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Abstract

This study presents the case of 11-year-old Amanda and her mother (Ms. Jones) who completed Project SAFE (Sexual Abuse Family Education), a manualized group treatment for sexually abused children and their nonoffending caregivers. Amanda experienced sexual abuse by her stepfather on multiple occasions over a 4-year period. Prior to treatment, Amanda reported symptoms of anxiety, posttraumatic stress, and fear related to victimization. Ms. Jones also reported clinically significant internalizing problems for Amanda. Ms. Jones presented with stress related to parenting as well as depression and anxiety. Both Amanda and Ms. Jones completed the entire 12-session protocol. Amanda and Ms. Jones's progress throughout treatment are described, along with implications of the case and recommendations for clinicians and students. Results support the efficacy of the group modality, the importance of including nonoffending caregivers, and the necessity of broad treatment strategies when treating children who have experienced sexual abuse.

Keywords: child sexual abuse, cognitive-behavioral treatment, group treatment

1. Theoretical and Research Basis for Treatment

Child sexual abuse (CSA) is a widespread problem that is often associated with impaired psychological functioning (Putnam, 2003). Children who have been exposed to sexual abuse are a heterogeneous group, with some children displaying little or no difficulties and some children displaying severe psychiatric symptoms (Sawyer & Hansen, 2009). Symptoms of posttraumatic stress disorder (PTSD), depressive disorders, anxiety disorders, and behavioral disorders are common among children exposed to CSA (Kendall-Tackett, Williams, & Finkelhor, 1993; Putnam, 2003; Sawyer & Hansen, 2009). Sexually abused children are also at increased risk for suicidality, alcohol and drug abuse, academic difficulties, childhood sexualized behavior problems, and risky sexual behavior (Boden, Horwood, & Fergusson, 2007; Hardt et al., 2008; Herbert, Tremblay, Parent, Daignault, & Piche, 2006; Moran, Vuchinich, & Hall, 2004; Nagy, Adcock, & Nagy, 1994; Sartor, Agrawal, McCutheon, Duncan, & Lynskey, 2008). Resiliency, however, is also common following CSA, and many children do not experience decreases in functioning (Haskett, Nears, Ward, & McPherson, 2006).

CSA can also cause a great deal of distress for caregivers (Elliott & Carnes, 2001; Lewin & Bergin, 2001; Mannarino, Cohen, Deblinger, & Steer, 2007). In a review of the literature on nonoffending caregivers' reactions to disclosure of sexual abuse experienced by their children, Elliot and Carnes (2001) found that many nonoffending caregivers report symptoms of PTSD and depression. Caregiver distress may lead to poorer outcomes for children who experience abuse, as distressed caregivers are less likely to be able to provide support for their children and model appropriate coping strategies (Deblinger, Stauffer, & Steer, 2001). Support from nonoffending caregivers can serve as a buffer against the decreased psychological functioning that children may experience following CSA (Rosenthal, Feiring, & Taska, 2003). Many treatments for children who have experienced sexual abuse include components for nonoffending caregivers aimed at decreasing their abuse-related distress and increasing their ability to provide support for their children (Cohen, Mannarino, Berliner, & Deblinger, 2000; Tavkar & Hansen , 2011).

Research examining treatment outcomes for sexually abused children has demonstrated that cognitive-behavioral therapy (CBT) can be helpful in decreasing symptoms associated with CSA (for reviews, see King et al., 2003; Saywitz, Mannarino, Berliner, & Cohen, 2000). Given the diversity of outcomes following CSA, CBT protocols used with children who have experienced abuse must be capable of addressing a wide range of symptoms and difficulties (Saywitz et al., 2000). Inclusion of nonoffending caregivers in the treatment process appears to be an integral component of successful CSA treatment (e.g., Cohen & Mannarino, 1998, 2000). Such inclusion can teach caregivers strategies for providing children with support, help them to identify and monitor a child's symptoms, and address areas of dysfunction in the family that may be contributing to those symptoms (Cohen et al., 2000). Furthermore, caregivers may also learn how to better cope with their own abuse-related distress (Saywitz et al., 2000).

One effective treatment modality for delivery of services to children who have experienced sexual abuse is group treatment (Avinger & Jones, 2007; Reeker, Ensing, & Elliott, 1997). There are several benefits of this type of treatment. Group treatment allows members

to discuss the abuse and their feelings about it with others who have had similar experiences. Children and parents learn that other families have also experienced abuse and related symptoms, which may help to reduce feelings of isolation and stigmatization (Hetzel-Riggin, Brausch, & Montgomery, 2007). The group setting also allows for educational experiences such as opportunities to enhance social skills, practice new behaviors with peers (e.g., assertiveness), and participate in role-play situations with other group members (De Luca, Boyes, Furer, Grayston, & Hiebert-Murphy, 1992). In addition, group treatment is a cost-effective modality, allowing multiple children with varying symptom presentations to be treated simultaneously.

