Heterogeneity of Symptom Presentation of Adolescent Sexual Abuse Victims Presenting to Treatment: Influence of Child, Family, and Abuse Characteristics.

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Introduction

➢Adolescence is a critical stage of development that is perceived as a time of difficulty and challenge due to social pressures, engagement in substance use and risky sexual behaviors, and performing well academically (American Academy of Child and Adolescent Psychiatry, 1999).
➢Because of this, adolescence has been identified as a peak period for the development of social, emotional, and behavioral problems. Specifically, experience of psychological difficulties such as anxiety and depression has been noted to increase in adolescence (Häfner et al., 1989; Kessler, Chiu, Demler, & Walters, 2005) as do rates of suicide, homicide, violence, risky sexual behaviors, and substance use (Ozer, Maconald, & Irwin, 2002).
➢One specific population of youth who are at an increased risk for developing a variety of social, emotional, and behavioral problems are those who have experienced childhood sexual abuse (CSA: Friedenberg, Hansen, & Flood, 2013; Kendall-Tackett, Williams, & Finkelhor, 1993; Tyler, 2002; V. Wolfe, 2007).
➢Evidence examining outcomes for CSA victims asserts that older children are more likely to be depressed and have lower self-esteem and self-worth (Feiring, Taska, & Lewis, 1999; Tebbutt, Swanston, Oats, & O'Toole, 1997) and are at increased risk for engaging in self destructive, delinquent, and risky sexual behaviors (Homma et al., 2012; Wright et al., 2004).
➢Although research has identified specific psychological and behavioral difficulties experienced by CSA victims, this population is a heterogeneous group in that victimization does not necessarily result in a unified presentation of symptoms (Friedenberg et al., 2013; Kendall-Tackett et al., 1993; Tyler, 2002; V. Wolfe, 2007). Moreover, some youth exhibit high levels of distressing symptoms while others exhibit little to no symptoms (Putnam, 2003; Wolfe, 2006).
➢Given the distinct, yet varying, impact of CSA on the development of psychopathology and engagement in risky behaviors in adolescence, a greater understanding of factors influencing this development is critical in providing appropriate services.
➢As such, the purpose of the current study is to explore differences in symptom presentation in a treatment seeking, sexually abused adolescent population, taking into consideration adolescent, caregiver, and family functioning.

Methods

➢Participants included 79 females and their nonoffending caregivers. Adolescents were primarily European American (82.5%) with a mean age of 14.47 (SD = 1.57). Caregivers were primarily biological mothers (75.9%), European American (89.6%), with a mean age of 39.81 (SD = 7.38).
➢Measures
•**Child Behavior Checklist - Youth Self Report** (YSR; Achenback, 1991).
•**The Children's Depression Inventory** (CDI; Kovacs, 1992).
•**Children's Manifest Anxiety Scale-Revised** (CMAS-R; Reynolds & Richmond, 1985).
•**Children's Impact of Traumatic Events-Revised** (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991).
•**Coopersmith Self-Esteem Inventory** (SEI; Coopersmith, 1981).
•**Child Expectations Scale** (CES: Meidlinger et al., 2012).
•**Family Adaptability and Cohesion Evaluation Scale** (FACES-III; Olson, 1986).
•**Family Crisis Oriented Personal Evaluation Scales** (F-COPES; McCubbin, Larsen, & Olson, 1982).
•**Parental Efficacy Questionnaire** (PEQ; Teti & Gelfand, 1991).
•**Parenting Stress Index** (PSI; Abidin, 1983).
➢Participants in the current study were referred from the local Child Advocacy Center to participate in Project SAFE (Sexual Abuse Family Education), a 12-week group treatment program for sexually abused youth and their nonoffending family members. Participants completed a number of empirically supported self- and parent-report measures as part of an assessment battery for a larger study examining treatment efficacy for victims of CSA.

Result

➢A hierarchical cluster analysis was conducted using adolescent pre-treatment, self-report assessments (i. e., CITES-R/PTSD subscale, CDI, CMAS-R, and YSR internalizing and externalizing subscales) to create clinical profiles of the participants as they presented to treatment resulting in four clusters. The cluster analyses were created using Ward's method and Squared Euclidean Differences, and were examined to discover the most consequential interpretation of the data and the most meaningful profiles of the adolescents. All scores were converted to z-scores to eliminate possible conflicts related to standardization differences among measures. Refer to Table 1 and Figure 1 for specifics regarding cluster membership and z-scores.
➢ANOVAs were conducted to identify variables associated with the clusters in regards to adolescent, caregiver, and family functioning (Table 2).

➢**Adolescent Functioning**
•There were significant differences in self-esteem, self-attributions, self-blame, and negative expectations but no difference in age at which they presented to treatment or age at which abuse occurred.
•Specifically, youth in the Highly Distressed and Anxious clusters reported significantly more self-blame and self-attributions related to the abuse than youth in the Externalizing Problems and Subclinical clusters.
•Further, youth in the Highly Distressed cluster reported significantly lower self-esteem than youth in all other clusters, and youth in the Anxious cluster reported significantly lower self-esteem than the Externalizing Problems and Subclinical clusters.
•Finally, youth in the Highly Distressed cluster reported significantly more negative expectations for their future than youth in all other clusters, and there were no significant differences in reports of negative expectations among the other three clusters.

