Kayla Epp

Relationships between caregiver support, self-blame, and sexual anxiety in sexually abused children

Abstract

Child sexual abuse (CSA) has detrimental effects on the child and the family. This study examined caregiver support in relation to self-blame and anxiety about sex in CSA victims. With a sample of 120 participants ages 7 to 19, this study analyzed how caregiver support (e.g., sense of competence and whether a second caregiver attended therapy) helps explain self-blame and sexual anxiety within CSA victims. Preliminary results included an interaction between parental sense of competence, the number of caretakers attending therapy, and sexual anxiety as well as an interaction between parental sense of competence and self-blame.
Introduction

Child maltreatment is related to a variety of psychosocial difficulties such as and cognitive distortions such as self-blame and low self-esteem, anxiety, depression, posttraumatic stress, somatic preoccupation, substance abuse, self-mutilation, and suicidality (Briere & Jordan, 2009). Factors correlated with outcomes of child sexual abuse (CSA) include characteristics such as child age, gender, whether or not they received treatment, and factors pertaining to the abuse such as duration and affiliation with the perpetrator (van Toledo & Seymour, 2016).

Victims of CSA may also experience sexual anxiety. While sexual anxiety may be directly related to the instance of CSA, according to a study from Bigras, Godbout, and Briere (2015), it is more likely that it has an indirect impact. In their study they found that interpersonal conflicts and identity impairment after experiencing CSA helped explain sexual anxiety, although the effect sizes were relatively small.

A cognitive distortion that many victims of CSA experience is Self-blame. There are two forms of self-blame, characterological (blaming something innate and stable within oneself) and behavioral (blaming one’s actions) (Filipas & Ullman, 2014). Frazier’s (2003) longitudinal study of self-blame in CSA victims revealed that both forms of self-blame are correlated with greater psychological symptoms.

Another important factor in predicting CSA symptomology is caregiver support. Grosz, Kempe, and Kelly (2000) examined the treatment of 246 children and their 323 parents
and found that parental involvement in therapy was significantly correlated with less victim symptomology.

A study by Hubel et al. (2014) showed that caregivers of children presenting with clinically significant symptoms reported higher distress in their competence as a parent when compared to caregivers of children presenting with subclinical symptoms. This study suggests that caregivers experience a low sense of competence as a parent when their children experience greater symptomology.

It is important to understand the role that caregiver support and sense of competence have with the symptoms of CSA and the effectiveness of treatment. By gaining a deeper understanding of the relatedness of caregiver support and CSA symptomology, treatment could be better suited to meet the needs of particular families. It is hypothesized that lower parental sense of competence scores will be correlated with higher sexual anxiety, and there will be greater decreases in sexual anxiety across time for participants attending therapy with two caregivers. It is hypothesized that lower parental sense of competence scores will be correlated with higher self-blame. Additionally, it is expected that there will be a significant main effect of self-blame and sexual anxiety.

**Method Section**

**Participants**

Participants reported to the Child Advocacy Center for mental health treatment after the disclosure of sexual abuse.
Participants included 120 participants with ages ranging from 7 to 19 years of age. Five of the participants were African American (4.2%), 104 of the participants were Caucasian (86.7%), 1 of the participants was Hispanic (0.8%), 4 of the participants were Bi-racial (3.3%), and 4 of the participants was multiracial (3.3%). Twenty-two of the participants were male (18.3%) and 98 were female (81.7%).

Measures

**Parenting Stress Index (PSI; Abidin, 1995).** The PSI is a 101-item self-report questionnaire measuring a parent’s degree of stress in their role as a parent along. Project SAFE uses a 20-item subset of the complete PSI which produces two subscales, one that measures parent’s assessment of their competence (Sense of Competence) and one that evaluates the restrictions that they face as a result of their parental role (Restriction of Role). The PSI demonstrates internal consistency (alphas ranging from .70 to .84), test-retest reliability, and validity (Abidin, 1995). This study utilized Sense of Competence Subscale.