Project SAFE (Sexual Abuse Family Education) is a manualized, cognitive-behavioral group treatment for children who have experienced CSA (aged 7-16 years) and their nonoffending caregivers. The 12-session protocol uses parallel treatment groups for children and their nonoffending caregivers. Different developmentally appropriate versions of the protocol exist for younger children and adolescents. Development of the manual was based on systematic review of the literature on treatment for CSA, which revealed a need for treatments capable of addressing a heterogeneous range of symptom presentations (Hansen, Hecht, & Futa, 1998). Project SAFE provides treatment to groups of children with varied levels and types of symptoms simultaneously. The treatment focuses on three broad areas often affected by CSA: (a) the individual/self (e.g., self-esteem, self-blame, internalizing difficulties), (b) relationships (e.g., social skills, externalizing problems with peers and family), and (c) sex (e.g., sexual knowledge, sexual abuse–specific psychoeducation, sexual behavior problems). A comprehensive battery of standardized measures is used to assess functioning in these three areas at pretreatment and to monitor changes as treatment progresses (Hsu, 2003). The broad focus and inclusive nature of the protocol differentiate it from individual treatment options for children who have experienced CSA, such as trauma-focused CBT (Cohen, Mannarino, & Deblinger, 2006), which focuses on ameliorating specific trauma-related psychiatric diagnoses (e.g., PTSD) that children may experience following abuse (Lang, Ford, & Fitzgerald, 2010).

Project SAFE is designed to improve outcomes for children's sense of stigmatization and isolation associated with the abuse, to assist them in exploring and coping with their feelings about the abuse, and to empower them in preventing future victimization. The parallel parent group assists parents in understanding and dealing with their children's behaviors and feelings in an attempt to ensure that the children's in-session therapeutic gains are generalized and maintained. Each Project SAFE session incorporates psychoeducation, skill building, problem solving, and supportive procedures, as well as emphasizing strategies to prevent further abuse (Hsu, Sedlar, Flood, & Hansen, 2002). Skills for identifying and coping with the wide range of affect that children and caregivers experience in response to abuse are taught in the initial portions of treatment and practiced throughout group as feelings related to different aspects of the abuse (e.g., the perpetrator, related changes in the family) are explored. Throughout group, therapists ask group members to articulate thoughts about the abuse, especially those that may be maladaptive or inaccurate. Therapists assist group members in examining evidence related to their thoughts about the abuse, especially evidence that can be generated based on psychoeducation that

has been provided, and help clients modify thoughts that may lead to maladaptive emotions or behaviors.

Project SAFE groups are conducted by a trained master's level therapist, along with a cotherapist. Cotherapists are pre–master's level doctoral students in clinical psychology, who participate in training by experienced master's level therapists prior to delivery of Project SAFE services. The master's level therapist delivers weekly material, facilitates and responds supportively to the group, and engages group members in problem-solving and skill-building exercises. The role of the cotherapist is to assist in skill modeling, encourage participation, and observe client reaction to treatment (Hansen et al., 1998). Project SAFE evaluations comparing scores on assessment measures delivered prior to and following treatment have documented posttreatment improvements for children, including lower anxiety, fewer posttraumatic stress symptoms, increased basic sexual knowledge, fewer negative perceptions of social reactions, increased self-esteem, and fewer maladaptive abuse attributions (Campbell et al., 2006; Hsu, 2003; Sawyer et al., 2005). Follow-up assessments have demonstrated maintenance of these gains for 3 months following treatment completion (Campbell et al., 2006).

2. Case Introduction

This study presents the case of an 11-year-old girl (Amanda) in fifth grade and her mother (Ms. Jones), who both completed Project SAFE. Amanda is biracial (Hispanic and White) and Ms. Jones is Hispanic. At the time of treatment, Amanda lived at home with her mother and her two younger half-sisters. Ms. Jones was divorced and had been married twice previously: the first time to Amanda's biological father and the second time to the biological father of Amanda's half-sisters. Prior to treatment, Ms. Jones provided consent and Amanda provided assent for deidentified records related to assessment of their treatment progress to be presented in scientific journals. Names have been changed, and information that could identify the family has been modified or left out.

