



The Risky Behaviours of the Adolescents Exposed to Sexual Revictimization and One-Time Sexual Abuse *

Nilüfer Koçtürk ¹, Filiz Bilge ²

Abstract

Sexual Revictimization (SR) is one of the most important individual and social problems. Determination of the risky behaviours of the sexually revictimized adolescents will be useful in determination of the victims who have not reported the case, in organizing necessary psychosocial services and in preventing the sexual revictimization. For this reason, the levels of the risky behaviours of the adolescents who have been exposed to SR, one-time sexual abuse (SA) and those who haven't been exposed to SA have been examined in this descriptive study. The participants of the research are 15-18 year old 210 female adolescents. There are 70 adolescents from each three groups and the total number is 210 adolescents. The data have been collected via Risky Behaviour Scale (Gençtanırım & Ergene, 2014). According to the findings, it has been detected that the risky behaviours -such as tobacco use and alcohol use, suicidal tendency and tendency of school dropout- of the adolescents exposed to SR are higher than the comparison group and the ones who have been exposed to one-time SA. It has been concluded that the antisocial behaviours of the adolescents who have been exposed to SR have been different from the adolescents in the comparison group and there have been no meaningful differences among three groups in eating habits dimension. These results show that there is need of both individual and social studies to decrease and prevent the risky behaviours of the adolescents exposed to SR and one-time SA.

Keywords

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Introduction

Sexual revictimization which is defined as 'the exposure of sexual abuse of the individual who was exposed to sexual abuse in childhood, in adolescence or adulthood again (Arata, 2000), is one of the most important both individual and social problems (Gidycz, Hanson, & Layman, 1995). In addition, the risk of lifelong revictimization is high in childhood victimizations (Coid et al., 2001; Widom, Czaja, & Dutton, 2008). In a study, there were 179 adolescents and young adults and it has been found that the risks of sexual abuse (SA) of sexual abuse victims got 1.99 times higher than the control group (Barnes, Noll, Putnam, & Trickett, 2009). Besides, it has been stated in literature review that the rate of

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¹ Republic of Turkey Ministry of Health, Ankara Çocuk İzlem Merkezi, Turkey, nilkeser@hacettepe.edu.tr

² Hacettepe University, Faculty of Education, Psychological Counseling and Guidance, Turkey, fbilge@hacettepe.edu.tr

revictimization changes between 8.9% (Krahé, Scheinberger-Olwig, Waizenhöfer, & Kolpin, 1999) - 29.8% (Messman-Moore, Walsh, & DiLillo, 2010). In Turkey, this rate isn't known because there aren't any researches on sexual revictimization (SR).

In literature review, there are various views trying to explain SR. According to The Traumagenic Dynamics Model, SA causes psychological problems, and risky sexual behaviours and revictimization are among them (Finkelhor & Brown, 1985). In the Theory of Emotional Avoidance it is also stated that SA victims use some ways of coping such as dissociation, self-injury, drug use, unselected sexual intercourse and abstain from close relationships to decrease the effects of memories and thoughts of abuse (Polusny & Follette, 1995). Polusny and Follette (1995) say that even if these ways of coping with the problem relief the pain of the victim in the beginning, they may cause negative results such as social isolation, sexual dysfunctions and revictimizations in long term.

It is underlined in the studies that the psychological problems (Messman-Moore & Long, 2003), alcohol and drug use (Messman-Moore & Long, 2003), risky behaviours about sexuality (Bramsen et al., 2013; Krahé et al., 1999; Messman-Moore & Long, 2003), inability to identify risky situations (Messman-Moore & Long, 2003), not going to school (Meinck, Cluver, & Boyes, 2015) and a feeling of worthlessness in the family life (Krahé et al., 1999) which were observed post CI, were related to revictimization. In a study carried out by Bramsen et al. (2013) with 327 female adolescents, it was determined that the number of the sexual partners and the risky behaviours, explained the connection between childhood SA and adolescence SA. In the one-year longitudinal study carried out by Meinck et al. (2015) with 3515 children, it was detected that being exposed to abuse, not going to school and being physically attacked in society increased the risk of SR.

