has only been openly recognized by the welfare services of the western world in the last fifteen years (Berry, 1990). In the last few years there has been increased concern about study of child sexual abuse (CSA) in the home (Jones et al., 1987). It is very difficult to think clearly about the sexual abuse of children, because it unsettles deep-seated assumptions about the nature of human beings, about parenthood and the family (Fontaine, 1991). It is often assumed that children, particularly girls, are sexually abused as they begin to reach physical maturity, the age of attractiveness (Fontaine, 1991). In Arab societies, we have to look to several socio-cultural characteristics that may be relevant to the different dimensions of the problem, including definitions of CSA and its implications, attitudes toward victims of sexual abuse, and approaches toward coping with the problem (Haj-Yahia & Tamish, 2001). The major characteristic of Arab society is its patriarchal perspective, which ascribes relatively high status to males and relatively low status to females (Al-Khayyat, 1990; Barakat, 1993; Haj-Yahia, 1995). The patriarchal perspective not only advocates male dominance and subordination of women in public as well as the private spheres of life, but also views females as a source of evil, anarchy *fitna*, trickery and deception *kaid*. Another characteristic of Arab societies is the centrality of honour. The Arab concept of honour is generally linked with

the sexual conduct of women; because members of Arab society represent various kin groups, they must behave honourably and not disgrace the group (Haj-Yahia & Tamish, 2001). If a girl is immodest or brings shame on her family by her sexual conduct, she shames and dishonours all of her kin. It is difficult to overemphasise the importance of honour to the Arab; men swear by the honour of their sister, and women swear by their own honour (Al-Khayyat, 1990). All of this should not be taken to mean that male victims of sexual abuse are never blamed for damaging their family's honour but the repercussions in the community are different (Haj-Yahia & Tamish, 2001). Another characteristic of Arab societies that should be taken into account in this context is the sanctity of the family and the high level of commitment to maintaining family solidarity. The well being of individuals is seen as an outcome of their family's well being and therefore it is not surprising that most Arab families prefer to solve problems by themselves, behind closed doors in order to avoid dissolving the family (Barakat, 1993; Haj-Yahia 1995). We know very well that abused children in general may take refuge in denial to avoid the destructive effects of recognising what is being done to them (Wilson & James, 2002). There are several areas of denial to disclaim responsibility for abuse, e.g

- Primary denial of any abuse.
- Denial of severity of acts.

- Denial of knowledge of abuse "perpetrators may say they were drunk, asleep, depressed, tired".
- Denial that the maltreatment was abusive "this may involve pretending that the abuse was a normal/educational activity".
- Denial of the harmful effects of the abuse "the abusive act is said not to have harmed the child".
- Denial of responsibility "perpetrator makes the child responsible for the abuse, saying that the child triggered the abuse by their behaviour" (Wilson & James, 2002 p 91).

Sexual abuse can take place in normal families, where the abusing father appears to be a normal upstanding, god-fearing man and a pillar of his community (Bagley & King, 1990). Sexual abuse is sometimes accompanied by physical injury and both of them are accompanied by emotional abuse (Browne, 1988). A postal survey to relevant professionals in the United Kingdom conducted by Mrazek et al (1981) revealed that 1,065 reported cases of sexual abuse could be classified into three types:

① Battered children whose injuries were primarily in the genital area (4%).

② Children who have experienced attempted or actual intercourse, or other inappropriate genital contact with an adult (68%).

③ Children who have in some or other way been involved with an adult in sexual activities (16%).

10% of children with type 2 or 3 abuse had also suffered a physical injury.

2.4.1 Definition

Before the definition of child sexual, a question arises: What is child sexual health? General health is defined as the state of being a mind free from ignorance and prejudice, a body free from illness and handicaps, and a soul free from guilt and fear (Bagley & King, 1990). Spelman (1993) states that child sexual abuse is sexual contact between a child and adult or older child for the sexual gratification of the offender. It includes: physical contact, such as handling of the child's or the offender's genitals or breasts, oral sex, or attempted or actual penetration of the child's vagina or rectum; and non-physical contact, such as forcing a child to look at the offender's genitals, exposure of a child's genitals, or talking to the child in a sexually explicit manner (p.3).

2.4.2 Types of sexual abuse

Sexual abuse is divided into the following forms:

- Sexual intercourse with a person below the age of 14.
- Rape. If the victim is a child below the age of 16 or younger.
- Incest. All sexual relations between parents and children or between adopters and adopted.

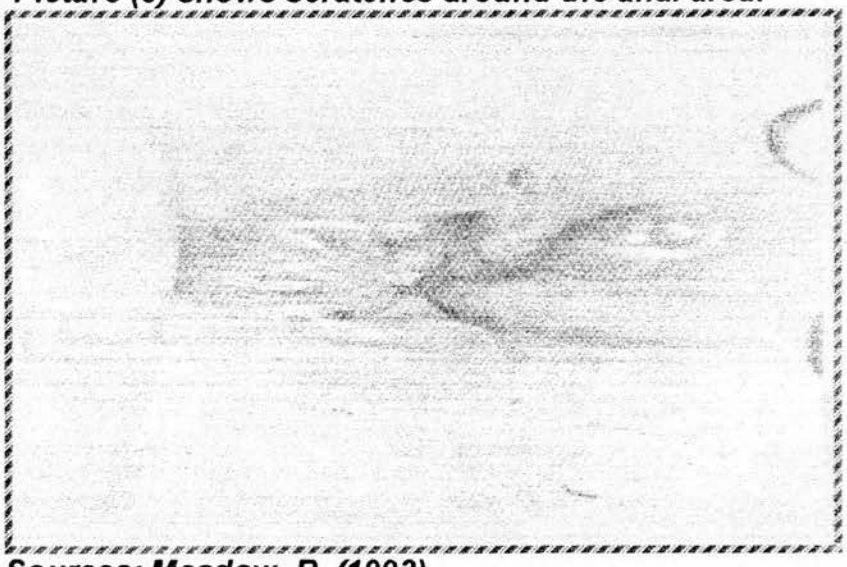
- Molestation. Any sexual assault without intercourse against a child below the age of 14.
- Act of homosexual assault against a child below the age of 16.
- The sexual exploitation of children
- The distribution of pornographic material.
- Watching sexual activity (Freeman, 2000; Collier, 1999).

2.4.3 Indicators of sexual abuse

It is important to diagnose or recognise it early, otherwise it may persist undiscovered for many years. There are many indicators that help us to recognise it:

- ***Familial Indicators***
  - Frequent absences from school by the child, which are justified by the male guardian, or parent.
  - Frequent absences from the home by the guardian /parent.
  - Isolation / alienation of child and family members in the community.
  - Jealousy about, and extreme protectiveness of, the child (Mayes et al., 1992 p92).
- ***Physical Indicators***
  - Bruises or scratches to the genital and anal areas, chest or abdomen and buggery (see picture 8).

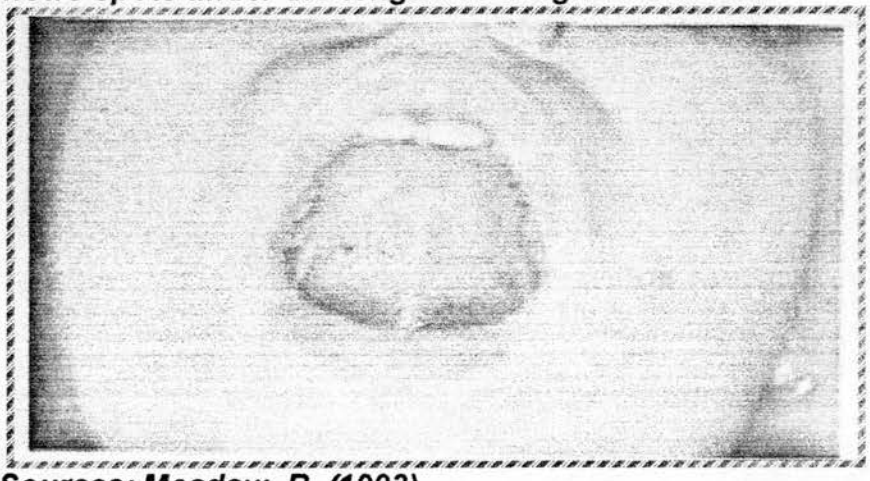
Picture (8) shows scratches around the anal area.



Sources: Meadow, R. (1993).

- Bites.
- Blood stains on underwear.
- Infection with sexually transmitted diseases.
- Semen on skin, clothes or in the vagina or anus.
- Internal small cuts (lesions) in the vagina or anus.
- Abnormal swelling out (dilation) of the vagina or anus.
- Itchiness or discomfort in the genital or anal areas (Beaver et al, 2002 p 221).
- And finally it is important to look in the mouth (see picture 9) for signs of oral sex (Meadow, 1993).

Picture (9) shows spots under the tongue as a sign of oral sex.

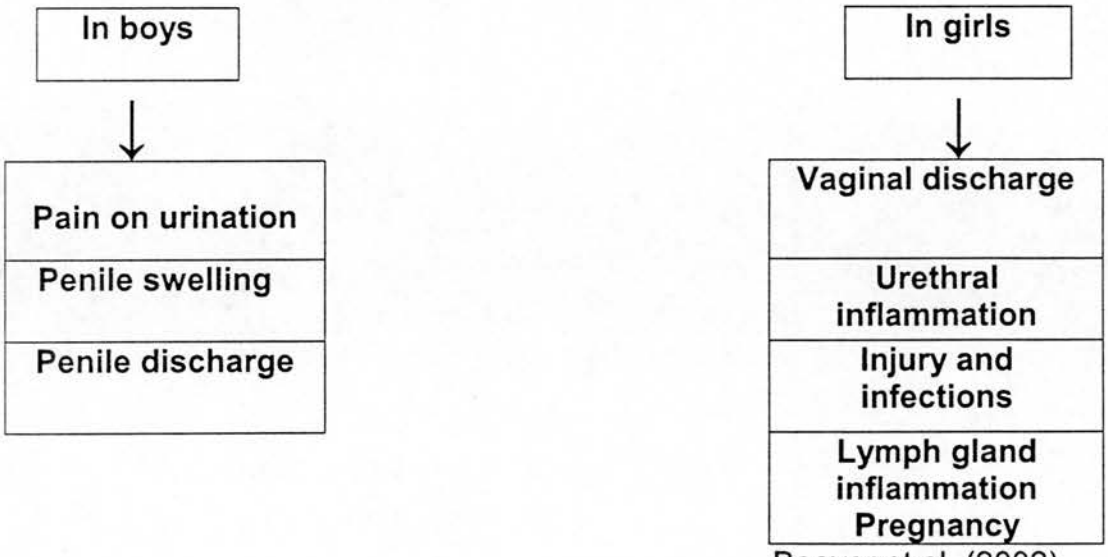


Sources: Meadow, R. (1993).

- ***Behavioural Indicators***
  - Sudden inexplicable changes in behaviour i.e. the child becoming aggressive or withdrawn.
  - Showing behaviour appropriate to an earlier stage of development.
  - Showing eating or sleeping problems.
  - Showing signs of social relationships being affected, for example: becoming inappropriately clingy to carers; showing extreme fear of, or refusing to see, certain adults for no apparent reason; ceasing to enjoy activities with other children.
  - Saying repeatedly bad words that are bad, dirty, or wicked (having a poor self-image).

- Acting in a way that they think will please and prevent the adult from hurting them (placatory), or in an inappropriately adult way (Beaver et al, 2002 p221).
- Reluctance on the part of the child to go home after school.
- Manifestation through the child's schoolwork, art, poems, and stories of unusual sexual behaviours or themes.
- Increase in physical complaints, for instance headaches and other miscellaneous illnesses of a psychosomatic nature (Mayes et al., I992 p 92).

❖ ***Additional indicators***



Beaver et al, (2002).

2.4.4 Prevalence of Sexual Abuse

Prevalence studies of child sexual abuse attempt to estimate the proportion of the population that have been sexually abused in the course

of their childhood (Berry, 1990). Prevalence studies start from the premise that because most sexual abuse is never reported, the most valid measures of scope would have to be based on victim or offender self-reports (Berry, 1990). According to the NSPCC (1992) the estimated national number of registrations increased by over 30% between 1988 and 1989 (see table 4).

Table (4) estimates of occurrence of sexual abuse in England between 1988-1989.

Year	DofH	NSPCC
1988	4.100	5.800
1989	4.200	6.300

Creighton,1992

1% of young people in England and Wales suffered sexual abuse by a parent or carer and 3% by another relative (NSPCC, 2000). In America a summary of studies found that the prevalence of child sexual abuse varied from 6 to 62% for females and 3 to 31% for males (Corby, 1993). It is noticeable that there are variations between some studies in their assessment of the prevalence of child sexual abuse across the world, and even in the same country. Corby (1993) contends that this happens for the following reasons:

- The lack of standard definitions of child sexual abuse; some studies adopt broad definitions, others narrow definitions. For instance, some studies incorporate non-contact sexual abuse in their definition, others do not. In addition, some studies include extra-familial abuse in their definitions whereas others do not.
- The lack of a standard upper age limit, some studies adopt an upper age limit of 15, others 18.
- The lack of agreement about the age difference between the abused child and the perpetrator; some studies do not consider this a factor at all, others use five and ten-year age gaps as defining factors.
- The use of different sample selections; some studies are drawn from college students only, while others are drawn from a more diverse background in terms of class and age.
- The use of different forms of data collection; some studies use face-to-face interviews with trained interviewers, which seem to elicit higher incidences than do more impersonal approaches (p.60).

Summary of findings

Neglect is the most common and occasionally leads to abuse. The syndrome called "Failure to thrive" has been associated with the neglect of

children. Neglect and emotional abuse are more difficult to define. There is no standardised definition of child abuse or child neglect that has been developed by researchers and accepted by welfare professionals.

Neglect has five types such as emotional, educational, physical, intellectual, and medical.

Emotional abuse has different names such as psychological abuse, psychological maltreatment, and emotional maltreatment. Emotional abuse is sustained, repetitive, inappropriate emotional response to the child's expression of emotion and its accompanying expressive behaviour. The classification of types of emotional abuse is rejecting, isolating, terrorising, ignoring, and corrupting.

The majority of children who are physically abused suffer soft tissue injuries such as bruises and lacerations. 70% of abused children suffer soft tissue injury, such as bruises, lacerations, or weals. Around 10% of all abused children suffer burns. Physical abuse is categorised by the severity of the injuries to three types; fatal, serious, and moderate.

The sensitive area of childhood sexual abuse has only been openly recognised by the welfare services of the western world in the last fifteen years. Sexual abuse can take place in normal families, where the abusing father appears to be a normal upstanding, god-fearing man and a pillar of his community. Sexual abuse is sometimes accompanied by physical injury and both of them are accompanied by emotional abuse.

Sexual abuse is divided into several types; sexual intercourse with a person below the age of 14, rape of a child below the age of 16, incest which means all sexual relations between parents and children or between adopters and adopted, molestation which means any sexual assault without intercourse against a child below the age of 14, acts of homosexual assault against a child below the age of 16, the sexual exploitation of children, the distribution of pornographic material, and watching sexual activity.

Chapter 3.
Causes of Child Abuse & Neglect

Introduction

Numerous studies have found that the risk of childhood abuse is associated with multiple interacting factors including social class; level of education, unemployment; maternal age; marital status; family size; family conflict; whether a pregnancy was desired; prematurity; infant illness or handicap; the temperament of the child; parental exposure to stress; level of social support; depression; anxiety or antisocial behaviour including alcohol or drug abuse; a history of maltreatment and family violence; and a tendency to perceive the child as more aggressive (Klevens et al; 2000 p.323). The prenatal characteristics identified in one study as risk factors are: Premarital conception; unwanted pregnancy; illegitimacy; forced marriage; social isolation of the parents before the birth; emotional problems in the spouse relationship; financial difficulties before the birth; and poor attendance at prenatal clinics (Browne et al, 1989).

In seeking to understand the many causal factors involved in child abuse and neglect, various theoretical models have been proposed (Wilson & James, 2002):

3.1 Individually focused models

This perspective concentrates on individual personality characteristics, often of a psychopathological or deviant nature (Wilson & James, 2002).

3.1.1 the psychopathic perspective

The psychiatric approach to child abuse sees the parent as the principle cause of the problem (Browne et al 1989). Early research focused on the abnormal characteristics of the abuser and emphasized the psychological dysfunctions characteristic of certain abusing adults (Elmer, 1967). However, Kempe and Kempe (1978) suggest that only 10 per cent of child abusers can accurately be labelled as mentally ill. Nevertheless, the model has been useful in recognizing certain predispositions of abusive individuals (Browne et al, 1989). These include a tendency to have a distorted perception of their dependents (Rosenberg & Reppucci, 1983; Spintta & Rigler, 1972); difficulty dealing with aggressive impulses as a result of being impulsively immature; being depressed and self-centred (Hyman, 1977; Kempe et al, 1962; Steele & Pollock, 1968); and having a history of having been abused, neglected or witnessing violence as children (Hunter et al, 1978; Spinetta & Rigler, 1972; Wasserman et al, 1968). The emphasis of this model is on the abusers abnormal personality, which is the result of adverse socialization experiences that produce a psychopathic character with a predisposition to behave violently (Browne et al, 1989). One form of this predisposition involves transference from parent to child (Galdston, 1965). For example, the parent often perceives the child as if s/he were a hostile and persecuting adult, projecting that part of their own personality they wish to destroy (Steele &

Pollock, 1968). Thus, the child is seen as the cause of the parent's troubles and becomes a scapegoat against which all anger is directed (Wasserman et al, 1983). In abusive mothers at least, psychiatric problems, thought patterns and some personality traits may distinguish them from matched non-abusive mothers (Estroff et al, 1984; Lahey et al, 1984; Stringer & La Greca, 1985). These problems include: a misperception of the victim; low self-esteem; a sense of incompetence; feelings of social isolation and a lack of support; lack of empathy; perceived marital difficulties; depression; attempted suicide; poor self-control; alcohol and drug misuse; poor marriage; ill health; psychiatric problems and an unhappy childhood can make parents more disposed to perpetrating child abuse and neglect (Browne et al, 1989). In fact the authors who promote the psychopathological model claim that social variables do not enter into the causal scheme of child abuse (Browne et al 1989). This is of course, a narrow viewpoint, and a major fault of the model is its failure to examine the possible social causes of psychological stress that may lead to violent interactions within families (Browne et al 1989). The factors above are now examined in more depth.

3.1.1.1 mental illness

10% of child abusers can be accurately labelled as mentally ill (Kempe & Kempe, 1978; Browne et al., 1989). In Hyman's (1978) study, half of the Surrey mothers were reported as having received treatment for

psychological illness before the reported abuse. The NSPCC Battered Research Team (Baher et al, 1976) also found some examples of antisocial behaviour in the form of drunkenness and mental health problems of a bizarre and obsessive nature in the families of abusing parents. Depression and anxiety have been recognized as psychological problems in the study of abuse, and are sometimes associated with bereavement or attempted suicide (Browne et al, 1988).

3.1.1.2 drug and alcohol abuse

Another growing group of vulnerable parents are those addicted to alcohol or drugs (Browne et al, 1989). Drug abuse and alcoholism have become increasingly cited as contributory factors in the abusive care of children (Hindman, 1979; Martin & Wlters, 1982). Hindman (1979) has written pessimistically about the care of children by alcoholic parents and it is well known that alcohol releases inhibitions and causes violence.

3.1.1.3 pathologically jealous

Fathers in particular can be pathologically jealous of their spouse's fondness for anyone other than themselves (Ounsted & Lynch, 1976). The child, as the rival, may therefore be unloved (Ounsted & Lynch, 1976).

3.1.2 the social learning perspective

This approach is based on the assumption that people learn violent behaviour from observing aggressive role models (Bandura, 1973). Roy (1982) has stated that four out of five abusive men were reported by their

partners as either having observed their fathers abusing their mothers and/or being a victim of child abuse themselves. In comparison, only a third of the abused partners had been victims of parental violence as a child (Wilson & James, 2002). Jaffe et al (1990) and Carroll (1994) found evidence that violence between parents affects the children in a family. Women who have been beaten by their spouses are, in turn, reportedly twice as likely as other women to abuse a child (McKay, 1994). The question here what is the connection between spousal abuse and child abuse? Children who are witnessing spousal abuse do not fully understand the dynamics of domestic violence, they may come to view and control, aggression and violence as the only means of getting one's needs met (McKay, 1994). Children may also imitate the violent adult behaviour they observe by victimizing younger siblings, peer, and animals and other may adopt the victim role, becoming passive and withdrawn in their interactions with other people (McKay, 1994). Child witnesses of domestic violence may also display an inability to control and express emotion, or to delay gratification (McKay, 1994).

3.1.2.1 unhappy childhood

Growing up in an unhappy family appears to be the most powerful risk factor for abuse. It is easy to understand why a child from an unhappy family might be vulnerable to the manipulations of an abuser who was offering affection or companionship in order to trick the child (Finkelhor et

al, 1990). One study has suggested that there is a link between experiencing abuse during childhood and abusing in adult life (Browne et al, 1989), and indeed, it has also been suggested that being abused as a child can lead to an overall sense of worthlessness.

3.1.3 Special victim perspective

In direct contrast to the viewpoints considered so far are suggestions that the children themselves may be instrumental in some way in eliciting attack or neglect (Browne et al, 1989). Gil (1970) was the first to suggest that children who were abused by their parents may possess some characteristics, which either attract abuse or make them more vulnerable to abuse. For example, Lynch (1976) compared 25 abused children with 35 of their unharmed siblings and noted that no sex differences or birth order effects were apparent. However, 60 per cent of abused children had been the result of abnormal pregnancies, compared with only 20 per cent of their siblings; 40 per cent of the abused children had experienced neonatal separation from their mother compared with 6 per cent of siblings; and 60 per cent of the abused children had been ill in their first year compared with 10 per cent of the non-abused group. Friedrich & Boroskin (1976) review the complex reasons why a child may not fulfil the parent's expectations or demands. The dependent may in some way be regarded as 'special.' For instance, studies have found that prematurity, low birth weight, illness and handicap are associated with abuse (Elmer &

Gregg, 1967; Lynch & Roberts, 1977).

Certainly, the difficulty of caring for, and the physical unattractiveness of premature, low birth weight and handicapped children does not always result in pathological parenting (Berkowitz, 1988), but Browne & Saqi (1987) suggest there is a high chance in the presence of other predisposing factors.

3.1.3.1 children born too soon

Lynch & Roberts (1982) state that abused children may well have been born before their parents were emotionally ready for them. That could particularly affect parents who are working and cannot find childcare provision, or who are economically disadvantaged. The abused child is statistically more likely to have been born prematurely (Skinner & Castle, 1969). The effects of prematurity are complex. The child is likely to weigh less, be more vulnerable to ill health, be less easy to handle and generally cause more anxiety all around (Browne et al, 1989). It is easy to imagine the effect the arrival of such a baby may have on already stressed parents or those adults who already have an overall sense of low achievement (Browne et al, 1989).

3.1.3.2 prematurity and low birth weight

A number of reports suggest a higher prematurity rate among abused children which they estimate ranges from 13 to 30 per cent (Skinner & Castle, 1969; Elmer & Gregg, 1967). For example, Klein (1971) found that

23 to 25 per cent of abused children in their sample had been prematurely born compared to the incidence rate in the normal population of 7 to 8 per cent. It is possible that premature children are subject to abuse because of their somewhat unattractive appearance (Berkowitz, 1988). Because they are born before development is complete, they usually lack the attractive facial characteristics of the typical newborn, furthermore, Frodi & Lamb (1980) have shown that their cries are perceived as more piercing and aversive than the cries of normal infants. It is possible, therefore, that their cries act as aversive stimuli, which promote aggression in their caretakers. Lynch & Roberts (1978) noted that 28% of their sample of abused children had been prematurely born compared to 2 per cent of the controls. In addition, 22% of the abused sample were small for gestational age compared to 10% of the controls. Hunter et al (1978) in their prospective study recorded that 39% of their sample of 255 premature infants were abused. This figure is somewhat higher than would be expected but it does not suggest that premature infants are a major risk population.

3.1.3.3 children born sick or handicapped

Child care professionals are more concerned with children who are not getting enough to eat, who may be ill and whose parents may need careful help over providing that child with adequate nourishment (Lynch & Roberts, 1982). In 1975 Lynch found that when physically abused children

were compared with their unharmed siblings for factors surrounding their early months of life, there was a clear contrast between the two groups. Six factors were highly significantly over represented in the abused child's biography: abnormal pregnancy, abnormal labour or delivery, neonatal separation, other separations in their first six months, illness in their first year of life and illness in their mother during their first year (Browne et al 1988). It is well documented that growth failure is often associated with physical abuse of a child, even 50% of some samples of abused children being identified as failing to thrive (Elmer & Gregg, 1967). Another research study in Australia showed that children admitted to hospital because of growth failure were at risk of physical injury from their parents (Oates & Hufton, 1977).

3.1.3.4 unwanted pregnancy

The first three months of pregnancy are often described as a period of heightened emotional sensitivity, of elation, depression, irritability, and aggression (Cheetham, 1977).

3.1.3.5 unwanted children

The most obvious predisposing factor for abuse is the parents not wanting the child in the first place (Browne et al, 1989). If parents have suffered the loss of a previous child or the loss of someone precious to them during pregnancy then the actual child born can be a disappointing replacement or even a totally unwanted one (Roberts et al, 1980). It is possible to help

parents gain a love for a previously unwanted child by pointing out to the parents the positive, individual and endearing aspects that can be found in almost all children and simultaneously help the children achieve their individual potential to act as the parents' therapist (Browne et al, 1989).

3.1.3.6 bereaved parents

Another group of parents with an increased risk of abusing their children may be those who have already lost a child (Browne et al, 1989). In a research study on a sample of families identified through child abuse. Roberts et al (1980) found that the abusive families had a much higher than expected rate of post-neonatal deaths. Ounsted et al (1982) found in clinical practice that any parent who has suffered a loss during pregnancy may be identified as having a relationship problem with their newborn.

3.2 Social and environmental focused models

3.2.1 Social stress perspective

By contrast, the social and environmental approaches take into account external factors that can promote family violence such as low wages, unemployment (Krumman, 1986; O'Brien, 1971), social isolation (Garbarino, 1977), early parenthood, economical difficulties, the size of the family (Sperly & Lauderdale, 1988), overcrowding and poor housing (Skinner & Castle, 1969). Gelles (1973) claims that violence is an adaptation or response to structural or situational stress, which is not confined to families in lower socio-economic groups.

A broader perspective is put forward by Gil (1970) who emphasizes the role of violence in society and cultural values and beliefs that affect parental standards of care giving. Gelles & Cornell (1985) point out that an individual's acceptance of violence as the norm may influence the extent to which they exhibit or tolerate violence. Gelles (1983) analyses the causes of family violence in terms of cost and benefit. His exchange theory considers that the private nature of the home environment reduces the cost of the overt aggression in terms of official reprimand. This, in turn, leads to a higher probability of aggression in the home, where there are less social constraints on behaviour (Browne et al, 1989). Thus, privacy makes child abuse less detectable and therefore easier to perpetrate (Browne et al, 1989).

3.2.1.1 social isolation

Social psychologists have suggested that the presence or absence of social support has an effect on psychological well-being (Seagull, 1987). It is assumed that a person with a weak supportive network of friends and family is less likely to be able to cope with stressful events and will have low self-esteem (Seagull, 1987). Social isolation can be the final, crucial vulnerability in abusing families; they have been found to be more likely to be isolated and to lack a lifeline during a crisis (Baher et al, 1976; Lynch & Reberts, 1978; Smith et al, 1974). A review of the research has confirmed the link between social isolation and child neglect, but has suggested that

the relationship between child abuse and social isolation is more complicated and multivariate (Seagull, 1987). Wahler (1980) notes that the frequency of contacts a mother had with friends was universally related to the number of problems she had at home with her child and with her own skill in dealing with them. Interestingly, when a parent had increased social contacts with others, her interactions with the child were also more positive. Garbarino & Sharman (1980) compared two neighbourhoods matched for social class but differing in reported abuse and neglect rates. Families in low maltreatment neighbourhoods had more extensive social networks, were more available to meet their children's needs, and were subjected to less stress. Among high maltreatment neighbourhoods there was an attitude of competition rather than cooperation.

3.2.1.2 early parenthood

Traditionally, physical abuse and neglect of children has been associated with young and immature parents (Corby, 1993). Abusing parents have often been noted for their relative youth and immaturity when embarking on parenthood (Skinner & Casle, 1969; Lynch & Roberts, 1977). This has produced in some families unrealistic expectations of the child so that only the really well advanced, healthy and bright children survive (Brown et al, 1988). Kempe (1971) observed this phenomenon and wrote that there is a premature demand for satisfying behavioural responses from the infant and parental disregard of the infant's own needs, wishes and age-

appropriate abilities. For other young deprived parents there are unmet dependency needs, so that the child is looked to for comfort and not expected to make the huge emotional demands a normal child would (Steele & Pollock, 1968; Baher et al, 1976). Children of adolescent mothers are twice as likely to be abused as the children of adult mothers (Kelly & Steven-Simon, 2001). Dukewich et al (1997) found that adolescent mothers raise 36% to 51% of all abused children. Lynch & Roberts (1982) found 30% of the mothers were less than 21 years old at the time of the abuse. However, another survey shows significantly lower rates of abuse for women over 60 and significantly higher rates for women aged between 40 to 49, while no significant trend is apparent for men (Finkelhor et al, 1990).

3.2.1.3 family size

First we have to distinguish between the nuclear and extended family; the former is common among western families and the latter is common among eastern families, particularly Moslems. This is quite visible in a multicultural society like the UK. In Great Britain the average household size has been found to be substantially higher among certain ethnic minorities than among the white population (Rutter & Smith, 1995). Thus, mean household size was 2.43 among white people, 4.22 among South Asians, 2.59 among black people, and 2.96 among Chinese people and other groups (Rutter & Smith, 1995). Within the South Asians, household

sizes were particularly high for Bangladeshis 5.34 and Pakistanis 4.81 (Owen, 1993). In the EU most European women still do desire children (Rutter & Smith, 1995). The most common desire is for two children. The ideal family size for Swedish women is most commonly two children; 10% of women favour a single child whereas 25% prefer three children (Popenoe, 1987). There is a growing literature, which demonstrates that the number of children can significantly influence the marital satisfaction of parents, which in turn can affect the future stability of family structures (Hernandez, 1986). The potential for negative effects may be greater for women who are employed full-time than for other women, due in large part to increased demands on their time (Glenn & McLanhan, 1982). In fact single children may have the advantage of receiving more adult attention and interaction (Chesnais, 1985). Blake (1981) found that people who had grown up with no siblings were equally or even more likely to rate themselves as generally happy, and satisfied with their heath, leisure activities, and job. However, children raised in large families do seem to be more at risk of under- achievement and maladjustment (Rutter & Smith, 1995). Large numbers of children can dilute parents' emotional and financial well-being, and as such can drive them to treat their children badly.

3.2.1.4 social class

Smith (1975) states that child abusers predominantly come from the lower social classes. Jason & Andereck (1983), Robertson & Juritz (1979) and Oates et al (1979) found the highest child abuse fatality rates among poor people.

3.2.2 environmental and cultural perspective

Cultural values could affect personal attitudes towards violent behaviour (Wilson & James, 2002). There is a general acceptance of physical punishment as an appropriate method of child control, with nine out of ten children being disciplined in this way (Nobes & Smith 2000, Gelles & Cornall 1997).

3.3 integrated models

3.3.1 the psychosocial perspective

The psychosocial model emphasizes the social-situational approach to family violence (Browne et al, 1989). This approach was originally proposed by American researchers such as Gelles (1973), and Gelles & Cornell (1985). They suggest that certain stress factors and adverse background influences may serve to predispose individuals to perpetrate abuse, such as the misbehaviour of the child. Frude (1988) takes a similar perspective and puts forward the notion of a causal chain leading to an incident of abuse:

Objective stressful situations which are usually long-term, such as poverty;

↓

Abusing parents assess the situation differently from non-abusing parents i.e. they might consider it to be threatening more readily;

↓

Anger and emotional distress are likely as a response to these situations; and

↓

Lack of inhibitions with regard to violent expression, together with a lower threshold of tolerance, leads to

↓

Child abuse.

These causal links result in the caregiver being more easily provoked to take violent action against the child. Frude (1980) challenges the assumption that abusers differ from non-abusers and suggested that they might be more usefully considered as points on a continuum. For this reason he argues that studies of parent-child interaction may have much to contribute to our understanding of child abuse and our approach to its prediction ad prevention.

3.3.2 the multifactor perspective

Browne (1988) presented a multifactor model, which suggests that stress factors and background influences are mediated through the interpersonal relationships within the family. The model assumes that the 'situational stressors' are made up of the following four components:

- Relations between caregivers-inter-marriage, marital disputes, step-parent/cohabitee or separated/single parent.
- Relations to children-such as spacing between births, size of family, caregivers' attachments to expectations of their dependants.
- Structural stress-poor housing, unemployment, social isolation, threats to the caregiver's authority, values, and self-esteem.
- Stress generated by the child- for instance, an unwanted child (Wilson & James, 2002 p. 58).

The chance of these situational stressors resulting in abuse and neglect are mediated by and depend on the interactive relationships within the family (Wilson & James, 2002).

3.4 interaction models

Some researchers have advocated a more interactive approach that includes the social relationships of the participants and their environmental setting, rather than seeking to isolate the person or situation (Wilson & James, 2002).

3.4.1 the person-environment interactive perspective

Frude (1980) puts forward the notion of a causal chain leading to 'critical incidence' of child abuse. This is a function of complex interactions between the individual and their social and social physical environments

(Wilson & James, 2002). The critical incidence model of child abuse is described as follows.

- Environmental stress situations, which are usually long term such as poverty, influence domestic abusers to assess their personal situations differently from non-abusing family members.
- They perceive a discrepancy between their expectations for life and social interactions and what they actually see happening.
- Anger and emotional distress are likely as a response to these situations rather than problem-solving strategies for change.
- Lack of inhibitions with regard to violent expression, together with a lower threshold of tolerance, increases the possibility for violence.
- Under the above conditions, even a facial expression can lead to, or trigger, an incidence of violence (Wilson & James, 2002 p.57).

3.4.2 the interpersonal interactive perspective

Toch (1969) in his study entitled Violent Men looked not only at the characteristics of these men but also at the context of their violence and the characteristics of their victims. He concluded that aggressive behaviour was associated with 'machismo' and the maintenance of a particular personal identity in relation to others.

Summary of Findings

Various models have been advanced to explain the causes of child abuse, such as individually focused models, socially and environmentally focused

models, integrated models, and interaction models. Each employs a different perspective e.g. individually focused models have three perspectives; the psychiatric, the social learning and the 'special victims'. Socially and environmentally focused models have two perspectives; 'social stress', and 'environmental and cultural'. Integrated models have two perspectives; the 'psychosocial', and 'multifactor'. Finally the interactive model has also two perspectives; the 'personal – environmental interaction' perspective, and the 'interpersonal interaction' perspective.

The psychopathic perspective (e.g. low self-esteem; social isolation, depression; attempted suicide; poor self-control; alcohol and drug misuse; poor marriage, unhappy childhood) sees the parent as the principle cause of the problem (Browne et al, 1989). The emphasis of this perspective is on the abuser's abnormal personality, which is the result of adverse socialization experiences that produce a psychopathic character with a predisposition to behave violently. One form of this predisposition involves transference from parent to child. The social and environmental approach take into account external factors that can promote family violence such as low wages, unemployment, social isolation, early parenthood, economical difficulties, large family size, overcrowding and poor housing (Krumman, 1986; O'Brien, 1971; Garbarino, 1977; Sperly & Lauderdale, 1988; Skinner & Castle, 1969; Gelles 1973). The role of violence in society and cultural values are seen as affecting parental standards of care giving.

The 'special victim' model suggests that the children themselves may be instrumental in various ways in eliciting attack or neglect (Gil, 1970; Browne et al, 1989). Some children may possess characteristics, which either attract abuse or make them more vulnerable to abuse such as low birth weight, and being premature or handicapped.

'Psychosocial' models emphasize the social-situational approach to family violence (Browne et al, 1989; Gelles, 1973; Gelles & Cornell, 1985). Certain stress factors and adverse background influence may serve to predispose individuals to becoming abusers, such as misbehaviour in the child. Frude (1988) adopts a similar perspective and puts forward the notion of a causal chain leading to an incident of abuse.

Chapter 4.
The consequences of Child abuse & Neglect

Introduction

> *" I think about it frequently. An experience I wish I could forget. It's not on my mind 24 hours a day, but always at the back of my mind".*
>
> *"It will never go away. It is like a never-ending story. It still worries me".*

The above quotes are from Scottish children speaking out about their experiences as victims of child sexual abuse *(Waterhouse, 1993)*. The consequences of the abuse may vary; but it is the case that they should not be underestimated either immediately subsequent to the abuse or in the child's later life (Browne et al, 1989). Some professionals hold that major harm only results from sexual abuse while in fact physical abuse can have as powerful effects as sexual abuse. However, there is no doubt that all abuse of children is likely to have harmful consequences. However, some forms of abuse may be more harmful than others, and as a result have different implications for intervention (Corby, 1993).

Most studies of the effects of child sexual abuse or other forms of abuse differentiate between short-, medium-, and long-term consequences; the second pertaining to childhood and the last carrying over to adulthood (Bagley & King, 1990; Corby, 1993). Greater focus on the effects of abuse can lead to more effective treatment, which will reduce the likelihood of abuse being repeated in the next generation (Corby, 1993, 2000).

In the following sections, focus will be placed on the short, medium, and long-term effects of child abuse and neglect.

4.1 The Consequences of Physical Abuse

Physical abuse does not necessarily have very many negative effects, particularly if it happens over a short period and is followed by social support for the victim (Steele, 1986). It is also realistic to recognise that some are more resilient (Heller et al, 1999) than others and the consequences of physical abuse do not in all cases lead to the same effects (Wilson & James, 2000) Over a million adults in the United Kingdom have had physical injuries, fractures or bumps during childhood due to purely accidental causes and have not suffered psychological harm as a result because they have been comforted and cared for by competent care-givers subsequent to the incident (Steele, 1986). However, it is important to distinguish between short-term; medium and long-term consequences (Hill, 1989). Long-term consequences are likely to cause significant trouble for children in their adulthood; less damage in the medium term; and much less in the short term. Damage is likely to occur when the injuries are inflicted by those to whom the child looks for love and protection, in a situation where there is no mediation for the trauma (Steele, 1986).

4.1.1 Short-term effects

Browne & Finkelhor (1986) prefer the term 'initial effects' to 'short-term effects' because the latter suggests that such effects do not persist, which in fact in some cases they do. They define initial effects as those, which become evident in the first two years after the known onset of the abuse. Beitchman et al (1991) make the important point that there may be long-term effects without short-term effects having first been apparent. Short-term effects are not demonstrated; rather, effects are seen in the long term, and therefore more likely to be reported by adults (Waterhouse, 1993).

The following effects have been found to be evident in the short term:

4.1.1.1 School Performance

This issue has been highlighted by research into the causes of poor educational achievement by children in care in Britain, many of whom are likely to have experienced some form of abuse (Jackson, 1996). Most studies of the early school performance of mistreated children point to underachievement (Corby, 2000). Lynch and Roberts (1982); Oates et al (1984); and Kendall-Tackett and Eckenrode (1996) found that most of their sample performed below their IQ potential at school, the most notable deficiency being in use of language. Martin (1972) hypothesized that language delay is characteristic of abused children because of lack of trust in their environment, which in turn results in their being afraid of risk-

taking. As such they acquire little practice in speech and expressive language.

4.1.1.2 Low self-esteem

Extreme reduction in self-esteem is also referred to by the dramatic term 'soul murder', due to the actual destruction of the victim of child abuse that can result (Ebeling & Hill, 1983). Low self-esteem is characterized by negative thoughts about oneself, or can be more accurately characterized as a chronic feeling of being 'bad' or 'unworthy' or a 'cut below zero' (Gannon, 1989). Erickson et al (1989) carried out a series of studies to discover the effects of different types of abuse on children. They studied four abused groups of children over the first six years of their lives. These groups consisted of

- Children who were physically abused
- Children whose parents were hostile and verbally abusive
- Children who were neglected
- Children whose parents were psychologically unavailable (that is they were emotionally abusive).

Overall there were 84 abused children and they were compared with a control group of 85 non-abused children from similar socio-economic backgrounds. Children from all the abused groups were generally rated as having less confidence and lower low self-esteem than those in the control group (p.161).

4.1.2 Medium-term effects

The medium term consequences of physical abuse seem to have cumulative effects unless they are responded to early on.

4.1.2.1 Developmental Delay

Reviews of findings from a variety of follow-up studies conducted in different countries indicate that abused children are at high risk of damage to the central nervous system and of mal-development of ego function (Martin et al, 1974; Jones, 1977; Lynch, 1978; Solomons, 1979). A number of studies report poor physical growth and poor nutrition in approximately 25-35% of abused children at the time of identification (Frude, 1980). Gough (1993) found that 49% of physically abused children were developmentally delayed particularly in speech, while 18% showed growth retardation. 28% of physically abused children suffered permanent brain damage, and 19% of the sample were mentally retarded (Corby, 1993). He adds that mental retardation as an outcome of abuse can happen in two ways: as a direct consequence of physical injury; and as a result of gross under-stimulation (p.113).

4.1.2.2 Aggression/ Withdrawal/ Anger

Aggression usually conveys some behaviour, which is intended to harm another (Cross, 1996). Aggression always refers to some kind of behaviour, either physical or symbolic, that is carried out with the intention of harming someone (Berkowitz, 1993). Humanistic psychologist Maslow

(1968) has distinguished between natural or positive aggression, which is aimed largely at self-defence or combating prejudice and other social injustice, and pathological aggression or violence, which results when our inner nature has become twisted or frustrated. Various studies have found that physically abused and neglected children are both more aggressive and more withdrawn than their peers in play and general interaction. (Corby, 2000). Briere & Runtz, (1990) found that there is a link between physical abuse and later manifestations of anger and/or aggression.

4.1.2.3 Depression

'Depression', as a diagnostic term appears in psychiatric literature as early as the start of the century (Stefanis, 1983). Many people feel down from time to time, but these are usually passing phases (Long, 1999). In wondering where such moods end and proper depression begins, it should be remembered that is not a simple condition (Long, 1999). It can show itself in various ways and have a number of causes. Neither does it respect sex or occupation, and it strikes at any time from the teens to middle age, when it claims greatest number of victims: for serious depression, the peak is about 60 years old for men 55 for women; for milder causes, the peak age is about 50 for men and 45 for women (Long, 1999 p236). Mulien et al (1996) found that physically and emotionally abused children are more likely to develop a depressive illness.

4.1.3 Longer-term effects

The long-term effects of physical abuse are the most damaging both physically and emotionally. The long-term consequences are naturally experienced in the adulthood of the victim.

4.1.3.1 Mental Illness

Mental disorders are common and affect all of us at some time, if not ourselves directly then friends, family or work colleagues (Goldberg et al, 2000). Most people suffer from mild conditions and recover quickly, a significant proportion suffer from chronic condition, which cause moderate or high disability (Goldberg et al, 2000). Until the 1990s surprisingly little attention was paid to the connection between child abuse and later mental illness (Corby, 2000). Carmen et al, (1984) analysed the case-records of 188 inpatients in a US psychiatric hospital to see if there was evidence of abuse in their backgrounds. They found that 80 (43%) of these patients had histories of some form of abuse; 64 of these (80%) had been physically and sexually abused. In Hyman's (1978) study, half of the survey mothers were reported as having receiving treatment for psychological illness before reported abuse. The NSPCC Battered Child Research Team (Baher et al, 1976) also found some examples of antisocial behaviour in the form of drunkenness and mental health problems of a bizarre and obsessive nature in the families of abusing parents.

4.1.3.2 Drug-taking

Studies of the social histories of 178 American and Australian patients being treated for drug or alcohol addiction found that 84% of them had been physically abused and neglected as children (Cohen and Denson-Gerber 1982). Ferguson and Lynsky (1996) found a high correlation between young adults experiencing physical punishment as children and drug taking. Harrison et al (1996) found a correlation between physical and sexual abuse and drug taking in adolescents.

4.1.3.3 Dissociation

Lynn & Rhue (1994) described dissociation in at least three distinct ways:

- Dissociation is used to characterize semi-independent mental modules or systems that are not consciously accessible, and/ or not integrated within the person's conscious memory, identity, or volition.
- Dissociation is viewed as representing an alteration in consciousness wherein the individual and some aspects of his or her self or environment become disconnected or disengaged from one another.
- Dissociation is described as a defence mechanism against such disparate phenomena as the warding off of current physical or emotional pain, and other

- alterations of consciousness, including a chronic lack of personality integration, such as with Multiple Personality Disorder (p. 16).
- Sanders & Lausen (1995) found the results of child abuse to be dissociation and difficulties in interpersonal relationships.

4.1.3.4 Delinquency and Violent Crime

The prevalence of delinquent activity is highest in overcrowded, urban industrial areas with inferior housing, overcrowding, and poor facilities for recreation (Hill, 1989). Delinquency rates differ between city boroughs, between electoral wards within boroughs, and between streets (Power et al, 1972). Lewis et al (1989) summarises research in the USA into the links between delinquency and child abuse. Most prospective studies show that about 20% of abused children go on to commit crimes as juveniles (Corby, 2000). A study of 411 boys that was conducted in Britain showed a link between harsh parental discipline and violent crime (Lewis et al, 1990).

