

PARALLEL GROUP TREATMENTS FOR SEXUALLY ABUSED CHILDREN AND THEIR NONOFFENDING CAREGIVERS: CHILD AND FAMILY OUTCOME AND SATISFACTION

Project SAFE (Sexual Abuse Family Education)

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Introduction

Child sexual abuse continues to be a prevalent concern for American families. The Third National Incidence Study of Child Abuse and Neglect estimated that in 1993 approximately 217,700 children nationwide were known to have experienced harm from sexual abuse (National Center on Child Abuse and Neglect, 1996). In addition, sexually abused children accounted for 29 percent of the total children who suffered any form of child maltreatment (i.e., physical, sexual, and emotional abuse and neglect).

Extensive research has examined the short- and long-term effects of childhood sexual abuse, and a wide range of psychological and behavioral problems have been identified as sequelae of sexual abuse (e.g., poor self-esteem, anxiety, depression, sexualized behavior, acting out behaviors, post-traumatic stress symptoms) for children and adolescents. Research also indicates that therapeutic intervention can be effective in alleviating these problems. Finkelhor and Berliner (1995) concluded in their review of treatment literature that therapeutic intervention for sexually abused children facilitates recovery. Children who are left untreated may exhibit difficulties in areas of daily functioning (e.g., school, peer and familial relationships), and have a significant chance of being revictimized (Browne & Finkelhor, 1986; Kendall-Tackett, Williams, & Finkelhor, 1993). Despite this strong documentation of the need for treating sexually abused children, there are few empirically validated treatments in the area.

Project SAFE (Sexual Abuse Family Education) was developed as a standardized group treatment program for sexually abused children and their non-offending caregivers. A systematic review of the literature on treatment programs, prior research and practice, and methodological issues provided the foundation for the treatment protocol (Hansen, Hecht, & Futa, 1998; Hecht, Futa, & Hansen, 1995). The intervention was designed to address three critical target areas impacted by sexual abuse: the individual or "self" (e.g., internalizing feelings); relationships (e.g., social interactions and externalizing problems); and sexual abuse related issues (Futa, Hecht, & Hansen, 1996). Project SAFE is unique in that it utilizes a standardized manual, involves the nonoffending caregivers in a parallel group, and incorporates a comprehensive assessment battery to evaluate treatment efficacy. The purpose of the current study is to examine Project SAFE's efficacy using an open clinical trial to explore child and family outcomes and satisfaction (i.e., social validity).

Methods

Participants

Participants included 24 children (ages 7 to 16) and 23 non-offending caregivers who completed Project SAFE treatment. The 24 children ranged in age from 6.1 to 16.1 years old, with a mean age of 12.2 years (SD = 2.9). There were 7 boys (29.2%) and 17 girls (70.8%). The ethnic backgrounds for the children included 15 Whites (62.5%), 1 Mexican American (4.2%), 6 Bi-racial youths (25%), and 2 Multi-racial youths (8.3%). The majority of the non-offending primary caregivers were biological mothers ($N = 21$, 91.3%) whereas the remaining two participants were a biological father and an aunt. The average parents' age was 36 (SD = 5.56; range of 23 to 48 years) and most were White ($N = 20$, 87%).

Thirty-seven alleged perpetrators were identified by the non-offending parents; 19 (51.4%) had an intrafamilial relationship with the child (e.g., biological parent, sibling, grandparent) while 18 (48.6%) had an extrafamilial relationship with the child (e.g., adult or child family friend, neighbor, peer). The majority of the alleged perpetrators were men ($N = 32$, 86.5%) and ranged in age from 10 to 69, with a mean of 25.8 years. The majority of victims in this sample experienced digital penetration or intercourse (vaginal, anal, or oral) ($N = 18$, 66.7%). Eight of the child victims were sexually assaulted by multiple perpetrators (i.e., two or three).

