NEAR EAST UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

GENERAL PSYCHOLOGY

MASTER'S PROGRAMME

MASTER'S THESIS

LONGTERM PSYCHOLOGICAL CONSEQUENCES OF CHILD ABUSE AMONG YOUNG ADULTS

CHIDO VIMBAI HUNGWE

NICOSIA

2016

NEAR EAST UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

General Psychology Master Program

Thesis Defence

Longterm psychological consequences of child abuse among young adults

We certify the thesis is satisfactory for the award of degree of

Master of GENERAL PSYCHOLOGY

Prepared by

Chido Vimbai Hungwe

Examining Committee in charge

Assoc. Prof. Dr. Ebru Çakici	**Near East University** **Department of Psychology**
Dr. Deniz Ergün	**Near East University** **Department of Psychology**
Assist. Prof. Zihniye Okray	**European University of Lefke** **Department of Psychology**

Approval of the Graduate School of Social Sciences

Assoc. Prof. Dr. Mustafa SAĞSAN

Acting Director

NEAR EAST UNIVERSITY

GRADUATE SCHOOL OF SOCIAL SCIENCES

GENERAL PSYCHOLOGY

MASTER'S PROGRAMME

MASTER'S THESIS

LONGTERM PSYCHOLOGICAL CONSEQUENCES OF CHILD ABUSE AMONG YOUNG ADULTS

PREPARED BY

CHIDO VIMBAI HUNGWE

20135864

SUPERVISOR

ASSOC. PROF. DR. EBRU ÇAKİCİ

NICOSIA

2016

I dedicate this thesis to the people who have touched my life in so many, the people I have met throughout this journey of my life, to my wonderful and inspiring family who have stood by me in trying times, to my mother who financially helped me better myself and who never gave up on me, my pillar of strength I will forever be grateful

This one is for you dad, the man behind most of my achievements, though you in heaven I know I have made you proud

CHIDO VIMBAI HUNGWE

Ocale 2016

ÖZET

Bu araştırmanın amacı çocuk istismarı öyküsü olan genç erişkinlerde çocuk istismarının uzun dönem psikolojik sonuçlarını araştırmaktır. Araştırmanın örneklemini 18-24 yaş arası, örseleyici çocuk istismarı deneyimi olan, Zimbabve'de bulunan Shurugwi Bölge Hastanesi'nin tecavüz kurbanlarına hizmet veren merkezine grup terapi veya bireysel danışmanlık için Ağustos 2015'te gelen genç erişkinler oluşturmaktadır. 95 gönüllü (47 erkek ve 48 kadın) araştırmaya katılmıştır. Nicel araştırma metotlarından anket çalışması veri toplamada kullanılmıştır. Katılımcılara araştırmacılar tarafından hazırlanan sosyo-demografik bilgi formu, Travma Belirti Kontrol Listesi, Olayların Etkisi Ölçeği ve Belirti Tarama Listesi-90 verilmiştir. Geçmişte yaşanan psikolojik istismar ve ihmal şiddeti arttığında, kaçınma belirtilerinin de arttığı bulunmuştur. Evli bireylerde agresyon, depresyon ve paranoid belirtiler boşanmış ya da bekâr olan katılımcılara göre daha az tespit edilmiştir. Bu araştırma çocuk istismarının genç erişkinlikte de devam eden psikolojik etkileri olduğunu göstermektedir. Çocuk istismarı sonuçlarının sosyal destek ve psikolojik tedavilerden nasıl etkilendiğinin gösterilmesi için uzamsal çalışmalar gerekmektedir.

Anahtar Kelimeler: Çocuk istismarı, Çocuk istismarı genç, Yetişkinler sonuçları

LONGTERM PSYCHOLOGICAL CONSEQUENCES OF CHILD ABUSE AMONG YOUNG ADULTS

CHIDO VIMBAI HUNGWE

JANUARY 2016

ABSTRACT

The present study was designed to investigate the long-term psychological consequences of child abuse among young adults who had a history of child abuse. The present study sampled young adults between the ages of 18 – 24 years who had a history of a traumatic experience of child abuse and came for group sessions and individual counselling to the Rape Centre of Shurugwi Provincial Hospital, Zimbabwe in August 2015. 95 volunteers (47 males, 48 females) participated the study. Quantitative research method of survey study was utilised as a mean of collecting data. The participants were administered a socio demographic information form prepared by the researchers, Trauma Symptoms Checklist, Impact of Event Scale and Symptom Check List – 90. It was found that as the severity of past experiences of psychological maltreatment and neglect increase, the severity of symptoms of avoidance also increased. Married people had less aggression, depression and paranoid symptoms than divorced and single participants. This study shows child abuse may have enduring psychological effects among young adults. Longitudinal studies are needed to show how the effects of child abuse experience are influenced by social support and psychological treatment.

Key words: Child abuse, Young adults, Long-term consequences of child abuse

ACKNOWLEDGEMENTS

I would like first most to express my appreciation to God because without him I would not be the person I am today. My sincere thanks to my thesis supervisor Dr. Ebru Çakici for her professional help, advice, support and encouragement. Without her continuing support this study would have not been a success. Also would like to thank my brother in law Busisani Dube who helped me in many areas of my study, my family who have stood by me through this journey. My mother who has always been my pillar of strength and has always encouraged me to never give up. Without her love and financial support I would have never been able to complete my studies.

TABLE OF CONTENTS

ABBREVIATIONS

SCL -90: Symptoms checklist

PTSD: Post traumatic stress disorder

MWAGDB: Ministry of women affairs and gender development

ZW: Zimbabwe

IES: Impact of event scale

TSC -40: Trauma symptoms checklist

DAPS: Detailed assessment of posttraumatic stress

SATI: Sexual abuse trauma index

LIST OF TABLES

1. INTRODUCTION

1.1. Child Abuse

Child abuse is a clear and present danger plaguing Africa. In Africa, acts of child abuse are said to be usually committed in polygamous homes as well as in extended family settings where children who have lost either or both parents are left in the care of distant relatives or guardians and step-parents who treat them as if they are animals (Wood K, Jewkes R, 1997,41-46). Violence against children is a widespread problem in sub-Saharan Africa. Surveys conducted in sub-Saharan Africa reveal that 46 percent of Ugandan children, 60 percent of Tanzanian children, 42 percent of Kenyan children, and 40 percent of Zambian children report regular physical abuse. In a Nigerian survey, 81 percent of married women report being verbally or physically abused by their husbands. Forty-six percent report being abused in the presence of their children. (Wjau W, Radeny S, 1995)

According to the World Health Organization (WHO), child abuse includes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect and negligent treatment and exploitation

1.2. Definition of Child Abuse

When a child is born their first attachment is with their caregiver or their parents, these people give a form of security, love and support in everything. Any form of child abuse violates the child's trust with the world (Paul Walker, 1994, p283-292). In most cases when any form of abuse is inflicted on a child this might affect them for the rest of their lives when it comes to attachment. They inhibit signs of inability to form adult intimate relationships and display chaotic behaviours (Henderson,2006 ,94).In most cases survivors of child abuse have frequent crises in their lives e.g. job disappointments, relocations, failed relationships, financial setbacks. Many of these characteristics are the result of unresolved childhood abuse issues. The reasons are complex, but for many survivors ongoing internal chaos prevents the

establishment of regularity, predictability and consistency. Many survivors function in a crisis mode, responding with stop gap measures which don't resolve the underlying issues.

A number of studies conducted by Spila, Makara, Kozak, & Urbanska 2008 explored the link between childhood trauma and later health concerns. Results concluded that childhood abuse contributed to the likelihood of depression, anxiety disorders, addictions, personality disorders eating disorders, sexual disorders and suicidal behaviour (Draper et al., 2007, 55). A study conducted on 384 survivors of childhood abuse found that survivors of child abuse had symptoms of depression, had low-self esteem, problems with family functioning. Another recent study found that almost 76% of adults reporting child physical abuse and neglect had at least one psychiatric disorder in their lifetime and nearly 50% had three or more psychiatric disorders (Harper et al., 2007, 123). Adults who had history of an abusive past also showed signs of physical problems more frequently than those who had not experienced abuse (Draper et al., 2007, 55).

According to a study conducted by Widom, DuMont, and Czaja (2007) in the United States, they found that most children who were physically abused or experienced multiple types of abuse were at increased risk of lifetime major depressive disorder in early adulthood. To add to this, a large, nationally representative study in the US also found that those survivors who had experienced child physical abuse were at a higher risk for a range of psychiatric disorders in adulthood than those not reporting such abuse (Sugaya et al., 2012). Results from the same study reported that many young adults reporting child physical abuse also reported child sexual abuse and neglect and, importantly, the study found a dose-response relationship with those experiencing a higher frequency of abuse at higher risk of psychiatric disorder than those reporting lower frequency of abuse.