4.1.3.5 Neurological Damage

Physical assaults to the head may be the cause of a child's neurological handicap. However, it is important to emphasize that a young child can suffer significant damage to the brain through violent shaking with no outward sign of damage to the head such as bruises or fractures to the skull (Frude, 1980). The nervous systems of abused children may also be

at risk from the psychological and environmental stresses to which they are exposed, and that neurological dysfunction may be an adaptation to the abusive environment (Frude, 1980).

4.1.3.6 Death

Child abuse has been reported to be the fourth most common cause of death in pre-school children (Browne et al, 1988). Death is considered to be the worst thing that can happen to the child as a consequence of child abuse. Young children, particularly those aged under one year are more at risk of dying (Meadow, 1997). This could be because they are too weak to defend themselves or ask for help. According to a report published in 1995 in the USA on the age of those children who die as a consequences of child abuse, 39% of those who died faced child abuse and neglect were under one, 46% were aged between 1-5 years; and 10% were aged between 6-12 years (Petit & Curtis, 1997). In 1970 Myers found that 134 children had been killed deliberately between 1940-1965 in the USA (Kashani & Allan, 1998). The perpetrators were mothers (26%), and then fathers or stepfathers (11%). According to various reports published in 1991 in 45 American states, 1081 children had died as a consequence of child abuse and neglect (Brissett-Chapman, 1995). In Britain the House of Commons Select Committee on Violence in the Family (1977) reported that there is one severely injured child per thousand children under four years of age. Approximately 10% of these will die and a further 10% will

suffer from brain damage of other severe handicaps.

4.2 The Consequences of Child Sexual Abuse:

Over a million adults in the United Kingdom may still be suffering from the consequences of sexual child abuse into adulthood (Baker & Duncan, 1985). Child sexual abuse has short-term and long-term effects on psychological functioning (Nolan et al, 2002). It is important to distinguish between short-term consequences and long-term consequences (Hill, 1989). The consequences in the short-term are typically fear, anxiety, depression, guilt, and shame while those in the long-term are low self-esteem chronic anxiety, substance abuse, and self-harm (Hill, 1989). About two-thirds of sexually abused children develop transient psychological problems, and a fifth of cases show clinically long-term problems that persist into adulthood (Kendall-Tackett, 1993).

4.2.1 Short-term Effects

The research on the short-term effects of sexual abuse is not as well developed as that in relation to the long-term effects (Corby, 2000). Beitchman et al (1992) pointed out the important point that there may be long-term effects without short-term effects first having been apparent. The following behavioural and emotional responses have been found to be evident in the short term.

4.2.1.1 Guilt and Shame

Gomes-Schwartz et al (1990) found that their preschool age sample of sexually abused children exhibited a more negative self-concept than the normative population. This finding held true in older age groups also. Conte & Schuerman (1987) report on the adverse effect that guilt can have as victims mature, but there is no evidence of such guilt among preschool children.

4.2.1.2 Low self-esteem

Hall & Lioyd (1993) found that low levels of low self-esteem are fundamental to the difficulties of many survivors of child sexual abuse. People who had been sexually abused as children, of both sexes, had lower levels of low self-esteem than other people in the sample (Finkelhor, 1984).

4.2.1.3 Depression

Periods of depression and low moods are common in survivors of child sexual abuse (Hall & Lioyd, 1993). Friedrich et al, (1986) found from a sample of 61 sexually abused females that 46% were experiencing a range of internalised emotions, including depression, within two years of being abused. They also found that a withdrawn reaction was more common in younger victims. Anderson et al (1981) found that 25% of females who had been sexually abused showed symptoms of depression afterwards. Calam et al (1998), in a study of 144 cases of child sexual

abuse reported in Liverpool, found that 36% were experiencing anxiety and depression nine months after intervention, and that this number had reduced only slightly after two years. Koreola et al (1993) found high levels of depression in a sample of 39 sexually abused 6- to 12-year-olds, but concluded that the level of depression was not linked to the severity of abuse.

4.2.1.4 Hostility and Aggression

Some victims of child sexual abuse respond by directing anger and aggression outwards, which is more common among adolescents (Corby, 2000). Gomez-Schwartz et al (1990) identified an anger reaction in between 45 and 50 percent of the 7- to 13-year-olds in their sample, while Calam et al (1998) reported anger as a response occurring in one-third of their sample after nine months. Gomez-Schwartz et al (1990) point out that there are problems associating aggressive reactions purely with sexual abuse because many of children in their sample were also subjected to physical violence or the threat of it.

4.2.1.5 Sleeping Disorders

During a normal working day, we use up energy and tire ourselves both physically and mentally, and if we try to do without regular periods of rest, we become exhausted (Long, 1999). The most complete form of rest is sleep: for our bodies and minds to be fresh and healthy and to work efficiently, each of us needs to spend a part of each 24 hours in sleep

(Long, 1999 p796). Corby (1993) states that there is an association between sexual abuse and subsequent sleeping disorders. In one study 72% of the sample reported nightmares and sleeping difficulties as a result of child sexual abuse (O'Hagan, 1989). Browne & Finkelhor (1986) report clinical studies that find an association between sexual abuse and subsequent sleeping and eating disorders. In addition, Calam et al (1998) found that one-third of their sample experienced sleep problems.

4.2.1.6 Eating Disorders

Two important and well-defined eating disorders are outlined here; anorexia nervosa, and bulimia nervosa (Puri, 1995). Anorexia nervosa is characterized by weight loss and an exaggerated fear of gaining weight, an unrealistic perception of body shape (the subject believes he/she is fat when in fact they are thin), and in girls by the cessation of menstruation (Rutter & Smith, 1995; Puri, 1995). The essential features of anorexia nervosa vary in detail according to the criteria used by different centres, but in general are as follows:

- The presence of abnormal attitudes to normal body shape, weight, and eating.
- Substantial loss of weight e.g. 25% of premorbid body weight as a result of self-starvation.
- Amenorrhoea over several e.g. cycles (Hill, 1989 p.192).

There is linkage between anorexia nervosa and a history of childhood sexual abuse (Hall & Lloyd, 1993). It affects 1%-1.5% of young adult females (Crow et al, 2001); anorexia nervosa is the third most common chronic illness among adolescent females (Turner et al, 2000).

Bulimia nervosa is characterized by episodes of binge eating along with the use of extreme methods to instigate weight loss, while body weight remains roughly normal (Rutter & Smith, 1995). There is growing evidence that between one and two-thirds of women with eating disorders have experienced childhood sexual abuse (Hall & Lioyd, 1993). Hall and Lloyd (1993) state that as many as two-thirds of women with bulimia nervosa had been sexually abused before the age of 15. Two studies conducted using a non-clinical sample of over 36,000 Minnesota youth in public schools provide evidence for an association between abuse and disordered eating behaviour (Ackard et al, 2001). Mullen et al (1996) also found that physically abused children are more likely to develop an eating disorder.

4.2.1.7 Running Away

Sexual abuse of adolescents has been associated with their leaving home in several studies (Meiselman, 1978; Herman, 1981; Silbert & Pines, 1981). 96% of female prostitutes who had been sexually abused as children were also found to be runaways (Corby, 2000). Other acting out behaviours associated with sexual abuse are truanting, drug and alcohol

abuse and promiscuity. However, there are some studies that do not support such connection e.g. Johnston (1979); Goldston et al (1989).

4.2.1.8 General Psychopathology

Gomes-Schwartz et al. (1990) studied 156 sexually abused children treated by a family crisis programme in New England, USA. They assessed these children on a variety of emotional and behavioural criteria, and compared them with children referred to them for reasons other than sexual abuse, and also with similarly aged children in the general population. In overall ratings, severe psychopathology was higher for children of all ages who had been sexually abused.

4.2.1.9 Fearfulness

Browne & Finkelhor (1986) stress that the most common initial effect noted in empirical studies is fear. Gomes-Schwartz et al (1990) found that 45% of their most vulnerable group of children (the 7-to 13-years-olds) were experiencing fearful reactions to what had happened to them within the first six months following the onset of abuse.

4.2.1.10 Cognitive Disability, Developmental Delay and School Performance

Gomes-Schwartz et al (1990) found relatively high rates of both cognitive disability and developmental delay in their preschool sample. As mentioned above, Calam et al (1998) found that one-third of the children in their sample were experiencing school difficulties nine months after intervention and one-quarter were experiencing problems with peer

relationships.

4.2.1.11 Inappropriate Sexual Behaviour

Sexualised behaviour was the short-term effect most closely related to child sexual abuse (Corby, 2000). Briere & Runtz (1990) found there to be a statistically significant unique relationship between sexual abuse and dysfunctional sexual behaviour. Adams et al (1995) found very high rates of sexually inappropriate behaviour among mentally ill children and adolescent with histories of being sexually abused.

4.2.2 Long-term Effects

In addition to the above consequences to victims of sexual abuse in the short-term, in the longer-term sexual abuse has a severe and vinous consequence when compared with other forms of child abuse as follows:

4.2.2.1 Suicide

The problem of attempted suicide now poses one of the major challenges facing health care services in many countries (Hawton & Catalan, 1987). In England and Wales, there were 5,545 suicides and deaths from undetermined causes in 1998; 4,206 by men and 1,339 by women (Bird & Faulkner, 2000). In Scotland, the male suicide rate has continued to rise (General Register Office Scotland, 1998). Rates for men and women in Northern Ireland continue to fluctuate (General Register Office Scotland, 1998). In Saudi Arabia no official statistical figure has been published so

far, though we can read of a handful of Saudi cases in the Saudi newspapers. Official statistics suggest that men are more likely to use more violent and therefore successful methods of suicide such as hanging and asphyxiation by car exhaust fumes, while women are more likely to overdose with drugs, which can be more unpredictable in its results (Bird & Faulkner, 2000). Suicide among young people has risen over the last two decades to become one of the main causes of death in this age group; for example, the suicide rate for men aged between 15 and 24 years rose by 64% between 1984 and 1994 (Office for National Statistics Series, 1998). Read (1998) found there to be a relationship between childhood sexual or physical abuse and suicide. Between 0.5% and 1% of all deaths amongst survivors of abuse are due to suicide (Alec Roy, 1986). This is among those who have a history of sexual, physical and emotional abuse. Mullen et al (1996) also found that physically and emotionally abused children are more likely to attempt suicide.

4.2.2.2 Likelihood of Revictimization

Russell (1986) found that 65% of women sexually abused as children were victims of subsequent or attempted rape, compared with 36% of non-abused women. She also found that between 38 and 48% had been subjected to physical violence by husbands and partners compared with 18% of the control group. Briere (1984) stated that 49% of his sample of women abused as children had been violently assaulted by men as adults.

Various reasons have been put forward for the association of child sexual abuse and subsequent abuse, ranging from increased vulnerability in the case of girls leaving home as a result of their abuse experiences, to psychological needs to have their feeling of low self-esteem reinforced by further ill-treatment (Corby, 2000).

4.2.2.3 Sexual Disturbance

It has been noted in clinical studies of victims of sexual abuse that the experience often seems to have particular effects on sexual emotion and sexual behaviour including: confusion about sexual encounters; compulsive sexual activity; and avoidance of all sexual activity (Herman, 1981; Herman & Hirschman, 1977; Meiselman, 1978).

4.3.2.4 Symptoms of Psychiatric and Psychosomatic Stress

During the last decade numerous studies have found that a significant proportion of adults seeking psychiatric help report sexual abuse in childhood (Stalker & Davies, 1995). An analysis of the case-records of 188 in-patients in an American psychiatric hospital revealed that 43% of these patients had histories of some form of abuse; while 80% of these had been physically abused and half had been sexually abused (Corry, 1993 p.114). Rogers et al (1989) found bed-wetting, tantrums, and bizarre behaviour to be quite common among children suffering abuse. In addition, young girls who are forced to have sex are three times more likely to develop psychiatric disorders in adulthood than girls who are not

sexually abused (Kendler et al, 2000).

4.2.2.5 Alcohol and Drug Abuse

Harrison et al (1996) found a correlation between physical and sexual abuse and drug taking in adolescents. Young girls who are forced to have sex are three times more likely to abuse alcohol and drugs in adulthood than girls who are not sexually abused (Kendler et al, 2000).

4.2.2.6 Post- traumatic Stress Disorders (PTSD)

Childhood trauma is likely to affect the child immediately-during and after the abuse-and this can cause PTSD, resulting in painful; physical and emotional effects (Bowlby, 1988). Symptoms of PTSD are common among adult survivors of childhood abuse and other traumatic events (Kathleen, 2000). In 1941, Kardiner published *Traumatic Neurosis of War* where he provided a clinical description of PTSD (Figueroa & Silk, 1997). That description is still valid today, and he describes the main characteristics of PTSD as follows:

- Fixation on, or inability to escape for any sustained period, the memory of trauma.
- Proclivity to explosive outbursts of aggression.
- Persisting of startle response and irritability.
- Constriction of the persons overall level of personality functioning; and
- An atypical dream life (p79).

Schaaf & McCanne (1998) found that there are significantly higher rates of PTSD and trauma symptoms among childhood sexual and physical abuse cases as compared with the non-abused.

4.2.2.7 Borderline Personality Disorders (BPD)

According to Diagnostics and Statistical Manual of Mental Disorders, Third Edition (DSM3), BPD is characterised by a pervasive instability of mood, interpersonal relationships, and self-image, beginning in early adulthood and present in a variety of contexts, as indicated by the presence of at least five of the following:

- A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of over idealisation and devaluation.
- Impulsiveness in at least two areas that are potentially self-damaging such as spending, sex, substance use, shoplifting, reckless driving, binge eating (suicidal or self-mutilating behaviour are not included).
- Affective instability i.e. marked shifts from base-line mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days.
- Inappropriate, intense anger or lack of control of anger, such as frequent displays of temper, constant anger, and recurrent physical fights.

- Recurrent threats of suicide, suicidal gestures or behaviour and self-mutilating behaviour.
- Marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals, or
- Career choice, type of friends desired, and preferred values.
- Chronic feelings of emptiness or boredom.
- Frantic efforts to avoid real or imagined abandonment (Hill, 1989 p.85).

BPD is one of the most extensively studied of the personality disorders (Figueroa & Silk, 1997). Figueroa & Silk (1997) explored the relationship of childhood sexual abuse to the diagnosis in adulthood of BPD.

4.2.2.8 Self-harm

A great many people, both men and women, hurt themselves in various ways, including cutting, scratching or bruising, as an expression of distress and often as a means of coping with that distress (Bird & Faulkner, 2000). It is very difficult to estimate the numbers of people who self-harm, because of the considerable under-reporting of what can be a wholly private event. However, various researchers have made estimates that vary from between 400 to 1400 per 100.000 per year (Babiker & Arnold, 1997). Self-harm can be the result of distress caused by previous abuse, whether physical, mental, or sexual (Bird & Faulkner, 2000).

It is generally believed that self-harm is twice as common among women as it is among men, although this is based simply on the visible numbers of people being treated in hospitals or by other health care services (Bird & Faulkner). A survey of women who self-harm found that 90% of the women had begun self-harm during childhood or adolescence and 69% had been injuring themselves for more than five years (Arnold, 1995).

4.2.2.9 Aggression/ Anger

It has been found that of the 45% to 50% of 7 to 13 year olds, who were victims of sexual abuse, anger/aggression was a significant feature of their behaviour, (other studies made similar findings amongst 6 to 12 year olds) (Corby, 1993).

4.2.2.10 Irritable Bowel Syndrome (IBS)

IBS is a disorder of the lower gastrointestinal tract whose cause is currently unknown (Kathleen, 2000). The symptoms can be continuous or recurrent and must be present for at least 3 months (Kathleen, 2000). IBS was significantly related to abuse in childhood and adulthood in recent studies. Those who had an abuse history were twice as likely to have IBS than the remainder of the sample. Those who reported abuse in both child and adulthood were three times as likely to have IBS (Kathleen, 2000).

4.3 The Consequences of Child Emotional Abuse:

As mentioned in chapter 2, there is still no clear consensus on how to define emotional abuse, not least because there are different opinions of whether the emphasis should be on the abuse of the child or the behaviour of the parent (Wilson & James, 2002). It is not fully understood why children react differently in the face of maltreatment and why some show more severe consequences than others when they have had abusive experiences (Wilson & James, 2002). Egeland (1988) said in his study that emotional abuse has the most serious consequences for a child's social and intellectual development.

4.3.1 Longer-term Effects

4.3.1.1 Low self-esteem

Briere & Runtz (1990) and Mullen et al (1996) found there to be a unique relationship between emotional abuse and subsequent low self-esteem.

4.3.1.2 Depression

As mentioned in the consequences of physical abuse, Mulien et al (1996) found that physically and emotionally abused children are more likely to develop a depressive illness.

4.4 The Consequences of Neglect

The consequences of neglect, as in physical abuse, can range from death of a child through neglect (death from cold, starvation, lack of medical and daily care) to children who are dirty and unkempt, not stimulated to learn

and left to their own devices (Wilson & James, 2002). The impact of neglect on children's development is at least as damaging as the more overt types of abuse, especially during the first two years of the child's life (Daniel, 2000).

4.4.1 Longer-term Effects

4.4.1.1 Low self-esteem

As mentioned earlier in the discussion of the consequences of physical abuse in the short-term, Erickson et al (1989) found the neglected group in their study to have low self-esteem and less confidence. Oates et al (1985) found that neglected children seem to be lower in low self-esteem than children who had been physically abused.

4.4.1.2. School performance

Erickson et al (1989) found very low achievers in school among neglected children. Most studies of the early school performance of mistreated children point to underachievement (Corby, 2000). Lynch and Roberts (1982) found that most of their sample performed below their IQ potential at school, the most notable deficiency being in use of language. Martin (1972) hypothesized that language delay is characteristic of abused children because of lack of trust in their environment, which in turn results in being afraid of risk-taking and acquiring little practice in speech and expressive language. Knowledge of family background may lead to low expectations in terms of intellectual performance (Corby, 2000). This issue

has been highlighted by research into poor educational achievements of children in care in Britain, many whom are likely to have experienced some form of abuse (Jackson, 1996).

4.4.1.3 Drug-taking

As mentioned in the section dealing with the long-term consequences of physical abuse, a study of the social histories of 178 American and Australian patients being treated for drug or alcohol addiction found that 84% of them had been physically abused and neglected as children (Cohen & Denson-Gerber, 1982).

Summary of Findings

There is no doubt that abuse of children is likely to have harmful consequences, and that some forms of abuse may be more harmful than others, and as a result have different implications for intervention. The consequences of the abuse may vary, and depend to an extent on the child's environment. Most studies of the effects of child sexual abuse and other forms of abuse differentiate between short-, medium-, and long-term consequences. The consequence of physical abuse in the short-term is primarily low self-esteem, while the medium-term effects are developmental delay; aggression; withdrawal; anger; dissociation; and poor school performance. Longer-term consequences of child physical abuse can be mental illness; drug taking; dissociation; delinquency and violent crime, neurological damage and even death.

The short-term effects of child sexual abuse are general psychopathology; fearfulness; guilt; shame; depression; withdrawal; hostility; aggression; sleeping disorders; eating disorders; running away from home; cognitive disability; developmental delay; poor school performance; inappropriate behaviour; and low self-esteem. The longer-term consequences include suicide; likelihood of revictimization; sexual disturbance; psychiatric and psychosomatic stress symptoms; alcohol and drug abuse; PTSD; impulsiveness; self-harm and anger.

The longer-term effects of child emotional abuse are low self-esteem; depression; and withdrawal. The long-term effects of neglect in children are low self-esteem; low educational achievement; and drug taking.

Chapter 5.
Review of Literature

Introduction

Child abuse and neglect are important subjects for several reasons; first, because they concern the most vulnerable section of humanity, children, and, second, because this group is not yet aware of its rights and, it follows, the need to defend and protect these rights (Freeman, 2000). Therefore, thousands of articles and books have been written since the child-welfare movement began in the US during the middle and late 19th century particularly when the landmark article was written by Dr. C. Henry Kempe (1962) which brought the problems of abuse, and neglect to public attention worldwide. The first book on child rearing was published in 1923 entitled '*Advice to young Mothers on the Physical Education of Children*', and then *'The ABC of child abuse'* was first published in the BMJ in 1981 (Valman, 1987; Lynch, 1985) The International Journal of Child Abuse & Neglect celebrated in May 2002 the 40th anniversary of the publication of "The Battered Child Syndrome", however, no article appeared in it dealing with child abuse in Saudi Arabia during that period. Until the 1990s, cases of child abuse and neglect went unpublished by medical professional in Saudi Arabia (Al-Eissa, 1998). As far as the researcher knows, in the last decade there have been only 7 articles published. A total of 39 cases have been published by paediatricians in the local medical journal (see table 87). In addition, one thesis has been presented by a PhD student to the Department of Sociology, King Saud University (Al-Saud, 2000).

The literature review has been divided into three sections; local studies; Arabic studies; and international studies as follows:

5.1 Local Studies:

- **Al-Saud (2000)**

"Child Abuse in Riyadh: Causes, Forms & the Characteristics of Victims"

Sample: 181 participants from various major hospitals in Riyadh, Saudi Arabia (including Ministry of Health hospitals, King Saud University hospitals, the King Faisal & Research Centre Hospital, the National Guard's hospital, Security Force's hospital and Military hospital) participated in this study. 40.6% of participants were social workers, 37.3% were paediatricians, 7.3% were psychiatrists, 5.6% were psychologist, 6.1% were doctors, and 3.5% belonged to other categories. 31.1% have been working for more than 9 years, 25.3% for between 3-6, 24.2% for under 3 years and 18.2% for between 6-9 years. 53.9% have a BA, 18.7% have an MA and 26.4% have an MD or PhD. 25 cases of child abuse in different hospitals were also interviewed and their case files examined.

Focus: Children or teenagers who face any form of child abuse and neglect in the city of Riyadh, Saudi Arabia.

Measures: Triangulation methods such as questionnaires, the examination of related records & documents and un-structured interviews.

Results: 39% of the sample asserted that they had seen cases of child abuse, and 61% said they had not. 30.2% asserted that they have a colleague/colleagues who work with cases of child abuse while 68.2% said that they have not seen any cases of child abuse. 91.5% were of physical abuse; 87.3% were of neglect; 53.5% were of emotional abuse; and 46.5 were sexual. 22.7% of cases seen by paediatricians involved child abuse (30 cases a year); while amongst social workers the figure is 13.3% (p 169).

- **Al-Ayed et al (1998)**

"The Spectrum of Child Abuse: A University Hospital, Riyadh, Saudi Arabia"

Sample: A total of thirteen cases (7 girls, 6 boys) aged under five years, except for two cases; one of which was nine and the other seven. Two Arabic and another Saudi. They were seen in the emergency room (ER) of King Khalid University Hospital, Riyadh (KKUH), over a period of one year from July 1996 to June 1997.

Focus: Child abuse and neglect.

Objective: Family support and child protection.

Measures: Physical examination.

Results: There were four cases of non-accidental injury, three of which were serious. There were three cases of sexual abuse, and four cases of neglect that resulted in the death of one child and severe emaciation in

another. There was one suspected case of Munchausen by proxy (factitious Illness), and one case of child labour with neglect.

❖ **Elkerdany, et at (1998)**

"Fatal Child Physical Abuse in Two Children of a Family"

Sample: Two tragic cases encountered in one family in the emergency room in Jubail General Hospital (JGH). One, a six-day-old neonate Saudi, was brought to the hospital in May 1997 by his parents, with a history of sudden onset swelling above the right eye and focal convulsions for one day, followed on the second day by loss of consciousness. The other patient, an 18-month-old Saudi female (sister of case 1) was brought to the ER by her parents because of a sudden loss of consciousness. The parents gave a history of head trauma two days earlier, but they gave different reasons for its cause.

Focus: Children suffering from abuse.

Objective: Treatment of children.

Measures: Medical examination.

Results: The parents were cousins. The mother was a 16-year-old uneducated second wife of a 35-year-old soldier. They stated that they also had an 18-month-old daughter suffering from frequent fractures, who had been repeatedly admitted to the hospital. The first wife of the man was also a relative and had three normal children. The patient was

unconscious, with generalized convulsions and irregular breathing. Both eyes were deviated to the right side with excessive salivation. (p.2).

❖ **Kattan et al (1995)**

"Subcutaneous Fat Necrosis as an Unusual Presentation of Child Abuse"

Sample: Two Saudi females under two years of age. They were presented at King Faisal Specialist Hospital and Research Centre KFSH&RC. The father is 38 years of age, the mother is 24 years of age, and the parents are not related. The father is married to four women and has a total of 20 children.

Focus: Child protection.

Objective: Support family and protect the children.

Measures: Physical examination and interview.

Results: Two cases had developed swelling of the dorsal of the feet, legs, and arms. The swelling became progressively worse. After long investigation their mother admitted that she was striking her children with any object at hand (p.162).

❖ **Kattan (1994)**

"Child Abuse in Saudi Arabia: Report of Ten Cases"

Sample: A total of ten abused children under five years of age (four males, six females) all of them Saudi except for one Egyptian. They registered at department of paediatrics, KFSH&RC, Riyadh, Saudi Arabia over period of six years from 1986 to 1992. The majority of cases were of serious injury.

Focus: Abused children who are under five years.

Objectives: Family support and child protection.

Measures: Medical examinations and medical case record.

Results: Two children died, five had serious injuries, and three had moderately severe injuries. In one of the fatalities, the diagnosis was not suspected until four years after death, when her sister was diagnosed as case of child abuse. Three children suffered varying degrees of physical abuse, one of physical neglect, and two of sexual abuse. The remaining four children were the subject of the effects of Munchausen by proxy. 70% of abusers were found to be mothers (p.129).

5.2 Arabic Studies:

- **Haj-Yahia & Temish (2001)**

"The Rates of Child Sexual Abuse and Its Psychological Consequences As Revealed By A Study Conducted Among Palestinian University Students"

Sample: A cross-sectional survey was conducted among a convenient sample of 652 Palestinian undergraduate college students, of who 60%, N=391 were female. Participants ranged in age from 18 to 37 years (Mean=20.64 years, SD=2.28 years). About 22% were first-year students; 28% were second-year students; 29% were third-year students; and the remaining 21% were fourth-year students. About 81% of the participants were Muslim and 19% were Christian. 59% lived in urban regions of the

Palestinian Authority; 33% lived in rural regions; and 8% lived in refugee camps. Average monthly family income ranged from about 1000 New Israeli Shekels to about 20,000. The size of the student's family of origin ranged from 3 to 22 members (Mean=8.66, SD=2.85), and the size of their homes ranged from 1 to 10 rooms. Regarding the parent's level of education: 4.3% and 16% of the fathers and mothers respectively, were illiterate; 17.4% and 14.7% of the fathers and mothers respectively, completed elementary school; 37.3% and 49% of the fathers and mothers respectively, had partial or complete secondary education; and 41% and 20.3% of the fathers and mothers, respectively, had some level of postsecondary education.

Objective: The aim of the study was to achieve the following two objectives: First, it sought to examine the rates of sexual abuse in Palestinian society in three age ranges; 12 and under, 12-16 years, and 16+ years, by three perpetrators; a family member, a relative, and a stranger. Second, the study sought to assess some of the psychological implications of sexual victimization.

Focus: University students, who faced child sexual abuse between the ages of 12 and 16.

Measures: A revised version of Finkelhor's scale was used to measure sexual abuse, and a revised and culturally adjusted version of Derogates

and Melisaratos' Brief Symptoms Inventory was used to measure nine psychological symptoms.

Results: The results provide strong support for the existence of sexual abuse in Palestinian society, as well as for the hypothesis that sexual abuse has a strong psychological impact on victims resulting in psychoticism; hostility; anxiety; depression; somatization; phobic anxiety; paranoid ideation; obsessive-compulsiveness; and psychological distress (p 1303).

❖ **Qasem et al (1998)**

"***Attitudes of Kuwaiti Parents toward Physical Punishment of Children***"

Sample: A total of 337 couples in Kuwaiti who attended one of five general clinics for consultation during the second week of December 1996. 36% of the total population were Kuwaiti. All Kuwaiti parents had at least one child. The majority (58%) had 1 to 6 children, and almost 14% had 10 or more children. The majority (61%) were aged less than 45, and about the same percentage were of Bedouin ethnic background. The average age was 41.8 years. About 39% of the population were illiterate or could only read and write minimally, while 31% had completed 12 or more school grades.

Focus: Parental attitudes toward the physical punishment of children.

Object: To describe parental attitudes to physical punishment and examine their socio-demographic correlates.

Measures: Interview.

Result: 86% of parents agreed with physical punishment as a means of child discipline. The results of multiple regressions showed that parent's having a low level of education and Bedouin ethnicity were positively associated with endorsement of physical punishment. A larger percentage of parents who had experienced physical punishments themselves agreed with such punishments as a means to discipline their children, but this was not statistically significant (p.1189).

5.3 International Studies:

- **Sacco & Farber (1999)**

"Reality Testing In Adult Women Who Report Childhood Sexual And Physical Abuse"

Sample: Participants in this study, all of whom were female, were recruited from several colleges and universities in New York City and asked at the beginning of class to take part in a study of the psychological function of women. Of the 300 women who agreed, 259 completed the study. The final group of participants ranged between 18 and 30 years of age. 79.5% were unmarried. The sample was predominantly White 69% and other racial groups represented included Asian (13.9%), African/Black (5.8%),

and Hispanic (5.8%). The sample was divided into two groups on the basis of reported abusive experiences prior to age 18.

Focus: Women who have experienced childhood sexual and physical abuse.

Objective: To investigate the differential effects of sexual and physical abuse in childhood on the quality of reality testing (perceptual disorders and dissociative symptoms) in later adult life.

Measures: various questionnaires.

Results: Participants in the study who did not report abuse in any form in childhood composed a surprisingly small 32.8% of the total sample. By contrast, 66% of the sample reported some form of abuse before the age of 18. Of those reporting abuse 27.4% reported only sexual abuse, 18.5% reported only physical abuse, and 20.1% reported both sexual and physical abuse in childhood.

Participants were also queried regarding the perpetrators of any reported abuse. The most common perpetrators were boyfriends 23.3%, followed by acquaintances 21.1%, and strangers 20.3%. Fathers and stepfathers were most often cited as physical abusers 36%. Brothers or sisters were listed in 23% of the cases of physical abuse, and mothers or stepmothers were reported in 21% of the cases of physical abuse.

College women who reported abuse continue to experience acceptable accuracy in their reality testing, but in comparison to their cohorts who

have not been abused, more often become "distant" from the world and their sensory experiences (p.1193).

❖ **Gough (1993)**

"Consequences of Child Abuse"

Sample: Total sample of 42 abused children and 27 siblings from 40 families admitted to project between 1966 and 1974 at the Park Hospital in Oxford. The children were aged between 1 month and 3.5 years. Most were under one year. They had experienced serious physical abuse in 23 cases and moderate abuse in 19 cases. Half the children had been in life threatening situations and half displayed frozen watchfulness. Infants were often discontented and fussy. Older children were often aggressive and attention seeking. 49% were developmentally delayed particularly in speech. 18% showed growth retardation. Parental age varied from 16 to 36 years. The average age for mothers was 24 and for fathers was 26. Over half of the mothers had experienced emotional illness since the birth of their child and even more had earlier problems. Difficulties in all areas of life were prevalent including health and marital and sexual relationships. 20% lived in substandard housing and the sample was of lower than average socio-economic status. The majority of families were white though there was one Chinese family and one mixed marriage.

Focus: Individual and family functioning and relationships.

Objective: To provide total family care and a safe place of escape from normal pressures.

Programme: Residential unit with links to the main hospital to which families are admitted for an average of 3 weeks. Full assessment at intake. Family provided with total care. Individual psychotherapy, and marital therapy. Follow up support service with a 24-hour hotline.

Design: Outcome study of case series with an average four-year follow up.

Measures: Formal test of linguistic and intellectual development; medical assessment of physical growth and of neurological functioning; parental interview. Also measures of re-abuse, social circumstances, family relations, and social activities.

Results: 9 children in long term care, 16 under some form of compulsory order, 8 children were re-abused – one seriously. Half of parents reported medical and psychological problems. There were poor ratings of the home child environment in 13 of the 33 homes where the abused child was not in care, but 70% of these families had at least one problem free child. 23% of all the abused children and 51% of siblings were problem free. Half of school aged children showed no classroom disturbances. Many parents had made good progress in their general life management. Siblings who were born after abusive incident did best (p.192).

❖ **Gough (1993)**

"A Longitudinal Study of Child Abuse in Glasgow, Scotland"

Sample: A total of 202 children under 5 years of age placed upon the child abuse register of one British city over 15 months period. The children came from 147 families; the majority of parents were single or had relatively unstable, cohabiting relationships. Serious injury was uncommon and although many children had some bruising, most were suspected or at risk cases. The families were virtually all in receipt of public welfare benefits and under financial stress.

Focus: Decision-making and case outcome in routine cases.

Objective: Family support and child protection.

Programme: Social services casework.

Design: Two-year prospective study with multiple measures on the treatment group.

Measures: Descriptive analysis of case decision making and case progress, using agency case record.

Result: 50% of the families had their children removed from the child abuse register within 10 months and 92% after two years. 40% of the cases were referred to the Children's Hearing System to obtain legal powers of supervision. In 21% of cases the children spent some time in the care of the local authority and half of these children were still in care at two years post-initial registration. Factors most associated with long-term

placement were single parenthood and not coping with childcare. Child injury or risks from cohabiters did not seem to be important factors (p.220).

❖ **Gough (1993)**

"Evaluation of a Child abuse Intervention Programme"

Sample: The 65 abusing (or at risk of abusing) parents enrolled in programme at pre-test and 20 of them were still in programme at post-test 4 months later. The families tended to have many children; to be of low socio-economic status and a third were Catholic. Control families recruited from Child Protection Services.

Focus: Parents attitudes/skills.

Objective: To change attitudes to parenting, to increase ability to deal with child management problems and knowledge of child development. To provide nurturing experience and social support and to teach problem solving abilities.

Programme: Group with 20-minute socialization period, followed by 25-minute educational presentation. Also, similar group for discussion and intensified training or work on personal problem. Children provided with individual and group activities.

Design: Repeated measures (pre and post-test) with one treatment group and one control condition. Cross sectional comparison of treatment length with outcome.

Measures: Research instrument consisting of 24 correct/false statements, developed by staff. Statements refer to knowledge, attitude, and values in parenthood and childcare.

Results: Treatment group showed significantly greater increase in scores compared to controls. In the cross sectional analysis comparison, first time participants scored higher than controls or more experienced programme clients (p.158).

❖ **Gough (1993)**

"Intervention in Child Abuse: Experience in Liverpool, England"

Sample: 50 children who presented at the Casualty Department of a children's hospital in Liverpool and who were subjects of case conferences and subsequently taken into care; 78% physical abuse, 22% severe neglect.

Focus: Children received into care because of risk of abuse.

Objective: Providing a service for children at risk of abuse.

Programme: 25 children were in foster care for periods ranging from 10 months to five years and then returned home. 25 children remained in care with up to seven changes of placement. 36% of the sample had more than 2 placements.

Design: Post-test on treatment sample.

Measures: Workers' assessments of emotional disturbance, educational progress, re-abuse, physical and neurological development of the

children. Outcomes, including one major problem, rated as unsatisfactory. *Results:* Abnormal development in 7 cases including epilepsy, handicap, and failure to thrive (n=4). Emotional disturbance in 18 cases of which 12 were referred for specialist help. 11 children were behind in school progress. 5 children were re-abused. 26 (52%) of case outcomes coded as unsatisfactory. 19 of the 26 unsatisfactory outcomes were for the 25 children who were returned home. Quality of outcome relative to assessment at placement: Those under 3 years had significantly better outcomes (p.222).

❖ **Barth (1989)**

"Evaluation of A Task Centred Child Abuse Prevention Programme"

Sample: Clients were referred by public health social workers, social services, teen parent programmes, and a total of 17 different agencies serving high-risk mothers and pregnant women. There were 9 paraprofessionals providing services. These parenting consultants were mostly women (78%) with a mean age of 29 and a modal education of college graduate; several were in masters programs (n=2) or applying to graduate programs (n=2). The demographic breakdown of clients shows that mothers were on average six months pregnant at the time they began the programs. Overall, 25% were? Primaparas, 39% had one child, 18% had two children, and 18% had three or more children. Among pregnant women, 46% were primaparas, 27% had one child, 12% had two children,

and 15% had three or more children. 44% were white, 32% were Latino, 18% were black, 3% were Asian, and 1% was Native American.

Focus: Education of parents (mothers) for primary and secondary prevention of child abuse and/ or neglect.

Objective: To teach and devise individual coping strategies for stress and childcare in the home setting by working at specific tasks and developing personal coping styles for handling new or additional parenting responsibilities; to help clients change their social environment by building formal and informal resource networks.

Programme: The Child Parent Enrichment Project Programme (CPEP), taking a social ecological model of child maltreatment. Trained parenting consultants offer suggestions for changes in parenting style, give demonstrations of parenting techniques and help clients to obtain community services that offer food, shelter and financial assistance. Parenting consultants, in consultation with the mothers, decide on a minimum of three goals to pursue for the next six months. Each goal is divided into manageable tasks detailed on task sheets, and the parenting consultants visit the home bi-weekly.

Design: Repeated measures (pre- and post-test) on intervention group only.

Measures: Child Abuse Potential Inventory (CAPI). Goal Attainment Scales were completed by clients and parenting consultants. Consumer

satisfaction forms completed by clients.

Results: 17.15 tasks were accomplished per client (approximately one task per visit). 49% were accomplished by the parenting consultant, 41% by the client alone, and 9% by the two together. Significant increase in mean goal attainment level, with the greatest goal gains being related to improvement in the environment of the mother and child. Pre-test CAPI scores averaged 108.9 indicating very high risk, but fell significantly at post-test to 96.8 ($p<0.05$). Improvement in CAPI scores more strongly associated with tasks undertaken by client rather than by staff. Greatest satisfaction was with their relationship with the parenting consultant and the practical help provided. Dissatisfaction expressed was that programme was too short (117).

- **Creighton (1979)**

"An Epidemiological Study of Child Abuse"

Sample: 905 cases notified to NSPCC Special Unit Registers of Suspected Non-Accidental Injury during 1976. These were maintained by NSPCC Special Units sited in Manchester, Leeds, Newcastle upon Tyne, Northampton, Coventry, Nottingham, and Goldthorpe. Children were aged less than 16 years. 656 of these children had been injured and 249 were to be at serious risk of injury. This represents a registration rate of 0.68 per thousand children and an injury rate of 0.5 per thousand children less than 15 years old. Amongst the injured were 12 children whose injuries

were subsequently judged to have been caused accidentally. The injured children were divided into five categories depending on the type and severity of their injury. These categories were fatal, serious, moderate, failure to thrive, and sexual abuse.

Focus: Analysis cases of Non-Accidental Injury were notified to NSPCC.

Results: Thirteen per cent of the child population of England and Wales were living in areas covered by Registers of suspected Non-Accidental Injury in 1976. Seven children were fatally injured, 91 seriously and 520 moderately, 24 failed to thrive and there were two cases of sexual abuse. Three of the dead children came from one family, where the father had killed them.

There was a high rate of illegitimacy amongst the sample. Only 52% of the injured children were living with both natural parents at the time of incident. 22% were living with their mother and a father substitute and 20% were living with one parent alone, usually the mother. The mean ages of the male and female guardians were 30 and 26½ years respectively. The male guardians were in mainly semi-skilled and unskilled occupations and a third of them were unemployed at the time of the incident. 34% of the male and 12% of the female guardians had a criminal record.

There was information on the perpetrator in two thirds of the cases. Mother or father substitutes were suspected of injuring the child twice as

often as the natural parent. There was a slight tendency for mothers to injure younger children and fathers older ones and also for mothers to injure their children more seriously. 50% of the children came from families with three or more children, 76% of them were either the first or second born in their families (p.601).

Summary of Literature Review:

Looking to those studies that had been done in Saudi Arabia in the last decade and to other international studies that included in the literature review, the conclusion was as follows:

- Most abusers were women.
- Most of the victims were under five years.
- Abusers were predominantly young; married; uneducated and low income.
- A large age gap between wife and husband was also common.
- There was evidence that abusers had traumatic experiences in their childhood.
- There was a high rate of illegitimacy amongst the Saudi samples.
- The mean ages of the male and female caretakers were 30 and 26½ years respectively.

- The male caretakers were in mainly semi-skilled and unskilled occupations and a third of them were unemployed at the time of the incident.
- 34% of the male and 12% of the female guardians had a criminal record.
- Mother or father substitutes were suspected of injuring the child twice as often as the natural parent.
- There was a slight tendency for mothers to injure younger children and fathers older ones and also for mothers to injure their children more seriously.
- 50% of the children came from families with three or more children, 76% of them were either the first or second born in their families.

Researcher's comment

When we look to Arabic and international studies on the one hand and Saudi studies on the other hand and make a comparison between them, you will find the international studies recruited samples from various universities, colleges, or hospitals with sufficient sample size in order to represent the vast majority of the population. For example, although the studies of Creighton (1979) and Haj-Yahia & Temish (2001) had samples of 905 and 652, respectively, the former was based on reported cases of suspected non-accidental injury and the latter sample on Palestinian

University students, retrospective reports of their previous history of abuse. These, and other studies (example Farber 1999 and Gough 1993), are limited in terms of their representative status of the problems of abuse in epidemiological terms. In the Arabic studies, the numbers of cases were not only far fewer but also more biased in terms of selection of cases, and the categorisation of abuse in some studies was determined by professionals with limited training. The implication is that whereas there is a greater extent of knowledge about the problems of child abuse in the western world, there is very much less known about the extent of the problems in the Arab world.

Chapter 6. Methods

Introduction

The methodological problems associated with the survey method fall into three broad categories; where to collect the information from; what method to use for collecting it; and how to process, analyse and interpret it (Moser & Kalton, 1971). In this chapter we are going to talk about the aims of the study, the sample, the method of collecting data, which is here a questionnaire. With reference to this questionnaire, its formulation for the purpose of this study is described in the following pages. The structure of the questionnaire is divided into three sections. Namely; personality problems, child traumas and demographic data. Furthermore, rate of responses and statistical methods are also described.

2.1 Aims

This study has three aims:

2.1.1 Aim One:

To ascertain some of the reasons for child abuse in the society of Saudi Arabia.

2.1.2 Aim Two:

To identify the types of child abuse that are most common in Saudi Arabia.

2.1.3 Aim Three:

To examine a number of key issues about the sequelae of the experience of abuse.

2.2 Target Population:

The target population here were those adult males and females who have experienced any type of abuse (emotional, physical, or sexual), or neglect (emotional, physical, or medical) during their childhood.

2.3 Sample:

It is apparent that there was not enough time or money to interview the entire target population, particularly since there is no evidence about the prevalence of child abuse in Saudi. We therefore need to select a section of the target population that will be representative of its totality. This selection of representative people is called a sample (Nichols, 1991). Abramson (1974) states that the sample must be well chosen, so as to be representative of the population, must be sufficiently large, and must provide adequate coverage of the sample.

In this study we selected two kinds of population; university' students; and households. We selected the students population from two universities; King Faisal University (KFU), which is located in the Eastern Region of Saudi Arabia; Umm Al-Qura University (UQU), in the Mecca Region in the west of Saudi Arabia; and Teachers College (TC) in the same city. We planned to visit students at their classes in order to explain the aims of this study and to answer any questions. However, I was asked to conform to the official procedure, which consisted of leaving the questionnaire with the university with an explanation of how they were to be administered.

We were to return after 3 weeks to the Information Department or Director of Student Affairs to collect the questionnaires that had been submitted. We distributed a total of 800 amongst the various departments, with 400 going to KFU, 200 to UQU and 200 to TC.

In the selection of the household population, I chose two major regions; the Riyadh Region in central Saudi Arabia, and the Eastern Region. Each region was divided into five areas; north; south; east; west and central. The upper classes usually live in the north area and part of the north-west area, middle classes live in central and west areas, and the lower classes live in the south and south-west areas. The directorate of the post offices provided me with a list of households for each area. The list included useful information about the householders including their names, their PO box numbers, and the area box numbers from which it was possible to distinguish natives from foreigners by family name. For instance, most Saudi family names are prefixed with "Al" and indicate the tribe of origin. It is also possible to gauge the economic level of the family from the area where they live. It was also possible to recognize a private box in contrast to one belonging to a business or organisation. After completed lists of households for all areas in both cities we took a systematic sample; i.e. we selected number 5, 10, 15, 20 until we had a sufficient sample. If one of the numbers selected happened to be a foreigner or business we jumped to the next in the sequence.

We sent 500 questionnaires to householders in the Riyadh Region and the same number to the East Region.

2.3.1 Sample frame:

The sampling frame used was as follows:

2.3.1.1 Location Frame:

Country: Saudi Arabia.

Region: East (households & Students), West (students only) and Central (households & students).

Cities: Mecca (West), Riyadh (Central), and Dammam, Dhahran, Al-Jubail, Al-Khobar, Al-Hasa, Ras Tanura, and Qatif (East).

