

Factors associated with perceptions of child sexual abuse and lack of parental knowledge: a community-based cross-sectional study from the Eastern Province of Saudi Arabia

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BACKGROUND: Child sexual abuse (CSA) has serious consequences that can affect the physical, social and mental health of a child. In the last two decades, concern about CSA has increased around the world including Saudi Arabia.

OBJECTIVE: Evaluate factors associated with parental perceptions and knowledge of CSA.

DESIGN: Cross-sectional survey.

SETTINGS: Primary health care clinic.

SUBJECTS AND METHODS: Simple random sampling was used to select participants. The main tool for data collection was a self-administered questionnaire.

MAIN OUTCOME MEASURES: Factors associated with knowledge and perceptions of CSA.

SAMPLE SIZE: 400.

RESULTS: Most respondents (69%) had good knowledge of the signs of sexual abuse in children. For perception scores, statistically significant variables were age ($P=.004$), educational level ($P=.005$), income ($P<.001$), number of wives ($P=.004$), number of male children ($P=.021$), and number of female children ($P=.027$). For knowledge scores, statistically significant variables were income ($P=.008$), number of wives ($P<.005$), number of male children ($P=.003$) and number of female children ($P<.003$). Logistic regression showed that the older age group was significantly associated with a good perception score ($P<.046$).

CONCLUSIONS: Risk factors for parental lack of knowledge and poor perception associated with CSA are poverty and low education. Protective factors included the older parent age, size of the family and families with more than one wife. Education should be designed for parents and the community to increase the knowledge and perception of CSA.

LIMITATIONS: Single-center study and short study period.

CONFLICT OF INTEREST: None.

Child sexual abuse (CSA), a major public health concern worldwide,^{1,2} has been called a “silent health emergency”,³ but one that is amenable to change. CSA has been defined as the unwanted contact or non-contact sexual experience perpetrated on a child and/or act of sexual intercourse between an adult and a child.^{4,5} The problem of CSA and the devastating short- and long-term health consequences, manifesting as physical, mental and psychiatric disorders, are well-documented.^{1,6,7} The World Health Organization (WHO) has estimated that 40 million children annually are victims of child abuse and neglect by the age of 14 years.^{8,9} The psychological health problems that result from CSA are growing at an escalating rate.^{10,11} Prospective studies on CSA are difficult to carry out for ethical and legal reasons.² The prevalence rate of CSA in Africa was 34%¹¹ and more than 50% in Swaziland.² However, other studies have reported that Europe is the global center for the hosting of CSA—The Internet Watch Foundation reported that 60% of images of abuse were found. In Saudi Arabia, earlier studies reported significant figures for CSA (56.3%),⁶ with a majority of the cases involving primary school students, and the place of assault was mainly at the victim’s home. In the study in Saudi Arabia, CSA was significantly more frequent in older children (13 and older) Nonsexual assault more often involved children of younger ages.

Internationally, a number of research studies have examined parent’s perceptions of maltreatment directed toward their children, about violence and specifically about sexual abuse.¹²⁻¹⁸ Ige and Fawole (2011) explored the perceptions of Nigerian parents of CSA and found that the majority knew about a CSA incident. Of these, only 18.8% defined CSA as sexual intercourse with a child. Most (84.2%) of the respondents agreed that CSA occurred in their community.¹⁹ However, only 34.6% agreed that CSA could have serious health impact even if there was no actual contact. Even though a good proportion of parents (70.3%) agreed that CSA was most often committed by familiar adults, 45.2% of the parents agreed that boys could also be sexually abused. Furthermore, 46.8% of the parents felt their children could not become victims of CSA. Systematic reviews of prevalence estimates and health consequences of CSA are important for the development of prevention programs and the provision of support.²⁰

Parents and family members are thought to be significant actors in defending their children from any activity that is prohibited, including sexual abuse.¹ Knowledge and perceptions of responsible parents are influential in the prevention of sexual abuse, so it is of interest to determine if parents and the general community in

Saudi Arabia have any basic knowledge of CSA and to understand their perceptions of CSA. There is a need to conduct detailed research on parental knowledge and perceptions about sexual abuse. The objective of this study was to evaluate factors associated with parent’s lack of knowledge and to understand perceptions about child sexual abuse in Saudi Arabia.

