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Tara K. Cossel
University of Nebraska - Lincoln, tkcossel@gmail.com

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Child Sexual Abuse Victims and their Families Receiving Services at a Child Advocacy Center: Mental Health and Support Needs

Tara K. Cossel

Mentor: David J. Hansen, Ph. D.
Department of Psychology

Abstract

The present study aimed to document the effects of child sexual abuse among children, non-offending parents, and siblings to further address the needs of child victims and their families. Following abuse, children are often referred to Child Advocacy Centers (CACs) for mental health and other support needs. Today most sexually abused children receive homogenized treatment from CACs; however, there is variability in the needs these children and their family members present with (Finkelhor & Berliner, 1995). Research has begun to investigate the variability in symptom patterns of sexual abuse victims, finding aspects of the abuse including severity, duration, frequency, and amount of force seem to affect the types of symptoms displayed by sexual abuse victims (Kendall-Tackett et al., 1993).

This exploratory study examined the nature of presenting needs of sexually abused youth and their families. Participants were child victims, their siblings, and their caregivers seeking treatment at a Midwestern CAC. Participants were given a battery of measures that assessed mental health, efficacy, expectations, knowledge and behaviors. As we hypothesized, there was heterogeneity in the mental health and support needs of child victims and family members. Varying expectations, levels of efficacy, and mental health states of child victims, siblings and parents seem to contribute to the need for different types of treatment and support for sexually abused children and their families. Based on these findings, it would be beneficial for CACs to incorporate programs to address the varied mental health and support needs of child sexual abuse victims and their families.

Child sexual abuse is a widespread problem. Recent reports from child protective agencies indicate that 78,120 children were sexually abused in the United States in 2006 (U.S. Department of Health and Human Services, 2006). Among nonclinical adults, an estimated 17% of women and 8% of men experienced sexual abuse as children (Gorey & Leslie, 1997).

Research has shown child victims of sexual abuse display a multitude of symptoms, including: poor self-esteem, anxiety, self-harm behavior, sexual behavior problems, cognitive distortions and attribution errors (Paolucci, Genuis, & Violato, 2001).

However, research consistently demonstrates child sexual abuse does not necessarily have an inevitable pattern or a unified presentation of symptoms. Rather, sexually abused youth display a myriad of symptoms at varying levels of severity, and some children display few or no symptoms following abuse (Kendall-Tackett, Williams, & Finkelhor, 1993).

In response to the significant problem of sexual abuse, the development of Child Advocacy Centers (CACs) has increased nationwide. CACs provide community-based, child-focused programs to investigate, treat, manage, and prosecute child sexual abuse cases (Jackson, 2004). Within the National Children's Alliance, CACs follow a model with nine core components, including: a child-friendly facility, a multidisciplinary team, an investigative child interview, a medical examination of the child, provision of mental health services, victim advocacy, case review, case tracking, and organizational structure (Jackson, 2004). This model reduces the number of repeat interviews conducted with children, provides the victim with support, and facilitates better-informed decision-making (APSAC, 2002, Lanning, 2002, National Children's Advocacy Center, 2005a and national Children's Advocacy Center, 2005b).

One essential component of CACs is mental health. In all CACs, services are provided to ease the emotional impact of sharing the details of abuse and to mediate long-term effects of the experience and disclosure of abuse (Jackson, 2004). Jackson (2004) found 93% of affiliated CACs provide mental health services to non-offending caregivers as well. Still, little is known of the type of mental health services provided to families coping with sexual abuse or of the mental health and support needs with which these families present because of the variability of symptoms displayed by sexually abused youth.

Recent research has begun to show the variability in symptom patterns of sexual abuse victims. While children who have been sexually abused tend to exhibit more PTSD symptoms and sexualized behavior

than other children referred to services (Beitchman et al., 1991; Friedrich et al., 2001; Green, 1993; Kendall-Tackett et al., 1993), there is great heterogeneity of presenting symptoms across these victimized children (Beitchman, et al., 1991; Finkelhor & Berliner, 1995; Green, 1993; Wolfe & Birt, 1995). Research has been done to explore the reasons for this variability. Aspects of the abuse including severity, duration, frequency, and amount of force seem to affect the type of symptoms displayed by child sexual abuse victims (Kendall-Tackett et al., 1993; Wolfe & Birt, 1995). Through exploratory analyses, the present study examines the nature of the presenting needs of child sexual abuse victims and their families.

