Child Sexual Abuse in African Nations:
Lessons from Research and Therapeutic Implications

A Literature Review

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Abstract

The aim of this paper is to study the prevalence of familial and community Child Sexual Abuse (CSA) across the continent of Africa, a subject that has been barely studied. This paper first reviews the general theories of CSA and its various definitions, and applies them to what is currently known about CSA in Africa. The continent of Africa is examined regionally using the United Nations sub-regional categorization, taking into account political, historic, cultural, economic, legal, and educational factors. Individual African nations in each sub-region are examined, illustrating the occurrence of CSA in a regional context depending on the amount of research available. Common themes and trends concerning CSA across the African nations are identified, especially with respect to patriarchy. Also studied is the efficiency of local health and legal authorities in dealing with CSA in the few nations where it is recognized. This paper presents guidelines for clinicians in how to deal with patients of African origin who have experienced CSA amongst many other possible traumas, and how to clinically isolate the CSA aspects and approach them in a societally appropriate African context. Recommendations are made regarding further research.
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Dedication

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Child Sexual Abuse in African Nations:
Lessons from Research and Therapeutic Implications

In the years between 1981 and 1995, thirty-seven studies pertaining to Child Sexual Abuse, (subsequently referred to as CSA) have been published mostly in the United States. Between these dates, a total of 25,367 subjects participated in ongoing research into this traumatic experience (Paolucci, Genuis, & Violato, 2001). From the research, the prevalence of CSA appears to be alarming. For example, in the general population the prevalence of CSA is between 15% and 20%, with an estimated prevalence for children and adults falling in a range between 4% and 50% (Paolucci et al., 2001). Another research study indicated that in the United States the prevalence of CSA is approximately 15%, or 150,000 children who experience some form of CSA each year. Of these, 50% involve vaginal and/or anal penetration (Nurcombe, 2000).

The purpose of this study is to explore the mental health implications of CSA specifically, amongst African nations and within the broader context and definition of CSA as described in the current research literature.

Definitions of CSA

Over the past two decades, the literature on CSA has defined the term in several ways, and this variation has had a major impact on the disparity in the reported prevalence of CSA (Nurcombe, 2000). Various early definitions of CSA suggest that it is sexual contact between a child and an adult, whether by force or consent and including direct and observed contact (Friedrich, Urquiza, & Beilke, 1986). Others define CSA as any form of sexual interaction (e.g., from touching to vaginal and/or anal intercourse) with someone at least five years older than a child who is under the age of 15 (Leitnberg, Greenwarld, & Cado, 1992; Schaaf & McCanne,
A more descriptive definition of CSA is “a sexual interaction involving either physical contact or no contact (e.g., exhibitionism) between either a child or adolescent and someone significantly older, or between two peers who are children or adolescents when coercion is used” (Rind, Tromovitch, & Baur, 1998, p. 23). Similarly, Paolucci et al. (2001) adopted the definition of CSA as “any unwanted sexual contact (ranging from genital touching and fondling to penetration) during the period in which the victim is considered a child by legal definition and the perpetrator is in a position of relative power over via à vis the victim” (p. 21).

Inconveniently, the current Diagnostic and Statistical Manual [DSM-IV-TR] (2000) does not establish any specific criteria for CSA except within the generalized criteria of Pedophilia (Mannon & Leitschuh, 2002). According to the DSM-IV-TR (2000), a Pedophilic is a perpetrator who “…is at least 16 years of age and at least five years older than the child or children” (p. 738). Consequently, due to the lack of a consensus on the scope of CSA, it appears that there is little consistency or general agreement upon its precise definition (Haugaard, 2000; Paolucci et al., 2001). Haugaard (2000) stated, “Several fundamental issues about child sexual abuse remain unresolved and controversial. The most basic of these is how to define child sexual abuse” (p.1036). This resulting ambiguity in precisely defining CSA has complicated the outcome of clinical research into its effects, prevalence, and severity (Haugaard, 2000; Mannon & Leitschuh, 2002). In an attempt to reduce the use of too ambiguous and broad definitions of CSA, Haugaard (2000) suggested those researchers, clinicians, legal workers, and other professionals who both work with and study cases of CSA might benefit from establishing a narrower and more unified definition.
Theories of CSA

While over the past thirty years, the research literature pertaining to CSA has made substantial efforts to define and explore its prevalence, effects, and severity, other researchers have focused on the etiological theories of child sexual offenses in hopes of creating prevention and treatment programs for offenders. In their paper, Ward & Siegert (2002) summarized and reviewed three well-known etiological theories and models of child sexual offense: The Precondition Model of CSA, (Finkelhor, 1984); the Quadripartite Model, (Hall & Hirschman, 1992); and the Integrated Theory, (Marshal & Barbaree, 1990). Subsequently, Ward and Siegert (2002) established their own Pathways Model as a final model derived from the previous three models of child sexual offending etiology.

Precondition Model of Child Sexual Abuse

Finkelhor’s (1984) Precondition Model of child sexual abuse (which is also a useful model for the topology of child molesters) suggests that child sexual offenders first experience three internal offense processes, which lead to precondition I: the motivation to abuse a child. These factors include: 1. the need for emotional gratification from children, 2. factors that make children sexually arousing to the offender, and 3. factors that block socially appropriate sexual experiences with age appropriate partners. In precondition I, the offender is motivated to be sexual with children based on the above stated phases. Disinhibition characterizes the next two preconditions with Precondition II concerning the perpetrator overcoming internal inhibitions against sexual behavior with children and precondition III (with the perpetrator overcoming external inhibitions to such abuse, like picking a time and place where they will not be discovered. The last precondition phase also involves the pedophile overcoming the child’s resistance (Finkelhor, 1984; Ward & Siegert, 2002).
Quadripartite Model

Hall and Hirschman’s (1992) Quadripartite Model of sexual aggression against children suggests that there are four factors that motivate and increase the occurrence of aggressive sexual behaviors against children: Psychological sexual arousal (offenders who have a strong sexual inclination only with children), cognitions justifying sexual aggression (e.g., the offender is well known to the victim such as an incest offender who will skillfully plan sexual activity with a child), affective dyscontrol (impulsive offenders), and personality problems (offenders who have difficulties maintaining socially acceptable sexual and intimate relationships with adults).

According to the Quadripartite Model, a child molester and sexual offender’s psychological state of sexual arousal, cognitive justification of sexual aggression, and affective dyscontrol, form the main motivations for deviant sexual arousal and related situational factors. However, the offender’s principal vulnerabilities leading to disinhibited or deviant sexual behavior stem from personality deficiencies (Hall & Hirschman, 1992; Ward & Siegert, 2002).

Integrated Theory

Marshal and Barbaree’s (1990) Integrated Theory of sexual offenses explains the mechanism of the onset and development of the offender’s deviant sexual behavior towards children. According to Marshal and Barbaree, (1990) the onset and predisposition of deviant sexual arousal begins at adolescence in which the experience of a challenging childhood leaves the offender without the adequate social skills necessary to develop a heterosexual relationship. Although the Integrated Theory explores multifactorial motivating factors such as biological, psychological, social, cultural, and the situational factors of child sexual offenses, they suggest that the transition to adolescence increases the vulnerability of becoming a child sexual offender (Marshal & Barbaree, 1990; Ward & Siegert, 2002).
Overall, the previous three etiological models and theories of child sexual offenses: Precondition Model of CSA, (Finkelhor, 1984); Quadripartite Model, (Hall & Hirschman, 1992); and Marshal & Barbaree’s (1990) Integrated Theory, have substantially influenced theories on the onset, development, and motivational factors of a child sexual abuser’s psychological mechanisms (Ward & Siegert, 2002). Based on a critical analysis of the above-mentioned theories of sexual offenses, Ward and Siegert (2002) added their own model - the Pathways Model, based on previous clusters and motivational factors of theories of child sexual offense.

**Pathway Model**

Ward and Siegert’s (2002) Pathway Model focuses on four psychological mechanisms found in child sexual offenders and child molesters: intimacy and social skills deficits, deviant sexual scripts, emotional dysregulation, and cognitive distortion. The authors describe psychological mechanisms as the motivation for child molesters continuing to abuse children sexually. According to Ward and Siegert (2002), child molesters and child sexual abusers lack the socially appropriate skills to build intimacy. This first psychological mechanism could be attributed to the idea that the abuser may have experienced insecure and impaired attachment as a child. The second psychological mechanism of a child abuser pertains to deviant sexual scripts such as inappropriate sexual partners (e.g., children), inappropriate or deviant sexual behaviors, or unsuitable sexual contexts (e.g., impersonal sex). Emotional dysregulation, the third psychological mechanism, suggests that a lack of self-regulation and inhibitions leading to inappropriate sexual behaviors (e.g. intercourse with a child) are additional factors that encourage the abuser to commit sexual offenses against a child. The fourth psychological mechanism, cognitive distortion, is the product of problems with intimacy and social skills,
deviant sexual arousal (e.g., arousal by children), and emotional disturbance removing any inhibitions against deviant sexual offenses against children (Ward & Siegert, 2002).