Procedures

Participants received the standardized 12-session Project SAFE group treatment. Procedures used in sessions are psychoeducational, skill building, problem-solving, and supportive. Child and parent groups each meet for 90-minute sessions. Project SAFE services are provided in the Psychological Consultation Center (PCC) of the Department of Psychology at UNL. Groups are co-facilitated by therapists who are doctoral students in the clinical psychology program at UNL.

Assessments are conducted at pre-treatment, post-treatment and three-month follow-up. Child-completed measures selected for the present study included:

Children's Depression Inventory (CDI; Kovacs, 1992). The CDI is a 27-item measure used to assess recent cognitive and somatic symptoms of depression.

Children's Fears Related to Victimization (CFRV). The CFRV is a 27-item subscale of the Fear Survey Schedule for Children – Revised (FSSC-R; Ollendick, 1983; Wolfe & Wolfe, 1986). The CFRV lists situations that sexually abused children seem to find particularly distressing (e.g., people not believing me, being lied to by someone I trust, people knowing bad things about me) and children rate how afraid he or she is of the situation.

Children's Impact of Traumatic Events – Revised (CITES-R; V.V. Wolfe, Gentile, Michienzi, Sas, & D.A. Wolfe, 1991). The CITES-R is a 78-item semi-structured interview developed to measure the impact of sexual abuse from the child's perspective across areas of Post-Traumatic Stress, Abuse Attributions, Social Reactions, and Eroticism.

Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985). The CLQ is a 24-item questionnaire that assesses children's feelings of loneliness, social adequacy, and subjective estimations of peer status.

Children's Manifest Anxiety Scale - Revised (RCMAS; Reynolds & Richmond, 1985). The RCMAS is a 37-item measure that assesses general anxiety with a Total Anxiety score comprising physiological, subjective, and motor symptoms of anxiety.

Self-Esteem Inventory (SEI; Coopersmith, 1981). The SEI contains 58 items that measure children's attitudes about themselves in social, academic, family, and personal areas of experience.

Parents provided abuse-related and demographic information. Parental measures used in this study included:

Child Behavior Checklist - Parent Report Form (CBCL; Achenbach, 1991). The CBCL - Parent Report Form is a 113-item checklist used for the assessment of parents' perceptions of social competence and behavioral problems of their children ages 4 to 18 years.

Child Sexual Behavior Inventory (CSBI; Friedrich, Grambsch, Damon, Hewitt, Koverola, Lang, Wolfe, & Broughton, 1992). The CSBI is a 35-item inventory completed by parents on the frequency of various sexual behaviors pertaining to sexual aggression, self-stimulation, gender-role behavior, and personal boundary violation observed in their children ages 2 to 12.

Family Adaptability and Cohesion Evaluation Scales (FACES-III; Olson, Portner, & Lavee 1985). The FACES-III is a 20-item self-report measure that assesses adaptability, cohesion, and family satisfaction.

Family Crisis Oriented Personal Evaluation Scales (F-COPES; McCubbin, Olson, & Larsen 1987). The F-COPES is a 30-item measure to assess effective problem-solving coping attitudes and behavior used by families in response to problems or difficulties. Two dimensions of family

interactions are assessed by the F-COPES: internal family strategies and external family strategies.

Parenting Stress Index (PSI; Abidin, 1986). The PSI is a 120-item self-report index for the assessment of stress associated with parenting. In this project, a modified version (20-items) of the PSI is used to assess two domains related to the parent: Restrictions of Role and Sense of Competence.

Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983). The SCL-90-R is a 90-item multidimensional symptom inventory to assess psychological distress.

Children and nonoffending caregivers also completed Project SAFE Evaluation Forms to assess social validity of treatment. Evaluation forms were designed for children and parents to provide feedback about their experience in therapy at the post-treatment assessment.