SUBJECTS AND METHODS

A cross-sectional survey was conducted at the Primary Health Care Center (PHCC) of Imam Abdurrahman Al-Faisal Hospital in Dammam, one of the National Guard Health Affairs Medical Cities. All adult males and females who attend the PHCC in Dammam were included in the study. Parents of children older than 18 years old, parents with no children, singles, and parents with psychiatric disabilities were excluded from the study. Necessary permission to conduct the study was obtained from King Abdullah International Medical Research Center (KAIMRC). Before participation, every subject was briefly informed about the study and confidentiality of the information, and his/her verbal agreement to participate in the study was assured before his/her involvement in the study.

A simple random sampling technique was used to collect the data in which each sample has an equal probability of being chosen. Parents and attendance who are attending the primary health care center during month of December 2014 were selected for the study. A well-structured questionnaire was developed from an extensive literature review of studies of CSA.^{19,21} The questionnaire was composed of closed-ended questions and contained sociodemographic and family data. It assessed parental perception about CSA myths, assessed with the CSA myths scale.^{19,21} This scale consisted of 10 items with response choices on a 3-point Likert scale of “agree” “disagree” and “unsure”. An affirmative response to each item was given a score of 1, while negative or unsure responses were scored as 0. The questionnaire was translated into Arabic, then translated back to English to ensure consistency in meaning before data collection. A pilot study was conducted at PHCC of Imam Abdurrahman Al-Faisal Hospital in Dammam and the PHCC in AlKhobar, under supervision of the investigator for the purpose of evaluating the response of the subject, measuring the validity of the questionnaire, testing the study tools; and choosing the best manner of data collection and management. The pilot study, completed in 2 weeks, involved 44 subjects. All the necessary additions or changes in the study tools were made. The results of the pilot study are not included in the report of the

main study. Cronbach alpha, used as a measure of reliability, was 47.0% for the parents perception score and 63.0% for the knowledge score. The perception scale consisted of 10 items with response choices being on a 3-point Likert scale of "agree," "disagree," and "unsure." Negative responses are scored one point, unsure responses scored two points, and affirmative responses scored three points. Thus, the range of total scores on this instrument was 10 to 30 points below 10 considered as poor 10-20 average 20 to 30 points considered as good. Based on attendance trends in the PHCC, a sample size of 374 subject was calculated as enough to produce a 95% confidence interval with 5% accepted margin of error when the estimated proportion of CSA was 50.0%, using the Raosoft sample size calculator.²¹ Ten percent was added to the required sample size to overcome any rejected or incomplete questionnaire.

The data analysis was done by using statistical package for social science SPSS version 22 for Windows (SPSS) for analysis. Descriptive statistics including percentages and frequency distribution were calculated for each variable. The chi-square test was used to assess the significance of differences between categories. Significant variables were subjected to multiple logistic regression to find any relationship between categorical variables and parent scores as the dependent variable (good or poor perception and knowledge).

RESULTS

There were 411 study participants, but 11 questionnaires were excluded because of incomplete data, leaving 400 subjects for a response rate of 97.3%. Sociodemographic characteristics are shown in **Table 1**. The majority of the participants were married (n=366, 91.5%), and most of the families were composed of one wife (n=218, 84.5%). Ninety-three percent (n=369) of families were composed of more than five male children and almost the same proportion had more than five female children.

Of the 400 participants, the majority (n=330, 82.5%) agreed that CSA occurred in their community (**Table 2**). Almost three-quarter of participants (n=248, 71%) scored high on perception of CSA, while (n=116, 29%) scored poorly. Parents were asked about the signs of sexual abuse to assess their ability to recognize sexual abuse. The highest percentage was for sudden withdrawn behavior (n=356, 89.6%), followed by unusual fear of being left alone with a given person (74%), while the least identified sign was abnormal interest in or curiosity about sex or genitals (50.4%) (**Table 3**). Most parents scored good on knowledge of signs of sexual abuse in children (n=276, 69%).

Table 1. Sociodemographic characteristics of parents in primary health care center (N=400).