The purpose of this study is to document the effects of child sexual abuse among children, non-offending parents, and siblings to further address the needs of child victims and their families. Child victims of sexual abuse were expected to show varied needs with diversity in mental health symptoms, sexual behavior, sexual knowledge and attitudes, and expectations regarding the impact of abuse. We also hypothesized non-offending parents would present with varied mental health symptoms, expectations, and efficacy and require differing mental health and support services. Further, preliminary analyses were expected to show heterogeneity in the mental health symptoms displayed by siblings of victimized youth.

Method

Participants

Participants in this study included 207 sexually abused youth, their siblings and their non-offending caregivers seeking treatment at a Midwestern CAC. The children ranged in age from 4 to 17 years with a mean age of 11.02 years (*SD* = 3.16). Of the child victims, 154 (75.9%) were female and 156 (76.8%) were Caucasian. One hundred sixty-four (84.1%) were abused by only one perpetrator. Of the offenders, 183 (94.8%) were male, and 97 (50.3%) were family members.

The mean age of the non-offending parents was 37.1 years (*SD* = 7.43; range of 23 to 72 years). The majority of the non-offending caregivers were a biological parent with 152 (75.6%) being the biological mother and 28 (13.9%) being the biological father. One hundred seventy-three (86.9%) identified themselves as Caucasian. The sample was primarily middle class and 82 (42.7%) were married.

The following measures were used to assess the mental health and support needs of child victims and their non-offending parents and siblings.

Measures

Child victim-report measures. The following measures were given to child victims.

Child Expectations Following Abuse Scale. The Child Expectations Following Sexual Abuse Scale (Project SAFE) is a 10-item self-report instrument used to assess the child's expectancies in social, emotional, and behavioral domains.

Children's Impact of Traumatic Event-Revised. The Children's Impact of Traumatic Events-Revised (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991) is a structured interview measuring the child's perspective, the impact of sexual abuse across areas of Post-Traumatic Stress, Abuse Attributions, Social Reactions, and Eroticism. Moderate support has been demonstrated for the reliability and validity of the CITES-R (alpha = .89) (Chaffin & Shultz, 1999; Crouch, Smith, Ezzell, & Saunders, 1999).

Children's Loneliness Questionnaire. The Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985) is a 24-item measure that assesses children's feelings of loneliness, social adequacy, and subjective estimations of peer status. Children were asked to rate each statement on a 5-point scale ranging from 1 (*That's always true about me*) to 5 (*That's not true at all about me*). Eight items on the CLQ are "filler" items and are not scored. The CLQ has good reliability (alpha of .90) for the 16 primary items (Asher & Wheeler, 1985). Validity of the CLQ distinguishing social status of children has also been established (Asher & Wheeler, 1985).

Children's Manifest Anxiety Scale-Revised. The Children's Manifest Anxiety Scale-Revised (CMAS-R; Reynolds & Richmond, 1985) is a 37-item self-report measure that assesses general anxiety in children and adolescents ages 6 to 19. The Total Anxiety score is based on 28 items pertaining to physiological, subjective, and motoric symptoms of anxiety. Reliability has been established with the CMAS-R (alpha = .83).

Sexual Knowledge & Attitude Inventory. The Sexual Knowledge & Attitude Inventory-Revised (Malinosky-Rummell, Hoier, & Pisaruk, 1989) assesses the child's basic sexual knowledge and attitudes about sex and sexual abuse (e.g., "sexual abuse only means forced private part touching").

Child victim and sibling-report measures. Child victims and their siblings were given the following measures.

Adolescent Clinical Sexual Behavior Inventory-Self-Report. The Adolescent Clinical Sexual Behavior Inventory-Self-Report (ACSBI-S) for 12-18 year olds only is a 45-item checklist that assesses sexual behavior of adolescents in the past 12 months. Participants answered each item on a 3-point scale (1 = *not true*, 2 = *somewhat true*, 3 = *very true*). Good reliability has been established for the ACSBI-S (alpha = .86; Friedrich, et al., 2004).