3. History

Amanda reported contact sexual abuse by her 40-year-old stepfather on multiple occasions over a 4-year period, from the time she was 8 to the time she was 11 years old. The first person whom Amanda told about the ongoing abuse was her mother, after they got into an argument related to Amanda's refusal to accompany her stepfather on an overnight trip. According to Ms. Jones, when Amanda first disclosed the abuse, she shared few details and appeared very uncomfortable and upset. In the month following this disclosure, Amanda's mother took her to the local area child advocacy center (CAC), a child-friendly agency where forensic interviews are conducted using a multidisciplinary team approach. The abuse was reported to the police and Child Protective Services (CPS). The allegations of abuse were substantiated by CPS and Amanda's stepfather was criminally charged. His criminal trial had not yet occurred when treatment terminated.

4. Presenting Complaints

During the forensic interview, Amanda reported experiencing forced vaginal intercourse by her stepfather on numerous occasions over the past several years. She indicated that her stepfather had used threats of violence to prevent her disclosure.

5. Assessment

Both Amanda and Ms. Jones were asked to complete a battery of measures to assess their symptoms related to the abuse, as well as their current level of functioning. These assessments were completed at three time points: pretreatment (3 months after Amanda's disclosure), posttreatment, and 3-month follow-up. Child- and parent-report measures are described below (see Tables 1 and 2 for a summary of Amanda's and Ms. Jones's pre- and posttreatment assessment scores).

Table 1. Summary of Amanda's Assessment Scores

Measure	Pretreatment	Posttreatment	3-month follow-up	Score range/ cutoff
CFRV[a]	69	59	40	27–81[b]
CITES-R-PTSD[a]	48	28	17	0–52[b]
R-CMAS[c]	68	47	41	> 65[d]
MASC[c]	73	69	47	> 65[d]
CBCL[c]	69	53	54	> 60[d]
CSBI-3[a]	17	8	6	0–114[b]

Note: CFRV = Children's Fears Related to Victimization; CITES-R-PTSD = Children's Impact of Traumatic Events–Revised–Posttraumatic Stress Disorder Scale; R-CMAS = Revised Children's Manifest Anxiety Scale; MASC = Multidimensional Anxiety Scale for Children; CBCL = Child Behavior Checklist; CSBI-3 = Child Sexual Behavior Inventory–3rd Revision.
[a]Total score
[b]Range
[c]*T*-score
[d]Clinical significance cutoff

Table 2. Summary of Ms. Jones's Assessment Scores

Measure	Pretreatment	Posttreatment	3-month follow-up	Score range/ cutoff
PSI				
Sense of competence[a]	28	30	32	13–65[b]
Restriction of role[a]	22	14	14	7–35[b]
SCL-90-R				
Depression[c]	47	34	32	> 65[d]
Anxiety[c]	58	37	31	> 65[d]
Global Severity Index[c]	52	39	34	> 65[d]

Note: PSI = Parenting Stress Index; SCL-90-R = Symptom Checklist-90–Revised
[a]Total score
[b]Range
[c]*T*-score
[d]Clinical significance cutoff

The pretreatment assessment session of Project SAFE occurred approximately 3 weeks after Amanda and Ms. Jones participated in the forensic interview at the CAC. On self-report measures that were administered, Amanda endorsed symptoms of anxiety, post-traumatic stress, and fears related to the victimization. Ms. Jones's responses to self-report measures about Amanda's emotions and behavior also indicated clinically significant internalizing symptoms for Amanda. When questioned about her own level of functioning, Ms. Jones reported stress related to her role as a parent as well as feelings of depression and anxiety. In addition, during initial treatment sessions, Ms. Jones demonstrated some difficulties providing support for her daughter and appeared to believe that her daughter was partially to blame for the abuse.

Child Report Measures

Children's Fears Related to Victimization (CFRV)

The CFRV, a 27-item subscale of the *Fear Survey Schedule for Children–Revised* (FSSC-R; Ollendick, 1983; Wolfe & Wolfe, 1986), is a self-report measure for children aged 7 to 12 years, which assesses situations that may be distressing to sexually abused children (e.g., people not believing me, people knowing bad things about me, sleeping alone, saying "no" to an adult). This measure utilizes a 3-point scale for children to rate their level of fear in these situations. Scores range from 27 to 81, with higher scores indicating greater level of fear. The CFRV consists of two subscales: sex-associated fears and interpersonal discomfort. Both have been found to have high internal reliability, although their validity has not yet been established (Feindler, Rathus, & Silver, 2003).

