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The Cost of Telling the Painful Experiences: Family Factors for Child Sexual Abuse Disclosure

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Abstract: *Child Sexual Abuse (CSA) is categorized as one of the forms of child abuse and is one of the most confusing and perplexing problems facing many societies in the world. Child Sexual Abuse cannot be alleviated without disclosure, making it necessary to establish CSAD factors as a pathway to increase community resources (e.g., mental health and social services) for survivors. CSA affects the health of a community, but it is highly unreported. Perpetrators mask their behavior from community and survivors and appear normal and harmless. It is on this premise that the study purposed to examine the understanding of Child Sexual Abuse Disclosure from participants' perspective in relation to family factors at Thika Level 5 Hospital in Kiambu County, Kenya. The major research question was; what family factors encourage/discourage child sexual abuse disclosure at Thika Level 5 Hospital in Kiambu County? The stuyd was carried out at Thika Level 5 Hospital (TL5H) in Kiambu County, Kenya. Data collection included in-depth interviews and survey questionnaires. The study utilized a convergent mixed method design. Descriptive and thematic approaches were applied to analyse qualitative data. The study found that family characteristics such as positive relationships acted as social processes that encouraged survivors to participate in the disclosure process. Emotional and physical support from trusted adults or family members played a significant role in CSA disclosure, especially during the treatment process. The stuyd recommends that the Cabinet Secretary in the Ministry of Gender, Youth and Social Development craft new laws and policies that mandate adults in Kiambu County to report Child Sexual Abuse as soon as it occurs.*

Keywords: *Child, Sexual Abuse, Family Factors, Disclosure, Thika*

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1. Introduction

Child Sexual Abuse (CSA) is categorized as a form of child abuse and is one of the most confusing and perplexing problems facing many societies in the world. CSA is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society (World Health Organization, 2003).

Wihbey (2011) writes, Center for Disease Control (CDC) established that globally, 11% and 4% of high school girls and boys respectively had reported CSA. However, cases of under-reporting were common due to the stigma associated with Child Sexual Abuse. Pereda, Guilera, Forns and Gómez-Benito (2009) analysed 65 research studies in 22 countries and found 7.9% of males and 19.7% of females world-wide experienced CSA before they turned eighteen. In North America, prevalence of CSA was 7.5% and 25.3% for males and females respectively while Europe had a prevalence of 9.2%. CSA prevalence for Asia and Africa stood at 23.9% and 34%, meaning Africa had the highest incidence of CSA. Specific to various African countries,

prevalence rate for South Africa was highest at 61% for males and 43.7% for females; Tanzania had 25% and 31.0% prevalence rate among males and females respectively (Pereda, Guilera, Forns and Gómez-Benito, 2009). Kenya's reported CSA incidence was slightly lower at 22% and 17% for male and females respectively (Sumner et al., 2015). A report by UNICEF (2014) indicates that more than 10% of Kenyan females experience CSA before 19 years. The same report indicated at least 37% of those victims were abused before they reached 10 years. UNICEF noted that 24% of the male victims experienced their first CSA before they reached 14 years. Across the globe, CSA is a predominant problem and needs to be addressed to support survivor's recovery.

A study by Ulibarri, Ulloa, & Salazar (2015), found CSA to be associated with both depression and Post-Traumatic Stress Disorder (PTSD). CSA causes suffering for the survivors, families and communities while lack of CSAD or delayed CSAD is associated with PTSD and other mental health problems (Cantón-Cortés, Cortés, & Cantón, 2012; Easton, 2013; Karakurt & Silver, 2014; Vizard, 2013). The survivors of CSA are known to develop a sense of hopelessness, shame, and fear especially if the abuse continues (Easton, 2013).

Child Sexual Abuse cannot be alleviated without disclosure, making it necessary to establish CSAD factors as a pathway to increase community resources (e.g., mental health and social services) for survivors. Research continues to motivate medical professionals and service providers to address mental health issues and post traumatic disorder (PTSD) related to CSA (Ulibarri et al., 2015). Sufficient mental health and social services, both formal and informal, encourage survivors to seek support to minimize the effects of trauma during the CSAD process (Vizard, 2103). If CSA survivors feel safe in the hands of supportive confidants and trained staff, they are more likely to give full disclosure (Jackson et al., 2015; Vizard, 2013). Awareness of resources makes survivors safe throughout recovery.