Child Behavior Checklist-Youth Self-Report. The Child Behavior Checklist-Youth Self-Report (CBCL-YSR) is a self-report measure that assesses internalizing and externalizing behaviors in 11-18 year olds (Achenbach, 1991).

Children's Depression Inventory. The Children's Depression Inventory (CDI; Kovacs, 1992) is a 27-item self-report measure that assesses depression in children between the ages of 7 and 17. Respondents are asked to rate how they felt in the past two weeks based on three choices that are scored from 0 to 2. The CDI has been shown to have good internal consistency (r = .71 to .89; Kovacs, 1992).

Children's Fears Related to Victimization. The Children's Fears Related to Victimization (CFRV) is a 27-item subscale of the Fear Survey Schedule for Children-Revised (FSSC-R; Ollendick, 1983) and was previously known as the Sexual Abuse Fear Evaluation (SAFE; Wolfe & Wolfe, 1986). Children rate their distress in situations that sexually abused children tend to find stressful (e.g., people not believing me). Two reliable subscales, the *sex-associated fears* (alpha = .81) and *interpersonal discomfort* (alpha = .80) have been identified (Wolfe et al., 1989; Wolfe, Gentile, & Klink, 1988).

Coppersmith Self-Esteem Inventory. The Self-Esteem Inventory (SEI; Coopersmith, 1981) is a 58-item questionnaire that measures children's attitudes about themselves in social, academic, family, and personal areas. The SEI concept of self-esteem refers to the child's approval or disapproval of him or herself. For each item, respondents are asked to check *like me* or *unlike me*. The SEI has adequate reliability (alpha = .80 - .92; Coopersmith, 1981).

Parent-report measures. Non-offending caregivers were given the following measures.

Child Behavior Checklist. The Child Behavior Checklist (CBCL; Achenbach, 1991) is a 113-item checklist that assesses parents' percep-

tions of social competence and behavioral problems displayed by children ages 4-18. Parents were instructed to rate the presence of problem behaviors in the previous six months on a three-point scale ranging from 0 (*not true*) to 2 (*very true*). Reliability and validity have been well established with the CBCL (Achenbach, 1991).

Child History Form. The Child History Form (CHF) is an unstructured interview that addresses relevant abuse-related information. The CHF was completed by one of the Project SAFE staff members while parents verbally provided information about the abuse in their own words. Abuse characteristics gathered include age at onset and cessation of abuse, abuse duration, relationship to perpetrator, frequency of abuse, nature of abuse, and severity of abuse. This information was used for descriptive purposes.

Child Sexual Behavior Inventory-3. The Child Sexual Behavior Inventory-3 (CSBI-3) measures the frequency of various sexual behaviors pertaining to sexual aggression, self-stimulation, gender-role behavior, and personal boundary violation parents observed in children ages 2 to 12. Good reliability has been demonstrated by the CSBI-3 in children with a confirmed history of sexual abuse (alpha = .93). Validity has also been established for the CSBI-3 (Friedrich, et al., 2001).

Childhood Trauma Questionnaire. The Childhood Trauma Questionnaire (CTQ; Bernstein, & Fink, 1998) is a 28-item self-report measure that addresses history of abuse and neglect in childhood. Participants were asked to rate each item on a five-point scale from "*never true*" too "*very often true*."

Family Adaptability and Cohesion Evaluation Scales. The Family Adaptability and Cohesion Evaluation Scales (FACES-III; Olson, 1986) is a 20-item self-report measure that assesses adaptability, cohesion, and family satisfaction. The FACES-III is given twice to assess the respondent's perceptions of the current and ideal family systems using a 5-point scale from 1 (*almost never*) to 5 (*almost always*). The FACES-III has fair reliability (alpha = .62 - .77; Olson, 1986).

