2013

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Published in *Journal of Family Violence* 28:1 (2013), pp. 31–42; doi: 10.1007/s10896-012-9485-6

Published online November 30, 2012.

The Relationship of Personal, Family, and Abuse-Specific Factors to Children's Clinical Presentation Following Childhood Sexual Abuse

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Abstract
Past literature has proposed potential variables (e.g., age, gender, attributional style) that may relate to clinical presentation following childhood sexual abuse (CSA). However, few studies have tested these relationships. The current study examined multiple factors related to clinical presentation following CSA in 101 children and adolescents presenting for treatment at Project SAFE, a parallel group treatment for children/teens and their nonoffending parents. Using clusters developed in a previous study, relationships between proposed variables and pretreatment clinical presentation were examined. Results indicated that attributions about the abuse, parental mental health, and severity of abuse related to the differentiated clinical presentation. These results are important because pinpointing correlates to clinical presentation following CSA helps elucidate differences among those with a history of CSA and gives greater insight into the impact sexual abuse has on children. Knowing these differences may also benefit treatment providers in the development of individual treatment goals during therapy.

Keywords: childhood sexual abuse, symptoms, clinical presentation

The clinical presentation of children following child sexual abuse (CSA) is a complex topic to explore. Research has suggested multiple possible presentations following CSA (for meta-analytic reviews, see Kendall-Tackett et al. 1993; Paolucci et al. 2001) and influences from varied aspects of the child, the child's family, and features of the abuse itself. Some of these factors are static (i.e., child's age, child's gender, features of the abuse), but others may be amenable to change via treatment (i.e., child's attributions regarding the abuse, parental mental health). Knowing more about the relationships between these factors and children's clinical presentation following CSA may assist therapists in providing individualized treatment.

The Clinical Presentation of Child Sexual Abuse

Sexually abused children often exhibit differences in their clinical presentation of symptoms, such as differences in their self-reported anxiety and depression or their parents' perception of problem behaviors. These symptoms of clinical presentation are often treated as separate units in research (i.e., posttraumatic stress disorder [PTSD] studied by Wolfe et al. 1994; externalizing behaviors studied by Bergen et al. 2004), although some studies have incorporated multiple symptoms into research without differentiating among victims of CSA (i.e., comparing adults with a history of CSA to those with no history, Asberg and Renk 2012; study of psychopathology in those with a history of CSA, Cutajar et al. 2010). Yet prior literature has suggested that these symptoms can be aggregated into groups (for a review see Yancey and Hansen 2010). Indeed, recent research has confirmed this hypothesis and categorized the symptoms occurring during clinical presentations among child and adolescent victims of CSA, which may make exploring clinical presentations and correlates of these presentations easier (Yancey et al. 2011).

To summarize Yancey et al.'s (2011) study, children with a history of sexual abuse reported their depression (Children's Depression Inventory; Kovacs 1992), anxiety (Revised Children's Manifest Anxiety Scale; Reynolds and Richmond 1985), and PTSD symptoms (PTSD subscale of the Children's Impact of Traumatic Events Scale; Wolfe et al. 1991). A parent reported the extent that children displayed internalizing and externalizing behaviors (Internalizing and Externalizing Behaviors scales from the Child Behavior Checklist; Achenbach 1991) and sexualized behaviors (Child Sexual Behavior Inventory; Friedrich et al. 2001). Using a cluster analysis, Yancey and colleagues established four distinct subtypes of clinical presentation following CSA. Children in the *highly distressed* group reported high levels of depression, anxiety, and PTSD symptoms, and their parents reported high levels of internalizing/externalizing behaviors and sexualized behaviors. Children in the *problem behaviors* group self-reported normal levels of depression, anxiety, and PTSD symptoms, but their parents reported high levels of internalizing/externalizing behaviors and sexualized behaviors. Children in the *subclinical* group reported low levels of depression, anxiety, and PTSD, and their parents reported low levels of internalizing/externalizing behaviors and sexualized behaviors. Finally, children in the *self-distressed* group reported high levels of depression, anxiety, and PTSD symptoms, but their parents reported low levels of internalizing/externalizing behaviors and sexualized behaviors. In short, the authors condensed

the myriad of symptoms typically associated with the clinical presentation of CSA into four distinct groups.

Correlates to the Clinical Presentation of Symptoms Following Child Sexual Abuse

Previous research has identified several factors that correlate with the clinical presentation of CSA, but clinical presentation tends to be a fusion of several symptoms rather than the distinct four groups. For ease of discussion, we review these factors that correlate with the clinical presentation as three categories, each consisting of both static and malleable variables: (a) personal factors (e.g., gender, age, attributional style); (b) familial factors (e.g., parental history of CSA, socioeconomic status, parental mental health); and (c) abuse-specific factors (e.g., severity of abuse, duration of abuse, victim-perpetrator relationship).