2.3.1.2 Human Frame:

Ages: 18 years and over

Gender: Male and female

Undergraduate Students at King Faisal University; Umm Al-Qura University; and Teachers College.

Householders in the cities of Mecca, Riyadh, Dammam, Dhahran, Al-Jubail, Al-Khobar, Al-Hasa, Ras Tanura, and Qatif.

Socio-economic Class: in fact under the Islamic law there are no social classes. All people must be at the same level even the governor. The government is very careful on this particular point. Sometimes the media divides the population according to income. For instance if your income above 10,000 ($2,666) per month then you are considered to be among

upper classes; between 5000-10000, middle class; and less than 5000 you are considered to be among lower class.

2.3.1.3 Date Frame:

The study took place between the 25th of March 2001 and the 20th June 2001.

2.4 Method of Collecting Data:

There are many methods of collecting information including observation, interview, and questionnaire. Before beginning this study, it was necessary to consider the most effective method of data collection. It was necessary to consider whether we were going to conduct a condensed, factual enquiry, or would we conduct analytical research on a set of attitudes? There were further questions: How large is the sample likely to be? Will we be dealing with adults or children? If we are dealing with adults, will they be householders, prisoners, students, all these, and many other issues, have a bearing on the selection of measurement specifications and procedures (Oppenheim, 1992). In a sensitive study like this, it is important to choose a suitable method for the collection of accurate information. Many large or detailed research projects collect information by sending out questionnaires to the participants (Lynch & Roberts, 1982), and we decided that this was the most appropriate method for this study for the following reasons:

- In the attempt to ascertain the prevalence of child abuse in Saudi Arabia the use of a questionnaire was the most practical way of doing so.
- There was no likelihood of collecting cases of child abuse through interview, because of the avoidance of individuals to this approach for fear of being identified.
- Difficulties of males in Saudi Arabia meeting females, and training females to interview victims would take time.

2.4.1 Questionnaire:

Questionnaires take a variety for forms including self-administered questionnaires, postal questionnaires, and structured interview schedules (Oppenheim, 1992). The investigator must make a decision regarding what sort of questionnaire should be used, how many questions should be asked, what the best question to ask is, and whether open or closed ended questions should be used, among other considerations (Groves, 1989). We found the use of a questionnaire to be very appropriate to the study, particularly a mail questionnaire. Oppenheim (1992) summarized the main advantages and disadvantages in the following checklist:

The main advantages are:

- Low Cost of data collection.
- Low cost of processing.
- Avoidance of interview.

- And ability to reach respondents who live at widely dispersed addresses or abroad.

The main disadvantages are:

- Generally low response rates and consequent biases.
- Unsuitability for respondents of poor literacy; for the visually handicapped, the very old or for children below the age of say ten, and people with language difficulties.
- No opportunity to correct misunderstandings.
- No check on incomplete responses, incomplete questionnaires.
- No opportunity to collect ratings or assessment on observation (p.102).

Having opted for the mail questionnaire as the most fitting method, we found closed-questions to be most suited to the sensitive nature of the study, also easy for clients to answer, and easier for the researcher to analyse.

2.5.1.1 Building the Questionnaire:

- **Step 1**

As mentioned early in this chapter, the aims of the study are: the investigation of child abuse from three aspects; the prevalence, the causes and the consequences of child abuse in the Saudi society in adulthood. That is meant that we had, essentially to integrate three

questionnaires; one exploring the types of child abuse; an other one exploring as much as possible the consequences of child abuse, and the last one exploring the reasons for child abuse. It was surmised on the basis of previous investigations that the consequences of child abuse in adulthood would most likely be medical or psychological. Our primary concern here is to determine the psychological consequences. A search of various libraries for questionnaires that measure child abuse and its consequences turned up the Child Trauma Questionnaire CTQ (The Psychological Corporation, 1998). We did not find many questionnaires dealing with the consequences of child abuse. As such we created new questionnaires by selecting 13 questions that address different aspects of the sequelae we considered relevant from various existing questionnaires as follows; low self-esteem (Rosenberg, 1965); Borderline Personality Disorders or "impulsiveness" (First et al, 1997); Post-traumatic Stress Disorders PTSD (Joseph et al, 1997); Dissociation (Vanderlinden et al, 1993); Self-harm (First et al, 1997); Eating Disorders (The Centre for Eating disorder. Com), and Aggression (Briere & Runtz, 1990). In addition, we used the General Health Questionnaire GHQ (Goldberg & Williams, 1988), which was developed and translated to Arabic language by Hasan (1999). And finally the third part of the questionnaire associated with the causes of child abuse, which we designed demographic questions to deal with clients themselves and their parents.

❖ **Step 2**

After formulating the questionnaire, we submitted it for review by 10 of my colleagues PhD students and employees in the Department of Psychiatry, Royal Edinburgh Hospital to find out their views about the questionnaire. We asked the following questions: Is the questionnaire in the correct order? Is it suited to the measurement of child abuse and psychological problems? Is there any question that allows the possibility of a variety of answers, and is thus not sufficiently specific? Six of my colleagues replied. Some asked me to change some words in the covering letter, while none of them submitted any corrections to my questions.

Taking into consideration their advice we rewrote the questionnaire and put it in initial draft form.

❖ **Step 3**

We translated the questionnaire into the Arabic language and then submitted it to the Associate Professor of Linguistics for his criticism. He qualified from Edinburgh University 15 years ago, and has established several English Language programmes in different ministries in Saudi Arabia.

❖ **Step 4**

We submitted copies to several Professors of Psychology who qualified from universities in Great Britain or the United States of America. Some of them have extensive experience in the translating and establishment of

inventories and scales, and in certain cases their work is used widely in psychiatric clinics and hospitals. From the 20 copies of the questionnaire that we submitted, including both Arabic and English Versions, 7 copies were returned. Nearly all of the correspondents made useful suggestions including: The accurate identification of income bracket; and assessing the feasibility of applying a study concerned with sexual histories in a country like Saudi Arabia. Others offered minor corrections relating to the wording of the questions. One of them recommended the use of the GHQ Arabic version (Hasan, 1999), which is already translated and standardized in Arabic language as mentioned in step 1.

Taking the above into consideration, we revised the questionnaire.

- **Step 5**

We requested five friends and colleagues in Edinburgh who are studying for their PhDs to complete the questionnaire and to ascertain that it was clear and well ordered.

- **Step 6**

We then made a pilot study sending 2 copies to 40 Saudi and Arabic PhD and Master's students at Edinburgh, Heriot-Watt, and Napier Universities. One copy was to be completed by the respondent, and the other by his/her partner, meaning that 50% of respondents were male and 50% females. They were aged were between 20-40. 29 questionnaires were returned which gave a 74% response rate. Some of the respondents in

fact warned me of the difficulties associated with the inclusion of sexual questions in a questionnaire that is to be applied in Saudi, due to the sensitivity of the society.

On arriving in Saudi to conduct the study, the officials in the post offices and universities referred us to a committee, which is responsible for checking the questions before the conduct of a study. They informed us of the difficulties associated in allowing such direct, sexually related questions. We were informed that it was unlikely that the government would allow the study to proceed in its current form. We were advised to limit sexually related questions to one indirect question.

In accordance with their directives we changed the following five questions:

- Q45- "someone in my family tried to touch me in a sexual way, or tried to make me touch them".
- Q46-"Some in my family threatened to hurt me or tell lies about me unless I did something sexual with them".
- Q48- "someone tried to make me do sexual things or watch sexual things.
- Q49- someone molested me".
- Q52-"I believe that I was sexually abused".

To the indirect question below:

- "I was subjected to an immoral situation that has negatively affected my personality".

I then rewrote the questionnaire and distributed ten copies amongst friends, relatives, and colleagues in order that above question be subjected to their assessment. Six of the respondents took it refer to their being forced to touch someone in a sexual way. Four of them took it to mean being touched physically for sexual gratification. All of the respondents understood what I meant by this particular question.

Here is more detail regarding the final draft of the questionnaire:

2.4.1.2 Demographic and Background Data:

Background

The first part of the questionnaire consisted of questions about the demographic and background characteristics of the participants and their families, as follows: age, nationality, sex, father's age, mother's age, father's education, mother's education, siblings, social status and residence (see table 5). This was in order to explore some of epidemiological factors, which we believe could be related to child abuse.

Administration

We attempted to demographically categorise the population in a way that is useful to our understanding of child abuse, as follows: sex (male, female); age (18-20, 21-25, 26-30, 31-35, 36-40, and over 41); nationality (Saudi, non-Saudi); mother's age (30-40, 41-50, 51-60, and over 61);

father's age (30-40, 41-50, 51-60, and over 61); mother's job (employed, non-employed); father's job (employed, non-employed); siblings (none, under 2, between 2-5, 6-10, and more than 11), mother's education (illiterate, primary school, high school, university); father's education (illiterate, primary school, high school, university); income (less than usual, usual, more than usual); social status (live together, divorce/divorcee, and widow/widower); residence (urban, village, and Bedouin). While some questions seek information on the subjects themselves, others seek information about the subjects relatives and family background.

Table No (5) shows the frequency, and percentage, of demographic factors.

Question	Option	Frequency	%
Sex	Male	535	65
	Female	285	34.6
	Didn't mention	3	.4
Age	18-20	182	22.1
	21-25	363	44.1
	26-30	86	10.4
	31-35	74	9
	36-40	49	6
	Above 41	8	1
	Didn't mention	61	7.4
Nationality	Saudi	787	95.6
	Non-Saudi	24	2.9
	Didn't mention	12	1.5
Mother's Age	30-40	179	21.7
	41-50	319	38.8
	51-60	175	21.3
	Above 61	72	8.7
	Didn't mention	78	9.5
Father's Age	30-40	15	1.8
	41-50	263	32
	51-60	196	23.7
	Above 61	220	26.7
	Didn't mention	129	15.8
Mother's job	Employed	80	9.7
	Non-employed	627	76.2
	Didn't mention	115	14.1
Father's job	Employed	450	54.7
	Non-employed	200	24.3
	Didn't mention	173	21
Siblings	None	17	2.1
	Under 2	78	9.5
	2-5	244	29.6
	6-10	319	38.8
	Above 11	95	11.5
	Didn't mention	70	8.5
Income (parents)	Less than average	116	14.1
	Usual	461	56.0
	More than usual	217	26.4
	Didn't mention	29	3.5
Social Status (Parents)	Live together	655	79.6
	Divorce/divorcee	49	6.0
	Widow/widower	96	11.7
	Didn't mention	23	2.7
Residence	Urban	628	76.3
	Village	150	18.2
	Bedouin	27	3.3
	Didn't mention	18	2.2

2.5.1.3 General Health Questionnaire, GHQ 12

Background

The GHQ was designed by Goldberg (1978) to detect psychiatric disorders such as severe depression, social dysfunction, sleep disturbance, anxiety, and dysphoria in people in community and medical settings, using a self-report questionnaire. It is a shortened version of the well-validated full version, the GHQ 60 but is equally reliable (Goldberg, 1992). The split-half reliability in an English version was 0.83 and test-retest reliability was 0.73. In the original validation sensitivity was 93.5 per cent and the specificity in detecting cases of disorder only was 78.5 per cent (Goldberg, 1992). The GHQ has been translated into more than 16 languages including Arabic. Hasan (1999) produced a standardisation of the GHQ in Kuwait. She took two samples of university students and a pathological sample, and also made a comparison between GHQ and the Present State Examination (PSE). She found the GHQ has a high ability to distinguish the pathological cases from the non-pathological.

Administration

The administration of this part was according to the GHQ manual. The scale is self-administered using the instructions on the form, and takes about five minutes (Goldberg, 1978).

Scoring

Each item consists of 4 options, for example: not at all; more than usual; rather more than usual; and much more than usual. A minority of items

offer a slightly different set of options such as; better than usual; same as usual; less than usual; and much less than usual.

There are two scoring systems; GHQ scoring, where responses score 0, 0, 1 and 1 respectively; and Likert scoring which I chose here in this study as follows:

- Score 0 for the first option.
- Score 1 for the second option.
- Score 2 for the third option.
- Score 3 for the fourth option (see table 6).

Reliability of the GHQ

As mentioned in the GHQ's introduction, it was the best-validated, self-administrated measure for detecting psychiatric disorders in a British population and has also been validated and translated for other populations. Hasan (1999) translated it to an Arabic language used in a number of Arabic states practically in Arabic Gulf states. Internal consistency reliability coefficients for the entire the GHQ scale Arabic version were r=. 90. While Cronbach-alpha for each branch was as follows; anxiety r=. 88; sleeping disturbance r=. 83; depression r=. 88; general health r=. 75; psychosomatic r=. 75; and social functional disorder r=. 78.

Table (6) shows the frequency, percentage, mean, and standard deviation of GHQ12.

Question	Option	Freq	%	Mean	SD
Have you been able to concentrate on whatever you're doing?	Better than usual	56	6.7	1.76	.80
	Same as usual	224	27.2		
	Less than usual	405	49.3		
	Much less than usual	138	16.8		
Have you been lost much sleep over worry?	Not at all	169	20.6	1.42	.97
	No more than usual	255	30.9		
	Rather more than usual	280	34.2		
	Much more than usual	119	14.3		
Have you been felt that you are playing a useful part in things?	More so than usual	289	35.3	.80	.72
	Same as usual	431	52.2		
	Less useful than usual	80	9.7		
	Much less useful	23	2.8		
Have you been felt capable of making decisions about things?	More so than usual	258	31.6	.88	.75
	Same as usual	425	51.5		
	Less so than usual	113	13.6		
	Much less capable	27	3.3		
Have you been felt constantly under strain?	Not at all	116	14.1	1.69	.98
	No more than usual	212	25.8		
	Rather more than usual	300	36.5		
	Much more than usual	195	23.6		
Have you been felt you couldn't overcome your difficulties?	Not at all	201	24.7	1.19	.90
	No more than usual	330	39.9		
	Rather more than usual	221	26.9		
	Much more than usual	71	8.5		
Have you been able to enjoy your normal day-to-day activities?	More so than usual	78	9.4	1.53	.85
	Same as usual	349	42.6		
	Less so than usual	277	33.4		
	Much less than usual	119	14.6		
Have you been able to face up to your problems?	More so than usual	182	21.9	1.11	.82
	Same as usual	423	51.7		
	Less able than usual	163	19.6		
	Much less able	55	6.8		
Have you been feeling unhappy and depressed?	Not at all	215	26.2	1.33	1.03
	No more than usual	249	30.3		
	Rather more than usual	226	27.3		
	Much more than usual	134	16.2		
Have you been losing confidence in yourself?	Not at all	454	55.5	.71	.93
	No more than usual	197	23.2		
	Rather more than usual	122	14.9		
	Much more than usual	49	6.4		
Have you been thinking of yourself as a worthless person?	Not at all	558	67.9	.50	.83
	No more than usual	154	18.8		
	Rather more than usual	73	8.7		
	Much more than usual	38	4.6		
Have you been feeling reasonably happy, all things considered?	More so than usual	145	17.6	1.13	.76
	About same as usual	468	56.9		
	Less so than usual	164	19.9		
	Much less than usual	46	5.6		

2.4.1.4 psychological problems Scale

Background

We collected several questions from different scales in order to explore the various areas of personality disorder caused by child abuse:

- *Low self-esteem*: (Q13 & Q14) from (Rosenberg, 1965).
- *Dissociation*: (Q15 & Q16) from Vanderlinden et al (1993).
- *Post-traumatic Stress disorder, PTSD*: (Q17 & Q18) from Joseph et al (1997).
- *Self-harm: (Q19)* from First et al (1997).
- *Impulsiveness:* (Q20 & Q 21) from First et al (1997).
- *Eating Disorder: (Q22 & Q23)* from The Centre for Eating disorder. Com
- *Aggression:* from Briere & Runtz (1990).

Administration

This section consists of 13 questions (see table 7) intended to explore the several psychological problems mentioned earlier. The questions are related to the feelings of the subjects during the last few weeks including the day of testing.

Scoring

Each item consists of 2 options "Yes" and "No". The client is scored as follows:

- Score 0 if the client answers "NO".
- Score 1 if the client answers "Yes".

Reliability

The reliability coefficient for the psychological problems scale was r=. 65 according to Cronbach-alpha.

Table (7) shows the frequency, percentage, mean, and standard deviation of psychological problems scale.

Question	Option	Freq	%	Mean	SD
At times I think I am no good at all.	Yes	186	22.8	.220	.414
	No	637	77.2		
I take a positive attitude toward myself.	Yes	683	82.8	.166	.372
	No	140	17.2		
It happens that sometimes when I am listening to someone, and I suddenly realize that I have not heard part or the whole of the story.	Yes	253	30.9	.302	.459
	No	570	69.1		
Sometimes I suddenly notice that I find myself in a place that is unknown to me, without knowing how I got there.	Yes	164	20.3	.196	.397
	No	659	79.7		
I sometimes think it's not worth being a good person.	Yes	311	37.4	.375	.484
	No	512	62.6		
I have felt very little trust in other people now.	Yes	279	34.2	.338	.473
	No	544	65.8		
Have you ever cut, burned, or scratched yourself on purpose?	Yes	98	12.6	.115	.320
	No	725	87.4		
Have you often done things impulsively?	Yes	315	38.1	.379	.485
	No	508	61.9		
Do even little things get you angry?	Yes	598	72.5	.270	.444
	No	225	27.5		
I spent a significant amount of time thinking about food and when I will eat.	Yes	220	27	.263	.440
	No	603	73		
After I eat, I may use laxatives, diuretics, exercise, etc, to prevent weight gain.	Yes	122	15.0	.145	.352
	No	701	85.0		
I have got into a lot of physical fights.	Yes	95	11.8	.112	.315
	No	728	88.2		
Sometimes I am afraid I might hurt someone physically, without good reason.	Yes	122	15.0	.146	.353
	No	701	85.0		

2.4.1.5 Child Traumatic Questionnaire (CTQ)

Background

The CTQ is a 28-item (see table 8) self-report inventory that provides brief, reliable, and valid screening for histories of abuse and neglect. The CTQ is appropriate for adolescents (aged 12 and over) and adults. The CTQ inquires about five types of maltreatment emotional, physical, and sexual abuse, and emotional and physical neglect with five items representing each type. The CTQ also includes a 3-item minimization/Denial Scale for detecting false-negative trauma report (Bernstein & Fink, 1998).

Administration

The administration of this part was according to the CTQ manual (Bernstein & Fink, 1998).

Scoring

Each item consists of 5 options such as; never true; rarely true; sometimes true; often true; and very often true. The client is scored as follows:

- Score 0 for the first option.
- Score 1 for the second option.
- Score 2 for the third option.
- Score 3 for the forth option.
- Score 4 for the fifth option.

Reliability

Internal consistency reliability coefficients for the CTQ scale were computed with Cronbach-alpha for the entire validation sample. Reliability coefficients ranged from satisfactory to excellent, with the highest for the Sexual Abuse Scale, median=. 92 and the lowest for the Physical Neglect Abuse Scale, median=. 66.

Test-Retest: intraclass correlation between the first and second test were high: emotional abuse, r = .80; physical abuse. r = .80; sexual abuse, r = .81, emotional neglect, r = .81; physical neglect, r = .79; overall, r = .86. These results suggest that respondents' trauma reports on the CTQ are quite stable, even in a relatively uncontrolled setting and over a lengthy interval of time (Bernstein & Fink, 1998 p. 23).

Table (8)shows the frequency, percentage, mean, and standard deviation of CTQ.

Question	Never true	Rarely true	Sometimes true	Often true	Very often true	Mean	SD
I didn't have enough to eat.	690 83.4%	5 .9	6 .9	24 2.9%	98 11.9%	1.58	1.36
I knew that there was someone to take care of me and protect me.	101 12.3%	19 2.3%	6 .7%	5 .6%	692 84.1%	1.58	1.36
People in my family called me things like "stupid," "lazy," or "ugly.	487 59.2%	133 16.2%	120 14.6%	43 5.1%	40 4.9%	1.75	1.10
My parents were too drunk or high to take care of the family	674 81.9%	6 .7%	17 2.1%	26 3.2%	92 11.2%	1.60	1.35
There was someone in my family who helped me feel that I was important or special.	208 25.3%	140 16.7%	196 23.8%	131 16.2%	148 18.0%	3.16	1.43
I had to wear dirty clothes.	662 80.4%	9 .8%	25 2.8%	36 4.7%	91 11.3%	1.63	1.37
I felt loved.	271 32.9%	196 23.6%	168 20.8%	82 9.9%	106 12.8%	3.56	1.36
I thought that my parents wished I had never been born.	702 85.3%	49 5.8%	33 3.9%	20 2.6%	19 2.4%	1.28	.81
I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	665 80.8%	53 6.4%	39 4.7%	27 3.4%	39 4.7%	1.43	1.03
There was nothing I wanted to change about my family.	264 32.1%	107 13.0%	145 17.4%	97 11.7%	210 25.8%	2.85	1.61
People in my family hit me so hard that it left me with bruises or marks.	630 76.5%	78 9.5%	64 7.8%	23 2.8%	28 3.4%	1.45	.99
I was punished with a belt, a board, a cord, or some other hard object.	545 66.7%	99 12.0%	89 10.7%	35 3.9%	55 6.7%	1.71	1.20
People in my family looked out for each other.	418 50.8%	169 20.9%	98 11.8%	57 6.7%	81 9.8%	3.97	1.34
People in my family said hurtful or insulting things to me.	459 55.8%	154 18.9%	113 13.7%	51 6.1%	46 5.5%	1.82	1.16
I believe that I was physically abused.	638 77.5%	52 6.3%	38 4.6%	27 3.3%	29 3.5%	1.41	.99
I had the perfect childhood.	73 8.9%	93 11.1%	167 20.2%	215 26.1%	275 33.7%	3.65	1.29
I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor.	660 80.2%	69 8.4%	27 3.3%	20 2.4%	32 3.9%	1.38	.96
I felt that someone in my family hated me.	540 65.6%	86 10.7%	90 10.9%	32 3.9%	75 8.9%	1.75	1.25
People in my family felt close to each other.	413 50.0%	192 23.3%	91 11.1%	56 6.9%	73 8.7%	4.01	1.26
I had the best family in the world.	104 12.6%	89 10.8%	168 20.6%	177 21.4%	285 34.6%	3.56	1.39
I believe that I was emotionally abused.	524 63.7%	89 10.8%	92 11.2%	32 3.9%	51 6.2%	1.72	1.20
There was someone to take me to the doctor if I needed it.	72 8.9%	43 4.9%	75 8.7%	141 17.7%	492 59.8%	4.17	1.27
My family was a source of strength and support.	454 55.2%	157 19.1%	105 13.5%	51 6.0%	56 6.2%	4.18	1.17
I was subjected to an immoral situation that has negatively affected my personality. *	610 74.1%	51 6.2%	41 5.9%	27 3.3%	68 8.3%	1.61	1.25

* The five questions that originally dealt with sexual abuse were condensed to one in order to avoid offence.

2.5 Response Rates

There is no doubt that in general, research strategies in which there is direct contact between researcher and subject yield higher response rates than those in which the contact is indirect, e.g. postal surveys (Goldberg & William, 1988). Most researchers such as Bailey (1987) and Nachmias & Nachmias (1987) put their preferred high response rate at 75%, while others like Babbie (1979) state that a 50% response rate is acceptable. It is not surprising, then, that users of mailed questionnaires regard response rates of well below 50% as "acceptable" (Dillman, 1978). Abu Saleh & awd (1982) state 30-35% response rate in mailed questionnaires is very good.

We attempted to increase the response rate by taking several key steps as described below:

- Anonymity and confidentiality: this is an important issue. We designed a questionnaire without a field for the client name. We asked the client not write his or her name anywhere on the questionnaire (unless he/she wanted a result from the study when it is ready or for any other reason). The client was informed that we had not included any coding system from which they could be identified. The questionnaire was completely anonymous.
- Covering Letter: This included a plea for help, a request for a favour, stress on the social usefulness of the study, and the

importance of each respondent to the study's success.

- Attractive questionnaire layout: We tried to make the design clear, aesthetically pleasing in order to make the questionnaire more attractive. We used simple language and a clear font.
- Incentives: We provided each client with a stamped addressed envelope and pledged that a copy of the survey results would be made available upon completion.
- Shorter questionnaire: 6 months was spent seeking the shortest possible effective questionnaire, in the belief that in a sensitive questionnaire of this sort the response rate would be low particularly if the questionnaire was lengthy. The final questionnaire contained only 49 questions and took between 15-20 minutes to complete.
- In addition, the questionnaire was printed only on one side of A4 paper with good quality paper and standard headings.

As mentioned at the beginning of this chapter, we sent 800 copies of the questionnaires to students in three universities, and 1000 copies to householders. The total number of respondents was 823 representing an overall response rate of 46%.

2.6 Statistical Analysis:

Statistics is the name given to the mathematics of organizing and interpreting numerical information (Fink, 1995). The statistical analysis

was performed using SPSS for windows, V10.01. SPSS was a set of computer programs that enable the researcher to perform a variety of statistical analyses such as T-Test, Correlation, Regression, Frequencies, Descriptives and Graphs (Hedderson, 1986). There was also another sophisticated statistics programmed called EQS that was used in this study in order to see the direct impact of child abuse, and epidemiological factors on a range of psychological problems.

Chapter 7. Results

Overview: This chapter consists mainly of results with a brief discussion. A fuller discussion will follow in later chapters.

7.1 Description Of Data

7.1.1 Participants

The following tables contain a description of the general characteristics of the whole sample, which includes students and households grouped together, students as a separate sample and households as a separate sample.

Approximately two thirds of the whole sample (65%) were male (see table 9). 66.9% of the students and 61.8% of the householders sampled were male. There were students who did not reveal their sex (.6%), though they otherwise completed their questionnaires.

Table (9) shows the composition of the sample groups by gender.

Sample	Gender	Frequency	%
Households & Students	Male	535	65.0
	Female	285	34.6
	Didn't mention	03	.4
Students	Male	347	66
	Female	169	33
	Didn't mention	3	1
Households	Male	188	61.8
	Female	116	38.2
	Didn't mention	00	00

44.1% of the males were aged between 21-25 (see table 10). It is not surprising that the majority of the sample fall into that category because

60.5% of sample were students and this is the normal age of undergraduate students.

Table (10) shows the age groups included in the sample.

Sample		18-20	21-25	26-30	31-35	35-40	Above 41	Didn't mention
Households & Students	*Frq	182	363	86	74	49	8	61
	%	22.1	44.1	10.4	9	6	1	7.4
Students	*Frq	155	314	11	5	1	00	33
	%	29.8	60.5	2.1	1.0	.2	00	6.4
Households	*Frq	27	49	75	69	48	8	28
	%	8.9	16.1	24.7	22.7	15.8	2.6	9.2

**Frq=Frequency*

The latest statistics for population and housing published by the Saudi Ministry of Planning in (1992) show that 15.4% of the whole population at that time were aged between 5 and 10, with 14.6% falling into the 0-4 category (see table 11). It is those who fell into the 5-10 age group in 1992 that form part of my sample for this study. Roughly two-thirds of the whole population 66.2% are aged between 18-25, while 7.4% of the participants did not clarify their age.

More than half of the sample (56% - consisting of 26.8% students; and 25.7% households) came from the middle classes, while 26.4% (entire sample); 26.8% (students); and 25.7% (households) came from the upper classes, and 15.1% (entire sample), 12.5% (students); and 16.21% (households) came from the lower classes (see table 12).

Table (11) shows the population of Saudi Arabia by age-group, sex and nationality.

Age Groups	Saudi			Non-Saudi			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Less than 1y	237710	232974	470684	46223	43663	89886	283933	276637	560570
1-4	1104861	1063699	2168560	193869	199629	393498	1298730	1263328	2562058
5-9	1163561	1123187	2286748	216099	223397	439496	1379660	1346584	2726244
10-14	988067	961877	1949944	153425	157233	310658	1141492	1119110	2260602
15-19	808253	816754	1625007	92551	100330	192881	900804	917084	1817888
20-24	598377	686072	1284449	256325	122859	379184	854702	808931	1663633
25-29	521038	552053	1073091	592822	184437	777260	1113861	736490	1850351
30-34	430419	442178	872597	618112	272740	890852	1048531	714918	1763449
35-39	365224	369260	734484	497163	171424	668587	862387	540684	1403071
40-44	288766	290278	579044	323101	86659	409760	611867	376937	988804
45-49	214903	219356	434259	174921	43996	218917	389824	263352	653176
50-54	165189	173671	338860	96159	27677	123836	261348	201348	462696
55-59	128037	141947	269984	42742	12400	55142	170779	154347	325126
60-64	100984	112778	213762	23208	11440	34648	124192	124218	248410
65-69	127517	91576	219093	11484	7978	19462	139001	99554	238555
70-74	87628	55014	142642	4751	3791	8542	92379	58805	151184
75-79	55654	32960	88614	2334	2727	5061	57988	35687	93675
80-84	34405	26862	61267	1539	866	2405	35944	27728	63672
85 and more	36757	22958	59715	947	1406	2353	37704	24364	62068
Total	7457350	7415454	14872804	3347776	1674652	5022428	10805126	9090106	19895232

Table (12) shows the sample distribution according to income.

Sample	Income	Frequency	%
Households & Students	More than average	217	26.4
	Average	461	56.0
	Less than average	116	14.1
	Didn't mention	29	3.5
Students	More than average	139	26.8
	Average	302	58.2
	Less than average	65	12.5
	Didn't mention	13	2.5
Households	More than average	78	25.7
	Average	159	52.3
	Less than average	51	16.8
	Didn't mention	16	5.2

Roughly 38.8% of the total sample have between 6-10 siblings, 47.7% among households, and 33.5% among students and 8.5% of the clients did not answer this question (see table 13). As can be seen from the table, households seem to have a larger number of siblings in comparison with students. The average number of siblings among students was 3-5. Students have fewer siblings than households because their parents have a lower average age than those of householders.

Table (13) shows the distribution of siblings.

Sample		None	1-2	3-5	6-10	Above 11	Didn't mention
Households & Students	*F	17	78	244	319	95	70
	%	2.1	9.5	29.6	38.8	11.5	8.5
Students	F	13	69	186	174	37	40
	%	2.5	13.4	35.8	33.5	7.1	7.7
Households	F	4	9	58	145	58	30
	%	1.3	3.0	19.1	47.7	19.0	9.9

**F=Frequency*

7.1.2 The Parents:

Table (14) shows the age distribution of the mothers and fathers in the sample. Roughly one-third, (32% of fathers, and 38.8% of mothers) in the sample were aged 41-50. When we combine the mothers and fathers together 70.8% fall into this category. This high percentage is attributable to the fact that 85% of the parents of the subjects in the student sample fall into that category. As can be seen from the table there are 130

(15.8%) females and 78 (9.5%) males who did not provide data on their parents. It is likely that this is due to their having died, and their son or daughter finding it in bad taste to mention this. However, some clients did comment that a parent had died, and as such they felt that questions regarding them were rendered obsolete.

Table 14 shows the age distribution of parents in the sample.

		30-40		41-50		51-60		Above 61		Didn't mention	
		M	F	M	F	M	F	M	F	M	F
Households & Students	*Frq	179	15	319	263	175	195	72	220	78	130
	%	21.7	1.8	38.8	32.0	21.3	23.7	8.7	26.7	9.5	15.8
Students	*Frq	145	10	234	207	90	146	12	97	38	59
	%	27.9	1.9	45.2	39.9	17.3	28.1	2.3	18.7	7.3	11.4
Households	*Frq	34	5	85	56	85	49	60	123	40	71
	%	11.1	1.6	28.0	18.4	28.0	16.1	19.7	40.5	13.2	23.4

**Frq=Frequency*

Roughly half of the mothers sampled were illiterate (see table 15). This percentage was quite high among mothers in households (68.4%), and decreased in the student sample (37.4%).

Table (15) shows the level of education among mothers & fathers in the sample.

Sample		Illiterate		Primary		High School		University		Didn't mention	
		M	F	M	F	M	F	M	F	M	F
Households & Students	*Frq	402	234	213	214	103	164	93	186	12	25
	%	48.8	28.5	25.9	26.0	12.5	19.9	11.3	22.6	1.5	3.0
Students	*Frq	194	125	148	108	90	119	81	152	6	15
	%	37.4	24.1	28.5	20.8	17.3	22.9	15.6	29.3	1.2	2.9
Households	*Frq	208	109	65	106	13	45	12	34	6	10
	%	68.4	35.9	21.4	34.9	4.3	14.8	3.9	11.2	2.0	3.3

Table (16) shows that more than two-thirds, (79.6%) of parents in the sample were living together, while a small group (11.7%), were widows or widowers, and 6.0% were divorcees.

Not surprisingly, the majority of the mothers sampled (76.2%) were unemployed (housewives) while 9.7% were employed (see table 17). 14.1% of the overall sample was missing.

Table (16) shows the distribution of social status among parents in the sample.

Sample		Living Together	Divorce	Widow/ Widower	Didn't mention
Households & Students	*Frq	655	49	96	23
	%	79.6	6.0	11.7	2.7
Students	Frq	440	26	44	9
	%	84.8	5.0	8.5	1.7
Households	Frq	215	23	52	14
	%	70.7	7.6	17.2	4.5

**Frq=Frequency*

Table (17) shows distribution of types of employment undertaken by mothers.

Variables	Mother's job	N	%
Households & Students	Employed	80	9.7
	Unemployed	627	76.2
	Didn't mention	116	14.1
Students	Employed	71	14.0
	Unemployed	375	71.9
	Didn't mention	73	14.1
Households	Employed	2	.7
	Unemployed	259	85.2
	Didn't mention	43	14.1

Table (18) shows distribution by employment type of fathers sampled.

Variables	Father's job	N	%
Households & Students	Employed	459	54.7
	Unemployed	200	24.3
	Didn't mention	164	21.0
Students	Employed	115	22.0
	Unemployed	314	60.0
	Didn't mention	90	18.0
Households	Employed	87	28.6
	Unemployed	137	45.1
	Didn't mention	80	26.3

Table (18) shows that 54.7% of the entire sample their fathers were employed, while 24.3% were unemployed, and 21.0% were missing.

Table (19) shows that 76.3% of the entire sample inhabit urban areas, while 18.2% come from villages, and 3.3% were Bedouin.

Table (19) shows distribution of location of parents sampled.

Sample		Urban	Village	Bedouin	Didn't mention
Households & Students	*Frq	628	150	27	18
	%	76.3	18.2	3.3	2.2
Students	Frq	398	96	15	10
	%	76.7	18.5	2.9	1.9
Households	Frq	230	54	12	8
	%	75.7	17.8	3.9	2.6

**Frq=Frequency*

Conclusions from descriptive data

The sample was considered in three groupings; students, households and students and households together. 65% of the whole sample was male and 34.6% was female, while 66.9% of the student sample was male and 32.6% was female. Among the householders sampled 61.8% were male and 38.2% were female.

44.1% of the total sample were aged 20-25, as were 60% of students sampled. This in fact reflects the normal age distribution for undergraduate students, and is why the 20-25 age bracket seems to dominate the sample, in spite of 24.7% of the householders sampled being aged 26-30.

56% of the total sample came from the middle class, 58.2% of the student sample and 52.3% of households also came from the middle class.

38.8% of the entire sample have 6-10 siblings, 47.7% of the households fall into the same range, while 35.8% of the student sample have less than that number, i.e. 3-5.

In the entire sample 38.8% of the subjects' mothers and 32% of their fathers were aged 41-50. The distribution of the ages of the mothers and fathers of the subjects in the household sample is different: 40.5% of fathers have passed sixty and 28% mothers fall into the ranges 41-50 and 51-60. Half of the mothers of the entire sample were illiterate; two-thirds of the subjects' mothers in the household sample were illiterate; as were

37.4% of the mothers' of those in the student sample. 28.4% of the fathers' of the entire sample were illiterate; 35.9% of the fathers of the household sample were illiterate and 29.3% of the fathers of the student sample had no university qualifications. 79.6% of the subjects' parents were living together; 84.8% among students, and 70.7 among households.76.2% of the mothers of the entire sample were housewives, 83.2% in the household sample and 72.1% in the student sample. 76.3% of the entire sample lived in an urban situation, 18.2% in villages, and 3.3% were Bedouins.

7.2 Cut-off Points

As mentioned earlier in the chapter on methods (building the questionnaire), the survey questionnaire was divided into different types of questions: epidemiological questions that explore the phenomena behind abuse; questions on psychological problems; and questions on child abuse which were designed to explore the different types of child abuse. In some cases several questions were deemed necessary to adequately explore each topic:

I combined GHQ12 questions to one summary variable and called it "TotGHQ".

I combined dissociation from two questions to one summary variable and called it "TotDiss".

I combined PTSD from two questions to one summary variable and called it "TotPTSD".

I combined impulsiveness from two questions to one summary variable and called it "TotImp".

I combined low self-esteem from two questions to one summary variable and called it "TotSelfe".

I combined eating disorders from two questions to one summary variable and called it "TotEatdi"

I combined aggression from two questions to one summary variable and called it "TotAggre".

I combined physical abuse from five questions to one summary variable and called it "TotPhyAb".

I combined emotional abuse from five questions to one summary variable and called it "TotEmoAb".

I combined physical neglect from four questions to one summary variable and called it "TotPhyNe".

I combined emotional neglect from five questions to one summary variable and called it "TotEmoNg" (see tables 20, 21).

Table (20) shows minimum, maximum, mean and standard deviations for those questions that were combined.

Items	N	Minimum	Maximum	Mean	SD
Emotional Abuse	823	.00	18.00	3.32	3.8
Physical Abuse	823	.00	20.00	2.39	3.7
Emotional Neglect	823	.00	21.00	13.97	4.6
Physical Neglect	823	.00	17.00	2.41	5.2
Low self-esteem	822	.00	2.00	.38	.55
PTSD	822	.00	2.00	.62	.66
Impulsiveness	821	.00	2.00	.65	.66
Eating Disorder	820	.00	2.00	.41	.56
Dissociation	820	.00	2.00	.50	.60
Aggression	821	.00	2.00	.26	.50
Psychological Distress	823	00	34.15	14.64	6.03

Table (21) shows comparison between means for student (male & female) and households (male & female).

Item	Households N=304				Students N=519			
	Male		Female		Male		Female	
	N	Mean	N	Mean	N	Mean	N	Mean
Emotional Abuse	188	3.13	116	3.44	347	2.29	169	3.54
Physical Abuse	187	2.30	116	2.04	347	2.80	169	1.89
Emotional Neglect	188	14.14	116	13.48	347	13.87	169	14.51
Physical Neglect	188	2.01	116	1.01	347	3.02	169	2.54
Low self-esteem	188	.30	116	.36	347	.38	169	.50
Eating Disorders	188	.38	116	.40	347	.42	168	.43
Impulsiveness	187	.93	116	.84	347	.58	168	.36
PTSD	188	.67	116	.56	345	.60	168	.65
Aggression	188	.17	116	.27	345	.30	168	.25
Dissociation	188	.54	116	.46	347	.44	168	.59
Psychological Distress	188	13.33	116	16.13	345	13.66	169	16.94

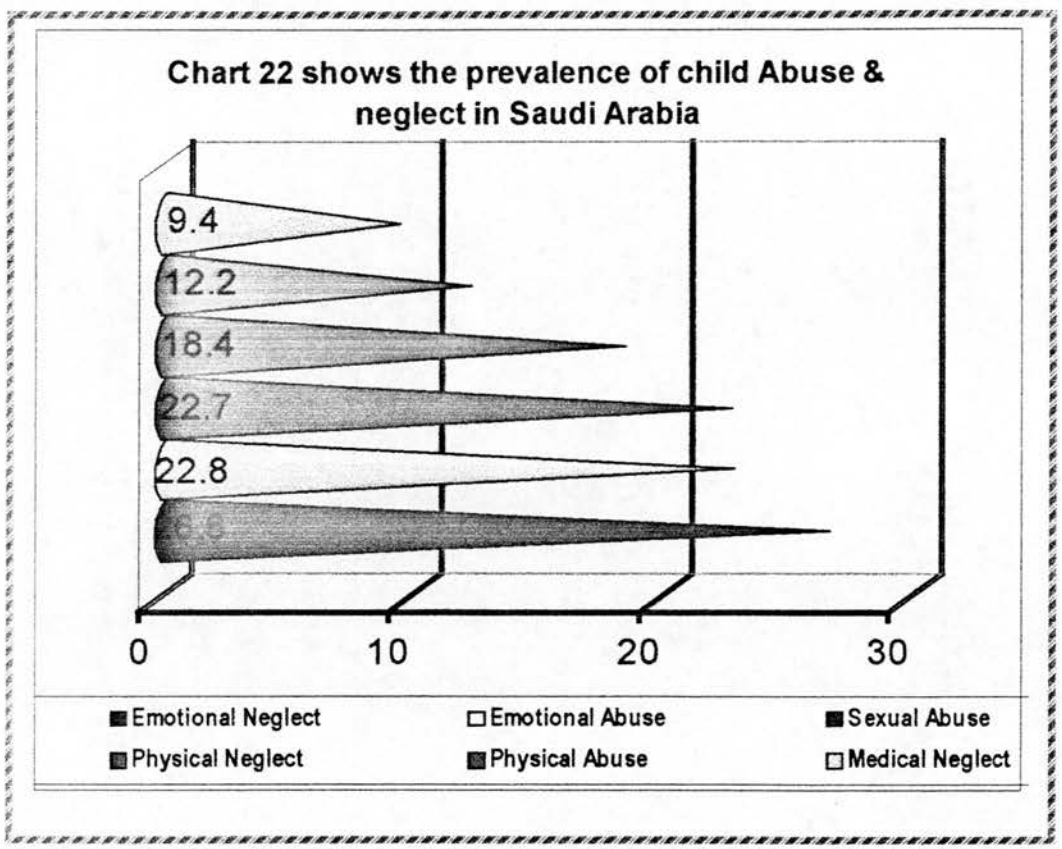
7.3 Description of abusers in Saudi Arabia

As discussed in the previous chapter, the last part of the questionnaire (CTQ) had five possible answers; *never true, rarely true, sometimes true, often true* and *very often true*. The value of each item ranges from 1 to 5 or from 5 to 1. Scale total scores range from 5 to 25 and this is applied for physical abuse, emotional abuse, and emotional neglect. More specifically, cut-off scores have been set for each type of trauma at 4 levels of maltreatment: *none (or minimal)* if the score was between 5-8; *low (to moderate),* if the score was between 9-12; *moderate (to severe)* if the score was between 13-15, and *severe (to extreme)* if the score was ≥16 (Bernstein & Fink, 1998). Other forms of child abuse and neglect, such as sexual abuse and medical neglect, have one only one question each, while others like physical neglect have 4 questions. The higher the score, the greater the severity of abuse and neglect.

In this study, we considered '*rarely true*' to be unsuitable for inclusion as an option, except in response to questions on sexual abuse, in order to reduce the likelihood of victims believing that occasional abuse is not worthy of consideration. Also, it is believed that 'rarely true' in the case of sexual abuse has a greater impact than a more frequent occurrence of other types of abuse and neglect.

Before discussing each type of child abuse and neglect, I should clarify the prevalence of child abuse and neglect in Saudi Arabia.

Chart (22) shows that child emotional neglect came first (26.6%), then child emotional abuse (22.8%), then child sexual abuse (22.7%), then child physical neglect (18.4%), then child physical abuse (12.2%), and finally medical neglect (9.4%).



Before discussing the prevalence of any type of child abuse or neglect I have to mention that missing data indicates those clients who did not answer a question at all. Therefore, they had no bearing on the assessment of the prevalence of child abuse and neglect.

The distribution of types of child abuse and neglect in Saudi Arabia was found to be as follows:

- Child emotional abuse: The prevalence of child emotional abuse in the total Saudi Arabia society was 22.8% (see chart 23). The prevalence of emotional abuse among students was 21.3% (see chart 23, top left) while it was 23.1% among households (see chart 23, top right).

