

Social Workers' Views on the Differential Outcomes in Child Sexual Abuse Victims

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Abstract

Past research on outcomes for child sexual abuse victims has used quantitative measures to delineate risk and protective factors. This study sought to understand how social workers describe the differential outcomes they have observed in practice. Using a qualitative interview, five social workers experienced in working with victims were interviewed. The participants were asked for their opinions regarding what led to better and poorer outcomes for victims, as well as what factors could contribute to children presenting with a poor outcome despite the presence of protective factors, a question that had not been asked in previous research. Four themes emerged as accounting for differential outcomes: the ability of the victim to be connected, external resources, reactions surrounding the abuse, and psychopathology.

Statement of the Problem

Child sexual abuse is pervasive in the United States, and many victims come to the attention of social workers. Based on community samples, 12 to 35% of women and 4 to 9% of men report they were sexually abused as a child (Putnam, 2003). In the city of Chicago, 13,970 children under the age of 18 were reportedly victims of sexual abuse in the 1990s. Of these children, 9 out of 10 were minorities and 60% were girls (Chicago Children's Advocacy Center, 2005). Treating the victim of sexual abuse can be difficult because of the varying ways in which these clients present. The most frequently reported symptoms of child sexual abuse victims are fear, posttraumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem. However, no single symptom has been reported by the majority of victims, suggesting there is not a specific syndrome in children who have been victims of sexual abuse (Kendall-Tackett, Williams, and Finkelhor, 1993).

Since many victims receive clinical attention, it is important for social workers to understand the risk and protective factors that can lead to differential outcomes. Many of these factors can be targets of intervention in order to promote the healing process. So that they may best assist these clients, social workers should know what can help and what

may hinder clients' progress. Numerous studies have examined the risk and protective factors associated with a differential outcome in child sexual abuse victims. The majority of these studies have relied on parent, therapist, and child reports through the use of standardized measures of symptoms (for examples see Berliner & Conte, 1995; Cohen & Mannarino, 2000; and Tremblay, Hébert, & Piché, 1999). Few of them directly asked social workers to share in narrative form their opinions of what these factors are; similarly, only a limited number of works have used qualitative methodologies. The present study sought to address these gaps. By using a qualitative interview, the researchers hoped to receive responses that may not have been captured by the standardized instruments used in previous studies. Additionally, there have not to the researchers' knowledge been any studies that have explored what can lead victims with many protective factors to still have a poor outcome. This study asked social workers to share their perceptions of why poor outcomes sometimes occur even for clients who do have many protective factors.

Literature Review

As noted above, a number of studies have been conducted investigating the effects of childhood sexual abuse and the factors that may put children at a greater risk for adverse outcomes or serve as protective factors (See, for example, Berliner & Conte, 1995; Cohen & Mannarino, 2000; Kendall et al., 1993; Tremblay et al., 1999). Reviews of existing studies suggest that the effects of sexual abuse on children are inconsistent. These works indicate that abused children present with more psychological symptoms than non-abused children, with the most frequently reported symptoms being fear, posttraumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem. However, approximately one-third of the victims do not show any symptoms. This research suggests that clinicians cannot rely on a profile of the "typical" sexual abuse victim during diagnosis (Kendall et al., 1993).

Using samples of child victims as well as adult survivors of childhood abuse, studies that have examined protective factors have found that age of onset of the abuse, age of the child at the end of the abuse, the

relationship between the child and the abuser, family characteristics, including adaptability, as well as the extent to which the child is believed by those to whom he or she reports the abuse and the amount of social support provided by family and peers are related to outcomes (Steel, Sanna, Hammond, Whipple, & Cross, 2004; Cohen & Mannarino, 2000; Berliner & Conte, 1995; Tremblay et al., 1999; Romans, Martin, Anderson, O'Shea & Mullen, 1995; Spaccarelli, 1994; Conte & Shurman, 1987).