**Children's Impact of Traumatic Events Scale-Revised (CITES-R; Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991).** The CITES-R is a structured interview that measures the impact of CSA on posttraumatic stress, abuse attributions, social reactions, and eroticism. The CITES-R is comprised of 78 items that fall into 11 scales along four dimensions: PTSD symptoms, eroticism, abuse attribution, and social reactions. Internal consistencies for the scales average .69 (Chaffin and Schultz). This study utilized the Self-Blame and Guilt Subscale and the Sexual Anxiety Subscale which had alphas of .73 and .72 respectively (Chaffin & Schultz, 2001).
**Procedures**

Project SAFE (Sexual Abuse Family Education) is a 12-week, standardized, cognitive-behavioral group treatment for CSA victims and their non-offending family members. Separate groups are held for child and adolescent victims, and caregivers (Hansen, Hecht, & Futa, 1998). The treatment included a variety of techniques such as psychoeducation and anxiety management which are aimed at reducing symptomology of CSA victims.

**Results Section**

**Self-Blame and Caregiver Support**

Table 1. *Self-Blame Means for Participants across Competence Conditions*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Treatment Sexual Anxiety</th>
<th>Mid-Point Sexual Anxiety</th>
<th>Post-Treatment Sexual Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Sense of Competence</td>
<td>5.632</td>
<td>4.399</td>
<td>3.335</td>
</tr>
<tr>
<td>Medium Sense of Competence</td>
<td>5.783</td>
<td>4.300</td>
<td>3.539</td>
</tr>
<tr>
<td>High Sense of Competence</td>
<td>5.726</td>
<td>4.402</td>
<td>6.860</td>
</tr>
</tbody>
</table>
A 3-way within subjects ANOVA was run to examine the relationship between sexual anxiety, caregiver sense of competence, and the number of caregivers attending therapy. Additionally, a 2-way within subjects ANOVA was run to examine the relationship between self-blame and caregiver sense of competence. These interactions are illustrated in Figures 1 and 2 respectively.

There was a significant interaction between self-blame and caregiver sense of competence \( (F(4,228)=3.903, \text{MsE}=8.458, p=.004) \). Children with caregivers who have a low sense of competence did not have a significant change in self-blame from pre-treatment to mid-point \( (p=.079, r=.287) \) or mid-point to post-treatment \( (p=.056, r=.250) \), however there was a significant decrease in self-blame from pre-treatment to post-treatment \( (p=.002, r=.488) \).

Children with caregivers who have a medium sense of competence had significant decreases in self-blame from pre-treatment to mid-point \( (p=.022, r=.339) \) and from pre-treatment to post-treatment \( (p=.001, r=.479) \). However, there was not a significant change in self-blame for children with caregivers who have a medium sense of competence for mid-point to post-treatment \( (p=.136, r=.182) \).

Children with caregivers who have a high sense of competence had a significant increase in self-blame from mid-point to post-treatment \( (p=.001, r=.306) \). However, there was not a significant change for pre-treatment to mid-point \( (p=.154, r=.266) \), or pre-treatment to post-treatment \( (p=.249, r=.513) \).

There was a significant main effect of treatment for self-blame \( (F(2,228)=5.902, \text{MsE}=8.458, p=.003) \) such that there was a significant decrease in self-blame from pre-treatment to mid-point \( (p=003, r=.311) \) and from pre-treatment to post-treatment.
(p=.016, r=.266), however there was not a significant change from mid-point to post-treatment (p=.546, r=.051). The pattern was misleading for participants with caregivers with low competence for pre-treatment to mid-point, pre-treatment to post treatment, and mid-point to post-treatment. It was also misleading for participants with caregivers with medium sense of competence for mid-point to post-treatment and for caregivers with high sense of competence for pre-treatment to mid-point and pre-treatment and mid-point to post-treatment.

Table 1: Main effect of treatment for self-blame

<table>
<thead>
<tr>
<th>Self-Blame</th>
<th>Pre-treatment</th>
<th>Mid-point</th>
<th>Post-treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5.714</td>
<td>4.367</td>
<td>4.578</td>
</tr>
</tbody>
</table>

Sexual Anxiety
There was a significant interaction between the number of caregivers attending therapy, caregiver sense of competence, and sexual anxiety F(4,228)= 3.984, p=.004, MSE=2.532. For participants with one participating caregiver with low sense of competence, there was no change in sexual anxiety scores for pre-treatment to mid-point (p=.467, r=.154), pre-treatment to post-treatment (p=.105, r=.339), or mid-point to post-treatment (p=.175, r=.200). For participants with one participating caregiver with a
medium sense of competence, there was a significant decrease in sexual anxiety from pre-treatment to mid-point ($p<.001$, $r=.603$), pre-treatment to post-treatment ($p<.001$, $r=.760$), and mid-point to post-treatment ($p=.004$, $r=.382$). For participants with one participating caregiver with a high sense of competence there was a significant decrease in sexual anxiety from pre-treatment to mid-point ($p<.001$, $r=.657$), pre-treatment to post-treatment ($p=.004$, $r=.584$), however there was not a significant change in sexual anxiety from mid-point to post-treatment ($p=.346$, $r=.149$).