Personal Factors

CSA research has often examined the role of personal factors on clinical presentation following abuse, particularly the link between the victim's gender and clinical presentation. In the past, researchers defined victims of CSA as primarily female victims of male perpetrators, thus excluding male victims from early research and treatment efforts (Browne and Finkelhor 1986; Young et al. 1994).

More recent research has included male victims whose clinical presentations are similar to those of female victims (Kendall-Tackett et al. 1993; Putnam 2003), including anxiety disorders, substance use, depression, PTSD, and sexualized behaviors, among others (Cutajar et al. 2010; Putnam 2003). However, male and female victims do differ in clinical presentation, with male victims more likely to display externalizing symptoms (i.e., alcohol/drug use, fighting, stealing) and female victims more likely to have internalizing symptoms (i.e., PTSD, depression; Bergen et al. 2004; Heath et al. 1996; Moran et al. 2004). As gender is shown to relate to a factor predictive of cluster membership (specifically, internalizing and externalizing symptoms, depression, anxiety, and PTSD), it is predicted that gender will relate to cluster membership.

Like gender, researchers also include age as a demographic marker but seldom examine it as a potential correlate to clinical presentation (except in longitudinal research). One study, however, suggested that clinical presentation (sexualized behaviors and internalizing symptoms) of female children ages 3 to 5 years old are similar to those reported in other research using older or heterogeneous aged samples (Mian et al. 1996). Cutajar et al. (2010) found that children who were younger at the time of abuse were more likely than older children to experience Axis I clinical disorders, besides PTSD, in childhood. Conversely, Bergen et al. (2004) found no age differences related to increased substance use and externalizing behaviors following CSA. Clearly, more research on possible age-related differences in clinical presentation is needed.

Another personal factor associated with clinical presentation following CSA is attributional style. Kolko and colleagues (2002) reported that victims' attributions are as much a factor in the presentation following abuse as are the characteristics of the abuse, suggesting that focusing on the attributions and their relationship to clinical presentation will benefit treatment interventions. Together, gender, age and attributional style all appear related to

clinical presentation following CSA, although previous research may not have fully captured their roles in clinical presentation. Therefore, it is expected that these factors will be correlated in some way with cluster membership, although the direction of these correlations is difficult to predict based on past literature.

Familial Factors

Like personal factors, familial factors such as parental stress, coping, and mental health correlate with the clinical presentation following CSA (e.g., Baker 2001; Elliott and Carnes 2001; Jankowski et al. 2002). For instance, parents' ability to cope with their own history of abuse may influence how their children cope following abuse. Beitchman and colleagues (1991) reviewed several studies on CSA, noting the victims' parent's own history of abuse. However, none of the reviewed studies discussed the impact of the parent's abuse on their child's clinical presentation, suggesting more research is needed in this area. In a discussion of the effects of a child's abuse on the nonoffending parent, McCourt and Peel (1998) found that a parent's history of abuse may not be discussed or processed until their child discloses sexual abuse and the child's disclosure may bring up memories and traumatic reactions of the parent's own history of abuse.

Family stress can correlate with the way a child adjusts to sexual abuse. Mothers in families that had a child with a history of CSA were more likely to report low family cohesion regardless of whether or not the perpetrator was a member of the family (Mannarino and Cohen 1996). Parents who experience extremely negative emotions may be less able to support their children due to their attempts to cope with those negative emotions. These negative emotions may lead children to feel blame for the abuse, the disclosure, and the impact of the abuse on their parent (Mannarino & Cohen). In a retrospective study, Bhandari et al. (2011) found that family environment at the time of abuse, independent of CSA, influenced psychopathology in adulthood.

Parental mental health may also relate to clinical presentation following CSA. Deblinger and colleagues (1999) found that parents with significant depression were more likely to report PTSD and externalizing symptoms in their children and were less likely to be emotionally available for their children following disclosure of sexual abuse than parents with no depression. Further, when a victim perceives that his/her mother was rejecting of him/her, s/he reported greater depressive symptoms. A mother's own depressive symptomatology was also related to her report of her child's PTSD symptoms following sexual abuse; however, no causal relationship can be established (Deblinger et al. 1999). Further, Romans et al. (1997) found that parental mental health significantly contributed to negative outcome (i.e., clinical disorder, self-harm behaviors, teenage pregnancy, relationship difficulties) in adulthood for those with a history of CSA.

Given past research on the impact these family factors can have on clinical presentation as a whole, we expected that these factors would also relate to the clusters of clinical presentation. Specifically, the research suggests that being a child of a parent with a history of CSA, having more family stress, and having a parent with poor mental health would correlate with being in one of the clusters that indicates experiencing more symptoms (i.e., not in the subclinical cluster).