CSA affects the health of a community, but it is highly unreported. Perpetrators mask their behavior from community and survivors and appear normal and harmless hence increasing threat (Jackson et al., 2015). They manipulate and groom survivors, and as long as no disclosure is made, abuse continues without intervention. CSA survivors live with grave fear and shame, fear of breaking families and not being believed after disclosure (Jackson et al., 2015). To reduce the negative effects of CSA in Kenya, a documented list of accessible programs and community resources for the survivors may be beneficial. Few studies have considered the issue of CSA, and most of the past studies were done in western countries (e.g., Unites States of America). At a time when CSA is regarded as a global issue, a study investigating CSAD factors helps to improve understanding of the factors that promote or inhibit CSAD. Secondly, CSAD is listed as one of the coping mechanisms for survivors (Jackson, Newall & Backett-Milburn, 2015).

CSA is both a Social Justice and Public Health issue that continues to affect many societies around the world (Spröber et al., 2014; Vizard, 2013). There is scarce data on disclosure both globally and in Kenya. In Kenya, CSAD is expected to be minimal due to the level of silence and secrecy that surrounds the vice (Vizard, 2013). Due to the high levels of secrecy, silence and stigmatization, its impact has not been adequately analyzed. Fear of CSA survivors being stigmatized, and the encountered feelings of shame contribute to less disclosure and few studies on CSA (Jackson et al., 2015; Karakurt & Silver, 2014).

It is on this premise that the study purposed to examine the understanding of Child Sexual Abuse Disclosure from participants' perspective in relation to family factors at Thika Level 5 Hospital in Kiambu County, Kenya. The major research question was; what family factors encourage/discourage child sexual abuse disclosure at Thika Level 5 Hospital in Kiambu County?

2. Literature Review

Family social functioning examines the immediate relationships between child and family members. These relationships create a base for intergenerational socialization. Research indicates that both parenting, and parent-child relations determine a child's behaviour. Positive parent-child relationship promotes disclosure while positive communication between child and parents acts as a prevention and intervention aspect for children (Bentovim & Elliott, 2014; Menja, 2011; Tashjian, Goldfarb, Goodman, Quas, & Edelstein, 2016). Collin-Vézina et al., (2015) identified other factors that contribute to CSAD including violence and dysfunction in the family, power dynamics, and awareness of the impact of telling, a supportive confidant and fragile social network influence CSAD. Another longitudinal study indicated a positive relationship between spousal abuse and neglectful parenting (Nicklas & Mackenzie, 2013).

Survivors experiencing negative responses and lack of supportive adults, including family members and relatives, may discourage children from disclosing (Bentovim & Elliott, 2014). Hence, any strategies to increase CSAD awareness must be family focused. Parents and caregivers must be sensitized to monitor children's behaviour and ask questions if abuse is suspected. All survivors require a confidant to trust and one who can believe. To reduce the possibility of repeated CSA, a confidant must intervene as soon as the survivor discloses abuse (Jackson et al., 2015). However, in cases where the parent-child relationship quality is strong and positive, the family member who is told about the abuse may choose to believe and support the survivor instead of rejecting the child's allegations (Bentovim & Elliott, 2014). Supporting and believing the survivor is associated with reduced trauma and

increased disclosure since parents and family members play a significant role on a child's personal and environmental factors. Positive caregiver-child relationship is stronger among high social economic status families while lack of parental effectiveness is associated with frequent occurrence of child abuse in the home; meaning, unmet emotional and physical needs, child behaviour manipulation, strict parents, and punitive parental behavior were established as factors that inhibit CSAD (Bentovim & Elliott, 2014).

In a country like Kenya where discussion on sexual related matters is regarded as a taboo, most families dictate secrecy. The religious cultural beliefs shared with children by a certain tribe affect the likelihood that a survivor will tell someone (e.g., Bentovim &Elliott, 2014). Sometimes adults fail to intervene because of fear of breaking norms or experiencing stigma and discrimination (Easton, 2013; Kisanga et al.,2011). Children who expected negative consequences (e.g., physical punishment, death threats, loss of relationship), because of reporting someone, delayed disclosure (Malloy, Brubacher, & Lamb, 2011). Older family members, responsible caregivers, relatives and social workers entrusted with the role of protecting children within a social group are more likely to tell something "is not right "during abuse. In such cases, creating opportunities for the survivors to disclose leads to a pathway for intervention (Townsend, 2016). Also, negative responses received by the CSA survivors have been linked to more mental health symptoms (Jackson et al., 2015; Malloy et al., 2011)