Children's Impact of Traumatic Events–Revised (CITES-R)

The CITES-R (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991) is a structured interview that measures how sexual abuse has affected children aged 8 to 16 from their perspective (e.g., thoughts and feelings about what happened to them). This instrument has four main scales: posttraumatic stress, abuse attributions, social reactions, and eroticism. Only the posttraumatic stress scale was examined; scores range from 0 to 52, with greater scores indicating greater posttraumatic stress symptoms. Moderate support has been demonstrated for the psychometric properties of the CITES-R PTSD Scale, including reliability with alpha ranging from .56 to .79 (Chaffin & Shultz, 2001).

Revised Children's Manifest Anxiety Scale (R-CMAS)

The R-CMAS (Reynolds & Richmond, 1985) is a 37-item self-report measure that assesses general anxiety for children and adolescents aged 6 to 19. In this measure, children are asked to respond to each item by circling *yes* or *no*. The total anxiety score is based on 28 items that encompass physiological, subjective, and motor symptoms of anxiety. *T*-scores greater than 65 are considered elevated and indicate possible general anxiety of clinical significance. Reliability for the R-CMAS total anxiety score has been established with an alpha of .83 (Reynolds & Richmond, 1985). The validity and stability of this measure have also been established (Reynolds, 1980; Reynolds & Richmond, 1985).

Multidimensional Anxiety Scale for Children (MASC)
The MASC (March, Parker, Sullivan, Stallings, & Conners, 1997) is a 39-item self-report survey that evaluates anxiety symptoms (including physical symptoms, social anxiety, separation/panic, and harm avoidance) experienced within the previous 2 weeks for youth aged 8 to 14. This measure utilizes a 4-point scale ranging from 0 (*never true about me*) to 3 (*often true about me*). *T*-scores greater than 65 are considered elevated and indicate possible anxiety symptoms of clinical significance. The validity of this scale has been established, with internal consistency of .87 for the total measure. The subscale for female children aged 8 to 11 years ranges from .61 to .81 (March et al., 1997).

Parent Report Measures

Parent's Presenting Symptoms

Parenting Stress Index (PSI). The PSI (Abidin, 1986) is a 101-item self-report questionnaire that asks individuals to indicate the degree of stress they experience in their role as a parent. The Sense of Competence (PSI-SO) and Restriction of Role (PSI-RO) Scales were examined for Ms. Jones. The PSI-SO score ranges from 13 to 65 with higher scores indicating a greater sense of competence, whereas the PSI-RO score ranges from 7 to 35 with higher scores indicating that the parent experiences the parental role as frustrating and restricting his or her freedom. These scales assess the parents' appraisal of their competence and the restrictions they experience because of their parental role. The PSI demonstrates internal consistency (α ranging from .70 to .84), test-retest reliability, and validity (Abidin, 1995).

Symptom Checklist-90–Revised (SCL-90-R). The SCL-90-R (Derogatis, 1983) is a 90-item inventory assessing current symptoms of psychopathology. The Depression (SCL-90-R-D), Anxiety (SCL-90-R-A), and Global Severity Index (SCL-90-R-GSI) Scales were examined. *T*-scores greater than 65 are considered elevated and indicate possible difficulties of clinical significance related to depression, anxiety, and distress. The SCL-90-R has been shown to have adequate internal consistency, test–retest reliability, generalizability across populations, and concurrent validity (Derogatis, 1983).

Parent Report of Child Behavior/Symptoms

Child Behavior Checklist (CBCL). The CBCL (Achenbach, 1991) is a 113-item checklist used to assess parents' perceptions of social competence and behavioral problems in their children, aged 4 to 18. This measure utilizes a 3-point scale ranging from 0 (*not true*) to 3 (*very true* or *often true*) for parents to rate the presence of problem behaviors during the previous 7 months. *T*-scores greater than 65 are considered elevated and indicate possible behavioral problems of clinical significance. The reliability and validity of the CBCL have been well established (Achenbach, 1991).

Child Sexual Behavior Inventory–3rd revision (CSBI-3). The CSBI-3 (Friedrich, 1997) is a 38-item, parent-report inventory assessing the frequency of various sexual behaviors

observed in their children, aged 2 to 12. Sexual behaviors assessed include sexual aggression, self-stimulation, gender-role behavior, and personal boundary violation. Scores range from 0 to 114, with higher scores indicating increased sex behaviors exhibited by the child. The CSBI demonstrates validity as well as reliability both for a clinical sample of children (α = .93) with a confirmed history of sexual abuse and for a nonclinical sample (α = .82; Friedrich et al., 2001).