Higher levels of general psychological distress and higher rates of both major psychological disorders and personality disorders are some of the symptoms associated with survivors of child abuse. Some reports have shown that children who had been psychologically abused suffered from anxiety, depression, low self-esteem, symptoms of post-traumatic stress and suicidality in some cases, more than children who were physically or sexually abused. Psychological abuse was most strongly associated with depression, general anxiety disorder, social anxiety disorder, attachment problems and substance abuse.

In most case psychological abuse that has taken place with both physical and sexual abuse was highly associated with more severe and far ranging negative outcomes when compared to

children who had only been sexually and physically abused without the psychological abuse. This went on to prove that psychological abuse creates a greater tendency towards physical illness as well. Humans are, after all, one bio-social-psychological organism. The effects of all forms of abuse permeate one's entire system, as these studies confirm

1.3. Different types of child abuse

1.3. a. Emotional Abuse

Emotional abuse refers to the psychological and social aspects of child abuse; it is the most common form of child abuse. Many parents are emotionally abusive without being violent or sexually abusive; however, emotional abuse invariably accompanies physical and sexual abuse. Some parents who are emotionally abusive practice forms of child-rearing that is orientated towards fulfilling their own needs and goals, rather than those of their children. Their parenting style may be characterised by overt aggression towards their children, including shouting and intimidation, or they may manipulate their children using more subtle means, such as emotional blackmail.

Emotional abuse does not only occur in the home. Children can be emotionally abused by teachers and other adults in a position of power over the child. Children can also be emotionally abused by other children in the form of "bullying". Chronic emotional abuse in schools is a serious cause of harm to victimised children and warrants ongoing active intervention. (Johnson, Cohen, Brown &Bernstein 1999, pp87). One American survey found that a quarter of the sample of undergraduate students reported some form of emotional abuse by their parents. Another quarter reported other forms of emotional abuse outside the home, such as bullying (Doyle 1997).

1.3.b. Physical Abuse

This refers to an injury resulting from physical aggression, physical assaults that would be serious criminal offenses if committed by one man against another - for instance, hitting, slapping, or striking with an object - have been legally and socially sanctioned when committed by a man against his wife and child, or by parents against their children. According to the 2007 report of the Global Initiative to End All Corporal Punishment of Children, Australia is one of a number of countries that has failed to prohibit violence against children, and has failed to commit to legislative reform. In particular, the legal defences of

reasonable correction and reasonable chastisement are still available to adults who are charged with violent offenses against children in many jurisdictions.

According to past researches a large sample of American families found that 2.4% of children had been kicked, bitten, punched, beaten up, burned, scalded, or threatened or attacked with a knife or a gun by their parents. An additional 8.5% had been hit with an object by their parents (Straus and Gelles 1990). Adults physically abused in childhood are at increased risk of either aggressive and violent behaviour, or shy and avoidant behaviour leading to rejection or re-victimisation. This polarised behaviour is often driven by hyper-vigilance and the anticipation of threat and violence even in everyday situations. Men with a history of physical abuse in childhood are particularly prone to violent behaviour, and physically abused men are over-represented amongst violent and sexual offenders (Malinosky-Rummell and Hansen 1993, pp203).

1.3.c. Sexual Abuse

Sexual abuse describes any incident in an adult engages a minor in a sexual act, or exposes the minor to inappropriate sexual behaviour or material. Sexual abuse also describes any incident in which a child is coerced into sexual activity by another child. A person may sexually abuse a child using threats and physical force, but sexual abuse often involves subtle forms of manipulation, in which the child is coerced into believing that the activity is an expression of love, or that the child bought the abuse upon them self. Sexual abuse involves contact and non-contact offences.

Approximately one third of women surveyed in Australia have reported sexual abuse in childhood (Flemming 1997; Glaser 1997; Mazza, Dennerstein et al. 2001, pp615). Approximately 10% of Australian men report sexual abuse in childhood (Goldman and Goldman 1988, pp45).Whilst all children are vulnerable to sexual abuse, girls are more likely to be sexually abused than boys. Disabled children are up to seven times more likely to be abused than their non-disabled peers (Briggs 2006).In one study of Australian women, only 10% of child sexual abuse experiences were ever reported to the police, a doctor, or a health agency (Flemming 1997, pp435).

1.3. d. Neglect

This is defined as the persistent failure to meet a child's basic physical and /or basic psychological needs likely to result in the serious impairment of the child's health and development.

1.4. Childhood abuse and psychological consequences

Some researchers have concluded that childhood abuse is highly the result of adult depression, aggression, hostility, anger, fear, anxiety disorders, and personality disorders. 3 projects conducted on the effects of childhood sexual abuse find positive evidence of a relationship between such abuse and a host of adult psychological symptoms. According to Kessler and Magee childhood abuse had consistent significant effects on early onset and more episodes of depression and family violence (e.g., both parents) was most strongly associated with recurrent depression (323). Past researches also show that childhood abuse has consistent consequences on first onset of early adult psychopathology. A research conducted by MacMillan (2009) performed structured interviews in a random community sample of 391 women; results **found** that 46% of those with past evidence of childhood sexual abuse, compared with 28% of those with no abuse, had experienced a major depressive episode. Women with such abuse also had significantly greater lifetime prevalence of agoraphobia, obsessive-compulsive disorder, social phobia, sexual disorders, PTSD, and suicide attempts than women without such abuse.

1.4. a. Depression

According to Hartman et al (1987), depression has been found to be the most common symptom among adult survivors of child abuse, in most cases survivors have difficulties in talking about the abuse but instead they might keep it to themselves. Some researchers like Ratican (1992) have described this symptom in adult survivors as a feeling of always feeling down, sometimes always thinking of killing oneself. Survivors go through years of having negative thoughts about themselves, they always have the feeling that they are worthless and avoid being around people because they believe that they have nothing to offer. (Long et al, 2006, pp78). Most survivors of child abuse end up with sexual problems because of depression; they lack interest in sex and at times approach sex as an obligation. Adult survivors have a four-time greater lifetime risk for a major depressive episode compared with adults who have not been abused or neglected (Johnson, Cohen, Brown, Smailes & Bernstein

1999, pp600). Some of this vulnerability to depression has a physiological basis. Severe or chronic stressors may alter the way the brain handles stressful events, leaving one more vulnerable to depression when confronted with a current life stress (Weiss, Longhurst & Mazure 1999, pp573-6)

Depression is considered one of the most dominant psychological disorders. Symptoms of depression include poor morale, sleeping problems either insomnia or hypersomnia, recurrent thoughts of death or suicide, weight loss or gain, hopelessness, disinterest in social activities and eating problems where one eats too much or too little. Individual suffering from depression think that they are very unlucky, they are pessimistic and nostalgic. They often feel guilty and suppressed because they are unable to express their feelings easily. Depression is a common mood disorder, which inflicts decreased energy, low self-esteem and poor concentration on the afflicted. Moreover depression manifests itself with symptoms synonymous to those of anxiety (Davidson and Farlane, 2006, p.9-14).

Depression is a significant burden on global finances; it has far reaching effects on all people and is shared by people from all social ranks and groups. Recent studies suggest that depression affects 350 million individuals worldwide. The world mental health survey gathering data in 17 countries revealed that on average 1 in every 20 people has suffered from a single or multi-episodes of depression within the previous year (WHO, 2012).

Although depression is common it is still a serious illness, possibly leading to ill-conceived actions like suicide or social and professional incapacitation. The lifestyle choices by these individuals negatively affect the people around them including friends and family. Everyone occasionally feels sad, disinterested in social activities but these feels are short-lived lasting a few days. However if these feels persist then medical attention may be warranted according to Services (2011). Depression is the highest contributor to disability in both women and men however women are 50% more likely to suffer from depression than men (WHO, 2008). This prevalence of depression poses a threat to the global economy. Depression is also the foremost disease afflicting women in high- income, low as well as medium-income countries (WHO, 2008). Research in developing countries revealed that postpartum depression could subsequently lead to the infant‘s poor growth, according to Rahman et al (2008, p.13).

1.4. b. Guilt and Shame

Survivors usually take full responsibility for the abuse and at times they blame themselves for everything that happened to them. When the abuse was inflicted by someone close to them or they trusted they might find it difficult to view that person in a negative way and this leaves them unable to see that the abuse was not their fault.

1.4. c. Anxiety and Stress

According to Briere and Runtz (1998) as cited in Ratican (1992), child abuse can cause one to be afraid all their life and this may cause one to become stressed long after the traumatic event has stopped. Chronic anxiety, tension, anxiety attacks and phobias are some of the symptoms that survivors have. Anger, another symptom of emotional distress, includes chronic irritability, rage, and difficulties in expressing anger in a constructive way. Survivors may suppress their anger to such an extent that they feel they have no right to be angry with their partner, co-workers, friends or children. These suppressed feelings may eventually explode. Anger has obvious implications for parenting and other relationships.