Risky behaviours describes the behaviours which affect the health, goodness and the lives of youngsters directly or indirectly and which can cause negative results potentially (Alikaşifoğlu, 2008). The researches points out that a healthy family life and behaviours of the parents are important for the risky behaviours of the adolescents. According to the literature review, family integrity (Gonzalez-Blanks & Yates, 2016), parental monitoring and parental involvement (e.g., social support) and parent-child communication (Caldwell et al., 2010) are important for the adolescents to show less risky behaviours. Also, it is stated that it is necessary to study with parents and there should be both familial studies and studies with schools and the community in order to decrease the risky behaviours of the adolescents (Caldwell et al., 2010). In their meta analysis study, Metzger, Cooper, Zarrett, and Flory (2013) examined the features of culturally sensitive and effective programs for preventing risky behaviours. According to this study, the programs which make use of both universal and cultural theoretical approaches; which have strict methodological pattern; which care cultural integrity; which oversee the effects of a lot of fields such as family, school and communication; which aims differences in various fields such as behaviour and relationships; and which have sustainable qualities are effective in preventing risky behaviours.

The number of the studies carried out with revictimized adolescents on risky behaviours are limited, there are studies on risky behaviours of SA victims and most of the studies concentrated on sexual risky behaviours, committing suicide, alcohol and drug use. In literature review on this subject, especially, sexual behaviours (Gonzalez-Blanks & Yates, 2016; Heerde, Scholes-Balog, & Hemphill, 2015), suicide (Devries et al., 2014; Soylyu & Alpaslan, 2013), escaping from home (Heerde et al., 2015), smoking cigarette (Sartor et al., 2013), alcohol and drug use (Bergen, Martin, Richardson, Allison, & Roeger, 2004; Gidycz et al., 1995; Sartor et al., 2013) are seen as risk factors for SA. Gonzalez-Blanks and Yates (2016) define that sexual abuse and living in a government dorm is related with the risky behaviours of adolescents and that dissociative symptoms of adolescents strengthen the relation between sexual abuse and risky behaviours. According to a study carried out with 3761 female adolescents by Sartor et al. (2013), the rate of SA is 13% and when genetic and environmental factors are controlled, it has been stated that SA is a risk for smoking, drug use and alcohol use at an early age. According to the collected works of Hughes, Bean, and Harper (2015) increase in sexual interest, showing sexual behaviours, running aways and using drugs are risks for SR.

Shortly, in literature review there have been studies on SR and risky behaviours especially since 2000 and because it will be a risk factor to perform risky behaviours which will cause psychological vulnerability for the victim, it is offered to search on this subject (Messman-Moore & Long, 2003). Also in Turkey which has different cultures, there aren't any studies on risky behaviours caused by revictimization, and any studies comparing the ones exposed to one-time SA and the ones exposed to SR. To detect the risky behaviours of SR will be useful in preventing the problem. In addition, by detecting the risky behaviours, it will be easy to detect the victims of SA who haven't reported the case and necessary psychosocial intervention can be carried out. In order to meet the need of information mentioned before, to realize necessary interventions and protective and preventive studies for the children who are the victims of SA, it is necessary to determine the risky behaviours of the adolescents exposed to one-time SA and SR. For this reason, the aim of the study is to compare the levels of risky behaviours of the adolescents who are exposed to SR, one-time SA and aren't exposed to SA. With this general purpose, the answer of the below mentioned question have been searched in this study:

(a) Is there any meaningful difference between the arithmetic mean of risky behaviours in the dimension of tobacco use, alcohol use, antisocial behaviors, suicidal tendencies, eating habits and school dropouts of adolescents who were exposed to SR, one-time SA and those who weren't exposed to SA?

Method

In this descriptive research, since it has been tested whether there is a significant difference among arithmetic mean of risky behaviours of the adolescents who were exposed to SR, one-time SA and those who weren't exposed to SA. This research is a comparative relational model (Karasar, 2010). Convenience sampling method has been used in this study (Teddlie & Yu, 2007).

Totally 210 15-18 year old female children who were exposed to SR (n=70), one-time SA (n=70), who weren't exposed to SA (n=70) have participated in this study. The number of SA events of the ones exposed to SR changes between 2-30 and the abusives are different. Additionally, 34.8% of the children participated in this research are 15 years old (n=73), 34.3% of them are 16 years old (n=72), 31% are 17 years old (n=65). The age average of the participants is $\bar{X}=15.96$, $SD=0.81$. The age average of the group exposed to SR is $\bar{X}=15.93$, $SD=0.97$; the age average of the group exposed to one-time SA is $\bar{X}=15.96$, $SD=0.82$; the age average of the comparison group is $\bar{X}=16$, $SD=0.83$.