3. Methodology

The study was carried out at Thika Level 5 Hospital (TL5H) in Kiambu County, Kenya. The study subjects included survivors, caregivers and service providers using a mixed method analysis. Interviews were conducted with 30 CSA survivors (25 girls and 5 boys: 5-17 years), 30 caregivers, and 10 health and service providers. Data collection included in-depth interviews and survey questionnaires. TL5H and participants were achieved through purposive selection. The study utilized a convergent mixed method design. The design entailed QUAL (investigative open-ended questions and storytelling) approach with a QUAN component (structured survey) to identify CSA survivor's experiences while receiving medical treatment and therapeutic intervention at TL5H.

Descriptive and thematic approaches were applied to analyse qualitative data that revealed survivors' lived experiences with CSA. Informed by Bronfenbrenner's Socio-Ecological Model (SEM), saliency analysis was applied to code the recurring and important themes from the data in order to identify which factors (child, familial, perpetrator, and societal) played an important role in disclosure process.

4. Results and Discussion

4.1 Results

It was necessary to study the family characteristics in terms of relationships between caregivers and the survivors at the time of CSA and disclosure. The researcher sought to know whether the survivors had access to positive and supportive relationships; and if their immediate families were undergoing heightened conflict that may have affected the disclosure process negatively. These responses are presented in Table 1, which indicated that 60% (n=18) of the survivors originated from families that were going through a conflicted relationship, as opposed to 40% (n=12) of the children whose families displayed close familial ties or relationships.

Table 1: Family and Societal Characteristics

Variable of respondent (n=30)	Categories	Frequency (n)	Percentage (%)
Gender	Male	4	13.3
	Female	26	86.7
Age cohort	31-40 years	8	26.7%
	41-50 years	18	60.0%
	51-60 years	4	13.3%
Caregiver's level of education	High School	13	43.3
	College	6	20.0
	None	11	36.7
Occupation	Casual laborer	17	56.7%
	Not employed	10	33.3%
	Professional	3	10.0%
Marital status	Married	17	56.7%
	Single	10	33.3%
	Other	3	10%
Economic provider of the CSA survivor	Father	4	13.3
	Mother	5	16.7
	Father and mother	6	20.0
	Grandmother	4	13.3
	Perpetrator	3	10.0
	None	8	26.7

Examples of conflicted relationships included parents who had reported being deserted by their spouses as soon as CSA was discovered. Some caregivers reported having fled from their matrimonial home immediately after disclosure because the perpetrator was a spouse; and others reported having been separated or divorced before the abuse happened. During the interviewing process, some caregivers said they hesitated reporting abuse in fear of what the disclosure would bring into their marriages:

> *"I did not want to report the abuse because it would have caused a rift in my marriage…." (Parent 3)*

> *"…my husband was very violent after he discovered the abuse…. I left him… now I live with my brother because he supports me and my child through this…" (Parent 21)*

Mainly, for the families that reported hostile atmosphere, they blamed it on the sexual abuse of their children. Another male caregiver admitted having struggled with the process of disclosure even though his spouse was fully supportive to their child:

> *"I love my wife very much, but this case is challenging us…. I am afraid the community will know…" (Parent 10). In addition to marital problems, some of the children expressed having been neglected prior to the abuse by either one or both parents. A 6-year-old child narrated her ordeal and how she waited for several day without any adult to listen to her story of abuse.*

> *"My father left us long time ago, we have to help ourselves with food…I did not know who to tell" (Child 11)*

Another 17-year-old female survivor did not report the abuse to her father. She claimed that she was not

comfortable telling her father because he was a violent person:

> *"…my father chased my mother away…a week before I was abused…our youth pastor discovered my abuse three days after the rape happened…" (Child 16).*

Different survivors elaborated on some of the family dysfunctions that existed in their home environments which either made them delay disclosure or refuse to disclose at all. A 12-year-old female survivor described that she refused to disclose fearing her father would get more violent towards her mother:

> *"…I did not want my father to leave my mother… (Child 5)*

On the other hand, some survivors felt supported by caregivers; for example, 17-year-old male survivor told the researcher that they had a "good relationship" with his parents and that helped him share his rape experience immediately after it occurred. This high school student who had been sexually assaulted by his male teacher confessed that the relationship with his parents made him feel free to narrate his rape ordeal to them.