Anxiety is a sense of fright, worrying, and restlessness normally generalized to a situation when someone overreacts to a certain situation, which one may only subjectively consider as dangerous (Bouras and Holt, 2007). Anxiety is a globally observable fact that exists among all societies, despite the fact that cultural conventions and practices influence its contexts and occurrences (Good &Klein man, 1985, p.297-323; Guarnaccia, 1997, p.3-20). This phenomenon can be observed in all stages of life, yet it is predominantly existent among adults who are students in a global scale (Costello, et al., 2003, p. 837-844) In another attempt at characterizing anxiety, Essau et al 2000, p. 263-279) attribute the association of anxiety to some considerable negative impacts on the social, emotional and educational prosperity of children. Some of the typical effects cover the insufficiency of social interaction skills, which sometimes leads to evading to cooperating with others in social environments (Albano, at al., 2003, p. 279-329 Weeks, at, al., 2009), being alone, deficient self-esteem, the fear of being rejected socially, and the inability to make companionships (Bokhorst, et al., 2001, p. 789-798 Weeks et al., 2009

Anxiety is associated with substantial negative effects on children's social, emotional and academic success (Essau, et al., 2000, p. 263-279). Specific effects include poor social and coping skills, often leading to avoidance of social interactions (Albano, at al., 2003, p.279-

329 Weeks, at, al., 2009), loneliness, low self-esteem, perceptions of social rejection, and difficulty forming friendships (Bokhorst, et al., 2001 p. 789-798 Weeks et al., 2009). Rapee, et al, (2005, p73) associate anxiety to the relation between children and parents. They further fortify their point by saying that parental rejection and control are the triggering elements that cause high levels of anxiety and disorders.

When someone is anxious, he/she experience physical feelings and worrying thoughts. This can make it hard to do even simple tasks and so they begin to avoid things. Often the person does not understand why they feel as they do. When they are relaxed they can see that their worries are over the top, but when the anxiety builds up they feel overwhelmed once again. (Baty, 2005, p. 2-5).

1.4. d. Dissociation

In most survivors of child abuse they have dissociated so as to protect themselves from going through another abuse. As adults they continue to use this mechanism this mechanism when they go through anything frightening in their life (King 2009, pp153-157).Survivors go through periods in which they feel confused, disoriented, they have nightmares and at times they have flashbacks of that traumatic event.

1.4. e. Post-traumatic Stress Disorder (PTSD)

Most adult survivors of all the forms of abuse as stated by Lamont (2010, pp681-696) in his paper on Effects of child abuse and neglect for children and adolescent all show signs of PTSD. The diagnosis of post-traumatic stress disorder came about as a result of clinicians working with Vietnam veterans. It has since been applied to many other types of traumatic events as well. According to Bromfield (2007, pp320) to receive a formal diagnosis of PTSD, there must be a discernible traumatic event, such as past sexual abuse. And there must be the following symptoms:

1) Frequent re-experiencing of the event via nightmares or intrusive thoughts,

2) Numbing or lack of responsiveness to or avoidance of current events, and

3) Persistent symptoms of increased arousal including jumpiness sleep disturbance or poor concentration.

In researches conducted in past years it has been noted that many abuse survivors have symptoms of PTSD, even if they do not meet full diagnostic criteria for a formal diagnosis. For example, they estimate that 80% of sexual abuse survivors have some post-traumatic symptoms. These symptoms include hyper-vigilance, intrusive thoughts, and flashbacks. (Briere & Elliot 2003, pp1205-1222)A lot of things can trigger flashbacks including current abuse by another adult, a survivor talking to someone else about past abusive experiences, or learning of the abusive experiences of others. For some adult survivors of child sexual abuse, birth experiences can trigger flashbacks.. As noted in one qualitative study, birth can suddenly revive memories of sexual abuse that seem as if it was happening right then (Rhoades & Hutchinson 1994, pp500-507). Childhood abuse can also increase your vulnerability to stresses you may experience as an adult. In one study, Vietnam veterans who had been physically abused as children were significantly more likely to develop post-traumatic stress disorder (PTSD) after combat than were veterans who had not been abused as children (Bremner, Southwick, Johnson, Yehuda, & Charney 1993, pp78). These findings were true even when comparing veterans who had had the same amount of combat exposure.

According to results found in this study it meant was that a previous abusive experience, of whatever type, increased the risk for having a traumatic-stress reaction to something that happened adulthood. Experiences that could trigger this reaction include being mugged or assaulted as an adult, having a frightening birth experience, or having someone in your family (including you or your child) become seriously ill.

1.4. f. Cognitive Distortions

Gara, Allen, Herzog & Woolfolk (2000, pp204) came to the conclusion that if one has experienced an abuse in childhood they begin to view the world as a dangerous place. Some of the reasons for such thinking were because in the past victims had been in a situation where they felt powerless, they are now very fearful and can no longer control how they perceive danger and diversity in their current environment.. In one recent study, mothers who had been physically abused had significantly more negative thoughts about their babies than did the comparison mothers, who had not been physically abused (Gara, Allen, Herzog & Woolfolk 2000, pp204). These distortions contributed to a survivor’s emotional distress and increased their risk for depression.

1.4. g. Amnesia

Amnesia for abuse-related events is another type of avoidance response. Not everyone experiences amnesia, but many do. Linda Williams, of Wellesley College, conducted a prospective study of adult survivors who had been treated for sexual assault in an emergency room of a large urban hospital during the 1970s. When she re-contacted these women 20 years later, she found that 38% of the women she interviewed—all of whom had confirmed and documented sexual abuse experiences--had experienced total or partial amnesia regarding their abuse experiences. If you have large blocks of your childhood that you cannot remember, you may have had a traumatic experience in you life. It is normal to remember back to ages three or four.

Some of the more serious symptoms related to avoidance are substance abuse, compulsive high-risk sexual activities, eating disorders, and self-injurious behaviours. Not surprisingly, women who have had abuse experiences as children are more likely to abuse substances, engage in dangerous sexual liaisons, have eating disorders and injure themselves—including multiple suicide attempts. All of these behaviours can endanger you and your children. The immediate emotional effects of abuse and neglect—isolation, fear, and an inability to trust—can translate into lifelong consequences, including low self-esteem, depression, and relationship difficulties.

2. METHOD OF THE STUDY

2.1. Importance of the study

The aim of the study was to investigate the psychological consequences of child abuse on young adults who had a history of child abuse. The research aimed to explore whether these young adults' lives had been psychologically affected by such a trauma and what consequences had been brought about in their lives because of this past abuse. The research focused more on the psychological state of a survivor because any abuse inflicted upon someone during their formative years can cause permanent mental or physical damage which can impair their quality of life for years to come. The same is true of abuse suffered as a adult, although it is often more traumatic if the victim is a child.

2.2 The purpose and Problem Statements of the study

According to Bromfield and Huggins (2005), child abuse has been linked to adult health problems. Global 52% of children are reported affected annually, and 27% of these are from Africa. According to Child line Zimbabwe and average of 43% are reported to be abused yearly. Several researchers have investigated on the causes of child abuse. Also the major drivers of such are known. However, it is not known to what extent these abuses affect the victim survivors psychological state as they become adults. It is also not known if these effects continue to adulthood. This research aims at understanding the psychological impacts of child abuse psychological to an adult survivor in the Midlands Province, Zimbabwe.

2.3. Population and Sample

The researcher was conducted at a Rape centre located at Shurugwi District Hospital, Midlands Province, Zimbabwe in the month of August 2015.The participants of the study were formed from the volunteer group who applied for help from the centre. A total of 95 participants ranging from 18-24 years were used in the study. The centre was set up by the

Ministry of Women Affairs, Gender and Community Development with help from UNICEF and with aim of helping and treating survivors and victims of child abuse.

2.4. Instruments and measures

2.4.1 Socio-demographic variables

The socio demographic variables included age, marital status, gender, level of education, occupation.

2.4.2. The Symptoms Checklist-90-Revised (SLC -90)

The Symptom Checklist-90 Revised is an established instrument and has over 1,000 independent studies supporting is reliability and validity. The internal consistency coefficient rating ranged from 0.90 for Depression and 0.77 for Psychoticism. Test-retest reliability has been reported at 0.80 to 0.90 with a time interval of one week. All nine primary subscales are well correlated with the Minnesota Multiphase Personality Inventory. The Symptom Checklist-90 Revised was also correlated with the IIP, 0.73, and the SAS, 0.69 (Pearson).

2.4.3. Impact of event scale

This instrument, *Impact of Event Scale* (IES), evaluates the distress that is caused by traumatic *events.* The test is centred on two subscales – Intrusion and Avoidance. The IES-R is the revised edition of the original. The instrument is closely connected with symptoms of PTSD. The format for the test is a 22-item self-report in which respondents identify an stressful event and then respond to question measuring distress with a 5-point. According to this model, until traumatic experiences are psychologically assimilated, the individual will alternate between the experience of intrusive thoughts and feelings in one moment and avoidance strategies in the next. Following this model, the IES was constructed with two subscales, one tapping intrusions (e.g., repeated thoughts about the trauma) and the other tapping avoidance (e.g., effortful avoidance of situations that serve as reminders of the trauma). Shortly after the IES was published, Posttraumatic Stress Disorder (PTSD) was introduced into the DSM-III.

