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State of the Science: Group Therapy Interventions for Sexually Abused Children

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A B S T R A C T

Research investigating the use of group therapy treatment for sexually abused children is limited. This paper aims to review the current state of the science of group therapy and its outcomes with children and adolescents under age 18 who have experienced sexual abuse. A literature review was conducted which located eight articles meeting the inclusion criteria of this paper. These outcome studies utilized a wide array of theoretical orientations and intervention delivery, as well as an assortment of outcomes measurement. While the studies lacked consistency, there is some support that group therapy formats to treat sexually abused children and adolescents may be effective across a range of symptoms. Implications for practice, policy, and future research are discussed.

The scope of the problem of childhood sexual abuse (CSA) in the United States was only first recognized in the 1970s. Unfortunately, the taboo of CSA in western society continues to serve as a hindrance to much needed research in this area. Efforts to identify buffers to the development of negative sequelae in children and adolescents following CSA have been undertaken by researchers over recent decades, with perceived environmental support being identified as one of these key buffers. While group therapy treatments with young victims of sexual abuse may allow development of these supports, empirical outcome studies continue to be scattered and unfocused. The purpose of this paper is to review the current empirical knowledge of the use of group therapy formats with sexually abused children and adolescents under age 18 and to discuss implications for practice, policy, and future research.

METHODS

A review of the literature was conducted searching the electronic databases CINAHL, psychINFO, and psychARTICLES with the keywords "sex* abuse," and "group therapy" or "group intervention" during the time period 2005–2013. The search was limited to articles written in the English language and in peer reviewed academic journals. Unpublished studies were not included because they have not undergone peer review. Additionally, age parameters used in the search included "childhood," "adolescence," and "school age." Criterion for inclusion into the scope of the research of this paper included those studies utilizing a group therapy intervention with sexually abused children under the age of 18. Exclusion criteria included qualitative studies, case studies, and a lack of outcomes measurement. Of the 379 located studies, abstracts were reviewed as well as reference lists for additional studies meeting the inclusion and exclusion criteria. From this search, eight studies were located that met the inclusion criteria, which, while adding to the growing knowledge of group therapy interventions for sexually abused children and adolescents, is an inadequate number of studies to draw firm conclusions from.

BACKGROUND

Sexual abuse of children is a widespread societal problem. Surveys of national samples have indicated 16–27% of females and 8–16% of males retrospectively report CSA (Felitti et al., 1998; Finkelhor, Hotaling, Lewis, & Smith, 1990). A recent international meta-analysis found CSA prevalence among non-clinical populations to be 19.2% of adult females and 7.4% of adult males, with United States female prevalence being 25.3% (Pereda, Guilera, Forns, & Gomez-Benito, 2009). Determination of precise rates is fraught with difficulties, including systematic bias, definitional differences of CSA, and validity issues, such as under-reporting (Wynkoop, Capps, & Priest, 1995). Regardless of the challenges in defining the scope of the problem of CSA, it is clear that significant numbers of children have been exposed to this abuse.

The frequency of CSA in our communities makes crucial the need for effective treatments that will reduce the negative consequences to both individuals and society as a whole. A wide array of physical, psychological, and behavioral effects following CSA have the potential to impact victims throughout their lifespan. According to Sinclair et al. (1995), the symptom patterns for victims of CSA are "broader" and "less predictable" as compared to other disorders (p. 540).

This heterogeneous expression of symptoms creates considerable burdens on both mental and physical health services. CSA occurrence has been found to lead to a 16% adjusted increase in healthcare costs

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in adulthood, including costs for mental health, emergency care, primary care, and specialty and pharmacological services (Bonomi et al., 2008). In a cross sectional study ($n = 4{,}239$), adverse events in childhood increased functional disability in adult women two to three-fold, with a CSA event having the strongest association (Tonmyr, Jamieson, Mery, & MacMillan, 2005).

In addition to societal burdens, individuals with a history of CSA are more at risk for a myriad of personal dysfunction and disruptions in adulthood. Long term CSA outcomes include posttraumatic stress disorder (PTSD), anxiety disorders, sleep disorders (Perez-Fuentes et al., 2013), self injury (Maniglio, 2009), and suicide attempts (Perez-Fuentes et al., 2013). Additionally, high risk behaviors, such as substance abuse (Maniglio, 2009) and sexual promiscuity (Paolucci, Genuis, & Violato, 2001) are increased in adulthood. The National Comorbidity Survey found risk for adult development of mood, anxiety, and substance abuse disorders doubled following CSA, with the risk for PTSD increasing over non-abused populations eight-fold (Molnar, Buka, & Kessler, 2001). Lastly, this wide array of long term CSA outcomes has been found to lead to a 3.65 increased rate of public mental health service utilization (Cutajar et al., 2010).

In childhood, the immediate effects of CSA directly impact function regardless of social class, ethnicity, or other demographic variables (Mennen, 1994; Newcomb, Munoz, & Carmona, 2009). Commonly, these children experience feelings of isolation and differentness (Lubell & Soong, 1982), and significant social withdrawal is not uncommon (German, Habenicht, & Futcher, 1990). In addition to these stigmatic symptoms, sexually abused children oftentimes experience a damaged perception of self, with subsequent feelings of depression (Ji, Trickett, & Negriff, 2010; Orr & Downes, 1985; Rasmussen, Martin, & Sorrow, 2001). This damaged self concept can set a stage of "negative life orientation" if not immediately addressed (German et al., 1990, p. 435).