> *"I was able to talk about anything with my parents freely…I knew that they would believe my story…" (Child 30).*

4.1.1 Caregiver's Education Level

It was important to ascertain that the caregivers understood the research questions and the purpose of the study, well enough to provide meaningful responses. The researcher used their education level to gauge their understanding which also dictated how the question was phrased to the caregiver. The education level was gauged depending on the grade level each survivor had acquired by the time of the research. These education levels were divided into three main categories (i.e., High School, College and None). Frequencies and percentages were obtained from the responses and results are presented in Table 1. The results on the level of caregiver education revealed that 43.3% (n=13) of the caregivers had high school level of education; 20% (n=6) had some college education; and 36.7% n= 11) of the caregivers reported no education.

It was important to note that some of the caregivers that had at least a high school diploma said they immediately knew how to react to their children's CSA incidents. They also understood the purpose of reporting the matter to the police. For example, the researcher asked caregivers a standard question, "kindly share some of the cultural practices or beliefs which can affect your decision regarding CSA advocacy". After follow-up questions, some of the caregivers' responses included, "having received some training in school or received some formal education where they learned about advocacy, child abuse and signs of abuse:

> *"I knew something was wrong when I noticed the swollen stomach…She did not want to tell me until I told her we were going to the police…then she said her friend's dad raped her..." (Parent 24).*

> *'My child started vomiting every morning…the nurse tested her for pregnancy…she said her uncle raped her while I was at work…" (Parent 14)*

> *"I noticed my daughter having trouble with walking…. that right there made me know someone might have touched my child…" (Parent18)*

Other parents said they had worked in an environment that exposed them to awareness of government institutions and their functions, such as Children Protective Services, Gender Violence Desk and Law enforcement. The 17-year-old survivor's caregiver, whose son had been abused by a teacher, claimed that his pastoral job and education helped him understand the measures to take against his son's perpetrator. This caregiver (parent 30) explained the steps he had taken to have the perpetrator arrested. He also used his resources to provide the law enforcement officers with transportation to the police station:

> *"I used my money to fuel the police vehicle…I am not going to give up because I know my son's rights...I will involve the media if I need to for my son's perpetrator to pay for what he did…" (Parent 30).*

4.1.2 Caregivers' Awareness of Child Sexual Abuse

The method, through which CSA was revealed to the caregiver, was captured by the researcher through the options provided to the participants: discovery (accidental/unintentional discovery by caregiver) and intentional disclosure by the survivor after the abuse. Child survivors, together with the caregivers confirmed either of the options as described in Table 1. From the responses, 60% (n=18) were brought to the knowledge and attention of the caregivers after disclosure by the survivor; while 40% (n=12) of the cases were never disclosed until the caregiver discovered, accidentally or intentionally, that abuse had occurred. Some of the caregivers said they discovered abuse after their children exhibited one or more signs of abuse:

> *'My child started vomiting every morning…the nurse tested her for pregnancy…she said her uncle raped her while I was at work…" (Parent 14)*

"I noticed my daughter having trouble with walking…. that right there made me know someone might have touched my child…" (Parent18)

The study also discovered that some survivors were brought to the TL5H for sexually transmitted infections; however, the caregiver did not understand the source of those illnesses until the child disclosed to the medical provider about the sexual abuse. Whether the child disclosed immediately or delayed the disclosure, the symptoms prompted the caregiver to take the next step of helping the survivor. Parent 14 would never have known about the abuse were it not for the vomiting that started to happen every morning. This parent told the researcher that at first, she assumed that her daughter had contracted malaria. Parent 14's discovery in this study is categorized as "unintentional" because the child did not purpose to disclose the abuse. On the other hand, the 17-year-old male survivor who had also reported having a good relationship with his parents, willingly made an "intentional disclosure" to his parents:

"I was able to talk about anything with my parents freely…I knew that they would believe my story…" (Child 30).