As the research on both analyzing and preventing CSA has been expanding over the past two decades, many theoretical models focusing primarily on child and adult traumatization have appeared in the research literature. For example, Hulme (2004) summarized some of the previous and current theoretical models of CSA pertaining to its psychological and physical effects. The general Developmental Theory explains that any experience (negative or positive) has a crucial impact on a child or adolescent’s adjustment to adulthood (Nurcombe, 2000). Thus, the interruption of normal childhood developmental processes creates negative consequences.

Based on Developmental Theory, Hulme (2004) suggested that,

Consequently, any disrupting of critical developmental tasks of childhood has the potential to cause negative and profound long-term effects. In particular, areas of childhood development likely to be disrupted by repeated CSA are physical and psychological self-integrity, the self-regulatory skills of affect and impulse control, and the capacity for age-appropriate peer relationships (p. 343).

As summarized by Hulme (2004) in Psychosocial theories: Developmental, Family, and Feminist theories that describe the developmental, social, and familial aspect and effects of CSA, Family Theory is one of the psychosocial theories of CSA. According to this view “The family itself, which should be protecting the child, is viewed as both the root and the context of the problem” (Hulme, 2004, p. 344). As a result, adults who experience CSA indicate that they may have lived within a dysfunctional family.

Similar to the Family Theory and Developmental Theory, the Attachment Disruption model suggests that the disruption of attachment from caregivers leads to emotional distress and
denial of CSA (Nurcombe, 2000). Unlike Developmental and Family theory, Feminist Theory views CSA as an abuse of power by patriarchal society, “feminist theory casts blame for CSA not on the family per se, but on the values of our patriarchal society and on male socialization” (Hulme, 2004, p. 345). Other psychosocial theories of CSA: Learned Helplessness and Post Traumatic Reaction Theory describe the general traumatic effect of CSA on children and adults. Both Learned Helplessness and Post Traumatic Reaction Theories provide a different perspective towards explaining the common symptoms of PTSD and depression in adults who have experienced CSA (Hulme, 2004).

**Other Theories of CSA**

Additional theories that explain the long-term effects on adults who experience CSA include psychosocial theories specifically focusing on CSA: The Post Traumatic Stress Reaction Theory and Accommodation Syndrome Model. The Post Traumatic Stress Reaction theory suggests that repeated sexual abuse likely leads to immediate or delayed stress (Nurcombe, 2000). Accommodation Syndrome explains that children who experience CSA experience secrecy, helplessness, entrapment and accommodation, delayed, conflicted, and unconvincing disclosure (due to a lack of adult support and a negative reaction to CSA), and retraction (e.g., self-blame and self-hate). Secrecy suggests that children who experience CSA learn that the disclosure of their experiences leads to disbelief or punishment from adults who discourage the child from any future disclosures, and as a result, these children grow into adults who are fearful of trust, intimacy, and self-validation (Hulme, 2004; Nurcombe, 2000). Helplessness suggests that, “Children are helpless in the face of CSA, not only because of their size, but because society expects them to be obedient and affectionate with any adult in a caretaking role” (Hulme, 2004, p. 347). Entrapment and accommodation suggest that, in the face of repeated CSA, the
child learns to accept and accommodate the sexual perpetrator in order to survive. These children who have learned entrapment and accommodation often carry their childhood survival skills into adulthood in such forms as overachievement, extreme dependency, self-punishment, self-mutilation, dissociation, delinquency, and substance abuse (Hulme, 2004).

Empirical and Conceptual Frameworks

In addition to the above theories, there are the empirical and conceptual frameworks that explain the impact of CSA in depth. The primary three conceptual frameworks are: The Traumagenic Dynamics Model, Child Abuse Trauma Theory, and Neurobiological Theory (Hulme, 2004; Nurcombe, 2000). The Traumagenic Dynamic Model consists of four psychological impact models of CSA: a) traumatic sexualization (confusion about sexual identity and norms; confusion of sex with love, care-getting, and care-giving; and an aversion to sex or intimacy); b) Stigmatization (feelings of guilt, shame, low self-esteem, and a sense of difference from others); c) betrayal (feelings of grief, depression, extreme dependency, anger, hostility, mistrust, and difficulty in judging the trustworthiness of others); d) powerlessness (anxiety, fear, a lowered sense of efficacy, need to control, perception of oneself as victim, and identification with the aggressor (Hulme, 2004; Nurcombe, 2000). Child Abuse Trauma Theory is not specific to CSA but addresses all forms of child abuse (e.g., verbal, physical, and sexual) in which a child who experiences it grows into an adult who experiences psychological and physical health problems such Post Traumatic Stress Disorder (PTSD), cognitive distortions, altered emotionality, dissociation, and impaired self-reference (Hulme, 2004). The Neurobiological (Psychobiologic) information-processing model is a growing scientific field that has begun to explain the effect of CSA based on neurological factors (Hulme, 2004; Nurcombe, 2000). The importance of Neurobiological science on CSA has been explained as follows:
Based on the assumption that CSA creates stress in children that can be characterized as severe and/or prolonged, the physical and psychosocial health problems of the adults they become are theorized, according to neurological theories, to be either directly or indirectly related to biochemical, cellular, or structural changes resulting from the stress of CSA (Hulme, 2004, p. 352).

**Adlerian perspectives of CSA**

While many theories and conceptual frameworks have been developed as summarized above, Adlerian therapists have taken an additional step in exploring the causative factors that lie behind CSA. Slavik, Carlson, & Sperry (1995) suggest that, “In an Adlerian clinical model, it is not relevant whether abuse happened; what is relevant is the claim that it did and the use made of such a claim” (p. 358). As a result, Adlerians believe that a child’s experience (positive or negative) does not dictate their actions, and that the conclusions they draw from the experience are far more influential than the experience itself. In other words, Adlerians do not trivialize the effect of sexual abuse on children and adults with a history of CSA, but focus on the current functioning of the child or the adult who has experienced it (Cash & Snow, 2000; Slavik et al., 1993; 1995).

**Adlerian Lifestyle Convictions and CSA**

According to Adlerian theory, children begin to develop lifestyle convictions as early as the age of six, which is when they begin to draw conclusions from their experiences and act as their beliefs and feelings form guidelines and strategies to address real life situations (Cash & Snow, 2001; Slavik et al., 1995). For example, Slavik, et al. (1995) suggest adults who have experienced CSA as children develop many lifestyles; however there are two extreme lifestyle convictions that carry from childhood to adulthood that can significantly impact their functioning
as an adult. The first extreme lifestyle conviction, defiant and revengeful, suggests that adults with a history of CSA have a defiant personality, that they “actively preoccupy themselves with revenge and with disproving the world’s judgment of them as worthless; they vigilantly and impulsively demand their rights and share of love and attention. They may become perpetrators of child sexual abuse or sexual assault” (Slavik, et al., 1995 p. 363). The opposite extreme lifestyle conviction leads to defeated personality, in which the adult maintains a hopeless and inadequate lifestyle. Such individuals who experience sexual abuse as a child, “passively submit to the world’s apparent evaluation of them as worthless, have little confidence, avoid responsibility and competition, are close-minded, and rigidly think of themselves as worthless” (Slavik, et al., 1995 p. 363).

The above Adlerian perspectives seem to reiterate past and current research, explaining those prevalent theories of CSA that indicate a serious and alarming risk of psychiatric disorder and problems of adjustment in the transition from childhood to adulthood (Slavik, et al, 1995). In their article, Paolucci, et al, (2001) confirmed that regardless of the severity and repetition of sexual abuse, gender, socioeconomic status, and the child’s age and familiarity with the perpetrator, CSA carries with it a high risk of psychiatric disorder in both childhood and later in adult life.

**The Impact of CSA**

CSA also has both short-term and long-term negative effects including psychological and somatic health problems leading to psychopathy and emotional distress. For example, “CSA causes disruption in the development of a child’s sense of self, leading to difficulty in relating to others, inability to regulate reactions to stressful events, and other impersonal and emotional challenges that make psychiatric disorders more likely” (Molnar, Buka, & Kessler, 2001, p. 753).
Various research studies in the past two decades have confirmed the following consequences of CSA in adults: emotional distress, depression, anxiety, early or delayed PTSD, sexual promiscuity, victim-perpetrator cycle, academic achievement (poor or over achievement), low self-esteem, a sense of helplessness and self-hatred, an inability to trust others in an intimate relationship or interpersonal difficulties, eating disorders, suicide (actual or attempted), self-mutilation, delinquency, substance abuse and alcoholism, Dissociative Identity Disorder (DID), dissociation, borderline personality disorder, and sexual maladjustment. In addition to psychiatric disorders, adults with a history of CSA also experience physical health problems such as pseudo-seizures, somatization disorder, chronic pelvic pain, and multiple surgical procedures. Adults with a history of CSA are also at risk of being raped, being victims of coercive sexual experiences, encountering domestic violence, experiencing feelings of isolation, and exhibiting a stigma and tendency towards re-victimization (Mannon & Leitschuh, 2002; Molnar et al., 2001; Nurcombe, 2000 Paolucci, et al., 2001; Slavik, et al., 1995).