While these studies relied on quantitative measure, at least one qualitative study (Nelson-Gardell, 2001), identified similar factors. Using focus groups of sexually abused girls to explore the factors that from the point of view of the victims maximize coping capacities, four themes emerged from the girls' responses. The first and strongest theme was that having someone believe them was equated with help and support. When the girls were asked who helped them, they responded by identifying those who had believed them when they disclosed the abuse. They perceived those who did not believe them as unhelpful or harmful. The girls also believed that talking about the abuse helped them and that therapists should try and get abused girls to talk about the abuse. Further, the girls thought talking about their feelings was important because they believed keeping feelings inside would lead to future negative consequences.

Finkelhor (1995) discusses the developmentally-based effects of victimization, which include the impairment of attachment, lower self-esteem, highly sexualized or highly aggressive approaches to interpersonal relating, failure to acquire competence in peer relationships, the use of drugs, dissociation, self-injury, or other maladaptive ways of coping with anxiety. When the child is more impacted by victimization, the likelihood increases that he or she will display developmental effects such as repetitive and ongoing victimization, victimization that dramatically changes the nature of the child's relationship with her primary support system, additional serious stressors, or victimization that interrupts a crucial developmental transition. Child victims are more affected when they believe they are going to die or be seriously injured or when they feel helpless and out of control.

Child victims' reactions to intervention and how they view clinicians have also been studied. Berliner and Conte (1995) interviewed sexually abused children and their families about their experiences with disclosure and intervention. Overall, the children reported having a positive view of their therapists and feeling better after an interaction with a therapist.

Many of the positive experiences the children had with their therapists were due to the personality and performance of the therapist (such as being understanding, concerned, sincere, and treating the child in a respectful and personal manner). The children reported a negative experience when they felt as though they were one of many clients instead of a unique child facing a very difficult situation.

Because nearly all studies on child sexual abuse have been quantitative, the authors of this study sought to explore treatment outcomes for victims from a qualitative perspective. Much has been learned from quantitative studies of child sexual abuse, but the use of standardized instruments inevitably limits results to what is included in the instruments themselves. By using a qualitative interview, the researchers hoped to receive responses that were not captured by the standardized instruments used in previous studies. Additionally, because they were responding to open-ended questions therapists were able to respond in their own words, which the researchers thought might generate different or richer understandings than can be gained using standardized measures. Finally, in much of the previous research therapist study participants have been psychologists. The current study interviewed social workers in an attempt to see whether their perspectives would produce to unique responses.

In this study, child sexual abuse was defined as sexual activity before age 18 with an individual three or more years older, a sibling or other family member, or someone using threat, force, or coercion. Sexual activity ranges from physical contact (anal, oral, genital, or breast contact) to penetrative sexual intercourse. Four research questions were investigated: 1) What do social workers believe puts child sexual abuse victims at risk for a poor outcome? 2) What do social workers believe protects child sexual abuse victims and leads to a better outcome? 3) What do social workers believe accounts for children with some of the mentioned protective factors still presenting with a poorer outcome? and 4) What therapist characteristics do social workers believe lead to a better outcome in sexual abuse victims?

Method

Participants

In order to obtain a sample, the researchers sent letters explaining the study to the directors of Chicago-area agencies that specialize in treating child sexual abuse victims, along with contact information for the researchers so that therapists who

were interested in participating could reach them. The directors were asked to distribute the letter to their social work clinicians. The response to this method of sampling was low; therefore, the researchers solicited participants by networking with clinicians at their field placement agencies. In the end, five social workers consented to participate in one-on-one tape recorded interviews (see Table 1). All five participants were licensed clinical social workers, four of whom were master's level clinicians and one of whom possessed a doctoral degree. In addition, four of the five participants were working with child sexual abuse victims at the time of the study. The fifth clinician worked in academia but had previously worked directly with victims of childhood sexual abuse. Four of the participants were female and one was male. Although this convenient, non-random sample was small, the therapists did represent a variety of work settings that served clients from diverse socioeconomic and racial backgrounds. Therapists who participated also informed the researchers of other social workers who had expertise in the area being studied. Had time not been a constraint in this study, more interviews could have been conducted using the snowball sampling method in order to obtain a larger sample.