Abuse-specific factors

Abuse-specific factors, such as severity, duration, and victim-perpetrator relationship can also correlate with clinical presentation. Frequently, abuse that includes some type of penetration (oral, vaginal, or anal) is considered particularly severe, and abuse that does not involve contact (e.g., exposure, pornography, sexual talk) is considered less severe (Kendall-Tackett et al. 1993). Other factors that contribute to the severity of abuse include the use of force with or without weapons during the abusive acts, physical abuse of the victim, and threats by the perpetrator against the victim or the victim's family; yet, there is no universal differentiation between severity levels of abuse (Paolucci et al. 2001). Further, these other factors may be more related to symptomatology for victims, especially factors such as fear and humiliation (Young et al. 2011). These variances in definition make it difficult to identify the independent contribution of these factors on clinical presentation following CSA. Despite these difficulties, research supports that more severe abuse generally results in greater postabuse symptomatology. More severe abuse experience (those that involved penetration or multiple offenders) correlated with greater risk for psychopathology (including psychosis, alcohol abuse, anxiety disorders, or other Axis I disorders) in a longitudinal study of victims of CSA (Cutajar et al. 2010) and with incarceration in a sample of women with histories of CSA (Asberg and Renk 2012).

In general, the longer or more often a victim experiences abuse, the more likely the victim will experience symptoms following the abuse (Finkelhor and Dziuba-Leatherman 1994; Wolfe et al. 1994). In a study of 90 children recruited shortly following disclosure, Wolfe and colleagues found that duration of abuse contributed to the victims' clinical presentation, with more children who were abused for long durations (more than 1 year) displaying PTSD symptoms. Further, the results indicated that duration, age, and gender were the only studied variables which differentiated victims experiencing PTSD symptoms from those who did not.

Similarly, it is believed that the closer the victim-perpetrator relationship, the more severe the impact on the child (for a review see Kendall-Tackett et al. 1993; for alternate results see Paolucci et al. 2001). Most researchers have determined that an intrafamilial relationship (related through blood or marriage) will be a closer relationship than an extrafamilial relationship (not related, outside of the family). However, as Kendall-Tackett et al. discussed, the label given to a relationship may not accurately reflect the nature of the relationship. For example, a child who is abused by her stepfather who is the only father she has known may have a much closer relationship to her perpetrator than a child who is abused by a stepfather who she has only known a short time. Measuring the closeness of the relationship rather than the category the relationship falls into, gives a more accurate description of the nature of the relationship and the potential impact it may have on the clinical presentation following the abuse (Young et al. 2011).

Furthermore, perpetrators who are close in relationship with the victim often have more access to the child, which may also impact the severity and duration of the abuse. In a review of 1,037 cases of substantiated sexual abuse, intrafamilial abuse compared to extrafamilial abuse involved younger victims, more physical injury to the victim, longer abuse duration, and more severe acts of abuse. Extrafamilial abuse was more likely to involve physical force than intrafamilial abuse (Fischer and McDonald 1998). Another study

of adults with a history of CSA found that the relationship of victim-perpetrator relationship on psychological distress was not direct and was mediated by coping strategy and attributions regarding the abuse (Steel et al. 2004). Victim-perpetrator relationship appears to be another variable that is difficult to define and has mixed results in the literature regarding its impact on symptomatology following CSA.

Given past research on the impact these abuse-specific factors can have on clinical presentation as a whole, we expected that these factors would also relate to the identified clusters of clinical presentation. Specifically, the research suggests that more severe abuse of longer duration perpetrated by a person close in relationship to the victim would correlate with being in one of the clusters indicating the experiencing of more symptoms (i.e., not in the subclinical cluster). However, given mixed results from studies, results other than expected may occur.

The Present Study

The static factors of the abuse experience are unchangeable. However, there are therapeutic interventions available to ameliorate symptoms by focusing on those factors that are amenable to change (Bagley and LaChance 2000; Cohen et al. 2004; Grosz et al. 2000). The current study examined multiple correlates related to clinical presentation following CSA, both static and those amenable to change, in a population of children and adolescents presenting for treatment. Further, the current study included victims exhibiting a wide variety of clinical presentations, including asymptomatic or minimal symptoms; the potential protective factors displayed by some of these children can be incorporated into treatment with victims who display more symptoms.

To examine the relationship of these correlates to clinical presentation following CSA, comprehensive data available from pretreatment assessment of families presenting for a group treatment (Project SAFE; see below) were utilized as an indication of clinical presentation following CSA. In particular, the relationship between current functioning and factors related to the individual (i.e., age, gender, attributional style), the family (i.e., parental history of abuse, socioeconomic status, parental mental health), and the abuse (i.e., severity, duration, victim-perpetrator relationship) were examined. Using clusters of participants developed in a previous study based on clinical presentation (gathered through self- and parent-report measures) at pretreatment assessment (Yancey et al. 2011), the relationships of various variables to cluster membership were examined. Clinical presentation was assessed through self-report of depression, anxiety, and PTSD symptoms as well as parental report of internalizing symptoms, externalizing symptoms, and sexual behaviors of the child victims.