Cash and Snow (2001) stated “A child who experiences sexual abuse often presents emotional difficulties and behavioral problems including depression, anxiety, aggressive behavior, and inappropriate sexual behavior” (p. 102). Cash and Snow suggest that if these behaviors are not treated in childhood, then the problems will deepen and cause problems in adulthood. One of the effects of CSA in childhood is PTSD, however if the child experiences repeated sexual trauma that could lead to dissociative symptoms (Nurcombe, 2000). Additional long-term and short-term effects that are commonly found in children who experience CSA include but are not limited to: rage, aggression, hyperactivity, impulsivity, low self-esteem, and preoccupation with sexual behavior (Cash & Snow, 2001; Nurcombe, 2000). Cash and Snow (2001) expressed that the effect of CSA, particularity with respect to incest is:
When a child experiences sexual abuse, especially by a family member, trust is violated, and he or she can no longer depend on the family for needed physical and emotional security . . . The abusive adults’ misuse of power may lead a child to develop, feelings of powerlessness, inadequacy, and inferiority (p.104).

As a result, Adlerian theory reiterates alternative research that children who experience child abuse will also experience psychiatric disorders pertaining to discouragement and despair, self-blame for the abuse, difficulty in developing empathy and social skills, impaired self-perception and decision-making abilities (private logic), perfectionism, and variable academic achievements (Cash & Snow, 2001). In addition, children who experience CSA exhibit excessive crying, clinging behavior, detachment and isolation, attempt suicide, self-mutilation, and other self-destructive behaviors. A child who experiences CSA is at risk of abusing other children sexually and acting sexually seductive towards an adult to gain love (Cash & Snow, 2001).

Nurcombe (2000) suggests that even though the prevalence of psychiatric symptoms is high for children who have experienced CSA, some children may be resilient in spite of abuse and adjust well in adult life. In addition, Nurcombe (2000) stated that there are concurrent stressors including antecedent factors, abuse-related factors, post-disclosure factors, and mediating factors that increase the possibility of CSA impacting the adult. Antecedent factors are the quality of family life prior to the sexual abuse such as emotional neglect and abuse, physical abuse, exposure to domestic abuse, parental psychopathology, substance abuse, and marital difficulties, all decreasing the likelihood of the child becoming a well-adjusted person as an adult. Other CSA related negatives are abuse related factors such as the propinquity of the abuser, the duration and frequency of the CSA, genital penetration, coercion, and threats from the abuser. Post-disclosure stressors are lack of support from the non-offending parent and other
family members as well as the actual giving of testimony that sexual abuse has occurred. In addition to the antecedent factors, abuse related factors, and post-disclosure stressors, mediating factors such as negative self-concept, self-blame, external locus of control and negative coping style, have a major influence on how a child views and feels about himself or herself. As a result, mediating factors also present less favorable outcomes for adults who have been exposed to CSA. Negative coping: suppression, denial and avoidance of the perpetrator, dissociation (e.g., detachment and fantasizing), conversion and somatization, acting-out and externalization, alcohol ingestion and drug abuse, compulsion, reenactment of the abuse, and reversal victimization are just a few of the symptoms that not only decrease the odds of successful adjustment in adulthood, but also increase the odds that the outcome of experiencing CSA will be negative (Nurcombe, 2000).

To investigate the full scope of CSA in depth is beyond the scope of this paper. For more in depth studies on CSA and related subjects: sex crimes, incest, the prevalence of male sexual abuse victims, the psychological factors of child sexual abuse, coping with sexual abuse, the effects and prevention of CSA, severity of child sexual abuse, treatment of child sexual abuse, psychometric measurement of child sexual abuse, and the implications of child sexual abuse, please refer to Finkelhor, 1984; Friedrich, Urquiza, & Beilke, 1986; Hall & Hirschman, 1992; Leitnberg, Greenwarld, & Cado, 1992; Mannon & Leitschuh, 2002; Nurcombe, Wooding, Marrington, Bickman, & Roberts, 2000; Rind, Tromovitch, & Bauserman, 1998; and Schaaf & McCanne, 1998.

CSA in African Nations and the Criteria Concerning Its Inclusion

As stated in the introduction, the purpose of this paper is to explore the therapeutic implications of CSA amongst African nations in relationship to the general definition and
Theories of CSA outlined above. Many forms of CSA such as rape, forced early marriage, exploitation, prostitution, harassment, and female genital mutilation, are present in Africa, (Deedei Khalil, 2006) and in many of these countries child sexual exploitation and the commercial sexual exploitation of children (CSEC) includes but is not limited to; prostitution, pornography, and trafficking. As a result, CSEC is a significant issue in many African countries, where children and adolescents are exploited for sex in exchange for cash or other kinds of payment such as food, shelter, or gifts (Lalor, 2004a, 2008).

In addition, HIV transmission to children through incest, child rape, exploitation and prostitution is a growing concern in many African countries, especially in the sub-Saharan nations. However, CSA in the home and community has not received a great deal of critical analysis in the 53 African nations (Lalor, 2004a, 2008). The implications of the various forms of CSA in Africa form a very large subject, and can be difficult to disentangle from other forms of abuse against children. Though the commercial sexual exploitation of children, (CSEC) the impact of HIV/AIDS, child rape, child prostitution, and female genital mutilation, do not form the principal focus of this essay, they will often be mentioned because a great deal of data and information about CSA can be derived from research into these related forms of abuse. This paper, however, places primary emphasis on research that studies CSA in the home and community (family, parents, peers, teachers etc.), its prevalence, and its clinical implications in an African context.

Introduction to the Continent of Africa

Africa is the world’s second largest and second most populous continent (after Asia) consisting of 53 individual countries, and at least 1 billion people, (Central Intelligence Agency (CIA, 2009) accounts for 14% of the world’s population. The continent bisects the equator and
encompasses a wide range of distinct geographic, climatic, and cultural zones. Africa is the origin continent of humanity and as such, is highly diverse both ethnically and genetically. A number of geographic regions in Africa have developed distinct historic cultures that have influenced the modern-day countries that occupy their territories. Despite this wide geographic, political, and cultural diversity, there exist several international institutions that seek to address the continent’s problems in a common forum, notably the African Union, and the African Economic Community.

Although rich in natural resources, Africa remains the world's poorest and most underdeveloped continent. This is the historic product of a number of interrelated factors including political instability, economic exploitation, frequent military and tribal conflicts, the spread of diseases (particularly HIV/AIDS and malaria), corrupt governments often committing serious human rights violations, failed central planning, high levels of illiteracy, poverty, and a lack of access to foreign capital. According to the United Nations' Human Development Report, in 2003, the bottom 25 ranked nations (151st to 175th) were all African. According to the World Bank, 80.5% of the Sub-Saharan Africa population was living on poverty (CIA, 2011; United Nations (UN), 2011; World Health Organization (WHO), 2011).

It is important to note that most of the boundaries of today’s African nations were determined by European colonial powers in the 19th century, often dividing entire homogenous ethnic groups between several countries. Therefore, before looking at specific nations it is just as important to look at Africa in a regional context. The United Nations broadly divides modern Africa into 5 sub-regional groupings sharing common cultural, geographic, and linguistic traits. Due to this division, it is difficult to establish the prevalence of CSA in a general African context, without an empirical study of CSA at a regional level pertaining to its incidence in the
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home and community. Consequently, this paper follows the United Nations regional categorization of Africa selecting specific nations to illustrate the prevalence of CSA in those regions.

Northern Africa

The Northern African countries lie north of the Sahara and along the Mediterranean coast and are the location of some of the oldest civilizations on Earth. Culturally and historically, the barrier of the Sahara has separated these states from the rest of Africa and most of them look north and east as members of the broader Mediterranean and near eastern cultural sphere. All are primarily Islamic in culture though there are significant Christian minorities. Nations in this sub-region include Algeria, Egypt, Libya, Morocco, Tunisia, and the Western Sahara. Sudan is sometimes included but is usually categorized as part of the Eastern Africa sub-region (CIA, 2011; UN, 2011).

Morocco

Morocco is located along the northwestern coast of Africa. It is a majority Islamic nation with a population estimated at 32 Million. Morocco has a market economy that benefits from its proximity to Europe with low unemployment rates at 9% and with only 15% of the population below the poverty line. Ethnically, about 99% of the population is Arab-Berber. The official language is Arabic with French often spoken as the language of business. The legal system is based on Islamic (Sharia) law combined with elements of French and Spanish law. Children spend an average of 10 years in school and HIV/AIDS’s prevalence remains insignificant at 0.1% of the population. Morocco is also one of the world’s largest producers of illicit hashish and a transit point for cocaine to Europe (CIA, 2011; UN, 2011; WHO, 2011). In terms of cultural attitudes to women and children, Mchichi Alami and Kadri (2004) stated that:
In Morocco, the role of women and their status and function vary depending on ethnic origin, rural or urban setting, and the socioeconomic and intellectual level, as well as other factors. In this country, as in most Arab ones, sexuality remains a taboo. It is deeply linked to hchouma, A word difficult to translate: on one hand it means “disgrace” and on the other, “shyness”. It incites girl’s adolescents and women, to conform to the social rules and laws regarding their behavior, sexuality and relations to the “stronger sex” (p. 240).

Mchichi et al. (2004) define CSA as “the participation of a child or a teenager in sexual activities enforced by violence or seduction or through transgressing the social taboo” (p.238). In their research Mchichi et al. (2004) interviewed Moroccan women about CSA, which was a difficult task as there are no epidemiological studies of CSA in the Islamic world, since it and other sexual violence is a taboo subject.