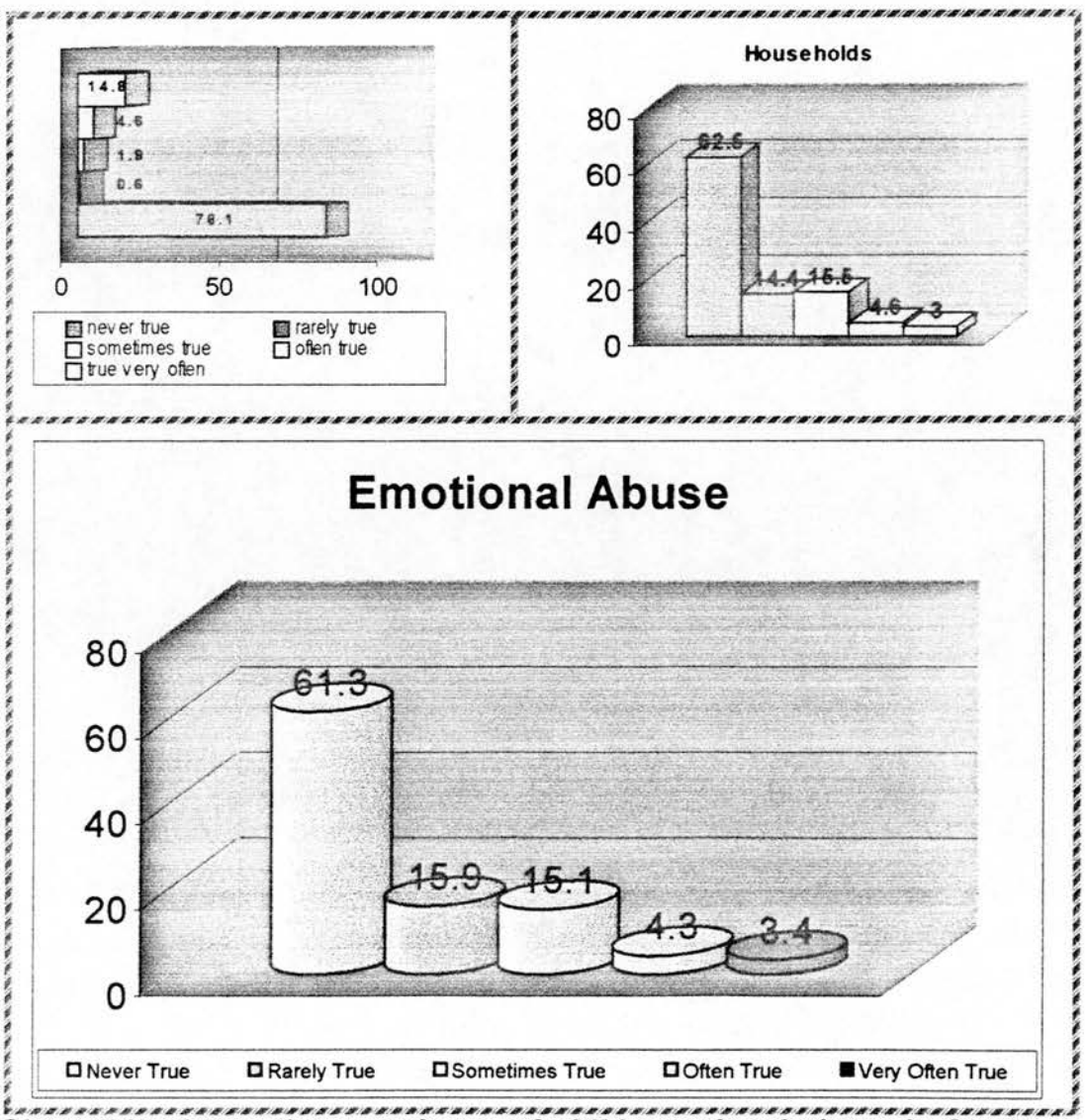


Chart (23) shows the prevalence of child emotional abuse in Saudi Arabia entire sample (students in the top left and households in the top right).

- Child sexual abuse - The prevalence of child sexual abuse in Saudi Arabia was 22.7 % (see chart 24). The prevalence of sexual abuse among students was 27.2% (see chart 24, top left) and 14.7% among households (see chart 24, top right).

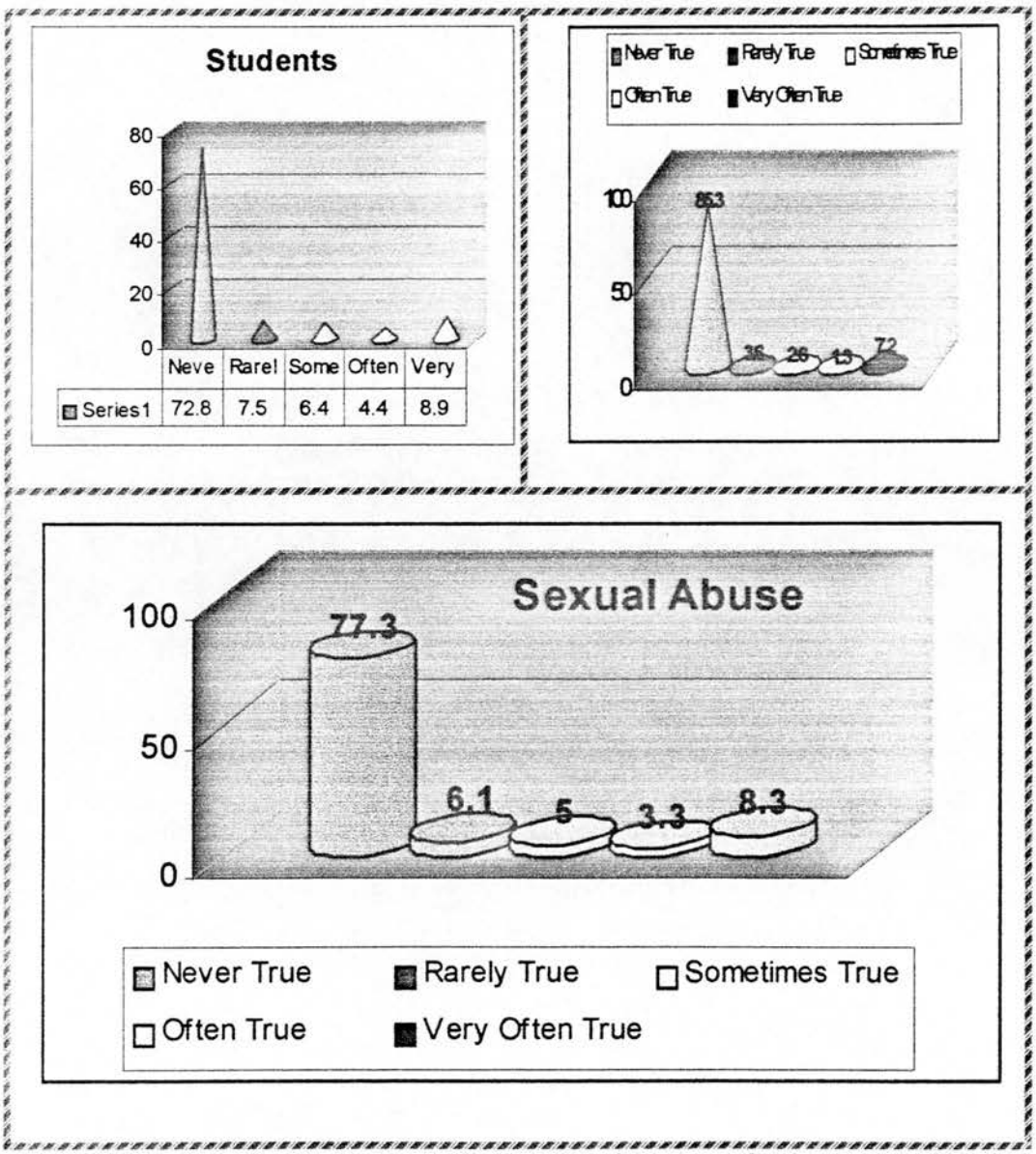


Chart (24) shows the prevalence of child sexual abuse in Saudi Arabia entire sample (students in the top left and households in the top right).

- Child physical abuse: The prevalence of child physical abuse in Saudi Arabia was 13% (see chart 25). The prevalence of physical abuse among students was 12.3% (see chart 25, top left) while it was 12.2% among households (see chart 25, top right).

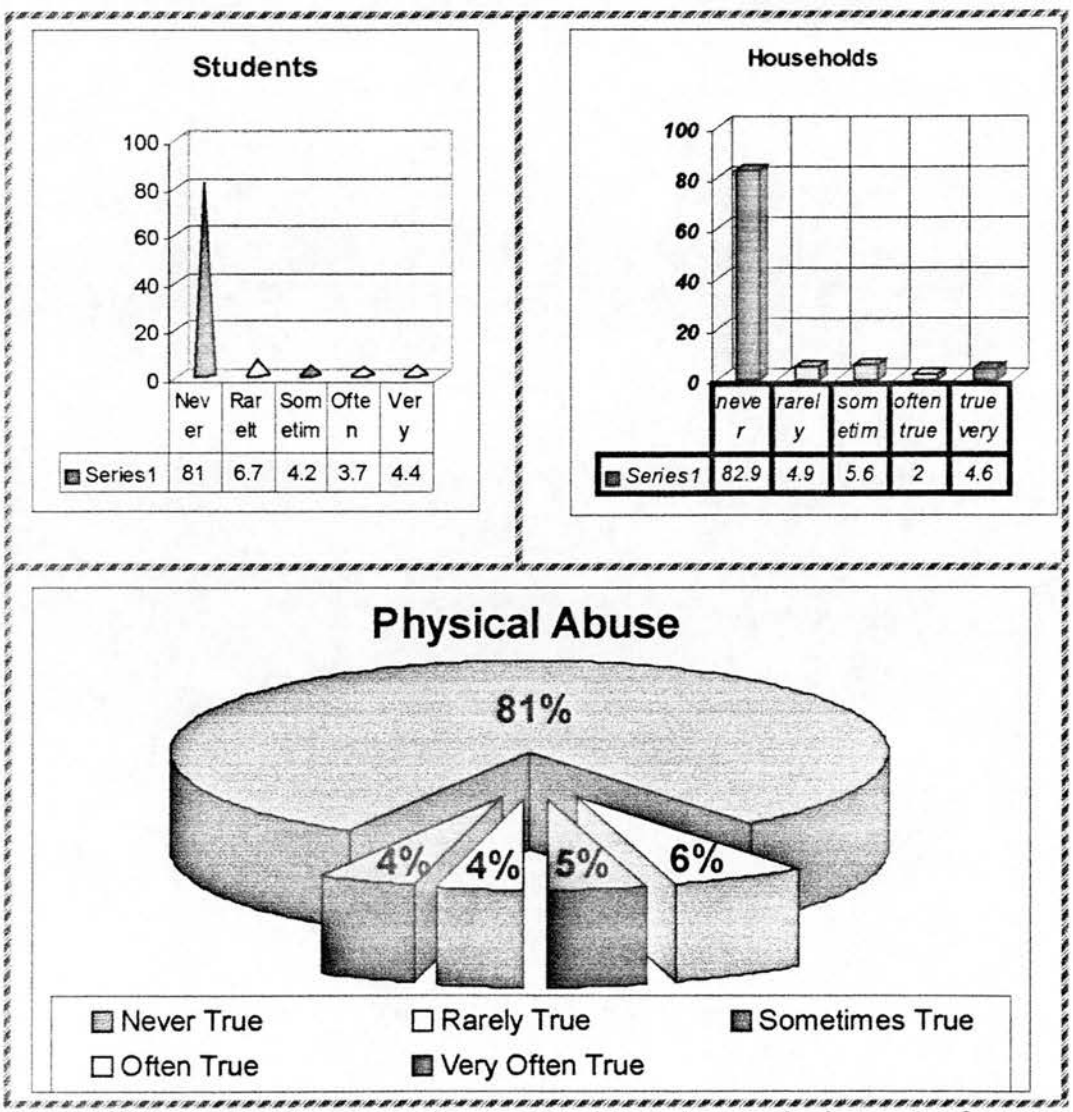


Chart (25) shows the prevalence of child physical abuse in Saudi Arabia entire sample (students in the top left and households in the top right).

- Child emotional neglect: The prevalence of child emotional neglect in Saudi Arabia was 26.6% (see chart 26). The prevalence of emotional neglect among students was 25.4% (see top left chart 26), and 27.3% among households (see top right chart 26).

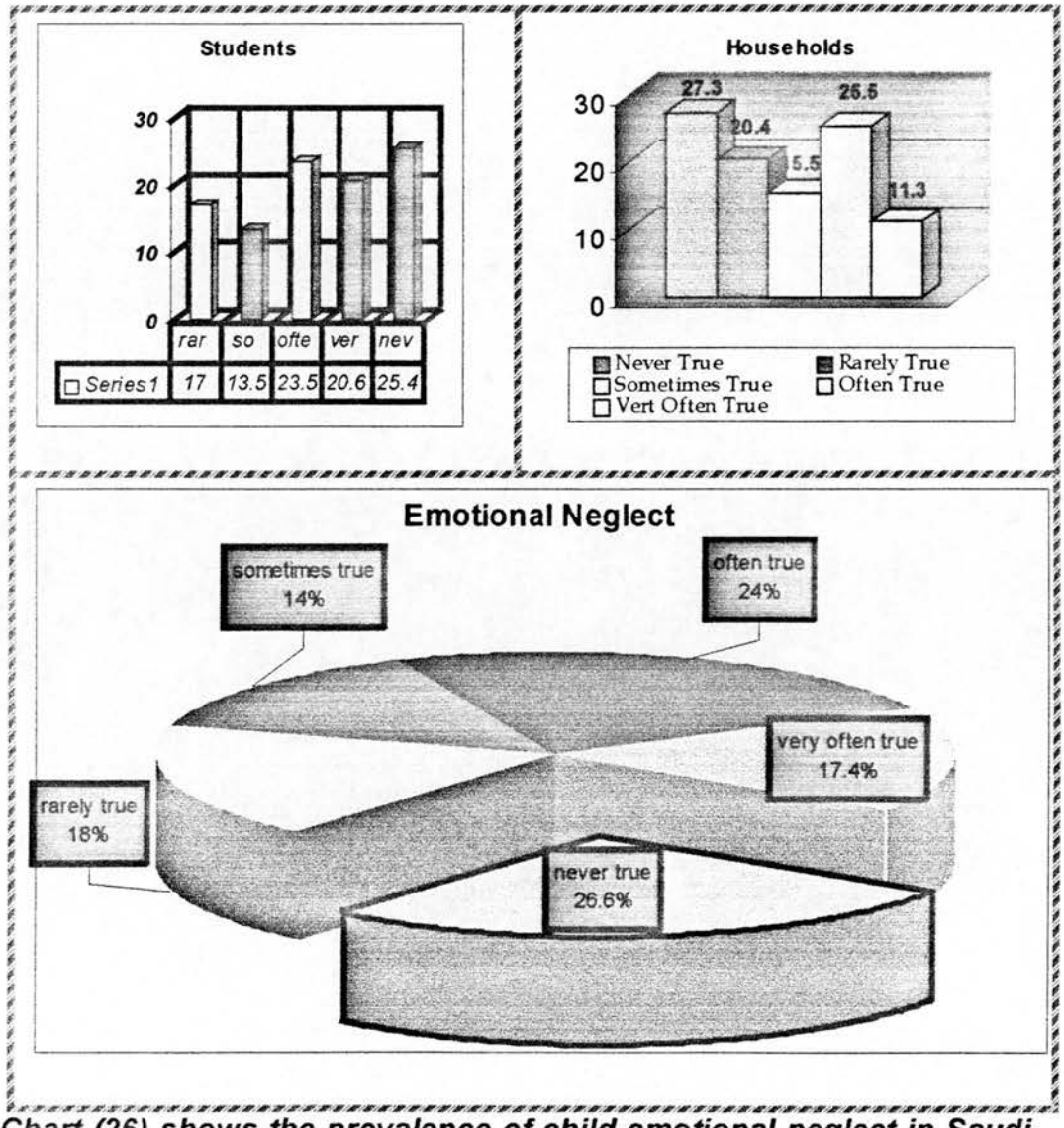


Chart (26) shows the prevalence of child emotional neglect in Saudi Arabia entire sample (students in the top left and households in the top right).

- Physical child neglect - The prevalence of child physical neglect in Saudi Arabia was 18.4% (see chart 27). Among students the prevalence was 21.1% (see top left chart 27), and 13.5% among households (see top right chart 27).

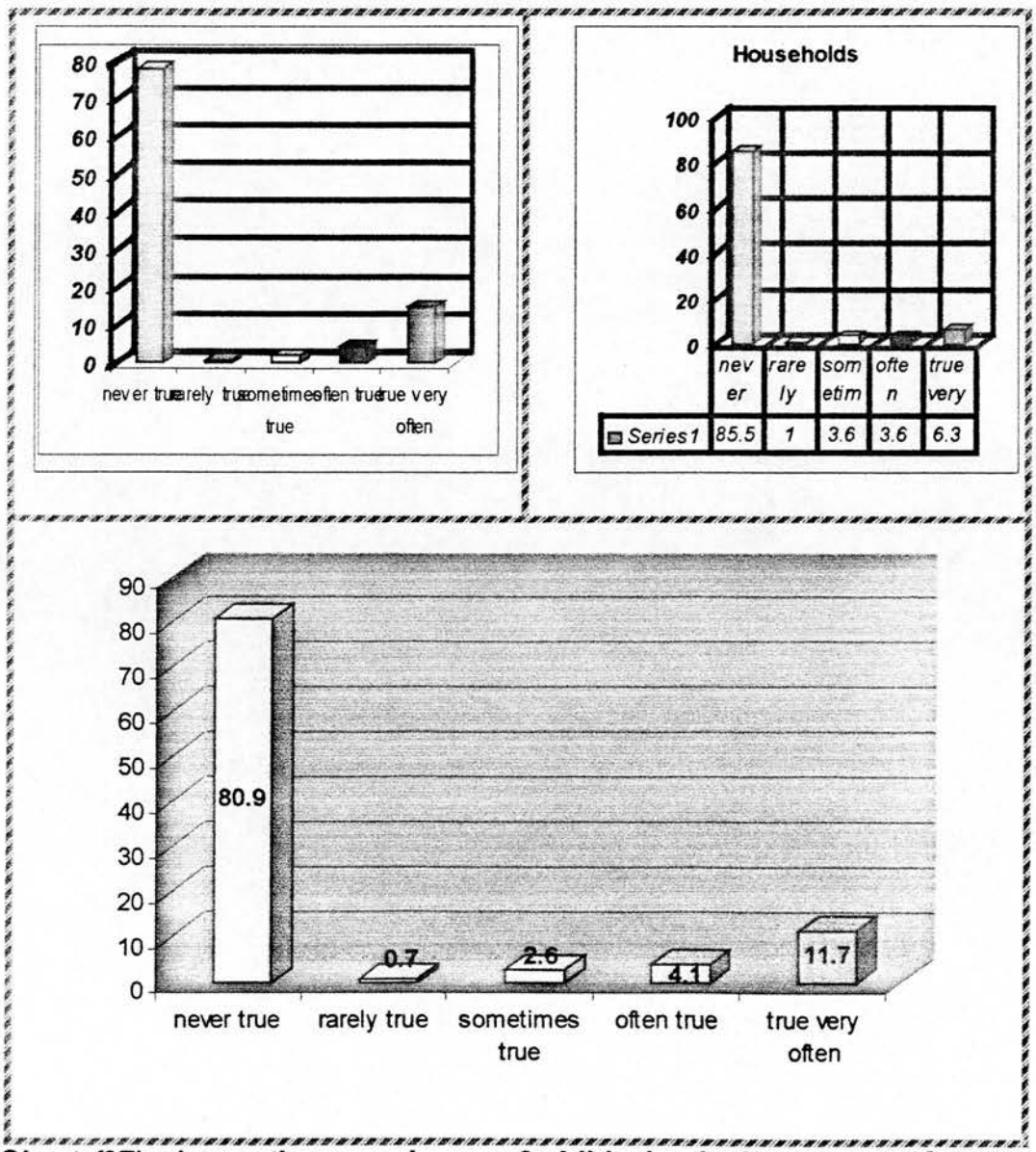


Chart (27) shows the prevalence of child physical neglect in Saudi Arabia entire sample (students in the top left and households in the top right).

- Child medical neglect: The prevalence of child medical neglect was 9.4% - (see chart 28) - 6.6% among students (see top left chart 28), and 14.5% among households (see top right chart 28).

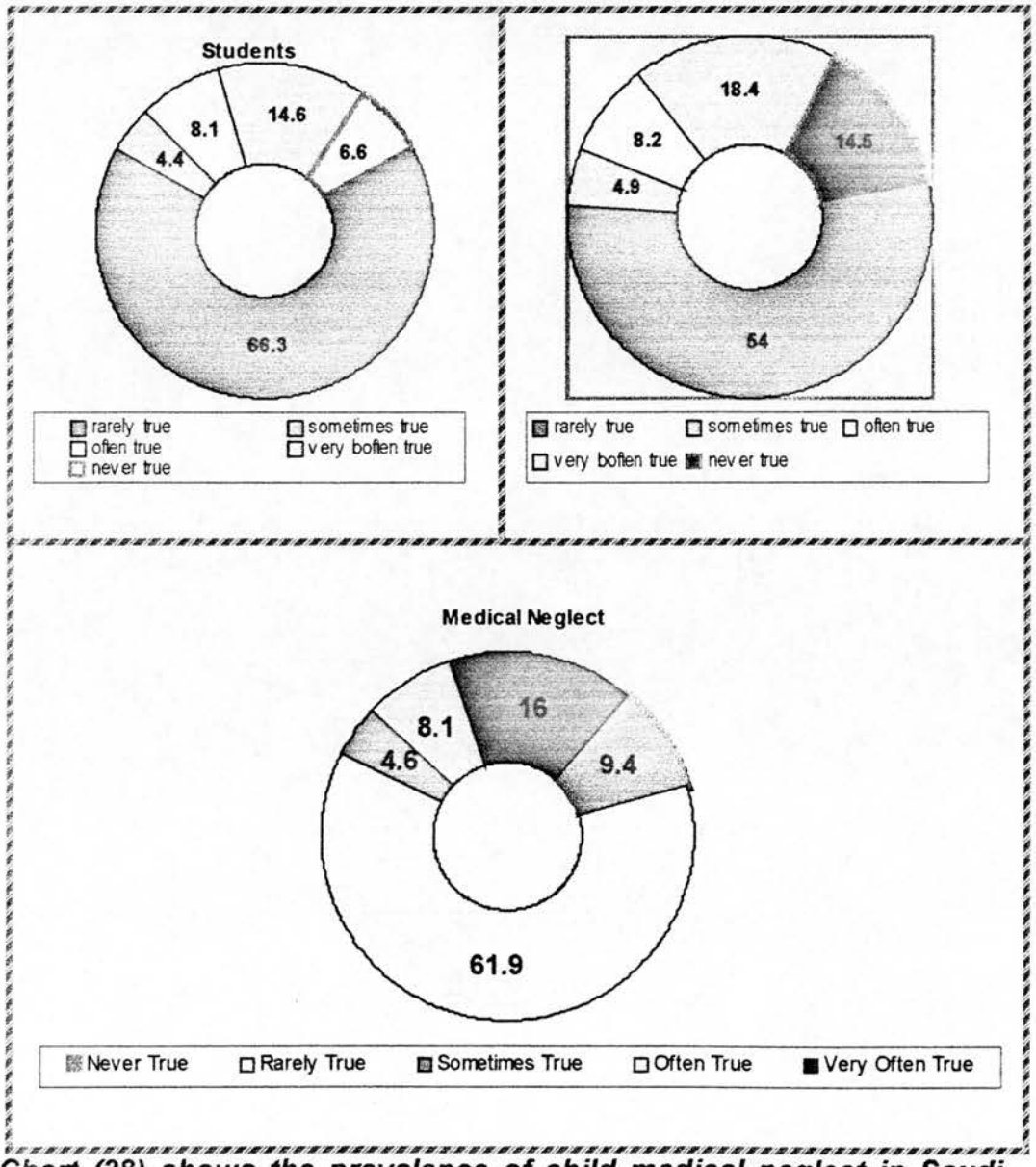


Chart (28) shows the prevalence of child medical neglect in Saudi Arabia entire sample (students in the top left and households in the top right).

In the coming pages we are going to look at the perpetrators of abuse, and the age at which children are abused:

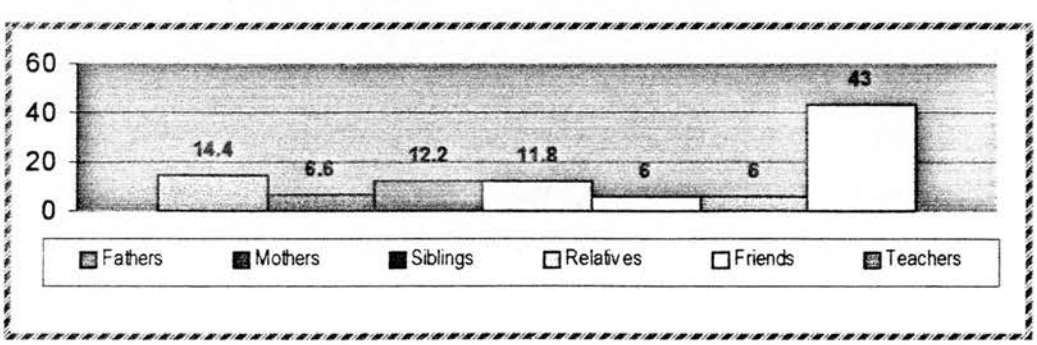
14.4% of the entire emotional abused sample said that they had been abused emotionally by their fathers (15.3% among students and 13.8% among households.) The second perpetrators were siblings 12.1%. The third category was relatives 11.8% entire sample, 12.6% students, and 11.2 households. Mothers, friends, and teacher each of them had 6% (see table 29 and chart 30). It will be noted here that 43% did not mention who abused them emotionally. It could be that the abuser is close to them and as such they failed to name them because of this close emotional bond.

Table (29) Distribution of the relationship of the emotional abuser to their victim in Saudi Arabia.

Sample		F	Mo	S	R	F	T	Didn't Mention
Households & Sample	F	50	23	42	41	21	21	150
	%	14.4	6.6	12.2	11.8	6	6	43
Students	F	34	7	28	28	12	15	98
	%	15.4	3.5	12.7	12.6	5	6.8	44
Households	F	16	6	14	13	9	6	52
	%	13.8	5.2	12.1	11.2	7.7	5.2	44.8

F=father. Mo=mother. S=siblings. R=relatives. F=friends. T=teachers.

Chart (30) shows emotional abuser in Saudi Arabia.



27.3% of the entire emotional sample said that they had received emotional abuse aged between 11-15, while it was 29.7% among students and 23.8% among households followed by the 6-10 year old 19.2% for entire sample, 19.3% for students and 19% for households. The third category was above 15 years, which is 12% for entire, 12.2% for students, and 11.9% for households. Only 2.3% reported they received emotional abuse under the age of 5 years (see table 31 and chart 32).

Table (31) the distribution of victims of emotional abuse by age.

Sample		Under 5y	6-10y	11-15y	Above 16y	Didn't mention
Households & Sample	F	8	67	96	42	135
	%	2.4	19.3	27.5	12	38.8
Students	F	4	43	66	27	82
	%	1.8	19.3	29.7	12.2	37
Households	F	4	24	30	15	53
	%	3.1	19.2	23.8	11.9	42

Chart (32) the age of victims of emotional abuse.

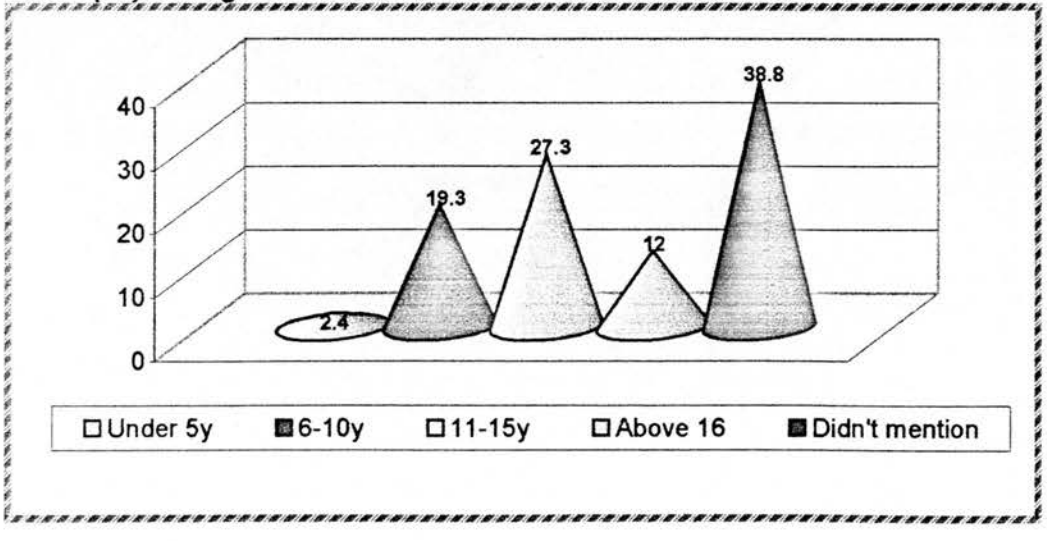


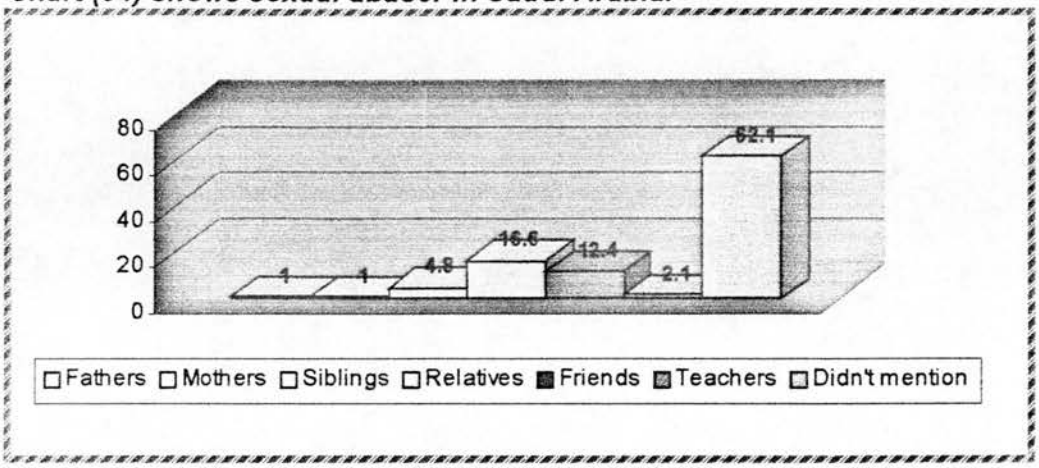
Table (33) and chart (34) shows the perpetrators of sexual abuse in Saudi Arabia. In spite of the 77% of the entire sample did not answer the question that deal with sexual abuse and in spite also 62.1% failure rate in answering the perpetrators of sexual abuse, 16.6% of those who answered reported that they had been sexually abused by a relative, nearly the same rate among students 16.2% and little bit high among households 17.8%. The second category was friends, 12.3% for the entire sample, 13.4% among student, and 8.8% among households. Siblings were the third category, which was 4.8% for entire sample, 4% among students, and 6% among households. Not surprisingly, only 1% of mothers and the same number of fathers admitted to performing sexual acts with their children. It is totally not acceptable to see parents doing sexual things with their children unless they were drunk. 62.1% of the entire sample refused to answer this question.

Table (33) shows the perpetrators of sexual abuse in Saudi Arabia.

Sample		F	Mo	S	R	Fr	T	Didn't mention
Households & Sample	F	2	2	9	31	23	4	116
	%	1	1	4.8	16.6	12.4	2.1	62.1
Students	F	2	2	6	23	19	3	87
	%	1.4	1.4	4	16.2	13.6	2.1	61.3
Households	F	0	0	3	8	4	1	29
	%	0	0	6	17.8	8.8	2.7	64.7

F=father. Mo=mother. S=siblings. R=relatives. Fr=friends. T=teachers.

Chart (34) shows sexual abuser in Saudi Arabia.



23% of those people who received sexual abuse in their childhood said they faced it when they were between 6-10 years (this is for the entire sample) with 19.7% for students and 33.3% for the households, while 19.8% received it when they were between 11-15 years for entire sample, 19% for students and 22.2% for households. The third category was above 16 years old, which the entire sample were 12.8%, students sample were 12.7% and households were 13.3%. Only 3.2% were under 5 years (see table 35 and chart 36).

Table (35) shows the age distribution of victims of sexual abuse.

Sample		Under 5y	6-10y	11-15y	Above 16y	Didn't mention
Households & Sample	F	6	43	37	24	77
	%	3.2	23	19.8	12.8	41.2
Students	F	3	28	27	18	66
	%	2.1	19.7	19	12.7	46.5
Households	F	3	15	10	6	11
	%	6.7	33.3	22.3	13.3	24.4

Chart (36) shows the age of victims of sexual abuse.

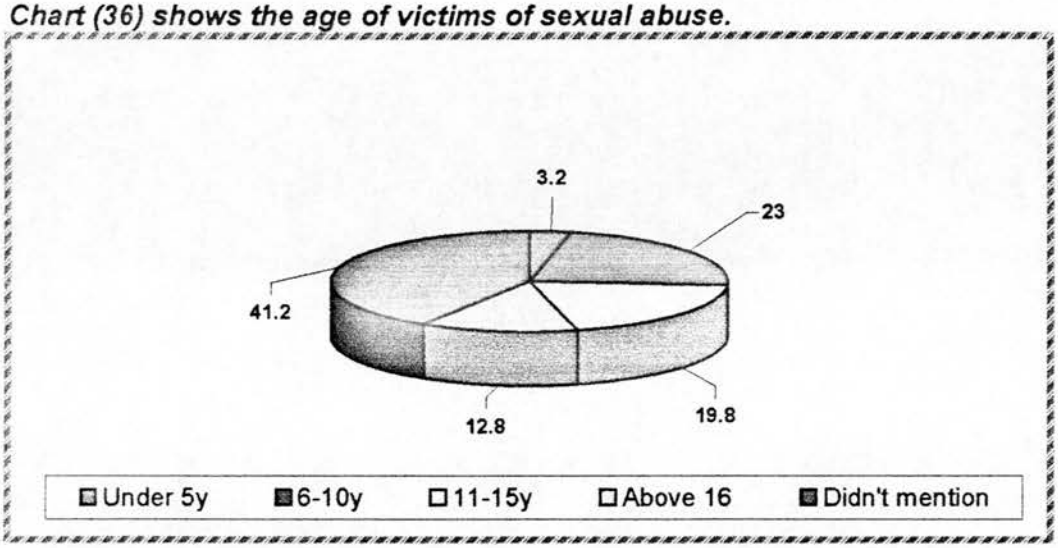


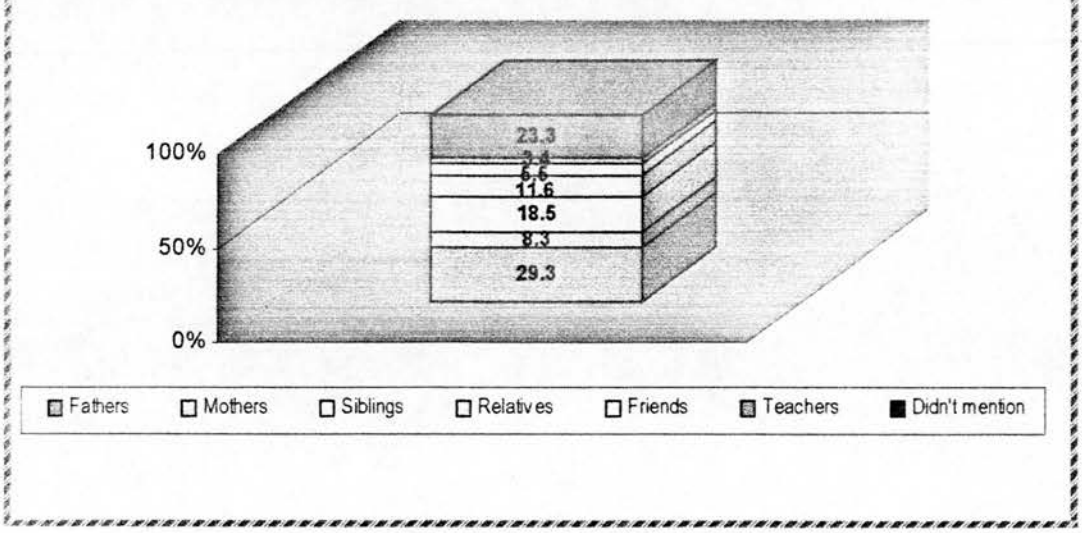
Table (37) and chart (38) shows that physical abuse by the father was again the most prominent. 29.4% of the entire sample, 29.6% for students, and 29.1% for households said they received physical punishment from their father. The second commonest of the abusers for physical abuse were siblings with 18.5% for the entire sample, 21.4 for students and 12.5% for households. Third in prevalence is abuse by a sibling; a typical example occurring when the father is not at home and somebody does something wrong - the eldest brother then takes responsibility for punishing the wrongdoer. Third in prevalence is abuse by another relative; for example, if an uncle sees his nephew or niece misbehaving, he might punish them without permission from the father, or with his encouragement, as the case may be. The victim's mother was fourth in prevalence 8.3% and then friends and teachers 5.5% and 3.4%, respectively.

Table (37) shows the perpetrators of physical abuse in Saudi Arabia.

Sample		F	Mo	S	R	Fr	T	Didn't mention
Households & Sample	F	43	12	27	17	8	5	34
	%	29.4	8.3	18.5	11.6	5.5	3.4	23.3
Students	F	29	6	21	13	7	1	21
	%	29.6	6.1	21.4	13.3	7.1	1.1	21.4
Households	F	14	6	6	4	1	4	13
	%	29.2	12.5	12.5	8.3	2.2	8.3	27

F=father. Mo=mother. S=siblings. R=relatives. Fr=friends. T=teachers.

Table (38) shows physical abuser in Saudi Arabia.

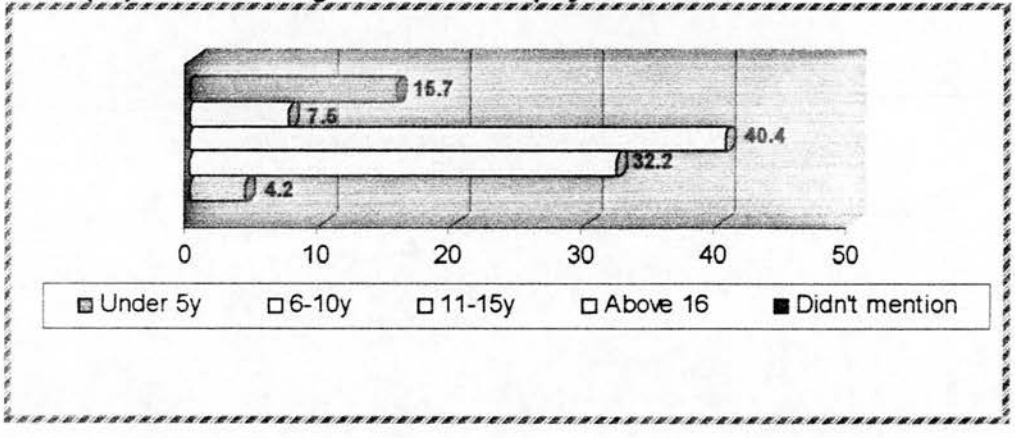


40.4% of those people who received physical abuse in their childhood said they received it when they were between 11-15 for the entire sample, while it was 40.8% among students and 39.6% among households; then 32.2%, when aged 6-10 for the entire sample, while it was 31.6% for students and 33.3% for households. 7.5% were aged above 16 years, and finally 4.2% at under 5-years (see table 39 and chart 40).

Table (39) shows the distribution of victims of physical abuse by age.

Sample		Under 5y	6-10y	11-15y	Above 16y	Didn't mention
Households & Sample	F	6	47	59	11	23
	%	4.2	32.2	40.4	7.5	15.7
Students	F	4	31	40	9	14
	%	4.1	31.6	40.8	9.2	14.3
Households	F	2	16	19	2	9
	%	4.2	33.2	39.6	4.2	18.8

Chart (40) shows the age of victims of physical abuse.



Looking at both physical and emotional abusers, we find a similarity between them. The most common perpetrators were the victims' fathers in both the emotional and physical categories, followed by the victims' siblings and then relatives, in both categories. In addition, the majority in both categories said that they had received emotional and physical abuse when aged between 11-15, followed by the 6-10 range, then the over 16 range, again in both categories, and less than 5% received emotional and

physical abuse when under the age of 5 years. Could it be there was a relationship between physical and emotional abuse? In other words, those who received physical punishment were not only affected physically, but emotionally as well.

Comments & Conclusions from the description of abusers in Saudi Arabia:

In spite of our considering the second option "*rarely true*" unsuitable for inclusion, the prevalence of child abuse and neglect in the survey in Saudi Arabia was quite high. Take for instance emotional neglect; with a 26.6% prevalence in this sample, indicating that about a quarter of the children in Saudi Arabia suffer from emotional neglect. Emotional abuse came second with a 22.8% prevalence. Sexual abuse had a 22.7% prevalence, which was surprising in that sexuality is not greatly to the fore in a traditional society like Saudi with a strong faith. Physical neglect came fourth with an 18.4% prevalence, while physical abuse was the fifth with a prevalence of 12.2%. Before commencing this study, it was believed that the prevalence of physical abuse would be quite high, since it is quite visible on our streets, in schools, on TV and in the media in general. The reason for the result appearing to be too low is in fact related to the questioner. As you can see from appendix 2, those questions that explored physical abuse included various conditions such as 'seen by a doctor, teacher, neighbour or any one'. If we include questions that

explore physical abuse according to the international definition then the prevalence of physical abuse in Saudi Arabia would be quite high. However, we insisted that physical abuse should be noticeable by the doctor, teacher, and neighbour. That is why the prevalence of physical abuse seems to be quite low.

62.1% did not reveal who it was that had abused them sexually. 43% did not reveal the perpetrator of their emotional abuse, and 23.3% did not reveal who it was that had abused them physically. The reason why the clients did not reveal who it was who had abused them could be related to the sensitivity of the relationship between the clients and abusers, or it could be that the abusers were strangers, for which there was no designated option provided in the questionnaire.

The distribution of the relationships between sexual abusers and their victims is as follows: 16.6% - relatives; 12.3% - friends; 4.3% - siblings; and 2.1% - teachers, while the distribution of the ages at which victims were sexually abused is as follows: 23% were aged between 6-10; 19.8% were aged between 11-15; 12.8% were aged above 16 years; and 3.2% were aged less than 5 years.

The distribution of the relationship of physical abusers to their victims was

as follows: 29.4% - fathers; 18.5% - siblings; 11.6% - other relatives; 8.3% -mothers; 5.5% - friends; and 3.4% - teachers, while the distribution of the ages at which victims were physically abuse were as follows: 40.4% were aged between 11-15; 32.2% were aged between 6-10; 7.5% were aged above 16 years; and 4.2% were aged less than 5 years.

The distribution of the relationship of emotional abusers to their victims was as follows: 14.4% - fathers; 12.1% - siblings; 11.8% - relatives; 6.6% - mothers; 6% - friends; and 6% - teachers, while the distribution of the age at which victims received emotional abuse was as follows: 27.3% were aged between 11-15; 19.2% were aged between 6-10; 12% were aged above 16 years; and 2.3% were aged less than 5 years.

7.4 The Hypotheses: accepted or rejected?

The first step in the decision-making procedure is to state the null hypothesis H_0 (Siegel, 1956). This is hypothesis of no differences or associations. If H_0 is tested and rejected, we will conclude that our experimental hypothesis, the alternative hypothesis H_1, is correct (Siegel, 1956; Kinnear & Gray, 2000). We will not reject the H_0 and accept H_1 unless the observed differences or associations are very unlikely to have occurred by chance. The usual criterion is to reject the H_0 if the probability of the observed or greater differences or associations is equal to or less than 0.05 (i.e. is significant at α-level). In this thesis I adopted this conventional (level of 0.05). In this thesis I am not relying on previous findings in this area and generally make no clear prediction about the direction of the differences or association. Accordingly I used 2-tailed tests throughout. *T*- tests were used in order to test H_0 of no difference. Levene's test for equality of variances was carried out automatically by SPSS. If the variances were unequal the t statistic with separate variance values is reported. Otherwise the pooled variances were used.

Hypothesis 1

H_1: "There is a relationship between age of parents and child abuse and neglect".

In the table (41) mean and standard deviations were used in order to establish if there is any relationship between teenaged parents and any

form of child abuse. It was found that there was no significant relationship between the age of parents and child abuse overall (P = .678), emotional abuse (P = .863), physical abuse (P = .426), sexual abuse (P = .162), emotional neglect (P = .690), and physical neglect (P = .066). There was only a significant relationship between medical neglect and the age of parents (< .001).

Table (41) shows the relationship between the age of parents and all forms of child abuse and neglect

Variables	Age	N	Mean	SD	t	Sig.
Child abuse (overall)	>= 40	566	6.47	7.11	.200	.678
	< 40	179	6.33	7.93		
Emotional Abuse	>= 40	566	3.39	3.74	1.00	.863
	< 40	179	3.07	3.73		
Physical Abuse	>= 40	566	2.36	3.63	.713	.426
	< 40	179	2.61	4.09		
Sexual Abuse	>= 40	566	.629	1.27	.785	.162
	< 40	179	.543	1.20		
Emotional Neglect	>= 40	566	13.81	4.58	.87	.690
	< 40	179	14.55	4.50		
Physical Neglect	>= 40	566	2.54	5.40	1.21	.066
	< 40	179	2.11	4.89		
Medical Neglect	>= 40	566	1.14	1.49	3.47	.000
	< 40	179	.728	1.34		

Hypothesis 2.

H1: "There is a relationship between the parents' employment status and child abuse."

Table (42) shows that there was a statistical significant relationship between the mother's employment status and physical abuse (< .044),

and medical neglect (< .006). No significant relationship was found between mother's employment and child abuse overall (P = .132), sexual abuse (P = .062), emotional abuse (P = .409), emotional neglect (P = .601), physical neglect (P = .054).