Variables	Number of patients (%)
Age (years)	
18-35	185 (46.6)
36-55	201 (50.6)
>55	11 (2.8)
Sex	
Male	231 (57.8)
Female	169 (42.2)
Occupation	
Not working	100 (30.4)
Military	140 (42.6)
Civilian	81 (24.6)
Retired	8 (2.4)
Education level	
Low	42 (10.7)
Average	286 (73)
High	64 (16.3)
Income	
Low (<9999 SAR)	66 (16.6)
Average (10000-19999)	224 (56.4)
High (>20000)	107 (27)
Marital status	
Married	366 (91.5)
Divorced	24 (6.0)
Widowed	10 (2.5)
Number of wives	
One	218 (84.5)
More than one	40 (15.5)
Number of male children	
<5	369 (93.2)
>5	27 (6.8)
Number of female children	
<5	370 (93.4)
>5	26 (6.6)

Fewer than 10 missing observations for all data except number of wives (data missing for 142 males).

Tables 4A shows the statistical relationship between sociodemographic features and perception scores. Variables that were significantly associated with good perception score were, old age ($P<.004$), low education level ($P<.005$), low income ($P<.001$). There were statistically significant differences between families who consisted of more than one wife, more than five male children or more than five female children in perception of CSA (**Table 4B**). There were statistically significant differences between parents with low income who had a good knowledge score (**Table 5A**), more families who consisted of more than one wife, more than five male children; or more than five female children had a good knowledge score (**Table 5B**).

Table 2. Parental perceptions of child sexual abuse.

Variables	Agree	Disagree	Not sure
Child sexual abuse is a common problem in our society	330 (82.5)	20 (5.0)	50 (12.5)
Abuse is only serious when it involve intercourse	231 (57.8)	60 (15.0)	109 (27.2)
Homosexual abuse is more serious than heterosexual abuse	215 (53.8)	55 (13.8)	130 (43.5)
The child who was sexually abused is not to be blamed	167 (41.8)	58 (14.5)	175 (43.8)
Most sexual abuse is committed by someone the child know and trusts	158 (39.5)	64 (16.0)	178 (44.5)
Female adult cannot sexually abuse children	151 (37.8)	91 (22.8)	158 (39.5)
Boys can be sexually abuse	199 (49.8)	92 (23.0)	109 (27.2)
It is only wayward children who are sexually abused	218 (54.5)	72 (18.0)	110 (27.5)

Values are number (percentage).

Table 3. Indications of child sexual abuse.

	Affirmative response
Sudden withdrawn behavior	356 (89.6)
Unusual fear of being left alone with a given person	291 (74.0)
Abnormal interest in or curiosity about sex or genitals	198 (50.4)
Genital/anal injuries	212 (53.0)
Refusal to undress	242 (61.7)

Values are number (percentage).

Logistic regression showed no significant association between perception score and these variables. The only variable significantly associated with a good perception score was age group (**Table 6**). For the knowledge score, logistic regression showed no significant associations for any of the variables (**Table 7**).

DISCUSSION

The concept of CSA is unknown in Arab countries with regards to cultural beliefs and family dynamics. Numerous recent reports document child abuse in Arabian countries.^{24,25} The current study reveals that the majority of Saudi parents had adequate knowledge and perception of CSA, which is consistent with other

published studies in Arab countries.²⁶⁻²⁹ This adequate knowledge and perception about CSA in the Saudi population could reflect the high educational level of Saudi parents and good economic conditions. Parents and elderly persons who know about the signs and symptoms of CSA had sufficient knowledge of CSA.³⁰

The majority of the respondents (83%) agreed that CSA is common in their community, as reported in other studies.^{21,27,31} More than half (57.8%) believed that the problem was serious only when intercourse was involved, while 54% agreed that homosexual abuse is more serious than heterosexual abuse. These results were similar to previous reports from Jordan and other countries.^{27,32} These responses could reflect cultural beliefs and values connected to a religious point of view that rejects homosexuality or same-sex gender. In Saudi Arabia, any form of sexual relations before marriage is offensive. A recently published study on the Saudi population reported that physical abuse was the most common form of sexual abuse (42% of the cases).²⁵ Interestingly, other studies have reported that psychological abuse was most prevalent.¹⁹

The relatively a high response rate in this study indicates that parents are willing to talk, share their fear and answer questions related to sexual violence, even though CSA is a very sensitive issue in this community. This could be the result of the society's recognition of the need to raise awareness and guidance in this particular issue. This high response rate should motivate health care providers to discuss these issues with parents, using proper communication skills in order to control and prevent the problem of CSA in the community. Most perpetrators of CSA are known to the victim and the family.^{1,33,34} However, in this particular study, around 40% of parents did not believe that the majority of abuse cases were committed by a familiar person, and half of the parents believed that boys are safe from sexual abuse. These findings are consistent with previous studies.^{21,35} Furthermore, parents in our study tended to leave their children under the supervision of a trusted adult. This risky behavior could put those children at potential risk and health education in this regards is very much needed. In addition, the majority of parents incorrectly believed that females cannot harm the child. Also, they believed that the abused child shares the fault and should be blamed. This could lead to the loss of trust between the parent and the child and make the children prefer to keep the sexual incident secret, which is likely to make the problem go undetected, as well as to subject them to future psychological complications.