In sum, sexually abused children display varied clinical presentations, as demonstrated by cluster membership. However, research is lacking on how the clinical presentation relates to personal, familial, and abuse-specific factors. The present study explored these relationships. Given that clinical presentation as a whole is related to personal, familial, and abuse-specific factors, it was hypothesized that cluster membership would correlate with personal factors (attributional style/attribution of blame, victim age, and victim gender), familial factors (parental history of CSA, parental mental health, and familial socioeconomic

status), and abuse-specific factors (abuse severity, duration, and the victim-perpetrator relationship).

Method

Overview

Project SAFE (Sexual Abuse Family Education), developed in 1996, is a 12-week cognitive-behavioral group treatment for victims of CSA (ages 7 to 18) and their nonoffending caregivers. The current study utilized archival data from previous groups. All participants complete a comprehensive assessment battery of both the victim and caregiver to assist in investigating the impact of CSA and the impact of treatment on the participants, the state of relationships (within and outside of the family), and sexual knowledge. For a more thorough discussion of Project SAFE, please see Tavkar and Hansen (2011).

Participants

To be included in this study, the case had to meet the following criteria: (a) the child was between 7 and 18 years of age at the initial Project SAFE assessment, (b) the nonoffending parent assumed a caregiving role within the family (e.g., parent, foster parent, grandparent), and (c) the allegation was investigated by protective services. All cases in this study had to be investigated but not verified by protective services, but all were understood to have a history of CSA based on child and parent report, referral source, and Project SAFE assessment. The only exclusionary criteria were significantly impaired cognitive/intellectual functioning of the child or parent. For these families, individual therapy services were provided at the child's developmental level covering similar material to what was presented in group.

Recruitment to Project SAFE was primarily via the community, including the Child Advocacy Center and the Department of Health and Human Services. Eight children and adolescents participated without a caregiver (e.g., the child was in foster care, the parent's work schedule did not permit their attendance), and eight parents participated without their child (e.g., their child was too young, their child was in foster care). Also, some parents (n = 13) participated in Project SAFE with multiple children who had been sexually abused. Only one child and one parent/caregiver from each family were included in analyses. As there was a smaller percentage of male participants in the sample, when available, a male sibling was selected over a female sibling. In the cases where both or all siblings were of the same gender, the oldest sibling was selected. In the cases where all siblings were the same age and gender, the child listed first was selected. Overall, 26 child participants were excluded from the original sample because a sibling had also participated in Project SAFE, leaving the current sample size of 101. Demographic data are provided in Table 1.

In the previous study (Yancey et al. 2011), four clusters were discovered: (a) a *highly distressed* group (n = 21), whose members had clinically elevated scores on all self- and parent-report measures; (b) a *problem behaviors* group (n = 36), whose members had scores within the normal range for self-report measures and elevated scores on all parent-report measures; (c) a *subclinical* group (n = 12), whose participants had scores below the mean

and below cutoff scores for all self- and parent-report measures; and (d) a *self-reported distress* group (n = 32), whose members had elevated scores on self-report measures and scores below clinical cutoffs for all parent-report measures (see Yancey et al. 2011 for a thorough description of the development of these clusters). These clusters were examined for possible correlations with personal factors (i.e., child's age, child's gender, attributions about the abuse), familial factors (i.e., parental mental health, familial stress), and abuse-specific factors (i.e., victim-perpetrator relationship, abuse duration and severity).

Table 1. Demographic information

	Frequency	Percentage
Gender (Child)		
Male	19	18.8
Female	82	81.2
Gender (Adult)		
Male	14	13.9
Female	84	83.2
Race/Ethnicity (Child)		
African American	8	7.9
Biracial	7	6.9
Caucasian	78	77.2
Hispanic	3	3.0
Multiracial	1	1.0
Native American	3	3.0
Unknown	1	1.0
Race/Ethnicity (Adult)		
African American	3	3.0
Biracial	4	4.0
Caucasian	86	85.1
Hispanic	2	2.0
Native American	1	1.0
Unknown	5	5.0
Caregiver Relationship to Child		
Biological Mother	77	76.2
Biological Father	14	13.9
Foster Parent	4	4.0
Grandmother	2	2.0
Step/Adoptive Mother	1	1.0
Other	3	3.0
	M	SD
Age (child)	11.74	2.68
Age (adult)	36.15	7.41

Child Report Measure

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

The CITES-R (Wolfe et al. 1991) is a structured interview measuring the impact of CSA from the child's (ages 8 to 16) perspective across areas of posttraumatic stress, abuse attributions, social reactions, and eroticism. Chaffin and Shultz (2001) found that internal

consistencies for the scales averaged 0.69. The four main scales yielded alpha coefficients of 0.78 (Abuse Attributions), 0.87 (Social Reactions), 0.88 (PTSD), and 0.57 (Eroticism; Wolfe et al. 1991). For the current study, only the Abuse Attributions scale was used.