Table (42) shows the mean and SD of the mother's employment and their relation to all forms of child abuse and neglect

Variables	Mother's job	N	Mean	SD	t	Sig.
Child abuse (overall)	Unemployed	627	6.32	6.98	.333	.132
	Employed	80	6.66	8.63		
Emotional Abuse	Unemployed	627	3.33	3.65	.382	.409
	Employed	80	3.15	4.03		
Physical Abuse	Unemployed	627	2.33	3.6	2.33	.044
	Employed	80	2.93	4.70		
Sexual Abuse	Unemployed	610	.59	1.24	.927	.062
	Employed	78	.47	1.03		
Emotional Neglect	Unemployed	627	14.08	4.50	.052	.601
	Employed	80	14.11	4.73		
Physical Neglect	Unemployed	627	2.33	5.21	1.05	.054
	Employed	80	2.98	5.62		
Medical Neglect	Unemployed	627	1.07	1.48	2.83	.006
	Employed	80	.77	1.36		

Table (43) shows that there was a statistical significant relationship between father's employment and physical abuse (<. 045), emotional neglect (< .004), physical neglect (< .018), and medical neglect (< .001). Employed fathers were more likely to neglect their children physically, and emotionally, while unemployed medically. No relationship was found between father's employment and sexual abuse (P = .259), and emotional abuse (P = .082).

Table (43) shows the mean and SD of the father's employment and their relation to all forms of child abuse and neglect

Variables	Mother's job	N	Mean	SD	t	Sig.
Child abuse (overall)	Unemployed	200	7.12	8.10	2.32	.065
	Employed	450	6.53	7.18		
Emotional Abuse	Unemployed	200	3.61	4.18	1.49	.082
	Employed	450	3.45	3.67		
Physical Abuse	Unemployed	200	2.83	4.17	2.40	.045
	Employed	450	2.36	3.69		
Sexual Abuse	Unemployed	200	.55	1.24	.886	.259
	Employed	450	.65	1.28		
Emotional Neglect	Unemployed	200	13.3	4.98	3.24	.004
	Employed	450	14.57	4.27		
Physical Neglect	Unemployed	200	2.20	5.05	2.91	.018
	Employed	450	2.77	5.59		
Medical Neglect	Unemployed	200	1.24	1.52	3.55	.000
	Employed	450	.81	1.35		

Hypothesis 3.

H_1: "There is a relationship between the number of children in a household and the occurrence of child abuse".

Table (44) shows that there was a statistically significant relationship between the number of siblings and child abuse overall (< .007), emotional abuse (< .003), physical abuse (< .036), sexual abuse (< .001), and medical neglect (< .001). The higher the number of siblings in the family, the more likely is the occurrence of child abuse.

No significant relationship was found between number of siblings and emotional neglect (P = .139), and physical neglect (P = .229).

Table (44) shows the Mean and SD of the number of siblings in the family and their relation to child abuse and neglect.

Variables	Siblings	N	Mean	SD	t	Sig.
Child abuse (overall)	>=6	414	7.00	7.99	2.58	.007
	< 6	339	5.61	6.78		
Emotional Abuse	>=6	414	3.54	3.97	2.79	.003
	< 6	339	2.97	3.48		
Physical Abuse	>=6	414	2.64	3.88	2.14	.036
	< 6	339	2.06	3.55		
Sexual Abuse	>=6	414	.69	1.31	3.19	.000
	< 6	339	.49	1.13		
Emotional Neglect	>=6	414	13.78	4.71	.90	.139
	< 6	339	14.31	4.42		
Physical Neglect	>=6	414	2.27	5.06	.45	.229
	< 6	339	2.44	5.41		
Medical Neglect	>=6	414	1.26	1.53	3.38	.000
	< 6	339	.89	1.42		

Hypothesis 4.

H_1: "There is a relationship between the low educational level of the parents and child abuse".

Table (45) shows that there was a statistically significant relationship between the educational level of mother and emotional neglect (< .008), physical neglect (< .022), and medical neglect (< .001). No significant relationship was found between the educational level of mother and emotional abuse (P = .470), physical abuse (P = .377), sexual abuse (P = .130).

Table (45) shows the Mean and SD of the level of educational level of the mother and its relation with child abuse and neglect.

Variables	Mother's educational level	N	Mean	SD	t	Sig.
Child abuse (overall)	Illiterate	409	6.44	7.77	.104	.689
	Others	402	6.49	7.23		
Emotional Abuse	Illiterate	409	3.32	3.78	.137	.470
	Others	402	3.36	3.73		
Physical Abuse	Illiterate	409	2.44	3.96	.292	.377
	Others	402	2.37	3.57		
Sexual Abuse	Illiterate	409	.57	1.21	.838	.130
	Others	402	.64	1.29		
Emotional Neglect	Illiterate	409	14.48	4.30	3.28	.008
	Others	402	13.42	4.87		
Physical Neglect	Illiterate	409	2.63	5.51	2.15	.022
	Others	402	2.21	5.01		
Medical Neglect	Illiterate	409	.77	1.31	6.10	.000
	Others	402	1.39	1.58		

Table (46) shows the Mean and SD of the level of educational level of the father and its relation with child abuse and neglect.

Variables	Father's educational level	N	Mean	SD	t	Sig.
Child abuse (overall)	Illiterate	234	6.41	7.37	.045	.895
	Others	564	6.43	7.62		
Emotional Abuse	Illiterate	234	3.22	3.79	.422	.475
	Others	564	3.35	3.82		
Physical Abuse	Illiterate	234	2.38	3.48	.032	.254
	Others	564	2.39	3.89		
Sexual Abuse	Illiterate	234	.64	1.29	.326	.640
	Others	564	.61	1.25		
Emotional Neglect	Illiterate	234	13.15	5.33	3.30	.000
	Others	564	14.33	4.28		
Physical Neglect	Illiterate	234	2.32	5.12	.206	.460
	Others	564	2.44	5.30		
Medical Neglect	Illiterate	234	1.37	1.57	3.95	.000
	Others	564	.93	1.42		

Table (46) shows that there was a statistically significant relationship between the educational level of father and emotional neglect (< .001), and medical neglect (< .001). No significant relationship was found between the educational level of father and emotional abuse (P = .475), physical abuse (P = .254), sexual abuse (P = .640).

Table (47) shows the Mean and SD of income and child abuse and neglect.

Variables	Income	N	Mean	SD	t	Sig.
Child abuse (overall)	High income	217	5.28	6.51	2.94	.006
	Low income	577	6.90	7.86		
Emotional Abuse	High income	217	2.84	3.50	.85	.158
	Low income	577	3.49	3.90		
Physical Abuse	High income	217	1.90	3.32	2.55	.002
	Low income	577	2.61	3.93		
Sexual Abuse	High income	212	.50	1.14	2.62	.004
	Low income	557	.66	1.30		
Emotional Neglect	High income	217	14.86	4.43	.83	.199
	Low income	577	13.64	4.67		
Physical Neglect	High income	217	2.22	4.98	.57	.194
	Low income	577	2.56	5.33		
Medical Neglect	High income	215	.92	1.47	1.78	.232
	Low income	571	1.14	1.49		

Hypothesis 5.

H_1: "There is a relationship between the level of income of a household and child abuse".

Table (47) shows that there was a statistically significant relationship between income and child abuse overall (< .006), physical abuse (< .002), and sexual abuse (< .004). In other words, the lower the income in the family the more likely is the occurrence of physical and sexual abuse.

No significant relationship was found between income and emotional neglect (P = .199), physical neglect (P = .194), medical neglect (P = .232), and emotional abuse (P = .158).

Hypothesis 6.

H_1: "There is a relationship between the existence of marital problems and child abuse".

Table (48) shows that there was a statistically significant relationship between marital problems and medical neglect (< .001). No significant relationship was found between marital problems and emotional abuse (P = .218), sexual abuse (P = .181), physical abuse (P = .054), emotional neglect (P = .628), and physical neglect (P = .107).

Table (48) shows the Mean and SD of the marital status of the parents and their relation to child abuse and neglect.

Variables	Marital Status	N	Mean	SD	t	Sig.
Child abuse (overall)	Divorce/ Widow	145	7.10	8.63	1.75	.086
	Living together	655	6.37	7.27		
Emotional Abuse	Divorce/ Widow	145	3.65	4.00	.90	.218
	Divorce/ Widow	655	3.30	3.77		
Physical Abuse	Divorce/ Widow	145	2.89	4.22	1.99	.054
	Living together	655	2.38	3.68		
Sexual Abuse	Divorce/ Widow	145	.69	1.31	.743	.181
	Living together	655	.60	1.25		
Emotional Neglect	Divorce/ Widow	145	13.50	4.50	1.33	.628
	Living together	655	14.06	4.63		
Physical Neglect	Divorce/ Widow	145	2.09	4.83	.763	.107
	Living together	655	2.46	5.33		
Medical Neglect	Divorce/ Widow	145	1.45	1.62	3.48	.000
	Living together	647	.98	1.43		

Hypothesis 7.

H_1: "There is a relationship between the type of the parental residence and child abuse."

Table (49) shows that there was a statistically significant relationship between parental residence and sexual abuse (< .001), emotional neglect (< .013), and physical neglect (< .034). No significant relationship was found between parental residence and emotional abuse (P = .245), physical abuse (P = .490), and medical neglect (P = .109).

Table (49) shows the Mean and SD of the residence of the parents and their relationship to child abuse.

Variables	Residence	N	Mean	SD	t	Sig.
Child abuse (overall)	Village/ Bedouin	177	7.00	7.06	1.08	.791
	Urban	628	6.31	7.65		
Emotional Abuse	Village/ Bedouin	177	3.47	3.52	.525	.245
	Urban	628	3.30	3.90		
Physical Abuse	Village/ Bedouin	177	2.66	3.63	1.03	.490
	Urban	628	2.33	3.81		
Sexual Abuse	Village/ Bedouin	175	.79	1.41	2.13	.001
	Urban	605	.65	1.21		
Emotional Neglect	Village/ Bedouin	177	12.93	5.03	3.34	.013
	Urban	628	14.24	4.46		
Physical Neglect	Village/ Bedouin	177	2.05	4.85	2.07	.034
	Urban	628	2.50	5.35		
Medical Neglect	Village/ Bedouin	177	1.28	1.52	2.00	.109
	Urban	628	1.02	1.46		

Hypothesis 8.

***H_1:* "There is a difference between women and men in their abuse of children in Saudi Arabia, in other words one parent has a greater tendency to abuse than the other".**

Before addressing this issue I have to make it clear that 62.1%, 43%, and 23.3% of the victims of child sexual abuse, emotional abuse and physical abuse respectively did not identify the perpetrators, perhaps because they were a close relative.

You can see from page 225 that table (37) shows that there were differences between fathers and mothers in their abuse of children physically (fathers 29.4% and mothers 8.3%). Also table 29 in page 220 shows that there were statistical differences between fathers and mothers in their abuse of children emotionally (fathers 14.4% and mothers 6.6%). However, fathers and mothers were equally likely to sexually abuse their children (fathers 1%. and mothers 1%) (see page 223, table 33).

Hypothesis 9.

H_1: "There is a relationship between the age of the child and the form of child abuse experienced by it in Saudi Arabia."

Means in table 50 show that there was a relationship between the age of the child and emotional abuse (< .011), and sexual abuse (< .018). In other words, children under ten years of age were more likely to receive emotional abuse than children above 10, while children above 10 years old were more likely to receive sexual abuse than children below 10.

No significant relationship was found between the age of the child and physical abuse (P = .099).

Table (50) shows the ages (before and after 10th birthday) at which victims faced abuse, and the degree of sexual, physical, and emotional abuse at each age level; together with t values for the differences on each of these measures.

Variables	Age	N	Mean	SD	t	Sig
Emotional Abuse	<10y	75	7.37	4.61	2.54	.011
	≥10y	38	6.19	3.82		
Sexual Abuse	<10y	48	2.79	1.34	2.38	.018
	≥10y	60	2.88	1.15		
Physical Abuse	<10y	50	7.15	5.49	1.57	.090
	≥10y	66	6.64	4.34		

Hypothesis 10.

H_1 "There is a relationship between child abuse/ child neglect and subsequent psychological problems in adulthood in Saudi Arabia".

In this study we found that there was a statistically significant correlation found between child abuse overall and low self-esteem (r = .12, p<. 001), impulsiveness (r = .09, p<. 010), aggression (r = .12, p<. 001),and psychological distress, (r = .22, p<. 001) (table 51). More specifically, table (52) shows that there was statistically significant correlation between child emotional abuse and low self-esteem (r = .11, p<. 003), impulsiveness (r = .09, p<. 007), aggression (r = .10, p<. 004), and psychological distress, (r = .22, p<. 001) while there was a statistically significant correlation found between sexual abuse and low self-esteem (r =. 13, p<. 001), impulsiveness (r = .10, p<. 005), and psychological

distress, (r = .17, p<. 001) and there was a statistically significant correlation found between Child physical abuse and low self-esteem (r = .08, p<. 02), aggression (r = .12, p<. 001), and psychological distress, (r = .14, p<. 001). On the other hand, there was a statistically significant correlation between child emotional neglect and impulsiveness (r = .08, p<. 03), psychological distress (r = .15, p<. 001), while no correlation was found between child physical neglect, medical neglect, and any form of psychological problems (see more detailed information about correlation analyses in section 7.5).

Conclusion of hypotheses

Though various studies have found there to be a link between the parents being in their teens and the abuse of their children such as Elkerdany et al (1998), and Kattan (1994), this study found no statistically significant relationship between the parents being in their teens and any form of child abuse or neglect, except medical neglect. This study found there was a relationship between the occupations of the parents and some forms of child abuse and neglect. There was a statistically significant relationship found between the number of children in a household and all forms of abuse, and medical neglect. There was a relationship between the level of education of the parents and some forms of child abuse and neglect.

There was a statistically significant relationship found between the level of income of a household and physical and sexual abuse.

There was a relationship between the existence of marital problems and physical abuse and medical neglect. There was a relationship found between the place of residence of the family and sexual abuse, emotional neglect, and physical neglect. There were statistically significant differences between women and men in their abuse of children; males have a greater tendency to abuse their children physically and emotionally than females. There was a statistically significant relationship found between the age of the child and the form of child abuse experienced. There were statistically significant relationships found between sexual, physical and emotional abuse and emotional neglect and the following psychological problems; self-esteem, aggression, psychological distress, and impulsiveness in adulthood.

7.5 Correlation Analyses

The word "correlation" is used in everyday life to denote some from of association (Swinscow, 1999). However, in statistical terms correlation is used to denote association between two quantitative variables. We assume that the association between variables is linear, that means if one variable increases or decreases a fixed amount for a unit increase or decrease in the other (Swinscow, 1999). The output of the Pearson analysis summarizes the strength of an association through the Pearson Correlation Coefficient, which is in the range from – 1.0 to + 1.0 (Headderson, 1987; Kinnear & Gray, 2000). One advantage of the Pearson Correlation Coefficient is that it indicates whether the association is positive or negative. A negative coefficient means that, when one variable is higher in value, the other variable tends to be lower in value, while a positive coefficient means that, when one variable is higher, the other variable also tends to be higher (Headderson, 1987). The Pearson Correlation requires the assumptions that the variables are interval level and linearly associated (Headderson, 1987; Kinnear & Gray, 2000). 2 tailed Pearson correlations were carried out in this study to determine the correlation between each of the various categories of abuse (i.e. child abuse overall, child sexual abuse, child physical abuse, child emotional abuse, child emotional neglect, child physical neglect and child medical neglect) and all forms of psychological problems (i.e. self-harm, low self-

esteem, eating disorders, impulsiveness, PTSD, dissociation, aggression and psychological distress) and also with all of the epidemiological variables (i.e. client's age, mother's age, father's age, mother's job, father's job, number of siblings, mother's education, father's education, income, social status and type of parental residence).

Table 51 shows N, p, and r for child abuse overall and its relation to psychological problems and epidemiological factors among the overall sample, and students and households considered separately.

Child Abuse ↓	Households & Students (N=823)		Students (N=519)		Households N=304	
	P	r	p	r	p	r
Self-harm	.969	.00	.949	.00	.474	.04
Low self-esteem	.001	.12	.040	.09	.004	.17
Eating Dis.	.696	.00	.148	.06	.068	.11
Impulsiveness	.010	.09	.195	.07	.016	.14
PTSD	.177	.04	.584	.02	.267	.06
Dissociation	.832	.01	.338	.04	.607	.03
Aggression	.001	.12	.076	.08	.000	.21
Psychological distress	.000	.22	.001	.15	.000	.36
Age	.127	.05	.094	.07	.063	.11
M.age	.104	-.06	.796	-.01	.037	-.13
F.age	.900	.00	.299	.05	.129	.10
M.job	.514	.02	.885	.01	.197	.08
F.job	.922	.00	.970	.01	.576	.04
Siblings	.008	.10	.003	.14	.130	.09
M.edu	.356	.03	.121	.07	.418	.05
F.edu	.091	.06	.017	.11	.518	.04
Income	.000	-.13	.000	-.17	.300	-.06
Social S	.881	.00	.890	.01	.846	.01
Residence	.516	.00	.420	.04	.877	.01

Table (51) shows that the higher the rates of the occurrence of child abuse overall the higher the rates of occurrence of low self esteem (r = .12, p<. 001), impulsiveness (r = .09, p<. 010), aggression (r = .12, p<. 001), and psychological distress score (r = .22, p<. 001). No statistical correlation was found between child abuse overall and the following measures; self-harm (r = .00, p<. 97); eating disorders (r = .00, p<. 70); PTSD (r = .04, p<. 18); and dissociation (r = .01, p<. 83). With regard to the epidemiological variables, there was a statistical correlation found between child abuse overall and the number of siblings (r = .10, p<. 008), in other words, that the rate of child abuse increased with the number of siblings in the family. There was a negative correlation between child abuse and income (r = -.13, p<. 001); the lower the family income the more likely child abuse was to occur in the family. No statistical correlation was found between child abuse overall and the following epidemiological factors; age of clients (r = .05, p<. 13), mother's age (r = .06, p<. 10), father's age (r = .00, p<. 90), mother's job (r = .02, p<. 51), father's job (r = .00, p<. 92), mother's education (r = .03, p<. 36), father's education (r = .06, p<. 09), social status (r = .00, p<. 88), and residence (r = .00, p<. 52). However, among students, the highest correlation was found between child abuse overall and psychological distress, which means the higher the rates of the occurrence of child abuse overall among students, the higher the psychological distress scores(r =. 15, p<. 001), while the lowest correlation

was found between child abuse overall and low self-esteem, which means the higher the rates of the occurrence of child abuse overall among students the higher the rates of occurrence of low self-esteem (r =. 09, p<. 04). With regard to the epidemiological variables, there was a negative correlation between child abuse overall and income (r = -. 17, p<. 001), which means the lower the family income the more likely child abuse overall is to occur; where was also a negative correlation between child abuse overall and father's education (r = -. 11, p<. 017), which means the lower the father's education level the more likely child abuse overall is to occur. Among households, the highest correlation was found between child abuse overall and psychological distress, aggression, and self-esteem; while the lower significant correlations were found between child abuse overall and impulsiveness. In other words, the higher the rates of the occurrence of child abuse overall among households the higher the rates of occurrence of psychological distress (r =. 36, p<. 001), aggression (r =. 21, p<. 001), low self esteem (r =. 17, p<. 004), and impulsiveness (r =. 14, p<. 02). With regard to the epidemiological variables, only the mother's age was found to correlate negatively with child abuse overall (r = -. 13, p<. 037), which means that young mothers were more likely to abuse their children.

Table 52 shows N, p, and r for emotional abuse and its relation to psychological problems and epidemiological factors in the overall, student and household samples.

Emotional Abuse ↓	Households & Students (N=823)		Students (N=519)		Households (N=304)	
	p	r	P	r	p	r
Self-harm	.646	.01	.796	.01	.347	.05
Low self-esteem	.003	.11	.066	.08	.008	.11
Eating Disorder	.898	.00	.411	.04	.206	.09
Impulsiveness	.007	.09	.197	.06	.132	.09
PTSD	.126	.05	.470	.03	.540	.03
Dissociation	.753	.01	.139	.06	.847	.01
Aggression	.004	.10	.121	.07	.001	.20
Psychological distress	.000	.22	.001	.15	.000	.27
Age	.101	.05	.223	.05	.550	.04
M.age	.441	.02	.391	.04	.087	.11
F.age	.644	.01	.100	.08	.258	.07
M.job	.421	.03	.773	.01	.399	.05
F.job	.788	.01	.780	.01	.899	.01
Siblings	.034	.08	.033	.10	.359	.06
M.edu	.190	.04	.105	.07	.479	.04
F.edu	.232	.04	.051	.08	.690	.02
Income	.004	--.10	.001	--.14	.345	.05
Social Status	.765	.01	834	.01	.781	.02
Residence	.849	.00	.597	.02	.948	.00

Table (52) shows that the higher the rates of the occurrence of child emotional abuse the higher the rates of occurrence of low self-esteem (r = .11, p<. 003), impulsiveness (r = .09, p<. 007), aggression (r = .10, p<. 004), and psychological distress score (r = .22, p<. 001). No statistical correlation was found between child emotional abuse and the following psychological problems; self-harm (r = .01, p<. 82), eating disorders (r = .00, p<. 90), PTSD (r = .05, p<. 13), and dissociation (r = .01, p<. 75).

With regard to the epidemiological variables: there was a statistical correlation found between child emotional abuse and the number of siblings (r = .08, p<. 03), which means the higher the number of siblings, the higher the chance there is of child emotional abuse occurring in the family. There was a negative correlation between child emotional abuse and income (r = -.10, p<. 004). In other words, the lower the family income the more likely child emotional abuse is to occur in the family. No statistical correlation was found between child emotional abuse and the following epidemiological factors; age of clients (r = .05, p<. 10), mother's age (r = .02, p<. 44), father's age (r = .01, p<. 64), mother's job (r = .03, p<. 42), father's job (r = .01, p<. 79), mother's education (r = .04, p<. 19), father's education (r = .04, p<. 23), social status (r = .01, p<. 77), and residence (r = .00, p<. 85). However, among students, the highest correlation was between child emotional abuse and psychological distress, which means the higher the rates of the occurrence of child emotional abuse the higher the psychological distress score (r =. 15, p<. 001). With regard to the epidemiological variables: there was a negative correlation between child emotional abuse and income (r = -. 14, p<. 001), which means the lower the family income the more likely child emotional abuse is to occur, and also a correlation between child emotional abuse and siblings (r =. 10, p<. 03). In other words, the rate of child emotional abuse increased with the number of siblings in the family.

Among households, there was highest correlation between child emotional abuse and psychological distress score, aggression, and low self-esteem. In other words, the higher the rates of the occurrence of child emotional abuse the higher the psychological distress score (r =. 27, p<. 001), aggression (r =. 20, p<. 001), and low self-esteem (r =. 11, p<. 008). No correlation was found between child emotional abuse and epidemiological factors.

Table 53 shows N, p, and r for sexual abuse and its relation to psychological problems and epidemiological variables in the overall, student and household samples.

Sexual Abuse ↓	Households & Students (N=823)		Students (N=519)		Households (N=304)	
	P	R	p	r		r
Self-harm	.912	.00	.519	.03	.536	.04
Low self-esteem	.000	.13	.008	.12	.024	.13
Eating Disorders	.281	.04	.108	.09	.318	.06
Impulsiveness	.005	.10	.099	.07	.205	.07
PTSD	.080	.06	.186	.06	.217	.07
Dissociation	.206	.04	.153	.06	.860	.01
Aggression	.956	.00	.249	.05	.107	.09
Psychological distress	.000	.17	.001	.15	.000	.21
Age	.037	.04	.188	.06	.369	.05
M.age	.329	.04	.418	.04	.476	.04
F.age	.920	.03	.428	.04	.211	.08
M.job	.894	.00	.173	.07	.148	.09
F.job	.278	.04	.760	.01	.251	.07
Siblings	.022	.08	.005	.13	.142	.09
M.edu	.136	.05	.003	.13	.869	.01
F.edu	.437	.03	.087	.08	.823	.01
Income	.026	-.08	.033	-.10	.299	.06
Social Status	.944	.00	.931	.00	.460	.04
Residence	.147	.05	.401	.04	.190	.07

Table (53) shows that the higher the rates of the occurrence of child sexual abuse the higher the rates of occurrence of low self-esteem (r =. 13, p<. 001), impulsiveness (r = .10, p<. 005), and psychological distress score (r = .17, p<. 001). No statistical correlation was found between child sexual abuse and the following measures; self-harm (r = .00, p<. 91), eating disorders (r = .04, p<. 28), PTSD (r = .06, p<. 08), dissociation (r = .04, p<. 22) and aggression (r = .00, p<. 91). With regard to the epidemiological variables: there was a statistical correlation found between child sexual abuse and the number of siblings (r = .08, p<. 02), which means the higher the number of siblings, the higher the chance there is of child sexual abuse occurring in the family. There was negative correlation between child sexual abuse and income (r = -.08, p<. 03). In other words, the lower the family income the more likely child sexual abuse is to occur in the family. No statistical correlation was found between child sexual abuse and the following epidemiological factors; mother's age (r = .04, p<. 33), father's age (r = .03, p<. 92), mother's job (r = .00, p<. 89), father's job (r = .04, p<. 28), mother's education (r = .05, p<. 14), father's education (r = .03, p<. 44), social status (r = .00, p<. 94), and residence (r = .05, p<. 15). However, among students, there were significant correlations between child sexual abuse and psychological distress, self-esteem. In other words, the higher the rates of the occurrence of child sexual abuse the higher the psychological distress

scores (r =. 15, p<. 001), and self-esteem (r = .12, p<. 008). With regard to the epidemiological variables: there was a correlation between child sexual abuse and siblings (r =. 13, p<. 005), which means the rate of child sexual abuse increased with the number of siblings in the family, and a negative correlation between child sexual abuse and income (r = -. 10, p<. 03), and mother's education (r = -.13, p<. 003). In other words, the lower the income and the mother's education level the more likely child sexual abuse is to occur. Among households, there was a correlation between child sexual abuse and psychological distress score, low self-esteem, which means the higher the rates of the occurrence of child sexual abuse the higher the rates of occurrence of psychological distress (r =. 21, p<. 001), and self-esteem (r =. 13, p<. 024). No correlation was found between child sexual abuse and any of the epidemiological factors.

Table (54) shows that the higher the rates of the occurrence of child physical abuse the higher the rates of occurrence of low self-esteem (r = .08, p<. 02), aggression (r = .12, p<. 001), and psychological distress score (r = .14, p<. 001). No statistical correlation was found between child physical abuse and the following measures; self-harm (r = .00, p<. 89), eating disorders (r = .00, p<. 90), impulsiveness (r = .02, p<. 27), PTSD (r = .02, p<. 52), and dissociation (r = .00, p<. 88). With regard to the epidemiological variables: there was a statistical correlation found

Table (54) shows N, p, and r for physical abuse and its relation to psychological problems and epidemiological variables among the overall, student, and household samples.

Physical Abuse ↓	Households & Students (N=823)		Students (N=519)		Households (N=304)	
	P	r	p	r	p	r
Self-harm	.887	.00	.714	.02	.347	.05
Low self-esteem	.024	.08	.150	.06	.057	.11
Eating Dis.	.903	.00	.261	.05	.086	.10
Impulsiveness	.272	.02	.706	.02	.128	.09
PTSD	.517	.02	.707	.02	.540	.03
Dissociation	.875	.00	.872	.01	.915	.01
Aggression	.001	.12	.066	.09	.001	.20
Psychological distress	.000	.14	.070	.08	.000	.27
Age	.687	.01	.051	.03	.534	.03
M.age	.047	-.07	.049	.03	.141	.10
F.age	.514	.02	.872	.01	.302	.07
M.job	.622	.02	.921	.00	.397	.05
F.job	.736	.01	.856	.01	.899	.01
Siblings	.020	.09	.007	.12	.369	.05
M.edu	.772	.01	.401	.04	.489	.04
F.edu	.105	.05	.014	.11		.02
Income	.001	-.11	.001	.15	.395	.05
Social Status	.953	.00	.575	.02	.791	.02
Residence	.439	.03	.369	.04	.891	.00

between child physical abuse and income (r = -.11, p<. 001). In other words, the lower the family income the more likely child physical abuse is to occur in the family. There was also a significant correlation found between child physical abuse and number of siblings (r = .09, p<. 02), which means the higher the number of siblings, the higher the chance there is of child physical abuse occurring in the family. There was low but significant negative correlation between child physical abuse and mother's age (r = -.07, p<. 05). In other words, young mothers are more likely to

punish their children physically. No statistical correlation was found between child physical abuse and the following epidemiological factors; age of clients (r = .01, p<. 69), father's age (r = .02, p<. 51), mother's job (r = .02, p<. 62), father's job (r = .01, p<. 74), mother's education (r = .01, p<. 77), father's education (r = .05, p<. 11), social status (r = .00, p<. 95), and residence (r = .03, p<. 44). However, among students, there was no correlation found between child physical abuse and psychological problems. With regard to the epidemiological variables: there were negative correlations between child physical abuse and income (r = -. 15, p<. 001), and father's education(r = -.11, p<. 014). Among households, there was a correlation between child physical abuse and psychological distress score, and aggression. In other words, the higher the rates of the occurrence of child physical abuse among households the higher the psychological distress score (r =. 27, p<. 001), and aggression (r =. 20, p<. 001). No correlation was found between child physical abuse and any of the epidemiological factors.

Table (55) shows that the higher the rates of the occurrence of child emotional neglect the higher the psychological distress score (r = .15, p<. 001), and impulsiveness (r = .08, p<. 03). No statistical correlation was found between child emotional neglect and the following measures; self-harm (r = .01, p<. 77), eating disorders (r = .03, p<. 29), PTSD (r = .00, p<. 93), dissociation (r = .03, p<. 36) and aggression (r =. 02, p<. 51).

Table (55) shows N, p, and r for emotional neglect and its relation to the occurrence of psychological problems and epidemiological variables in the overall, student, and household samples.

Emotional Neglect ↓	Households & Students (N=823)		Students (N=519)		Households (N=304)	
	P	R	p	r	P	R
Self-harm	.769	.01	.910	.00	.341	.05
Low self-esteem	.433	.02	.852	.01	.183	.08
Eating Disorders	.285	.03	.732	.01	.181	.08
Impulsiveness	.031	.08	.254	.05	.010	.15
PTSD	.928	.00	.892	.00	.966	.00
Dissociation	.360	.03	.981	.01	.095	.10
Aggression	.507	.02	.969	.02	.281	.06
Psychological distress	.000	.15	.027	.10	.000	.25
Age	.283	.04	.002	.14	.939	.00
M.age	.056	.07	.205	.05	.126	.09
F.age	.001	.12	.011	.12	.037	.14
M.job	.417	.03	.755	.01	.293	.06
F.job	.005	.11	.001	.16	.676	.03
Siblings	.238	.04	.674	.02	.142	.09
M.edu	.002	.11	.000	.16	.708	.02
F.edu	.000	.18	.000	25	.483	.04
Income	.000	.16	.000	.23	.311	.06
Social Status	.504	.02	.361	.04	.890	.00
Residence	.000	.14	.000	.16	065	.10

With regard to the epidemiological variables: there was negative correlation found between child emotional neglect and father's age (r = -.12, p<. 001), and that means, young fathers are more likely to neglect their children emotionally. There was a correlation between child emotional neglect and income (r = .16, p<. 001), mother's education (r = .1, p<. 002), father's education (r = .18, p<. 001). In other words, the higher the family income, or parent's education the more likely emotional

neglect is to occurring in the family (we will talk about these and the results in the discussion chapter). No statistical correlation was found between child emotional neglect and the following epidemiological factors; age of clients (r = .04, p<. 28), mother's age (r = .07, p<. 06), mother's job (r = .03, p<. 42), siblings (r = .04, p<. 23). However, among students, there was a correlation between child emotional neglect and psychological distress (r =. 10, p<. 03). With regard to the epidemiological variables: there was a correlation between child emotional neglect and father's age (r =. 12, p<. 011), father's job (r =. 16, p<. 001), mother's education (r =. 16, p<. 001) father's education (r =. 25, p<. 001), income (r =. 23, p<. 001), and residence (r =. 16, p<. 001). Among households, there was a correlation between child emotional neglect and psychological distress, and impulsiveness. In other words, the higher the rates of the occurrence of child emotional neglect among households the higher the psychological distress score (r =. 25, p<. 001), and impulsiveness (r =. 15, p<. 010). Only one correlation was found between child emotional neglect and father's age (r = -. 16, p<. 001), which means that young fathers were more likely to neglect their children emotionally.

Table (56) shows that there was no statistical correlation between child physical neglect and of the measures or epidemiological variables.

Table 56 shows N, p, and r for physical neglect and its relation to psychological problems and epidemiological variables in the overall, student and household samples.

Physical Neglect ↓	Households & Students (N=823)		Students (N=514)		Households (N=304)	
	p	r	p	r	p	r
Self-harm	.102	.05	.956	.01	.689	.02
Low self-esteem	.605	.02	.840	.02	.711	.02
Eating Dis.	.964	.00	.783	.02	.704	.01
Impulsiveness	.131	.05	.215	.04	.572	.03
PTSD	.342	.03	.653	.02	.298	.06
Dissociation	.813	.00	.757	.01	.922	.00
Aggression	.189	.04	.155	.06	.533	.03
Psychological distress	.726	.01	.956	.00	.469	.04
Age	.275	.04	.803	.01	.138	.09
M.age	.214	.04	.949	.00	.747	.02
F.age	.483	.02	.355	.04	.194	.08
M.job	.672	.01	.570	.03	.277	.07
F.job	.536	.02	.983	.00	.427	.05
Siblings	.793	.01	.676	.02	.611	.03
M.edu	.161	.04	.599	.02	.618	.03
F.edu	.404	.03	.658	.02	.405	.05
Income	.750	.01	.953	.00	.420	.05
Social Status	.562	.02	.314	.04	.236	.07
Residence	.356	.03	.662	.02	.369	.05

Table (57) shows that there was no statistical correlation between child medical neglect and all measures among overall, students, and households, while there was a statistical correlation between it and all epidemiological variables except mother's age among overall and students.

Table 57 shows N, p, and r for medical neglect and its relation to psychological problems and epidemiological variables in overall, student and household samples.

Medical Neglect ↓	Households & Students (N=823)		Students (N=514)		Households (N=304)	
	r	P	r	p	r	p
Self-harm	.01	.700	.04	.423	.07	.194
Low self-esteem	.01	.194	.01	.817	.08	.172
Eating Disorders	.01	.823	.00	.934	.03	.566
Impulsiveness	.01	.795	.01	.854	.00	.953
PTSD	.02	.535	.02	.607	.02	.687
Dissociation	.02	.482	.03	.448	.01	.803
Aggression	.03	.351	.03	.465	.09	.122
Psychological distress	.01	.777	.00	.967	.00	.975
Age	.17	.000	.15	.001	.07	.032
M.age	.20	.000	.11	.005	.13	.004
F.age	.16	.000	.13	.008	.16	.010
M.job	.01	.869	.03	.934	.09	.129
F.job	.13	.001	.17	.000	.05	.417
Siblings	.13	.000	.08	.080	.06	.303
M.edu	.21	.000	.21	.000	.11	.050
F.edu	.22	.000	.28	.000	.14	.015
Income	.10	.007	.13	.003	.13	.028
Social S	.14	.000	.14	.002	.09	.138
Residence	.10	.005	.14	.001	.06	.303

After we talked about the correlation between forms of child abuse & child neglect and psychological problems, epidemiological factors among overall, students, and households, we are going to see if there are different patterns of correlations between males and females in the overall sample.

Table (58) shows that among males there was a statistical correlation between impulsiveness and child sexual abuse ($r = .11$, $p < .01$), physical

abuse (r = .09, p<. 04), emotional abuse (r = .12, p<. 005), emotional neglect (r = .12, p<. 006), mother's education (r = -.11, p<. 01), father's age (r = .11, p<. 02), and mother's age (r = .12, p<. 006). Among females, there was a statistical correlation between impulsiveness and income (r = .17, p<. 006), siblings (r = -.17, p<. 005), and mother's education (r = .14, p<. 02). Among males, there was no statistical correlation between PTSD and any form of child abuse or epidemiological factors, while among females there was a correlation with siblings (r = .14, p<. 03), mother's education (r = -.14, p<. 02), and father's education (r = -.16, p<. 01).). With regard to eating disorders, there was no statistical correlation found for either males or females. With regard to psychological distress, among males, there was a correlation between it and sexual abuse (r = .18, p<. 001), physical abuse (r = .17, p<. 001), emotional abuse (r = .23, p<. 001), emotional neglect (r = .14, p<. 002) and income (r = .10, p<. 002). Among females, there was a statistical correlation between psychological distress and sexual abuse (r = .17, p<. 004), physical abuse (r = .16, p<. 01), emotional abuse (r = .21, p<. 001) and emotional neglect (r = .22, p<. 001). Among males with regard to aggression, there was a correlation between it and physical abuse (r = .12, p<. 006), and emotional abuse (r = 09, p<. 03). Among females with regard to dissociation, there was a correlation between it and the following measures; sexual abuse (r = .15,

p<. 02), physical abuse (r = .18, p<. 002), and emotional abuse (r = .14, p<. 02). Among female in regard to self-esteem, there was a correlation between it and the following; sexual abuse (r = .13, p<. 03), emotional abuse (r = .19, p<. 001), mother's education (r = .15, p<. 01) and father's education (r = .14, p<. 002), while only sexual abuse was correlated among males (r = .13, p<. 003). No significant correlation was found between child abuse, epidemiological factors and self-harm for either males or females.

Table (59) shows that there was a strong correlation between all forms of child abuse particularly between physical abuse and emotional abuse (r = .59, p<. 001), then sexual abuse and emotional abuse (r = .33, p<. 001), and then physical abuse and sexual abuse (r = .26, p<. 001). Emotional neglect was correlated with emotional abuse (r = .40, p<. 001), physical abuse (r = .30, p<. 001), and with sexual abuse (r = .15, p<. 001). It was also correlated with medical neglect (r = .30, p<. 001). In conclusion to this table we can say there were a strong correlation between all forms of child abuse especially between physical and emotional abuse, which already mentioned earlier in this chapter when we talked about description of abusers in Saudi Arabia.

Table 58 shows p, and r for child abuse and some epidemiological variables and their relation to psychological problems and in overall sample.

			Imp	PTSD	EatingD	PsD	Agg	Diss	Self-e	Self-h
Sexual Abuse	M	r	.11	.03	.05	.18	.00	.02	.13	.02
		p	.01	.49	.26	.000	.90	.66	.003	.61
	F	r	.08	.12	.01	.17	.01	.15	.13	.03
		p	.15	.05	.80	.004	.85	.02	.03	.61
Physical Abuse	M	r	.09	.04	.02	.17	.12	.08	.08	.01
		p	.04	.37	.67	.000	.006	.07	.06	.85
	F	r	.01	.01	.05	.16	.11	.18	.09	.01
		p	.89	.85	.43	.01	.06	.002	.14	.87
Emotional Abuse	M	r	.12	.03	.04	.23	.09	.07	.05	.01
		p	.005	.53	.36	.000	.03	.10	.25	.77
	F	r	.04	.10	.07	.21	.10	.14	.19	.06
		p	.51	.10	.22	.000	.08	.02	.000	.31
Emotional neglect	M	r	.12	.03	.01	.14	.02	.05	.01	.00
		p	.006	.52	.74	.002	.70	.29	.88	94
	F	r	.01	.06	.08	.22	.04	.00	.09	.01
		p	.88	.30	.15	.000	.54	.97	.13	.88
Income	M	r	.05	.03	.06	.10	.05	.04	.07	.06
		p	.24	.57	.18	.02	.24	.41	.13	.20
	F	r	.17	.06	.09	.08	.07	.07	.03	.01
		p	.006	.31	.14	.17	.24	.22	.62	.87
Siblings	M	r	.01	.02	.10	.04	.02	.02	.04	.01
		p	.79	.64	.02	.34	.65	.60	.37	.76
	F	r	.17	.14	.07	.10	.10	.05	.01	.08
		p	.005	.03	.23	.10	.11	.44	.88	.22
Mother's education	M	r	.11	.02	.00	.06	.00	.00	.00	.00
		p	.01	.67	.93	.19	.98	.93	.95	.93
	F	r	.14	.14	.05	.10	.03	.03	.15	.06
		p	.02	.02	.36	.10	.64	.58	.01	.33
Father's education	M	r	.08	.03	.05	.07	.02	.05	.05	.06
		p	.08	.48	.25	.12	.58	.30	.27	.14
	F	r	.09	.16	.06	.12	.05	.02	.19	.04
		p	.13	.01	.29	.05	.45	.79	.002	.56
Father' age	M	r	.11	.07	.08	.04	.05	.08	.00	.07
		p	.02	.14	.10	.37	.26	.11	.96	.14
	F	r	.11	.14	.01	.02	.04	.04	.11	.06
		p	.13	.06	.90	.73	.55	.50	.10	.38
Mother's age	M	r	.12	.02	-.13	.03	.08	.00	.04	.03
		p	.006	.63	.00	.49	.07	.94	.40	.56
	f	R	.09	.08	.01	.01	.04	.02	.04	.05
		P	.13	.22	.80	.91	.52	.74	.56	.45

Table 59 shows p, and r for all forms of abuse and neglect in all the sample.

	Sexual abuse		Physical abuse		Emotional abuse		Emotional neglect		Physical neglect		Medical neglect	
	r	P	r	p	r	p	r	p	r	p	r	P
Sexual Abuse			.26	.000	.33	.000	.15	.000	.05	.19	.05	.29
Physical Abuse	.26	.000			.59	.000	.30	.000	.05	.20	.10	.004
Emotional Abuse	.33	.000	.59	.000			.40	.000	.06	.10	.12	.000
Emotional Neglect	.15	.000	.30	.000	.40	.000			.05	.16	.30	.000
Physical Neglect	.05	.19	.05	.20	.06	.10	.05	.16			.08	.02
Medical Neglect	.04	.29	.10	.004	.12	.000	.30	.000	.08	.02		

7.6 T-Tests Between Abused & Non-abused Groups and their relation to Psychological Problems in Adulthood:

The t-test is commonly used to ascertain the significance of a difference between two means (Kinnear & Gray, 2000). It is used when we wish to check whether two samples are likely to have come from the same or from the different populations (Rowntree, 1981). The smaller the samples, the larger the difference required by the t-test; otherwise, since differences occur more frequently as samples get smaller, the probability of getting a significant result would increase as the sample size decreases (Rowntree, 1981). With the t-test, then, a big difference is needed to establish significance if the samples are small. As the sample size increases, smaller differences become significant (Rowntree, 1981 p140). The intention was to determine the relation of abused children and non-abused children to psychological problems by using SPSS, specifically the Independent-Samples T-Test. Analyses were carried out with the Independent-Samples T-Test with reference to all forms of abuse (i.e. sexual, physical, and emotional), and all forms of neglect (i.e. emotional, physical, and medical). A further analysis was carried out for the purpose of grouping variables, which here include all types of psychological problems (i.e. self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; and aggression), and also 'general health'.

Table (60) shows significant differences between abused /non-abused children in the occurrence of low self-esteem (<. 001), aggression (<. 001)

and psychological distress (<. 006). However, no differences were obtained between the two groups with respect to the following measures: Self-harm (P=. 396), PTSD (P=. 335), impulsiveness (P=. 653), eating disorders (P=. 598), and dissociation (P=. 374).

Table 60 shows Means and Standard Deviation of the two groups (Overall child abused & non-overall child abused), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Overall Child Abuse Group (N=223)		Non-overall Child Abuse Group (N=599)		t	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.108	.311	.119	.324	.429	Yes	.396
Low self-esteem	.484	.567	.349	.536	3.15	No	.001
PTSD	.569	.673	.636	.653	1.27	Yes	.335
Impulsiveness	.586	.637	.673	.666	1.72	Yes	.653
Eating Disorders	.396	.559	.413	.565	.376	Yes	.598
Dissociation	.527	.621	.487	.600	.928	Yes	.374
Aggression	.329	.551	.232	.478	2.46	No	.000
Psychological distress	16.24	6.60	14.05	5.70	4.68	No	.006

Table 61 shows Means and Standard Deviation of the two groups (emotionally abused & non-emotionally abused), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Emotionally Abused Group (N=191)		Non-Emotionally Abused Group (N=632)		t	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.115	.320	.116	.321	.033	Yes	.947
Low self-esteem	.476	.487	.358	.536	2.61	No	.001
PTSD	.508	.631	.651	.663	2.72	Yes	.446
Impulsiveness	.555	.637	.677	.664	2.31	Yes	.799
Eating Disorders	.424	.583	.404	.558	.425	Yes	.326
Dissociation	.529	.596	.490	.609	.790	Yes	.326
Aggression	.319	.569	.240	.476	1.93	No	.000
Psychological distress	16.44	6.66	14.10	5.73	4.76	No	.001

Table (61) shows highly significant differences in the means existing between the emotionally abused group and the non-emotionally abused group with respect to the following measures: low self-esteem (<. 001), aggression (<. 001), and psychological distress (<. 001). However, no significant differences were observed between the two groups in the following measures: self-harm (P=. 947), PTSD (P=. 446), impulsiveness (P=. 799) eating disorders (P=. 326), dissociation (P=. 789).