For participants with two participating caregivers with low sense of competence, there was a significant decrease in sexual anxiety scores from pre-treatment to mid-point ($p=.027$, $r=.528$), pre-treatment to post-treatment ($p=.001$, $r=.719$), and mid-point to post-treatment ($p=.038$, $r=.382$). For participants with two participating caregivers with a medium sense of competence, there was a significant decrease in sexual anxiety from mid-point to post-treatment ($p=.015$, $r=.406$), however there was not a significant decrease from and pre-treatment to mid-point ($p=.923$, $r=.027$) or pre-treatment to post-treatment ($p=.115$, $r=.385$). For participants with two participating caregivers with a high sense of competence there was a significant decrease in sexual anxiety from pre-treatment to mid-point ($p=.001$, $r=.813$), pre-treatment to post-treatment ($p=.20$, $r=.800$), however there was not a significant change in sexual anxiety from mid-point to post-treatment ($p=.827$, $r=0.062$).

Table 2. Sexual Anxiety Means for Participants across Caregiver and competence Conditions

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Treatment</th>
<th>Mid-Point Sexual</th>
<th>Post-Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual Anxiety</td>
<td>Anxiety</td>
<td>Sexual Anxiety</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>One Caregiver</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Sense of Competence</td>
<td>5.04</td>
<td>4.69</td>
<td>4.23</td>
</tr>
<tr>
<td>Medium Sense of Competence</td>
<td>5.83</td>
<td>4.13</td>
<td>3.20</td>
</tr>
<tr>
<td>High Sense of Competence</td>
<td>5.25</td>
<td>3.29</td>
<td>3.63</td>
</tr>
<tr>
<td><strong>Two Caregivers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Sense of Competence</td>
<td>6.13</td>
<td>4.73</td>
<td>3.80</td>
</tr>
<tr>
<td>Medium Sense of Competence</td>
<td>5.94</td>
<td>6.00</td>
<td>5.00</td>
</tr>
<tr>
<td>High Sense of Competence</td>
<td>6.57</td>
<td>3.43</td>
<td>3.57</td>
</tr>
</tbody>
</table>

Figure 2: Sexual anxiety across caregiver and competence conditions

![Sexual Anxiety and Caregiver Support](image)
There was a significant interaction between sexual anxiety and caregiver sense of competence (F(4,228)=2.450, MsE=2.532 p=.047) although the pattern was misleading. For caregivers with a low sense of competence, sexual anxiety decreased from pre-treatment to mid-point (p=.028, r=.362), from pre-treatment to post-treatment (p<.001, r=.572), and from mid-point to post-treatment (p=.014, r=.296). This was misleading for participants with one caregiver attending for pre-treatment mid-point, pre-treatment to post-treatment and mid-point to post-treatment. For caregivers with a medium sense of competence, sexual anxiety decreased from pre-treatment to mid-point (p=.024, r=.343), from pre-treatment to post-treatment (p<.001, r=.622), and from mid-point to post-treatment (p<.001, r=.395). For participants with two caregivers attending therapy, this pattern was misleading for pre-treatment to mid-point and pre-treatment to post-treatment. For caregivers with a high sense of competence, sexual anxiety decreased from pre-treatment to mid-point (p<.001, r=.742) and from pre-treatment to post-treatment (p<.001, r=.707), however there was not a significant change for mid-point to post-treatment (p=.522, r=.105). This was descriptive for both conditions.