Results

Child Self-Report

Within-groups factorial ANOVAs were performed to examine the treatment effects of Project SAFE on the child-report measures. No significant differences were found between the pre- and post-treatment scores on the CDI, RCMAS, CFRV, CLQ, SEI, CITES Social Reaction Scale, or CITES Eroticism Scale. As shown in Figure 1, results revealed significant differences on the CITES PTSD Scale ($F(1, 23) = 21.55, p = .000$) and the CITES Attributions About Abuse Scale ($F(1, 23) = 5.57, p = .027$). Because these CITES scales were significant, additional ANOVAs were performed on the subscales of the CITES PTSD Scale and the CITES Attributions About Abuse Scale (see Figure 2 and 3). For the subscales of the PTSD Scale, significant differences were found on the Intrusive Thoughts ($F(1, 23) = 26.09, p = .000$), Avoidance ($F(1, 23) = 7.04, p = .014$), and Sexual Anxiety ($F(1, 23) = 8.862, p = .007$) subscales. The Hyperarousal subscale was not significant. For the subscales of the Attributions About Abuse Scale, significant differences were only found on the Self-Blame/Guilt subscale ($F(1, 23) = 6.503, p = .018$). No significant differences were found on the Personal Vulnerability, Dangerous World, or Empowerment subscales.