5. Case Conceptualization

Spaccarelli's (1994) comprehensive review of the literature on the relationship between CSA and mental health difficulties demonstrates that a heterogeneous range of variables play a role in increasing the risk for maladaptive outcomes among children who have experienced sexual abuse. Spaccarelli presents a transactional model wherein characteristics of the abuse itself, characteristics of children who experience abuse (e.g., coping style), and family environment all play a role in determining outcomes following CSA. In Amanda's case, characteristics of the abusive episodes that she experienced are important to consider in conceptualizing the development of her presenting symptoms. Amanda's abuse occurred frequently for a period of several years, and she was abused by someone she knew well. These characteristics made it difficult for Amanda to attribute the abuse to chance and external factors, and led to the belief that the abuse would reoccur. For example, Amanda did not believe that her stepfather had randomly chosen her as a victim. These attributions, in turn, led to the anxiety and abuse-related fears that Amanda reported prior to treatment.

Amanda also experienced stressors in her family environment that led to and exacerbated the symptoms she reported prior to treatment. Her mother's relationship with her stepfather ended, causing a significant change in the structure of their family. As Spaccarelli's (1994) model predicts, this stressor led to increased feelings of guilt and negative self-evaluation for Amanda. Furthermore, Ms. Jones experienced personal distress related to the abuse, which appeared to affect her ability to provide support for Amanda. Ms. Jones's distress decreased her ability to model appropriate coping strategies for her daughter and, therefore, appeared to play a role in the development of Amanda's symptoms. Furthermore, Ms. Jones's tendency to blame Amanda for the abuse made it difficult for Amanda to seek her mother's support. This led to a tendency for Amanda to utilize more avoidant methods of coping, thereby increasing her vulnerability to mental health symptoms.

6. Course of Treatment and Assessment of Progress

Course of Treatment

Amanda and Ms. Jones participated in twelve 90-min sessions over the course of approximately 4 months. Five other children, ranging from the age of 8 to 12, participated in sessions with Amanda, and their nonoffending primary caregivers participated in sessions with Ms. Jones. See Table 3 for a summary of the 10 core modules introduced over the course of the 12 sessions (Hansen et al., 1998). Overall, both Amanda and her mother participated actively and appropriately in treatment. Amanda was, at first, very quiet during

group sessions. During the first session, which focused mainly on explaining group structure and content, Amanda rarely spoke unless specifically addressed by one of the therapists. However, Amanda gradually began to initiate participation and engage in conversation with other group members. Recognizing that other group members frequently experienced thoughts and feelings that were similar to her own appeared to increase Amanda's comfort with sharing during group. She frequently initiated participation by agreeing with another group member but was also able to elaborate on the differences between her personal experiences and those of other group members when prompted to do so by group therapists.

Although Ms. Jones participated actively throughout the course of group treatment, she began with some doubts regarding the degree to which her own participation in treatment would be helpful. During initial sessions, she made statements indicating that she wanted her daughter to receive help but was not sure if coming to group sessions herself was necessary. Other members of the group were helpful in enabling Ms. Jones to recognize the benefits of treatment for herself. Ms. Jones appeared much more engaged in group content after others expressed doubts and questions about their ability to recognize distress in their children and support them through it. She indicated that she shared similar apprehensions and began to talk about how she had utilized strategies covered in group to engage her daughter in conversations about feelings and topics related to the abuse.

During Session 5, while covering the module titled "My Family," Amanda revealed her interactions with her two younger half-sisters to be a major struggle for her. Amanda said that both half-sisters were very similar in appearance to her stepfather, the perpetrator of the abuse. Amanda began to describe her distress during the portion of the module that focused on special concerns when the offender is a family member. To help Amanda identify methods of coping with this problem, she was asked to identify ways in which her half-sisters were both similar to as well as different from her stepfather. Other members of the group participated in discussion and helped Amanda identify several ways in which her half-sisters were different from her stepfather. This discussion, along with hearing other group members talk about their own reminders of abuse (e.g., certain rooms in their homes), appeared to help Amanda cope with her uncomfortable emotions associated with her half-sisters and family relationships.

During Module 6 of the parent's group (Sharing What Happened Part II: Offenders), Ms. Jones revealed that she still had mixed feelings about who was to blame for the abuse. She expressed a great deal of guilt about her possible role in the abuse and reported that she felt as though the abuse could have been prevented if she had not let Amanda be alone with her ex-husband or if she had recognized warning signs earlier. She also indicated that she believed Amanda was partially to blame for the abuse. She described feeling as though Amanda should have "known better" and should have told her about the abuse sooner. The therapists reflected the conflicting feelings and guilt Ms. Jones described. At the same time, they provided information about manipulation strategies that offenders use to make victims feel trusting and powerless, reasons why children are easily manipulated by adults, and coercion strategies that offenders use to prevent their victims from telling others about the abuse.