The Impact of Event Scale-Revised (**Weiss & Marmar, 1997**) is a 22-item scale which is rated on a 0 (**not at all**) to 4 (**extremely**) scale with respect to how distressing each item has been during the past week. Scale scores are formed for the three subscales, which reflect intrusion (8 items), avoidance (8 items), and hyper arousal (6 items), and show a high degree of intercorrelation (**rs** = .52 to .87, **Creamer et al., 2003**). High levels of internal consistency have been previously reported (Intrusion: Cronbach's alpha = .87 – .94, Avoidance: Cronbach's alpha = .84 – .87, Hyper arousal: Cronbach's alpha = .79 – .91, **Creamer et al., 2003;Weiss & Marmar, 1997).** Test-retest reliability, collected across a 6-month interval, ranged from .89 to .94 (**Weiss & Marmar, 1997).** Similar internal consistency and test-retest values have been reported with a Japanese translation of the IES-R **(Asukai, et al., 2002).**

2.4.4. Trauma symptoms checklist (TSC-40)

The TSC-40 is a research measure that evaluates symptomatology in adults associated with childhood or adult traumatic experiences. It measures aspects of posttraumatic stress and other symptom clusters found in some traumatized individuals. It does not measure all 17 criteria of PTSD, and should not be used as a complete measure of that construct. The TSC-40 is a revision of the earlier TSC-33 (Briere & Runtz, 1989). Those requiring a validated psychological test of posttraumatic response, using a similar format, should consider the Trauma (TSI) or (for evaluation of a specific trauma) the **Detailed Assessment of Posttraumatic Stress (**DAPS).

The TSC-40 is a 40-item self- report instrument consisting of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual Problems,, and Sleep Disturbance, as well as a total score. Each symptom item is rated according to its frequency of occurrence over the prior two months, using a four point scale ranging from 0 ("never") to 3 ("often"). The TSC-40 requires approximately 10-15 minutes to complete, and can be scored in approximately 5-10 minutes

2.5. Procedure

A questionnaire was administered to the patient and responses recorded. Out of 95 selected participants all of them managed to complete the questionnaires. The process of data collection was done by the researcher through the use of the Rape centre were participants checked in for their routine checkups. A paper and pencil were primary data collection tools that were used for this method because these are cheap and affordable. The data collection

was used as a paper form, however at the end of each day data entry in the electronic was done by the researcher as part of preparation for analysis and backing up purposes.

2.4.5. The Comprehensive Child Maltreatment Scale

CCMS is a paper-and-pencil, self-report measure of an adult's perception of his or her experience of childhood maltreatment (Higgins & McCabe, 2001). It is designed to be administered individually to protect the confidentiality and privacy of the respondent. The measure consists of 21 items and asks the respondent to answer how frequently he or she experienced each potentially maltreating situation before the age of 13. The respondent is asked to report the frequency with which his/her primary maternal figure, primary paternal figure, or another older adolescent or adult performed each action using a Likert-type scale ranging from 0 (never) to 4 (very frequently) for the first 11 items (i.e., physically punished for wrongdoing, such as smacking, grabbing, shaking) and 0 (never) to 5 (more than 20 times) for the last 10 items (i.e., touched your penis, vagina, or breast). Each item loads on only one of five scales: Physical Abuse, Witnessing Family Violence, Psychological Maltreatment, Neglect, and Sexual Abuse.

The score for each scale is determined by summing the responses to each item on the scale; higher scores indicate a greater frequency of perceived maltreatment.

Higgins and McCabe (2001) examined the psychometric characteristics of the CCMS with a community sample of 179 adults. Internal consistency for the entire CCMS scale is excellent (Cronbach's alpha = .92). Internal consistency estimates for the individual scales range from a low of .76 (Physical Abuse and Neglect) to a high of .88 (Sexual Abuse). Test-retest reliability for the entire CCMS was also good (r = .92). Test-retest reliability for the individual scales range from a low of .62 (Neglect) to .95 (Sexual Abuse). The authors of the scale examined concurrent criterion-related validity by correlating the CCMS scales with the scales from the Child Abuse and Trauma (CAT) scale. Results showed that the CAT Neglect/Negative Home Atmosphere scale strongly correlated with the CCMS Neglect scale (r = .77, p < .001) and Psychological Maltreatment Scale (r = .71, p < .001), and moderately correlated with the Physical Abuse and Sexual Abuse scales.

2.6. Statistical analysis

All questionnaires were entered into SPPS (version 21) electronic questionnaire. SPSS was used to calculate t-test, ANOVAs and also the correlation. SPSS was also used to populate tables for use in the analysis of the study results

Table 1.Demographic Characteristics of the participants

		n%
Age	18	16(16,8)
	19	19(20,0)
	20	12(12,6)
	21	15(15,8)
	22	15(15,8)
	23	7(7,4)
	24	11(11,6)
	Total	100(100)
Gender	Male	47(49,5)
	Female	48(50,5)
	Total	95(100)
Occupation	Self-employed	25(26,3)
	Formally-employed	34(35,8)
	Unemployed	36(37,9)
	Total	95(95)
Marital status	Single	34(35,8)
	Married	31(32,6)
	Divorced	30(31,6)
	Total	95(100)

Education level	Illiterate	15(15.8)
	Primary	25(26,3)
	Secondary	21 (22,1)
	High school	20(21,1)
	University	14(14,7)
	Total	95(100)

95 participants were part of the research and answered the questionnaires. According to their age n=16(16,8%) were aged 18years, n=19(20,0%) were aged 19years , , n=12(12,6%) were aged 20years, n=15(15,8%) were aged 21, n=15(15,8%) were aged 22 years, , n=7(7,4%) were aged 23years ,n=11(11,6%) were aged 24years according to gender n=47(49,5%)were males, n=48(50,5) were females, according to employment status n=25(26,3%) were self employed , n=34(35,8) were formally employed ,n=36(37,9%) were unemployed , according to marital status n=34(35,8%) were single ,n=31(32,6) were married ,n=30(31,6) were divorced ,according to educational level n=15(15,8%) were illiterate ,n=25(26,35%) were primary ,n=21(22,15%) were secondary ,n=20(21,1%) had high school education ,n=14(14,7%) had reached university level

Table 3. Comparison of mean scores of TSC-40 subscales according to marital status

	Single	Married	Divorced	df F p
Dissociation	8,61±4.22 (n=31)	10,36±4,68 (n=28)	11,96±3,84 (n=27)	2 4,57 0,13
Anxiety	19,80±2,18 (n=31)	20,11±3,07 N=28	20,21±3,37 N=30	2 0,159 0,853
Depression	21,77±2,50 (n=34)	22,10±2,88 N=28	23,46±3,95 N=28	2 2,239 0,104
SATI	14,35±3,07 (n=34)	25,35±6.77 N=28	27,87±4,01 N=28	2 3,009 0,055
Sleep disturbance	15,61±2,56 N=34	15,96±2,79 N=28	16,21±2,63 N=28	2 0,381 0,684
Sexual problems	16,58±4,87 n=34	18,18±4,97 N=28	19,54±3,79 N=28	2 3,075 0,51

*p≤0,05 **p<0,001

When the mean scores of TSC-40 subscales of the participants were compared according to marital status with one way ANOVAs no significant difference was found for anxiety and sleep disturbance. For the dissociation, SATI, sexual problem subscales significant difference were found.Tukey analysis showed that in all these 3 subscales single participants had less dissociation, SATI and sexual problems when compared with divorced participants

Table 4 . Comparison of mean scores of IES scale according to marital status

	Single	Married	Divorced	df F p
Intrusion	16,49±5,77 (n=47)	17,51±6,56 (n=31)	16,6±5,56 (n=30)	2 0,456 0,635
Avoidance	17,64±4,47 (n=34)	17,96±3,77 N=31	16,76±2,76 N=30	2 0,832 0,438
Hyper arousal	16,00±2,50 (n=34)	15,45±3,66 N=31	16,27±3,74 N=30	2 0,440 0,646

*p≤0,05 **p<0,001

When the mean scores of TSC-40 subscales were compared according to gender no significant difference was found.