4.1.3 Economic Provider for Survivor

The study examined the social economic status of the survivor by evaluating who was financially supporting the child at the time of abuse. Different sources of economic supporters were identified (father, mother, both parents, grandparent, perpetrator and non-relative). The responses were subjected to frequencies and percentages and the results are presented in Table 1. The results revealed that 26.7% (n=8) of the children that disclosed abuse had no economic supporter; 20% (n=6) were supported by father and mother, 16.7% (n=5) by the mother and 13.3% (n=4) by father; 13.3% were supported by a grandmother; and 10% (n=3) were supported by the perpetrator.

It is worth noting that the lowest percentage of the survivors who reported CSA were being economically supported by the perpetrator. Several survivors described that they did not want to make a disclosure because the perpetrator threatened to withdraw their economic support if abuse was disclosed; in addition, a perpetrator like the one who abused Child 20 declared a bribe to prevent the survivor from telling anyone:

"…I did not want to go back home…. he said that he would not give us money for food… he said if I told anyone he would go to jail and would not see him again… (Child 8)

"I tried to stop my dad from getting into my bed…he said I cannot tell mom…he promised to buy a phone for me" (child 20)

Even if the perpetrator did not use a threat to withdraw support, some survivors assumed that they would lose the support once a disclosure was made:

"…I didn't want to report because he gave us milk all the time… (Child 3).

4.1.4 Effects of Abuse on Survivor

From the current study, there emerged a common theme amongst the survivors and as reported by the caregivers - effects of CSA on the survivors. Although this was not a standard interviewing question, it was worth recording since the effects of CSA seemed somehow interrelated with "Caregivers' Awareness of Abuse". From the responses in Table 2, 50% of the survivors suffered an illness after abuse; 26.7% of the children suffered from other effects resulting from abuse; and 23.3% of the survivors ended up with an unwanted pregnancy.

Table 2: Caregiver, Perpetrator and Institutional Characteristics

Variable of respondent (n=30)	Categories	Frequency (n)	Percentage (%)
Time lapse before disclosure	Immediately	9	30
	Delayed	14	46.7
	Never	7	23.3
Feelings after abuse	Fear	14	46.7
	Shame	7	23.3
	Anger	4	13.3
	Not understanding	5	16.7
Threatened against disclosure	Yes	30	100
	No	0	0
Type of threat	Denial of support	4	13.3
	Harm (physical harm)	24	80
	Death	2	6.7
Caregivers knowledge of abuse	Caregiver discovery	12	40
	After survivor's disclosure	18	60
Caregiver's initial response	Denial	11	36.7
	Believed	10	33.3
	Defensive	9	30
Effects of abuse on survivor	Illness	15	50
	Pregnancy	7	23.3
	Other	8	26.7
Law enforcement responses	Yes	12	40
	No	18	60

According to the doctor's records, it appeared that some of these perpetrators were multiple offenders given the presence of sexually transmitted diseases (STD) or HIV AIDS to the survivors. Figure 1 is an example of some of the effects of abuse, which the medical officers translated as an indication that the perpetrator used the mark "nine" on the survivor's arm to indicate that this was the nineth victim of rape.

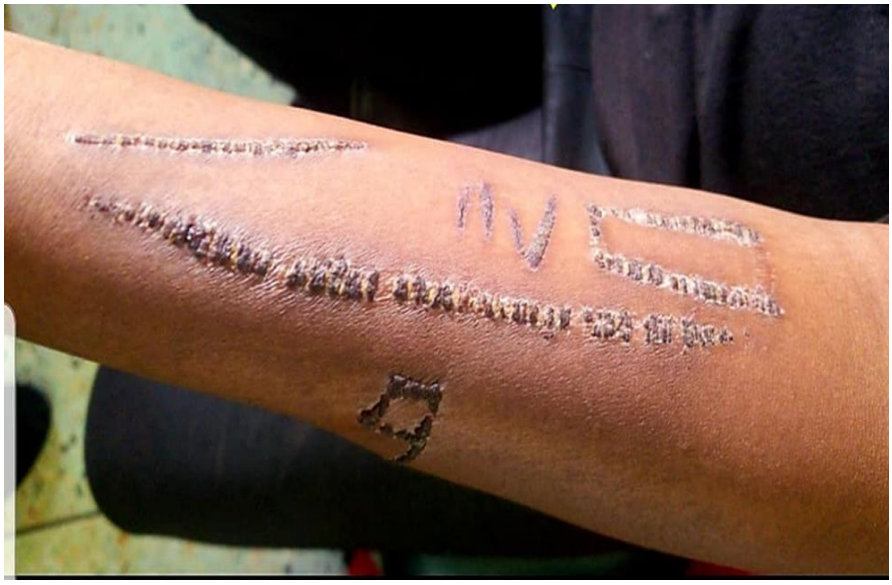

Figure 1: 17-Year-Old Female Survivor (Child 16) Sexual Assault Related Markings.