Table 4A. Sociodemographic features of parents by perception score.

Variables	Total	Good	Poor	P value
Age (years)				
18-35	185	118 (63.8)	67 (36.2)	.004
36-55	201	152 (75.6)	49 (24.4)	
>55	11	11 (100.0)	0 (00.0)	
Total	397	281 (70.8)	116 (29.2)	
Gender				
Male	231	162 (70.1)	69 (29.9)	.06
Female	169	122 (72.2)	47 (27.8)	
Total	400	284 (71.1)	116 (29.0)	
Occupation				
Not working	100	76 (76.0)	24 (24.0)	.069
Military	140	100 (71.4)	40 (28.6)	
Civilian	81	57 (70.4)	24 (29.6)	
Retired	8	8 (100)	0 (00.0)	
Total	329	241 (73.3)	88 (26.7)	
Education level				
Low	42	37 (88.1)	5 (11.9)	.005
Average	286	189 (66.1)	97 (33.9)	
High	64	50 (78.1)	14 (21.9)	
Total	392	276 (70.4)	116 (29.6)	
Income (SAR per month)				
Low (<9999 SAR)	66	62 (93.9)	4 (6.1)	<.001
Average (10000-19999)	224	133 (59.4)	91 (40.6)	
High (>20000)	107	87 (81.3)	20 (18.7)	
Total	397	282 (71.0)	115 (29.0)	

Values are number and percentage. Statistical analysis by chi-square test. Data missing for 142 of 231 males. Fisher exact test used for comparisons with cell value <.05.

Table 4B. Family features of participants by perception score.

Variables	Total	Good	Poor	P value
Marital status				
Married	366	256 (69.9)	110 (30.1)	>.05
Divorced	24	18 (75.0)	6 (25.0)	
Widowed	10	10 (100.0)	0 (00.0)	
Total	400	284 (71.0)	116 (29.0)	
Number of wives^a				
One	218	151 (69.3)	67 (30.7)	.004
More than one	40	36 (90.0)	4 (10.0)	
Total	258	187 (72.5)	71 (27.5)	
Number of male children				
<5	370	257 (69.4)	113 (30.6)	.021
>5	26	23 (88.9)	3 (11.1)	
Total	396	280 (70.7)	116 (29.3)	
Number of female children				
<5	369	257 (69.5)	113 (30.5)	.027
>5	27	23 (88.5)	3 (11.5)	
Total	396	280 (70.7)	116 (29.3)	

Values are number and percentage. ^aData missing for 142 of 231 males. Fisher exact test used for comparisons with cell value <.05.

Table 5A. Sociodemographic features of parents by knowledge score.

Variables	Total	Good	Poor	P value
Age (years)				
18-35	185	124 (67.0)	61 (33.0)	>.05 ^a
36-55	201	140 (69.7)	61 (30.3)	
>55	11	11 (100)	0 (00.0)	
Total	397	276 (69.9)	122 (30.7)	
Sex				
Male	231	152 (65.8)	79 (34.2)	>.05 ^a
Female	169	124 (73.4)	45 (26.6)	
Total	400	276 (69.0)	124 (31.0)	
Occupation				
Not working	100	75 (75.0)	25 (25.0)	>.05 ^a
Military	140	78 (62.1)	53 (37.9)	
Civilian	81	51 (63.0)	24 (29.6)	
Retired	8	7 (87.5)	1 (12.5)	
Total	329	220 (66.9)	109 (33.1)	
Education level				
Low (Schooling)	42	34 (81.0)	8 (19.0)	>.05 ^a
Average (High school and diploma)	286	187 (65.4)	99 (34.6)	
High (Graduation)	64	48 (75.0)	16 (25.0)	
Total	392	269 (68.6)	123 (31.4)	
Income				
Low (<9999 SAR)	66	56 (84.8)	10 (15.2)	.008
Average (10000-19999)	224	150 (67.0)	74 (33.0)	
High (>20000)	107	68 (63.6)	39 (36.4)	
Total	397	274 (69.0)	123 (31.0)	

Values are number and percentage. ^aData missing for 142 of 231 males. Fisher exact test used for comparisons with cell value <5.