Family Crisis Oriented Personal Evaluation Scales. Family Crisis Oriented Personal Evaluation Scales (F-COPES; McCubbin, Olson, & Larsen 1987) is a 30-item measure that assesses effective problem-solving, coping attitudes and behavior used by families when responding to problems or difficulties. Participants rate each item on a scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Two dimensions of family interactions are assessed by the F-COPES: internal family strategies (resources within the nuclear family system) and external family strategies (behav-

iors used to acquire resources outside of the family). The F-COPES demonstrates good reliability (alpha = .86; Hsu, 2003).

Parental Efficacy Questionnaire. The Parental Efficacy Questionnaire (PEQ) is a questionnaire developed by the University of Rochester Toddler Project that assesses the extent to which a caregiver feels that he or she is an effective parent. Parents are presented with various parent-child situations and then asked to rate how good they feel they are at accomplishing a specific parenting task. Good reliability was established (alpha = .80; Hsu, 2003).

Parenting Stress Index. The Parenting Stress Index (PSI; Abidin, 1986) is a 120-item self-report measure that assesses stress associated with parenting using a scale from 1 (*strongly agree*) to 5 (*strongly disagree*). The PSI assists with the identification of dysfunctional parent-child relationships. Although the PSI includes parent and child domains, only two subscales from the parent domain were used for this study: Restrictions of Role and Sense of Competence. Good reliability has been established for the parent domain of the PSI (alpha = .55 - .80; Hsu, 2003).

Post Sexual Abuse Expectations Scale. The Post Sexual Abuse Expectations Scale (PSAES) is an 8-item inventory on which parents rate the negative impact they expect sexual abuse to have on their child over the next 12 months on a 5-point scale ranging from 1 (*no negative impact*) to 5 (*substantial negative impact*). Parents indicate the degree of impact they expect in several domains, including school, behavioral and emotional adjustment, and relationships with peers, parents, caregivers, and siblings, and overall functioning. Good reliability has been demonstrated for the PSAES (alpha = .90; Kouyoumdjian, Perry, & Hansen, *in press*).

Symptom Checklist-90-Revised. The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1983) is a 90-item multidimensional symptom inventory. Respondents rated the degree of distress experienced for each symptom using a 5-point rating scale ranging from 0 (*not at all*) to 4 (*extremely*). The Global Severity Index provides a global measure of psychological distress. The SCL-90-R has shown high levels of both internal consistency and test-retest reliability (Derogatis, 1983). Validity of the SCL-90-R has been well established (Derogatis, 1983).

Procedure

Therapists collected data through evaluations at the CAC. All families were referred to Project SAFE, a curriculum-led group treatment pro-

gram for sexually abused youths ages 7 to 17 and their non-offending parents or caregivers (Hansen, Hecht, & Futa, 1998). Parents and children participated in separate groups covering parallel topics. The groups were co-facilitated by doctoral students under the supervision of licensed clinical psychology faculty in the Clinical Psychology Training Program at the University of Nebraska-Lincoln.

Participant recruitment. Interested families meeting the inclusion criteria were informed they would receive $20 for completing the assessment. Families were given the option to participate in Project SAFE without participating in the research, although none refused to complete the assessment. Families participating in Project SAFE were considered clients of the Psychological Consultation Center (PCC), a training clinic for the Clinical Psychology Training Program at the University of Nebraska-Lincoln. Per PCC policy, limits of confidentiality and consent forms were completed for each family member participating in the program.

Assessment. Parents and children were surveyed in separate rooms, and a staff member was present to administer the measures. Both groups took about 1.5 to 2 hours to complete the packets. If the parents did not attend the parents' group, the family was given a packet to complete and promptly return to the program director.

Child sexual abuse victims were given all child-report measures listed above. Siblings of victimized youth were given the ACSBI, CBCL-YSR, CDI, CFRV and SEI. Non-offending caregivers responded to all adult measures listed above.

Data analysis.

Participant description. Descriptive analyses (mean, standard deviation and frequencies) were used to determine participant demographic and abuse history variables.

Summary of child victim mental health symptoms. Descriptive analyses (mean and standard deviation) were run on child mental health scores for sexual abuse victims, including those from child and parent report-measures (CITES-R, CLQ, CMAS-R, Sexual Knowledge & Attitude Inventory, ACSBI, CBCL-YSR, CDI, CFRV SEI, CBCL, CHF, CSBI-3, and CTQ). These results are summarized in Table 1 displaying the number and percentage of youth who score above the established clinical cutoff. Scores in related areas (e.g., internalizing symptoms, externalizing symptoms) are presented together.