In this study, SR means the re-exposure of the child, who was exposed to SA before the adolescence (before 13 years old), who was re-exposed to SA in adolescence. One-time victimization means SA which was experienced in adolescence. SA groups were formed as the result of the forensic interviews with the adolescents.

Measures

Risky Behaviours

In this study there are six dimensions of risky behaviours such as antisocial behaviours, alcohol use, tobacco use, suicidal tendency, eating habits and tendency of school dropout. In order to determine the risky behaviours, 'Risky Behaviour Scale' (RBS) has been used (Gençtanırım & Ergene, 2014). RBS includes 36 articles and the articles were signed according to five scale likert (certainly not convenient=1, not convenient=2, partially convenient=3, convenient=4, certainly convenient=5). The highest point to be obtained from the scale is 180 and the lowest one is 36. If low points are obtained from RBS, it means risky behaviours are in low level; if high points are obtained, it means risky behaviours are in high level.

For the validity of the scale, expert, structure and similar scales validity have been carried out (Gençtanırım & Ergene, 2014). An expert opinion has been applied for coverage validity. In order to test the validity based on structure, exploratory factor analysis has been used. As the result of the analysis,

it has been found that the scale has six dimensions. These are named as antisocial behaviours, alcohol use, tobacco use, suicidal tendency, eating habits and school dropout. The variances explained by these factors are respectively as follows: 11.58%, 11.01%, 10.72%, 9.19%, 6.51% ve 6.41%. The total variance explained via the scale is 55.43% (Gençtanırım & Ergene, 2014). In order to test the similar scale validities, Pearson Correlation Coefficient between the points obtained from sub-dimension of the family, friend and teacher support of Perceived Social Support Scale (Yıldırım, 2004) and the points obtained from RBS have been calculated. It has been found that there is a negative relation between the points obtained from two scales and coefficients change between -.10 and -.35. For the reliability of RBS, cronbach alpha reliability coefficient and test-retest reliability coefficient have been calculated (Gençtanırım & Ergene, 2014). Internal consistency coefficient of the scale changes between .70-.91 and test-retest reliability coefficient is between .56-.90. Cronbach alpha coefficient calculated in this study is .82 for the dimension of antisocial behaviours, .91 for the dimension of alcohol use, .94 for the dimension of tobacco use, .71 for the dimension of suicidal tendency, .69 for the dimension of eating habits and .82 for the dimension of school dropout.

As can be seen above, the psychometric features of RBS show that it is an acceptable and a reliable measurement instrument. However, at the level of development of RBS, since the adolescents didn't answer the questions regarding sexual risky behaviours and substance use, there isn't such dimensions in this scale (Gençtanırım & Ergene, 2014). This is one of the limitations of the scale.

Procedure

Ethics Committee Permit was taken to carry out this study in Ankara Child Advocacy Center working under Ministry of Health Yenimahalle State Hospital where forensic interviews were carried out with SA victims. After the permission period, Informed Consent Form which was prepared by the researches was used and the participants took part in the research as volunteers. In paralel with all those procedures, the scale was applied to 15-18 year-old 70 adolescents exposed to SR and 15-18 year-old 70 adolescents exposed to one-time SA who were chosen according to convenient sampling method in Ankara Child Advocacy Center. In order to form the comparison group, 70 15-18 year-old female adolescents who give importance to the study and who consulted the pediatric polyclinic of the hospital where is Ankara Child Advocacy Center, have been reached. In the study, chronic disease and the existence of the story of sexual abuse are the criteria to be excluded. Whether the comparison group was exposed to sexual abuse or not was evaluated by the interview made by the first researcher. The reason why the first researcher evaluates the victimization of abuse is that she has experience and education in the field of forensic interview with children victims of SA. The rate of participation into the study both of SA group and of the comparison group is 100%. Data collection period started in August, 2013 and ended in June, 2014. After data collection period, necessary psychosocial guidance was supplied by the first researcher for the victims in SA group and for their families in accordance with the function of the center. Also, the adolescents in the comparison group were educated about taking care of themselves and where to consult in the case of SA and about their rights.

Analysis

SPSS 21.0 was used for statistical solution of the collected data. Firstly, whether the collected data fulfill the hypothesis of the parametric tests was controlled. According to this, One Way ANOVA was used to test the research question. In multiple comparison tests, homogeneity of the variances was analysed by Levene F test and if the variances were homogeneous, Tukey test was used; if the variances were not homogeneous, Dunnet C test was used (Büyükoztürk, 2011). Also, the effect size (eta squared) values were examined. The effect size was commented as $0,01 \leq \eta^2 < 0,06$ "low size effect", $0,06 \leq \eta^2 < 0,14$ "medium size effect" and $\eta^2 \geq 0,14$ "high size effect" (Cohen, 1988).