Table 5. Comparison of mean scores of SCL-90 subscales between male and female participants

	Male	Female	t df p
Somatisation	32,48±5,79 (n=48)	30,93±6,99 (n=47)	1,141 87 0,257
Interpersonal	28,64±5,84 (n=44)	27,39±6,26 (n=44)	1,053 93 0,295
Depression	35,57±9,06 (n=44)	34,73±9,98 (n=44)	0,542 93 0,589
Anxiety	27,47±4,90 (n=44)	26,36±5,92 (n=44)	1,066 93 0,289
Aggression	16,70±4,41 (n=44)	16,34±4,94 (n=44)	0,438 93 0,662
Phobia	18,91±4,06 (n=44)	18,43±3,86 (n=44)	0,519 93 0,605
Paranoid	16,52±4,35 (n=44)	15,80±4,80 (n=44)	0,757 93 0,451
Psychotism	27,00±6,15 (n=44)	26,30±5,70 (n=44)	0,663 91 0,509
Addition	20,00±4,33 (n=44)	19,22±4,48 (n=44)	0,812 93 0,419

GSM	2,80±0,56 (n=44)	2,69±0,62 (n=44)	0,801 86 0,425
Obsession	28,64±5,84 (n=44)	27,39±6,26 (n=44)	1,053 93 0,295

*p≤0,05 **p< 0,001

When mean scores of SCL-90 subscales were compared with t-test analysis according to gender, no significant difference was found.

Table 6:Comparison of mean scores of TSC-40 subscales between male and female participants

	Male	Female	df F p
Dissociation	9,95±4,37 (n=42)	10,59±4,48 (n=46)	1 0,552 0,460
Anxiety	22,40±3,51 (n=47)	22,31±2,63 (n=48)	1 0,140 0,906
Depression	20,06±2,69 (n=41)	20,00±2,85 (n=46)	1 0,093 0,761
SATI	15,17±3,11 (n=41)	15,48±3,13 (n=46)	1 0,089 0,766
Sleep disturbance	17,96±4,52 (n=41)	15,75±2,78 (n=46)	1 0,019 0,891
Sexual problem	17,96±4,52 (n=41)	18,17±4,58 (n=46)	1 0,031 0,860

*p≤0,05 **p< 0,001

When the mean scores of TSC-40 subscales were compared with t-test according to gender of the participants no significant difference was found.

Table7:Comparison of mean scores of IES subscales between male and female participants

	Male	Female	t df p
Intrusion	16,49±5,77 (n=47)	16,95±6,13 (n=48)	-0,384 93 0,702
Hyper arousal	15,94±3,49 (n=47)	15,88±3,49 (n=48)	0,086 93 0,932
Avoidance	17,60±3,69 (n=47)	17,35±3,85 (n=48)	0,312 93 0,756

*p≤0,05 **p< 0,001

When mean scores of IES subscale were compared with t-test analysis according to gender of participants no difference was found

Table 8. The relation of severity of different types of child abuse with the mean scores of IES subscales

	Physical Abuse	Witnessing Family Violence	Psychological Maltreatment	Neglect	Child Abuse
Intrusion	r =0,026 p =0,801	r = -0,159 p =0,125	r= -0,017 p=0,866	r= -0,108 p=0,298	r=0,042 p=0,688
Avoidance	r =0.099 p =0.338	r = 0,116 p =0,264	r =0.242 p=0,018*	r=0,268 p=0,009**	r=0,055 p=0,598
Hyper arousal	r =0,077 p =0,460	r =0,014 p = 0,895	r =0,091 p=0,382	r= -0,009 p=0,931	r=0,126 p=0,225
Total	r =0,048 p =0,644	r = -0.046 p=0,660	r=0,111 p=0,283	r=0,161 p=0,120	r=0,088 p=0,396

*p≤0, 05 **p< 0,001

When the relation between mean scores of IES subscales and the severity of different types of child abuse was analysed by using Pearson's correlation it was found that there was signicant difference between avoidance and physical abuse. This meant that when a participant subjected to more physical abuse showed more symptoms of avoidance (r=0,242 p=0,018)

Significant difference was also noted between avoidance and neglect, and this meant that the more the neglect the participants were subjected to the more the avoidance they show. (r=0,268 p=0,009)

Table 9. The relation of severity of different types of child abuse with the mean scores of SCL - 90 subscales

	Physical Abuse	Witnessing Family Violence	Psychological Maltreatment	Neglect	Child Abuse
Somatisation	r =0,040 p =0,712	r=0,037 p=0,734	r=0,032 p=0,766	r=0,013 p=0,905	r=-0,103 p=0,336
Interpersonal	r=0,059 p=0,573	r=0,068 p=0,515	r=-0,002 p=0,983	r=-0,053 p=0,601	r=-0,142 p=0,170
Depression	r =0,087 p=0,399	r=0,049 p=0,639	r=-0,003 p=-0,974	r=0,005 p=0,960	r=-0,124 p=0,232
Anxiety	r=0,008 p=0,939	r=0,123 p=0,234	r=0,063 p=0,547	r=0.059 p=0,570	r=-0,089 p=0,391
Aggression	r=0,086 p=0,408	r=0,052 p=0,617	r=0,004 p=0,970	r=-0.014 p=0,890	r=-0,168 p=0,104
Phobia	r=0,019 p=0,854	r=0,147 p=0,156	r=0,081 p=0,435	r=0,052 p=0,619	r=-0,066 p=0,524
Paranoid	r=0,047 p=0,649	r=0,075 p=0,471	r=0,036 p=0,732	r=0,009 p=0,932	r=-0,138 p=0,182
Psychotism	r=0,065 p=0,539	r=0,143 p=0,170	r=0,032 p=0,758	r=0,052 p=0,620	r=-0,126 p=0,229
Addition	r=0,073 p=0,486	r=0,115 p=0,269	r=0,058 p=0,578	r=0,008 p=0,941	r=-0,166 p=0,109
GSM	r=0,074 p=0,493	r=0,1070 p=0,319	r=0,044 p=0,687	r=0,026 p=0,812	r=-0,173 p=0,106
Obsession	r=0,059 p=0,573	r=0,068 p=0,515	r=-0,002 p=0,983	r=-0,053 p=0,607	r=-0,142 p=0,170

*p≤0,05 **p< 0,001

There was no significant correlation of mean scores between SCL-90subscales and the severity of different types of child abuse when analysed with Pearson correlation method.

Table 10.The relation of severity of different types of child abuse with the mean scores of TSC-40 subscales

	Physical Abuse	Witnessing Family Violence	Psychological Maltreatment	Neglect	Sexual Abuse
Dissociation	r=0,015 p=0,893	r=0,103 p=0,340	r=0,017 p=0,874	r=-0,064 p=0,554	r=0,033 p=0,762
Anxiety	r=-0,011 p=0,913	r=-0,098 p=0,346	r=-0,120 p=0,250	r=-0,182 p=0,079	r=0,074 p=0,762
Depression	r=0,026 p=0,802	r=0,058 p=0,577	r=0,034 p=0,742	r=-0,159 p=0,123	r=0.028 p=0,788
SATI	r=-0,003 p=0,976	r=0,069 p=0,505	r=-0,013 p=0,902	r=-0,092 p=0,328	r=0,013 p=0,897
Sleep disturbance	r=-0,091 p=0,378	r=0,039 p=0,709	r=-0,016 p=0,875	r=-0,102 p=0,328	r=-0,077 p=0,457
Sexual problem	r=-0,050 p=0,628	r=0,069 p=0,508	r=0,005 p=0,959	r=-0,110 p=0,289	r=-0,044 p=0,669
Total	r=-0,057 p=0,602	r=0,055 p=0,611	r=-0,026 p=0,810	r=-0,170 p=0,115	r=-0,049 p=0,651

*p≤0,05 **p> 0,001

There was no significant correlation between mean scores of TSC-40 subscales and the severity of different types of child abuse when analysed with Pearson correlation method.

4. DISCUSSION

The aim of the study was to investigate the psychological consequences of child abuse in adult survivors. Three hypotheses were tested (1) more severe child abuse experience is related with higher psychopathology ,(2) more severe child abuse experience is related with severe trauma symptoms (3) more severe child abuse experience is related with stronger impact of events.

The first hypothesis of this investigation received partial support; the results suggested that there was significant relation between avoidance and psychological maltreatment and neglect. This meant that when a participant was subjected to more psychological maltreatment and neglect they showed more symptoms of avoidance. In a research conducted Einsenberg et al.(1996) , he proved that negative parental responses to children's emotions which are considered to be a form of psychological abuse has been predictive of an avoidant coping response and a predictive of increased negative psychological symptoms. Survivors of abuse who had a history of psychological abuse as well as physical and sexual abuse were likely to engage in avoidance coping in adulthood.

Some adult survivors of psychological maltreatment and neglect go through avoidance (Hayes, Wilson, Strosahl, Gifford, & Follete, 1996). While employing an avoidant coping style and attempting to inhibit thoughts and feelings may be adaptive in the short term, it often leads paradoxically to increased rumination of the very thing sought to be avoided. Greater use of avoidance has been associated with psychopathology including anxiety (Craske, Hazlett-Stevens, 2002), depressive symptoms, severity of posttraumatic stress disorder(Boeschem,Koss,Figueredo&Coan,2001).