Table 3. Summary of Core Treatment Modules

Module	Title	Parent's group topics	Children's group topics
1	Welcome and orientation	Confidentiality; group rules; the prevalence of sexual abuse	Confidentiality; group procedures; group rules; what it means to be a member of a group
2	Understanding and recognizing feelings	How parents respond to feelings; appropriate and effective emotion expression; encouraging appropriate and effective emotion expression in children	Labeling and expressing feelings; causes and consequences of feelings; good and bad feelings; having two feelings at once; intensity of feelings
3	Learning about our bodies	Differences between boys and girls; body image; gender identity; "good" and "bad" touches; reactions that children may have to this topic; childhood sexuality; any concerns about poor developmental outcomes and sexual identity issues in their children	Differences between boys and girls; basic sexual education (e.g., puberty, sexual development, basic facts about sex); body image; gender identity; "good" and "bad" touches
4	Standing up for your rights	Ways to generalize skills taught in children's group to the home; assertive communication; ways to prevent future abuse	Assertiveness; how to communicate feelings appropriately; knowing whom to tell when something is wrong; enhancing social networks
5	My family	Feelings about the abuse; how to share these feelings with children; effective communication skills	The effects of disclosure on family members; special concerns when the offender is a family member; sources of support in the family; friends and other sources of social support
6	Sharing what happened	Parents briefly share details about their children's abuse; discussion of feelings and consequences for the family after disclosure; concerns about the impact of abuse	Other's reactions to the abuse; rules about secrets; prevention strategies; feelings about disclosure; children disclosure details of their abuse experience at their own comfort level
7	Sharing what happened, Part II: Offenders	Children's reactions to discussion of abuse; feelings about offenders; how feelings about offenders might affect children	Why offenders offend; who is to blame for abuse; general education about the nature of sexual abuse
8	Understanding my feelings about what happened to me	Explore feelings such as guilt, shame, problems with trust, self-esteem, anger and other emotions; how to be sensitive to children's feelings	Explore feelings such as guilt, shame, problems with trust, self-esteem, anger, and other emotions; effects of feelings on behavior, self-image, and interpersonal relationships; reminder about upcoming termination of group.
9	Learning to cope with my feelings	The nature of anxiety and depression in children and how to alleviate the symptoms	Review feelings; learn relaxation exercise; problem solving; changing maladaptive thoughts and the relationship between mood and behavior; feelings about the end of group
10	Saying goodbye	Maintenance of gains made in group; how to cope with future difficulties; provision of referrals if necessary; parents provide feedback on the group	Ways to handle ending of the group; how to keep up with the work that has been done; likes and dislikes about the group

Other group members were instrumental in helping Ms. Jones recognize that the perpetrator was solely to blame for the abuse. They frequently modeled appropriate statements of blame during discussions about offenders and gently questioned Ms. Jones's statements of self- and victim-blame for the abuse. By the end of treatment, Ms. Jones appeared to fully accept that her ex-husband was to blame for the abuse. She frequently made statements during the last several sessions of treatment that assigned her former partner full blame for the abuse. For example, in a discussion of his upcoming court trial, Ms. Jones reported hoping that her former partner would receive the maximum sentence possible because he "committed a crime that hurt my child." Ms. Jones's recognition of her former partner's blame for the abuse also seemed to alleviate some of her own related guilt. She indicated that she now recognized tactics he had used to successfully hide the abuse and that she had responded quickly and appropriately when her daughter told her about the abuse.

Assessment of Progress

Pre- and posttreatment assessments demonstrated that Amanda's level of functioning had improved by the end of treatment. See Table 1 for a summary of Amanda's pre- and posttreatment assessment scores. Pretreatment assessments indicated that Amanda was initially experiencing concerning symptoms of anxiety as indicated by elevated R-CMAS and MASC scores, as well as endorsing numerous items on the CFRV. She reported experiencing fears of many situations that were related to her victimization, including saying "no" to an adult, people knowing bad things about her, taking off her clothes, and sleeping alone. Amanda also reported experiencing distressing symptoms of posttraumatic stress, including nightmares, difficulty concentrating because of unwanted memories of the abuse, guilty feelings, startling easily, and trying not to think about what happened. Furthermore, Ms. Jones reported that Amanda displayed numerous behavioral problems of clinical significance as indicated by an elevated CBCL score, including somatic complaints, becoming withdrawn, and attentional and social problems. In addition, both Ms. Jones and Amanda reported numerous sexual behaviors displayed by Amanda, including acting out what happened during the sexual abuse during play, often touching private parts, masturbating with her hand, and making sexual sounds. Posttreatment assessments demonstrated an observable decrease in Amanda's reported symptoms of anxiety, victimization-related fears, and posttraumatic stress. Specifically, Amanda's scores were no longer clinically elevated on the R-CMAS and MASC, and she endorsed experiencing a lot fewer PTSD symptoms on the CITES-R following treatment. In addition, as reported by her mother, Amanda exhibited fewer sexual behaviors and a clinically significant decrease in the frequency of behavioral problems as indicated by her CBCL score following treatment.