Results

In this study there are six dimensions of risky behaviours such as antisocial behaviours, alcohol use, tobacco use, suicidal tendency, eating habits and tendency of school dropout. As can be seen in Table 1, according to having been exposed to SA, the arithmetic mean of risky behaviours of the adolescents are different from each other in all dimensions. When the results of variance analysis have been examined, according to having been exposed to SA, at least one of the arithmetic means of the risky behaviours of adolescents in the dimensions of except eating habits ($F_{2,207}=1.66$; $p>.05$), tobacco ($F_{2,207}=26.64$; $p<.001$) and alcohol use ($F_{2,207}=18.99$; $p<.001$), antisocial behaviours ($F_{2,207}=7.33$; $p<.01$), suicidal tendencies ($F_{2,207}=16.11$; $p<.001$) and tendency of school dropout ($F_{2,207}=11.08$; $p<.001$) is meaningful (Table 1).

Table 1. Descriptive Values and Variance Analysis Results of Adolescents' Risky Behaviours Scores According to SA Exposure Status

Variables	CG	SA	SR	All	$F(2, 207)$	Levene	η^2
	($n = 70$)	($n = 70$)	($n = 70$)	($N = 210$)			
Tobacco use	M (SS) 10.07 (7.06)	M (SS) 13.51 (8.38)	M (SS) 19.61 (8.01)	M (SS) 14.4 (8.74)	26.64***	3.92*	0.20
Alcohol use	8.19 (2.82)	9.07 (4.63)	13.43 (7.6)	10.23 (5.83)	18.99***	33.74***	0.15
Antisocial	12.67 (3.93)	13.93 (4.7)	15.97 (6.48)	14.19 (5.3)	7.33**	8.42***	0.07
Suicidal tendency	10.33 (3.82)	12.21 (3.35)	13.97 (4.18)	12.17 (4.06)	16.11***	1.78	0.13
Eating habits	14.67 (4.91)	13.33 (4.05)	14.29 (4.46)	14.10 (4.50)	1.66	0.42	0.01
School dropout	11.56 (5.45)	12.34 (6.84)	16.27 (6.66)	13.39 (6.65)	11.08***	2.88	0.10

Note. CG = Comparison group; SA = One-time sexually abused group; SR = Sexually revictimized group.

* $p<0.05$. ** $p < .01$. *** $p < .001$.

Since Levene statistics showed that group variances were not homogeneous in the dimension of tobacco ($F_{2,207}=3.92$; $p<.05$) and alcohol use ($F_{2,207}=33.742$; $p<.001$) and anti-social behaviours ($F_{2,207}=8.421$; $p<.001$), Dunnett C test was used to define between which arithmetic means there is meaningful difference. Since Levene statistics showed that group variances were homogeneous in the dimensions of suicidal tendency ($F_{2,207}=1.781$; $p>.05$) and tendency of school dropout ($F_{2,207}=2.876$; $p>.05$), Tukey test was used. According to the results shown in Table 2, the dimensions of tobacco and alcohol use, suicidal tendency and tendency of school dropout of adolescents who were exposed to SR had a higher arithmetic mean when compared to comparison group and those who were exposed to one-time SA and the difference between groups' arithmetic means was meaningful ($p<.05$). Similarly, risky behaviour arithmetic mean in the dimension of anti-social behaviours of the adolescents who were exposed to SR had a higher arithmetic mean when compared to comparison group and the difference between the arithmetic means of two groups are meaningful, but the difference of arithmetic mean of one-time SA victims and the comparison group was not meaningful ($p>.05$). In addition, arithmetic mean in the dimension of tobacco use and suicidal tendency of the adolescents who were exposed to one-time SA had a higher arithmetic mean when compared to comparison group, but there was not a meaningful difference between two groups in the dimensions of alcohol use, anti-social behaviours and tendency of school dropout (Table 2). When the effect size (eta squared) values were examined, there was a high size effect in the dimensions of tobacco ($\eta^2=.20$) and alcohol use ($\eta^2=.15$); there was a medium size effect in the dimensions of anti-social behaviours ($\eta^2=.07$), suicidal tendency ($\eta^2=.13$) and tendency of school dropout ($\eta^2=.10$) (Table 1).