Significant relationships were found between marital status and some of the subscales of the SCL-90, (depression, and aggression, paranoid). Married people had lower mean scores proving that marriage creates a safe place for most survivors of childhood abuse. Most survivors settle well in their marriages and in the end they are able to cope with past trauma

According to a study conducted by Lisa Rapaport (2015, pp45), child abuse survivors who find stable romantic relationships as adults may also find that these relationships help protect against depression. A research conducted on a group of 485 young adults in Rochester, New York, for 12 years to see how exposure to neglect or maltreatment during childhood would influence their ability to have satisfying relationships with intimate partners and their

susceptibility to depression. Results showed that about 65% of the young adults were able to have steady relationships and they got married, there was less depression evident in such adults.

Molly McElroy (2001), used records from Child Protective Services to identify 99 participants who had been abused before the age of 18 and compared their experiences to a group of 386 people who were not maltreated. Results showed that abused survivors were more likely to be depressed, but a history of maltreatment didn't impact whether they were in a committed relationship or their level of satisfaction with the relationship. Both survivors and non-survivors were less likely to experience depression when they were in a stable, satisfying relationship. Participants who became parents and had solid relationships with intimate partners were also less likely to be depressed.

Single participants had lower scores for TSC-40 subscales of dissociation, SATI, and sexual problems compared to divorced participants. In all the cases single participants had lower scores than divorced ones. A child who experiences extreme trauma or abuse has few coping mechanisms at their disposal. Understanding and integrating the experience may overwhelm the child's coping mechanisms. In the absence of effective coping skills, the child's best option for psychologically surviving is to dissociate or shut off the experience from their consciousness (Henderson, 2006; Perry et al., 1995).

Dissociation refers to the mental processes that create a lack of connection in the person's thoughts, memories, feelings, actions or sense of self (Amir & Lev-Wiesel, 2007; Reber & Reber, 2001). Traumatized children use a variety of dissociative techniques. In dissociating, the child (or adult survivor) alters the normal links between thoughts, feelings and memories (Briere, 1992) and so decreases awareness of, or numbs the pain of distressing events (Putnam, 1985). Dissociation can be referred to as being spaced out, blocking things out and being out of touch with one's emotions. Infants and young children commonly employ a variety of dissociative responses such as: numbing, avoidance, and restricted affect.

When gender was compared to the subscales of IES, TSC-40, SCL-90 no statistical difference was found.

Research on long-term psychological consequences of child abuse among young adults is extensive. In this research it was expected that the more severe the abuse, the more symptoms present but such a relation was not entirely found.

In this study a relation between IES and marital status was not found. This could have been because child abuse survivors could have been receiving psychological help. Laura King (2015, 153-167) states that adolescent vary in their nature of their responses to traumatic experiences, the majority of adolescents manifest resilience in the aftermath of traumatic experiences. Despite exposure to traumatic events and experiencing short term distress, most young adults return to their previous levels of functioning after several weeks or months and resume a normal developmental course. (Briere & Hutchinson 1994, 500-507). In some cases individual family cultural and community strengths can facilitate recovery and promote resilience. Social and governmental support networks are critical for recovery, particularly when an entire community is affected. (Gara, Allen & Herzog, 2000, 204)

On another study (Cohen et al, 2004) a research was conducted involving 229 children ages 12-16 years and all had a history of some type of child abuse and neglect. It was found that children who received CBT had lower levels of depression and psychological problems as well as higher levels of interpersonal trust, perceived credibility and lower levels of shame

Research has shown that various protective factors can impact the relationship between childhood trauma and adult psychopathology (Aspinwall & Tedeschi, 2010). Perkins and Jones (2004), found in a sample of 3281 adolescents who reported that they had experienced physical and sexual abuse that religiosity and support from family and adults predicted lower levels of depression and sexual behaviour. The research shows that in such cases at time when a survivor is asked about a past trauma they no longer stress more on such topics. Longitudinal studies are needed for better understanding.

5. CONCLUSSION

The aim of the present study was to find the psychological consequences of child abuse among young adults. When gender was compared with the subscales of IES, SCL-90, TSC-40 no significant difference was found. Divorced participants had a significantly higher scores for depression than married participants and higher scores for aggression and paranoid than single participants

In the research it was expected that the more severe the abuse, the more severe the symptoms that should be evident but such a relation was not entirely found. The participants were receiving psychological support from the center. Longitudinal studies that start from childhood till young adulthood may show the psychological consequences of abuse and how it is affected by psychological treatment.

REFFERENCES

Adam, E. K., Pierce, S. L., Holland, J. F., Desmond, E., & Gunnar, M. R. (August, 1996). **Cognitive and physiological correlates of internal working models.** Paper presented at the International Society for the Study of Behavioural Development, Quebec City, Canada,

Allen, B. (2005, June). **The illusion of normality: Non-pathological personality characteristics of young adult survivors of childhood maltreatment**. Paper presented at the colloquium of the American Professional Society on the Abuse of Children, New Orleans, LA.

Anderson, P. L., Tiro, J. A., Price, A. W., Bender, M. A., & Kaslow, N. J. (2002). Additive impact of childhood emotional, physical, and sexual abuse on suicide attempts among low-income African-American women. **Suicide and Life-Threatening Behavior**, *32*(2), 131-138.

Arata, C. M., Langhinrichsen-Rohling, J., Bowers, D., & O'Farrill-Swails, L. (2005). Single versus multi-type maltreatment: An examination of the long-term effects of child abuse. **Journal of Aggression, Maltreatment, and Trauma**, *11*(4). 29-52.

Bandura, A. (1978). Social learning theory of aggression. **Journal of Communication**, *28*(3), 12-29.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. **Journal of Personality and Social Psychology**, *51*, 1173-1182.

Bennett, D. S., Sullivan, M. W., & Lewis, M. (2005). Young children's adjustment as a function of maltreatment, shame, and anger. **Child Maltreatment**, *10*(4), 311- 323.

Bensley, L. S., Spieker, S. J., Van Eenwyk, J., & Schoder, J. (1999). Self-reported abuse history and adolescent problem behaviors, II: Alcohol and drug use. **Journal of Adolescent Health**, *24*(3), 173-180.

Berliner, L., & Elliott, D. M. (2002). Sexual abuse of children. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), **The APSAC handbook on child maltreatment** (2nd ed.). Thousand Oaks, CA: Sage.

Bierer, L. M., Yehuda, R., Schmeidler, J., Mitropoulou, V., New, A., Silverman, J.M., et al. (2003). Abuse and neglect in childhood: Relationship to personality disorder diagnoses. **CNS Spectrums**, *8*(10), 737-754.

Bifulco, A., Moran, P. M., Baines, R., Bunn, A., & Stanford, K. (2002). Exploring psychological abuse in childhood II: Association with other abuse and adult clinical depression. **Bulletin of the Menninger Clinic**, *66*(3), 241-258.

Bowlby, J. (1982). **Attachment and loss: Vol. 1. Attachment**. New York: Basic Books. (Original work published 1969).

Bowlby, J. (1973). **Attachment and loss: Vol. 2. Separation**. New York: Basic Books.

Breslin, F. C., O'Keeffe, M. K., Burrell, L., & Ratliff-Crain, J. (1995). The effects of stress and coping on daily alcohol use in women. ***Addictive Behaviors,*** *20*(2), 141-147.

Briere, J. (1992). **Child abuse trauma: Theory and treatment of the lasting effects**. Newbury Park, CA: Sage.

Briere, J. (1996a). **Therapy for adults molested as children: Beyond survival**. New York: Springer.

Briere, J. (1996b). A self-trauma model for treating adult survivors of severe child abuse. In J. Briere, L. Berliner, J. A. Bulkley, C. Jenny, & T. Reid (Eds.), **The APSAC handbook on child maltreatment**. Thousand Oaks, CA: Sage.

Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, & T. A. Reid (Eds.), **The APSAC handbook on child maltreatment** (2nd Ed.). Thousand Oaks, CA: Sage.

Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. **Child Abuse and Neglect**, *27*, 1205-1222.

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. **Child Abuse and Neglect**, *14*(3), 357-364.

Brodsky, B. S., Oquendo, M. A., Ellis, S. P., Haas, G. L., Malone, K. M., & Mann, J. J.(2001).The relationship of childhood abuse to impulsivity and suicidal behavior in adults with major depression***. American Journal of Psychiatry****, 158*(11), 1871- 1877.

Brown, J., Cohen, P., Johnson, J. G., & Smailes, E. M. (1999). Childhood abuse and neglect.Specificity and effects on adolescent and young adult depression and suicidality. **Journal of the American Academy of Child & Adolescent Psychiatry**, *38*(12), 1490-1496.

Brown, S. E. (1984). Social class, child maltreatment, and delinquent behavior. **Criminology,** *22*(2), 259-278.