Figure 1. Treatment Outcome on CITES Scales

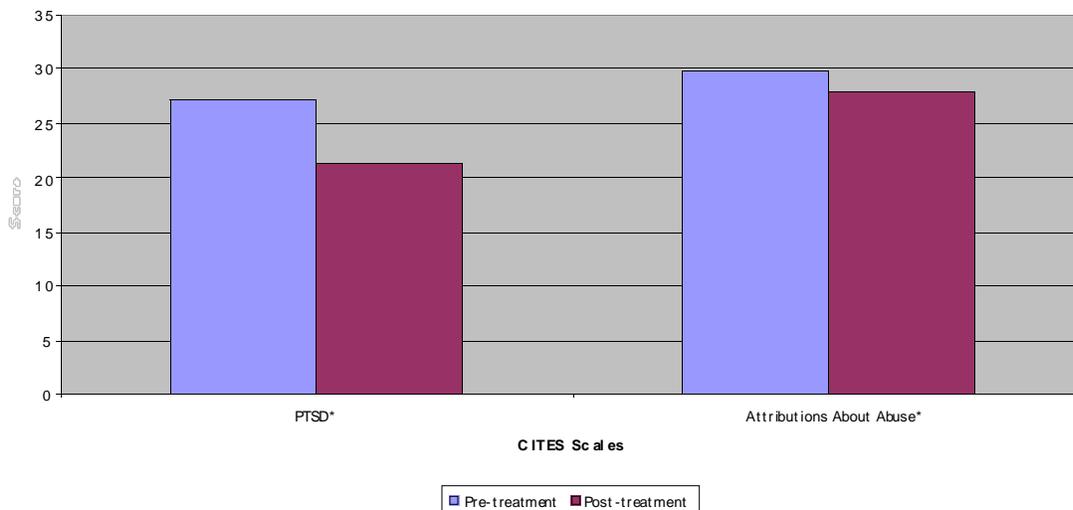


Figure 2. Treatment Outcome on CITES PTSD Subscales

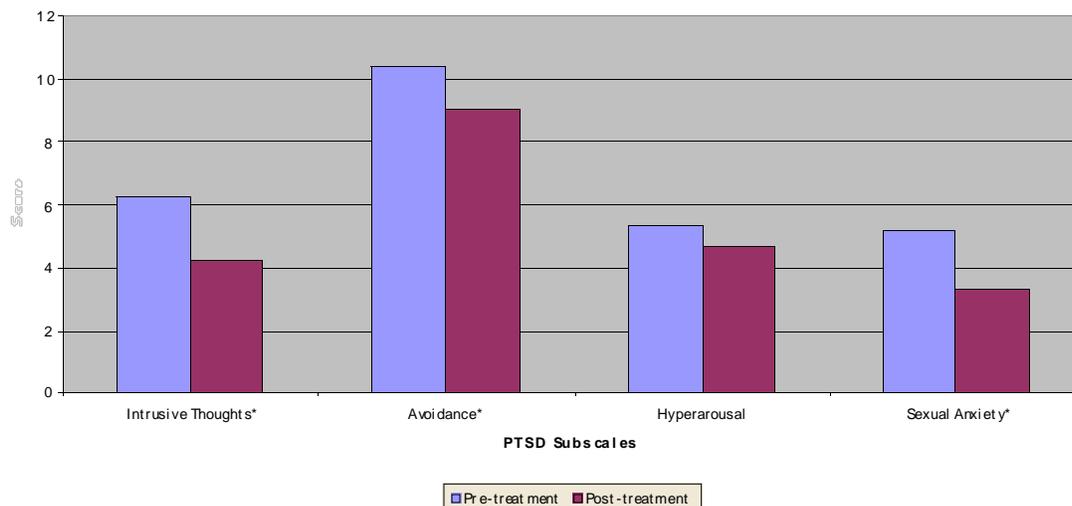
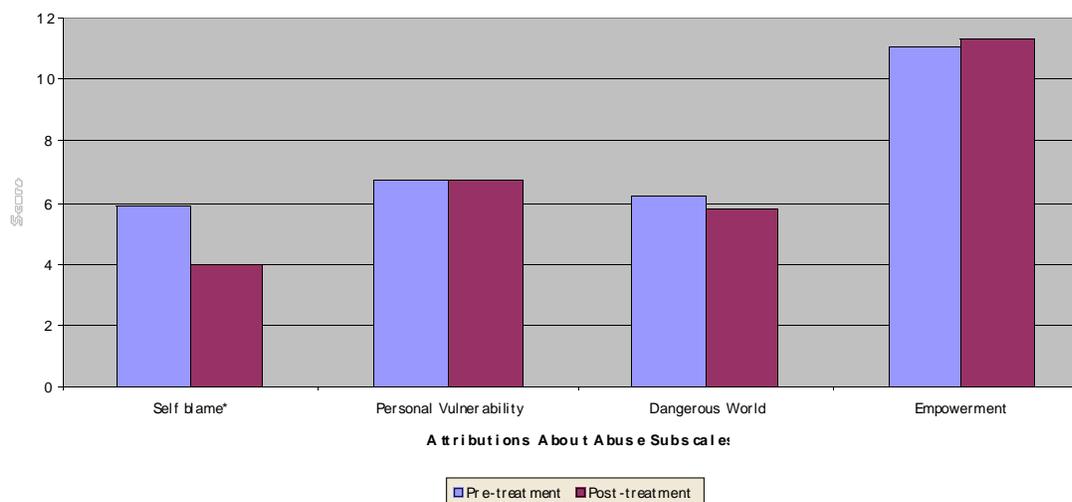