In additional to the marks, this survivor bore other deep cuts all over her body. Likewise, to the idea of "Caregivers' Awareness of Abuse", some of the caregivers described that disclosure happened after they discovered the effects the abuse had on their children:

"The Sunday School `teachers noticed my daughter was in pain…they questioned her and that is when she said that someone had attacked her while walking home…" (Parent 16).

On one Friday afternoon, Child 16's perpetrator had raped and marked his victim before abandoning her in a building. When the child returned home, her mother was not there. Her father, who had chased her mother away after a domestic violence incident; and not knowing about the assault, forced Child 16 to go to church on Sunday- three days after the assault. Both the cuts and sexual assault resulted to unbearable emotional and physical turmoil which alarmed her Sunday School teachers that the survivor was in pain. Subsequently, the teachers questioned the child about the cuts on her body which led to disclosure. Once the teachers established the details of the assault, they contacted the mother and reported the matter to the local subchief.

> *I was not crying…it was hard for me to sit in class…so the teachers asked me what was wrong…I told my Sunday School teachers what happened. Then one of the teachers took me to the dispensary near my house before my mother arrived… (Child 16)*

Other caregivers narrated the effects of abuse such as sexually transmitted diseases, pregnancy, child running away, inability to walk, crying, bleeding from private parts, survivor displacement from home, withdrawing or being expelled from school facilitated the CSA discovery or disclosure. Some of the caregivers reported they became more proactive in the disclosure process after recognizing that the abuse had long term effects on their children:

> *"She is on medication for Sexually transmitted disease (STD)…" (Child 5)*

> *"At first, I did not believe that my child could be pregnant...I thought her stomach was big…" (Child 2)*

> *"I bring my child here (TL5H) for monthly treatment because she was infected with HIV by her uncle…" (Child 11)*

Some of these effects were the reasons the caregivers brought their children to TL5H while other caregivers claimed the effects acted like a "confirmation" that SA happened; hence, believed their children were telling the truth: "It was very hard to accept that my child had been abused by her father…*I initially believed my husband when he denied having touched my child…but I noticed my child's walking style was abnormal" (parent 4).*

Consequently, some of the major life changing effects of abuse, such as pregnancy and illnesses, motivated some of the caregivers to follow through with reporting the abuse to the authority as well as completing the disclosure process.

4.1.5 Caregivers' Initial Response

Since the survivors had expressed having received mixed responses from their caregivers after making the disclosure (e.g., caregiver denial, disbelief, defensiveness, etc.). Caregivers were asked a standard question, "describe the outcome after the child disclosed" and their responses captured in Table 2 whereby 36.7% (n=11) exhibited denial. The researcher established that the caregivers expressed denial if the perpetrator was a relative:

> *"It was very hard to accept that my child had been abused by her father…I initially believed my husband when he denied having touched my child…but I noticed my child's walking style was abnormal…" (Parent 4).*

Additionally, 33.3% (n=10) immediately believed that the abuse had occurred. Here is an example of a response from a caregiver who trusted their child to tell the truth.

> *"I had to believe my son because we are always open…my son is not a bad child…but when he failed to come home, I knew something was very wrong…he always calls me whenever he is about to get late to come home…the first thing he said after he arrived home… mom please let me explain what I went through… (Parent 30).*

Finally, the rest of the caregivers, 30% (n=9) of the caregivers became defensive upon learning about their child's abuse. Consistent with the caregivers who responded with denial, other caregivers revealed they initially defended the perpetrator (relative) rather than supporting their child:

> *"I defended the perpetrator because he was a good cousin, there is no way I let my child get assaulted by him…" (Parent 12).*

> *"My first reaction was, there is no way my own brother could do that…I thought my child was lying to me…" (Parent 9)*