Measure

This study was conducted using a qualitative, exploratory approach. The purpose of conducting a qualitative study was to give therapists the opportunity to discuss factors that may not have been captured in quantitative studies and to expand on ideas in a format where they did not feel limited or constricted by the measurement tool. A 15-question, semi-structured interview that addressed the participants' experiences and perceptions about poor and good treatment outcomes for child sexual abuse victims was created for use in this study. All 15 questions were open-ended. The participants were asked to report on their experience working with individuals who had been sexually abused while not revealing any confidential information about these clients. The questions were based on variables that have been researched using standardized measures in previous studies. In order to operationally define "better outcome" and "poorer outcome," the researchers asked the participant to explain the meaning of these terms. Participants were also asked to define characteristics of a therapist that they believe lead to "better outcomes" in sexual abuse victims, as well as the characteristics of the abuse experience, the family environment, and the victim that lead to a "poorer or

Table 1
Demographic Characteristics of Participants

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Gender	Female	Male	Female	Female	Female
Age	38	37	29	60	34
How long they have been in the field	15 years	13 years	7 years	30 years	10 years
Length of time they have worked with child sexual abuse victims	9 years	13 years	3 years	30 years	10 years
Percentage of clients that are child sexual abuse victims	85%	Currently 3-5%	85%	Currently work with adult survivors, past experience with children	N/A
Preferred theoretical orientation with this population	"Feminist orientation," cognitive behavioral, family systems	Structural family therapy, family systems	Cognitive behavioral, play therapy, family systems	"Integrative ecological model"	"very eclectic"

better outcome.” Finally, they were asked what factors account for children with protective factors still having a “poor outcome.”

The interview developed for this study has face validity because it appears to ask about what the study is attempting to measure. The measure also appears to have content validity. The questions, which seem to cover the factors associated with differential outcomes, were based on variables other researchers have examined regarding the differential outcome in victims (the characteristics of the abuse experience, the child, the family environment, and the therapist). These variables were explored via the use of open-ended questions in order to gain a deeper understanding of them. A limitation of this measure is that reliability has not been established because the interview had not been used before.

Procedures and Data Analysis

One-on-one interviews were scheduled with the social workers who agreed to participate in the study. The researcher who conducted the interview accommodated the participant by traveling to his or her agency for the interview. Due to time constraints, one interview was conducted via telephone at a time convenient for the participant. The participants were asked to read and sign the consent form and the consent to audiotape. In order to account for threats to reliability, interviewers only asked the designated research questions. Any additional comments made by the interviewers during the interviews were transcribed from the interview audiotapes for the other researchers to note. The interviews took approximately 25 minutes to complete. After the interview questions were asked, the interviewer turned off the tape recorder and then thanked the participants for their contribution to the study and asked if they would like a copy of the results.

After each interview was completed, the researcher who conducted the interview transcribed it and provided the other researchers with a typed copy. Each researcher then coded the data individually by reviewing the data twice. The first read of the data was literal, looking at the quotes and the content of what was said. The second read was interpretive, as each researcher looked for common themes among the responses. Each researcher put together a list of themes with quotations that she considered to be a part of the theme. Once each of the researchers had examined the data, commonalities in how themes were interpreted within and across the questions were identified. When all of the coded data was compared, four overarching themes emerged.