Table 5B. Family features by knowledge score.

Variables	Total	Good	Poor	P value
Marital status				
Married	366	253 (69.1)	113 (30.9)	>.05
Divorced	24	16 (66.7)	8 (33.3)	
Widowed	10	7 (70.0)	3 (30.0)	
Total	400	276 (69.0)	124 (31.0)	
Number of wives				
One	218	146 (67.0)	72 (33.0)	.005
More than one	40	35 (87.5)	5 (12.5)	
Total	258	181 (70.2)	77 (29.8)	
Number of male children				
<5	369	248 (67.2)	121 (32.8)	.003
>5	27	25 (92.6)	2 (7.4)	
Total	396	273 (68.9)	123 (31.1)	
Number of female children				
<5	370	249 (67.3)	121 (32.7)	.004
>5	26	24 (92.3)	2 (7.7)	
Total	396	273 (68.9)	123 (31.1)	

Values are number and percentage. Statistical analysis by chi-square test. The Fisher test used where appropriate.

Table 6. Logistic regression analysis of variables associated with perception score (good or poor).

Variables	B	SE	Odds ratio	Significant	95% CI
Education	0.120	0.317	1.127	.706	(0.605-2.100)
Age group	0.577	0.289	1.781	.046	(1.010-3.141)
Number of male children	0.711	0.816	2.037	.383	(0.412-10.077)
Number of female children	-0.186	0.720	0.830	.796	(0.202-3.404)
Income	-0.094	0.253	0.910	.711	(0.554-1.496)
Number of wives	1.671	0.586	2.762	.083	(0.876-8.709)

Table 7. Logistic regression analysis of variables knowledge score (good or poor).

Variables	B	SE	Odds ratio	Significant	95% CI
Number of male children	0.837	0.794	2.309	0.292	(0.487-10.956)
Number of female children	1.673	1.061	5.330	0.115	(0.666-42.661)
Income	-0.365	0.226	0.694	0.105	(0.446-1.080)
Number of wives	0.840	0.522	2.316	0.108	(0.832-6.448)

In our sample, the majority of respondents were in early or middle life, the ideal childbearing period. More than half of the sample was male and the majority were military employees because eligibility for treatment in this PHCC is limited to employees of the Ministry of National Guard and their dependents. This is in contrast to a study done in Nigeria,¹⁹ where the majority were female, middle aged and unemployed. This could be because of the difference in the study setting where the researcher visited the parents at home and interviewed one of them.

Our study results suggest that age is significantly associated with good perception of CSA. As age increases, experience and knowledge increase. Older parents tend to have more knowledge of CSA signs and symptoms and are able to educate and protect their children from CSA.²⁷ Calvert and Munsie-Benson (1999) reported that women, married people, people with children, older people, and people with higher incomes had the best perceptions and knowledge of CSA as they gave the most correct answers.³⁶ Surprisingly, our study results found no significant association between the number of male and female children, income and number of wives and knowledge score. This may be attributed to differences in cultures and religious beliefs and the restrictions in Saudi environments where male and female do not mix and are unable to discuss anti-CSA strategies.

The study has identified areas that need more focus in parent's perception and knowledge of CSA. Because the study was cross-sectional, it is difficult to draw causal inferences. In addition, the study involved attendees of one primary health care center over one month only, which may have introduced referral bias so it is difficult to extend our findings to the general population. Also, the data collection tool is a self-administered questionnaire, which might be read incorrectly and may be subject to recall bias. In conclusion, the findings of this study support the risk factors related to parent's knowledge and perception of CSA are poverty and lack of education. The findings show that protective factors associated with prevention of CSA include elderly age, size of the family and families with more than one wife. It is recommended that education be designed for parents and the community to increase knowledge and perceptions of this subject. Community-based support services should be established in health care centers and professional health awareness campaigns must be organized to develop preventive strategies for CSA. As good parenting skills in the community knowledge-based perceptions on this social issue are significant when determining ways to prevent sexual abuse. There is a need for further extensive nationwide research in the general community for a better understating of CSA and its prevention in Saudi Arabia.

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