Parent Report Measures

Demographic Questionnaire

The Demographic Questionnaire was designed specifically for this project to collect general information about family members, including marital status of parents, ethnic background, employment status of parents, family income, and age of family members.

Child History Form (CHF)

The Child History Form, designed for Project SAFE, is an unstructured interview that collects relevant abuse-related information, including: (a) age at onset and end of abuse, (b) abuse duration and frequency, (c) victim/perpetrator relationship, (d) number of times abused, (e) characteristics of the abuse, and (f) intrusiveness of abuse (i.e., whether penetration occurred). The CHF is completed by one of the Project SAFE staff members as parents provide information about the abuse in their own words.

Childhood Trauma Questionnaire (CTQ)

The CTQ (Bernstein et al. 1994) is a 70-item self-report measure designed to retrospectively assess childhood maltreatment. The CTQ has four factors which correspond to the four scales, Physical and Emotional Abuse, Emotional Neglect, Sexual Abuse, and Physical Neglect. Only the Sexual Abuse scale scores were used in the current study. Test-retest reliability was found to be high (intercorrelation coefficient of 0.80 to 0.83 for the individual scales and 0.88 for the Total Score). Internal consistency was also high, with an alpha coefficient of 0.95 for the total scale and ranging from 0.79 to 0.94 for the subscales. The Sexual Abuse subscale had internal consistency of $\alpha = 0.92$.

Symptom Checklist-90-Revised (SCL-90-R)

The Symptom Checklist-90-Revised (Derogatis 1983) is a 90-item multidimensional symptom inventory. For this study, the caregivers rated the degree of distress they were experiencing for each symptom listed using a 5-point rating scale (from 0 = *not at all* to 4 = *extremely*). The Global Severity Index provides a general measure of psychological distress. The SCL-90-R has shown high levels of both internal consistency and test-retest reliability, and validity has been well established (Derogatis).

Results

Preliminary Analyses

Prior to analyzing the data to test the hypotheses, the data were examined to more fully describe the abuse experienced by the participants of the current study. The average age of the perpetrator was 29.16 (SD = 13.66) and the perpetrators were primarily male (Male: $n = 94$, 93.1%; Female: $n = 6$, 5.9%; Unknown: $n = 1$, 1.0%). Most victims ($n = 85$, 84.2%) had

one perpetrator, while 12 had two (11.9%), and three victims had three perpetrators (3.0%). Many victims were abused only one time (n = 37, 36.6%), but a large minority were abused an unknown number of times (n = 23, 22.8%). Most victims disclosed their abuse (n = 71, 70.3%), while four victims had a perpetrator who disclosed the abuse (4.0%). Many victims experienced multiple forms of sexual abuse, and 22 (21.8%) had perpetrators who used force during the abuse.

Primary Analyses

To examine the relationship of personal, familial, and abuse-specific factors to group membership, we calculated ANOVAs with group membership as the independent variable or Chi-squares for categorical variables. Variances in degrees of freedom indicated are due to unavailability of data for all participants.

Personal Factors

The results for personal factors (gender, age, and attribution regarding the abuse) are summarized in Tables 2 and 3. Group membership predicted neither age nor gender. However, 53% of the male participants were categorized in the problem behaviors group.

Table 2. Mean (SD) of personal factors according to cluster membership

Cluster Membership						
Personal Factor	Highly Distressed	Problem Behaviors	Subclinical	Self-Reported Distress	F	p
Age	11.66 (2.58)	11.65 (2.77)	10.90 (2.49)	12.20 (2.74)	0.73	0.54
CITES – R Attributional Scale	32.57[a] (6.55)	23.58[b] (8.50)	17.50[c] (5.89)	27.84[d] (8.12)	11.63	0.001

Table 3. Percentage (Frequency) of personal factors according to cluster membership

Cluster Membership						
Personal Factor	Highly Distressed (n = 21)	Problem Behaviors (n = 36)	Subclinical (n = 12)	Self-Reported Distress (n = 32)	χ^2	p
Gender					3.80	0.28
Male	19.05% (4)	27.78% (10)	16.67% (2)	9.38% (3)		
Female	80.95% (17)	72.22% (26)	83.33% (10)	90.63% (29)		

Group membership was significantly correlated with CITES-Attribution Scale scores, $F(3, 97) = 11.63$, $MSE = 59.95$, $p < 0.001$. Pairwise comparisons using LSD revealed that individuals in the highly distressed group had significantly higher scores, indicating more negative attributions about the abuse than all of the other groups. Additionally, individuals in the problem behaviors group reported more negative attributions about the abuse than those in the subclinical group, and fewer negative attributions than the self-reported distress group. As predicted, the subclinical group had the lowest mean score on the Attributional Scale, which was significantly lower than the other groups.