Table 3. Sexual Anxiety Means for Participants across Competence Conditions

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-Treatment Sexual Anxiety</th>
<th>Mid-Point Sexual Anxiety</th>
<th>Post-Treatment Sexual Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Sense of Competence</td>
<td>5.586</td>
<td>4.713</td>
<td>4.015</td>
</tr>
<tr>
<td>Medium Sense of Competence</td>
<td>5.889</td>
<td>5.067</td>
<td>4.100</td>
</tr>
</tbody>
</table>
There was not a significant interaction between sexual anxiety and number of caregivers attending therapy. There was a significant decrease in sexual anxiety for participants with one caregiver from pre-treatment to mid-point and pre-treatment to post-treatment, however there was not a significant decrease from mid-point to post-treatment. For participants with two caregivers attending therapy there was a significant decrease in sexual anxiety from pre-treatment to mid-point, pre-treatment to post-treatment and mid-point to post-treatment. However, this pattern was misleading. For low sense of competence with two caregivers, the pattern was misleading for pre-
treatment to mid-point. For medium sense of competence with two caregivers, the pattern was misleading for pre-treatment to mid-point and pre-treatment to post-treatment. For high sense of competence with two caregivers, the pattern was misleading for mid-point to post treatment. For low sense of competence with one caregiver, the pattern was misleading for pre-treatment to mid-point and pre-treatment to post-treatment. For medium sense of competence with one caregiver, the pattern was misleading for mid-point to post-treatment.

There was a significant main effect of treatment for sexual anxiety. There was a significant decrease in sexual anxiety from pre-treatment to mid-point (p<.001, r=.527), from pre-treatment to post-treatment (p<.001, r=.639), and from mid-point to post-treatment (p=.008, r=.207). However, the pattern was misleading for two caregivers with low sense of competence for pre-treatment to mid-point, with medium sense of competence for pre-treatment to mid-point and pre-treatment to post treatment, and with high sense of competence for mid-point to post-treatment. It was also misleading for participants with one caregiver with low sense of competence for all times and high sense of competence at mid-point to post-treatment.
Discussion

The study examined how caregiver sense of competence and the number of caregivers attending therapy relates to sexual anxiety and self-blame.

The results show partial support for the research hypothesis that lower parental sense of competence scores will be correlated with higher sexual anxiety, and there will be greater decreases in sexual anxiety across time for participants attending therapy with two caregivers. Contrary to the research hypothesis, participants with one caregiver who had a medium sense of competence presented with greater sexual anxiety than participants with one caregiver with either a low or high sense of competence, which were equal, although they experienced the greatest decrease in sexual anxiety. Participants with one caregiver with a high sense of competence had the greatest decrease from pre-treatment to mid-point, but experience a slight increase in sexual anxiety from mid-point to post-treatment, while participants whose caregiver had a low sense of competence experienced the smallest decrease in sexual anxiety.
Contrary to the research hypothesis, participants with two caregivers who have a high sense of competence experienced slightly greater sexual anxiety than those whose caregivers had a low or medium sense of competence, which were equal. In accordance with the research hypothesis, participants with two caregivers who had a high sense of competence experienced the greatest decrease in sexual anxiety overall. Contrary to the research hypothesis, participants with two caregivers with a medium sense of competence experienced the smallest decrease in sexual anxiety, while those whose caregivers had a low sense of competence experience a moderate decrease in sexual anxiety.

In partial support of the research hypothesis and prior research which suggests that participants whose caregivers have a low sense of competence will experience higher sexual anxiety, the pattern was different for presenting symptoms with participants whose caretakers had medium and high senses of competence had the highest sexual anxiety (Hubel et al., 2014). However, participants whose caregivers had a high sense of competence experienced greater decreases in sexual anxiety over the course of treatment than participants whose caregivers had a medium sense of competence. Participants whose caregivers had a low sense of competence experienced the smallest decrease in sexual anxiety.

Also in support of the research hypothesis, there was a significant main effect of treatment for sexual anxiety and self-blame such that they both showed successive decreases with treatment. This provides support for previous research showing that the treatment provided by Project SAFE is effective by showing that throughout treatment, participants on average experience a decrease in sexual anxiety and self-blame.
There was no support for the hypothesis that lower parental sense of competence scores will be correlated with greater initial self-blame and smaller decreases in self-blame. Contrary to the research hypothesis, there was no difference in initial self-blame between caregivers with a low, medium, or high sense of competence. Also contrary to the research hypothesis, participants with caregivers with a low or medium sense of competence showed equal decreases in self-blame, however participants with caregivers with a high sense of competence showed a decrease from pre-treatment to mid-point, but an equal increase from mid-point to post-treatment.

The results of this study provide a deeper understanding of the relationship between caregiver support and symptomology of CSA victims. Furthermore, it helps to expand on previous research about the relationship between caregiver sense of competence and overall symptomology. This study also highlights the need for a deeper understanding of the specific components that influence symptomology in CSA victims, so that treatment can be more effective and more individualized.
References