4.1.6 Time Lapse before Disclosure

The researcher sought to establish from survivors the time that elapsed from the actual abuse to when disclosure was made. Three options were provided as immediately, delayed and never disclosed. Research

findings are presented in Table 2. Concerning the duration that elapsed between the actual abuse and disclosure, it was established 30% (n=9) of the survivors reported immediately; 46.7% (n=14) of the survivors delayed disclosure; and 23.3% (n=7) of the cases were never disclosed until someone else discovered. This implies that over two thirds of the abuse cases are not disclosed within reasonable time for medical-preventive measures to be given. Some of the delayed disclosure resulted to manifestation of serious health effects associated with the abuse (e.g., illness, pregnancy) as described by the caregivers: TL5H Clinical Management and Referral Centre administers preventive treatment that minimize or eliminate the effects of sexual abuse on the victim's health and body. Unfortunately, some of the caregivers admitted that delay of disclosure resulted to unwanted pregnancies and manifestation of Sexually Transmitted Diseases:

> *"She is on medication for STD…" (Parent 5) "At first, I did not believe that my child could be pregnant... I thought her stomach was big…" (Child 2)*
>
> *"I bring my child here (TL5H) for monthly treatment because she was infected with HIV by her uncle…" (Child 11)*
>
> *"I knew something was wrong when I noticed the swollen stomach…She did not want to tell me until I told her we were going to the police…then she said her friend's dad raped her..." (Parent 24).*

4.2 Discussion

According to the current study, family functioning (e.g., aggregated responses of caregivers, family relationship, etc) were captured through the interviews and narratives by participants as some of the important elements and behaviors surrounding the disclosure process at Thika Level 5 Hospital. Family characteristics such as positive relationships acted as social processes that encouraged survivors to participate in the disclosure process. CSA experience is a stressor to a family and the process of disclosure, especially if a family member is a perpetrator which may cause extra strain on the relationship.

In consistency with past research, the study established that caregivers who observed their children's behavior after abuse were more likely to detect CSA; hence, more likely to encourage disclosure (Bentovim & Elliott, 2014; Jackson et al., 2015). Some of the caregivers reported having seen their children "looking sick", "enlarged bellies as a result of pregnancy", or "discomfort" which prompted them to probe further and later discovered that the change of behavior was a result of illness due to sexual abuse.

Additionally, caregivers brought their children to the hospital to follow up with treatment since they wanted to support their children through the disclosure and treatment process. This positive support and believing the survivor's story is documented in past research as an enhancer for CSAD (Schonbucher et al., 2012). Being in a supportive relationship with family members and older adults acted as an intervention aspect for the survivors since it helps to stop abuse and also as a predictor of disclosure.

During the interview, a few survivors sat on their guardians' lap which made the children more relaxed during the disclosure process. Other times the children held onto their guardians' hands and looked up to their faces as if the adults in the room were their reference points and a green light to continue narrating the CSA stories to regain support and assurance that it was okay to tell their stories to the researcher. The importance of such emotional and physical support from trusted adults or family members during disclosure and treatment is supported by past research that suggests disclosure can be increased by supporting children to disclose (Townsend, 2016; Easton, 2013).

Caregivers and survivors valiantly reported dysfunctional families and lack of support from family members as the main reasons that caused the delay in disclosure. Inconsistent with recent research, McCarthy, et al., (2019), the current study demonstrated more female parents (87%) supported their children through disclosure process and treatment. A female guardian explained that she had requested her husband to accompany her to TL5H, but he declined and told the child "that is your mother's issue", which may be supported by past research, that claimed maternal support was one of the most important protective factors for survivors' healing after CSA (McCarthy, et al., 2019).

5. Conclusion and Recommendations

5.1 Conclusion

Family characteristics such as positive relationships acted as social processes encouraged survivors to participate in the disclosure process. CSA experience is a stressor to a family and the process of disclosure, especially if a family member is a perpetrator which may cause extra strain on the relationship.

The caregiver's support was critical in influencing children's sexual abuse disclosure. This was specifically on emotional and physical support from trusted adults or family members during the disclosure and treatment process.

5.2 Recommendations

This research recommends the following policies to support CSAD in TL5H:

i. The Cabinet Secretary in the Ministry of Gender, Youth and Social Development craft new laws and policies that mandate adults in

Kiambu County to report Child Sexual Abuse as soon as it occurs.

ii. The national assembly strengthens existing laws and policies to support and encourage survivors to report the CSA. All adults should be sensitized to inform children workers and service providers about these policies that safeguard children.

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