Bryant, S. L., & Range, L. M. (1997). Type and severity of child abuse and college students' lifetime suicidality. **Child Abuse and Neglect**, *21*(12), 1169-1176.

Clark, D. B., Lesnick, L. A., & Hegedus, A. M. (1997). Traumas and other adverse life events in adolescents with alcohol abuse and dependence. **Journal of the American Academy of Child and Adolescent Psychiatry**, *36*(12), 1744-1751.

Dopheide JA, 2006. Recognizing and treating depression in children and adolescents. **International Journal of Emergency Mental Health,** 2nd Edition , V olume 3, 303

Widom C.S, Dumont K,Czaya SJ, A Prospective investigation of Major Depressive Disorder and Comorbidity in abused children grown up , **Arch Gen Psychiatry** 2007;64(1):49-56.

Walker P, Complex PTSD: From Surviving to Thriving – A guide and Map for Recovering from Childhood Trauma, **Journal of Child Psychology and Psychiatry Volume 4,** 283-292

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to _____ _____(event) that occurred on _____(date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score:_____

INT: 1, 2, 3, 6, 9, 14, 16, 20
AVD: 5, 7, 8, 11, 12, 13, 17, 22
HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.)
Assessing psychological trauma and PTSD: a practitioner's handbook (2nd ed., pp. 168-189). New York: Guilford Press.

Revised Impact of Event Scale (22 questions):

The revised version of the Impact of Event Scale (IES-r) has seven additional questions and a scoring range of 0 to 88.

On this test, scores that exceed 24 can be quite meaningful. High scores have the following associations.

Score (IES-r)	**Consequence**
24 or more	PTSD is a clinical concern.[6] Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
33 and above	This represents the best cutoff for a probable diagnosis of PTSD.[7]
37 or more	**This is high enough to suppress your immune system's functioning** (even 10 years after an impact event).[8]

The IES-R is very helpful in measuring the affect of routine life stress, everyday traumas and acute stress

References:

1. Horowitz, M. Wilner, N. & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective stress. Psychosomatic Medicine, 41, 209-218.
2. Weiss, D.S., & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P. Wilson & T.M. Keane (Eds.), Assessing Psychological Trauma and PTSD (pp.399-411). New York: Guilford.
3. Hutchins, E. & Devilly, G.J. (2005). Impact of Events Scale. Victim's Web Site. http://www.swin.edu.au/victims/resources/assessment/ptsd/ies.html
4. Coffey, S.F. & Berglind, G. (2006). Screening for PTSD in motor vehicle accident survivors using PSS-SR and IES. Journal of Traumatic Stress. 19 (1): 119-128.
5. Neal, L.A., Walter, B., Rollins, J., et al. (1994). Convergent Validity of Measures of Post-Traumatic Stress Disorder in a Mixed Military and Civilian Population. Journal of Traumatic Stress. 7 (3): 447-455.
6. Asukai, N. Kato, H. et al. (2002). Reliability and validity of the Japanese-language version of the Impact of event scale-revised (IES-R-J). Journal of Nervous and Mental Disease. 190 (3): 175-182.
7. Creamer, M. Bell, R. & Falilla, S. (2002). Psychometric properties of the Impact of Event Scale-Revised. Behaviour Research and Therapy. 41: 1489-1496.
8. Kawamura, N. Yoshiharu, K. & Nozomu, A. (2001) Suppression of Cellular Immunity in Men with a Past History of Post Traumatic Stress Disorder. American Journal of Psychiatry. 158: 484-486

Table 2. Comparison of mean scores of SCL-90 subscales of the participants according to marital status

	Single	Married	Divorced	df F p
Somatisation	32.03±5.98 (n=32)	30.23±6.99 (n=30)	32.93±6,09 (n=27)	2 1.339 0,268
Interpersonal	28,76±5,25 (n=34)	31,6±7,27 N=31	29,1±4,77 N=30	2 2,397 0,097
Depression	36,67±7,89 (n=34)	25,35±11,07 N=31	37,1±7,80 N=30	2 3,562 0,032*
Anxiety	27,76±4,51 (n=34)	25,35±6.77 N=31	27,87±4,01 N=30	2 2,311 0,105
Aggression	17,32±3.39 N=34	14,62±5,85 N=31	17,56±3,56 N=30	2 4,330 0,016*
Phobia	19,09±3,51 n=34	17,67±4,52 N=31	19,47±3,44 N=30	2 1,852 0,163
Paranoid	17,09±3,39 n=34	14,35±5,84 N=31	16,97±3,41 N=30	2 3,959 0,022*
Psychotism	27,41±5,51 n=34	25,17±6,86 N=30	27,51±4,67 N=29	2 1,162 0,204
Addition	20,12±3,74 n=34	18,29±5,37 N=31	20,43±3,38 N=30	2 2,297 0,106
GSM	14,35±5,84 N=31	17,32±3.39 N=34	14,62±5,85 N=31	2 2,602 0,080
Obsession	28,76±5,25 n=34	26,13±7,27 N=30	29,1±4,77 N=31	2 2,397 0,97

*p≤0,05 **p< 0,001

When the mean scores of SCL -90 subscales were compared according to the marital status of the participants using one way ANOVAs, no difference was found for somatisation,interpersonal,anxiety, phobia,psychotism and obsession subscales. For depression subscale significant difference was found between the groups.Tukey analyses showed that married participants had significantly less depression than divorced ones. There was also significant difference for the aggression which proved that single participants had less aggression than divorced participants, also for paranoid subscales it was also seen that single participants were also less paranoid as compared to divorced participants.

Name_____ ID# _____Date _____

SCL-90

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, select one of the numbered descriptors that best describes HOW MUCH THAT PROBLEM HAS BOTHERED OR DISTRESSED YOU DURING THE PAST WEEK, INCLUDING TODAY. Circle the number in the space to the right of the problem and do not skip any items. Use the following key to guide how you respond:

Circle 0 if your answer is NOT AT ALL
Circle 1 if A LITTLE BIT
Circle 2 if MODERATELY
Circle 3 if QUITE A BIT
Circle 4 if EXTREMELY

Please read the following example before beginning:

Example: In the previous week, how much were you bothered by:

Backaches 0 (1) 2 3 4

In this case, the respondent experienced backaches a little bit (1).
Please proceed with the questionnaire.

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1.	Headaches	0	1	2	3	4
2.	Nervousness or shakiness inside	0	1	2	3	4
3.	Unwanted thoughts, words, or ideas that won't leave your mind	0	1	2	3	4
4.	Faintness or dizziness	0	1	2	3	4
5.	Loss of sexual interest or pleasure	0	1	2	3	4
6.	Feeling critical of others	0	1	2	3	4
7.	The idea that someone else can control your thoughts	0	1	2	3	4
8.	Feeling others are to blame for most of your troubles	0	1	2	3	4
9.	Trouble remembering things	0	1	2	3	4
10.	Worried about sloppiness or carelessness	0	1	2	3	4
11.	Feeling easily annoyed or irritated	0	1	2	3	4
12.	Pains in heart or chest	0	1	2	3	4
13.	Feeling afraid in open spaces or on the streets	0	1	2	3	4
14.	Feeling low in energy or slowed down	0	1	2	3	4
15.	Thoughts of ending your life	0	1	2	3	4
16.	Hearing voices that other people do not hear	0	1	2	3	4
17.	Trembling	0	1	2	3	4
18.	Feeling that most people cannot be trusted	0	1	2	3	4
19.	Poor appetite	0	1	2	3	4

SCL-90 (*continued*)

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
20.	Crying easily	0	1	2	3	4
21.	Feeling shy or uneasy with the opposite sex	0	1	2	3	4
22.	Feeling of being trapped or caught	0	1	2	3	4
23.	Suddenly scared for no reason	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling afraid to go out of your house alone	0	1	2	3	4
26.	Blaming yourself for things	0	1	2	3	4
27.	Pains in lower back	0	1	2	3	4
28.	Feeling blocked in getting things done	0	1	2	3	4
29.	Feeling lonely	0	1	2	3	4
30.	Feeling blue	0	1	2	3	4
31.	Worrying too much about things	0	1	2	3	4
32.	Feeling no interest in things	0	1	2	3	4
33.	Feeling fearful	0	1	2	3	4
34.	Your feelings being easily hurt	0	1	2	3	4
35.	Other people being aware of your private thoughts	0	1	2	3	4
36.	Feeling others do not understand you or are unsympathetic	0	1	2	3	4
37.	Feeling that people are unfriendly or dislike you	0	1	2	3	4
38.	Having to do things very slowly to insure correctness	0	1	2	3	4
39.	Heart pounding or racing	0	1	2	3	4
40.	Nausea or upset stomach	0	1	2	3	4
41.	Feeling inferior to others	0	1	2	3	4
42.	Soreness of your muscles	0	1	2	3	4
43.	Feeling that you are watched or talked about by others	0	1	2	3	4
44.	Trouble falling asleep	0	1	2	3	4
45.	Having to check and double-check what you do	0	1	2	3	4
46.	Difficulty making decisions	0	1	2	3	4
47.	Feeling afraid to travel on buses, subways, trains	0	1	2	3	4
48.	Trouble getting your breath	0	1	2	3	4
49.	Hot or cold spells	0	1	2	3	4
50.	Having to avoid certain things, places, or activities because they frighten you	0	1	2	3	4
51.	Your mind going blank	0	1	2	3	4
52.	Numbness or tingling in parts of your body	0	1	2	3	4
53.	A lump in your throat	0	1	2	3	4
54.	Feeling hopeless about the future	0	1	2	3	4
55.	Trouble concentrating	0	1	2	3	4