Table 62 shows Means and Standard Deviation of the two groups (sexually abused & non-sexually abused), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Sexually Abused Group (N=187)		Non-Sexually Abused Group (N=610)		t	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.124	.330	.110	.313	.528	Yes	.281
Low self-esteem	.481	.616	.358	.525	2.75	No	.000
PTSD	.545	.665	.607	.655	1.75	Yes	.450
Impulsiveness	.537	.642	.680	.665	2.54	Yes	.902
Eating Disorders	.398	.581	.412	.561	.237	Yes	.802
Dissociation	.186	.624	.491	.599	.107	Yes	.316
Aggression	.237	.485	.264	.485	.623	Yes	.256
Psychological distress	16.30	6.58	14.1	5.72	4.63	No	.036

In table (62) a highly significant difference in the means between sexually abused groups and non-sexually abused groups can be noted in the following areas: low self-esteem (<. 001), and psychological distress (<. 036). However, no differences were observed between the two groups in the following measures: self-harm (P=. 281), PTSD (P=. 550), impulsiveness (P=. 902), eating disorders (P=. 802), dissociation (P=.316),

and aggression (P=. 256).

Table (63) also shows highly significant differences in the means between the physically abused group and non-physically abused group with respect to the following measures: low self-esteem (<. 013), aggression (<. 025), and psychological distress (<. 006). However, no significant differences were observed between the two groups with respect to: self-harm (P=. 282), PTSD (P=. 207), impulsiveness (P=. 801) eating disorders (P=. 790), and dissociation (P=. 297).

Table 63 shows Means and Standard Deviation of the two groups (physically abused & non-physically abused), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Physical Abused Group (N=101)		Non-Physical Abused Group (N=720)		t	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.100	.301	.118	.323	.556	Yes	.282
Low self-esteem	.505	.594	.369	.542	2.33	No	.013
PTSD	.634	.703	616	.652	.241	Yes	.207
Impulsiveness	.620	.648	.653	.662	.480	Yes	.801
Eating Disorders	.410	.552	.408	.565	.028	Yes	.790
Dissociation	.510	.643	.497	.601	.188	Yes	.297
Aggression	.320	.529	.249	.496	.132	Yes	.025
Psychological distress	16.20	7.05	14.43	5.85	2.77	No	.006

Table (64) shows that there were significant differences between the emotionally neglected and non-emotionally neglected groups in two areas of measures: psychological distress (<. 009), and low self-esteem (<. 021). However, non-statistically significant differences were observed between the two groups with respect to: self-harm (P=. 103), PTSD (P=.

738), impulsiveness (P=. 867), eating disorders (P=. 214), dissociation (P=. 811), and aggression (P=. 326).

Table 64 shows Means and Standard Deviation of the two groups (emotionally neglected & non-emotionally neglected), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Emotionally neglected Group (N=214)		Non-Emotionally neglected Group (N=609)		T	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.131	.330	.110	.314	.796	Yes	.103
Low self-esteem	.449	.569	.363	.542	1.95	No	.021
PTSD	.619	.666	.618	.656	.030	Yes	.738
Impulsiveness	.582	.651	.673	.662	1.74	Yes	.867
Eating Disorders	.441	.577	.397	.559	.792	Yes	.214
Dissociation	.446	.617	.517	.602	.146	Yes	.811
Aggression	.272	.533	.253	.489	.458	Yes	.326
Psychological distress	16.01	6.68	14.16	5.72	3.89	No	.009

Table 65 shows Means and Standard Deviation of the two groups (physically neglected & non-physically neglected), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Physically neglected Group (N=150)		Non-physically neglected Group (N=673)		T	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.412	.570	.408	.563	.050	Yes	.738
Low self-esteem	.400	.543	.382	.552	.785	Yes	.568
PTSD	.546	.619	.634	.666	1.46	Yes	.404
Impulsiveness	.570	.660	.666	.659	1.92	Yes	.637
Eating Disorders	.412	.571	.408	.562	.114	Yes	.250
Dissociation	.486	.623	.501	.603	.137	Yes	.601
Aggression	.266	.501	.223	.478	.145	Yes	.326
Psychological distress	14.86	6.37	14.59	5.98	.633	Yes	.589

Table (65) shows that there were no significant differences between the physically neglected and non-physically neglected groups in all of the

listed measures; self-harm (P=. 738), low self-esteem (P=. 568), PTSD (P=. 404), impulsiveness (P=. 637), eating disorders (P=. 250), dissociation (P=. 601), aggression (P. 326) and psychological distress (P=. 589).

Table (66) shows also there were no significant differences between the medically neglected and non-medically neglected groups in all of the listed measures; self-harm (P=. 137), low self-esteem (P=. 476), PTSD (P=. 695), impulsiveness (P=. 589), eating disorders (P=. 319), dissociation (P=. 601), and aggression (P=. 080). However, only psychological distress (<. 005) had statistical significant differences between two groups.

Table 66 shows Means and Standard Deviation of the two groups (medically neglected & non-medically neglected), and t values for the difference between the means, for the different measures of psychological problems.

Psy. Problem ↓	Medically neglected Group (N=69)		Non-medically neglected Group (N=738)		t	Variances Equal or not equal	Sig
	Mean	SD	Mean	SD			
Self-harm	.145	.355	.114	.318	.703	Yes	.137
Low self-esteem	.435	.555	.380	.549	.781	Yes	.476
PTSD	.739	.678	.612	.656	1.49	Yes	.695
Impulsiveness	.710	.688	.646	.670	7.39	Yes	.589
Eating Disorders	.478	.564	.402	.563	.103	Yes	.319
Dissociation	435	.556	.381	.550	.137	Yes	.601
Aggression	.434	.555	.381	.550	1.12	Yes	.080
Psychological distress	14.73	7.23	14.62	5.86	.143	No	.005

Conclusions from T-Test Between Abused & Non-abused Groups and the relation of these types of abuse to psychological problems:

A close examination of the results reveal that, within the limitations of this study, affective domain psychological problems such as low self-esteem, aggression and psychological distress may have been affected by emotional, physical and sexual abuse and emotional neglect that had been inflicted upon the individuals concerned in childhood. It is likely that those victims of sexual abuse were also physically and emotionally abused.

In conclusion to this section, it can be stated that there are differences between those children that have been emotionally abused and those who have not been abused in the prevalence of their manifesting the following psychological problems: low self-esteem, aggression, and higher psychological distress scores. It is noticeable that the same difference was found between those who had been physically abused and those who had not. This result is in fact confirmed by what we had found in our profiling of abusers in Saudi Arabia in which, it appeared that there were similarities between emotional abuse and physical abuse. Maybe that is why both categories manifest the same consequences in relation to the measures. Psychological distress seemed to be the common denominator between all forms of child abuse and neglect with the exception of physical neglect. This is in fact related to the conventions of Saudi society, where it is more socially acceptable not to be seen to be suffering from any psychological

pain. With regards to neglect only those who had been emotionally neglected seemed manifested differences from those who had not in relation to low self-esteem and psychological distress.

7.7 Multiple Regression

Another technique that is often used in the analysis of correlational designs is regression, which involves estimating the straight line that best summarises the association (Swinscow, 1999). The advantage of multiple regression is that it shows the combined effects of a set of independent variables on a dependent variable and the separate effects of each independent variable controlling for others (Hedderson, 1987). Multiple regression applies best to an analysis in which both the dependent variable and independent variable are normally distributed interval level variables (Hedderson, 1987). Multiple regression also assumes that the effects of the independent variables are linear, that is, the effect of a unit difference in an independent variable is the same as all points in the range of the variable (Hedderson, 1987). Another assumption of multiple regression is that the independent variables are not correlated with one another (Hedderson, 1987). Multiple regression can be used with categorical variables through a technique known as dummy coding (Hedderson, 1987).

Regression has three required subcommands. The first subcommand, 'Independent Variables', is followed by a list of all the variables which are here epidemiological variables including income, number of siblings, and age, occupation, educational level of the parents, social status and residence. Also, all forms of child abuse and neglect, which here are

sexual abuse, emotional abuse, emotional neglect, physical abuse, physical neglect, and medical neglect. The dependent variables that were explained include all measures such as psychological distress, aggression, self-esteem, self-harm, eating disorders, impulsiveness, PTSD, and dissociation. The third command is 'Method = e.g. Stepwise Regression'. A stepwise regression was run, whereby predictors are added to the equation one at a time and subsequently may even be removed if they no longer contribute significantly to regression (Kinnear & Gray, 2000). All of the independent variables were entered with one of the dependent variables to ascertain if there was any relationship between them. If a variable was not significant (>0.1) then it was removed from the list, which happened here in the case of self-harm, and eating disorder.

Table (67) shows the overall score yielded by a multiple regression analysis of the psychological distress scores in the sample. The analysis revealed three significant variables. These variables were emotional abuse (< .001), father's education (< .001), and sexual abuse (< .004). With respect to males, the multiple regression analysis of psychological distress was; emotional abuse (< .001); and sexual abuse (< .028) (see table 68), while the multiple regression analysis with respect to females was; (< .008) father's educational level; and (< .034), sexual abuse (see table 69).

Table 67 shows multiple regression analysis for the overall sample using GHQ 'overall' as the dependent variable.

Step	Psychological distress ↓	Standard Error	Beta	t	Sig
1	Emotional abuse	.063	.179	4.49	.000
2	Father's education	.196	.124	3.32	.001
3	Sexual abuse	.189	.115	2.88	.004

Table 68 shows multiple regression analysis for males using GHQ as the dependent variable.

Step	Psychological distress ↓	Standard Error	Beta	t	Sig
1	Emotional abuse	.073	.195	4.04	.000
2	Sexual abuse	.223	.106	2.20	.029

Table 69 shows multiple regression analysis for females using GHQ as the dependent variable.

Step	Psychological distress ↓	Standard Error	Beta	t	Sig
1	Father's education	.359	.166	2.66	.008
2	Sexual abuse	.294	.137	2.11	.035

Table (70) shows the multiple regression analysis of aggression score for the sample, which revealed three significant variables. These variables were physical abuse (< .001), residence (< .012), and income (< .038). With respect to males the multiple regression analysis of aggression and physical abuse was (< .021) (see table 71), while the multiple regression analysis among female was (< .012) among physical abuse (see table 72).

Table 70 multiple regression analysis for overall sample using aggression as the dependent variable.

Step	Aggression ↓	Standard Error	Beta	t	Sig
1	Physical abuse	.005	.123	3.19	.001
2	Residence	.039	.100	2.51	.012
3	Income	.032	.083	2.07	.038

Table 71 shows multiple regression analysis for males using aggression as the dependent variable.

Step	Aggression ↓	Standard Error	Beta	t	Sig
1	Physical abuse	..006	.111	2.32	.021

Table 72 shows multiple regression analysis for females using aggression as the dependent variable.

Step	Aggression ↓	Standard Error	Beta	t	Sig
1	Physical abuse	.009	.162	2.52	.012

Table (73) shows the score for the sample for the multiple regression analysis of self-esteem, which reveals three significant variables. These variables were child sexual abuse (< .012), father's education (< .001), and child emotional abuse (< .038). Among males, the multiple regression analysis of self-esteem and child sexual abuse was (< .013) (see table 74), while the multiple regression analysis for females was (< .008) child emotional abuse, father's education (< .001), and child sexual abuse (< .031) (see table 75).

Table 73 shows multiple regression analysis for overall sample using self-esteem as the dependent variable.

Step	Low Self-esteem ↓	Standard Error	Beta	t	Sig
1	Sexual abuse	.018	.103	3.53	.012
2	Father's education	.018	.129	3.40	.001
3	Emotional abuse	.006	.084	2.08	.038

*Table 74 shows m*ultiple regression analysis for males using self-esteem as the dependent variable.

Step	Low Self-esteem ↓	Standard Error	Beta	t	Sig
1	Sexual abuse	.021	.119	2.50	.013

Table 75 shows multiple regression analysis for females using self-esteem as the dependent variable.

Step	Low Self-esteem ↓	Standard Error	Beta	t	Sig
1	Emotional abuse	.009	.172	2.66	.008
2	Father's education	.033	.209	3.26	.001
3	Sexual abuse	.028	.142	2.16	031

Table (76) shows the score for the sample for the multiple regression analysis of impulsiveness, which reveals three significant variables. These variables were income (< .001), child sexual abuse (< .012), and child emotional abuse (< .041). It can be seen from table (77) that the multiple regression analysis of impulsiveness and child emotional abuse for males was (< .026), and sexual abuse (< .044), while the multiple regression analysis for females was (< .009) income (see table 78).

Table 76 shows multiple regression analysis for overall sample using impulsiveness *as the dependent variable.*

Step	Impulsiveness ↓	Standard Error	Beta	t	Sig
1	Income	.038	.115	3.19	.001
2	Sexual abuse	.020	.092	2.52	.012
3	Emotional abuse	.007	.077	2.04	.041

Table 77 shows m*ultiple regression analysis for males using* impulsiveness ***as the dependent variable.***

Step	Impulsiveness ↓	Standard Error	Beta	t	Sig
1	Emotional abuse	.008	.102	2.23	.026
2	Sexual abuse	.025	.092	2.01	.044

Table 78 shows multiple regression analysis for females using impulsiveness **as the dependent variable.**

Step	Impulsiveness ↓	Standard Error	Beta	t	Sig
1	Income	.064	.158	2.63	.009

Table (79) shows score for the multiple regression analysis of PTSD for the sample, which reveals two significant variables. These variables were father's educational level (< .036), and child sexual abuse (< .045). There was no multiple regression analysis found among males, while females reveals one significant variable (see table 80).

Table 79 shows m*ultiple regression analysis for overall sample using PTSD as the dependent variable.*

Step	PTSD ↓	Standard Error	Beta	t	Sig
1	Father's educational level	.022	.081	2.10	.036
2	Sexual abuse	.020	.077	2.00	.045

Table 80 shows multiple regression analysis for female sample using PTSD as the dependent variable

Step	PTSD ↓	Standard Error	Beta	t	Sig
1	Father's educational level	.036	.150	2.48	.014

Table (81) shows the multiple regression analysis of dissociation score for the sample, which reveals two significant variables. These variables were residence (< .008), and income (< .019). For males, table (82) shows that the multiple regression analysis of dissociation and residence was (< .030), while no multiple regression analysis was found among females.

Table 81 shows multiple regression analysis for overall sample using dissociation as the dependent variable.

Step	Dissociation ↓	Standard Error	Beta	t	Sig
1	Residence	.047	.106	2.66	.008
2	Income	.038	.094	2.35	.019

Table 82 shows multiple regression analysis for males using dissociation as the dependent variable.

Step	Dissociation ↓	Standard Error	Beta	t	Sig
1	Residence	.052	.104	2.17	.030

Conclusions from Multiple regression analyses

As can be seen from the results of the multiple regression, psychological distress, low self esteem, and impulsiveness seem to have a link with the following measures: sexual abuse and emotional abuse. A similar pattern

is obtained by correlation analyses. Aggression was found to have a link with only one measure, namely child physical abuse, and this result supports that found by correlation analyses. However, correlation analyses found that both forms of abuse (physical and emotional) are associated with aggression. PTSD was found to have a slight link with child sexual abuse, which was not confirmed by correlation analyses. Child sexual abuse here appeared to have a link with the following measures; is; low self-esteem; impulsiveness; and PTSD, and this was confirmed by correlation analyses, with the exception of PTSD.

The level of education of the father was found to have a link with is, low self-esteem, and PTSD, while income was found to have a link with dissociation, impulsiveness, and aggression. The area of residence was found to have a link with aggression, and dissociation.

7.8 EQS Analysis

The statistical modelling program EQS was developed by Professor Peter M. Bentler and is marketed by BMDP Statistical Software, Inc (Bentler, 1989). EQS runs as a batch program. This means that in order to fit a model we have to set up an input file containing the appropriate statement and commands (Dunn et al, 1993). This input file is then read into the EQS package. EQS only then attempts to execute the instructions, sending the results to an output file for later inspection (Dunn et al, 1993 p2). In this study I transferred the data from SPSS to EQS.

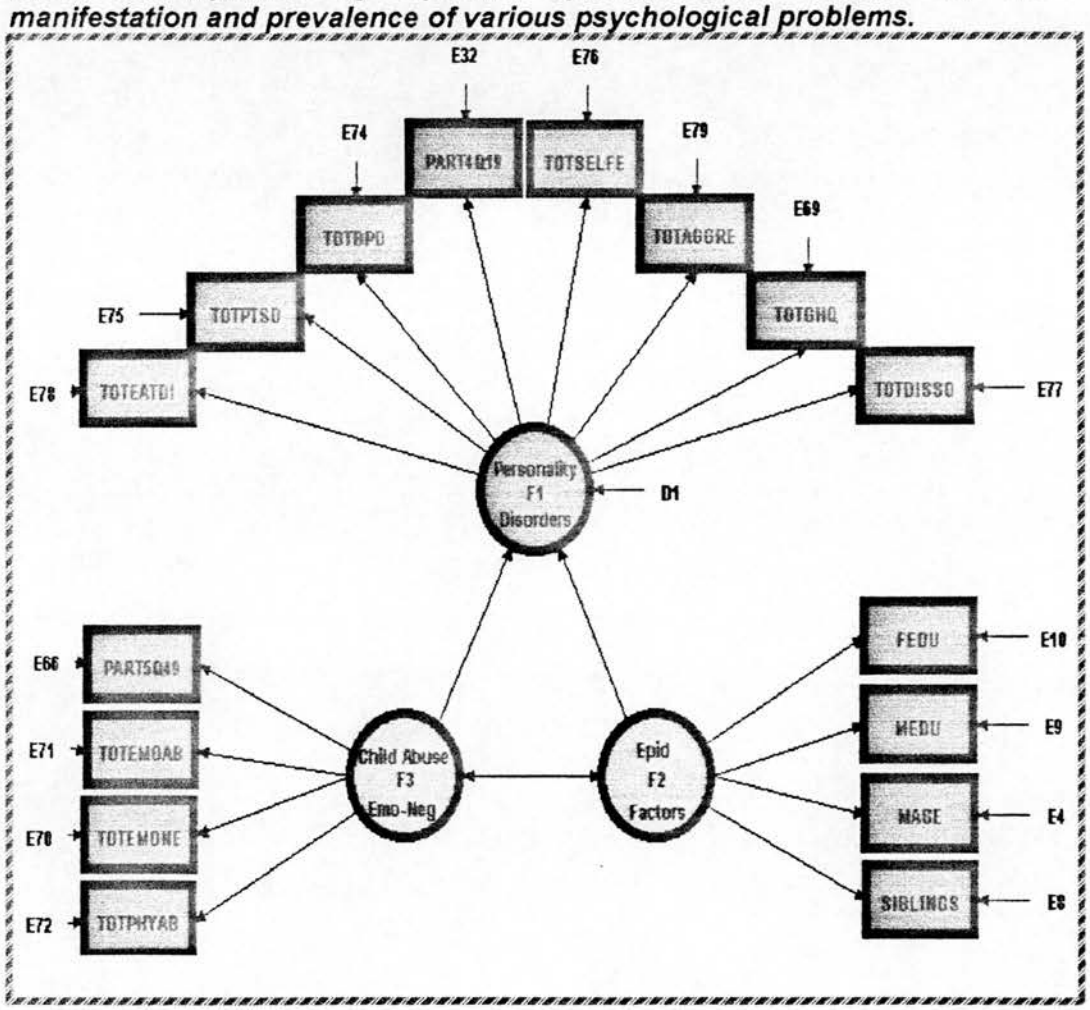
EQS generates several sections of output information (Dunn et al, 1993). The output produces eight pages; the first page contains a list of lines of the input file numbers. Page 2 begins with the first line of the /TITLE paragraph, together with the data of the run. It then proceeds to describe the analysis that has been requested in the input. Pages 3 and 4 started with the statement that maximum likelihood estimates are being used under the assumption of multivariate normality of the Vs and Es, and went on to produce various summaries of the residual covariance matrix. The next statement to consider is 'CHI-SQUARE=BASED ON 2 DEGREES OF FREEDOM'. This is the test for the goodness-of-fit of the proposed model. The final three pages of output provide a reasonable description of the data. This is the most interesting part of the output, containing the parameter estimates, standard errors, and regression coefficients.

The final section provides the so-called 'STANDARDIZED SOLUTION' (Dunn et al, 1993 p35).

The string data and to the EQS program were then returned to in order to test a few simple and obvious hypotheses. The first was based on the assumption that there is a relationship between all forms of child abuse and neglect, various epidemiological factors and various psychological problems. Here we have pointed three underlying factors, F1 psychological problems, F2 epidemiological factors, and F3 child abuse and neglect. It was necessary to determine the consequences of F2 and F3 in their various combinations on F1. Chart (83) shows that if a child faces sexual abuse; physical abuse; emotional abuse; emotional neglect and his or her parents are poorly educated, the mother is young, and the family has more than six siblings, then the outcome psychological problems would be; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress. This result was named the 'Child Abuse & Epidemiological Factor's Group CA&EFG".

The Chi-Square for the independent model in this group was 2067.477 with 120 degrees of freedom. The Chi-Square for the model tested was 205.377 based on 98 degrees of freedom. Probability value for the Chi-Square statistic was < 0.001. The most important factor is the comparative fit index (CFI), which was 0.945.

Chart (83) shows the direct impact of the various forms of child abuse when accompanied by specific epidemiological factors on the manifestation and prevalence of various psychological problems.

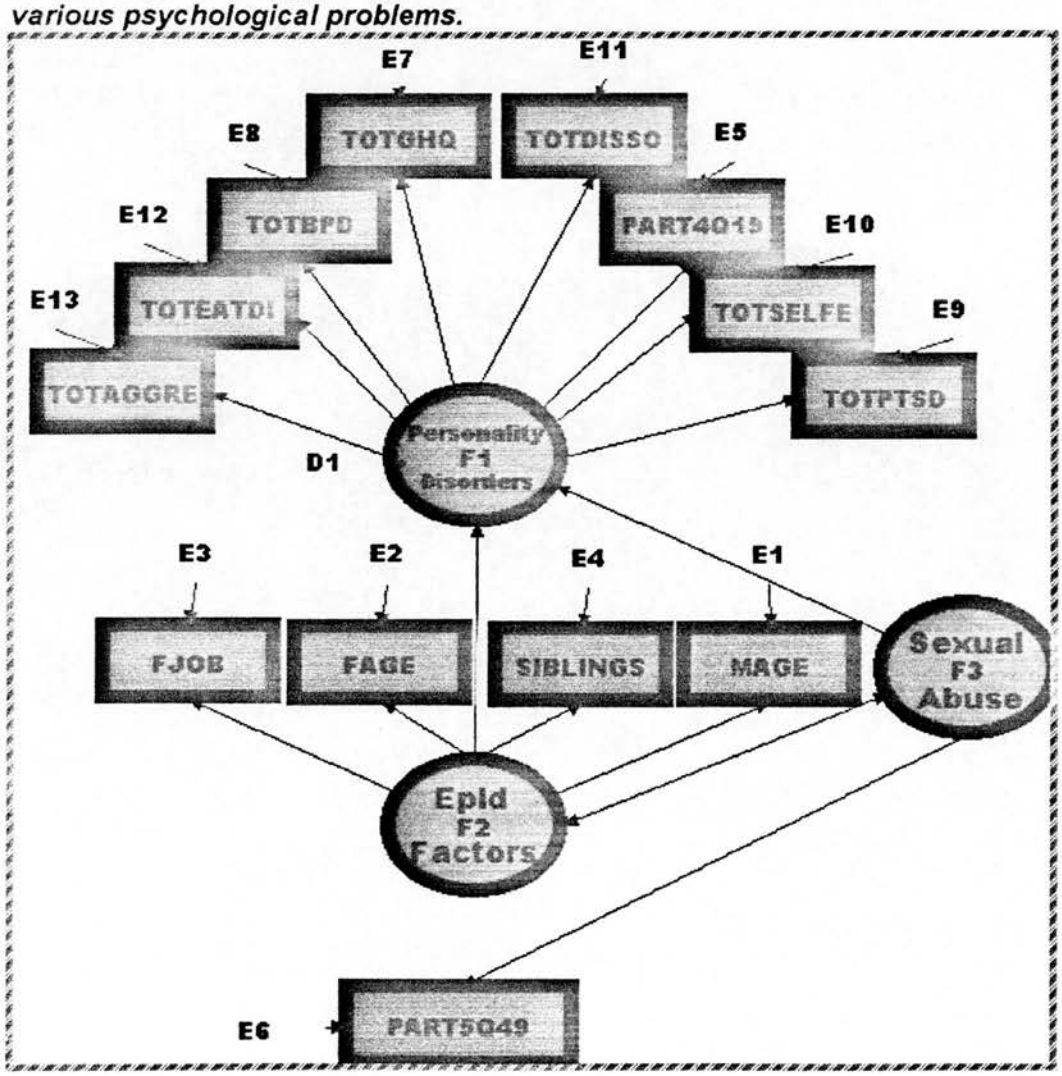


In the case of sexual abuse, if, at the time of the abuse, the parents were young, the father was in unskilled employment, and there were more than 6 siblings in the family, then the following psychological problems result; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress *(see chart 84)*. I would call this group "Sexual Abuse & Epidemiological Factor's Group

SA&EFG".

The Chi-Square for the model tested was 112.713 based on 59 degrees of freedom. Probability value for the Chi-Square statistic was < 0.001 and CFI was = 0.955.

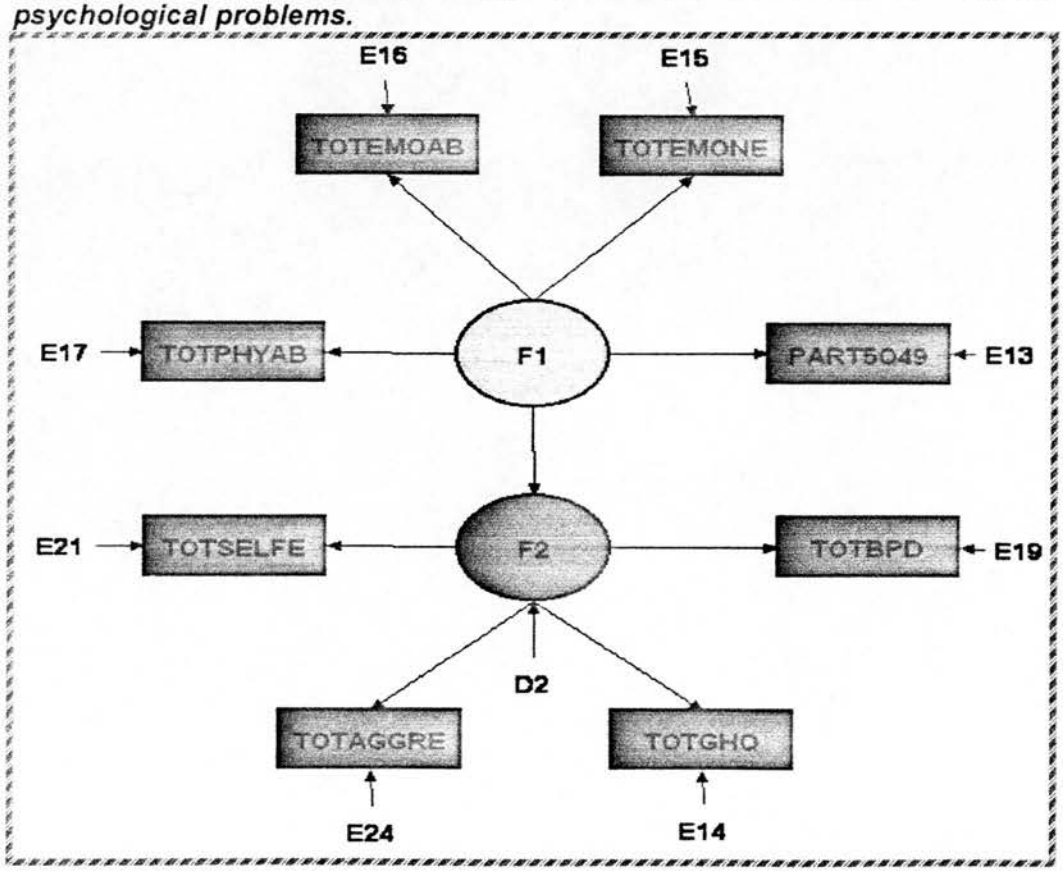
Chart (84) ***shows the direct impact of sexual abuse when accompanied by specific epidemiological factors on the manifestation and prevalence of various psychological problems.***



If child abuse happens without the attendant epidemiological factors mentioned above then the outcome psychological problems are different; for a child that has received all forms of child abuse and child neglect, the consequences would be low self-esteem; aggression; impulsiveness; and psychological distress. I would call this group (Child Abuse's Group).

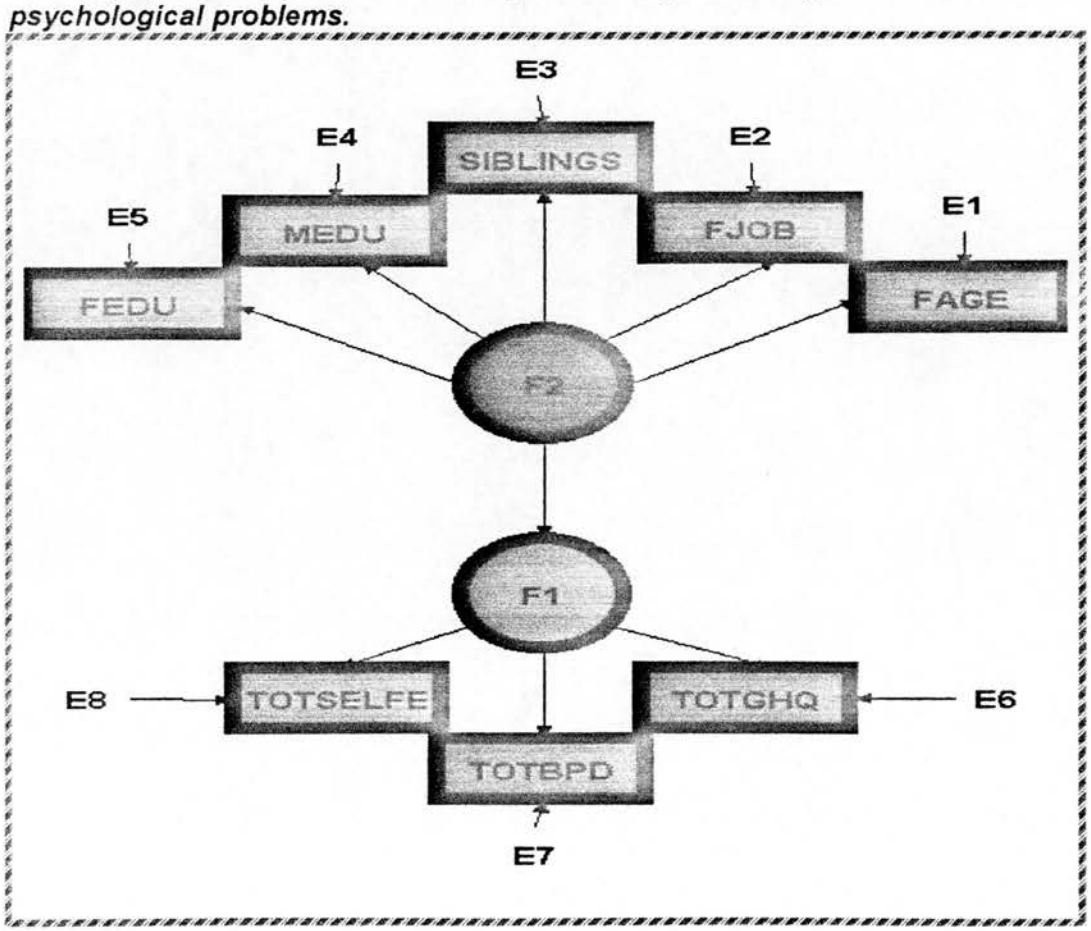
The Chi-Square for the independent model in this group was 732.529 with 28 degrees of freedom. The Chi-Square for the model tested was 27.248 based on 17 degrees of freedom. Probability value for the Chi-Square statistic was < 0.001 and CFI was = 0. 985 (see chart 85).

Chart (85) shows the direct impact of child abuse on subsequent psychological problems.



Various epidemiological factors (the level of the parent's education, the father's job, the father's age, and the number of siblings) indirectly cause certain psychological problems such as low self-esteem; impulsiveness; and psychological distress. Situations related to these factors have a psychological effect on the parents and can create a problem between the children and their parents. The Chi-Square for the model tested was 77.820 based on 17 degrees of freedom. Probability value for the Chi-Square statistic was < 0.001 and CFI was = 0.890 (see chart 86).

Chart (86) shows the direct impact of epidemiological factors on psychological problems.



In conclusion to this section, we know from SPSS analyses that there were several variables that appeared to be related to one another due to their being different ways of measuring one general variable or factor. Take for instance all forms of child abuse, child neglect, and their relationship with psychological problems. Correlation analysis and multiple regression found there to be a relationship between sexual abuse, physical abuse, emotional abuse and emotional neglect, on one hand and low self-esteem, aggression, psychological distress and impulsiveness on the other hand. This was in agreement with the EQS (chart 85). However, we were looking for a technique for condensing many variables into a few underlying constructs. For instance, we might find in EQS that one or all forms of child abuse occurring with one or various epidemiological factors have a strong relationship with the manifestation of one, various or all psychological problems. Our analysis in the EQS revealed which variables were most closely associated with the other factors. Chart 84 shows that when a child faces sexual abuse; physical abuse; emotional abuse; and emotional neglect together, and his or her parents are poorly educated, the mother is young, and the family has more than six siblings, then the outcome psychological problems would be as follows; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress. The conclusion was reached that if any Saudi child faces all forms of abuse and neglect when his or her parents are

poorly educated, the mother is young, and the family has more than six siblings, then the consequent psychological problems would be as above. When looking at sexual abuse alone with the epidemiological factors (sibling, mother's age, and parent's education) the CFI was 0.69, which means that there is a weak unsatisfactory relationship between them. However, when I included the epidemiological factors that appear in chart (83) then the CFI jumped to 0.955. As such, in Saudi Arabia, if the parents are young, the father is in unskilled employment, and there are more than 6 siblings in the family, then the victims of sexual abuse will manifest the following psychological problems; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression; and psychological distress.

Conclusions from EQS analyses

EQS revealed that there was a direct link between all forms of abuse (sexual, physical, emotional), emotional neglect and the following measures; impulsiveness, aggression, low self-esteem, and psychological distress. This result supported by SPSS's result whether that found among multiple regression or correlation analyses. EQS confirmed that emotional abuse, physical abuse, sexual abuse, emotional neglect would cause the following measure; low self-esteem, aggression, psychological distress, and impulsiveness.

You noticed in SPSS that one of forms of child abuse could cause four psychological problems. Take for instance correlation analyses, emotional abuse is associated with low self-esteem, psychological distress, aggression, and impulsiveness.

The consequence of all forms of child abuse (emotional, physical, sexual) and emotional neglect with some of epidemiological factors (mother's age, mother's education, father's education, siblings) would be the following; impulsiveness, PTSD, dissociation, self-harm, self-esteem, eating disorders, aggression, and psychological distress.

There was a direct link between some of epidemiological factors (siblings, father's education, mother's education, father's job, father's age) and the following psychological problems; impulsiveness, low self-esteem, psychological distress.

The consequence of sexual abuse alone with some of epidemiological factors (father's job, father's job, mother's job, siblings) would be the following; impulsiveness, PTSD, dissociation, self-harm, self-esteem, eating disorders, aggression, and psychological distress.

Chapter 8. Discussion

Before discussing the epidemiological aspects of this study, we have to mention that a minority of respondents did not answer some of the epidemiological items of the questionnaire. Take for instance 'father's age' & 'mother's age'; 15.8%, and 9% of them respectively did not answer these questions. This does not mean that they did not answer the rest of the questionnaire. Missing items among those who answered the questions relating to self-harm were found in 3 cases (.4%), while among the sensitive questions, such as those relating to sexual abuse, only in 26 cases (3.2%) were questions found to have been missed. The reason for this could be that one or both parents might already have died, while there was no space to clarify this in the questionnaire.

As mentioned in chapter 6, the first aim of this study was to ascertain the reasons underlying child abuse in Saudi Arabia. In exploration of this, I hypothesized that parent's ages, parent's occupations, parent's education, parent's income, parent's residence, the number of siblings in the family, marital problems, and the age of the child could be among the factors underlying child abuse. This was based on a review of the related international literature, and upon the findings of local studies in the field of child abuse in Saudi Arabia that had been carried out in the last decade, such as Al-Essa (1991); Al-Jumaah et at (1993); Kattan (1994); Kattan (1995); Al-Ayed et al (1998); Roy et al (1999); Elkerdany et al (1999); Karthikeyan et al (2000); and Al-Saud (2002) (see table 87).

Table 87 shows the spectrum of chid abuse cases reported in Saudi Arabia from 1991-2000.

Authors	Type of sample	Type of abuse						
		Physical	Sexual	Emotional	Neglect	M. Syndrome	Child Labour	Overall
Al-Essa 1991	Patients	4	0	0	0	1	0	7
Al-Jumaah et at, 1993	Patients	0	0	0	0	1	0	1
Kattan 1994-1995	Patients	5	2	0	1	4	0	12
Al-Ayed et al 1998	Patients	4	3	0	4	1	1	13
Roy et al 1999	Patients	1	0	0	0	0	0	1
Elkerdany Et al 1999	Patients	2	0	0	0	0	0	2
Karthikeyan et al 2000	Patients	2	1	0	0	0	0	3
Total		18	6	0	7	7	1	39
Al-Saud 2000	Doctors & Carers	91.5%	46.5%	53.5%	87.3	0	0	

Source: Karthikeyan et al, (2000) with some changes from the researcher.

The number of children in a household seemed to be the main epidemiological reason behind child abuse. In other words households in Saudi Arabia that have more than 6 children, were more likely to punish their children physically, ignore them emotionally, perpetrate sexual abuse against them and neglect them medically. Having many children is culturally endorsed, regardless of financial circumstances. This stems from the Islamic faith; the Prophet Muhammad advised his followers to marry a fertile woman, because he will be proud of the size of his nation on the Day of Judgment (Al-Siad, 1997). Another factor that leads women to bear more children is the mistaken belief held by some women that the more children there are in the family the more stable it becomes

(Elkerdany, 1998). Their strategy is to burden the husband financially through children, in order that he does not consider marrying another wife. This conclusion is in agreement with other studies that also assert that there is a link between the number of children in the family and child abuse, such as Oates et al (1979); Qasem et al (1998); Ishmael (1995); and Miller-Perrin & Perrin (1999) who found that the majority of abused children come from families with three or more children.

Physical and sexual abuses are more likely to be found among the lower and middle classes in Saudi Arabia. The average annual income in Saudi Arabia is between *SR*60,000 - 120,000 (teachers, civil servants, police men, and fire fighters fall into this bracket), while the average annual income for the lower class is between 25,000 - 50,000 (this includes builders, plumbers, taxi drivers) (*source*: Planning. org. sa). The middle classes in Saudi Arabia tend to aspire to an upper classes lifestyle, generally through the use of credit. They put their children in private schools; treat themselves and their families in private hospitals and so on. However, in many cases, they find this level of expenditure to be unsustainable. This can have a negative effect on the atmosphere of the home. These circumstances apply also to the lower classes, who in turn tend to aspire to a middle class lifestyle.

Some researchers attempt a causal explanation of the link between poverty and child abuse. Al-Dakail (1990) asserts that low income can

produce two forms of abuse. In both the child is the victim. In the first instance, the children put their parents under pressure when they are unable to fulfil their needs. This pressure could affect the parents' attitudes leading to rift between them and their children. Secondly, the parents inability to respond to their children's needs could reach the level of negligence, and thus abuse. Various studies consider low family income as potentially leading to child abuse such as Miller-Perrin & Perrin (1999); Toscano (1998); Jason & Andereck (1983); Robertson & Juritz (1979); and Oates et al, (1979), who found that the highest rates of child abuse fatality occur among poor people. However, some like Bamford & Roberts (1997) assert that it happens in all levels of society, but is easier to explore among poor societies.

Sexual abuse was more likely to be found among the Bedouin and village dwellers, while physical and emotional neglect were found more likely among urban-dwellers. It is customary in Saudi Arabia, particularly among villagers and Bedouins, to allow related boys to stay together without supervision, and girls also, at the sexually critical ages between 8-12 years. This is in spite of the warning given by Prophet Muhammad 1423 years ago, when he said to his followers,

> ***"Teach the child to pray at the age of seven and beat them if they do not at the age of ten. And separate them in their bedding.*** *(Abu Dawad)*

Parents also let children sleep together in the same place because they are poor or do not understand or believe that a brother/sister or relative could be sexually active at this age, and this is of course a question of education. In fact when the children themselves tell their parents that they have been abused sexually by a relative (some clients reported this at the back of the questionnaire), it can happen that the parents do not believe the children. If they do believe them, they may not seek outside recourse because this could bring shame to the family. Instead they may prefer to solve it as an internal family matter (Barakat, 1993; Haj-Yahia, 1995). Saudi society is highly conservative; it is not permitted for boys to play with girls, but boys playing with boys and girls with girls is allowed. This creates a situation where the younger, weaker personality can be forced to perform sexual acts and be humiliated if they refused. This could have a negative effect on his or her personality in the future.

This study found a link between instability at home such as separated or divorced and physical abuse and medical neglect. Living together does not mean stability in Saudi society for various reasons; the first one, in Islamic societies, it is not easy for couples to divorce each other. Islam seeks both wife and husband to use every means to avoid separation. Allah says in the holy *Quran*:

> ***"If you fear a branch between them twain (the husband and wife) appoint (two) arbitrators, one from his family and the other from her's; if***

they both wish for peace, Allah will cause their reconciliation" (al-Nisa35).

Moreover, under Islamic law, you have to verbally divorce your wife thrice at different times, in order for the marriage to be voided. The scholars assert that if someone declares it three times on one occasion then it is considered as one, in order to give him the chance to weigh up the consequences of the divorce, since it could have been said in anger. The second one, reputation of the divorcees is destroyed, and it is not easy for him and even more for her to find another partner. That is why spouses try to cope with their problems even if they are very averse to one another. As such, it could be that among the 79.6% who live together there are various problems, that could affect the relationship between the parents and their children. This result is in agreement with Kasim et al (1994); Robertson & Juritz (1979), who found there to be a relationship between marital problems and child abuse. Also Lynch & Roberts (1982) found that 24% of abusing parents were separated or divorced.

This study found a link between illiterate's mother and emotional and physical neglect, while the educated father was more likely to neglect his child emotionally and physically. When I said educated fathers I do mean those fathers who had a first degree. Here in this study I integrated those fathers who had primary school (26%), high school (19.9%), and university (22.6) in one category for statistic proposes. The level of education of the

young generation is quite high compared with that of the preceding one (Planning. org. sa). There is in fact commonly a gap between the educational level of parents and their sons or daughters. Forty years ago, people generally did not value education, particularly for girls. In 1960, the girls who enrolled at primary school represented only 2% of the population, while boys who enrolled to the primary schools represented 22% (Planning. org. sa). Then the government initiated new efforts to encourage school attendance. Pupils were given a free snack every day, and a monthly grant to encourage parents and their children to come to school (*Source*: Planning. org. sa). Within a few years, public perception of education for girls had changed radically and the general population become strongly supportive. That is why the number of students increased nearly three times from 669,000 in 1972 to 1,691,000 in 1982 (Al-Farsy, 1986), and five times 2,600,000 by the end of 1989 (Ministry of Panning, 1990). By the end of 1981 the number of girls enrolled at primary school had increased by 43% and boys 81% (*source:* Planning. org. sa), and by the end of 1989 the enrolment levels of both sexes were nearly the same (*source:* Ministry of Planning, 1990). When the people started to realise the value of education the government stopped these initiatives. However, money is still given to undergraduate students (nearly £180 per month) plus free accommodation and a free plane ticket once a year.

To understand better what kind of factors may cause child abuse and

neglect, we looked at two types of SPSS; correlation, and multiple linear regression (2 tailed). Pearson correlations told us that there was a significant correlation between child abuse overall and the number of siblings in the family and income level. When looked at each form of child abuse individually we found all three to be linked with the number of siblings in the family and income, while physical abuse was also linked to the mother's age. Emotional neglect was linked with the father's age, the mother's level of education, the father's level of education, income and residence, while medical neglect was linked with the mother's age; father's job; the number of siblings in the family; the mother's level of education; the father's level of education; income; social status and residence. In attempting to determine the epidemiological factors that could cause child abuse, we used another statistics analysis; multiple regression. Multiple regression showed that income, and father education's level were found to be linked to some forms of psychological problems such as psychological distress, aggression, low self-esteem, impulsiveness, PTSD. EQS confirmed that the number of siblings in the family; the father's level of education; the mother's level of education, the father's age and the father's job influenced the manifestation of the following psychological problems; low self-esteem; impulsiveness; and psychological distress.