Table 2. Differences Between the Mean Scores of Adolescents' RBS Subscales According to Their Exposure to SA

Variables	Group Comparisons	Difference between Means
Tobacco use	Comparison - One-time SA	-3.44286*
	Comparison - Revictimized SA	-9.54286***
	Revictimized SA - One-time SA	6.10000**
Alcohol use	Comparison - One-time SA	-.88571
	Comparison - Revictimized SA	-5.24286***
	Revictimized SA - One-time SA	4.35714***
Antisocial behaviours	Comparison - One-time SA	-1.25714
	Comparison - Revictimized SA	-3.30000**
	Revictimized SA - One-time SA	2.04286
Suicidal tendency	Comparison - One-time SA	-1.88571*
	Comparison - Tekrarlanan	-3.64286***
	Revictimized SA - One-time SA	1.75714*
School dropout	Comparison - One-time SA	-.78571
	Comparison - Revictimized SA	-4.71429***
	Revictimized SA - One-time SA	3.92857**

* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

Discussion

In this research, risky behaviour dimensions of antisocial behaviours, alcohol use, tobacco use, suicidal tendency, eating habits and tendency of school dropout of the adolescents who were exposed to SR, one-time SA and those who weren't exposed to SA have been studied. According to the findings, it has been found that in terms of antisocial behaviour, the adolescents exposed to SR has a higher point than only the adolescents in the comparison group, in terms of risky behaviour in eating habits dimension there isn't a meaningful difference between the groups. It has been detected that the risky behaviours of the adolescents exposed to SR are higher than the comparison group and the ones exposed to SA, in dimension of tobacco use and alcohol use, suicidal tendency and school dropout.

It has been determined that in terms antisocial behaviour, the adolescents exposed to SR and one-time SA have a higher point than the adolescents in the comparison group. No findings have been reached in literature review on antisocial behaviours of the adolescents exposed to SR in adolescence. However, it has been seen that the antisocial behaviours of the ones exposed to SA were studied and the results are paralel with this study. Bu çalışmalardan biri olan According to the studies of Gault-Sherman, Silveri and Sigfúsdóttir (2009), there was a relation between SA history and anti-social behaviours and it was stated that SA victims' anti-social behaviours did not show any differences according to gender. In the above mentioned study, it was defined that having negative friendship, having been exposed to physical abuse by the parents, low education level of the parents, low level of parent-child connection increased aggressive tendencies of adolescents (Gault-Sherman et al., 2009). However, in a study caried out in Taiwan, it was found that fighting was related with the boys who were exposed to SA, but this kind of connection wasn't the same for the girls (Zhu et al., 2015). In another study, it can be seen that even when the variables of familial features and depression were controlled, the ones exposed to SA performed 2-3 times more antisocial behaviours than the ones who didn't have a story of SA (Bergen et al., 2004). In a study focusing on crime commitment of girls, it was stated that SA was a risk factor for commitment and these girls were antisocial; had antisocial behaviours, attitudes and personalities (Hubbard & Pratt, 2002). As it can be seen, the findings of this study are compatible with the above-mentioned studies except one (Zhu et al., 2015). The reason of the antisocial behaviours

of the ones exposed to SA may be the severity of abuse, lack of psychological and social support after SA, being labelled and not being understood by people around. Also, the antisocial behaviours may be the reflection of anger because of the traumatic experiences of the victims; in other words the expression of the anger. The reason of the different results of the findings of Zhu et al. (2015) can be a different way of expression of anger according to cultural differences.

In this study, the findings of tobacco use, alcohol use and suicidal tendency are usually parallel with literature review. According to research findings in Turkey the rate of alcohol use of the SA victims is 10.4-11.1% (Bulut, 2013; Soylu & Alpaslan, 2013), the rate of tobacco use is 14.2-31.2% (Bulut, 2013; Soylu & Alpaslan, 2013), suicidal tendency is 14-50% (Bulut, 2013; İmren, Ayaz, Yusufoglu, & Rodopman-Arman, 2013), and the thought of suicide is 40-63.2% (Demir, 2008; Soylu & Alpaslan, 2013). In similar with the results of this study, in a study of Soylu and Alpaslan (2013), they scanned the files of 106 SA victims who were aged between 12-18 and found that the thought and the committing of suicide were higher for those who had many or more than one abusers. Sachs-Ericsson, Stanley, Sheffler, Selby, and Joiner (2017) stated that physical, sexual, emotional abusive behaviours which both include and don't include violence are related to suicidal tendency, but abuse which includes violence increases the possibility of suicide of the victim. All these findings show that, the variables specific to abuse are effective variables for the occurrence of risky behaviours. In addition, the reason why the adolescents exposed to SR smoke more, use more alcohol and have suicidal tendency may be that they see it a way of forgetting SA, a way of coping with the psychological problems originating from SA. This situation can be a sign that shows that the ones exposed to SR need more and urgent psychological support than the ones in other groups.