➢**Parent Functioning**
•No significant differences were found between clusters when considering caregiver distress. However, results were significant for differences between clusters considering caregiver efficacy, sense of competence, and restriction of role.
•Youth in the Highly Distressed cluster had caregivers who reported less efficacy than caregivers with youth in the Anxious and Subclinical clusters but no difference between the Externalizing Problems cluster. Additionally, youth in the Externalizing Problems cluster had caregivers who reported less efficacy than caregivers with youth in the Anxious cluster.
•Youth in the Anxious and Subclinical cluster had caregivers who reported more competency as a parent than caregivers with youth in the Highly Distressed and Externalizing Problems clusters.
•Youth in the Externalizing Problems cluster had caregivers who reported more restriction by their parental role than caregivers with youth in the Anxious and Subclinical clusters. Additionally, youth in the Highly Distressed cluster had caregivers who reported more restriction by their parental role than caregivers with youth in the Subclinical cluster.

➢**Family Functioning**
•There were no significant differences in caregiver reports of family functioning in regards to family cohesion, adaptability, and problem solving.
•However, there was a significant difference in adolescent report of family functioning. Specifically, youth in the Subclinical cluster reported better family functioning than youth in the Highly Distressed, Anxious, and Externalizing Problems clusters but there were not significant differences between the latter three clusters.

Table 1:
Cluster membership, number, and z-scores

Clusters	*n(%)*	CDI-Depression	CITES-R-PTSD	CMAS-R-Anxiety	YSR-Internalizing Problems	YSR-Externalizing Problems
1 - Highly Distressed	18 (22.5%)	1.3961645	.7375247	1.0682597	1.0415493	1.0821625
2 - Anxious	20 (25.0%)	.0195094	.5952565	.4657596	.3256457	-.1390750
3 - Externalizing Problems	17 (21.2%)	-.5470720	-1.0898568	-.5330285	-.2658984	.4420155
4 - Subclinical	24 (30.0%)	-.6758719	-.2750284	-.7914126	-.8774342	-.9594769

Figure 1:
Clinical Profiles (based on z-scores) of self-report measures.

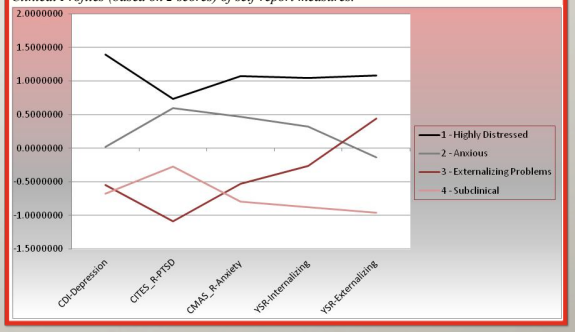

Table 2:
Summary of Mean Comparisons Across Clusters

Category	Variable	Cluster 1 Highly Distress *M (SD)*	Cluster 2 Anxious *M (SD)*	Cluster 3 Externalizing Problems *M (SD)*	Cluster 4 Subclinical *M (SD)*	LSD	F (1, 75)
Adolescent Funcitoning						**0.000**	
	Current Age	14.96 (1.06)	14.05 (1.49)	14.36 (1.30)	14.56 (2.06)		1.112
	Age at Onset of Abuse	11.83 (3.26)	10.63 (2.45)	10.69 (3.51	11.05 (3.08)		.579
	Self Blame	7.72 (5.38)	6.90 (5.53)	3.24 (2.22)	4.00 (3.38)	2.78	4.750**
	Self-Attributions	26.61 (7.88)	23.55 (9.78)	18.24 (8.11)	17.46 (7.62)	4.91	6.367***
	Self Esteem	39.78 (13.53)	58.00 (12.10)	70.51 (1.84)	74.17 (17.39)	9.161	22.958***
	Expectations	37.44 (8.53)	29.08(7.72)	26(8.90)	24.19 (10.51)	8.094	4.887**
Parent Functioning							
	Distress	45.29 (11.83)	44.06 (11.00)	43.73 (7.84)	44.91 (10.55)		.081
	Efficacy	14.76 (4.78)	18.44 (2.81)	15.81 (3.83)	17.74 (3.51)	2.49	3.651*
	Competence	35.63 (8.10)	30.00 (5.52)	35.13 (6.40)	31.32 (6.71)	4.585	2.874*
	Restriction of Role	20.62 (4.71)	17.8 (3.67)	22.00 (6.64)	17.00 (4.14)	3.275	3.780*
Family Functioning							
	Home-Parent	3.16 (2.46)	4.68 (2.40)	4.35 (2.45)	6.29 (2.40)	1.538	6.141***
	Cohesion	31.35 (9.22)	37.61 (5.45)	32.75 (7.10)	34.83 (6.98)		0.70
	Adaptability	23.71 (4.51)	24.83 (5.66)	26.94 (5.64)	25.00 (4.82)		1.111
	Problem Solving	96.35 (15.17)	102.94 (16.43)	104.81 (9.49)	98.87 (11.42)		1.417

*** p < .001; ** p < .01; * p < .05

Discussion

➢Results support the notion that adolescent sexual abuse victims are a heterogeneous population (Freidenberg et al., 2013) and builds upon the increasing understanding of factors associated with the development of psychological symptoms following CSA. Overall, these results suggest that adolescent, parental, and family distress is associated with experiencing a number of psychological symptoms among adolescent CSA victims.
➢Specifically, results suggest that adolescents who experience a number of symptoms and are highly distressed take more personal blame for the abuse and have more negative expectations for the future. Further, adolescents who experience externalizing problems tend to have caregivers who experience difficulties specifically related to parenting. Finally, adolescents who experience any psychological symptoms also perceive their families as not functioning well compared to adolescents who experience little to no symptoms.