Familial Factors

Familial factors included parental history of CSA (n = 46, measured via the Sexual Abuse subscale of the CTQ), parental mental health (n = 92, measured via the SCL-90-R), and family stress (assessed via marital status, n = 94; unemployment, n = 97; and family income, n = 95). Results for all familial factors are summarized in Tables 4 and 5. There were no significant mean differences in the scores on the Sexual Abuse subscale of the CTQ across cluster membership. There were also no differences noted among the groups for marital status, employment, or family income.

Table 4. Percentage (Frequency) of familial factors according to cluster membership

Cluster Membership						
Familial Factor	Highly Distressed	Problem Behaviors	Subclinical	Self-Reported Distress	*F*	*p*
CTQ—Sexual Abuse Scale (Parental History of CSA)	9.00 (4.42)	8.40 (6.68)	8.63 (7.13)	14.23 (7.40)	2.19	0.103
SCL-90-R Global Severity Index	48.47[a] (11.36)	44.15[a] (9.05)	36.73[b] (8.67)	43.00[a,b] (12.14)	2.97	0.036
SCL-90-R Depression Scale	50.05[a] (10.73)	44.21[b] (8.07)	38.91[b] (8.58)	43.39[b] (10.17)	3.66	0.015

Table 5. Percentage (Frequency) of familial factors according to cluster membership

Cluster Membership						
Familial Factor	Highly Distressed	Problem Behaviors	Subclinical	Self-Reported Distress	χ^2	*p*
Marital Status						
N	19	33	11	31	4.68	0.59
Married	42.11% (8)	39.39% (13)	36.36% (4)	45.16% (14)		
Divorced/Separated	52.63% (10)	57.58% (19)	63.64% (7)	41.94% (13)		
Never Married	5.26% (1)	3.03% (1)	0.00% (0)	12.90% (4)		
Income						
N	19	43	11	30	12.15	0.668
< 15,000	42.11% (8)	31.34% (11)	27.27% (3)	26.67% (8)		
15,000–40,000	42.11% (8)	31.34% (11)	36.36% (4)	46.67% (14)		
> 40,000	15.79% (3)	37.14% (13)	36.36% (4)	26.67% (8)		
Employment						
N	19	35	11	32	1.80	0.614
Employed	63.16% (12)	74.29% (26)	81.82% (9)	78.13% (25)		
Unemployed	36.84% (7)	25.71% (9)	18.18% (2)	21.88% (7)		

The clusters differed significantly in mean scores on the Global Severity Index of the SCL-90-R, $F(3, 88) = 2.97$, $MSE = 110.88$, $p = .036$. Pairwise comparisons using LSD revealed that parents of participants in the subclinical group had significantly lower scores, indicating less symptomatology than parents of those in the highly distressed and problem behaviors groups. This confirms the hypothesis that familial factors correlate with group membership. There were no other significant differences among the groups. Further, analyses using the Depression subscale of the SCL-90-R indicated a significant mean difference

among the groups, $F(3, 88) = 3.657$, $MSE = 88.115$, $p = 0.015$. Pairwise comparisons using LSD revealed that parents of participants in the highly distressed group had significantly higher Depression subscale scores, indicating greater symptomatology than all of the other groups. There were no other significant differences among the groups.

Abuse-specific Factors

Statistics for all abuse-specific factors are summarized in Tables 6 and 7. Abuse duration was measured based on parental report of abuse onset and the number of months the abuse occurred ($n = 92$), and no significant mean differences were discovered among the groups. Abuse severity was measured using parental report and data from the available records ($n = 99$). Abuse severity was collapsed into three levels, which from higher to lower severity was: (a) penetration involved (anal, vaginal, or oral), (b) fondling/digital manipulation, and (c) exposure/pornography. The highest level of severity for each participant was used to categorize their abuse experience. There was a significant correlation between group membership and severity of abuse, $\chi^2(6) = 12.99$, $p = 0.043$. Specifically, a much larger percentage of those in the highly distressed group experienced penetration of some form compared with those in the other three groups.

Table 6. Mean (SD) of abusue-specific factors according to cluster membership

Cluster Membership						
Abuse-Specific Factor	Highly Distressed	Problem Behaviors	Subclinical	Self-Reported Distress	*F*	*p*
Duration (months)	11.89 (15.57)	14.73 (19.05)	6.00 (10.89)	14.45 (22.06)	0.68	0.567

Table 7. Percentage (Frequency) of abuse-specific factors according to cluster membership

Cluster Membership						
Abuse-Specific Factor	Highly Distressed	Problem Behaviors	Subclinical	Self-Reported Distress	χ^2	*p*
Abuse Severity						
n	20	25	11	32	12.991	0.043
Penetration	70% (14)	40.0% (14)	16.67% (2)	37.50% (12)		
Fondling/Digital Manipulation	15% (3)	51.43% (18)	75.0% (9)	53.13% (17)		
Exposure/ Pornography	15% (3)	8.57% (3)	8.33% (1)	9.38% (3)		
Victim/Perpetrator Relationship						
n	20	45	12	32	13.27	0.350
Parent Figure	30% (6)	58.33% (21)	33.33% (4)	34.38% (11)		
Other Family Member	20% (4)	8.33% (3)	33.33% (4)	31.25% (10)		
Teacher/Coach/ Babysitter	30% (6)	16.67% (6)	8.33% (1)	15.63% (5)		
Stranger	0%	2.78% (1)	8.33% (1)	3.13% (1)		
Peer	20% (14)	13.89% (5)	16.67% (2)	15.63% (5)		