Pre- and posttreatment assessments demonstrated that Ms. Jones's level of functioning had improved by the end of treatment. See Table 2 for a summary of Ms. Jones's pre- and posttreatment assessment scores. Pretreatment assessments indicated that Ms. Jones was initially experiencing some psychological distress, including symptoms of depression and anxiety. Although Ms. Jones's SCL-90-R scores were within average range at pretreatment, Ms. Jones reported experiencing psychological distress related to her child's sexual abuse, which decreased by the end of treatment. In addition, her assessments signified she

experienced some stress related to her role as a parent, including feelings of restriction and incompetence. In particular, Ms. Jones reported she often felt that her child's needs controlled her life and that most of her life was spent doing things for her child. Posttreatment assessments indicated that Ms. Jones's level of functioning had greatly improved, especially her overall psychological distress, anxiety symptoms, and feelings of being restricted by her role as a parent.

At the end of treatment, both Amanda and Ms. Jones indicated being very satisfied with the treatment and feeling as though their level of functioning had greatly improved. Although not reflected in the assessments, the most significant change for Ms. Jones was her acceptance that Amanda was not to blame for the abuse. In addition, Ms. Jones reported liking the support she had received from the other parents, while Amanda reported that meeting other children who shared similar experiences to her had been beneficial.

7. Complicating Factors

Overall, there were few factors that complicated treatment. Ms. Jones and Amanda arrived on time for every session, were prepared to participate in treatment, and consistently appeared engaged in activities. At the onset of treatment, it seemed as though Amanda had difficulty answering some questions and following along with material at the same pace as other group members. Therapists suspected that Amanda might have some minor learning problems. Following recognition of this issue in Session 2, the therapists made modifications to the delivery of each week's material to ensure that Amanda had the opportunity to reach weekly treatment goals as well as to express her thoughts and feelings during group. Efforts were made to deliver the material in a concrete and uncomplicated manner. For example, during the module on assertiveness (Session 4), group therapists modeled simple statements that could be used to decline a request from a stranger politely and firmly and then asked group members to practice using these statements during a role-play activity. This differed from the way the material on assertiveness had typically been delivered in the past in that group members were not asked to create their own statements. Therapists were also careful to ensure that Amanda had as much time as she needed to answer questions and to give her opinions.

Although there were few complications that interfered with treatment in Amanda's case, there are some challenges that arise commonly when delivering Project SAFE services. Consistent attendance is sometimes difficult for families, especially those living in rural areas far away from the location of services or those with limited access to transportation. All families receive a reminder phone call from a lead therapist, who can help problem solve around barriers to attendance. Furthermore, coordination with the CAC staff involved with family's cases has helped reduce some barriers to treatment attendance; for example, CAC staff frequently encourage parents to attend sessions and provide assistance with transportation expenses for families with particularly limited resources. High levels of family stress, not always related directly to the abuse experienced by children participating in Project SAFE, also leads to treatment complications for some families. To address this difficulty, a brief portion of each weekly session is reserved for parents and children to discuss happenings and stressors that have occurred over the past week. Moreover,

families who are experiencing significant difficulties beyond those addressed in Project SAFE treatment (e.g., problematic parent-child relationships) are often referred for appropriate additional community services.

8. Access and Barriers to Care

Project SAFE is a grant-funded, university-based research and clinical intervention project. Families are not charged for services and are compensated for the time they take to complete assessment packets. Therefore, managed care considerations did not play a role in Ms. Jones and Amanda's treatment. If the treatment had been delivered in another setting, however, managed care demands may have been important to consider. The time-limited nature of the 12-session Project SAFE protocol would be amenable to the session limits often imposed by managed care organizations. Furthermore, the group treatment modality is a less costly format than traditional individual outpatient services and therefore may present fewer financial constraints (Sanchez & Turner, 2003). In addition, the pretreatment, midtreatment, and posttreatment assessments built into the protocol could prove helpful for clinicians required to document achievement of treatment goals (Berliner & New, 1999).

