



Assessment for self-blame and trauma symptoms during the medical evaluation of suspected sexual abuse



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ABSTRACT

The purpose of this study was to describe behavioural and emotional symptoms and to examine the effect of abuse-related factors, family responses to disclosure, and child self-blame on these symptoms in children presenting for medical evaluations after disclosure of sexual abuse. A retrospective review was conducted of 501 children ages 8–17. Trauma symptoms were determined by two sets of qualitative measures. Abstracted data included gender, ethnicity, and age; severity of abuse and abuser relationship to child; child responses regarding difficulty with sleep, school, appetite/weight, sadness, or self-harm, parent belief in abuse disclosure, and abuse-specific self-blame; responses to the Trauma Symptom Checklist in Children-Alternate; and the parent's degree of belief in the child's sexual abuse disclosure. Overall, 83% of the children had at least one trauma symptom; 60% had difficulty sleeping and one-third had thoughts of self-harm. Child age and abuse severity were associated with 3 of 12 trauma symptoms, and abuse-specific self-blame was associated with 10 trauma symptoms, after controlling for other variables. The children of parents who did not completely believe the initial disclosure of abuse were twice as likely to endorse self-blame as children of parents who completely believed the initial disclosure. Screening for behavioural and emotional problems during the medical assessment of suspected sexual abuse should include assessment of self-blame and family responses to the child's disclosures. In addition, parents should be informed of the importance of believing their child during the initial disclosure of abuse and of the impact this has on the child's emotional response to the abuse.

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Introduction

Impact of child sexual abuse

Childhood sexual abuse (CSA) is an unfortunate but common childhood experience associated with many adverse consequences. Prevalence studies (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Briere & Elliott, 2003; Pereda, Guilera, Forns, & Gomez-Benito, 2009; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; (Vogeltanz et al., 1999) estimate that from 11% to 53% of girls and 4% to 60% of boys worldwide experience sexual abuse before their 18th birthday. Victims of child sexual abuse are at significant risk for a wide spectrum of emotional and behavioural problems and negative social

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and developmental outcomes. These include depression, anxiety, post-traumatic stress disorder (PTSD), dissociation, self-esteem and self-concept impairment, self-injurious thoughts and behaviors, substance use, risky sexual behaviors, and early pregnancy (Maniglio, 2009; Tyler, 2002). No single factor or simple model explains the variability in number and severity of symptoms following abuse; rather, a complex interaction among abuse-related factors, responses to disclosure, and individual factors such as self-blame and coping strategies, appears to mediate victim recovery and outcomes (Barker-Collo & Read, 2003). Identifying the types of behavioural and emotional responses and the factors that modify the severity of these symptoms are important to the diagnosis and treatment of sexual abuse victims.

Abuse-related factors such as the child's age at the time of abuse and the severity of abuse have been found to correlate with trauma symptoms in one longitudinal study (Lynskey & Fergusson, 1997). Other studies have examined the influence of race/ethnicity (Mennen, 1995) and gender (Garnefski & Arends, 1998) on type and severity of emotional and behavioural symptoms in sexually abused children. Mian, Marton, and LeBaron (1996) reported that mothers of female victims of intrafamilial abuse aged 3–5 years were more likely to blame the child and minimize or deny the abuse, but the effect of this parental response on the child's behavior was not examined. Tremblay, Hebert, and Piche (1999) examined the effects of supportive responses following disclosure and found that support from parents and friends was associated with more positive self-worth and fewer externalizing problems in child sexual abuse victims aged 7–12 years. A research review by Tyler (2002) further confirmed the importance of parental support in mitigating negative outcomes among victims of child sexual abuse. Individual factors such as a victim's negative self-assessment and self-blame have also been described as mediators of trauma symptoms in sexually abused children. Daigneault, Tourigny, and Hebert (2006) found that general and abuse-specific self-blame were associated with trauma symptoms as measured by the Trauma Symptom Checklist in Children (TSCC). Similarly, Feiring and Cleland (2007) found that abuse-specific self-blame at initial presentation predicts depression, intrusive thoughts, and flashbacks at 1 and 6 years following the abuse.

The multidisciplinary assessment of child sexual abuse

In the United States, multidisciplinary facilities known as Children's Advocacy Centers (CACs) have increasingly assumed responsibility for the assessment of, legal intervention on behalf of, and psychotherapy for children who have disclosed sexual abuse. In 2012, 286,457 children received services at U.S. CACs (National Children's Alliance National Children's Alliance [NCA], 2012). Of these, 197,902 (69%) were believed to be victims of child sexual abuse. Among the total that received services, 71% had forensic interviews, 28% had medical evaluations, and 25% received counseling. The NCA has published accreditation standards for the core functions of CACs, including forensic interviews, medical assessments, and mental health services. Forensic interviewers focus on the structured elaboration of children's initial disclosures and do not routinely assess their emotional and behavioural symptoms (Lamb, Orbach, Hershkowitz, Esplin, & Horowitz, 2007). Although therapists do assess emotional and behavioural symptoms, the initial therapy sessions often do not occur for days or weeks after the initial disclosures, and many children do not receive therapeutic services at all.

By contrast, the NCA medical assessment standard includes “assess[ing] the child for any developmental, emotional, or behavioural problems needing further evaluation and treatment and make referrals as necessary” (NCA, 2011). Beyond screening for suicidal ideation, this standard does not give specific guidance in regards to the assessment of the type and severity of emotional and behavioural symptoms. A recent American Academy of Pediatrics publication on the evaluation of children for sexual abuse in a primary care setting (Jenny, Crawford-Jukubiak, & Committee on Child Abuse and Neglect, 2013), recommended that all patients be assessed for behavioural and mental health problems, including depression and post-traumatic stress disorder. This statement also acknowledged that parental response to children's disclosure of abuse is important and may vary from being protective of the abuser to guilt for not protecting the child. The statement gives no other specific guidance on screening for emotional and behavioural symptoms and family responses to disclosure.

In conducting medical assessments of suspected victims of child and adolescent sexual abuse, the authors (JM, NK, JL) have utilized a psychosocial assessment tool developed by one of the authors (NK). This tool was amended 3 years ago to include questions about self-blame, family responses to disclosure, and victim disclosure characteristics (Table 1) due to clinical observations that these factors appeared to impact the number and severity of emotional and behavioural symptoms among children evaluated for sexual abuse.

The goal of this study is to evaluate the effects of abuse-related factors, family responses to disclosure, and child self-blame on trauma symptoms identified in children suspected of having been sexually abused, as assessed at the time of the medical evaluation.

Method

Participants

We conducted a retrospective chart review of 501 children ages 8–17 who presented consecutively for medical evaluation following a disclosure of sexual abuse to a large child advocacy center (CAC) serving an urban, predominantly Hispanic population. The children in this sample all presented at least 3 days after the most recent sexual contact, as those children who were identified more acutely were triaged for examination to a downtown children's hospital emergency department. All children had forensic interviews prior to and on separate days from their medical assessments. The children evaluated at the

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