Mchichi et al. (2004) interviewed 728 Moroccan women who admitted experiencing CSA including abuse without contact, abuse with contact, no penetration, and abuse with contact and penetration. In addition, they examined the effects of CSA including depression, anxiety, sleep disorders, hypoactive sexual desire disorder, orgasmic disorder, dyspareunia, vaginismus cigarette dependency, and alcohol dependency. The results indicate that 27 out of 278 women had experienced CSA, and that out of the 27 women 17 of them reported experiencing CSA between the age of 2 and 10. Based on their study, the authors estimated the prevalence of CSA in Morocco at about 9% considering the fact that sexual violence or abuse is a taboo subject in Morocco and the Islamic world in general.

In their research, Mchichi Alami and Kadri (2004) confirmed that there is no association between the severity of CSA and depression. Nonetheless, they confirm that psychiatric
symptoms such as depression, hypoactive sexual desire, and substance abuse are negative consequences associated with CSA. The authors contend that in their own social groupings, the victims know the offenders, and that incest appears to be the most distressing form of CSA prevalent in Morocco (Mchichi et al., 2004).

**Western Africa**

The Western African countries lie in the westernmost region of the African continent and consist of: Benin, Burkino Faso, Cape Verde, Cote d’Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, and Togo. Despite the wide variety of cultures in West Africa, from Nigeria through to Senegal, there are general similarities in dress and culture that are not shared significantly with nations outside of this geographic region. Linguistically West Africa is non-bantu speaking unlike central and southern Africa. Islam is the predominant historical religion of the West African interior and the far west coast of the continent. Christianity is the predominant religion in the central and southern part of Nigeria, and coastal regions of Ghana, and elements of indigenous religions are still practiced throughout the region (CIA, 2011; UN, 2011).

**Ghana**

Ghana is located in Western Africa between Cote d’Ivoire and Togo and was the first sub-Saharan colony to achieve independence from Britain in 1957. The new country experienced considerable political instability with a long series of coups over its first four decades, with multi-party elections established since 1992. The population is currently just under 25 million and is highly mixed ethnically. The official language is English with a large variety of minority indigenous languages spoken. The majority of the population is Christian (68%) with a significant Muslim and indigenous belief minorities. Ghana has an abundance of
natural resources including oil and agriculture and is one of the more efficient economies in Africa. 28.5% of the population lives below the poverty line with an unemployment rate of 11%. Life expectancy is 61 years. The legal system is based on English common law. School attendance averages 10 years. Ghana is a source of cannabis for the international drug trade and a center of money laundering. HIV/AIDS prevalence in Ghana is relatively low for Africa at 1.8% of the population (CIA, 2011; UN, 2011; WHO, 2011).

Kofi Boakey (2009) explored the wide nondisclosure of CSA and the cultural influences that lie behind its underreporting in a Ghanaian and African context. In his research, he suggested that despite the social problems that influence the likelihood of CSA, Ghana appears to actively recognize the occurrence of violence against women and children and especially CSA. For example, in Ghana, the establishment of the Domestic Violence and Victim Support Unit (DOVVSU) and the Children’s Act of 1998 (Act 560) indicate an ongoing and positive effort to address CSA and other forms of violence against women and children. Boakye (2009) suggests that it is essential to understand the three cultural barriers against the disclosure of CSA within a Ghanaian and African context including patriarchy, the myth of child rape, and collective shame (Boakye, 2009).

As mentioned above, Feminist Theory views CSA as an abuse of power by patriarchal society: “feminist theory casts the blame for CSA not on the family per se, but on the values of our patriarchal society and on male socialization” (Hulme, 2004, p. 345). Another reason for the nondisclosure of CSA is the acceptance of the child rape myth. There is a widely held belief in Ghana and in other sub-Saharan African countries that men are naturally incapable of controlling their sexual urges but that also child abusers must be suffering from extreme mental illness. As a result, when a man rapes a child, this behavior is accepted as a natural consequence of both
myths and the victim receives little or no attention. The rape acceptance myth is directly or indirectly influenced by patriarchy. The last factor that contributes to the underreporting of CSA is collective shame, which consists of two aspects which end up in opposition to each other, protecting the child and protecting the family. Protecting the child exposes the family to neighbors or police which causes them to be shamed by others. Thus, the family reputation is deemed more important than the child’s experience of CSA. Collective shame occurs because families feel ashamed and embarrassed about any incident of CSA, not just that which occurs in their own family. Thus, it is conceivable that children in Ghana and other African countries learn to accept male authority without question, which in turn minimizes the likelihood of any disclosure of CSA (Boakye, 2009).

Nigeria

Nigeria is located in Western Africa between Benin and Cameroon and is the most populous nation on the continent at 155 million people. After many years of military rule, Nigeria is now a civilian based government that continues to face substantial religious and ethnic tensions from over 250 ethnic groups divided into 40% Christian, 50% Muslim, and 10% indigenous beliefs. The official language is English, followed by Hausa, Yoruba, Igbo, Fulani, and over 500 additional languages. Approximately 70% of the population lives below the poverty line with an unemployment rate of 5%. Life expectancy is low averaging 47 years. Nigeria’s economy is heavily based on oil and agriculture but has been handicapped by political instability, corruption, and poor macroeconomic management. The legal system is divided between English common law, Islamic (Sharia) law (in Islamic majority areas) and traditional law. School attendance is low by international standards with children only averaging 9-years attendance. Nigeria is a major transit point for the drug trade to Europe, East Asia, and North
America. Nigeria has been moderately exposed to HIV/AIDS with 3.6% of the population infected, ranking as 27th in the world in prevalence (CIA, 2011; WHO, 2011; UN, 2011).

In their research on childhood sexuality and CSA in Nigeria, Obisesan, Adeyemo, and Onifade (1999), interviewed 2000 men and 2000 women about their sexual experiences as children, their earliest experiences of sexuality and whether they had experienced any sexual abuse. The results astounded the researchers in that at least 5% of respondents reported having intercourse between the ages of 6 to 10 years. In addition, a total of 81 respondents reported that they were forced to have intercourse between the ages of 6 to 10 years. The research indicated that there was no difference between male and female respondents in the degree of sexual abuse they had been subjected to as children. They also learned that most of their respondents experienced CSA while in boarding schools. The authors stated that,

It is astonishing that as many as 1 in every 20 men and women had sexual intercourse between the ages of 6 and 10 years. More surprising, is the number of those who were forced to have sex at this tender age (81 respondents = 2.1%) (Obisesan, et al., 1999, p. 626).

The writers also suggest that there is a paucity of studies on CSA in Nigeria because any discussion of sexuality, between adults and children especially, is taboo. As a result, it is reasonable to conclude that the prevalence of CSA in Nigeria is high given that at least 5% of respondents stating that they agreed to have sex as children, thus, Obisesan et al. (1999) concluded that CSA is a worrying and alarming issue in Nigeria, and that policymakers should address the issue to prevent an increase in CSA, and consider the administration of preventative sex education programs.
Another body of research that explored sexual risk behaviors in adolescents, who have experienced CSA, suggested that there is a breath of empirical research exploring the link between risky sexual behaviors and CSA among socially disadvantaged adolescents (Olley, 2008). In Olley’s (2008) research, out of 2,290 senior high school students, 55% reported that they had experienced an unwanted kiss on their breast and genitals. “Thirty-six percent reported a history of intra-family CSA, whereas 46% had experienced inter-family CSA. Twenty-five percent had experienced both intra- and inter-family CSA” (Olley, 2008, p. 245). The study confirms the hypothesis that socially disadvantaged adolescents with a history of CSA are at risk of participating in higher risk sexual activities leading to infection by STD/HIV through not using condoms or having sex with partners with an unknown sexual history, all combined with increased tobacco and alcohol use. Olley (2008) concluded that the high prevalence of CSA in Nigeria is comparable to other studies in Europe, America and African countries.

**Eastern Africa**

This African sub-region encompasses 19 countries including: Kenya, Tanzania, Uganda, Burundi, Djibouti, Eritrea, Ethiopia, Rwanda, Sudan, and Somalia. Egypt is also in the northeastern area of Africa but is included in the Northern African sub-region for the purposes of this paper. With the exception of Ethiopia, the modern boundaries of all of these states were formed during the colonial era and do not necessarily reflect an underlying ethnic and cultural population that is homogenous (CIA, 2011).

**Ethiopia**

Ethiopia is one of the oldest nations in Africa with a recorded history and distinct culture stretching back over 2000-years. Ethiopia remained fully independent during the European colonial period with the exception of the Italian invasion between 1936 and 1941. Formerly, a
Monarchy, the last Emperor was deposed in 1974 and was replaced with an unstable military dictatorship torn by coups, uprisings, wide-scale drought, and massive refugee problems. After the military regime was toppled in 1991, a new constitution was adopted in 1994. Since the independence of Eritrea, Ethiopia is now a large landlocked country with the second largest population in Africa at 85 million people. Approximately 37% of the population lives below the poverty line in an economy that is primarily agricultural and often prone to climatic disruption. Ethiopia has a diverse ethnic mixture with a wide spectrum of languages spoken of which Amharic, Oromigna, and Tigrigna represent the most numerous speakers, with Somaligna, Guragigna, and English also spoken. Ethiopia is historically a Christian country with its own orthodox traditions, but also has a large Muslim community (34%). Schooling for children is low by international standards averaging 8-years. One widespread procedure that is commonly practiced independent of religion or economic status is female genital mutilation (FGM). Though a traditional practice, FGM is increasingly considered harmful with government and private organizations working to eliminate it. There are currently no accurate statistics on HIV/AIDS infection rates for Ethiopia (CIA, 2011; UN, 2011; WHO, 2011).