These themes, which were arrived at by consensus, were found across interviews and across questions. In order to determine the overarching themes, a standard was agreed upon that themes needed to be in at least four out of the five interviews and in response to different questions within interviews. Two additional themes emerged as being specific to social work ethics and values, and as a result these were included in the results as well. Due to the subjective nature of determining themes, the researchers used direct quotes from the interviews to further clarify their understanding of each theme. The biases that the researchers encountered dealt with expectations. Specifically, based on the previous research, there may have been certain answers that the researchers expected to be given, which may have influenced what researchers identified as the most important statements. In addition, data were coded as the researchers went along. Therefore, it is possible that as more data were collected, the analysis of the data began to be skewed to fit themes that the researchers identified in earlier interviews.

Results

Through the analysis of the results, four themes emerged: the ability to be connected, reaction to the abuse, external resources, and psychopathology (see Table 2).

The Ability to be Connected

In all of the interviews, the therapist stated that the child's ability to connect to another person could lead to a better outcome:

If the victim is able to have a solid connection with pretty much anyone, that makes a huge difference in whether or not they can get through.... whether the victim is able to connect with somebody...able to open the door far enough to let somebody that close.

One of the reasons mentioned for the impact of this ability to form relationships is that these relationships can demonstrate to the victim what an appropriate relationship is between an adult and a child. These can serve to show the child that it is possible to have a relationship with an adult in which he or she will not get hurt:

The kind of solid connection that would refute all of the things that the abuse broke down...that adults aren't supposed to do this. In relationships that are solid, these things don't happen.... They are effectively corrective experiences.

Similarly, when asked what characteristics of the

Table 2

What Accounts for Differential Outcomes among Child Sexual Abuse Victims: Themes and Categories

1. **Ability to be Connected**
 - Able to form relationships and let someone in
 - Able to establish a relationship with a therapist
 - Having a solid connection to refute what the abuse broke down
 - Poor outcome associated with an increased struggle in relationships
 - Poor outcome associated with being too afraid to talk
2. **Reaction to the Abuse**
 - Whether the child was believed, supported, and protected
 - Whether immediate action was taken after disclosure
 - Recognition that the abuse was not the child's fault
 - Level of blame, guilt, and shame within the family system
3. **External Resources**
 - Whether family has outside supports
 - Whether healthy extended family is available for support
 - Family's level of isolation
 - Whether resources are available within the community
 - Whether older children have a strong friend base and social network
4. **Psychopathology**
 - Genetic vulnerabilities – such as to mental illness or learning disabilities
 - Whether self-destructive coping mechanisms are adopted such as cutting
 - Presence of depression or eating disorders

victims can lead to a better outcome, one therapist responded:

Any semblance of a healthy relationship.... By virtue of her ability to connect to another human being she was able to feel that and internalize that and realize there was another way that life and a relationship could be.

When asked to define a good and poor outcome, some of the therapists defined a poor outcome as an increased struggle in relationships, while others said that a good outcome is the ability to form relationships:

A good outcome would be someone who could integrate that it was an experience of abuse for which they held no responsibility and then could move on into constructive, healthy relationships.

Some responses also stated specifically that the child's ability to have a solid connection with the therapist could also contribute to a better treatment outcome:

Victims who are either too afraid or too afraid to talk...if they don't feel like they can confide anything with their therapist...then that leads them to a poorer outcome...all of the kids are afraid, but the kids that have been believed and supported and protected and they are still so

afraid to tell someone or they are still so afraid they can't talk or they are so immersed in self-blame that they just can't get past any of that, that makes the biggest difference.

Reaction to the Abuse

After looking across all of the interviews, the data suggested that the therapists believed the most important factor contributing to the child's treatment outcome was the reaction she or he received regarding the abuse. Many different aspects of reaction were included in this theme, which was noted in four interviews. The most common response was whether the child was believed, supported, and protected:

It is the family's reaction to the abuse that makes the biggest difference rather than the actual characteristics of the abuse itself. And you know there are exceptions to that rule, but I would say that believe, support, and protect make more difference than what actually happens to the child.

Another commonality within this theme was the idea that familial blame, guilt, and shame contributed to a poorer treatment outcome:

One of the things I see is when the family of the child (and the child included) experience a lot of shame and guilt and they want to contain it as a secret. It really creates a risk that the child

and the family are unable to process it...to get some sense that this did happen to me and it's not okay.