Additionally, further immediate consequences of CSA, similar to those seen in adults, have been found in children. For example, CSA has been correlated with increased rates of PTSD (Danielson et al., 2010), general externalizing behaviors (Mannarino, Cohen, & Gregor, 1989) such as aggression (Kendall-Tackett, Williams, & Finkelhor, 1993), and risky behaviors, including substance abuse and promiscuity (Danielson et al., 2010), in childhood.

In a sample of college students who had experienced CSA, Teicher, Samson, Polcari, and Anderson (2009) found that 62% of the women met the diagnostic criteria for major depressive disorder, but the onset of the depression was 9 mean years after the abuse had occurred. These findings suggest the potential for a window of opportunity to intervene. Early and effective initial interventions are crucial to reduce the short term consequences and to prevent the opportunity for development of impaired functioning in adulthood (Black, Woodworth, Tremblay, & Carpenter, 2012).

SOCIAL SUPPORT

Meaningfully interpreting these CSA outcomes is compounded by lack of any CSA model which clearly describes possible trajectories, taking into account the many contextual variables of CSA (Horwitz, Widom, McLaughlin, & White, 2001). Identification of these potential variables has become a focus of researchers, with abuse characteristics, such as abuse that included penetration (Katerndahl, Burge, & Kellogg, 2005), use of physical force (Liem, James, O'Toole, & Boudewyn, 1997), an intra-familial perpetrator (Roesler, 1994), and younger age at time of abuse (Schoedl et al., 2010), all associated with increases in future adverse outcomes. Additionally, a multitude of childhood adversities, such as familial psychiatric history (Yancey, Naufel, & Hansen, 2013; Chen et al., 2010), family substance abuse history, or impaired maternal relationships, may also play a role in negative trajectories following CSA (Katerndahl et al., 2005). Personal traits, such as greater negative attributions or negative coping strategies, are related to more symptomatic clinical presentations during childhood (Daigneault, Hebert, & Tourigny, 2007). While some researchers have found the CSA event alone to independently predict adverse reactions (Meyerson, Long, Miranda, & Marx, 2002), others have found environmental contexts more predictive (Bhandari, Winter, Messer, & Metcalfe, 2011; Hazzard, Celano, Gould, Lawry, & Webb, 1995). Regardless, these risk factors provide a starting point for clinician assessment of potential resilience in childhood and adolescent victims, and focused intervention planning for those most vulnerable.

Availability of social supports has been significantly correlated with a decrease in PTSD symptoms and a decreased sense of loss in adult survivors of CSA (Hyman, Gold, & Cott, 2003; Murthi & Espelage, 2005). Using grounded theory to create a model of healing from CSA, Draucker et al. (2011) state that positive outcomes are enabled in adulthood when the CSA victim experiences acceptance, a sense of belonging, and social connectivity. Further, when adolescents face increased adversity, support of peers has been found to strongly influence a resilient trajectory (Tusaie, Puskar, & Sereika, 2007), as well as moderating adult anxiety levels (Adams & Bukowski, 2007). In several qualitative studies undertaken with adult women survivors, support from others was identified with facilitating healing and repair of self-esteem (Brown, Kallivayalil, Mendelsohn, & Harvey, 2012; Glaister & Abel, 2001; Valentine & Feinauer, 1993).

In addition to buffering psychological risk factors, social support may also serve to diminish future high risk behaviors. In a sample of incarcerated females and female college students who had experienced CSA, Asberg and Renk (2012) found that poor social support directly impacted coping behaviors, leading to negative strategies, such as substance abuse and promiscuity.

However, Reyes (2008) found that children's perception of social support following CSA did not moderate for PTSD symptoms and emotional functioning. In this study, it is possible that the severity of the PTSD in these children in and of itself necessitated their seeking of additional supports, making it difficult to assume causality. Further difficulty stems from the definitional and measurement differences of the concept of social support. Lam and Grossman (1997) concluded, following a study of college students who were CSA survivors, that an increase in familial and social protective factors was significantly more important in predicting positive outcome than any abuse factors.

GROUP THERAPY TREATMENT

Providing psychological treatment in a group versus an individual format is adventitious for sexually abused children for a number of reasons. According to Lubin (2007), "Effective treatment should aim at all domains affected by the trauma: personal, interpersonal, and societal," which group therapy is able to accomplish (p. 257).

To begin, group therapy treatments enable servicing of larger numbers of children and are therefore more cost effective than individual treatments. Group or individual treatments of sexually abused children and adolescents have been found to be equally efficacious (Hoag & Burlingame, 1997; McCrone et al., 2005; Trask, Walsh, & Dilillo, 2011), with McCrone et al. (2005) finding the adjusted expense of the individual therapy being 64% more than group treatment formats. According to Kruczek and Vitanza (1999), the current health care climate of high demand and limited resources makes group therapy formats fiscally responsible.

Notwithstanding the financial benefits of group therapy formats, Steward, Farquhar, Dicharry, Glick, and Martin (1986) state that: "the compelling argument is not economic but therapeutic" (p. 263). For example, children experience a critical period of development during adolescence, with tasks including the formation of a positive identity and self concept through peer relationships, peer approval, and belongingness (Hill, 2005; Khattab & Jones, 2007). Group modalities