In a comprehensive effort to explore the prevalence of CSA in southwest Ethiopia, Worku, Gebremariam, and Jayalakhmi (2006) conducted a cross-sectional study in Jirren High School. They surveyed 323 female students from the 9th grade, of which 222 students reported experiencing some form of sexual abuse at least once in their lifetime. According to the study, the most common form of sexual abuse is verbal harassment followed by sexual intercourse and unwelcomed kissing. Out of the 222 students, about 36% reported unwanted sexual advances by strangers, about 31% from school friends, 16% reported incest, and about 15% advances from neighbors. The authors reported the paucity of research on CSA and the lack of data, stating:
In the developed world, case registration and screening of suspected cases of child abuse using the standard definition is employed to document the magnitude and nature of child abuse. No such system exists in developing countries such as Ethiopia where there is a paucity of published data and records relating to child abuse (Worku et al., 2006, p. 137).

In addition, the effects of CSA such as genital lesions, genital discharge, unwanted pregnancy, abortion, suicide attempts and or ideation, sexual dysfunction, feelings of worthlessness and self-blame, and homelessness, have been observed among the high school female students of Jirren high school. The authors suggest that the prevalence of CSA in Southwest Ethiopia is as high as 67%. As a result, they suggested that schools, media, and government, should take concrete steps to protect children from sexual abuse. They also recommended that the school should add sex education classes focusing on reproduction and sexuality (Worku, et al., 2006).

**Tanzania**

Tanzania is an East African country on the Indian Ocean between Kenya and Mozambique and was formed from the merger in 1964 of Tanganyika and Zanzibar. The population is 42 million of primarily Bantu ethnicity, (95%) and by religion evenly divided between Christian, Muslim, and indigenous belief systems. The official languages are Swahili and English with many local languages also being spoken. The government was a one-party state until 1995, and several disputed elections have subsequently been held. Economically, Tanzania is one of the world’s poorest countries in per capita income heavily dependent on agriculture and some gold and tourism. 36% of the population lives below the poverty line with a life expectancy averaging 52 years. The legal system is based on English common law.

School attendance for children is 9 years for both males and females. Tanzania also supports half a million refugees from the ongoing unrest in The Democratic Republic of the Congo and
Burundi. There is extensive trade in illicit drugs, and Tanzania faces serious challenges from HIV/AIDS infection ranking 12th in the world at 6% of the population (CIA, 2011; UN, 2011; WHO, 2011). For the purposes of this paper Tanzania and Kenya are treated together as they are direct neighbors and share many common characteristics.

Kenya

Kenya is an East African country on the Indian Ocean between Somalia, Ethiopia, and Tanzania. From independence in 1963, Kenya was essentially a one party state until 1991 with several elections held since then, some marred by ethnic violence and fraud. The population is 41 million people consisting of several East African ethic groups with the largest being Kikuyu grouping only representing 22% and this diversity has been reflected in recent politics. Kenya is primarily Christian at 78% with Muslim and indigenous belief systems a minority. The official languages are English and Kiswahili with numerous local languages. Kenya has a market-based economy and is the regional financial center of East Africa, with trade heavily dependent on agriculture and tourism. Fifty per cent of the population lives below the poverty line with 40% unemployment, and an average life expectancy of 59 years. The legal system is based on both English common law and Kenyan tribal law. School attendance for children is 11 years for both males and females. For women, mortality in childbirth is high, partly due to female genital mutilation. Kenya currently provides shelter to a quarter of a million refugees. Kenya is a center for illicit drug distribution and cultivation, especially marijuana, and ranks 11th in the world for HIV/AIDS prevalence at 6.3% of the population posing significant challenges for economic growth (CIA, 2011; UN, 2011; WHO, 2011).

Case studies on the prevalence of CSA in the neighboring countries of Tanzania and Kenya are rare. Kevin Lalor (2004b) found it necessary to explore the unpublished literature on
CSA in Tanzania and Kenya due to the lack of empirical peer-reviewed studies. According to Lalor, (2004b), government agencies such as the United Nations Children’s Fund (UNICEF) and International Labor Organization (ILO) have focused on the prevalence of child prostitution and child rape to explore the prevalence of HIV/AIDS. As a result, CSA in the home/community has not been given extensive attention. For example, from the few published cases in Tanzania, some villagers reported that sexual relationships between a father and daughter or older relatives with female children do occur, but when it does, they stated that the situation is dealt with in the family. In addition, homeless teenagers, both boys and girls, experience ritual anal sex as a path to identity formation, perpetrated by older boys on younger boys. Also in Tanzania, sex for money and material gain is widely blamed on foreign cultures and visiting foreigners living in expensive hotels. In addition, poverty has influenced families to tell a child or young adolescent to bring money in without questioning how it is obtained. Also, the belief that men need to have sex to cleanse them of HIV is a widely held belief in Tanzania, and influences inappropriate sexual behavior and prostitution. Even though these reports, mostly from UNICEF and other organizations are linked to HIV/AIDS prevalence, it indicates that child sexual abuse in Tanzania does occur (Lalor, 2004b).

In Kenya, there appears to be more research available concerning CSA, however, most of this research exists only in the form of unpublished reports. These reports, from the African Network for Prevention and Protection against Child Abuse and Neglect (ANPPCAN), The African Medical and Research Foundation (AMREF), National Council for Population and Development (NCPD), and the Central Bureau of Statistics (CBS), reported a small amount of research on adolescent sexuality and HIV/AIDS prevalence, in which the surveyed participants reported when they first experienced coitus, anal sex, and at what age (Lalor, 2004b). Most of
the participants responded with under the age of 10, though some between the ages of 11 to 14 in these small surveys in the unpublished literature. However, none of these reports specifically describe incest or CSA. As a result, Lalor, (2004b) suggested that in both countries, government agencies should give more attention to CSA in the home and community. He also stated that the English common law in both countries protects the rights of children. Regardless of the law, however, there seems to be no action that has been taken to address CSA in the home and community. The author also stated that prevention programs could only be judged as unsuccessful without further empirical data and in depth research concerning CSA which is still not properly defined or accepted as a valid construct in Kenya and Tanzania (Lalor, 2004b).

Central Africa

Sometimes called Middle Africa, this is the core region of the African continent including Burundi, the Central African Republic, Chad, the Democratic Republic of the Congo, Rwanda, Angola, Cameroon, Equatorial Guinea, Gabon, and São Tomé and Príncipe. All of the states in this region comprise the Economic Community of Central African States and most speak dialects of the Bantu linguistic group. Most of these states lie in the tropical zone and several have experienced massive disruption through civil war leading to widespread violence and abuse of women and children including genocide, particularly in the Republic of the Congo and Rwanda (CIA, 2011). Unfortunately, due to political unrest, there is a complete lack of peer-reviewed studies pertaining to CSA in this region of Africa.

Southern Africa

Southern Africa is the southernmost region of the African continent and consists of the core countries of: Botswana, Lesotho, Namibia, South Africa, and Swaziland. Usually included in this sub-region are Angola, Madagascar, Malawi, Mozambique, Zambia, and Zimbabwe. This
is a distinct sub-region of Africa home to many cultures and peoples with poverty, HIV/AIDS and corruption significantly impeding economic growth (CIA, 2011; UN, 2011; WHO, 2011).

**South Africa**

The modern republic of South Africa has existed as a multi-party democracy since the first multiracial elections bought an end to apartheid in 1994. The population currently numbers 49 million and is mainly Christian of multiple denominations with 5% subscribing to other faiths. South Africa is a middle-income, emerging market economy that is one of the world’s major mineral producers, along with well-developed financial, communications and transport sectors. However, unemployment is at 23% and 50% of the population lives below the poverty line. Average life expectancy is low at 49 years. South Africa is very diverse linguistically and the official languages include: IsiZulu, IsiXhosa, Afrikaans, Sepedi, Setswana, English, Sesotho, and Xitsonga, with no one group dominant. The South African legal system is based on Roman-Dutch law and English common law. Most children fulfill a compulsory 13 years of schooling. South Africa has one of the highest incidences of child and baby rape in the world. More than 67,000 cases of rape and sexual assaults against children were reported in 2000 in South Africa compared to 37,500 in 1998. Child welfare groups believe that the number of unreported incidents could be up to 10 times higher than that. The largest increase in attacks was against children under seven. South Africa also has one of the world’s most serious epidemics of HIV/AIDS at a prevalence of 18% of the population and is number one in the world in AID’s related deaths. The prevalence of child sexual abuse in Africa appears compounded by the belief (also common in Kenya and Tanzania) that sexual intercourse with a virgin will cure a man of HIV or AIDS (CIA, 2011; UN, 2011; WHO, 2011).
Unlike all other African nations, South Africa offers numerous peer-reviewed research papers on CSA, most commonly pertaining to the connection between CSA and HIV/AIDS (Lalor, 2004a, 2008). Thus, due to the variety of the topic and its major clinical implications, it is beyond the scope of this paper to review the entire literature on this subject in South Africa. For additional research articles concerning South Africa, please refer to the following papers: Collings, 1991; 1997; Lalor, 2008; Madu, 2001; Madu & Peltzer, 2000, that are frequently quoted as references in the reviewed literature. However, Lalor (2004a) explores in depth the prevalence of CSA in sub-Saharan Africa, mostly focusing on the southern part of Africa.