When the studies carried out on eating habits are examined, it can be seen that there aren't any similar sampling groups as it is in this study and the results aren't parallel with the results of this study (Caslini et al., 2016; Gonçalves et al., 2016; Wonderlich et al., 2000). Most of the studies included adults and it was found that there was a relation between SA in childhood and malnutrition (Gonçalves et al., 2016; Wilson, 2010). According to the research findings of Wonderlich et al. (2000) which was done with the victims aged 10-15, SA victims were more unsatisfied with their bodies and weight and were on diet more than the children in the control group. The difference between the mentioned study and this study may be the measuring instrument or the different cultural features of the samplings. In other words, the Risky Behaviours Scale used in this research doesn't have a detailed eating habits dimension, it focuses on unhealthy eating habits (such as fast food).

Another significant finding of this research is that the adolescents exposed to SR have more tendency of dropping out of school than the ones in the comparison group and the ones exposed to one-time SA. Researches on tendency of dropping out of school because of SR hasn't been found in literature review and it has been found that the rate of dropping out of school of SA victims changes between 22.6% - 33.3% (Bulut, 2013; Önen Doğan, 2009). In another sampling group it was found that this rate increased. For example, this rate can reach 61.3% for the victims staying at government dorm (Akkuş, 2014). In this study, the reason why the rate of tendency of dropping out of school is higher in SR group than the other groups is that the victims have attentiveness and concentration problems, they can not concentrate on the lessons and the success rate is not at a requested level because of the severity of the psychological problems occurred after SA. Another reason may be the labelling of the victim after the school environment learned the story of SA. According to Hébert, Langevin, and Daigneault's studies (2016), SA victims are more exposed to peer bullying and peer bullying increases the rate of dissociation and depression symptoms three times more. When all these factors are evaluated together, victims drop out school because this may be a way of running away from a negative atmosphere where they feel themselves worthless. However, in order to reach a definitive view on this issue, there is a need of causal researches to determine the agent variables which increase the tendency of dropping out of school of SR victims.

To sum up, in this study which was carried out as the first in Turkey with the SR victims, it was stated that the adolescents exposed to SR performed risky behaviours such as tobacco use, alcohol use, antisocial behaviour, suicidal tendency and tendency of dropping out of school and it was stated that the adolescents exposed to one-time SA smoked cigarette and had the suicidal tendency. These findings are important indicators for determinings and defining the victims of SR and one-time SA. In this context, female adolescents who have tendencies of tobacco and alcohol use, antisocial behaviours, tendencies of suicide and school dropout should be examined in regard to SA. Moreover, the results show that there is a need of studies at the individual, familial and social level in order to decrease and prevent the risky behaviours of the adolescents exposed to SR and one-time SA. In this context, comprehensive psychoeducation and treatment programs should be carried out at first to victims who consulted to Ankara Child Advocacy Center and then to adolescents who perform risky behaviours in order to decrease and prevent the risky behaviours. To include the parents to these intervention programs is necessary for being successful. Also, it is very important for the psychological counselors and for the teachers, who study both with the adolescents and the families, to be well-equipped for preventing sexual abuse and risky behaviours and for applying the appropriate intervention programs for these problems. Bulut (2007) suggests that psychological counsellors and teacher candidates should take courses about this subject. When education faculty teaching programs and psychological counselling and guidance programs are reviewed (The Council of Higher Education, 2017), it can be seen that they don't include this lesson.

Limitations

There are some basic limitations in this study. One of them is that there weren't any male victims and so the risky behaviours of them couldn't be examined. There is a need of new studies to evaluate whether there are gender differences in terms of risky behaviours. Another one is that a causal connection between the risky behaviours and SR can not be set up because of the method of this research. In addition, since this research which was carried out with SR victims is the first in Turkey, causal and longitudinal studies which will include three groups as in this study to follow the risky behaviours and which will control the individual and familial variables, are needed to generalize the results. Finally, one of the limitations is that sexual risky behaviours weren't handled in this study. It is considered that it is important to make new researches in order to study the relation between sexually risky behaviours and SR and to study the cultural effects.

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