There are also aspects of Project SAFE services that could present challenges to delivery in a managed care setting. As was true in Amanda's case, many parents of children who have been sexually abused seek services for their children due to the disclosure of abuse and not because their children are experiencing symptoms of a specific psychological disorder. This can cause difficulties for clinicians who apply for reimbursement to managed care companies for services rendered, as documentation of a psychiatric diagnosis is usually required to justify service delivery (Berliner & New, 1999). Furthermore, if managed care restrictions required that only children diagnosed with a psychiatric disorder were allowed to attend group treatment, the inclusive and broad nature of Project SAFE would be affected. Project SAFE groups sometimes include children who do not meet criteria for a psychiatric diagnosis, allowing for subthreshold difficulties to be addressed as well as for more resilient children to model appropriate coping strategies for peers experiencing greater difficulty with functioning. Moreover, if managed care restrictions required that a psychiatric diagnosis be necessary for treatment, this inclusion criterion could foster or support inaccurate beliefs among families that sexual abuse automatically causes psychiatric disorders in children. Providing treatment to nonoffending caregivers could also be a challenge, as managed care organizations sometimes reimburse only services provided directly to the identified client. Also, the pretreatment assessment procedures included in Project SAFE might not be feasible, as many managed care organizations require an independent pretreatment evaluation by a clinician other than the primary treatment provider (Howard & Bassos, 2000).

9. Follow-Up

Three months following treatment, Amanda and Ms. Jones returned to the CAC to participate in assessment of their current functioning. Assessment results indicated that Amanda experienced fewer symptoms of anxiety, abuse-related fears, and PTSD compared to pretreatment (see Table 1). In addition, Ms. Jones reported that Amanda had fewer problematic

behaviors, including sexual behaviors, since ending treatment. Furthermore, Ms. Jones's assessment indicated that her own feelings of distress, depression, and anxiety had not increased since ending treatment (see Table 2). Both Amanda and Ms. Jones experienced either a decrease in distressing symptoms or maintenance of in-session treatment gains since concluding treatment. Follow-up assessment results indicate that treatment gains persisted and, in some cases, continued to increase once treatment had ended.

10. Treatment Implications of the Case

According to clinician observation and assessment results, Project SAFE group treatment decreased Amanda and Ms. Jones's distressing symptoms and behaviors. Treatment was successful in assisting Amanda to explore and cope with her feelings about the abuse. In addition, through the group format, Amanda's sense of stigmatization and isolation associated with the abuse was greatly reduced. Amanda specifically stated that being with other children who had also experienced sexual abuse was one aspect of Project SAFE that she especially liked. Through the group treatment format, Amanda was able to discuss the abuse and her feelings about it with others who had shared similar experiences, which helped to decrease her feelings of stigmatization and isolation. In addition, Amanda was able to practice these newly learned skills with the other children, helping to enhance her social skills. Amanda's progress speaks to the value of group treatment for CSA. The group format appears to be especially helpful in enabling children to recognize abuse as a relatively common experience, as well as in promoting positive coping skills through modeling by other group members (see Tavkar & Hansen, 2011).

Ms. Jones's participation in treatment resulted in a decrease in her depressive and anxious symptoms and helped to generalize and maintain Amanda's in-session treatment gains. Ms. Jones reported particularly liking the support she received from the other parents, which may have contributed to her feeling less restricted in her parenting role by the end of treatment. Participation in the parent's group helped Ms. Jones accept that Amanda was not to blame for the abuse. Blaming a child for experiencing sexual abuse may cause the child to blame themselves for the abuse, which has been shown to be associated with later psychological difficulties (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Hoagwood, 1990). By questioning her beliefs and modeling appropriate statements about perpetrators throughout the course of treatment, fellow group members helped Ms. Jones recognize that the perpetrator was solely to blame for the abuse.

11. Recommendations to Clinicians and Students

It is important for clinicians to take a broad and thorough approach to assessment and treatment when working with children who have experienced sexual abuse. Many sexually abused children, like Amanda, will present with a heterogeneous range of symptoms that may not fit a single diagnostic label (e.g., PTSD) or be treatable by a single treatment strategy (e.g., exposure therapy). Furthermore, although Project SAFE is a manualized treatment, it was noted early that Amanda needed special accommodations (i.e., presenting material in more concrete terms than usual). Slight modifications in how material was presented were implemented without compromising treatment integrity for other group

members. It is important for clinicians who are treating sexually abused children in a group format to be aware of the needs of each child and to make modifications when appropriate. This case study also demonstrates the importance of including nonoffending caregivers in their child's treatment. Ms. Jones's participation in treatment not only helped her cope with her own feelings related to the abuse but also made her more able to provide support and model appropriate coping skills for her daughter. This study also demonstrated the need for clinicians to be aware of family members placing blame on sexually abused children and to make efforts to eliminate this behavior (Coffey et al., 1996).

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