Excepting South Africa, empirical, peer-reviewed, and published studies of CSA in the other nations of sub-Saharan Africa (SSA) are rare (Lalor, 2004a). In his review of the literature on CSA in sub-Saharan Africa, Lalor (2004a) stated that due to the rarity of research supported by clinical studies, it is almost impossible to estimate the prevalence of CSA in the SSA region. Lalor (2004a) stated,

Cross-study comparisons are a central feature of any literature review. However, it is not yet possible to make a thorough comparison between studies of child sexual abuse in sub-Saharan Africa, as only a small number of studies have been conducted, and these have utilized definitions and operationalization that make comparison difficult (p. 447).

However, based on his theoretical and empirical research Lalor (2004b) estimated that the prevalence of CSA in SSA ranges from 3% to 54%. The disparity of peer-reviewed literature on CSA does not trivialize the existence of sexual abuse of children in the SSA regions. In addition, other factors such as absent parents due to economic reasons, single parenthood, and the high number of stepfathers without an emotional bond to their children, unaccompanied or street
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children, poverty, and the belief in HIV cleansing through sex, directly or indirectly impacts the negative outcomes of CSA in sub-Saharan Africa (Lalor, 2004a).

In addition, Lalor (2004) explored three categories: rapid social change, STD/HIV avoidance strategies, and a male-dominated social structure, as an explanation of why CSA in the home and community has not received extensive attention. In the SSA regions, there are primarily two factors that impede changes in attitudes to CSA, the mistaken and widespread belief that CSA does not happen, and competition from other social problems and social changes. In the SSA regions, there is a widespread belief that it is un-African, unnatural and rare to be sexually abused in the home or community. When confronted by media reports, the reaction mostly attributes any CSA to foreign (Western) influence and the influence of modern values. Lalor (2004a) concluded that no society is immune from CSA. Another factor is competing social issues: HIV, war, disease, poverty, hunger, and homelessness, all of which affect African children. Thus, sexual abuse receives little or no attention (Lalor, 2004a).

According to Lalor (2004a), there is a widespread belief in the SSA regions that having intercourse with a young, virgin girl, whom are believed to be free from HIV, will cleanse a man of HIV/AIDS. In other words, men who are HIV positive will have sex with children or young girls so that they can be free from the disease, and as a result there is a high demand for young prostitute girls, children, or adolescents. These beliefs directly or indirectly increase the prevalence of CSA and HIV transmission to children in the SSA regions (Lalor, 2004a). The last category that influences the increase of CSA is the traditional male-dominated social structure. Lalor (2004a) suggested that there is a widely held belief that “…men must have access to sex constantly” (p.452). In others words, men are viewed as incapable of controlling their sexual urges. As a result, children who are exposed to sexual abuse receive little or no attention. Other
than South Africa, Lalor (2004a) suggested that to explore in depth the prevalence and nature of CSA, base-line epidemiological data is required in sub-Saharan Africa. In his follow up article, *CSA and the transmission of HIV to children*, Lalor (2008) raises a growing concern about CSA, and that child protection intervention should be provided for children in sub-Saharan Africa.

**Summary of CSA in Africa**

Though there are variations by region and by country, there are a number of common themes with respect to the prevalence of CSA in Africa. In general, none of the current 53 countries in the African Union (AU) engages in open discussion on matters of sexuality. Almost all countries exhibit a strongly patriarchal culture where men hold more power and discussion of sexual issues is usually a taboo subject regardless of whether the belief system is Christian, Muslim, Indigenous, or a mixture. This paper focuses only on CSA; however, a broader understanding of the sexual attitudes within the countries mentioned in this paper is necessary to understand the context within which it occurs.

There are many cultural, economic, and belief based causative factors in the prevalence of CSA in Africa, especially in the sub-Saharan part of the continent. Though many African countries are slowly adopting international standards in child protection and child development, including universal education and limits on child labor, attitudes about CSA remain resistant to change. In much of Africa, perpetrators are shielded by the traditionally low status of girls and an historic reluctance to deal with CSA in the public courts; because of societal taboos, sexual violence is greatly underreported and statistics can be hard to obtain.

**Lessons Learned from a Review of the African Literature**

As stated in the introduction, in the years between 1981 and 1995, thirty-seven studies pertaining to CSA had been published, mostly in the United States. Between these dates, over
25,000 people participated in extensive and ongoing research (Paolucci et al., 2001). Thus, it is possible to assume that since 1995 research into CSA in United States and other developed countries has substantially increased if not doubled. In his review of the literature on CSA in sub-Saharan Africa, Lalor (2004a) noted “Outside of South Africa, it is only in the last 5 years that other countries in sub-Saharan Africa have begun to address the problem of child sexual abuse in their practice and professional literature” (p. 456). As a result, it is safe to assume that in an African context, CSA, especially pertaining to incest or neighborhood sexual abuse, has not been adequately explored in the last decade, let alone two decades.

As this paper has highlighted, the dearth of peer-reviewed studies into CSA, with the exception South Africa has left mental health and other professionals investigating this form of child abuse with many unanswered questions concerning its prevalence in the African nations. The full scope of this subject is enormous, however this author proposes eight general questions that may help mental health professionals and others who are interested in exploring CSA in an African context.

**Lack of Empirical Studies on Africa and CSA**

First, is there a published epidemiological CSA study that specifically addresses Africa? The answer to this question is problematic. For example, if one researches the topic of CSA in Africa, one will find at least 10 to 15 peer-reviewed studies, particularly in South Africa. Why has South Africa generated exceptionally well-organized clinical studies compared with the rest of the African nations? The simplest explanation is possibly derived from the general history and background of South Africa. According to the CIA, (2011) and WHO (2011) South Africa is a middle-income nation that has an emerging market economy, and it is one of the world’s major mineral producers, along with well-developed financial, communications, and transport
sectors. With a significantly developed medical infrastructure, more than 67,000 cases of rape and sexual assaults against children were reported in 2000 compared to 37,500 in 1998. In addition, in 2009 it was reported that South Africa has one of the world’s most serious epidemics of HIV/AIDS with a prevalence running at 18% of the population, and the country is currently number one in the world in HIV/AIDS related deaths. Thus, it is reasonable to assume that due to the high rate of HIV/AIDS infections including an increasing number of children, numerous opportunities have been presented to explore the topic of CSA directly or indirectly linked to HIV/AIDS in South Africa.

Even though Northern, Western, Eastern and Central Africa, have similar issues, such as poverty, HIV/AIDS, unemployment, and child rape, as are found in South Africa, there is a lack of peer-reviewed studies pertaining to CSA in most other African countries. For example, in the Northern part of Africa, only Morocco has explored CSA, in a similar manner to other well-known studies in the US and Europe. Mchichi et al. (2004) adapted the Hamilton depression rating scale and the Hamilton anxiety rating scale, which they used to inquire into CSA in a socially sensitive manner. They reported that all the questionnaires were translated in local Moroccan Arabic languages, thus the Mchichi et al. (2004) study appears to be exceptional in the Muslim World as well as Northern Africa.

Similar to Morocco, in Western Africa and particularly in Ghana “It is in this regard that the lack of research into the prevalence of child sexual abuse in Ghanaian society and the inadequate police data on incidents of child sexual abuse becomes worrying” (Boakye, 2009 p. 970). In another part of Western Africa, Nigeria, there appears to be a lack of empirical studies that specifically focus on CSA. For example, (Olley, 2008) interviewed 2,290 high school seniors who appeared to have experienced forms of CSA. Out of these 2,290, participants, only
55% of them admitted unwanted kissing or intra-family CSA. Eastern Africa appears to present similar research problems to other African regions, and there appears to be only one study in Ethiopia available. As Worku et al., (2006) indicated, there is only one thesis paper which is not peer-reviewed, that explores the prevalence of CSA in Ethiopia. So, to answer the first question of whether there is an epidemiological CSA study published that covers the African nations; the answer can be summarized that with the exception of South Africa there is a dearth of peer-reviewed studies pertaining to CSA in most African countries.

**Defining CSA in Africa**

Second, what exactly should be the definition of CSA in Africa? In Morocco, CSA is defined as “the participation of a child or teenager in sexual activities enforced by violence or seduction or by transgressing the social taboo” (Mchichi et al., 2004, p. 238). However, Africa has more than 53 countries with distinct cultural, language, ethnicity, and economic differences. As a result, it is difficult to find a universal definition of CSA in an African context. For example in Ethiopia, the research indicated that the most common from of sexual abuse is verbal harassment, followed by sexual intercourse, and then unwelcome kissing (Worku, et al, 2006). Similarity, in Nigeria

Despite comparable findings from other European, American and African countries, factors peculiar to Nigeria such as poverty and the social permissiveness of less serious aspects of CSA – unwanted touch and verbal threats – which are seen as part of romantic exuberance – may have accounted for the worrisome prevalence of CSA noted in this study (Boakye, 2009 p. 247).