SCL-90 (*continued*)

HOW MUCH WERE YOU BOTHERED BY:		NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
56.	Feeling weak in parts of your body	0	1	2	3	4
57.	Feeling tense or keyed up	0	1	2	3	4
58.	Heavy feelings in your arms or legs	0	1	2	3	4
59.	Thoughts of death or dying	0	1	2	3	4
60.	Overeating	0	1	2	3	4
61.	Feeling uneasy when people are watching or talking about you	0	1	2	3	4
62.	Having thoughts that are not your own	0	1	2	3	4
63.	Having urges to beat, injure, or harm someone	0	1	2	3	4
64.	Awakening in the early morning	0	1	2	3	4
65.	Having to repeat the same actions such as touching, counting, washing	0	1	2	3	4
66.	Sleep that is restless or disturbed	0	1	2	3	4
67.	Having urges to break or smash things	0	1	2	3	4
68.	Having ideas or beliefs that others do not share	0	1	2	3	4
69.	Feeling very self-conscious with others	0	1	2	3	4
70.	Feeling uneasy in crowds, such as shopping or at a movie	0	1	2	3	4
71.	Feeling everything is an effort	0	1	2	3	4
72.	Spells of terror or panic	0	1	2	3	4
73.	Feeling uncomfortable about eating or drinking in public	0	1	2	3	4
74.	Getting into frequent arguments	0	1	2	3	4
75.	Feeling nervous when you are left alone	0	1	2	3	4
76.	Others not giving you proper credit for your achievements	0	1	2	3	4
77.	Feeling lonely even when you are with people	0	1	2	3	4
78.	Feeling so restless you couldn't sit still	0	1	2	3	4
79.	Feelings of worthlessness	0	1	2	3	4
80.	Feeling that familiar things are strange or unreal	0	1	2	3	4
81.	Shouting or throwing things	0	1	2	3	4
82.	Feeling afraid you will faint in public	0	1	2	3	4
83.	Feeling that people will take advantage of you if you let them	0	1	2	3	4
84.	Having thoughts about sex that bother you a lot	0	1	2	3	4
85.	The idea that you should be punished for your sins	0	1	2	3	4
86.	Feeling pushed to get things done	0	1	2	3	4
87.	The idea that something serious is wrong with your body	0	1	2	3	4
88.	Never feeling close to another person	0	1	2	3	4
89.	Feelings of guilt	0	1	2	3	4
90.	The idea that something is wrong with your mind	0	1	2	3	4

Reference: Derogatis, L.R., Lipman, R.S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary Report. *Psychopharmacol. Bull. 9*, 13–28.

Please use the following scoring key to answer sections 1-5:
0 = *never or almost never*
1 = *occasionally*
2 = *sometimes*
3 = *frequently*
4 = *very frequently*

Section 1: Before the age of 13, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your primary maternal figure (i.e., biological mother, stepmother, grandmother), your primary paternal figure (i.e., biological father, stepfather, grandfather), and other adults or older adolescents. A primary figure is the individual most responsible for your care as a child. If you had more than one primary maternal or paternal figure, select the one that you feel was the primary figure for the greatest amount of time during your childhood and include the other figure in the other adult category.

	Maternal Figure	Paternal Figure	Other adult/older adolescent
Physically punished for wrongdoing (e.g., smacking, grabbing, shaking)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Other use of violence (e.g., hitting, punching, kicking)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Severely hurt you (requiring medical attention)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

Section 2: Before the age of 13, how frequently did you witness any of these behaviours listed in Section 1 directed toward others in the family?

0 1 2 3 4

Section 3: Before the age of 13, how frequently did you experience any of the following behaviours? Please rate the frequency with which the behaviours were directed toward you by your primary maternal figure (i.e., biological mother, stepmother, grandmother), your primary paternal figure (i.e., biological father, stepfather, grandfather), and other adults or older adolescents. A primary figure is the individual most responsible for your care as a child. If you had more than one primary maternal or paternal figure, select the one that you feel was the primary figure for the greatest amount of time during your childhood and include the other figure in the other adult category.

	Maternal Figure	Paternal Figure	Other adult/older adolescent
Yelled at you	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Ridiculed, embarrassed, used sarcasm (made you feel guilty, silly, or ashamed)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Provoked, made you afraid, used cruelty	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

Section 4: Before the age of 13, how frequently did you witness any of these behaviors listed in Section 3 directed toward others in the family?

0 1 2 3 4

Section 5: Before the age of 13, how frequently did you experience any of the following behaviors? Please rate the frequency with which the behaviors were directed toward you by your primary maternal figure (i.e., biological mother, stepmother, grandmother), your primary paternal figure (i.e., biological father, stepfather, grandfather), and other adults or older adolescents. A primary figure is the individual most responsible for your care as a child. If you had more than one primary maternal or paternal figure, select the one that you feel was the primary figure for the greatest amount of time during your childhood and include the other figure in the other adult category.

	Maternal Figure	Paternal Figure	Other adult/older adolescent
Not giving you regular meals or baths, clean clothes, or needed medical attention	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Shut you in a room alone for an extended period of time	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Ignored your requests for attention; did not speak to you for an extended period of time	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4

Please use the following scoring key to answer section 6:
0 = *never*
1 = *once*
2 = *twice*
3 = *3-6 times*
4 = *7-20 times*
5 = *more than 20 times*

Section 6: Many people report having childhood sexual experiences with other children or with older people. The following questions relate only to sexual activities with older people. These 'older people' include someone who at the time was either an adolescent (at least 5 years older than you) or an adult (18 years of age or older). Before you turned 13, did an older person engage in any of the following types of sexual activity with you?

	Maternal Figure	Paternal Figure	Other adult/older adolescent
Requested you to do something sexual	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Forced you to watch others have sex	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Showed you his erect penis		0 1 2 3 4 5	0 1 2 3 4 5
Touched your penis, vagina, or breasts	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Made you touch his penis/ her vagina, or breasts	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Put his/her mouth on your penis or vagina	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Made you put your mouth on his penis/her vagina	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Put a finger in your vagina or Anus	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
Put his penis in your vagina or anus		0 1 2 3 4 5	0 1 2 3 4 5
Put other object in your vagina or anus	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5

Dear Participant

The questionnaire below has been prepared as part of a research on the **Long-term Psychological Consequences of Child Abuse among Young Adults.** Please choose the appropriate answer for each question .The information submitted will be treated with top confidentiality your co-operation is sincerely appreciated.

SECTION A: Demographic details of participants

APPENDIX A

(General information about the participants)

1. Age……..

2. Gender a) Male…….. b) Female…….

3. Marital Status a) Single….. b) Married……. c) Divorced…….

4. Educational Level a) illiterate…….. b) Primary…… c) Secondary……..

b) High school…….. c) University…….

Telephone 798537-60
Telegraphic Address
"MEDICUS", Harare
Fax: 729154/793634 (702293 FHP)
Telex: MEDICUS 22211ZW

ZIMBABWE

Reference: Approval of research dat
MINISTRY OF HEALT
CHILD CARE
P.O. Box CY1122
Causeway
Zimbabwe

07 January 2015

RE: PERMISION TO COLLECT DATA AND USE FOR THE MASTER IN PSYCHOLOGY

Dear Sir/Madam

This letter serves to inform that Chido Vimbai Hungwe, a Master's student at Near Eas University was granted permission from our organisation to gather data for use for th purpose of her research. She worked at our organisation in August 2015 under o psychology department, working with victims and survivors of child abuse.She used t following psychology scales in obtaining data:

1. Impact of event scale
2. Trauma symptoms checklist
3. SCL-90
4. Comprehensive Child maltreatment scale

Chido has been approved and given permission to use the data collected for her Master's thesis on the ***Psychological consequences of child abuse on young adults.***

Thank you

A S Mapuranga (District Environmental Health Officer)

SHURUGWI DISTRICT HOSPITAL
DISTRICT ENVIRONMENTAL HEALTH OFFICER
07 JAN 2016
P.O. BOX 3, SHURUGWI
ZIMBABWE

For: District Medical Officer