



Effectiveness of a Manualized Group Treatment for Child Sexual Abuse in Addressing Risk Factors for Sexual Revictimization

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Introduction

- Approximately 24.7% of women and 16% of men endorse experiencing child sexual abuse (CSA; Centers for Disease Control and Prevention, 2010). In addition to psychological, behavioral, and neurobiological correlates (Putnam, 2003), victims of CSA are at a heightened risk for subsequent sexual victimization throughout the lifespan (Classen, Palesh, & Aggerwal, 2005).
- Psychological distress may mediate the relationship between CSA and revictimization within youth (Cuevas, Finkelhor, Clifford, Ormrod, & Turner, 2010) and evidence mounting in the adult literature suggests that risky behaviors, interpersonal difficulties, posttraumatic stress, maladaptive cognitions, and poor understanding of sexual knowledge all play a role in the pathway from CSA to subsequent sexual victimization (Arata, 2002).
- The current project hypothesized that: 1) psychological distress will be predictive of revictimization risk factors at time presenting to treatment; 2) higher distress will predict lower functioning following treatment in regard to risk factors for revictimization; and, 3) higher distress at presentation to treatment will blunt the effects of treatment on these factors.

Methods

Participants

- Participants were 101 children and 65 adolescents and their caregivers presenting to Project SAFE (Sexual Abuse Family Education), an ongoing treatment program for sexually abused youth and their non-offending family members. Participants in the child group were an average of 10.1 years old, 72% female, and 81% European-American. Participants in the adolescent group were an average of 14.7 years old, 92% female, and 81% European-American.

Self-Report Measures

- Children and adolescents completed the *Children's Depression Inventory* (CDI; Kovacs, 1992) and *Revised Children's Manifest Anxiety Scale* (RCMAS; Reynolds & Richmond, 1985), which were aggregated to determine a broad distress score. They also completed the *Children's Impact of Traumatic Events Scale* (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991) to measure abuse-specific and post-traumatic stress symptoms, the *Coopersmith Self-Esteem Inventory* (SEI; Coopersmith, 1981) to measure self-esteem, the *Child Expectations Following Sexual Abuse Scale* (CEFSA; developed for Project SAFE) to assess expectations of abuse impact on future functioning, the *Weekly Problems Scale - Child Report Version* (WPS-C; Sawyer, Tsao, Hansen, & Flood, 2006) to assess problem peer and parental interactions, and the *Sexual Knowledge and Attitudes Inventory* (SKAI, developed for Project SAFE), to measure knowledge about and attitudes toward sexual behaviors. In addition, adolescents completed the *Youth Self Report* (YSR; Achenbach, 1991a) to assess delinquent behaviors and social problems, as well as the *Adolescent Sexual Behavior Inventory- Self Report* (ACSBI-S; Friedrich, Lysne, Sim, & Shamos, 2004) to assess engagement in sexual behaviors.

Parent-Report Measures

- Parents completed the *Child Behavior Checklist* (CBCL; Achenbach, 1991b), used to measure delinquent behaviors and social problems, and the *Child Sexual Behavior Inventory* (CSBI-3; Friedrich, 2001), used to measure sexual behaviors.

Procedures

- Data were collected as part of Project SAFE, a collaboration between the University of Nebraska-Lincoln and a local Child Advocacy Center. All Project SAFE participants complete assessment batteries at pre- and post-treatment including the instruments described above.

Results

- All analyses were run separately for children and adolescents since they experienced different group treatment protocols. Z-scores were calculated for the CDI and RCMAS then summed to derive a distress score. Bivariate correlations between distress and various demographic and abuse characteristics indicated that age of participants in the children's group was significantly associated with distress ($r = .22, p = .03$).

Distress and Revictimization Risk for Children

- To accommodate for the age-distress relationship, R^2 change F -tests were calculated comparing a model with distress only and a model with distress, age, and the distress by age interaction as predictors. Nested model comparison indicated that higher distress predicted more dysfunction as evidenced by scores on the CBCL Delinquent Behaviors and Social Problems subscales, WPS-C, CITES Self-Blame, Empowerment, Intrusive Thoughts, Avoidance, and Hyperarousal subscales, CEFSA, and SEI, at pre-treatment. The full model accounted for significantly more variance on the WPS-C and SKAI, with older age predicting more problematic interactions and more sexual knowledge.

- At post-treatment, distress remained predictive of scores on the CBCL Delinquent Behaviors and Social Problems subscales, CITES Self-Blame and Guilt, Intrusive Thoughts, Avoidance, and Hyperarousal subscales, and the SEI. The full model accounted for significantly more variance on the CEFSA and CITES Empowerment Subscale.