The relationship between the victim and the perpetrator was collapsed into five categories: (a) parent or parent figure (including parent's significant other), (b) other family member, (c) special relationship (teacher, coach, parents' friend, neighbor, babysitter), (d) stranger, and (d) peer (n = 100). There was no significant correlation between victim-perpetrator relationship and group membership.

Discussion

This study was a comprehensive evaluation of multiple factors identified in the literature as related to clinical presentation following child sexual abuse. Several of the factors identified in the literature as correlated to clinical presentation were related to initial symptom presentation (pretreatment).

Contrary to expected findings, no significant differences were found between male and female participants in the current study. There were relatively few male participants (18.8%), and they were distributed across all four clusters, but the highest concentration (10 male participants; 53% of the males in the study) were in the problem behaviors cluster, characterized by self- and parent-report of elevated internalizing and externalizing difficulties. Although research estimates have indicated that males are less likely to be victimized than females (Berliner 2011), the significant discrepancy between numbers of male and female participants in the current study may have impacted analyses related to gender differences. With a larger sample of male participants, gender may correlate with cluster membership.

Significant differences among the clusters were found for scores on a measure of attributions related to the abuse—the CITES-Attribution Scale. Children in the highly distressed group attained the highest scores, indicating greater negative attributions related to their abuse than those in all of the other groups. Participants in the subclinical group reported the fewest negative attributions regarding their abuse. Taken together, these results indicate that those who report more symptomatology following abuse also report greater negative attributions regarding their abuse. These finding are consistent with studies on adults with a history of CSA that have indicated that shame and self-blame mediate the relationship between CSA and emotional distress in adulthood (for a review, see Whiffen and MacIntosh 2005). Additionally, having fewer negative attributions related to the abuse appears to be a protective factor for symptomatology. This relationship is important for therapists, as attributions related to abuse are amenable to change (Celano et al. 2002), and these attributions may have a greater impact on clinical presentation than other fixed variables (Zinzow et al. 2010). In other words, therapy that focuses on changing victims' attributions for the abuse may ameliorate long-term negative consequences of CSA. Also, such interventions may be useful for victims who are not currently reporting or displaying symptoms in order to focus on preventing future negative self-attributions for the abuse, and therefore preventing future psychological distress or revictimization (Saywitz et al. 2000).

As predicted, cluster membership was also correlated to both global symptomatology and depressive symptoms of victims' parents. SCL-90-R Global Severity Index scores were lower for parents whose children were in the subclinical group, although no differences

were found among the other clusters. Depression scores on the SCL-90-R were also related to cluster membership, with participants in the highly distressed cluster having parents who self-reported greater depressive symptomatology than the other clusters. Interestingly, both parent and self-report measures for this group were elevated, suggesting that for those victims who also had a parent who was depressed, parents observe greater symptomatology and participants report greater distress than those participants whose parents do not report depressive symptomatology. On a positive note, depressive symptomatology in parents is another area amenable to change and one that can be addressed in treatment following abuse. In short, these findings underscore the importance of family involvement in treatment for CSA victims (Putnam 2003; Ramchandani and Jones 2003; Saywitz et al. 2000).

As predicted, abuse severity was significantly correlated with cluster membership, with a higher percentage (70 %) of those in the highly distressed cluster having experienced some form of penetration (anal, vaginal, and/or oral), whereas most of the participants in the subclinical cluster (75 %) experienced fondling as the highest severity of abuse. These data are consistent with past research that has suggested that severity of abuse is related to clinical presentation following CSA (Asberg and Renk 2012; Cutajar et al. 2010).

Although no significant differences were found among the clusters for abuse duration (likely due to large standard deviations within each cluster), those in the subclinical group did experience, on average, the shortest duration of abuse (6 months). Those in the problem behaviors cluster experienced, on average, abuse of the longest duration (14.73 months). The lack of significant findings related to abuse duration and victim-perpetrator relationship may be explained by the complex relationships among abuse characteristics. Victims are more likely to be abused for longer periods by those who have access to them. Therefore, victims of family members who have frequent, unsupervised contact with them are more likely to be abused for a longer duration.

The use of multiple informants and comprehensive clinical measures during assessment was a particular strength of the current study. The use of multiple informants allowed for input from the victim and from someone with close contact to the victim (parent/caregiver). The greatest strength of the current study may be that comprehensive data were available for the participants in the study. Many past studies have reported limited information on the types of abuse experienced, and few have collected detailed information on the parents of victims. This study was able to incorporate data from three domains (personal, familial, and abuse-specific) to examine their relationship to clinical presentation following CSA.

Most analyses were conducted with data from 101 participants, which is a large sample compared to many studies in the literature. Having a smaller sample size is especially common in studies utilizing data collected from children (e.g., Mian et al. 1996, who examined 70 female victims; Nelson et al. 1999, who examined 25 female victims; Young et al. 1994, who examined 40 victims). The larger sample size allows for greater detection of relationships and more potential generalizability of results to other victims.

The literature is replete with contrary reports of the impact of the variables examined in this study. For example, some investigators (e.g., Cutajar et al. 2010; Feiring et al. 1998; Gries et al. 2000) have found that age is related to clinical presentation, while others (e.g.,

Bergen et al. 2004; Mian et al. 1996; Paolucci et al. 2001) have not found age to have an impact on outcome. Also, some studies (Baker 2001) have reported that parental history of CSA is related to clinical presentation, while others (Oates et al. 1998) found no relationship between parental history of CSA and clinical presentation following abuse. A final example is the relationship between the victim and the perpetrator. Some prior studies (Beitchman et al. 1991; Kendall-Tackett et al. 1993; Ketring and Feinauer 1999) have suggested that abuse by someone with whom the victim has a closer relationship (i.e., family member) results in greater symptomatology, while others (Paolucci et al. 2001; Wolfe et al. 1994) have found no impact of victim-perpetrator relationship on clinical presentation. Others still (Lucenko et al. 2000) have found that being victimized by a stranger corresponds to more psychological distress. The current study may have elucidated a reason for the varying results from past studies. There are distinct groups of victims of CSA and there are several factors correlated with these differences. Knowing victims of CSA show distinct clinical presentations that can be grouped based on parent- and self-report suggests that the way past studies have grouped all victims into one sample may not clearly represent the population.

This study aimed to be more comprehensive than past studies by examining many of the factors suggested to have an impact on clinical presentation following CSA and to include victims that display subclinical symptom levels in all analyses. The static factors of the abuse experience are unchangeable. However, existing therapeutic interventions can ameliorate symptoms by focusing on those factors that are amenable to change (Bagley and LaChance 2000; Cohen et al. 2004; Grosz et al. 2000). Further, by examining victims who exhibit asymptomatic or minimal negative symptoms, the protective factors present in those children can be incorporated into treatment with victims who display more negative symptoms. There were several significant differences among victims of CSA presenting for treatment, including some which are amenable to change via treatment (attributions regarding the abuse and parental mental health). These factors may be considered protective for those in the subclinical cluster, who had significantly lower scores on the CITES-Attributional scale and had parents who reported significantly fewer symptoms of depression and other disorders. These factors may provide these children more resiliency following a negative event. and they may also have greater resources in the form of parent figures who are able to better assist them in coping with their abuse. Further, these findings demonstrate the importance of treating the entire family, and not only the child who experienced sexual abuse.

When studying victims of CSA, there are always difficulties related to definitional issues of CSA, inability to infer causation of clinical presentation from the abuse, obtaining accurate information regarding the details of the abuse (e.g., severity, duration), and recruitment of participants during a difficult time, among others. There were no exceptions to these difficulties in the current study, with the possible exception of the close relationship built with the local Child Advocacy Center and their awareness of the importance of research on CSA. This relationship enabled many participants to be recruited through a forum already familiar and generally well received by the families. As always, there may be a difference between people who volunteer themselves and their children to participate and those who choose not to participate when recruited. There is no way to assess any

potential differences. More male participants would assist in parsing out gender differences related to clinical presentation, or at least make the fact that no significant differences were found between the genders for the current study more likely to reflect a true nonsignificant finding as opposed to the possibility that the results were linked to the limited number of male participants. In addition, no information was available regarding other forms of abuse. Although all the participants were in their parent/guardian's care, there are no available data at this point about previous maltreatment history aside from the sexual abuse reported. Therefore, any possible impact from other maltreatment cannot be evaluated.

Finally, more in-depth research on the factors that appear to foster resilience in victims is necessary to ascertain how these factors may be used during treatment to assist victims who are experiencing symptoms. Further, as attributional style and attributions related to the abuse appear to be related to clinical presentation, specifically addressing attributions in treatment may be beneficial for participants.

This study was a comprehensive examination of factors potentially correlated to clinical presentation following childhood sexual abuse. Consistent with previous studies, personal, familial, and abuse-specific factors related to clinical presentation of victims of CSA. Several factors related to cluster membership; specifically, victims' attributions regarding the abuse, parent's mental health and depressive symptoms, and abuse severity were all significantly correlated to group membership. Contrary to past research, the other variables examined were not correlated to the clinical presentation of victims at pretreatment. There are various reasons for the differences from previous findings, including the complex nature of abuse, the fact that many of the constructs had mixed results in past research, the use of a sample that presented for treatment, and the ratio of male to female participants.

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