Table 1. Summary of Child Victim Measures

Scales	N	Mean (SD)	Cutoff N (%)
CBCL-YSR	78	61.95 (11.26)	35 (44.87%)
CDI	168	54.98 (13.56)	40 (23.81%)
CMAS-R	165	53.87 (13.25)	37 (22.42%)
MASC	122	57.90 (13.41)	41 (33.61%)
CBCL (parent-report)	187	61.29 (11.89)	77 (41.18%)
CSBI-3 (parent-report)	79	4.89 (6.00)	0 (0.00%)
Scales without clinical cutoffs	N	Mean (SD)	
CITES-R PTSD	166	27.42 (9.80)	
CFRV	165	53.15 (10.84)	
CLQ	160	33.11 (13.84)	
SEI	162	62.76 (19.03)	
SKAI	159	14.10 (2.40)	
ASBI	25	18.60 (7.29)	

Summary of sibling mental health symptoms. Descriptive analyses (mean and standard deviation) were run on child mental health scores for siblings, including those from child and parent report-measures (CITES-R, CLQ, CMAS-R, Sexual Knowledge & Attitude Inventory, AC-SBI, CBCL-YSR, CDI, CFRV SEI, CBCL, CHF, CSBI-3, and CTQ). These results are summarized in Table 2 displaying the number and percentage of youth who score above the established clinical cutoff. Scores in related areas (e.g., internalizing symptoms, externalizing symptoms) are presented together.

Summary of parent mental health symptoms. Descriptive analyses (mean and standard deviation) were run on the scores for the parent mental health measures (PEQ, PSI, SCL-90-R). These results are

Table 2. Summary of Sibling Measures

Scales	N	Mean (SD)	Cutoff N (%)
CBCL-YSR	6	48.33 (8.24)	0 (0%)
CDI	18	8.17 (7.76)	0 (0%)
MASC	17	54.53 (13.16)	4 (23.53%)
Scales without clinical cutoffs	N	Mean (SD)	
CFRV	16	51.94 (12.03)	
SEI	18	74.06 (17.63)	
ASBI	4	7.50 (5.45)	

Table 3. Summary of Parent Measures

Scales	N	Mean (SD)	Cutoff N (%)
CTQ			
Emotional Abuse	124	11.57 (5.96)	50 (40.32%)**
Physical Abuse	124	9.24 (4.74)	28 (22.58%)**
Sexual Abuse	124	10.07 (7.08)	39 (31.45%)**
Minimization/Denying	124	11.50 (5.59)	52 (41.94%)**
SCL-90-R (Positive Symptom Total)	182	45.81 (11.49)	14 (7.69%)

***Note: extreme to severe criteria for the CTQ is ≥ 13*

summarized in Table 3, with scores in related areas presented together. In addition, the number and percentage of parents who score above the established clinical cutoff scores are presented in the table.

Summary of expectations and support variables. Descriptive analyses (mean and standard deviation) were run for the various expectations and support measures not addressed in the previous analyses (Child Expectations Following Abuse Scale, PES, PSAES, F-COPES, and FACES-III). These results are summarized in Table 4, with scores in related areas presented together.

Results

Characteristics of the sexual abuse were varied. The most common type of sexual abuse behaviors in this sample was fondling 132 (69.11%). Non-offending parents estimated 62 (32.6%) of children experienced one abuse incident and 97 (51.1%) were victimized multiple times. Thirty-one (16.3%) of non-offending parents were unsure of the total number of incidents. Age of onset of abuse ranged from 0 to 17 years with a mean age of 8.39 years (*SD* = 3.43). Duration of abuse ranged from 0 to 132 months, with a mean duration of 13.24 months (*SD* = 20.90).

Child Victim Results

Data for child victim measures is presented in Table 1. As was hypothesized, there was great heterogeneity in the mental health symptoms of child sexual abuse victims presenting to treatment. On the CDI, 40 (23.81%) scored above the clinical cutoff for depression. Of the child victims, 37 (22.42%) scored above the clinical cutoff for anxiety on the

CMAS-R. Forty-one (33.61%) scored above the clinical cutoff for anxiety on the MASC.