Thus, it is possible that verbal harassment in both Ethiopia and Nigeria may have been considered as a romantic gesture of interest in the opposite sex, rather than actual sexual abuse.
Consequently, victims might have accepted the myth that the offender is demonstrating romantic exuberance instead of sexual assault. As stated earlier, in the North America and European research literature there is a lack of a unified definition of CSA with no consistency and agreement (Haugaard, 2000; Paolucci et al, 2001). Similarly, it appears difficult to operationalize the definition of CSA in an African context.

**Limited data on CSA Prevalence in Africa**

Third, what is the prevalence of CSA in African Nations? With the exception of South Africa, Lalor (2004a) estimated that the prevalence of CSA in sub-Saharan Africa is between 3% and 54%. Similarly, in Morocco Mchichi et al. (2004) estimated the prevalence of CSA at about 9%, considering that it is a taboo subject in the Muslim world. Also in the same study out of 728 women interviewed only 27 confirmed experiencing some form of CSA. Even though the number appears very small, it shows that CSA is in reality not rare in Northern Africa (Mchichi et al, 2004). In western Africa, particularly in Ghana, Boakye (2009) suggested that due to underreporting and fear of disclosure, the prevalence rate of CSA is likely underestimated. Therefore, both Boakye’s (2009) and Lalor’s (2004a) reviews of the research literature suggest that due to a lack of research with clinical studies and a fear of disclosure, the prevalence of CSA in the African nations is not only inconclusive, but is also greatly underestimated.

**Culturally Based Theoretical Models**

Fourth, which theoretical models pertaining to the psychological and physical effects of CSA may apply in an African context? As stated earlier in this paper, there are many theories: Developmental, Family, and feminist, that have explored the psychological and physical effects of CSA in the past two decades, mostly in the U.S. In the African context, in Morocco for example, “In this country, as in most Arab ones, sexuality remains a taboo . . . It incites girls,
adolescents, and women, to conform to the social rules and laws regarding their behavior, sexuality and relations to the “stronger sex” (Mchichi et al., 2004 p.240). Similarly, in Ghana, Nigeria, Kenya, and Tanzania there is wide held acceptance of the myth of child rape pertaining to male dominance that supposedly explains why African men rape children. According to this unscientific belief, men are weak creatures who are not capable of controlling their sexual urges, therefore they need to have constant access to intercourse with children or young adolescents who are socially disadvantaged (Boakye, 2009; Olley, 2008; Lalor, 2004a). Additionally, in the study of CSA in Ethiopia, “It often goes unnoticed and undocumented partly due to taboo and its highly sensitive nature and because it particularly affects the less powerful individuals in society e.g., children, adolescents, and women” (Worku et al, p. 137). Based on these inferences, Africa as a nation is a male-dominated society where children and women, who are exposed to sexual abuse, receive little or no attention. Thus, feminist theory appears to be one of the theoretical models of CSA that explains its occurrence in an African context. However, this does not mean that other theoretical models of CSA do not apply to the African nations. As mentioned earlier, the literature from Morocco, (Mchichi et al., 2004) and from Nigeria, (Olley, 2008) indicates that the negative psychological outcome of CSA is comparable to US and European studies.

**Culturally Defined Etiological Theories of Sexual Offending**

Fifth, which etiological theories of child sexual offending models may apply to the African nations? As stated earlier in this paper, there are at least four well-known etiological theories and models of child sexual offense: The Precondition Model of CSA, (Finkelhor, 1984); The Quadripartite Model (Hall & Hirschman, 1992); The Integrated Theory (Marshal & Barbaree, 1990); and The Pathways Model (Ward & Siegert, 2002). This author believes that all of the above stated etiological theories of child sexual offenses seem to apply in an African
context. For example, we can apply Finkelhor’s (1984) Precondition Model of CSA to the widely held belief in many African countries that suggest that if a man has intercourse with a child/virgin; he will be cleansed from HIV/AIDS (Lalor, 2004; 2008; Boakye, 2009).

According to Finkelhor’s (1984) Precondition Model of child sexual abuse, that child sexual offenders experience four phases of Precondition Model. In precondition I, the offender is motivated to be sexual with children. Precondition II, characterizes Disinhibition, that is the perpetrator overcomes an internal inhibitions against sexual behavior with children. In precondition III, the perpetrator overcomes an external inhibitions to such abuse, like picking a time and place where they will not be discovered. Finally, the pedophile is able to overcome the child’s resistance. In the African context, the offender who experiences Emotional Congruence and the motivation to abuse children sexually may be ready to take action. However, he also lives in a culture and nation in any part of Africa, where intercourse with a child is a taboo subject. Thus, he will look for ways to have socially acceptable reasons to act on his Emotional Congruence and his sexual attraction to children. Thus, the offender’s first step might be to visit a “witch doctor” that are well known for recommending cleansing with a child/virgin in order to be free from HIV/AIDS (Lalor, 2008). In addition, Africa overall is a male-dominated continent where men created the notion that they need constant sex and that they are to be allowed to have their sexual needs satisfied even if it is with a child.

Based on the above stated example, the African offender appears to have two socially acceptable motivations such as obtaining permission from a “witch doctor” and being part of a patriarchal society that accepts the myth of child rape. Thus, the African man who is a potential offender easily reaches the Precondition I, of Finkelhor’s (1984) model, which easily transitions to Precondition II and III, which is where and how the offender actually commits an offense
against children and experiences sexual arousal with them. For example, in 2009 it was reported that South Africa has one of the world’s most serious epidemics of HIV/AIDS with a prevalence of 18% of the population (CIA, 2011; WHO, 2011). This could explain why there is a high demand for children who are assumed HIV/AIDS free (Lalor, 2008). In others words, it has become socially permissible for men to sexually abuse children. Accordingly, the wide held belief in their myth of child rape not only validates and encourages child sexual abusers in African nations, but when they commit an offense against children they are able to escape the consequences of victimizing children sexually. Overall, if mental health and other professionals conducted epidemiological research on etiological models of child sexual offense in different African nations, it is possible that some, if not all, etiological theories of child sexual offending models will be found applicable.

Sexual Education in Africa

Sixth, what sex education is available to address sexuality and sexual abuse in the African nations? This question also appears to be problematic due to a lack of enough information on sex education in Africa in general. For example, in Morocco, there is “… a restrictive religious education, negative beliefs relative to anatomy of the hymen, misconceptions about the mechanism of penetration” (Mchichi et al., 2004 p. 241). In other words, the lack of sex education impacts the knowledge Moroccan and other African women have about sexual assault, the impact of CSA, and even confusion about the physical mechanisms of intercourse. As a result, the lack of sex education establishes a level of sexual ignorance amongst African women and children about CSA and leads to misconceptions about what it is. Boakye (2009) explains this point well, “when individuals are uncertain about how widespread this type of crime is in their communities, the tendency is towards either denial or making exceptions for
such behavior when it occurs” (p. 970). Similarly, Lalor (2004a) suggests that in sub-Saharan Africa, there is a widespread belief that it is un-African, unnatural and rare that children and young adolescents are sexually abused in their homes or communities. When confronted by media reports, the reaction mostly attributes the cause to foreign (western) cultural influences and that CSA is a recent phenomenon influenced by modern values. In his study, Worku et al. (2006) concluded his literature review by recommending that policy makers and educators should add curriculum courses that introduce sexuality and reproductive health, and teach the consequences of unprotected sex. Thus, it appears that in depth sex education that addresses sexuality, let alone CSA in the African nations is rare. This lack of education about the existence of CSA keeps its victims in a state of ignorance and denial, and subject to unscientific beliefs about its causes.

**Lack of Legal Recourse and Ramifications on CSA in Africa**

Seventh, do African children (or adults) have any legal recourse if they are sexually abused? Do they have any legal protections regarding their bodies, sexually or otherwise? Where such laws exist, are they used to protect children? The answer to these questions is that it is ambiguous how proper legal recourse can be provided and made available for victims and their families impacted by CSA. For example, based on Mchichi et al. (2004) research in Morocco, because CSA is taboo and assumed to be rare, it seems the law in Morocco may not protect children from CSA at all. In western Africa, Ghana appears to have laws that protect children from CSA or women who are assaulted, however due to fear of disclosure the number of unreported incidents is high. According to Boakye (2009), in Ghana there are legal resources such as the Domestic Violence and Victim Support Unit (DOVVSU), the passage of the Criminal Code (Amendment), the Children’s Act (Act 560); the Juvenile Justice Act (ACT653),
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and Domestic Violence Act (Act 732). Considering the level of underreporting though, the
degree of legal recourse in Ghana appears to be inadequate and the above stated agencies seem to
focus mostly on domestic violence rather than CSA in particular. In Nigeria, research from
Obisesan, et al, (1999) seems to indicate that there are few, if any, legal resources to protect
children from sexual abuse and assault. Also, the victims’ families who report the offense, even
if there are legal resources, are afraid to report the crime due to fear of intimidation and
harassment. Obisesan et al. (1999) said, “Finally there is a need for a multidisciplinary team
approach to prevention, detection, reporting, treatment, and data collection of cases of child
abuse in the country” (p. 626). In Ethiopia, the answer to this seventh question is inconclusive as
CSA is a taboo subject and it is unlikely that it would be reported to legal authorities. However,
if citizens could report the offense, there are some laws that appear to protect children and
women against sexual abuse. However, legal recourse appears to be primarily available only to
those who are educated citizens and aware of the law. These educated citizens may have some
ability to report CSA.