The second aim of this study was to identify the types of child abuse that are most common in Saudi Arabia. To this end, we hypothesised that

there are statistically significant differences between the types of child abuse occurring in Saudi Arabia. Physical and emotional abuse were quite visible in Saudi whereas sexual abuse and neglect are not. We then hypothesised that there is a statistically significant relationship between the age of the child and the form of child abuse experienced by it in Saudi Arabia, and finally hypothesised that there are statistically significant differences between women and men in their abuse of children in Saudi Arabia. In other words, that one parent has a greater tendency to abuse their own children than the other, as is apparent from a review of locally conducted studies of child abuse.

As mentioned in the chapter 7, we consider 'rarely true' to be unsuitable for inclusion as an option, except in response to questions on sexual abuse, due its having a strong psychological impact on victims. Its inclusion reduces the chance of victims believing that occasional abuse is not worthy of consideration.

The highest prevalence rate of child abuse and neglect among participants was found to be that of child emotional neglect - 26.6%; 27.3% among households; and 24.3% among students. The second highest prevalence rate was found to be that of child emotional abuse - 22.8%; 21.1% among students; and 23.4% among households. The third highest was that of child sexual abuse - 22.7%; with 27.2% among students; and 14.7% among households. The forth highest was that of

child physical neglect - 18.4%; with 21.1% among student; and 13.5% among households. The fifth was that of child physical abuse - 12.2%; with 12.3% among students; and 12.2% among households. The sixth was medical neglect 9.4%; with 6.6% among students; and 14.5% among households. This result is in disagreement with Al-Saud (2000), who found that the highest prevalence rate of child abuse and neglect as reported by professionals and caregivers was that of child physical abuse at 91.5%; then neglect (all forms) at 87.3%; then child emotional abuse at 53.5%; then child sexual abuse at 46.5%. It is also in disagreement with Al-Eissa (1991); Kattan (1994); Kattan (1995); Al-Ayed et al (1998); Roy et al (1999); and Elkerdany et al (1999) who found that the majority of their child abuse cases in Saudi Arabia were of physical abuse. As can see from table 87, page 288, thirty-nine cases of child abuse have been reported in Saudi Arabia in the last decade, 18 of them were cases of physical abuse. The reason for physical abuse being found to be the most prevalent by these studies is because physical abuse is more easily diagnosable than other forms of abuse (Kashani & Allan, 1998; Wiehe, 1998). Kempe & Helfer, (1980) state that a third of abused children were not brought to the hospital until the morning after the injury, another third came in after one to four days. In other situations, parents usually go into denial, or convince themselves that the injury does not require medical care (p. 130). Even those who finally decide to go the hospital can offer no

explanation as to how the injury happened or attempt to conceal the truth with statements like, "I just found him that way", or "He awoke that way" (Kempe & Helfer, 1980 p.129). Parents try to persuade doctors and caregivers that the injury was spontaneous, but when pressed, they may become evasive or offer a vague explanation such as, "He might have fallen down" (Kempe & Helfer, 1980). It is possible that that is why the majority of cases were of physical abuse in their studies. In Saudi Arabia the duty of the doctor is simply to treat the victims of any type of child abuse, and they are not allowed to investigate any suspicious case. If any of the hospital's staff tries to do so, then they risk being disciplined. Parents and government officials consider this to be a family problem. In addition, some Saudi's doctors and caretakers do not have enough training to distinguish between physical injuries that happen by accident and those that are inflicted deliberately. It is also considered shameful for the victim of child abuse to report her or his parents to the police. It is thought mistakenly that educated children physically do not mean hate them but they will benefit from it when they grow up, this is on the one hand. On the other hand, some non-reporting victims of physical abuse perhaps faced it for a short period, while at the same time receiving strong emotional support from their mothers, grandmothers or other relatives. Dukewich et al (1996) believe that emotional support is an important aspect of social support in this situation. These are possible explanations

of the low prevalence of physical abuse found by this study in spite of its high visibility in day-to-day life.

29.4% of the sample said that they had received physical abuse from their father; then the second most likely origin of the abuser was from among the siblings (18.5%); then from among the relatives (11.6%); then the mother (8.3%), then friends (5.5%) and finally teachers (3.4%). This result is in disagreement with Al-Saud (2000) who found 74.6% of perpetrators to be the victims' mother, then their father (73.2%) and then the mother-in-law. It is also in disagreement with Kattan (1994) who found six cases out of ten to have been punished physically by their mothers. However, the result was in agreement with that obtained by Westcott & Clement (1992), who found that the majority of abusers reported to the NSPCC (81%) were males. Some studies (Petit & Curtis, 1997; Ginsberg, 1995; Al-Eissa, 1991) have found that fathers and mothers punish their children equally.

40.4% of the victims of physical abuse said that they had received it when aged between 11-15 years old, while 32.2% said that they had received it when aged between 6-10, and the third group said that they were aged above 16 years old. This result was also disagreed with Al-Saud (2000) where 66.2% of the sample said that they had dealt with children under two years old; then 63.4% when aged between 4-6 years and then 57.7% when aged between 2-4. Also this study is in disagreement with Kattan (1994) who found the victims in all cases to have been under five years

old. It is also disagreed with Al-Eissa who found all cases of abuse to have occurred when the victim was aged between five months and seven years old. It also differed from the results reached by Lynch & Roberts (1982) who found that 67% of physically abused children were aged less than 1 year. Creighton (1985), also reaches somewhat different conclusions, finding that 2455 (n=4329) cases of physical abuse to involve children under the age of 4. It must be appreciated that this is a critical stage in the child's development. They expect more understanding from their parents and better treatment. However, if it is found that their parents do not meet their expectations, there is a clash between parents and their children. The parents believe that it is their mandate to force children to listen to them, while some children ignore what are arguably their parent's rights. This can result in the physical punishment of the children by their parents. It is likely to be carried out by the father, because mothers may find it difficult to control their children at this stage in particular. It is possible that that is why the victim's mother was found to be the fourth most likely perpetrator of the abuse, while the siblings (male) were the second, and other relatives (male) the third. Physical punishment can come to include elements of emotional abuse particularly at this critical stage.

Child emotional abuse was found to be the second most prevalent form of child abuse and neglect (22.8%) in Saudi Arabia. Fathers were the most prevalent emotional abusers (14.4%); as followed by siblings (12.1%) and

then other relatives (11.8%). Mothers were the fourth most likely emotional abusers. 27% of clients were emotionally abused when they were between 11-15 years old; 19.2% when they were between 6-10 years old; 12% at above 16 years old; then 2.3% when aged under five years old. As mentioned in the result's chapter, on closer examination of both physical and emotional abusers we see a similarity between them. Take for example the perpetrators; fathers were the most likely perpetrators; followed by siblings and then other relatives, in both categories. Further, the majority were emotionally and physically abused when aged were between 11-15 years old, then 6-10 and then above 16 years old, with respect to both categories. In both categories less than 5% of clients were emotionally and physically abused when aged under five years old. This in fact indicates that emotional abuse could be happening as a consequence of physical abuse. In other words physical abuse could be commonly accompanied by emotional abuse.

The third most prevalent form of child abuse and neglect was child sexual abuse (22.7%). Even if we drop the first option - 'rarely true' -, which accounts for 6.2%, it remains the third most prevalent, before child physical abuse. The highest proportion was found among students at 27.2%, compared to 14.7% among households. 23% of victims were found to be aged between 6 – 10; the age at which the child is allowed some independence by the parents, in the company of relatives or friends.

Parents are naturally not prone to suspect their relatives of misconduct, and as such give the child relatively free rein in their company. It is apparent that the ages at which children were sexually abused differ from those of other categories of abuse. Take, for instance, physical abuse; 40% of those who were physically abused were abused between the ages of 11 and 15. Surprisingly 12.8% of the clients said that they had faced sexual abuse when aged above 16 years old, and just 3.2% when aged under 5 years old. This result was in complete disagreement with Ginsberg, (1995) who found that young children in the USA are more likely to be abused, than their older peers (see table 88).

Table 88 shows the victims of child abuse in the USA by age.

Number of victims	Age
61881	Under one year
50356	1
53927	2
52574	3
51186	4
50496	5
50469	6
47731	7
46465	8
44458	9
41179	10
41126	11
39485	12
40232	13
39317	14
35254	15
27885	16
20090	17
6322	Above 18

Source: Ginsberg, (1995).

This time the father was found to be the least likely perpetrator, along with the mother (1%). The most likely perpetrator in the case of sexual abuse were other relatives (16.6%), then friends (12.3%), then siblings (4.8%), and then teachers (2.1%). This result was in agreement with Larsen et al (1998) who found that in 47 cases (51.6%) the child had been sexually abused by people outside the home. It is also in agreement with Madu & Peltzer (2000), who found that in 39 of 45 cases (86.7%) the victims were

sexually abused by men such as the stepbrother, friends of the stepbrother, friends of the stepfather, and the mother's male friends.

Physical and medical neglect were the fourth and sixth most prevalent forms of child abuse neglect in Saudi Arabia respectively. The prevalence of child physical neglect was 18.4%, while the prevalence of child medical neglect was 9.4%.

The third aim of the study was to examine a number of key issues about the sequelae of the experience of abuse. To this end we hypothesised that there are statistically significant relationships between child abuse/ child neglect and subsequent psychological problems in adulthood in Saudi Arabia. We utilised different types of SPSS including the T-Test, correlation, and multiple regression. The T-test showed there to be significant differences between two groups, 'child abuse overall' and 'non-child abuse' overall in relation to low self-esteem, aggression, and psychological distress. This means that the 'child abuse overall' group showed a high level of occurrence of low self-esteem, aggression, and psychological distress when comparing with the group 'non- child abuse overall'. However, when looking at the forms of child abuse individually, we found emotional abuse to show significant differences between two groups in relation to the occurrence of low self-esteem, aggression and psychological distress, while physical abuse showed significant differences between the two groups in relation to low self-esteem,

aggression and psychological distress. Sexual abuse showed significant differences between the two groups in relation to the occurrence of low self-esteem, and psychological distress. Surprisingly, sexual abuse did not show a correlation with the occurrence of self-harm or eating disorders. This could be related to the prevalent beliefs in Saudi Arabia, where 99% of the whole of Saudi population are Muslims; 85% being Sunni Muslims and 14% Shiite Muslims (*source:* Planning. gov. sa). Muslims believe that if someone attempts suicide or harms themselves, they may repeat that action in the next world. For instance, if someone cuts themselves with a knife or throws themselves from a mountain they may keep repeating the same act in the same manner in the hereafter. It is considered appropriate that a Moslem should always ask God to relieve them of their pain and difficulty. In a *Hadith* narrated by *Abu Huraira* the Prophet Muhammad said:

> ***"Whoever purposely throws himself from a mountain and kills himself, will be in the (Hell) Fire falling down into it and abiding therein perpetually forever, and whoever drinks poison and kills himself with it, he will be carrying his poison in his hand and drinking it in the (Hell) Fire wherein he will abide eternally forever, and whoever kills himself with an iron weapon, will be carrying that weapon in his hand and stabbing his abdomen with it in the (Hell) Fire wherein he will abide eternally forever*** (Khan, 1994 p.944).

Prophet Muhammad used to teach his companions the following formula when they faced difficulties:

> ***"None of you should wish for death because of a calamity befalling him; but if he has to wish for death, he should say: 'O Allah! Keep me alive as long as life is better for me, and let me die if death is better for me*** **(Khan, 1994 p.944).**

Under Islamic law (Shari a) as applied (sic) by the Saudi government, the perpetrator self-harm or attempted suicide will be punished. The big challenge for those people who try to harm themselves comes from society itself. People in general try to avoid stigma as psychiatric patients. In Arabic societies, rejection of the mentally ill is endemic (Haj-Yahia, 1999). It is hard for psychiatric patients to integrate with society. It is difficult for them to make friends, to find a job, or to marry. Therefore, I believe, victims of child abuse try to transfer their psychiatric symptoms to a more socially acceptable mode, which may result in psychosomatic illness. It is possible that this is why general health was the most common disorder found by this study.

Further correlation analysis showed there to be a relationship between child abuse overall and low self-esteem, impulsiveness, aggression and psychological distress. However, on looking at the forms of child abuse individually we found that low self-esteem and psychological distress have a relationship with all forms of child abuse, while impulsiveness has a relationship only with emotional and sexual abuse. Aggression has a relationship with physical and emotional abuse.

Emotional neglect was found to have a relationship with impulsiveness and psychological distress, while only medical neglect has a relationship with aggression. Multiple regressions gave a confirmation that low self-esteem, aggression, and psychological distress were the most common psychological problems sequential to child abuse in Saudi Arabia. To confirm this an EQS was conducted. All forms of child abuse and neglect and psychological problems were entered. A strong link was found between all forms of child abuse; emotional, physical, and sexual abuse, emotional neglect, and four of the psychological problems; low self-esteem, impulsiveness, aggression and psychological distress (see chart 85).

In conclusion, emotional abuse, emotional neglect, physical abuse and sexual abuse individually or together would associate with the following psychological problems; low self-esteem; impulsiveness; aggression; and psychological distress. These findings are in agreement with Cerezo-Jimenez & Frias (1994) who found that the victims of child abuse showed greater feelings of sadness, lower self-esteem, and low self-worth during adulthood. When these forms of child abuse were accompanied by unfavourable epidemiological factors such as a low level of parental education, the mother's age, and the number of siblings in the family, then the following psychological problems occur; low self-esteem; self-harm; impulsiveness; PTSD; eating disorders; dissociation; aggression and psychological distress.

Chapter 9. Summary, Conclusion, and Recommendations

"The past has gone, the future is uncertain, and the present is a mess!
(J. Richards)".

Introduction:

As far as the researcher knows, this was the first time such a questionnaire was submitted in public about child abuse. Officials in the postal directorate and the universities told me that this was the first time that they had allowed such a questionnaire to be delivered. It is true that there have previously been investigations related to child abuse (mentioned in the previous chapter), but these did not probe people's feelings or experience directly. None of them went to the public and asked them directly about child abuse. This study can be considered to be the first Saudi Arabian nationwide study of child abuse & neglect, and it is intended to give a brief overview, while opening the door for other researchers by breaking the taboo that surrounds the issue of child abuse in Saudi Arabia. This study was carried out in 3 out of 5 of the major regions of Saudi Arabia, while certain forms of abuse were treated with only one question, and certain psychological problems with only two. However, it still provides strong support for the argument that child abuse exists in Saudi Arabia society. It also supports the hypothesis that child abuse has a strong psychological impact on victims in adulthood. Furthermore, the results highlight the need for further research into various aspects of the problem.

9.1 Summary of the main findings:

The target population in this study were those adult males and females who have experienced any type of abuse (emotional, physical, or sexual), or neglect (emotional, physical, or medical) during their childhood. We selected two populations; university' students; and households. We selected the student population from two universities; KFU, which is located in the Eastern Region of Saudi Arabia; UQU, in the Mecca region in the west of Saudi Arabia; and TC in the same city. In the selection of the household population, I chose two major regions; the Riyadh Region in central Saudi Arabia, and the Eastern Region. The study took place between the 25th of March 2001 and the 20th June 2001. A questionnaire was chosen because I found it to be a suitable method for the collection of accurate information in a sensitive study like this one. I divided it into three parts; the first part was intended to explore the cause of child abuse and neglect, the second part to explore the consequences of child abuse and neglect, with the aim of obtaining an overview of the prevalence of child abuse in Saudi Arabia. I sent 800 copies of the questionnaire to students and 1000 copies to householders. The total number of respondents was 823 representing an overall response rate of 46%.

Approximately two thirds of the whole sample (65%) were male. 44.1% of the males were aged between 21-25. More than half of the sample, (56% - consisting of 26.8% students; and 25.7% households) came from the

middle classes, while 26.4% of the entire sample; 26.8% of students; and 25.7% of households came from the upper classes. 15.1% of the entire sample; 12.5% of students; and 16.21% of households came from the lower classes. Roughly 38.8% of the total sample had between 6-10 siblings, (7.7% among households, and 33.5% among students). Roughly one-third, (32% of fathers, and 38.8% of mothers) in the sample were aged 41-50. Roughly half of the mothers sampled were illiterate. The percentage illiteracy was quite high among mothers in households (68.4%), and decreased in the student sample (37.4%). Two-thirds (79.6%) of parents in the sample were living together, while a small group (11.7%), were widows or widowers, and 6.0% were divorcees. 76.2% of the mothers sampled were housewives. 76.3% of the entire sample inhabit urban areas, while 18.2% come from villages, and 3.3% were Bedouin.

According to the aim of the study there were three questionnaires; first one to explore the types of child abuse; second one to explore as much as possible the consequences of child abuse, and the third one to explore the reasons for child abuse. It was surmised on the basis of previous investigations that the consequences of child abuse in adulthood would most likely be medical or psychological. Our primary concern here is to determine the psychological consequences. A search of various libraries for questionnaires that measure child abuse and its consequences turned up the Child Trauma Questionnaire CTQ (The Psychological Corporation,

1998). We did not find many questionnaires dealing with the consequences of child abuse. As such we created new questionnaires by selecting 13 questions that address different aspects of the sequelae we considered relevant from various existing questionnaires as follows; low self-esteem (Rosenberg, 1965); Borderline Personality Disorders impulsiveness (First et al, 1997); Post-traumatic Stress Disorders PTSD (Joseph et al, 1997); Dissociation (Vanderlinden et al, 1993); Self-harm (First et al, 1997); Eating Disorders (The Centre for Eating disorder. Com), and Aggression (Briere & Runtz, 1990). In addition to the General Health Questionnaire GHQ (Goldberg & Williams, 1988), which was developed and translated to Arabic language by Hasan (1999). And finally the third part of the questionnaire associated with the causes of child abuse, which we designed demographic questions to deal with clients themselves and their parents. After formulating the questionnaire, we submitted it for review by 10 of my colleagues in the Department of Psychiatry, Royal Edinburgh Hospital to find out their views about the questionnaire. Then we translated the questionnaire into the Arabic language and then submitted it to the Associated Professor of Linguistics for his criticism, then submitted copies to several Professors of Psychology who qualified from universities in Great Britain or the United States of America. Some of them have extensive experience in the translating and establishment of inventories and scales, and in certain cases their work is used widely in

psychiatric clinics and hospitals. Then I requested five friends and colleagues in Edinburgh who are studying for their PhDs to complete the questionnaire and to ascertain that it was clear and well ordered. We then made a pilot study sending 2 copies to 40 Saudi and Arabic PhD and Master's students at Edinburgh, Heriot-Watt, and Napier Universities.

As found by this study, the prevalence of child abuse and neglect in Saudi Arabia was as follows; the prevalence of child emotional neglect in Saudi Arabia was 27%, with 25.4% among students, and 27.3% among households, while the prevalence of child physical abuse in Saudi Arabia was 13%, with 12.3% among students, and 12.2% among households%. As mentioned in the previous chapter this result was in disagreement with Al-Saud (2000), who found that the highest prevalence rate of child abuse and neglect as reported by professionals and caregivers was that of child physical abuse at 91.5%, and also with disagreement with another local studies such as Al-Eissa (1991); Kattan (1994); Kattan (1995); Al-Ayed et al (1998); Roy et al, (1999); and Elkerdany et al (1999) who found that the majority of child abuse cases in Saudi Arabia were of physical abuse. Disagreements with these studies related to methods that were used in their studies. All of them except Al-Saud (2000) used the same methods with their patients who were brought to the hospitals seeking for help. These cases did not take into consideration all children in the Saudi society for various reasons; firstly, the patients were collected from only

three hospitals where there are more than two hundred hospitals in the whole country (*Source:* Ministry of Health, 1996*).* Secondly, a third of abused children were not brought to the hospitals until the morning after the injury, another third came in after one to four days. In other situations, parents usually go into denial, or convince themselves that the injury does not require medical care (Kempe & Helfer, 1980 p. 130). If that happened worldwide, I suspect that some parents in Saudi would not bring their children to hospital at all except in critical situations. If this problem exists within cases of physical abuse then what about other cases of neglect and emotional abuse within a society where figures for illiteracy have reached 25% (*Source*: Alwatan Newspaper, 2003).

This of course applies to Al-Saud (2000) where the sample was professional and consisted of the caregivers who work with cases of child abuse neglect or know someone who does. We have to understand that no one would bring his or her child to the hospital unless he/she was suffering from extreme physical abuse. As such, cases of child abuse and neglect that are brought to hospitals or custody houses do not represent the actual prevalence of child abuse or neglect. Even in the UK, cases of child abuse and neglect that brought to NSPCC in 1990 showed that physical injury to be most prevalent (29%), and neglect came third with just 7% (Creighton, 1992). We need to understand what is the reality of child abuse and neglect on the ground. A survey study conducted in

America by US Department of Health and Human Services (1993) found that the highest prevalence rate of child abuse was neglect with proportion of 44%. In Saudi Arabia physical abuse by the father was the most prominent - 29.4% of the entire sample, 29.6% for students and 29.1% for households. The second most prominent origin of physical abuse was from a sibling - 18.5% for the entire sample, 21.4 for students and 12.5% for households. The victim's mother was fourth in prevalence - 8.3%, and then friends and teachers - 5.5% and 3.4% respectively. This result was in disagreement with Al-Saud (2000) who found 74.6% of perpetrators were mothers, then fathers 73.2% and then mother-in-low. Also in disagreement with Kattan (1994) who found six cases from ten punished physically by mothers. This study agreed with review studies conducted by NSPCC between 1988-1990, which found 61% of perpetrators were natural fathers (Creighton, 1992). In Saudi Arabia people give a high status to males in their right to educate children and relatively low status to females (Al-Khayyat, 1990; Barakat, 1993; Haj-Yahia, 1995). The oldest male in the family gives high priority to supervising the finances and discipline in the household. That is why mothers came fourth after fathers, siblings, and relatives. This result is in agreement with Westcott & Clement (1992) who found (81%) of abusers that reported to the NSPCC were males. There are some studies like (Petit & Curtis, 1997; Ginsberg, 1995; Al-Eissa, 1991) who found fathers and mothers punished their children equally.

40.4% of those people who had been physically abused in their childhood were aged between 11-15 with respect to the entire sample (40.8% among students and 39.6% among households); then 32.2% of the entire sample when aged 6-10 (31.6% for students and 33.3% for households); 7.5% were aged above 16 years, and finally 4.2% were aged under 5 years. This result disagreed with Al-Saud (2000) who found 66.2% of the sample dealt with children under two years, then 63.4% for those who were aged between 4-6 years, and then 57.7% of those who were aged between 2-4 years. Also in disagreement with Kattan (1994) who found all cases were aged under five years old; and also disagreed with Al-Eissa who found all cases were aged between five months and seven years old. And in disagreement with Lynch & Roberts (1982) who found that 67% of physically abused children were aged less than 1 year. And also in disagreement with Creighton (1985) who found that 2455 (n=4329) cases of physical abuse involve children under the age of 4. This result was also in disagreement with Creighton, (2000) who found (57%) of physically abused children were aged between 0-4 years, followed by 5-9 years (23%), and then 10-14 years (17%). As mentioned in chapter 7, the majority of the sample were aged under 25 years, which means it was easy for them to remember when exactly faced physical abuse. It must be appreciated that adolescence is a critical stage in the child's development. They expect more understanding from their parents and better treatment.

However, if it is found that their parents do not meet their expectations, there is a clash between parents and their children. The parents believe that it is their mandate to force children to listen to them, while some children ignore what are arguably their parent's rights. This can result in the physical punishment of the children by their parents. It is likely to be carried out by the father, because mothers may find it difficult to control their children at this stage in particular. It is possible that that is why the victim's mother was found to be the fourth most likely perpetrator of the abuse.

The prevalence of child emotional abuse in the total Saudi Arabia society was 22.8%, (with 21.1% among students and 23.4% among households). This result is in disagreement with Al-Saud, (2000) who found emotional abuse to be the third most prevalent (53.5%). And also in disagreement with study conducted by US Department of Health and Human Services, (1993), who found cases of emotional abuse come fifth with proportion of 6%. Also disagreed with Meadow (1993) who found 6% from the children that registered at NSPCC in 1991 were cases of emotional abuse, and also disagreed with Creighton (1985) who found 2% of cases of emotional abuse that registered at NSPCC in 1988 increased to 3% in 1989, and decreased to 2% in 1990. It is noticeable fro the results that there is a big difference between this study and other studies mentioned earlier. Emotional abuse seems to be a quite visible in Saudi. Using dirty words

like 'stupid', 'lazy' and 'ugly' are quite common without realising these words could affect the children. As mentioned in the introduction of chapter one, a report published in 1997 by Riyadh education office shows that some schools in Riyadh region verbally abused children emotionally by using terms such as 'lazy', 'stupid', and 'ugly' (Al-Saud, 2000). We could not imagine that these things still occur now at our schools. Nobody can stop them because there is no Saudi regulation to try to stop this from occurring. You can imagine if that is occurring widespread at schools, then what within homes?

14.4% of the victims of emotional abuse said that, they had been abused emotionally by their fathers (15.3% among students and 13.8% among households.) The second perpetrators were siblings. The third category of perpetrator consisted of other relatives (11.8% overall 12.6% students and 11.2 households.) Mothers, friends, and teacher made up the other 6%.

This result disagrees completely with Creighton (1992) who found that 41% and 27% of mothers and fathers respectively were suspected to have been perpetrators of emotional abuse of their children by the NSPCC between 1988-1990. It also disagrees with Al-Saud who found the mother to be the most prevalent perpetrator of emotional abuse.

27.3% of the entire emotionally abused sample said that they had received emotional abuse when aged between 11-15 (29.7% among students and 23.8% among households); followed by the 6-10 age bracket

(19.2% for the entire sample, 19.2% for students and 19% for households). 12% of the entire sample (12.2% for students and 11.9% for households) were aged 15 years or over when emotionally abused. Only 2.3% reported that they had received emotional abuse when under the age of 5 years. This result was completely in disagreement with Creighton, (1992) who found the average age for those children who suffered from emotional abuse in NSPCC between 1988-1990 was as follows; 0-4 years (37%), 5-9 years (36%), and then 10-14 years (23%). Also in disagreement with Creighton, (2000) who found the average age of emotional abuse was 0-4 years (52%) followed by 5-9 years (43%), and then 10-14 years (5%).

Close examination of both physical and emotional abusers showed some similarities between them. Fathers were the most prevalent perpetrators of physical and emotional abuse, followed by siblings and then other relatives.

The victim's ages provide further similarities. The majority in both categories said that they had been emotionally and physically abused when aged between 11-15 years; then 6-10 years; and then above 16 years old. Again, with respect to both types of abuse, less than 5% were aged under 5 years at the time of abuse. Could it be that there is a relationship between physical abuse and emotional abuse? It is possible that those who received physical abuse were also affected emotionally.

The prevalence of sexual child abuse in Saudi Arabia was 22.7%, with 27.2% among students, and 14.7% among households. Before discussing this result, I should mention that I was hoping to raise other areas of discussion related to sexual abuse with respondents. Areas concerning people deliberately exposing their sex organs to respondent, people touching or fondling the respondent's sex organs or being hugged or kissed in sexual way, people making the respondent touch or fondle their sex organs or full sexual intercourse and people attempting sexual intercourse or oral intercourse or anal intercourse/buggery or any other sexual activity. However, as I mentioned in the chapter 6, when asked, Saudi officials about these matters, they replied you must integrate these questions into one general question. Here I found myself having two options; one to ignore what they said and delete all sexual questions or listen to them and integrate their requirement into one question. At this stage the method of asking one question covering the different subjects proved highly successful in order to advance the next area of researches. It is crucial to understand this is the first national survey in Saudi Arabia of adults and the possibility of them having been sexually abused as children. This question helped initially to understand the prevalence of sexual abuse in Saudi Arabia. This result gave us a clear sign that sexual abuse is a big problem across the nation, particularly amongst the younger generation. 66.2% of the whole of the sample were aged under

25 years old. Within the sample, student's age under 25 years amounted to 90.4%, and household amounted to 25%. This result was totally in agreement with Creighton (1992) who found 23% of those registered in NSPCC in 1988 was sexually abused. And slightly similar to Sacco & Farber (1999) who found 27.4% of the sample reported sexual abuse. Also in America, US Department of Health and Human Services (1993) found 15% who registered at the department was sexually abused.

In spite of the 77% of the entire sample did not answer the question dealing with sexual abuse, and in spite also of the 62.1% failure rate in answering the question relating to the perpetrators of sexual abuse - 16.6% of those who answered reported that they had been sexually abused by a relative. Nearly the same rate was found among students (16.2%) and a slightly higher rate was found among households (17.8%). The second most prevalent category was that of 'friends' - 12.3% for the entire sample, with 13.4% among student and 8.8% among households. Siblings were the third most likely source of abuse (4.8% for entire sample, 4% among students and 6% among households). Not surprisingly, only 1% of mothers and the same number of fathers admitted to performing sexual acts with their children. This result was in agreement with Larsen et al (1998) who found that in 47 cases (51.6%) the child had been sexually abused by people outside the home. It is also in agreement with Madu & Peltzer (2000), who found that in 39 of 45 cases (86.7%) the

victims were sexually abused by men such as the step-father, step-brother, friends or the mother's male friends. And also this result is agreement with Creighton, (1995) who found 24% of sexual abusers in NSPCC were relatives such as uncle, aunt, grandfather and other relatives. Friends of fathers or siblings were 10%. This study also in agreement with Finkelhor et al, (2000) who found 21% of sexual abusers (13% among men, 8% among women) were relatives, then friends 19% (10% among men, 9% among women). However, this study was in disagreement with Creighton, (1995) who found 8% the victims were sexually abused by fathers. As we can see, there was no difference between this study and other studies in relation the perpetrators. They totally agreed that the most perpetrators of sexual abuse came from outside the household.

23% of the entire sample said that they had been sexually abused when they were aged between 6-10 years (19.7% for students and 23.3% for the households). 19.8% of the entire sample were abused when they were aged between 11-15 years (19% for students and 21% for households). 12.8% of the entire sample were above 16 years old (12.7% of students and 13.3% of households). This study disagrees with the NSPCC where the distribution of ages of the children who registered between 1988-1990 for sexual abuse was: 10-15 years old (36%), then 5-9 years (28%), and then 0-4 years (22%) (Creighton, 1992). It also disagrees with Creighton

(2000) who found the distribution to be 10-14 years (56%), then 5-9 years (28%), and then >15 years old. The reason why 6-10 years in Saudi Arabia come the first rather than 11-15 was related to the society itself. Parents or guardians start to allow children to have some independence in the company of relatives or friends. Parents are naturally not prone to suspect their relatives of misconduct, and such give the child relatively free reign in their company. I believe that this age in particular the age when a child start to become attractive. At the same time, children of this age cannot understand what other people motives towards them might be. Unfortunately, some families in some areas such as villages of Bedouins would allow their children to stay alone with teenage relatives without realising something wrong could happen.

It is apparent that the ages at which children were sexually abused differ from those of other categories of abuse. 23% of the entire sample were sexually abused when they were aged between 6-10 years old, while 27.3% and 40.4% of emotionally and physically abused children respectively were abused while aged between 10-15.

A T-test showed highly significant differences in the Means existing between emotionally abused group and the non-emotionally abused group were noted with respect to the following measures: low self-esteem ($p<.001$); aggression ($p<.001$); and psychological distress ($p<.001$). This result was in agreement with Mulien et al (1996) who found that

emotionally abused

children are more likely to develop a depressive illness. And also agreed with Briere & Runtz (1990) and Mullen et al (1996) found there to be a unique relationship between emotional abuse and subsequent low self-esteem. As mentioned in chapter 2, there is still no clear consensus on how to define emotional abuse, because there are different opinions of whether the emphasis should be on the abuse of the child or the behaviour of the parent (Wilson & James, 2002). This could affect the researcher as to the real impact of it. You can see here the similarity of consequences of physical and emotional abuse, which could raise the question 'did this happen because of accompanied physical abuse?' To support this idea I did not find in the literature review in any study to suggest there could be a link between emotional abuse and aggression.

On the other hand, statistically, aggression seemed to be the real impact of emotional abuse ($p<.001$) comparing with physical abuse ($p<.025$).

In the case of physical abuse, highly significant differences in the Means between the physically abused group and non-physically abused group were noted with respect to the following measures: low self-esteem ($p<.013$); aggression ($p<.025$); and psychological distress ($p< 006$). This result was in agreement with Corby (2000), Briere & Runtz (1990) who found a link between physical abuse and later manifestations of aggression or anger. And also in agreement with Haj-Yahia & Dawud-

Noursi (1998), Haj-Yahia (2001), Ryan et al (2000) who found a link between aggression and physical abuse. This result also was in agreement with Mulien et al (1996) who found that physically abused children are more likely to develop a depressive illness. Figures relaying aggression towards others have become quite a concern among those officials in Saudi Arabia after they realized the figures increased day by day. Al-Mulk (1994) found that violence in the Saudi' society is excited not only among street's children but also among college's students.

In the case of sexual abuse, highly significant differences in the means between sexually abused groups and non-sexually abused groups were noted with regard to low self-esteem ($p<.001$) and psychological distress ($p<.036$). This result agreed with Mullen et al, (1996); Briere & Runtz, (1986); and Peters & Range (1993) who found a link between child sexual abuse and depression, low self-esteem and self-blame. Also this result was in agreement with Corby (1993) who found that there is an association between sexual abuse and subsequent sleeping disorders. And agreed with Read (1998) who found there to be a relationship between childhood sexual abuse and suicide. Mullen et al (1996) found attempt suicide not only among sexually abused but also among physically and emotionally abused. And in agreement with (Finkelhor, 1984) who found in the sample people who had been sexually abused as children, of both sexes, had lower levels of low self-esteem than other

people.

Surprisingly, there was no link between sexual abuse or physical abuse and self-harm or eating disorders, in spite some researchers such as Bird & Faulkner (2000), Arnold (1995) who found a link between self-harm and sexual abuse or even physical abuse. Could this be because we have only one question addressing self-harm. Or could this be because it is totally not acceptable for a Moslem to harm themselves. Under Islamic law (Shari a) as applied by the Saudi government, the perpetrator self-harm or attempted suicide will be punished. May be that is why self-harm seemed to be not significant.

Also in spite of some studies which have found a link between sexual or physical abuse and eating disorders such as Hall & Lloyd (1993), Mullen et al (1996), Ackard et al, (2001), this a study found no significant correlation between them. As far as the researcher knows, in our society losing a weight or having a beautiful body shape is not a concern to women or even to men. When a man searches for a woman to marry, he avoids a thin one, while among men to be a fat is sign of worth.

There were significant differences between the emotionally neglected and non-emotionally neglected groups with respect to low self-esteem ($p<.021$), and psychological distress ($p<.009$). This result was in agreement with Oates et al (1985) who found a link between neglected children and low self-esteem. There were no significant differences noted between the

Physically neglected and non-physically neglected groups with respect to all of the listed psychological problems. There were no significant differences between the medically neglected and non-medically neglected groups except psychological distress (p<. 005).

Correlation and Multiple regression analyses confirmed the findings of t-test analysis, which related to low self-esteem, aggression, and psychological distress. However, within correlation and multiple regression, each presented different findings. Take for instance correlation analysis, it was found a correlation between emotional abuse and impulsiveness (p<. 007), and between sexual abuse and impulsiveness (p<. 005), which means the higher the rate of occurrence of child emotional abuse, child sexual abuse the higher rate of occurrence of impulsiveness. This result was in agreement with Figueroa & Silk (1997) who found that there is a relationship between childhood sexual abuse and impulsiveness. On the other hand, multiple regression analysis of PTSD score for the sample revealed significant variable. This variable was sexual abuse (p<. 045). This result was in agreement with Schaaf & McCanne (1998) who found that there are significantly higher rates of PTSD and trauma symptoms among childhood sexual abuse and physical abuse. Each item of PTSD, impulsiveness, and other measures except psychological distress had only two questions to ask. I know it was not enough to explore the symptoms of any disorder by asking only two

questions. However, it is good at this stage to give a quick impression about the consequences of child abuse and neglect in Saudi Arabia with absence of such studies.

The results of correlation, t-test, and multiple regression presented low self-esteem, psychological distress, impulsiveness, PTSD, and aggression to be the major outcomes of sexual abuse, physical abuse, emotional abuse, and emotional neglect.

EQS analysis showed that child sexual abuse, emotional abuse, physical abuse, and emotional neglect occurring with a low mother's age, the mother's and the father's education being of a low level and a large number of siblings in the family have a strong link with self-harm, low self-esteem, impulsiveness, PTSD, eating disorders dissociation aggression and psychological distress. When sexual abuse was accompanied by certain epidemiological factors (i.e. father's job, father's age, mother's age, siblings), the outcome psychological problems were self-harm, low self-esteem, impulsiveness, PTSD, eating disorders, dissociation, aggression, and psychological distress. The direct impact of all forms of child abuse (sexual, physical, emotional) and emotional neglect could be seen on the occurrence of low self-esteem, impulsiveness, aggression and psychological distress. The direct impact of various epidemiological factors (i.e. father's age, father's job, the number of siblings in the family, the father's level of education, the mother's level of education) could be

seen on the occurrence of low self-esteem, impulsiveness, and psychological distress.

As can see from the result of EQS, there was a link between 'Child Abuse & Epidemiological Factor's Group', 'Sexual Abuse & Epidemiological Factor's Group' and 'Social and Environmental Models' particularly 'Social Stress Perspective'.

9.2 Theoretical Models

As mentioned in chapter three various theoretical models have been proposed with the aim of understanding the causes of the child abuse and neglect. Examples include, individually focused models, socially and environmentally focused models, integrated models, and interactive models. Individually focused models have three approaches. The psychopathic perspective sees the parent as the principle cause of the problem (Browne et al 1989). 10% of child abusers can accurately be labelled as mentally ill (Kempe & Kempe, 1978). This model has been useful in recognizing certain predispositions existing in abusive individuals (Browne et al, 1989). It is difficult to either validate or refute this theory, because in this study I did not include questions aimed at establishing whether or not the parents of the victims had a history of child abuse or neglect, had witnessed violence as children, or were mentally ill.

The social learning perspective is based on the assumption that people learn violent behaviour from observing aggressive role models (Bandura

1973). Four out of five abusive men were reported by their partners as either having observed their fathers abusing their mothers and/or as being a victim of child abuse themselves (Roy, 1982). Jaffe et al (1990) and Carroll (1994) found evidence that violence between parents affects the children in a family. Women who have been beaten by their spouses are, in turn, reportedly twice as likely as other women to abuse a child (McKay, 1994). Child witnesses of domestic violence may also display an inability to control and express emotion, or to delay gratification (McKay, 1994). Growing up in an unhappy family appears to be the most powerful risk factor for abuse. It is easy to understand why a child from an unhappy family might be vulnerable to the manipulations of an abuser who was offering affection or companionship in order to trick the child (Finkelhor et al, 1990) and indeed, it has also been suggested that being abused as a child can lead to an overall sense of worthlessness. In this study I posed only one question dealing with stability in the family i.e. the question regarding marital status - divorce can happen as consequence of domestic violence. These findings of this study are in agreement with this model in relation to physical and medical neglect.

The 'special victim' perspective suggests that the children themselves may be instrumental in some way in eliciting attack or neglect. Children who are handicapped, premature, and/or those with a low birth-weight are

examples of these. The findings of this study do not support or refute this perspective.

Social and environmental models have two perspectives. The 'social stress' perspective takes into account external factors that can promote family violence such as low wages, social isolation, family size, low social class, and unemployment. The findings of this study completely support social and environmental models, particularly the 'social stress' perspective. Take for instance family size; this study found that the higher the number of siblings (6 or more), the more likely are child physical abuse, child emotional, child sexual abuse, and medical neglect to occur. People who have grown up with no siblings are equally or even more likely to rate themselves as generally happy, and satisfied with their health, leisure activities, and job (Blake, 1981) as those who have siblings. By contrast, children raised in large families do seem to be more at risk of under-achievement and maladjustment (Rutter & Smith, 1995). I think large numbers of children can dilute the parents' emotional and financial well-being, and as such can affect their treatment of their children. This study also agreed with the 'social stress' perspective in relation to social class. Lower income parents were more likely to abuse their children physically and sexually. Smith (1975), Robertson & Juritz (1979), Oates et al (1979), and Jason & Andereck (1983) found the highest child abuse fatality rates among poor people.

The environmental and cultural perspective suggests that cultural values could affect personal attitudes towards violent behaviour (Wilson & James, 2002). There are aspects of Saudi Arabian cultural traditions and moral principles that are conducive to child sexual abuse. There is a general acceptance of physical punishment as an appropriate method of child control, with nine out of ten children being disciplined in this way (Nobes & Smith 2000, Gelles & Cornall 1997). However, the aim of this study is not to explore the effect of the culture on child abuse, though it must be noted that there are signs that our culture encourages parents to punish their children physically. A Kuwaiti study found that 86% of parents agreed to use physical punishment as a mean of child discipline (Qasem et al, 1998). Socially acceptable emotional abuse, or even physical abuse, in Saudi Arabia of children by their parents or guardians is quite visible in the streets, and at schools, while law is powerless to prevent it.

Integrated models also have two perspectives. The psychological perspective emphasises the social-situational approach to family violence. Certain stress factors such as poverty could lead to child abuse. Multifactor perspectives suggest that stress factors and background influences are mediated through the interpersonal relationships within the family.

Interaction models have two perspectives; the 'one person - environmental interactive' perspective concentrates on complex interactions between the

individual and their social and socio-physical environments; while the 'interpersonal interactive perspective' concentrates not only on personal characteristics but also on the context of the abuse.

The outcome of this study seems to support this perspective. Take for instance income; it appears to have a link with physical and sexual abuse. That means that low family income produces a tendency to physical and sexual abuse within the family. The same can be said for the existence of a high number of siblings in the family. It is undoubtedly the case that having six children or more in a poor family can cause stressful situations, leading at times to anger or emotional distress, and then to child abuse.

As far as the researcher knows, in the last decade only 7 articles have been published in Saudi Arabia, dealing with a total of 39 cases, by paediatricians in the local medical journal. In addition, a PhD student has presented a thesis to the Department of Sociology at King Saud University. All of these studies found the most prevalent form of child abuse and neglect to be physical abuse, and the majority of victims to be under five years old. Most abusers in the Saudi studies were women with a high rate of illegitimacy amongst them. A high proportion of the victims came from families with six or more children.

9.3 Conclusion

This study found that various epidemiological factors cause child abuse and neglect in Saudi Arabia. These factors include income; a family with a low income is more likely to be the setting of child abuse. A large family also increases the likelihood of abuse occurring, particularly if there are 6 or more siblings in the family. In addition, the younger the parents, the more likely it becomes that abuse will occur. Education is also a factor; the better educated the parents the less likely it is that neglect will occur, with the exception of neglect. The most prevalent type of child abuse and neglect amongst the participants was found to be child emotional neglect (26.6%; 27.3% among households, and 24.3% among students). The second most prevalent was found to be child emotional abuse (22.8%; 21.1% among students, and 23.4% among households). Ranking third in prevalence was sexual abuse (22.7%; with 27.2% among students, and 14.7% among households). The forth was child physical neglect (18.4%; with 21.1% among students and 13.5% among households). The fifth was child physical abuse (12.2%; with 12.3% among students and 12.2% among households). And the last was medical neglect (9.4%; with 6.6% among students, and 14.5% among households). The most common source of abuse was the father (29.4%), the second was found to be siblings (18.5%), then other relatives (11.6%), then the mother (8.3%),

then friends (5.5%) and finally teachers (3.4%). 40.4% of the victims of physical abuse said that they had been abused when aged between 11-15 years old while 32.2% were aged between 6-10, and the third group were aged above 16 years old.

With regards to emotional abuse, fathers were the most likely to abuse (14.4%), followed by siblings (12.1%); then relatives (11.8%); then mothers (6.6%). Of the participants who had been emotionally abused when aged between 11-15 years old, 19.2% were aged between 6-10 years old; 12% were aged 16; and 2.3% were under the age of five.

Close examination of the profiles of both physical and emotional abuse reveals a similarity between them. In both cases fathers were found to be the most likely to be abusers, followed by siblings, and then other relatives. Also, in both categories, abuse was most prevalent in the 11-15 years old age bracket; followed by 6-10; and then above 16 years old. In both categories, less than 5% of clients received emotional and physical abuse when aged under five years old. This gives us an indication that emotional abuse could be happening as a consequence of physical abuse. In other words, physical abuse could be commonly accompanied by emotional abuse.

With regards to the victims of child sexual abuse, 23% were aged 6-10 when abused, which I believe is the age when a child starts to become attractive and their parents start to allow them some independence, in the

company of relatives or friends. Surprisingly, 12.8% of clients said that they had faced sexual abuse when aged above 16 years old, and just 3.2% said that they had been under 5. This time, the father 1% and mother 1% were the least likely to be the perpetrators. The most likely perpetrators of sexual abuse were relatives (16.6%), then friends (12.3%), then siblings (4.8%), and then teachers (2.1%).

The highest correlation was found between all forms of child abuse (sexual, physical, emotional), emotional neglect and low self-esteem, aggression, psychological distress, and impulsiveness. More specifically, in these categories of abuse, the occurrence of low self-esteem, aggression, psychological distress, and impulsiveness is proportional to the extent of the abuse experienced.