Many child sexual abuse victims presented with sexual behaviors, knowledge and attitudes inappropriate for their age. The mean for the ASBI was 18.6 (*SD* = 7.29) and 44.87% of child victims scored above the clinical cutoff on the CBCL-YSR. The mean for the SKAI was 14.1 (2.4).

Victimized children showed symptoms in their general wellbeing in expectations regarding the impact of abuse, fears of re-victimization, and low self-esteem. The mean for the CFRV was 53.15 (10.84). The mean for the SEI was 62.76 (19.03).

Sibling Results

Data for sibling measures are summarized in Table 2. All siblings had subclinical scores for the CBCL-YSR or the CDI. On the MASC, 23.53% of siblings scored above the clinical cutoff for anxiety.

There was variability in the general wellbeing of siblings of victimized youth regarding fears related to victimization, self-esteem and sexual behaviors. The mean for the CFRV was 51.94 (*SD* = 12.03). For the SEI the mean was 74.06 (*SD* = 17.3). The mean for the ACSBI was 7.5 (*SD* = 5.45).

Non-offending Caregiver Results

Data for parent measures are summarized in Table 3. As was hypothesized, non-offending caregivers of sexually abused children presented with varied mental health symptoms. Among caregivers, 7.69% scored above the clinical on the SCL-90-R symptom total.

There was also variability in the abuse and neglect history of non-offending caregivers. On the CTQ, 40.32% of caregivers scored above the clinical cutoff for emotional abuse. For physical abuse, 22.58% had scores above the clinical cutoff. Of the caregivers, 31.45% were above the clinical cutoff for sexual abuse. For emotional neglect, 41.94% of caregivers had scores above the clinical cutoff.

Discussion

The present study found heterogeneous symptomotology across victims of child sexual abuse consistent with previous research (Hébert et al., 2006). Results of this study further showed heterogeneity in the mental health symptoms and support needs of the victims' non-offending sib-

lings and non-offending parents. Based on these findings, all family members could benefit from treatments more specific to their individual needs.

Sawyer (2005) and colleagues used cluster analyses to identify four distinct profiles of sexually abused children: Behavior Problem, Highly Distressed, Moderately Distressed and Subclinical. Similarly, findings in this study suggest variability in the severity and nature of symptoms of sexually abused youth, including youth who exhibit little to no symptoms across a variety of measures. The results from this study provide further evidence that members of these subgroups of sexual abuse victims could benefit from psychological treatment specific to their needs.

Strengths of the present study include the large sample size and wide variety of measures used. Further, this research is unique in that it is CAC-based and focuses on the heterogeneity of symptom presentation among sexually abused youth as well as their non-offending caregivers and non-offending siblings.

Limitations of the present study include the small sample size of the sibling group. Data was collected at one Midwestern CAC, which limits the generalizability of the findings. Additionally, not every family seeking treatment from the CAC was assessed.

Many youth scored above the clinical cutoffs on a variety of measures, however the current data does not capture individual youth who scored above the clinical cutoff on multiple assessment measures. Future analyses will investigate distinct groups of youth, as varying expectations, levels of efficacy, and mental health states of child victims, siblings and parents seem to contribute to the need for different types of treatment and support for sexually abused children and their families.

Findings from the current study provide further evidence of the heterogeneity of mental health symptoms and needs for child sexual abuse victims. Based on these findings, it would be beneficial for CACs to tailor intervention programs to specifically address the varied symptoms and behavior problems of each clinical subgroup.

Future research could incorporate participants from Child Advocacy Centers across the country to further examine the heterogeneity of symptom presentation and support needs among sexually abused youth and their non-offending caregivers. Additional measures may also assist in a better understanding of symptom presentation. For example, emotion regulation may be a factor of resiliency, and assessment measures, such as the Difficulties in Emotion Regulation Scale (DERS; Gratz, & Roemer, 2004), could be used to examine individuals who display few or no symptoms following abuse.

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