Ethiopia one of the nations that adopted the convention on the rights of a child including
article 16, No. 1: ‘state parties should take all appropriate legislative, administrative
social and educational measures to protect the child from all forms of physical or mental
violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation
including sexual abuse; while in the care of parents(s), legal guardian(s) or any other
person who has care of the child’ (Worku, et al, p. 140).

South Africa has a legal system based on Roman-Dutch law and English common law (CIA,
2011) that appears to provide legal resources and protection for victims of CSA and sexual
assault. However, from Lalor’s (2004a) article of CSA in sub-Saharan Africa, it is unclear how
South Africa and most other African nation’s laws are being implemented to protect victims of CSA. The paucity of legal resources available to protect African children from CSA in the home and the community is very concerning.

**Needed Research of CSA in African in the Home and Community**

The eighth and last question is what kind of research should be done in Africa pertaining to CSA, especially in the home and community? As has been mentioned several times in this paper and the referenced literature pertaining to CSA in Africa, there is a dearth of epidemiological research on this subject. Thus, the obvious answer is to conduct more research about CSA in the African nations, especially focusing on the prevalence and impact of sexual trauma on children, young adolescents, and women who are socially disadvantaged in a male-dominated African culture. In addition, it is apparent to this Author that most literature on CSA in Africa reviewed in this paper appears to be written by scholars who are not mental health professionals or are not African. For example, Lalor (2004a; 2004b; 2008) wrote literature reviews of CSA and HIV/AIDS in sub-Saharan Africa, and conducted additional literature reviews pertaining to CSA in Tanzania and Kenya. Lalor is from the Department of Social Sciences, Dublin Institute of Technology in Dublin, Ireland. Additionally, Boakye, (2009) is from the University of Cambridge in the UK. Even though, Worku, et al, (2006) is from Ethiopia and Obisesan, et al, (1999) is from Nigeria, they are medical doctors. However, Olley (2008) from Nigeria, and Mchichi, Alami & Kadri (2004) from Morocco; appear to be mental health professionals. Interestingly, Lalor (2004a; 2004b; 2008) reviewed research literature that is written in the English language and stated that he chose Tanzania, Kenya, and some sub-Saharan countries because they are English speaking. However, Mchichi et al., (2004) translated their questions into the Arabic language and conducted their research in more culturally sensitive
and appropriate ways for the women of Morocco. Accordingly, this author strongly believes that not only is there a paucity of epidemiological studies pertaining to CSA in Africa, but that there is also a dearth of African mental health professionals who are culturally embedded in the African context. African nations need African scholars who are not only socially embedded, but who are able to develop and create epidemiological studies within the distinctive societal parameters of Africa.

Based on the literature reviewed in this paper, this author also noticed that most studies link CSA with HIV/AIDS, which is understandable due to the epidemic of this alarming disease in many African nations. However, few scholars have explored incest and CSA in communities with non-HIV/AIDS populations. Even taking into account those CSA victims directly impacted by HIV/AIDS, this author has learned that none of the available research explored the psychological and traumatic effects of CSA. Not only is the victim betrayed and hurt by someone they know, trust, and probably loved, but also the offender condemns them to a short life by infecting them with a life threatening disease. The trauma of CSA combined with HIV/AIDS must be devastating and overwhelming for children and adults with a history of both. As a result, this author strongly believes that two different avenues of research into CSA in the African nations are appropriate for future evaluation: 1) to study CSA in the home and neighborhood within the non-HIV/AIDS population and 2) to explore the combined trauma of CSA and HIV/AIDS. Even, though there are many possible ways in which research into CSA can be undertaken in the African nations, this author argues that due to the inadequate research available, these two avenues of analysis will open the door to understanding the impact of CSA in a specifically African context, especially if the scholars are culturally embedded African citizens.
Therapeutic Implications and Conclusions

Based on the above research, this author has attempted to explore CSA specifically within an African context though there is a paucity of peer-reviewed studies of CSA along with inadequate legal resources for its victims. In addition, there are no qualified scholars who are culturally embedded in African society, which partly explains the dearth of epidemiological clinical studies of CSA in Africa. As a result, the therapeutic implications of CSA in an African context are essentially unexplored and inconclusive, with the possible exception of South Africa. However, this author would like to consider a few general clinical implications that should be considered when treating victims of CSA who originally come from any African country. This author, who was born and raised in Africa, acknowledges that the following therapeutic implications and conclusions are limited due to a lack of adequate peer-reviewed clinical studies of CSA in Africa and that further research should be conducted concerning these implications.

The first implication that mental health professionals should be aware of is to understand the basic cultural and societal background of their client’s nation, assuming that they either come directly from or have been raised within an African context. As this author has set an example by introducing and analyzing the basic background and cultural influences within the primary African sub-regions, and individual nations, clinicians are encouraged to undertake similar research to learn about their clients’ specific country of origin. This background information is easily accessed through websites that are updated annually; for example the CIA World Fact Book, the United Nations Statistics Division (UN), and the World Health Organization (WHO) are all excellent resources. Many of the basic facts presented may appear to be unimportant, however, they help clinicians to understand the client’s culture and socioeconomic influences. Most importantly, it helps them to understand their clients’ perspectives on subjects pertaining to
sexuality such as CSA and how African clients internalize and process this traumatic life experience.

Secondly, as stated earlier, Lalor (2004a) reported that in Africa there are other competing problems besides CSA such as poverty, male-domination, and HIV/AIDS. In addition, there is often a lack of adequate food, water, clothing, and education, which at times is compounded by the impact of civil wars. Thus, it is possible that a client with a history of CSA will not even consider or believe that the trauma caused by CSA is a major issue compared with their other life experiences. The client may already be traumatized by competing traumas, and may not be aware of CSA as a distinct trauma of its own, or they may have lost the energy and ability to understand the seriousness of it. This author strongly encourages clinicians to be aware of the possibility that their African clients with a history of CSA, may not only have lived through CSA and other competing traumas, but that also in order to obtain a visa to gain entry to developed countries such as the USA, additional traumas may have happened along the way. Many African citizens have to travel by foot to escape political and social pressures and will do so for many days to reach refugee camps. There is considerable peer-reviewed research pertaining to child prostitution in refugee camps. Clinicians are encouraged to explore this research to understand that their African clients may have experienced many traumas, and that an experience of CSA may not be a primary issue for them.

Finally, this author encourages clinicians to go beyond the basic counseling skills, therapeutic processes, and therapeutic alliances. For example, asking questions such as ‘have you experienced any childhood trauma?’ or ‘have you been sexually abused as a child?’ may not be the best way to learn about an African client’s traumatic childhood experience of CSA, especially incest. Clinicians may want to try to listen to their clients’ stories without asking
direct questions about these traumatic experiences. In addition, building therapeutic relationships requires more than basic counseling skills, therefore clinicians could try to relate to their African clients’ circumstances beyond their basic therapeutic skills. For example, it is recommended that clinicians in developed countries put themselves in their client's shoes and try to imagine what life would be like to live in a country where there is a lack of basic human needs such as safety, food, clean water, housing, and clothing in childhood. Clinicians are encouraged to imagine themselves as little children in complete poverty being sexually abused by men who consider them to be a cure for HIV/AIDS resulting in their lives being cut short by deadly infection. Clinicians are also encouraged to imagine once the sexual abuse happens, that the society and family trivialize their problems due to other competing issues so that they get no attention or support for being sexually abused by someone they know and trusted. Simply stated, clinicians do not have to be an expert in their clients’ culture, but they do need to be able to see the bigger picture of their client’s world, and how a life of multiple traumas coupled with CSA might generate double, if not triple, negative emotional, physical, and psychological consequences compared to victims of CSA in developed countries. Thus, when the clinicians are able to feel and imagine their clients’ experience of CSA within an African context, they may be able to relate, build alliances, and choose the appropriate therapeutic skills to help their African clients process the impact of CSA in a socially and culturally embedded manner.

In conclusion, the paucity of peer-reviewed studies in Africa and the dearth of culturally embedded scholars in African nations, indicates that CSA in Africa not only is understated and unexplored in depth, but that the world, especially developed countries, focus only on the impact of HIV/AIDS in a manner that often underplays the impact of CSA. African nations and their children and adolescents, especially those who are socially disadvantaged, deserve more
attention than HIV/AIDS. Their trauma, pain, and hurt deserve to be explored. They are entitled to be given access to the appropriate education and legal resources that can help reduce the prevalence and trauma of CSA, even if it is not possible to reduce other competing traumas in their lives. Clinicians should be encouraged to go above and beyond their basic clinical skills and relate to their African clients with a history of CSA from an appropriate cultural context, rather than a western context, with respect to therapeutic skills and implications.
References