In this study an attempt was made to create cluster groups; in other words, to determine which groups work with each other in the creation of outcome psychological problems. We found that if a child faces all forms of child abuse (i.e. sexual, physical, and emotional abuse), and one form of neglect (i.e. emotional neglect), and where this is accompanied by various epidemiological factors (i.e. a low level of parental education, a young mother, and six or more siblings in the family, then self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression and psychological distress would result. I have named this group the 'Child Abuse & Epidemiological Factor's Group'. However, if

sexual abuse alone is accompanied by various epidemiological factors such as the parents being young, the father being unemployed, and the number of siblings in the victim's family numbering more that six, then the consequences are; self-harm; low self-esteem; impulsiveness; PTSD; eating disorders; dissociation; aggression and psychological distress. This group has been named the 'Sexual Abuse Group'. If child abuse (i.e. sexual, physical and/or emotional abuse), and emotional neglect happen without the epidemiological factors mentioned above, then the outcome psychological problems were; low self-esteem; aggression; impulsiveness; and psychological distress. This group has been named the 'Child Abuse Group'.

In conclusion to this section, this study has broken the taboo on discussion of child abuse in Saudi Arabia and has established that child abuse and neglect are real problems in Saudi Arabia today.

9.4 Recommendations

1. I recommend that more studies in the field of child abuse are carried out for the following reasons:

- ❑ This study was conducted in only three regions; Western; Eastern and Central of Saudi Arabia. According to the Ministry of Planning (1992) there is also a Southern and a Northern region. 3,080,311 live in the central region, 3,380,216 live in eastern region, and

2,179,710 live in western region. As such, in the regions covered by this study there is a population of 8,640,237, while Saudi has a total population of 14,872,804. Therefore 42% of the whole population were not covered in this study.

- This study excluded the illiterate section of the population. It would have been difficult to include them because they would have needed someone to read the questionnaire to them. According to Alwatan Newspaper, (2003) 25% of the Saudi population are still illiterate.
- I feel that further study in this field would contribute to understanding amongst the public and even the government.
- We need to assess the cultural influences on child abuse.
- We need to assess the 'special victims' perspective; in other words, whether children born prematurely, those with a low birth weigh, those born with illness etc are more likely to be abused.

2) I recommend further study in the field of sexual child abuse for the following reasons:

- In this study had only one question was used that simply established whether abuse had occurred. As far as I know this is the first time that a researcher sent a questionnaire containing a sexual question. However, this question did not specify the type of sexual abuse faced by clients such as sexual intercourse with a

person below the age of 14; rape; incest; sexual relations between parents and children or between adopters and adopted; molestation; sexual assault without intercourse against a child below the age of 14; homosexual assault against a child below the age of 16; the sexual exploitation of children; the distribution of pornographic material; and the watching of sexual activity.

- ❑ The reasons recommended in (1) above also apply to sexual abuse.

3) I recommend that further studies are carried out to establish whether or not there is a correlation between child sexual abuse and self harm and/or eating disorders or other psychological problems in Saudi Arabia due to the following:

- ❑ In this study there was only one question relating to self-harm, or more specifically self-laceration, and two questions relating to each of the other psychological problems. I think that further study would serve to further establish (or not) the veracity of the findings of this study.

4) I recommend that new regulations are established relating to the relationship between children and their parents, guardian or relatives because:

- ❑ In Saudi Arabia there is no clear regulation specifically regarding the relationship between children and their parents (Al-Saud, 2000).

5) I recommend the establishment of a new organization with the aim of protecting children from their parents, guardians or relatives, should the need arise. This organisation should be supported by the government in fulfilling the following roles:

- ❑ Hosting of those children who have suffered emotionally, physically, or sexually or have been neglected by their families in special accommodation supported by the government.
- ❑ Provision of social workers to visit children at home and investigate any case where there is a history of child abuse or neglect.
- ❑ The establishment of a hotline with an easily recognisable phone number that can be accessed by children.

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Appendix 1. Referees

Table 89 shows the referees of the questionnaire.

No	Referee	Position	Department	University/Collage
1	A. Abdulghader	Professor	Clinical Psychology	Department of Psychology, Kuwait University, College of Social Science, Kuwait
2	A. Al-Rowaita	Assist Professor	Clinical Psychology	Department of Psychology, King Saud University, Riyadh, Saudi Arabia
3	G. Al-Ghamdi	Assoc Professor	English language	King Faisal Air forces, Riyadh, Saudi Arabia
4	A. A. Ibraham	Assist Professor	Clinical Psychology	Department of Psychology, Umm Al-Qura University, Mecca, Saudi Arabia
5	M. Nizar	Assoc Professor	Psychology	Department of Psychology, Umm Al-Qura University, Mecca, Saudi Arabia
6	Y. Nisar	Professor	Clinical Psychology	Department of Psychology, King Saud University, Riyadh, Saudi Arabia
7	J. Siad	Professor	Clinical Psychology	King Saud University, Riyadh, Saudi Arabia
8	R. Taher	Professor	Clinical Psychology	Department of Psychology, King Saud University, Riyadh, Saudi Arabia

Appendix 2. Questionnaire

English Version

Dear Householder

We are from the Department of Psychiatry at Edinburgh University, and are asking for your help in a study of the connection between childhood experiences and mental health in adulthood.

The purpose of the study is to examine the effects of childhood experiences on adult functioning.

We want to examine the effects in a sample of people chosen of random from the local community (such as yourself).

Your response will be treated in the strictest confidence. To maintain complete confidentiality, please do not write your name anywhere on the questionnaire (unless for any reason you would like to).

We have not included any coding system from which you could be identified. The questionnaire is completely anonymous.

So, we do hope that you will be able to spare approximately 10 minutes of your time to answer the following questions. We would be extremely grateful if you could help us in this important survey, which we hope will help us to better identify the help needed by people who have experienced problems both in childhood and adulthood.

When you have completed your questionnaire, please place it in the stamped addressed envelope provided.

If you have any questions or comments, please do not hesitate to telephone us at the telephone number above.

Thank you, in anticipation for your participation.

Yours Sincerely

Mr Ali Al-Zahrani

Yours Sincerely

Professor Mick Power

Note: please do not answer these questions if you are from the following groups: under 18, having learning difficulties, severely ill, or dementia.

Dear Student

We are from the Department of Psychiatry at Edinburgh University, and are asking for your help in a study of the Connection between childhood experiences and mental health in adulthood.

The purpose of the study is to examine the effects of childhood experiences on adult functioning. We want to examine the effects in a sample of people chosen of random from the undergraduate students (such as yourself).

Your response will be treated in the strictest confidence. To maintain complete confidentiality, please do not write your name anywhere on the questionnaire (unless for any reason you would like to). We have not included any coding system from which you could be identified. The questionnaire is completely anonymous.

So, we do hope that you will be able to spare approximately 10 minutes of your time to answer the following questions. We would be extremely grateful if you could help us in this important survey, which we hope will help us to better identify the help needed by people who have experienced problems both in childhood and adulthood.

When you have completed your questionnaire, please do the following:

- Put the answer in the envelope provide.
- Remember not to write your name.

If you have any questions or comments, please do not hesitate to telephone us at the telephone number above.

Thank you, in anticipation for your participation.

Yours Sincerely

Mr Ali Al-Zahrani

Yours Sincerely

Professor Mick Power

PART ONE:

Name(optional) .....

Gender (please tick): ( ) Male ( ) Female .. Age:.....

Nationality (please tick): ( ) Saudi ( ) Other (please state).....

PART TWO:

We would like to know more information about your family. So, please try to answer all the questions.

Mother's age:..... Father's age:.....

Mother's occupation:.....Father's occupation:.....

Number of sibling(s):

Mother's education: ( ) Primary ( ) High school ( ) University

Father's education: ( ) Primary ( ) High school ( ) University

Your parents income:( ) Less than average ( ) average( ) More than average

Your parents marital status:( )Married/living together( ) Divorced( ) Widowed

Parent's area of residence: ( ) Urban ( ) Semi rural ( ) Rural

PART THREE:

We would like to know if you have had any medical complaints and how your health has been in general over the past few weeks. Please answer ALL the questions simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past:

NO	HAVE YOU RECENTLY...	INTENSITY			
1	been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than Usual	Much less than usual
2	lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3	felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
4	felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5	felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6	felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7	been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8	been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
9	been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10	been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
11	been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12	been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual

PART FOUR

These questions are about the kind of person you generally are, or how you have usually felt or behaved over the past several weeks. Please circle "YES" in the question completely or mostly applies to you, or circle "NO" if it does not apply to you.

No	IN THE PAST SEVERAL WEEKS...		
13	I have at times I though I am no good at all.	Yes	No
14	I have taken a positive attitude toward myself.	Yes	No
15	It has happened that sometimes when I am listening to someone, and I suddenly realize that I have not heard part or the whole of the story.	Yes	No
16	Sometimes I suddenly notice that I find myself in a place that is unknown to me, without knowing how I got there.	Yes	No
17	I sometimes think it's not worth being a good person.	Yes	No
18	I have felt as if something bad is just waiting around the corner to happen.	Yes	No
19	have you ever cut, burned, or scratched yourself on purpose?	Yes	No
20	have you often done things impulsively?	Yes	No
21	have even little things get you angry?	Yes	No
22	I spent a significant amount of time thinking about food and when I will eat.	Yes	No
23	after I eating, I may use laxatives, diuretics, exercise, etc, to prevent weight gain.	Yes	No
24	I have got into a lot of physical fights.	Yes	No
25	Sometimes I am afraid I might hurt someone physically, without good reason.	Yes	No

PART SIX:

These questions ask about some of your experiences growing up as a child and a teenager. Although these questions are a very personal nature, please try to answer as honestly as you can. For each question, circle the dot under the response that best described how you feel. If you wish to change your response, put (×) through it and circle your new choice. Many of the questions may ask about experiences completely outside of your experiences, but it is important for us to know for how many people this is true. So please don't be put off by personal nature of the questions; the questionnaire is completely confidentional and anonymous.

No	WHEN I WAS GROWING UP	Never true	Rarely true	Sometime true	Often true	True Very often true
26	I didn't have enough to eat.	•	•	•	•	•
27	I knew that there was someone to take care of me and protect me.	•	•	•	•	•
28	people in my family called me things like "stupid," "lazy," or "ugly.	•	•	•	•	•
29	my parents were too drunk or high to take care of the family	•	•	•	•	•
30	there was someone in my family who helped me feel that I was important or special.	•	•	•	•	•
31	I had to wear dirty clothes.	•	•	•	•	•
32	I felt loved.	•	•	•	•	•
33	I thought that my parents wished I had never been born.	•	•	•	•	•
34	I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	•	•	•	•	•
35	there was nothing I wanted to change about my family.	•	•	•	•	•
36	people in my family hit me so hard that it left me with bruises or marks.	•	•	•	•	•
37	I was punished with a belt, a board, a cord, or some other hard object.	•	•	•	•	•
38	people in my family looked out for each other.	•	•	•	•	•
39	people in my family said hurtful or insulting things to me.	•	•	•	•	•
40	I believe that I was physically abused. Who did that?..... How old were you (approx)?.....	•	•	•	•	•
41	I had the a perfect childhood.	•	•	•	•	•
42	I got hit or beaten so badly that it was noticed by someone like a teacher, neighbour, or doctor.	•	•	•	•	•
43	I felt that someone in my family hated me.	•	•	•	•	•
44	people in my family felt close to each other.	•	•	•	•	•
45	I had the best family in the world.	•	•	•	•	•
46	I believe that I was emotionally abused. Who did that?..... How old were you (approx)?.....	•	•	•	•	•
47	There was someone to take me to the doctor if I needed it.	•	•	•	•	•
48	My family was a source of strength and support.	•	•	•	•	•
49	I was subjected to an immoral situation that has negatively affected my personality. Who did that?..... How old were you(approx)?.....	•	•	•	•	•

Please accept our considerable thanks for your participation in this study. We hope it will help us to understand better some of the effects that childhood experiences have in adulthood. If you would like to know more about our research or you would like to know about the general findings from the survey when it is ready, please feel free to contact us on the telephone number above (this will preserve the anonymity of your own questionnaire, or feel free to write your name and address below (though your questionnaire will no longer be anonymous then). Once more, please accept our thanks for your help.

Arabic Version

بسم الله الرحمن الرحيم

جامـــعـــة ادنـــبـــره
قسم الطب النـفسي
مستشفى ادنبره الملكي

عزيزي صاحب الصندوق
بادئ ذي بدء اسمحوا لي أن أعرفكم بنفسي، أخوكم أحد الطلبة المبتعثين لدراسة الدكتوراه بقسم الطب النفسي التابع لكلية الطب بجامعة إدنبره في بريطانيا.
استميحكم عُذراً في اقتطاع عشرة دقائق من وقتكم الثمين للإجابة على هذا الاستبيان والذي نهدف من ورائه إلى التعرف على:

العلاقة بين خبرات الطفولة والاضطرابات النفسية الناتجة عنها في الكبر"

أود أن أطمئنكم هنا بأن إجابتكم ستكون في غاية السرية والكتمان كما اقتضت به المواريث العلمية

وتأكدوا من حرصنا الشديد على ذلك انطلاقا من الأمانة العلمية. وتأكيدا على ذلك نرجو منكم عدم ذكر

اسمكم أو أي شي يدل عليكم.

تذكروا بأنه ليس شرطا أن تكونوا قد تعرضتم إلى أي خبرة سلبية ولكن كما تعلمون هدفنا هنا هو معرفة حجم المشكلة ومدى انتشارها ولهذا يظل رأيكم وإجابتكم على هذا الاستبيان مهم لدينا.

تأكدوا بأن مصداقيتكم في الإجابة على هذه الأسئلة ستكون دافع وباعث للمهتمين على الارتقاء

بالخدمات التي ستقدم للأطفال في المستقبل بمشيئة الله تعالى من اجل تهيئة الأجواء الصحية السليمة

وقاية لهم من الاضطرابات النفسية، فضلا على أن إجابتكم على هذا الاستبيان إنما ينم عن عقليتكم

الراقية والمتفتحة والداعمة للبحوث العلمية.

نرجو منكم التكرم عند الانتهاء من الإجابة اتباع مايلي:
ضع الإجابة في الظرف المخصص لذلك والمرفق مع هذا الاستبيان
غلف الظرف ومرره إلى زميلك الذي يجلس أمامك حتى يتم جمعها مع بعض.

إذا كان لديكم أي استفسار أو تعليق رجاء الاتصال بنا على أحد الوسائل المتاحة أو الميسرة لديكم

والموضحة بعاليه.

شاكرا ومقدرا لكم اقتطاع جزءا من وقتكم الثمين للإجابة على هذا الاستبيان.

والله يحفضكم ويرعاكم

أخوكم طالب دكتوراه
علي حسن صحفان

الجزء الأول:

الجنس ( ) ذكر ( ) أنثى الجنسية: ( ) سعودي ( ) أخرى (فضلا حدد).....
العمر

الجزء الثاني:

نود هنا بالحصول على معلومات كافيه عن أسرتك. لذا نرجو كرما الإجابة على جميع الأسئلة.

عمر الأم:.....عمر الأب:.....
وظيفةالأم:.....وظيفة الأب.....

عدد اخوتك:.....

تعليم الأم (1) ابتدائي (2) ثانوي (3) جامعي

تعليم الأب (1) ابتدائي (2) ثانوي (3) جامعي

:
دخل الأبوين (1) دون المتوسط (2) متوسط (3) فوق المتوسط

الوضع الإجماعي للوالدين: (1) يعيشون مع بعض (2) مطلقين (3) ارمل/ارمله

محل سكن الوالدين: (1) مدينه (2) قريه (3) هجره

الجز ء الثالث

سوف يعرض عليك فيما يلي مجموعة من العبارات الهدف من ورائها هو التعرف على صحتك العامة، من خلال معرفة ما إذا كان لديك أي شكوى مرضيه وكيف كانت صحتك بصفة عامة خلال الأسابيع القليلة الماضية بما فيها هذا اليوم، لذا نرجو منك وضع إشارة(3) أمام العبارة التي تنطبق عليك. تذكر بأننا نبحث عن الشكاوي المرضية الحاضرة وليست الماضية.

1- *هل شعرت مؤخرا بأنك قادر على تركيز انتباهك في أي شي تؤديه؟*
□ أحسن من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

2- *هل شعرت مؤخرا* أن نومك قل نتيجة للهموم
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

3-*هل شعرت مؤخرا بأنك تقوم بدور* مهم في الأمور المحيطة بك؟
□أكثر من المعتاد بكثير □ كالمعتاد تقريبا □ أقل من المعتاد □ أقل من المعتاد

4-هل شعرت مؤخرا بأنك قادر على اتخاذ قرارات بشان بعض الأمور
أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

5-*هل شعرت مؤخرا بأنك تعاني من ضغوط مستمرة؟*
□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

6- هل شعرت مؤخرا بأنك لا تستطيع التغلب على الصعوبات التي تواجهك؟

□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد بقليل □ أكثر من المعتاد بكثير

7-هل شعرت مؤخرا بأنك قادرا على الاستمتاع بأنشطتك اليومية؟

□أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

8-هل شعرت مؤخرا بأنك قادرا على مواجهة مشاكلك؟

□أكثر من المعتاد □ كالمعتاد □ أقل من المعتاد □ أقل من المعتاد بكثير

9-هل شعرت مؤخرا بأنك مكتئب وغير سعيد ؟

□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد *قليلا* □ أكثر من المعتاد بكثير

10-هل شعرت مؤخرا بفقدان الثقة بنفسك؟

□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد *قليلا* □ أكثر من المعتاد بكثير

11-هل شعرت مؤخرا بأنك إنسان عديم الفائدة؟

□إطلاقا □ ليس أكثر من المعتاد □ أكثر من المعتاد *قليلا* □ أكثر من المعتاد بكثير

12- هل شعرت مؤخرا بأنك سعيد بدرجة معقولة؟

□كثر من المعتاد □ كالمعتاد تقريبا □ أقل من المعتاد □ أقل من المعتاد بكثير

الجزء الرابع:

الأسئلة التالية تهدف إلى التعرف على شخصيتك بصفة عامة، كيف كان شعورك وتصرفك أو سلوكك خلال الأسابيع الماضية بما فيها هذا اليوم. لذا من فضلك ضع دائرة حول كلمة "نعم" إذا كانت العبارة تنطبق عليك في الغالب أو دائرة حول "لا" إذا كانت لا تنطبق عليك:

الرقم	العبـــــــارة		
13	في خلال الأسابيع القليلة الماضية اعتقدت أحيانا بأنني غير نافع على الإطلاق.	نعم	لا
14	في خلال الأسابيع القليلة الماضية كان لدي اتجاه إيجاب نحو نفسي.	نعم	لا
15	في خلال الأسابيع القليلة الماضية حدث أحيانا انه عندما كنت استمع إلى شخص ما أنني تأكدت فجأة بأنني لم استمع الى جزء من كلامه أو كله.	نعم	لا
16	في خلال الأسابيع القليلة الماضية وجدت نفسي أحيانا فجأة في مكان لا اعرفه ولا ادري كيف وصلت أليه.	نعم	لا
17	في خلال الأسابيع القليلة الماضية اعتقدت أحيانا بأنني غير جدير بان أكون شخص جيد.	نعم	لا
18	في خلال الأسابيع القليلة الماضية شعرت أحيانا بأنني على وشك الإصابة بمكروه.	نعم	لا
19	هل حدث أحيانا في خلال الأسابيع القليلة الماضية بان تعمدت خدش أو جرح أو حرق نفسك؟	نعم	لا
20	هل عملت في خلال الأسابيع القليلة الماضية الأشياء باندفاع؟	نعم	لا
21	في خلال الأسابيع القليلة الماضية هل جعلتك الأشياء البسيطة غضبان؟	نعم	لا
22	في خلال الأسابيع القليلة الماضية كنت اقضي قدرا كبيرا من الوقت أفكر في الأكل ومتى سأتناول الطعام.	نعم	لا
23	في خلال الأسابيع القليلة الماضية كنت عندما انتهي من الأكل استخدم بعض المسهلات أو التمارين الرياضية... الخ حتى لا يزداد وزني.	نعم	لا
24	في خلال الأسابيع القليلة الماضية كنت ادخل في مضاربات (عراكات) مع الآخرين.	نعم	لا
25	في خلال الأسابيع القليلة الماضية كنت أخشى أحيانا من أنني قد أقوم بإيذاء بدني لشخص ما دون سبب وجيه.	نعم	لا

الجزء الخامس:

الأسئلة التالية تدور حول خبراتك السابقة خلال مراحل عمرك الأولى والممتدة من بداية طفولتك حتى فترة المراهقة. لذا حاول قدر المستطاع التذكر بكل أمانة واخلاص.

غالبية هذه الأسئلة يغلب عليها الطابع الشخصي. ليس شرطا هنا أن تكون أنت المعني بهذه الخبرات ولكن كما أشرت في المقدمة من أن الهدف هو معرفة مدى انتشار هذه أتظاهره.
لهذا أخي الكريم أرجو عدم الأحجام أو ترك الإجابة على هذه الأسئلة بسبب حساسيتها لأنك ستخدم بإجابتك هذه المجتمع بأسره.
أقرا السوال جيدا ومن ثم ضع دائرة على النقطة السوداء في الخانة التي تراها تنطبق عليك. لا تنسى قبل أن تضع الدائرة بان تنظر إلى أعلى الصفحة للتأكد من انك اخترت الإجابة الصحيحة والتي تنطبق عليك خلال فترة الطفولة أو المراهقة.

رقم	العبـــــــارة	غير صحيح مطلقا	صحيح نادرا	صحيح أحيانا	صحيح غالبا	صحيح على الأغلب
26	في بداية حياتي لم يكن لدي ما يكفي من الطعام	●	●	●	●	●
27	في بداية حياتي كنت أحظى بالعناية والرعاية من هم حولي	●	●	●	●	●
28	في بداية حياتي كان بعض أفراد عائلتي ينعتونني بألقاب نابية مثل (غبي، كسول، قبيح)	●	●	●	●	●
29	في بداية حياتي كانا والدي لاهيان عنا لدرجة انهما لم يستطيعا العناية بالعائلة	●	●	●	●	●
30	في بداية حياتي كان هناك أحد أفراد عائلتي يحسسني بأني مهم أو مميز	●	●	●	●	●
31	في بداية حياتي لم أجد إلا ملابس باليه لا ارتديها	●	●	●	●	●
32	في بداية حياتي شعرت بأنني محبوب	●	●	●	●	●
33	في بداية حياتي شعرت بان والدي تمنيا بأنني لم اخلق	●	●	●	●	●
34	في بداية حياتي تعرضت إلى ضرب مبرح من أحد أفراد عائلتي احتجت على أثرها إلى عناية طبية	●	●	●	●	●
35	في بداية حياتي لم أتمنى بأنني ولدت لأبوين آخرين	●	●	●	●	●
36	في بداية حياتي كان بعض أفراد عائلتي يضربني بقسوة مما ترك اثر لعلامات وكدمات على جسمي	●	●	●	●	●
37	في بداية حياتي كنت أعاقب بربطي بلوح أو حبل أو أي شي آخر صلب	●	●	●	●	●
38	في بداية حياتي كان أفراد عائلتي حريصين على بعضهم البعض	●	●	●	●	●
39	في بداية حياتي كان أفراد عائلي يقولون لي كلام مؤلم ومهين	●	●	●	●	●
40	في بداية حياتي أسيئت معاملتي جسديا هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●
41	في بداية حياتي عشت طفولة ممتازة	●	●	●	●	●
42	في بداية حياتي ضربت بشكل سيئ لوحظ علي من قبل المعلم أو الجار أو الطبيب	●	●	●	●	●
43	في بداية حياتي شعرت بان أحد أفراد عائلتي يكرهني	●	●	●	●	●
44	في بداية حياتي كان أفراد عائلتي يشعرون بالتقارب فيما بينهم	●	●	●	●	●
45	في بداية حياتي كنت اشعر بان عائلتي من افضل العوائل.	●	●	●	●	●
46	في بداية حياتي أظن بان مشاعري قد أهينت هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●
47	في بداية حياتي كان هناك من يأخذني للطبيب عندما احتاج اليه	●	●	●	●	●
48	في بداية حياتي كانت عائلتي مصدر دعم وقوة لي	●	●	●	●	●
49	في بداية حياتي تعرضت إلى موقف غير لائق أخلاقيا أساء إلى شخصيتي لدرجة أنني لم استطع البوح به حتى لاقرب الناس الي هل تذكر من الذي فعل ذلك؟..... وكم كان عمرك آنذاك تقريبا؟.....	●	●	●	●	●

في نهاية هذا الاستبيان أود أن أتقدم لكم بجزيل الشكر وعظيم الامتنان على ما قمتم به مجهود إضافة إلى اقتطاعكم جزء من وقتكم الثمين للإجابة على هذه الأسئلة. ونحن واثقون من أن صنيعكم هذا ينم عن وعي وأدراك من شخصكم الكريم بأهمية البحث العلمي.

كما إنني على أتم الاستعداد بتزويدكم بصورة من نتائج هذا البحث إذا أردتم ذلك

واخيرا وليس أخيرا نوجه هنا دعوة خالصة لله عز وجل أن يجعل هذا العمل الذي قمتم به في موازين أعمالكم الصالحة وان يديم عليكم نعمة الصحة والعافية انه سميع مجيب.

وأخر دعوانا أن الحمد لله رب العالمين

والسلام عليكم ورحمة الله وبركاته

الباحث

Appendix 3: Permission to Use Questionnaires

1) Letter from BMJ Publishing Group granting permission to use the pictures.

BMJ Publishing Group

BMA House Tavistock Square
London WC1H 9JR
www.bmjpg.com
Tel: 020 7387 4499
Intl: +44 20 7387 4499
Fax:

Mr Ali Hasssan Al-Zahrani
8-1 Blacket Avenue
Edinburgh
EH9 1RS

13 October 2003

Tel: +44 (0)207 383 6169
Fax: +44 (0)207 383 6668
Email: cspencer@bmjgroup.com

Dear Ali Al-Zahrani

Copy right permission.

When requesting the use of material please include the full citation of the work to be used ie Journal Year;Volume:Pages along with the author and title of the article. Please specify the material to be taken from the article and the work in which it will be used. If the new work Is to be published please name the publishers.

Yours sincerely

Miss Clare Spencer
Permissions Administrator
BMJ Publishing Group

1) Letter from Dr Huda J. Hasan, Kuwait University granting permission to use the GHQ (Arabic Version).

To: Mr. Ali Hasan Al-Zahrani.

الأخ الفاضل علي حسن الزهراني ..... المحترم،،

تحية طيبة وبعد:

استلمت رسالتك قبل بضعة أسابيع ولم أتمكن من الرد عليها في حينها بسبب انشغالي بالإعداد لامتحانات آخر الفصل.

كما تعلم بأن مقياس GHQ الكامل يحتوي على ٦٠ بندا وأن جميع الصيغ الأخرى ١٢، ٢٨، ٣٠ هي صيغ مشتقة من المقياس الكامل واعتقد بأن لديك الصيغة العربية الكاملة ولا مانع لدي إذا أردت الاستعانة بها.

من وجهة نظري ، إذا رغبت في ترجمة المقياس مرة أخرى فإنك تحتاج إلى إنجاز عدة مراحل قبل أن تتمكن من استخدام المقياس في دراستك حيث تحتاج إلى ترجمة ثم ترجمة عكسية وحساب للصدق والثبات ولكن إذا كانت لديك صيغة جاهزة فهذا يوفر عليك كثيرا من الوقت.

أما ما يخص عنوان المؤلف فأعتقد بأنك يجب أن تأخذ تصريح من الناشر وليس المؤلف وعنوان الناشر هو الآتي:

The NFER-NELSON Publishing Company, Ltd.,
Darville House, 2 Oxford Road East.
Windsor, Berkshire SL4 DF
U.K.

أما فيما يتعلق بالترجمة المرفقة مع الرسالة في للصيغة ٣٠ والمؤلف لا أستطيع مراجعة الترجمة لأن النسخة الإنجليزية غير متوفرة عندي فإذا كانت موجودة لديك فيمكنك إرسالها على عنواني حتى أتمكن من مراجعة الترجمة.

أتمنى لك دوام التوفيق والنجاح

المرسلة

د. هدى جعفر حسن

Appendix 4. Permission to administer the questionnaire

1) Approval from the Vice President of King Faisal University of Saudi Arabia to the Dean of Veterinary Medicine.
2) Approval from the Vice President of King Faisal University of Saudi Arabia to the Department of Economics/ Female Section.
3) Approval from Director General of Post in Saudi Arabia.

1) Approval from the Vice President of King Faisal University of Saudi Arabia to the Dean of Veterinary Medicine.

بسم الله الرحمن الرحيم
المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل
KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

الرقم : P/١٩/٤٧ التاريخ : ٢٢ محرم ١٤٢٢ المرفقات : ٤٠ أستبيان

سعادة عميد كلية الطب البيطري والثروة الحيوانية المحترم

السلام عليكم ورحمة الله وبركاته

اشارة الى رغبة سعادة الأستاذ/ علي حسن صحفان الطالب المبتعث لدراسة الدكتوراه بقسم الطب النفسي التابع لكلية الطب بجامعة أدنبره ببريطانيا للتعرف على (العلاقة بين خبرات الطفولة والصحة النفسية الناتجة عنها في الكبر) ولموافقتنا على قيام المذكور بهذه الدراسة الميدانية لجمع المادة العلمية من جامعة الملك فيصل .

عليه أمل الاطلاع والاشارة لمن يلزم بتوزيع الاستبيان المرفق على طلاب كليتكم والعمل على تجميعها بعد الانتهاء من تعبئتها واعادتها الى ادارة العلاقات العامة والاعلام بالجامعة .

شاكرين للجميع لطيف تجاوبهم لما فيه المصلحة العامة .

وتقبلوا خالص تحياتي وتقديري ،،،

وكيل الجامعة للدراسات العليا
والبحث العلمي

د. سعد بن عبدالله البشراك

مطابع جامعة الملك فيصل

الأحساء - ص. ب. ٤٠٠ - تلكس ٨٦١٠٢٩ فيصل أس جي - تلفون ٥٨٠٠٠٠٠ - فاكس ٥٨٠١٢٤٣ - الدمام - ص ب ١٩٨٢ - تلكس ٨٧١٣٠٢ فيصل أس جي - تلفون ٨٥٧٧٠٠٠ - فاكس ٨٥٧٨٠٤٨
Al-Ahsa, P. O. Box 400 Telex 861028 Faisal S. J. Tel. 5800000- Fax 5801243 - Dammam, P. O. Box 1982 Telex 870020 Faisal S. J. Tel. 8577000 - Fax 8578048

2) Approval from the Vice President of King Faisal University of Saudi Arabia to the Department of Economics/ Female Section.

بسم الله الرحمن الرحيم
المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل
KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

الرقم : م/١٩/٤٨ التاريخ : ٢٢ ١٤٢٢هـ المرفقات : ٤٠ أستبيان

سعادة مشرفة قسم الاقتصاد المنزلي المحترم

السلام عليكم ورحمة الله وبركاته .

اشارة الى رغبة سعادة الأستاذ/ علي حسن صحفان الطالب المبتعث لدراسة الدكتوراه بقسم الطب النفسي التابع لكلية الطب بجامعة اكستر ببريطانيا للتعرف على (العلاقة بين خبرات الطفولة والصحة النفسية الناتجة عنها في الكبر) ولموافقتنا على قيام المذكور بهذه الدراسة الميدانية لجمع المادة العلمية من جامعة الملك فيصل .

عليه امل الاطلاع والاشارة لمن يلزم بتوزيع الاستبيان المرفق على كليتكم والعمل على تجميعها بعد الانتهاء من تعبئتها واعادتها الى ادارة العلاقات العامة والاعلام بالجامعة .

شاكرين للجميع لطيف تجاوبهم لما فيه المصلحة العامة .

وتقبلوا خالص تحياتي وتقديري ،،،

وكيل الجامعة للدراسات العليا
والبحث العلمي

د. سعد بن عبدالله البراك

٢١/٢/٩٩
إدارة العلاقات العامة والإعلام

مطابع جامعة الملك فيصل

الأحساء - ص.ب. ٤٠٠ - تلكس ٨٦١٠٢٩ فيصل اس جي - تلفون ٥٨٠٠٠٠٠ - فاكس ٥٨٠١٢٤٣ - الدمام - ص ب ١٩٨٢ - تلكس ٨٧١٣٠٢ فيصل اس جي - تلفون ٨٥٧٧٠٠٠ - فاكس ٨٥٧٨٠٤٨
Al-Ahsa, P. O. Box 400 Telex 861028 Faisal S. J. Tel. 5800000- Fax 5801243 - Dammam, P. O. Box 1982 Telex 870020 Faisal S. J. Tel. 8577000 - Fax 8578048

3) Approval from Director General of Posts in Saudi Arabia.

بسم الله الرحمن الرحيم

Kingdom of Saudi Arabia
Ministry of P. T. T.
Directorate General of Posts
Director General's Office

المملكة العربية السعودية
وزارة البرق والبريد والهاتف
المديرية العامة للبريد
مكتب المدير العام

Ref: 13338 — الرقم :
Date: 29/2/2000 — التاريخ : / /
Enclosures : — المرفقات :

Mr. Ali Hassan Al-Zahrani
Royal Edinburgh Hospital
Morningside Park. Kennedy Tower
Edinburgh EH 10 SHF
United Kingdom.

Dear Mr. Al-Zahrani

I hope everything is great with you and your study is progressing very well.

I have received your letter asking me if it is possible to conduct a survey research, in the topic of childhood experiences, in which you are planning to destribute a questionnaire to respondents in the three major regions (central, western, eastern) of Saudi Arabia.

I would like to inform you that we do not have a problem with your request and we will provide you with any assistance that you may also need. Your study is scientific and we believe it will have a good contribution to our knowledge in this particular area.

Once again, I wish you the best and successful completion of your study.

Dr. Khalid Faris Al-Otaibi

S-51/7

Director General of Posts
Saudi Arabia

RIYADH 11142
TEL. : (+ 9661) 4055671
FAX : (+ 9661) 4059684
CABLE : POSTGEN - RIYADH.

الرياض : ١١١٤٢
هاتف : ٤٠٥٥٦٧١ (٩٦٦١ +)
فاكس : ٤٠٥٩٦٨٤ (٩٦٦١ +)
برقياً : بوستجن الرياض

Appendix 5.
Letters approving the completed Applied Questionnaire"

1) Letter from Dr. K. F. Al-Otaibi, Director General of Post, Riyadh, Saudi Arabia.
2) Letter from Dr. H. S. Ghazala, Umm Al-Qura University, Mecca, Saudi Arabia
1) Letter from Dr A. I. Adam, Teachers College, Mecca, Saudi Arabia.
3) Letter from Dr. S. H. Wahass, King Faisal University, Dammam, Saudi Arabia.
4) Letter from the Dean of Veterinary Medicine, King Faisal University.
5) Letter from the Dean of Administrative Sciences, King Faisal University.
6) Letter from the Deputy Dean of Architecture, King Faisal University.
7) Letter from the Department of Economics, King Faisal University.

1) Letter from Dr. K. F. Al-Otaibi, General Director of Posts, Riyadh, Saudi Arabia.

بسم الله الرحمن الرحيم

المملكة العربية السعودية

وزارة البرق والبريد والهاتف

المؤسسة العامة للبريد

مكتب المدير العام

TO WHOM IT MAY CONCERN

I hereby confirm that Mr. Ali Hassan Al-Zahrani a Ph.D. student at the Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh University had applied 1000 questionnaires (500 Qs in the Central Region and 500 Qs in the Eastern Region) via P.O.Boxes.

The questionnaires were about "**Child Abuse and Subsequent Mental Health in Saudi Arabia**".

Mr. Al-Zahrani started sending them from the 1st of April until the 20th of June 2001.

This letter has been given to him upon his request.

Director General of Posts

Dr. Khalid Faris Al-Otaibi

A4

وزارة البرق والبريد والهاتف
المؤسسة العامة للبريد
مكتب المدير العام

الرقم : .....
التاريخ : / / ١٤ هـ
المرفقات : .....

الرمز البريدي الرياض ١١٤٢

2) Letter from Dr. H. S. Ghazala, Umm Al-Qura, University, Mecca, Saudi Arabia.

بِسْمِ اللهِ الرَّحْمَنِ الرَّحِيمِ

المملكة العربية السعودية
وزارة التعليم العالى
جامعة أم القرى

الرقم : .....
التاريخ : .....
المشفوعات : .....

To Whom it May Concern

This is to confirm that Mr. Ali Hassan Al-Zahrani, a Ph.D. student, Psychiatry Department, Edinburgh University, UK, had applied a questionnaire about Child Abuse and Subsequent Mental Health in Saudi Arabia, to a number of University students at College of Social Sciences, Umm Al-Qura University, Makkah Al-Mukarramah, Saudi Arabia, between 25 March-25 April, 2001.

This letter has been given to him upon his request.

Questionnaire administrator

H.S. Ghazala, Ph.D.

Umm AL - Qura University
Makkah Al Mukarramah P.O. Box 715
Cable Gameat Umm Al - Qura, Makkah
Telex 540026 Jammka SJ
Faxemely 5564560
Tel - 02 - 5574644 (10 Lines)

جامعة أم القرى
مكة المكرمة ص . ب : ٧١٥
برقيا : جامعة أم القرى مكة
تلكس عربي ٥٤٠٠٤١ م . ك جامعة
فاكسميلي : ٥٥٦٤٥٦٠
تليفون : ٥٥٧٤٦٤٤ ـ ٠٢ (١٠ خطوط)

مطابع جامعة أم القرى

3) Letter from Dr. A. I. Adam, Teacher College, Mecca, Saudi Arabia.

Kingdom of Saudi Arabia

Ministry of Education

Teachers College at Makkah

Department of Mathematics

Ref: 102/e

Date: 28.05.2001

To whom it may concern

This is to certify that the questionnaire related to the PhD student *Ali Hassan Al-Zahrani* has been distributed and filled by a random number of students at the department from the 10th of April 2001 to the 10th of May 2001 in a topic related to *child abuse and subsequent mental health in adulthood*.

Dr. Amin Ibrahim Adam

Assistant Professor in Statisitcs.

Makkah. P. O. Box 2064 – Tel: 5564171 . 5564066 – Fax: 5586531

4) Letter from Dr. S. H. Wahass, King Faisal University, Dammam, Saudi Arabia.

بسم الله الرحمن الرحيم
المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل
KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

الرقم : ٨٧٨/٢٩/د التاريخ : ١٤٢٢/٢/٢٤ المرفقات :

June 26, 2001

To: Professor Mack Power
Department of Psychiatry
University Edinburgh, UK

Re. Mr. Ali Sahfan AL-Zahrani's Thesis

Dear Professor Mack

I am writing this letter to inform you that Mr. Ali spent a period of time in King Faisal University, Eastern Province in order to collect data for his thesis. The collection process started at the beginning of April to the mid of May, 2001.

Mr. Ali however was closed to me at that time. He dedicated his efforts extensively so as to collect the date as planned.

I hope what he did here will help to complete his work. For further information regarding this subject, please do not hesitate to contact me.

With best regards

Yours sincerely

Saeed H Wahass, Ph.D., C Psychol.
Assistant Professor in Clinical Psychology
Head, The Division of Clinical Psychology
Department of Psychiatry
College of Medicine, King Faisal University

5) Letter from the Dean of Veterinary, King Faisal University.

KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل

الرقم : ١٧١/٤٤/٢ - التاريخ : ١٤٢٢/٢/١٣هـ المرفقات :

سعادة مدير إدارة العلاقات العامة والأعلام المحترم

السلام عليكم ورحمة الله وبركاته وبعد :-

إشارة إلى خطاب سعادة وكيل الجامعة للدراسات العليا والبحث العلمي رقم ١٩/٤٧/أ بتاريخ ١٤٢٢/١/٢٢هـ وذلك بشأن طلب سعادته توزيع الاستبيانات الخاصة بالأستاذ/ علي حسن صفحان الطالب المبتعث لدراسة الدكتوراه بقسم الطب النفسي التابع لكلية الطب بجامعة ادنبره ببريطانيا للتعرف على (العلاقة في خبرات الطفولة والصحة النفسية الناتجة عنها في الكبر) على طلاب الكلية .

عليه تجدون سعادتكم الاستبيانات المذكورة أعلاه وذلك بعد تعبئتها من قبل طلاب الكلية .

هذا لاحاطة سعادتكم والإطلاع .

وتقبلوا خالص تحياتي وتقديري ،،،

عميد كلية الطب البيطري والثروة الحيوانية

د. عبد الله بن محمد الدغيم

ا.ب٨٠/٨/٢

مطابع جامعة الملك فيصل

الأحساء - ص. ب. ٤٠٠ - تلكس ٨٦١٠٢٩ فيصل اس جي - تلفون ٥٨٠٠٠٠٠ - فاكس ٥٨٠١٢٤٣ الدمام - ص ب ١٩٨٢ - تلكس ٨٧١٣٠٢ فيصل اس جي - تلفون ٨٥٧٧٠٠٠ - فاكس ٨٥٧٨٠٤٨
Al-Ahsa, P. O. Box 400 Telex 861028 Faisal S. J. Tel. 5800000- Fax 5801243 - Dammam, P. O. Box 1982 Telex 870020 Faisal S. J. Tel. 8577000 - Fax 8578048

6) Letter from the Dean of administration Sciences & Planning, King Faisal University.

بسم الله الرحمن الرحيم

المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل

KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

الرقم : ٧٧/٣٠٠ التاريخ : ١/٨/١٤٢٢هـ المرفقات :

سعادة مدير العلاقات العامة بالجامعة المحترم

السلام عليكم ورحمة الله وبركاته وبعد

أهدي لكم أطيب التحية وأشير إلى خطاب وكيل الجامعة للدراسات العليا والبحث العلمي بخصوص الطالب المبتعث لدراسة الدكتوراه الأستاذ / علي حسن صفحان .

علية نرفق لكم الاستبيانات ، شاكرين لكم ومقدرين .

وتقبلوا خالص التحية والتقدير ،،،

مطابع جامعة الملك فيصل

الأحساء - ص.ب. ٤٠٠ - تلكس ٨٦١٠٢٩ فيصل اس جي - تلفون ٥٨٠٠٠٠٠ - فاكس ٥٨٠١٢٤٣ الدمام - ص ب ١٩٨٢ - تلكس ٨٧١٣٠٢ فيصل اس جي - تلفون ٨٥٧٧٠٠٠ - فاكس ٨٥٧٨٠٤٨
Al-Ahsa, P. O. Box 400 Telex 861028 Faisal S. J. Tel. 5800000- Fax 5801243 - Dammam, P. O. Box 1982 Telex 870020 Faisal S. J. Tel. 8577000 - Fax 8578048

7) Letter from the Deputy Dean of Architecture, King Faisal University.

بسم الله الرحمن الرحيم
المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك فيصل
KINGDOM OF SAUDI ARABIA
Ministry of Higher Education
KING FAISAL UNIVERSITY

الرقم : ٢٢٠/١٩٩/د التاريخ : ٢٠/٢/١٤٢٢هـ المرفقات : —

سعادة الدكتور سعيد وهاس المحترم

السلام عليكم ورحمة الله وبركاته..وبعد

إشارة إلى استمارة الباحث علي الزهراني حيث وصلنا من قسم الطالبات (٧٧) استمارة و (٤٥) استمارة من الطلاب وتبقى لدينا (٨٠) استمارة مرفقه .

لتفضل سعادتكم سعادتكم باستكمال الاجراءات

وتقبلوا وافر التحية والتقدير،،،

وكيل كلية العمارة والتخطيط

للشئون الأكاديمية

د. عقال بن خلف الجوفي

مطبعة جامعة الملك فيصل

علم (٢) ٢/٢٠

الأحساء - ص.ب. ٤٠٠ - تلكس ٨٦١٠٢٩ فيصل أس جي - تلفون ٥٨٠٠٠٠٠ - فاكس ٥٨٠١٢٤٣ - الدمام - ص ب ١٩٨٢ - تلكس ٨٧١٣٠٢ فيصل أس جي - تلفون ٨٥٧٧٠٠٠ - فاكس ٨٥٧٨٠٤٨
Al-Ahsa, P. O. Box 400 Telex 861028 Faisal S. J. Tel. 5800000- Fax 5801243 - Dammam, P. O. Box 1982 Telex 870020 Faisal S. J. Tel. 8577000 - Fax 8578048

8) Letter from the Department of Home Economy, King Faisal University.

بسم الله الرحمن الرحيم

جامعة الملك فيصل

كلية العلوم الزراعية والأغذية

إحالة داخلية من مديرة الشؤون الادارية بقسم الاقتصاد المنزلي ..مع التحية

الى :-

سعادة / وكيل الجامعة للدراسات العليا والبحث العلمي	المحترم
الموضوع :.إشارة الى خطابكم رقم ١٩/٤٨/أ بتاريخ ٢٢/ ١/ ١٤٢٢هـ بشأن طلب توزيع الاستبيان الخاص بسعادة الاستاذ/ علي حسن صحفان الطالب المبتعث لدراسة الدكتوراة بجامعة أدنبرة ببريطانيا . أود أن أفيد سعادتكم بأنه قد تم توزيع الاستبيان وتعبئته وتجميعه ،(مرفق عدد ((٤٣)) أستبيان)	

أكمال اللازم نظاماً	للعلم	للإعتماد

الرقم : ٥٨٠٢٠٣٦٢٤٦ التاريخ: ٩/ ٢/ ١٤٢٢ المرفقات: