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# Understanding Fear and Self-Blame Symptoms for Child Sexual Abuse Victims in Treatment: An Interaction of Youth Age, Perpetrator Type, and Treatment Time Period

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UNDERSTANDING FEAR AND SELF-BLAME SYMPTOMS FOR CHILD SEXUAL  
ABUSE VICTIMS IN TREATMENT: AN INTERACTION OF YOUTH AGE,  
PERPETRATOR TYPE, AND TREATMENT TIME PERIOD

An Undergraduate Honors Thesis  
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by  
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## **Abstract**

Child Sexual Abuse victims have been known to experience a wide array of emotional and behavioral symptomology following abuse. These symptoms can have a negative impact on victims in the future if proper intervention and treatment is not provided. This study focuses specifically on the symptomology of fear and self-blame in victims and what factors influence the efficacy of treatment due to these symptoms' continuous and impartial characteristics.

Participants were 333 sexually abused youth attending Project SAFE (Sexual Abuse Family Education), a cognitive-behavioral treatment program through a local Child Advocacy Center. Children were 6 to 18 years old, 79.9% female, and 71.8% European American. A repeated measures analysis was performed looking at the interaction between treatment time period (pre-treatment, midpoint-treatment, and post-treatment), victim age at the start of treatment (child vs. adolescent), and perpetrator type (family vs. non-family). The main effect of treatment time period was found to be significant for fear scores and self-blame/guilt scores. This indicates that, regardless of a child's CSA perpetrator or their age, the treatment is still beneficial at reducing symptoms of fear and self-blame/guilt.

**Key Words:** child sexual abuse, psychology, victim age, child, adolescent, intrafamilial perpetrator, extrafamilial perpetrator, cognitive behavioral therapy, fear, self-blame

## **Dedication**

I would like to dedicate this thesis to the University of Nebraska-Lincoln's *Child Maltreatment Laboratory*. This research lab has provided me with several wonderful opportunities over the past two years that have been integral in my acceptance to a school psychology doctoral program, as well as in building my confidence as a researcher in the psychological field. Many thanks to Dr. David J. Hansen and Dr. Mary Fran Flood for advising my thesis and being encouraging and helpful every step of the way. I am especially thankful for the endless support of Kate Theimer. You have been the best academic role model I could have ever asked for, and I would not have been able to accomplish my current goals had it not been for your incredible mentorship. I would also like to thank Jessica Pogue, my first mentor. You took me under your wing and inspired me to fully immerse myself in the lab and its research, opening my eyes to the countless possibilities to do more and work harder.

Lastly, I am extremely grateful for the love, assistance, and patience of my parents, Mark and Julie Nelson, and my sisters, Tori, Ali, and Sami. Thank you for helping me persevere through the challenges of college, being examples of hard work and dedication, and pushing me to achieve more every day.

**Understanding Fear and Self-Blame Symptoms for Child Sexual Abuse Victims in  
Treatment: An Interaction of Youth Age, Perpetrator Type, and Treatment Time Period**

Survivors of child sexual abuse (CSA) may experience a host of negative symptomology, presenting higher degrees of externalizing and internalizing behavioral issues compared to their non-abused peers (Hébert, Langevin, & Daigneault, 2016). Aydin, Akbas, Turla, and Dunder (2016) state, “Studies have emphasized the development of PTSD, depression, dissociation, behavioral problems, particularly anxiety disorders, compromised interpersonal relations, personality disorders, substance abuse, suicidal ideation or behavior, sexual-oriented behaviors, sexual dysfunction, high-risk sexual behavior and eating disorders in victims of child sexual abuse” (p. 418). Quas, Goodman, and Jones (2003) describe internalizing behavior problems and self-blame attributions as two central consequences linked to CSA, with self-blame potentially producing several other harmful outcomes (e.g., worthlessness, guilt, shame). This provides more insight into the wide array of varying and potentially harmful outcomes associated with CSA and why it is necessary that research be conducted to learn more about and aid in alleviating these symptoms.

Research on why victims obtain such diverse consequences following CSA has been mainly focused on specific characteristics of the abuse itself, offering explanations of the type of abuse inflicted, the length and frequency of the abuse, the victim’s relationship to the perpetrator, and the use of force (Aydin et al., 2016; Feiring, Taska, & Lewis, 1999). These differences in child sexual abuse endured help to explain why victims experience a range of outcomes, with some individuals experiencing limited symptomology to some individuals experiencing severe problems. As mentioned, posttraumatic stress disorder (PTSD) and self-blame have been discovered to arise in victims, with their severity and future outcomes depending on various

external factors, including perpetrator relationship and age of the youth (Aydin et al., 2016; Quas et al., 2003). The victim's relationship to the perpetrator (whether they are related by blood or marriage, or they are not related at all) and the age of the victim at the beginning of treatment (child vs. adolescent) are variables of particular interest in this research study due to their objective and enduring nature. Some factors that influence abuse outcomes may change or waiver over time. However, studying concrete and unchanging factors allows researchers to focus in on and better address associated victim symptomology, provide beneficial resilience promoting strategies, and improve psychological functioning.

Fear-related symptoms (common in PTSD and other anxiety disorders) and self-blame are also core components of this study because of how often they arise in CSA victims. Even individuals without major psychological problems might still exhibit some levels of self-blame following the abuse, and studying a self-functioning variable, like self-blame, offers greater comprehension of a CSA victim's longstanding adjustment (Feiring, Cleland, & Simon, 2010). Also, fear-related symptoms are frequent, with some victims presenting fear symptoms alone and some presenting the full criteria for PTSD (Cantón-Cortés, Cantón, & Cortés, 2012).

### **Relationship to Perpetrator**

For victims of CSA who have a closer relationship to their perpetrator (such as a familial association), previous research has shown that this can produce more detrimental psychological consequences following the abuse (Aydin et al., 2016). Due to an intrafamilial perpetrator potentially having more frequent interactions alone with the child, having greater trust with the child leading to less frequent disclosure, and not being viewed as threatening by fellow family members, this abuse can have a much longer duration than abuse committed by an extrafamilial perpetrator. Because of this prolonged sexual abuse, the abuse can further progress and become

more intrusive, which in turn has been found to lead to high levels of emotional and physical injury to the victim (Fischer & McDonald, 1998). Bal, De Bourdeaudhuij, Crombez, and Van Oost (2004) state, “several studies provide evidence that abuse by a family member, contrarily to a stranger, leads to long-term negative consequences and high levels of distress” (p. 109).

Although extrafamilial abuse can still produce very negative symptomology in CSA victims (e.g., creating more fear), the extended duration and conceivably increased severity of sexual abuse between relatives is thought to generate worse outcomes.

### **Age of Child**

Concerning the differences in amount of self-blame associated with age, Quas and associates (2003) discuss how younger children are not as capable of comprehending causality when it's related to challenging and personally significant circumstances. “We speculate that such reasoning contributed to the increased self-blame among the younger children in the sample relative to those whose abuse ended in middle to late childhood” (Quas et al., 2003, p. 732). As this finding portrays, due to this perspective held by younger children, they are at risk of developing more severe outcomes due to self-blame than older children, like helplessness and depression. As for the differing levels of fear exhibited by children and adolescents, adolescent victims of CSA have been identified as presenting more extensive PTSD symptoms at the start of treatment because of widespread developmental effects that come with age (Feiring et al., 1999). Feiring and colleagues (1999) describe developmental effects as interfering with valuable life milestones, such as gaining emotional management and self-esteem (characteristics that are necessary at this stage in life), and being extremely extensive. Therefore, due to adolescents' potential to have experienced significantly more negative life events, as well as more severe abuse, their fear levels are alleged to be greater than those of children.

### **Mental Health Treatment**

In order to diminish the occurrence of these future negative outcomes (depression, helplessness, substance use disorders, etc.) (Messman-Moore & Bhuptani, 2017; Quas et al., 2003), and control for extraneous factors, it is vital that victims be provided with prompt and effective therapeutic treatment. There are various types of treatments available to victims of CSA to aid in alleviating their symptomology, including general psychotherapy, cognitive therapy, and trauma-focused cognitive behavioral therapy (TF-CBT). The aim of general psychotherapy is to model a healthy and nurturing relationship for the victim that allows them to rebuild trust and work through their trauma in a positive and beneficial way (Sinanan, 2015). Sinanan (2015) also defines cognitive therapy for treating PTSD as focusing “on teaching clients how to identify, evaluate, and reframe the dysfunctional cognitions related to the specific trauma and its sequelae that contribute to the intense negative emotions and behavioral reactions” (p. 3). Lastly, TF-CBT focuses more on the educational components related to PTSD and trauma, such as teaching individuals how to regulate their emotions, having conversations where the individuals openly share their traumatic experience, providing skills for stress management and relaxation, and helping victims realize the connection between their trauma, the feelings they are perceiving, and the behaviors they are exhibiting (Sinanan, 2015). Additionally, Project SAFE, a program of the Child Maltreatment Laboratory and Psychological Consultation Center through the University of Nebraska-Lincoln (UNL), has been found to deliver beneficial cognitive-behavioral group therapy for decreasing a broad range of these symptoms linked with CSA in a heterogeneous population of individuals (Hubel et al., 2014). Cognitive-behavioral treatment centers on altering victims’ cognitive and emotional processing in order to reduce the development and perpetuation of emotional and behavioral symptoms (Sinanan, 2015). Project

SAFE also includes psychoeducation on CSA, skill building, sex education, and prevention of future abuse. The group therapy component allows both the victims and non-offending family members to not feel as isolated in or shameful of their current situation and learn valuable tools from others enduring the same types of experiences.

### **Study Aims and Hypotheses**

As discussed in the articles above, there are a multitude of potential negative outcomes accompanying CSA, as well as various factors that have the potential to influence the presentation and severity of these outcomes. Thus, due to the long-lasting and objective disposition of an individual's age at the start of treatment and their relationship to the perpetrator, as well as the large prevalence of fear and self-blame outcomes, the purpose of this study was to investigate the effects of a child's age, the closeness of their relationship with the perpetrator, and the Project SAFE treatment time period on their obtained fear and self-blame. It is hypothesized that as treatment progresses, victims of CSA will record significantly lower scores of fear and self-blame. It is also hypothesized that this treatment effectiveness will be consistent regardless of the interaction of age and perpetrator type, displaying a non-significant three-way interaction. It is anticipated that adolescents will present higher fear scores than children at the start of treatment, but that children will present higher self-blame scores than adolescents at the start of treatment. Lastly, it is predicted that a family relationship between the child and offender will result in higher scores for both fear and self-blame than a non-family relationship.

### **Method**

#### **Participants**

Participants included 333 sexually abused youth presenting to mental health treatment from Lincoln, Nebraska and surrounding areas. Of these, 266 (79.9%) participants were female,

while 64 (19.2%) of these participants were male. The age of participants ranged from 6 years of age to 18 years of age, with the average age being 11.69 years and a standard deviation of 2.98. In regards to ethnicity, 239 (71.8%) identified as European American, 16 (4.8%) identified as Hispanic American, 14 (4.2%) identified as African American, 6 (1.8%) identified as Native American, and 37 (11.1%) were of other ethnicity. The child group consists of individuals who are 6 to 12 years old and the adolescent group consists of individuals who are 13 to 18 years old. There were 151 (45.3%) individuals who participated in the child group, with a mean age of 9.35 years, and 105 (31.5%) individuals who participated in the adolescent group, with a mean age of 14.78 years. Participants with family member perpetrators were 192 (57.7%) individuals and participants with non-family member perpetrators were 104 (31.2%) individuals. These demographics are also summarized below in Table 1.

### **Measures**

Participants completed various child- and adolescent-report measures at three points in time throughout each treatment program: pre-treatment, midpoint-treatment, and post-treatment. Two measures were closely examined and incorporated into this study. The first measure was the children's fears related to victimization (CFRV; Wolfe & Wolfe, 1986), which is a 27-item measure assessing potentially distressing situations for sexually abused children through utilizing two subscales: sex associated fears and interpersonal discomfort. Participants ranked each statement as 1, 2, or 3, with 1 being *not that afraid* and 3 being *very afraid*. Total scores ranged from 27 to 81, with higher scores representing increased amounts of fear in victims. Statements relating to this consisted of "being alone on a playground," "telling on someone for bothering me," and "someone kissing or hugging me." This questionnaire has been tested for reliability and validity (Wolfe & Wolfe, 1986) and Cronbach's alpha in this sample was  $\alpha = .906$ ,

suggesting excellent internal consistency. The second measure was the children's impact of traumatic events scale, revised (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991), which is a 78-item measure assessing the effects of sexual abuse reported by the victim. The Self-Blame and Guilt subscale was used. Participants ranked each statement as *very true*, *somewhat true*, or *not true*. This measurement included statements such as "this happened to me because I acted in a way that caused it to happen," "this happened to me because I was too young to do anything about it," and "I feel I should be punished for what I did." Cronbach's alpha for this sample was  $\alpha = .968$ , suggesting excellent internal consistency.

### **Procedures**

Participating families attended Project SAFE (Sexual Abuse Family Education), a free 12-week parallel group cognitive-behavioral treatment program for victims of CSA, their non-offending, non-abused siblings, and their non-offending caregivers located at a local Child Advocacy Center. Most families were referred to Project SAFE by their advocate at the Child Advocacy Center. Each session lasted 90 minutes long, and victim and parent groups met independently but the treatment occurred concurrently. Following a treatment manual for each weekly session, trained master's level therapists in the UNL Clinical Psychology Training Program led every session and co-therapists, pre-master's level doctoral students, would assist. Hubel and associates (2014) state, "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" (p. 314). This describes the intentions behind the victims' group treatment sessions. As for caregivers, the goal of their treatment was to gain a greater understanding of their child's behaviors and feelings and provide assistance in positively managing these

behaviors in order to promote consistency across the home and treatment environment and maintain therapeutic advances (Hubel et al., 2014). Prior to treatment, mid-way through treatment, and after treatment completion, CSA victims completed multiple other measures along with the measures described above, including the children's depression inventory (CDI), the revised children's manifest anxiety scale (CMAS-R), the children's loneliness questionnaire (CLQ), and the child Project SAFE evaluation form. Non-offending caregivers also completed several measures throughout the course of treatment: the child behavior checklist (CBCL), the family adaptability and cohesion evaluation scale-IV (FACES-IV), the family crisis oriented personal evaluation (F-COPES), the parenting stress index (PSI), and the parent Project SAFE evaluation form. UNL graduate students in the Clinical Psychology Training Program administered these instruments. Following each treatment period, collected measures were coded, reviewed, and entered into a database by UNL undergraduate research assistants. Hypotheses were then formulated for this study and the proper analyses of the collected data were completed.

### Results

Repeated measures analyses were conducted to analyze the various interactions of the variables. Figures 1, 2, 3, and 4 summarize these results below. A main effect of treatment time period was found for both CFRV total scores,  $F(2,250) = 24.58$ ,  $Mse = 35.68$ ,  $p < .001$ ,  $r = .41$ , and CITES Self-Blame/Guilt scores,  $F(2,204) = 9.03$ ,  $Mse = 7.471$ ,  $p < .001$ ,  $r = .29$ , indicating that as treatment occurred, these variables improved overtime, providing support for the research hypothesis that Project SAFE treatment would be effective in decreasing negative symptoms. Participants exhibited significant decreases (decreases equal improvements) in their CFRV total scores from pre-treatment ( $M = 53.73$ ) to midpoint-treatment ( $M = 51.02$ ) to post-treatment ( $M =$

48.18). There were also significant decreases in participants' CITES Self-Blame/Guilt scores from pre-treatment ( $M = 5.58$ ) to midpoint-treatment ( $M = 4.61$ ) to post-treatment ( $M = 3.91$ ). However, this main effect was misleading for adolescents with family perpetrators as we saw a slight, but not significant, increase from pre-treatment ( $M = 5.32$ ) to midpoint-treatment ( $M = 5.45$ ) in their CITES Self-Blame/Guilt scores.

For CFRV total scores, there was also a main effect of the victim's age discovered,  $F(1,125) = 4.07$ ,  $Mse = 279.76$ ,  $p = .046$ , which showed that, contrary to the research hypothesis of adolescents being more symptomatic than children at the beginning of treatment in regards to fear, children ( $M = 52.80$ ) generally had more fear than adolescents ( $M = 49.15$ ) throughout treatment ( $r = .18$ ). For CITES Self-Blame/Guilt scores, no main effect of victim's age was discovered at beginning of treatment,  $F(1,102) = 1.84$ ,  $Mse = 31.32$ ,  $p = .178$ , displaying that children's scores ( $M = 4.25$ ) were not significantly different than adolescents' scores ( $M = 5.15$ ). This goes against the research hypothesis that children will present higher self-blame scores than adolescents ( $r = .13$ ).

The main effect of perpetrator type for either CFRV total scores,  $F(1,125) = 1.12$ ,  $Mse = 279.76$ ,  $p = .29$ ,  $r = .09$ , or CITES Self-Blame/Guilt scores,  $F(1,102) = 0.21$ ,  $Mse = 31.32$ ,  $p = .65$ ,  $r = .05$ , was non-significant. This does not provide support for the research hypothesis that CSA victims with family relationships to the perpetrator will have higher scores than those with non-family relationships to the perpetrator. Family perpetrators for CFRV total scores ( $M = 51.94$ ) and for CITES Self-Blame/Guilt scores ( $M = 4.55$ ) were not significantly different than non-family perpetrators for CFRV scores ( $M = 50.02$ ) and CITES Self-Blame/Guilt scores ( $M = 4.85$ ).

A three-way interaction was not discovered for either CFRV total scores,  $F(2,250) = 0.25$ ,  $Mse = 35.68$ ,  $p = .78$ ,  $r = .05$ , or CITES Self-Blame/Guilt scores,  $F(2,204) = 0.53$ ,  $Mse = 7.47$ ,  $p = .59$ ,  $r = .07$ . This suggests that, regardless of a child's sexual abuse perpetrator type or how old they are, Project SAFE treatment is similarly effective across these domains. This finding offers support to the research hypothesis that treatment will be comprehensively beneficial for a wide population of victims afflicted by differing trauma symptoms.

Significant two-way interactions were not present between perpetrator type and treatment time period,  $F(2,250) = 1.16$ ,  $Mse = 35.68$ ,  $p = .32$ , victim's age and treatment time period,  $F(2,250) = .05$ ,  $Mse = 35.68$ ,  $p = .95$ , and victim's age and perpetrator type,  $F(1,125) = .59$ ,  $Mse = 279.76$ ,  $p = .445$ , for CFRV total scores. There were also no significant two-way interactions found between perpetrator type and treatment time period,  $F(2,204) = 2.358$ ,  $Mse = 7.47$ ,  $p = .10$ , victim's age and treatment time period,  $F(2,204) = 1.42$ ,  $Mse = 7.47$ ,  $p = .25$ , and victim's age and perpetrator type,  $F(1,102) = 1.11$ ,  $Mse = 31.32$ ,  $p = .29$  for CITES Self-Blame/Guilt scores.

### **Discussion**

After further analyzing the results from this research study, support for Project SAFE's cognitive-behavioral group treatment program's efficacy for victims of CSA has been obtained. The collected results from these analyses indicate that this type of therapeutic treatment effectively decreases victims' obtained fear levels and self-blaming tendencies. Due to the innovative and unique characteristics of Project SAFE treatment, these positive outcomes can be contributed to years of thorough research in order to further advance and add on to strategies utilized, as well as the high quality training of the therapists and co-therapists administering the group treatment sessions. Child and adolescent victims of sexual abuse from Lincoln and several surrounding areas, along with their non-offending family members, are frequently referred to this

treatment program because of the positive outcomes portrayed, and this study's results continue to support the notion that Project SAFE is an evidence-based and reputable intervention.

Support has been acquired for the three-way interaction hypothesis that this treatment is effective regardless of an individual's age or relationship to the perpetrator. This finding portrays that even if a victim has a close, familial relationship to the offender, which has been found to produce greater levels of distress and increased negative symptomology (Bal et al., 2004), they still have just as positive of results through Project SAFE's treatment program as a victim with an extrafamilial perpetrator. It also shows that both children and adolescents progress through this treatment equally and are able to attain similar developments. This finding is regardless of the varying characteristics held by each age group that can make it more difficult for victims to achieve resilience due to increased fear or self-blame, as indicated by prior research (Feiring et al., 1999; Quas et al., 2003). These results may be because of the group therapy aspect of this treatment allowing victims to not feel as alone in their distress, decrease their perceived stigmatization, understand that they are supported and protected, and learn from others that they are not personally responsible for their abuse. By working with a group, these individuals can grow and benefit together despite their differing circumstances. Also, there are separate groups for adolescents and children, so each age group has their own custom treatment plans, which can better target potential age discrepancies in victims. This finding may also be a result of the cognitive behavioral component of the treatment assisting victims in reframing their beliefs regarding the abuse and gaining tools to effectively navigate their emotions and behaviors. The implications of these results are that group therapy should be utilized more often in conjunction with cognitive behavioral therapy in order to offer CSA victims both a supportive and collaborative environment and helpful techniques to positively alter their cognitions.

Although the main effect of victim's age at the start of treatment related to their fear scores was found to be significant, these results were opposite of the hypothesized direction, portraying that children actually had more fear than adolescents in this specific study. This may be due to the severity or particular type of sexual abuse the studied children suffered compared to adolescents treated by Project SAFE. This may also be a result of there being more children participating in this treatment program than adolescents, which could provide the child group with more victims suffering from severe traumatic experiences than the adolescent group. This indicates that future research should consider the severity and type of sexual abuse of each victim, group them accordingly, and then examine in contrast children and adolescent victims who share similar abuse experiences. For self-blame related to victim's age at the start of treatment, there was also no support for the hypothesis that children will present higher self-blame scores than adolescents, as the results were non-significant. This could be because these particular children did not have as much difficulty understanding causality in this situation, as previous research believed they would (Quas et al., 2003), or because they had already been reassured of their lack of responsibility for the sexual abuse by a caregiver or other individual before treatment began. To better control for these potential differences, a cognitive assessment of a child and their grasp of the concept of causality, along with an interview asking them what adults or other individuals in their life have told them about the abuse, could be conducted as well.

With the victim's relationship to their perpetrator, support for the research hypothesis that CSA victims with family relationships will have higher fear and self-blame scores than those with non-family relationships was not attained as well. This again could be a result of the two groups of victims' differences in the type and severity of abuse experienced. Whereas typically

intrafamilial abuse is prolonged and significantly increased in intrusion due to the close contact, alone time, and obtained trust the victim has with the offender (Fischer & McDonald, 1998), it is possible that this studied group of victims in Project SAFE did not have these same experiences. It is possible that their abuse, overall, was discovered earlier than the usual intrafamilial perpetrator case, or possibly did not progress as much to be as severe. Regardless, this finding indicates that more research should be conducted to gain information specifically related to both intrafamilial and extrafamilial sexual abuse, and then comparisons should be made between groups that have similar abuse experiences. This will allow for more conclusive results in how one's relationship to their perpetrator associates with outcomes.

Due to the discrepancy present between this study's results and the findings from Feiring and colleagues (1999) regarding differences between a victim's age and their level of fear, further research on the relationship between age and fear should be conducted. It would also be beneficial to conduct research on other potential external factors that could impact a victim's outcome with treatment, including frequency of abuse, abuse type, use of violence, and so on, as these are known to increase the negative impact for CSA victims (Aydin et al., 2016). Due to the harmful consequences of PTSD and victim self-blame if left untreated (Feiring et al., 2010; Messman-Moore & Bhuptani, 2017), such as dissociative symptoms, emotion dysregulation, and substance use disorders, treatments that combat other potential influencing components are necessary in order to increase success rates. These influencing components could include severity of abuse, parental reactions to discovery of abuse, and gender of victim. Future research should also be administered to develop a greater understanding of how the various types of CSA (e.g., fondling, intercourse, masturbation) influence fear and self-blame scores, and if the efficacy of Project SAFE treatment differs based on type of abuse.

**Limitations**

Limitations of this study include the non-experimental essence of the data collected, leading to random assignment and manipulation of individuals to the child and adolescent groups not being able to be enacted. Therefore, the results are unable to be causally interpreted. Also, a larger group of participants, including more equal amounts of male and female participants, more ethnically diverse participants, and equal numbers of participants in both the child and adolescent groups, along with additional measurements assessing the self-blame and fear of CSA victims, would allow this study to be more generalizable to a larger population of child and adolescent victims.

Overall, given that PTSD and victim self-blame occur often among victims, it is pivotal that programs such as Project SAFE continue to improve and revise their cognitive-behavioral treatments for CSA to more thoroughly address and diminish an individual's maladaptive attributions of blame and their feelings of fear resulting from the abuse.

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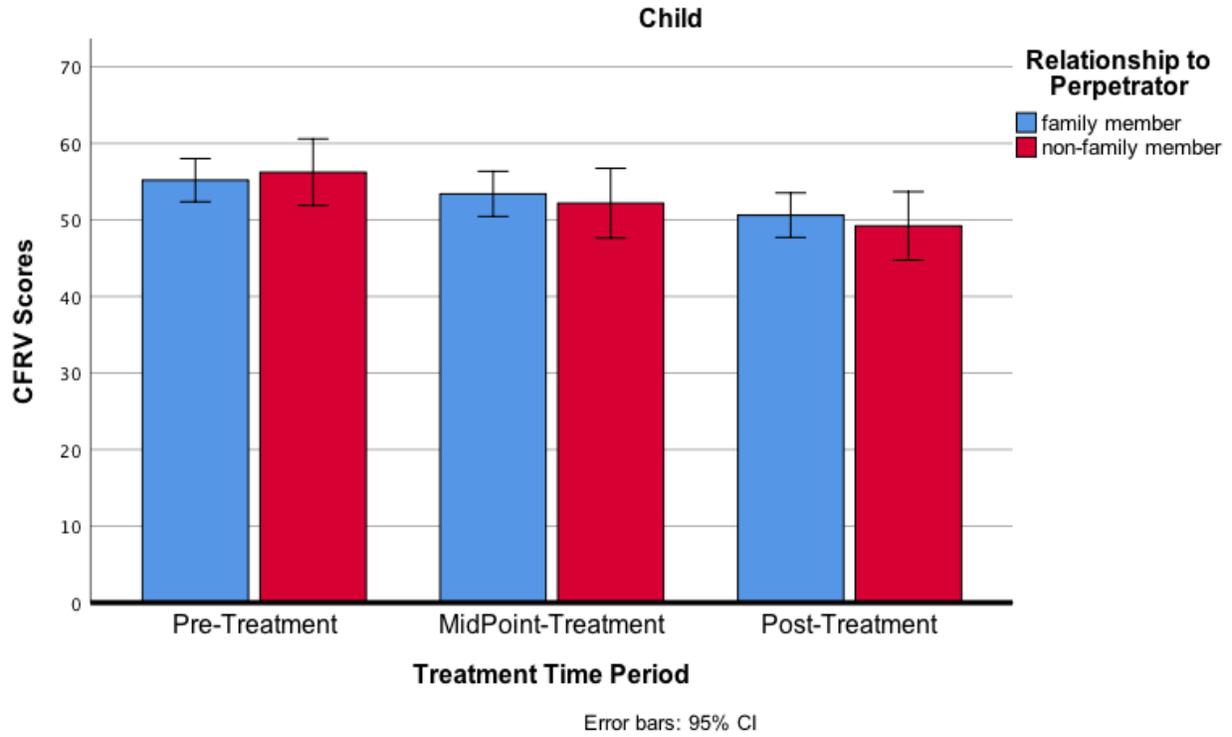
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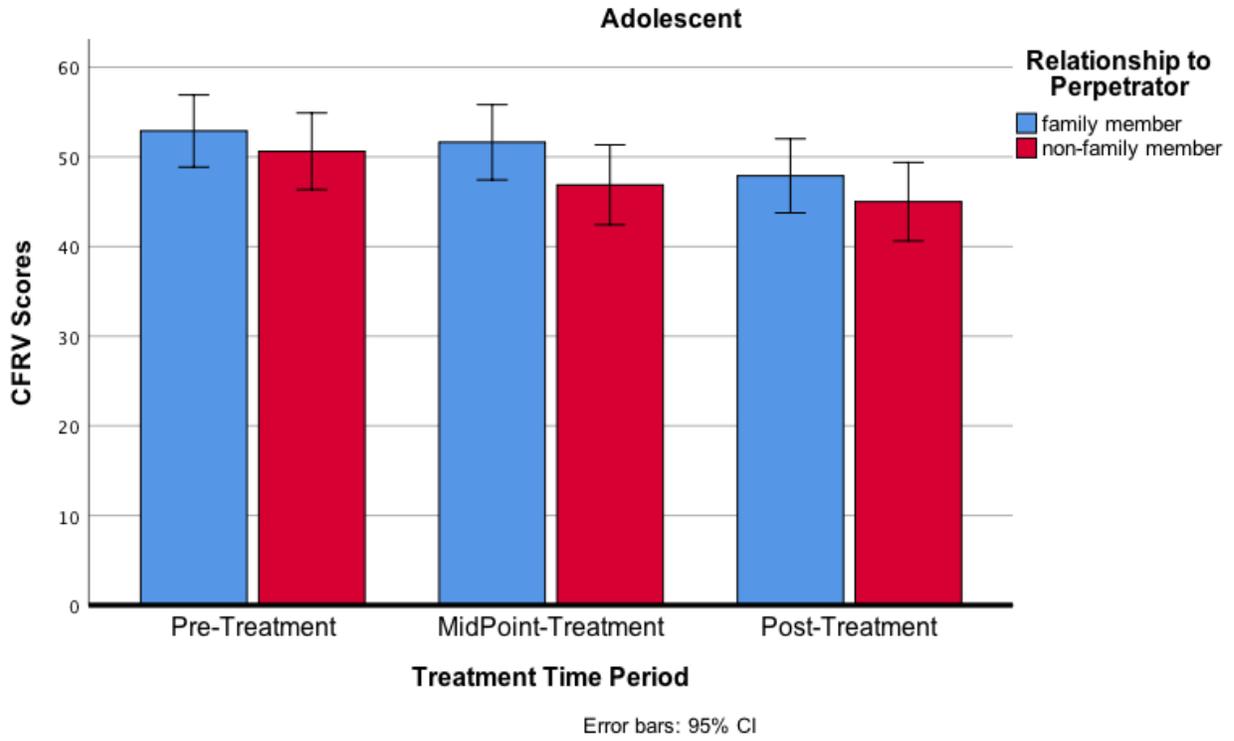
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**Table 1***Summary of Participant Demographics*

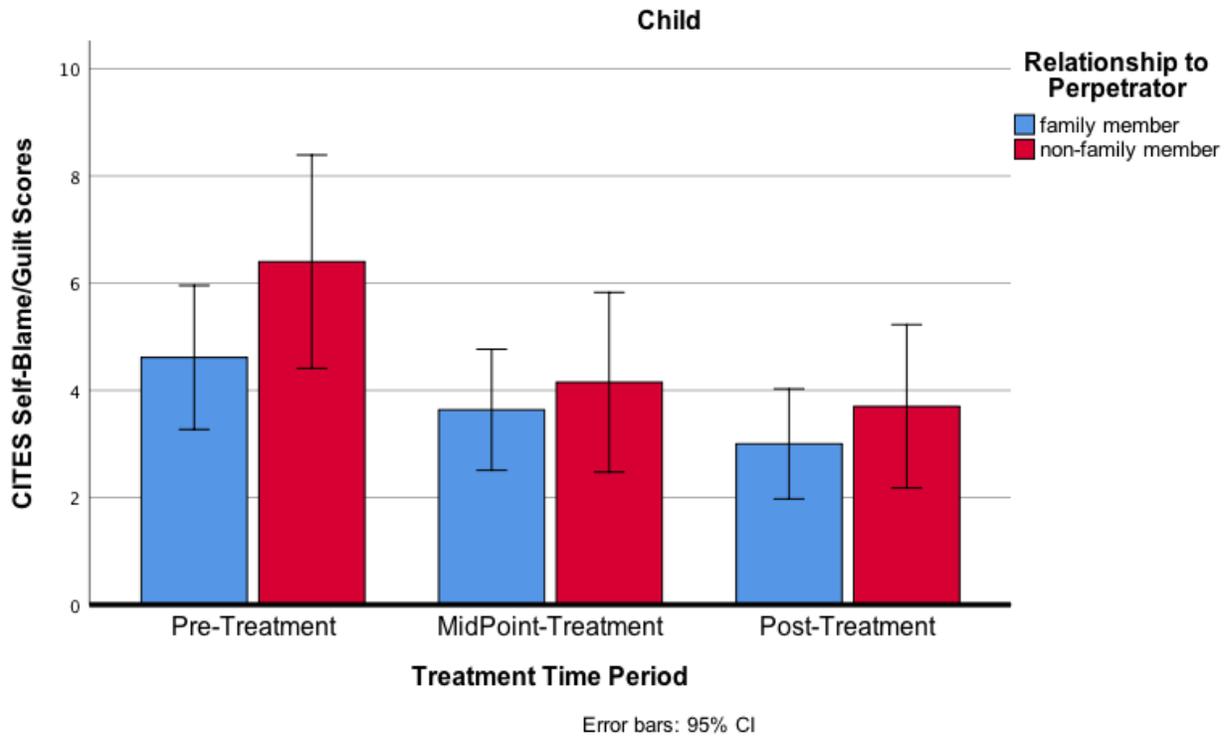
Variable		Frequency	Percent
Gender	Female	266	79.9%
	Male	64	19.2%
Ethnic Affiliation	African American	14	4.2%
	European American	239	71.8%
	Hispanic American	16	4.8%
	Native American	6	1.8%
	Other Ethnicity	37	11.1%
Project SAFE Group	Child Group	151	45.3%
	Adolescent Group	105	31.5%
Perpetrator Type	Family Member	192	57.7%
	Non-Family Member	104	31.2%
Age	<i>Range = 6-18 years</i>	<i>M = 11.69</i>	<i>SD = 2.98</i>



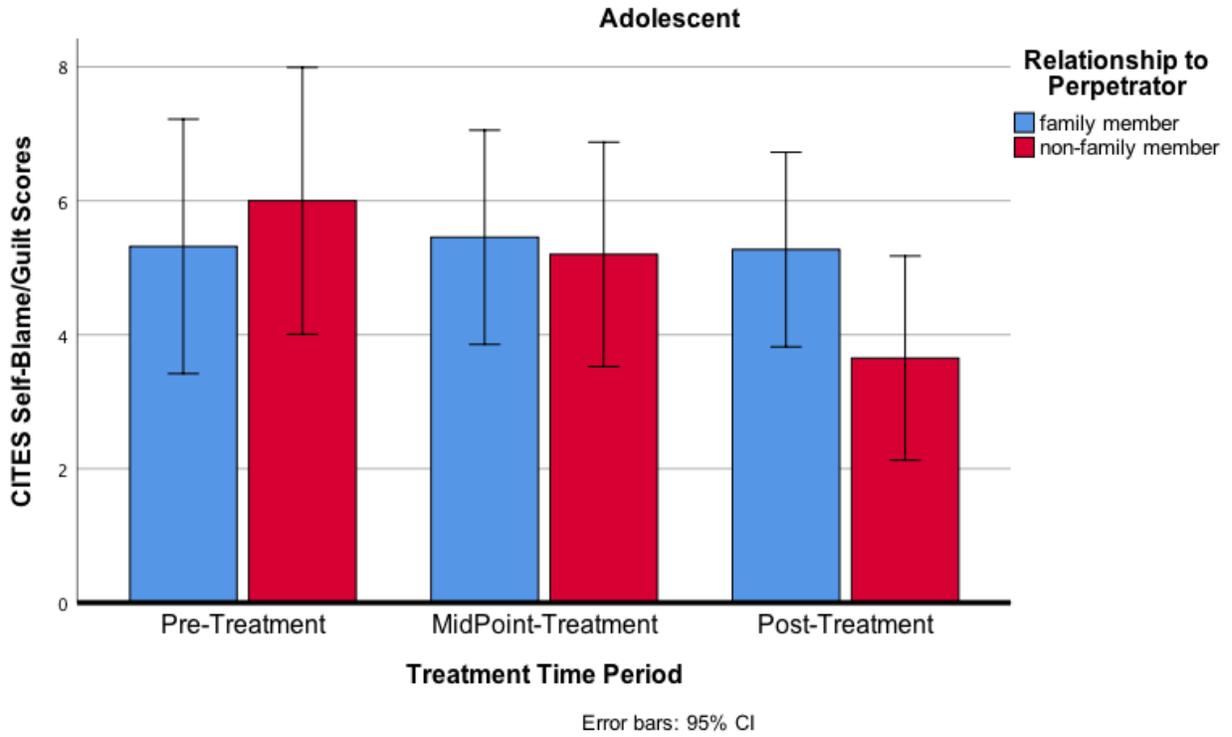
**Figure 1.** CFRV scores for children across relationship to perpetrator and treatment time period.



**Figure 2.** CFRV scores for adolescents across relationship to perpetrator and treatment time period.



**Figure 3.** CITES Self-Blame/Guilt scores for children across relationship to perpetrator and treatment time period.



**Figure 4.** CITES Self-Blame/Guilt scores for adolescents across relationship to perpetrator and treatment time period.