Table 1.
One-way ANOVA using time of assessment as a grouping variable.

Variable	Time	Mean (Sd)	df	F	Children	
					Pre	Post
CITES Self-Blame/Guilt	Pre	4.95 (4.23)	1, 165	8.66*		
	Post	3.18 (3.01)				
CITES Empowerment	Pre	3.01 (2.78)	1, 165	5.45*		
	Post	2.04 (2.32)				
CEFSA	Pre	23.83 (10.27)	1, 82	6.55*		
	Post	18.23 (8.56)				
SEI	Pre	64.81 (18.03)	1, 163	5.34*		
	Post	71.45 (18.01)				
CITES Intrusive Thoughts	Pre	5.50 (4.07)	1, 165	10.50**		
	Post	3.48 (3.68)				
CITES Hyperarousal	Pre	5.61 (3.06)	1, 165	6.88*		
	Post	4.38 (2.83)				
SKAI	Pre	13.48 (2.35)	1, 163	4.47*		
	Post	14.28 (2.38)				
Adolescents						
CITES Intrusive Thoughts	Pre	5.91 (3.80)	1, 108	5.65*		
	Post	4.22 (3.49)				

Note: * $p < .05$, ** $p < .01$.

Distress and Revictimization Risk for Adolescents

- Distress accounted for a significant amount of variance on the YSR Delinquent Behaviors and Social Problems subscales, CITES Self-Blame and Guilt, Empowerment, Intrusive Thoughts, Avoidance, and Hyperarousal subscales, CEFSA, SEI, and SKAI at pre-treatment.
- At post-treatment, distress remained predictive of scores on the YSR Delinquent Behaviors and Social Problems subscales, CITES Self-Blame and Guilt, Intrusive Thoughts, and Hyperarousal subscales, and SEI. Additionally, distress was predictive of scores on the ACSBI-S, and WPS-C at post-treatment.

Change in Risk Factors Over Time

- One-way ANOVA, presented in Table 1, was used to assess change in risk factors between pre- and post-treatment for the child and adolescent groups.
- Children showed improvement in regard to levels of self-blame and guilt, empowerment, expectations following sexual abuse, self-esteem, intrusive thoughts, hyperarousal symptoms, and sexual knowledge.
- Adolescents only showed improvement in regard to intrusive thoughts.
- Neither of the groups showed a decline in functioning.

Distress and Pre-Post-Treatment Change in Risk

- Regression models including distress as a predictor of pre-to-post-treatment change scores on each of the revictimization risk factors were run to explore the impact of initial distress on change over the course of treatment.
- For the children's group, R^2 change F -tests were again calculated comparing a model with distress only and a model with distress, age, and the distress by age interaction as predictors. Initial distress predicted less change in self-blame and guilt and intrusive thoughts. The full model accounted for significantly more variance in expectations following sexual abuse, with distress predicting less change and age predicting more change.
- Distress did not predict change over treatment on any risk factors for participants in the adolescent group.

Discussion

- Youth who have experienced sexual abuse present with myriad clinical problems, some of which may increase risk for future sexual victimization. Results indicate that self-reported psychological distress at presentation to treatment is predictive of more issues related to risky behaviors, interpersonal difficulties, maladaptive cognitions, and posttraumatic stress symptoms at pre-treatment and after three months of weekly cognitive behavioral therapy.
- Age at time presenting to treatment may also be an indicator of distress level, with younger children reporting less distress in the present study and younger age being associated with fewer interpersonal problems and less sexual knowledge at pre-treatment.
- Initial distress appeared to dampen the effects of treatment for participants in the Project SAFE children's group, predicting less reduction of self-blame and guilt, perceived expectations of abuse impact on future functioning, and intrusive thoughts related to the abuse.
- While distress was not associated with change in symptoms for participants in the adolescents' group, this may be attributed to the fact that symptoms didn't change overall except for a reduction in intrusive thoughts.

Implications

- Brief, self-report measures of depression and anxiety are available to a variety of professionals and provide an efficient and non-intrusive method of assessing psychological distress.
- Screening for these issues after disclosure of abuse may help direct youth and families to interventions that work to address abuse sequelae and prevent future abuse.
- Group or individual interventions offering psychoeducation, emotional processing, and skills training related to sexual abuse reduce symptoms associated with victimization and may help reduce risk for future abuse. More prospective research with treatment seeking and non-seeking families is necessary to understand the relationship between abuse sequelae and revictimization as well as the effect of intervention on revictimization risk.