Figure 3. Treatment Outcome for CITES Attributions About Abuse Subscales

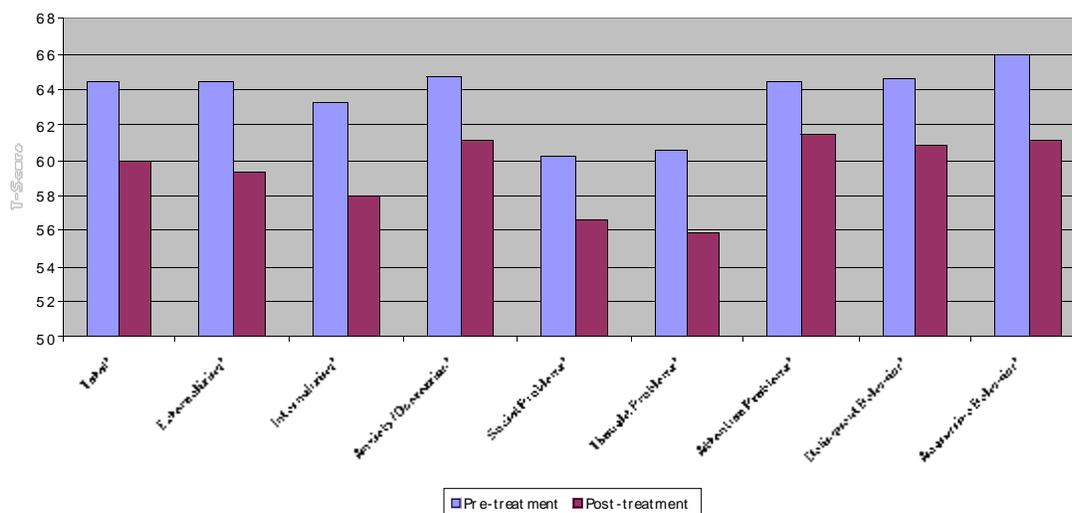


Parent Report

Within-groups factorial ANOVAs were performed to examine the treatment effects of Project SAFE on the parent-report measures. No significant differences were found between pre- and post-treatment scores on the CSBI, F-COPES, FACES Cohesion Now & Ideal Scales, FACES Adaptability Now Scale, PSI Restriction of Role Subscale, or SCL-90-R. As shown in Figure 4, results showed significant pre- to post-treatment differences on the CBCL Total Score ($F(1, 22) = 5.38, p = .030$), CBCL Internalizing Scale ($F(1, 22) = 7.62, p = .011$), CBCL Externalizing Scale ($F(1, 22) = 10.20, p = .004$), FACES Adaptability Ideal Scale ($F(1, 22) = 4.73, p = .042$), and PSI Sense of Competence Subscale ($F(1, 22) = 4.93, p = .037$). Because significant differences were found on the CBCL Scales, additional ANOVAs were performed on the subscales. As shown in Figure 4, results revealed significant differences between pre- and post-treatment scores on Anxiety/Depression ($F(1, 22) = 6.48, p = .018$), Social Problems ($F(1, 22) = 10.47, p = .004$), Thought Problems ($F(1, 22) = 5.12, p = .034$), Attention Problems ($F(1, 22) = 4.78, p = .04$),

Delinquent Behaviors ($F(1, 22) = 5.74, p = .026$), and Aggressive Behaviors ($F(1, 22) = 9.63, p = .005$) subscales. No significant differences were found on the Withdrawn or Somatic Complaints subscales.

Figure 4. Treatment Outcome on the CBCL



Maintenance of Treatment Gains

Fourteen children and 15 parents completed the three-month follow-up assessment to determine which treatment gains were maintained. Within-groups factorial ANOVAs were performed on all significant results by comparing the pre-treatment scores and the follow-up assessment scores. Similar to the previous analyses, significant differences were found on the CITES PTSD Scale, Intrusive Thoughts subscale, Avoidance subscale, Sexual Anxiety subscale, and Attributions Scale. The Self-Blame/Guilt subscale was no longer found to be significant, instead, the Personal Vulnerability ($F(1, 13) = 8.30, p = .024$) and Dangerous World subscales ($F(1, 13) = 6.50, p = .024$) of the Attributions About Abuse Scale were found to be significant at the follow-up assessment. On the parent-report measures, the PSI Sense of Competence Subscale and all of the CBCL Scales and Subscales continued to be significant whereas the FACES Adaptability Ideal was not found to be significant.

Family Satisfaction

Child and caregiver responses on the Evaluation Forms were examined systematically to determine the extent to which Project SAFE members believed that the treatment goals, procedures, and issues were addressed in treatment in a way that was helpful and relevant to the child and family's situation. Twenty-one children completed the Project SAFE evaluation form at the end of treatment. All youths rated their therapists as warm, understanding, and knowledgeable. Children felt that the group topics were important and were able to understand group topics most or some of the time. Overall, 20 children (95.2%) reported that most or some of the time (compared to "almost never") they feel better off than when Project SAFE groups began 3 month ago. See Table 1 for a list of activities and topics that children rated favorably (i.e., greater than 90%). The only exceptions to these favorable ratings included completing in-session worksheets (30% did not like this activity), talking about the offenders (38%), hearing that these things happened to other kids too (24%), and learning about secrets (29%).