Equally as important to treatment outcome was the level of blame, guilt, and shame the child felt. Self-blame was also used to define a poor or better outcome in the interviews:

Good treatment outcomes are usually about recognition of the abuse as a crime that was not the child's fault.

I think a poor treatment outcome for a child would be where the child remains having experiences and/or beliefs that reinforce the experience as their fault.

The therapists also felt that immediate action taken by the parents after disclosure was important:

I think the response time is important. I think it leaves a child with less time on their own to really try and move beyond and to not live in fear and guilt and shame and all of the other things that come from being victimized.

External Resources

A third theme that emerged from the interviews was that the external resources available to a child and family influence the treatment outcome. When asked what characteristics of the family led to a better outcome, two of the therapists replied:

Supportive family and a family that has outside supports.... [If] they are isolated, it is another huge thing because with outcomes, there is a much higher risk. I have seen families that are dealing with it by themselves without any support, which can be so much more stressful, and there can be a breaking point that there is only so much they can do.

The therapists also discussed that the child's external resources can lead to a better outcome, such as the child having a strong friend base and a social network in which they feel self-confident.

Psychopathology

All five of the therapists interviewed mentioned the effect psychopathology could have on treatment outcome. The presence of mental illness before the abuse can put the child at risk for a poorer outcome, as can psychopathology that develops after the abuse. The therapists mentioned some common psychological problems that can result after a child has been abused that make treatment more difficult:

Kids that might be delayed in some way or learning disabled or that have mental illness or depression already or kids that have developed

more severe reactions like depression as a result of it or eating disorders. Eating disorders is huge, it is a result of sexual abuse. They are so difficult to recover from, you have to go through abuse counseling and for anorexia, depending on how severe the eating disorder has gotten. Their outcome is hugely in question. There is a big correlation between those two, sex abuse and eating disorders.

They also mentioned self-destructive coping mechanisms:

Some clients...can't, for a variety of intrapsychic reasons, stop self-harming (cutting, tearing) and while it's not active suicidality, it's terribly debilitating behavior and it keeps them from moving on in any other kind of relationships.

Psychopathology can also become more severe over time, so as the children become adults, they may have an even poorer prognosis:

By virtue of their own vulnerabilities, personality characteristics, they might have borderline characteristics because it is pretty much an adaptive mechanism when people who are close to you hurt you to not have long-term relationships and to make sure you sort of move away from relationships fairly quickly. For most of these women, they have full blown borderline personality disorder and other kinds of psychopathology that make it much more difficult for them to establish interpersonal relationships with anyone and therefore the relationship with the clinician becomes paramount to help them work through this in some way. I do think it is possible to work through these things, but the time frame required is enormous. The longest I worked with someone was 13 years.

Some children will also develop severe psychopathology that may not have been a direct result of the abuse, and this has been attributed to a genetic vulnerability:

In some ways I think genetics [can lead to a poorer outcome]. You know they just got a bad genetic deal. You know we have a girl who I think will end up with paranoid schizophrenia and it doesn't matter how helpful her family is. She is going to have a tough road no matter what.

Themes Specific to the Field of Social Work

Two additional themes emerged across the interviews as being specific to social work ethics and values and the "person-in-environment" perspective: "being where the child is" and society's effect on sexual abuse. In every interview, therapists spoke of "being where the child is," which included developmentally appropriate reactions to the child and

intervention strategies based on the child's current needs. Therapists also discussed the importance of the family being aware of where the child is developmentally and emotionally:

The other thing that I've seen is where the family seems motivated to respond to the situation, but it's beyond the child's time of processing or what the child needs to get through this.... They try to get their hands around it and make sure everything is okay and then move forward. But the child, depending on where they are at, can't do that for whatever reason and that can become a risk factor that they internalize that something is wrong.