Table 1. Project SAFE Child Evaluation Form – Aspects about group that were rated positively.

<i>Activities:</i>	<i>Topics Important to Discuss:</i>
<ul style="list-style-type: none"> - circle time - when we talked - doing the art (drawing) - when therapists did role playing - when we played games 	<ul style="list-style-type: none"> - my feelings - how others in the group felt about things - what happened to me - my family - my friends - who I can go to if I need help - how to solve problems - the difference between good and bad touches - how boys and girls bodies change as they grow up - what to do if someone wants me to do something that makes me feel uncomfortable

Twenty-two parents completed Project SAFE evaluation forms when treatment terminated. Parents rated their therapists as very or extremely supportive and knowledgeable. Regarding procedures, parents found it beneficial to summarize the content of the children's group at the beginning of each session and to meet with the child therapist at the end of each session. When asked to rate the overall impact of Project SAFE, a majority of the parents felt their child, themselves, and their family were a little, much, or very much better since the onset of treatment. Parents also rated the likeability and benefit of several topics and features (see Table 2 for specific aspects rated at 80% or higher). In the open-ended questions, parents appeared to value sharing their feelings and being in a supportive environment with other parents who had similar experiences.

Table 2. Project SAFE Parent Evaluation Form – Examples of features and group topics that were rated as “especially liked” or “very beneficial.”

<i>Features:</i>	<i>Topics:</i>
<ul style="list-style-type: none"> - meeting with the parent therapists - my child talking with other children with similar experiences - my child talking with the therapists about their experiences - treatment is free 	<ul style="list-style-type: none"> - developing a better understanding of my child's feeling - discussing my child's sexual abuse and hearing about the experiences of other families in the group - identifying my family's strengths - identifying how to improve my relationship with my child - learning the stages of grief in recovering from sexual abuse - learning ways to support my child as s/he is dealing with her/his feelings

Conclusions

This examination of Project SAFE's efficacy and social validity found improvements in child behavior and functioning as reported by both children and their non-offending parents. Specifically, results from the parent-report measures suggested that Project SAFE is effective in reducing child emotional and behavioral symptoms. Project SAFE youth reported substantially less post-traumatic stress symptoms and less maladaptive attributions about the abuse. In general, treatment gains reported by parents and youths were maintained after 3 months in the subsample for whom follow-up data were available. Families also believed that treatment was helpful and pertinent to their situation.

These results are encouraging and suggest a need for using a comprehensive assessment battery to increase the current understanding of youth symptoms and the adjustment of families following disclosure of sexual abuse and for treating sexually abused children and their families.

Involving non-offending caregivers in treatment appears to be a valuable component of an effective treatment program. Future research is needed to understand which aspects of treatment are beneficial for which participants. In addition, examinations of the mechanisms through which parental support and family functioning relate to child adjustment are important. At this time, the small sample size of children and parents completing Project SAFE treatment limited the level and extent of analyses. With a larger sample size, researchers could investigate potential differential impact of group treatment for boys versus girls and for children versus adolescents. Larger sample sizes would also permit exploration of mechanisms of effect and target cognitions, behaviors, and emotional responses most likely influenced by group treatment.

These encouraging findings of post-treatment improvement for participants in a group treatment program underscore the importance of developing empirically validated treatments for sexually abused children and their non-offending parents. As part of this effort, future well-designed treatment studies are needed. To strengthen confidence in research findings, treatment protocols need to be disseminated for use by other researchers and practitioners for independent replication and subsequent controlled investigations.

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