Four out of the five therapists also felt society has an impact on child sexual abuse. One therapist stated:

I think children in general in America are glamorized and they are made into celebrities way too young and they are sexualized. They are making a lot of money by doing that. It's a trap. When you live in a culture that says you can make a lot of money if you are young and attractive, it puts a lot of pressure on children to be a certain way. I think it's real subtle, but I think there is a connection.

Discussion

There were several limitations in this study. One of the most significant limitations was the small sample, consisting of only five participants. A larger sample size may have elicited different results, but the high degree of consensus among the responses of the participants casts doubt on whether a larger sample would have resulted in more findings. In addition to being small, the sample was also non-random and thus not representative of all social workers who work with child victims of sexual abuse. Only social workers in the Chicago area were interviewed, and even though they came from a variety of agencies in Chicago and the suburbs, the study cannot claim to represent the views of all social workers. There was also only one male participant. The results of this study may not be able to be generalized to all childhood sexual abuse victims, but this is commonly the case as the aim of qualitative research is usually to gain a deep understanding rather than to achieve generalizability.

Taking into account these limitations, certain conclusions can be drawn from this study. The study supported the idea that numerous factors contribute to treatment outcome in child sexual abuse victims. The reactions of the family and the resources available to them are important, as are factors within the child

such as the ability to connect to another person and a vulnerability to psychopathology.

The qualitative nature of this study did lead to some responses that differ from those found in quantitative research. According to previous quantitative literature, a poorer outcome can result from the characteristics of the abuse experience itself (such as penetration, duration/frequency of abuse, number of offenders, age at onset/end of the abuse, helplessness or fear of being hurt or dying during the abuse, and a close relationship to the abuser – see for examples Berlinger & Conte, 1995; Kendall-Tackett, et al., 1993; Steel, Sanna, Hammond, Whipple, & Cross, 2004; Tremblay et al., 1999). In four out of the five interviews, however, the therapists did not feel the characteristics of the abuse itself were important to the outcome, except for the relationship of the victim to the abuser. Overall, the therapists thought that the reaction of the parents when the child told was more important than what actually happened to the child during the abuse experience.

Several different reasons were given for the therapists' belief that the relationship to the abuser could make a difference. One of the therapists stated that it could be difficult for the child if a breadwinner in the family was removed as a result of the abuse because the child could experience guilt due to the resulting financial hardship for the family. Another response was that it could be harder for children to say no to a family member or parent perpetrating abuse if they had been taught to obey their elders. A third therapist also said that it may be more difficult for a child to heal after being abused by a parent if this parent was also loving or nurturing because then the child would have a more difficult time seeing the perpetrator as bad. These three different explanations illustrate the role that qualitative studies play in expounding on previous quantitative research.

Steel, Sanna, Hammond, Whipple, and Cross (2004) found that those who had several perpetrators of abuse in childhood had more psychological distress because more people in their life perpetrating abuse limited the amount of people the child could disclose the abuse to or seek social support from. The therapists in the present study felt that the ability to seek social support and disclose the abuse was more important than the number of perpetrators. In Steel et al.'s study, the duration of the abuse was also found to be mediated by the internalization of the abuse. If a child experienced more abuse, he or she was more likely to attribute the abuse to

something within him or herself, whereas if it was a one-time event she or he was more likely to attribute it to chance. Even though the current study suggested that the self-blame the child experienced was a greater risk factor for a poor treatment outcome than the duration of the abuse, a longer duration may have led to greater self-blame in the victim.

Due to the qualitative nature of this study and the flexibility of the interview format, two additional themes that are consistent with the person-in-environment perspective emerged across the interviews. In every interview, participants discussed the importance of "being where the child is," which included developmentally appropriate reactions to the child and intervention strategies. Social workers value a client-centered approach to treatment, so it is not surprising that this idea was present in all of the interviews and across questions. Additionally, the person-in-environment perspective held by social workers naturally leads to thinking about the larger context and the influence society has on the issue of child sexual abuse. The therapists spontaneously incorporated their thoughts about the significance of macro-level influences into their answers of other questions, such as those about their theoretical backgrounds and the qualities of the victim that lead to poorer outcomes.

Some of the results of this study did support the previous research in the field. Previous research has suggested that better functioning families (more specifically, those who believe the child, are supportive, and act in a productive way after the abuse is disclosed) contribute to a better treatment outcome for that child (Kendall-Tackett, et al., 1993), which is consistent with the views of the therapists in this study. According to the interviews in this study, belief and support were the most important protective factors for an abused child. This is similar to the findings of other works, both quantitative and qualitative in nature (see Spaccarelli, 1994; Conte & Schuerman, 1987; and Nelson-Gardell, 2001). Taken together, the results show how important it is for therapists to look at the support system in place for the child, and attempt to intervene if this is lacking in the child's life.

The present study also produced some results similar to quantitative research regarding the child factors that can lead to a differential outcome. According to the previous research, the child's ability to seek support from others and be able to disclose and talk about the abuse can lead to a better outcome, but feelings of self-blame and not feeling believed can lead to a poorer outcome (Tremblay, et

al., 1999; Steel et al., 2004). A theme found among these interviews is that self-blame can contribute to a poorer treatment outcome. According to one interview, the child's ability to see the perpetrator as bad can lead to a better outcome. Also, a child who believes the abuse is her fault is likely to experience more internalizing symptoms, such as low self-esteem and depression, which could lead to a poorer outcome.

The therapists in this study believed that the child's ability to connect to another person was important to the child's outcome. Thus, even if the parents and therapist are attempting to support and help the child, that support will not be an effective protective factor if the child is not able to accept that support or connect to those trying to help. There is more to treatment outcome than simply those in the child's environment being supportive. The child needs to either accept that support or perceive that it is there in order for it to make a difference.

This study asked the exploratory question, "What could account for children possessing many protective factors still presenting with a poorer outcome?" The initial response of several of the therapists was that they were not sure because they had not thought about outcomes in this way before; most then generated a response based on their experiences. Answers to this question could also be teased out of the responses the therapists gave to other questions. In general it was found that poorer outcomes in spite of the presence of protective factors were related to the complex issue of psychopathology, which included a discussion of predisposition to mental illness before the abuse and a more severe psychopathological reaction after the abuse. Before the abuse, children were at greater risk for a poorer outcome if they had learning disabilities or mental illness such as depression. The more severe reactions to the abuse included depression, eating disorders, cutting and other self-harm behaviors, schizophrenia, and borderline features.

This greater risk for psychopathology may be able to be attributed to a genetic vulnerability. According to the diathesis-stress model of the development of psychopathology, those who have a greater vulnerability to develop a disorder need a lesser amount of life stressors to reach the threshold for that disorder. For some children, the experience of any type of sexual abuse, regardless of the severity, is enough for them to develop psychopathology that poses greater treatment difficulties and therefore increases the risk of a poorer outcome. When looking at the differential outcomes in child sexual

abuse victims, it is important to consider vulnerabilities within the child in addition to what is present in the environment. Cohen and Mannarino (2000) found that children's psychological symptoms were strongly impacted by their own cognitions and perceptions related to the abuse, parental support, and family stability and predictability.

Conclusion

The authors conducted this study with the intent of exploring via qualitative interviews therapists' perceptions of factors associated with better or poorer treatment outcomes. While a number of the findings were consistent with the quantitative literature (e.g., the importance of the child being believed about the abuse), the therapists interviewed did have a different perspective on the impact of abuse characteristics on outcome. Specifically, they thought the responses of parents and the child's support system to the abuse were more predictive of outcome than the nature of the abuse itself. Future research—particularly qualitative interviews with individuals other than therapists, such as children, parents and teachers—is important in order to further increase knowledge in this area.

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