Treatment Satisfaction and Adult Mental Health Outcomes of Childhood Sexual Abuse Survivors

by

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Abstract

Treatment Satisfaction and Adult Mental Health Outcomes of Childhood Sexual Abuse Survivors

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In the current study, we examined the impact of trauma-specific treatment and treatment satisfaction to determine if receiving treatment had an impact on the adult mental health outcomes of childhood sexual abuse survivors. One hundred ninety-four participants completed a series of self-report measures that captured their experience of childhood sexual abuse, possible enrollment in treatment, experience in treatment, and current PTSD, Depression, Alcohol Abuse, and Experiential Avoidance levels. MANOVAs were conducted to identify and examine any relationships between treatment groups. It was hypothesized that participants who received therapy specific to their childhood sexual abuse would endorse lower levels of PTSD, Depression, Alcohol Abuse, and Experiential Avoidance when compared to participants who did not receive treatment. This hypothesis was not supported. Revictimization and the severity of childhood sexual abuse was also analyzed for relationships to treatment outcomes. Participants’ reported treatment satisfaction and descriptions of their treatment experiences were analyzed for both qualitative and
quantitative themes. The implications for these findings, as well as directions for future research, are discussed.
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Introduction

Childhood sexual violence is noteworthy because of the potential for negative impact on women’s psychological health. Posttraumatic stress, depression, and an increased likelihood of substance abuse have been identified as long-term outcomes associated with a history of sexual abuse (Davidson & Omar, 2014; Fergusson, Boden, & Horwood, 2008). Though many survivors of childhood sexual abuse are resilient and experience no negative long-term mental health impact, analysis of retrospective reports given by adults who recall traumatic childhood events frequently indicate childhood stressors can be associated with strong and long-lasting impacts on adult mental health (Horwitz, Widom, McLaughlin & White, 2001; Kendall-Tackett, Williams & Finkelhor, 1993; Pérez-Fuentes et al., 2013).

Fergusson, Boden & Horwood (2008) studied the retrospective report of 1000 adults, regarding their experiences from birth to age 25. Fergusson et al. (2008) found that exposure to childhood sexual abuse was associated with increased risks of later mental disorders including depression, anxiety disorders, and substance dependence. The data collected by Fergusson et al. (2008) also indicated that adults who had experienced childhood sexual abuse were 2.4 times more likely to have a mental disorder than non-abused adults.

This introduction examines the research pertinent to the issues of the long-term psychological impact of childhood sexual abuse, and the comparison of treated and untreated adult female survivors of childhood sexual abuse. Research regarding
the four common symptoms associated with sexual abuse (e.g., Posttraumatic Stress Disorder, Depression, Alcohol Abuse, and Experiential Avoidance) were reviewed. In addition, three of the most commonly used treatment models for trauma-related abuse in children (e.g., Trauma Focused-Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, and Child Centered Play Therapy) are discussed. Finally, a review of the current literature addressing long term outcomes and satisfaction associated with therapy for the abuse was conducted. The current literature review uncovered few long-term follow-up studies of treatment outcomes or treatment satisfaction for adult survivors of childhood sexual abuse.

The sexual victimization of girls, and the short and long-term impacts of that abuse are important clinical issues. Moreover, learning more about survivors’ perceptions regarding psychological treatments and treatment satisfaction could also be valuable in learning more about this population. In this study, I collected retrospective data from female survivors of childhood sexual abuse. Symptoms associated with childhood sexual abuse were compared between those who reported treatment and those who did not. Subjective reports of the survivors’ satisfaction with the psychological treatment were assessed. While it is also important to evaluate the long-term issues for men with a history of child sexual abuse, that goes beyond the scope of this paper. Men with a history of abuse may have significant issues, however the symptom profiles differ between men and women (Gauthier-Duchesne, Hébert,
& Daspe, 2017). Due to potential confounding population differences between sexes, we focused on women with a history of abuse.

Prevalence

According to national statistics collected by a number of researchers, the rate of sexual abuse in children and adolescents continues to be a significant problem. The U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, [U.S. Children’s Bureau] (2013), report that 25% of girls aged 0-17 have been sexually assaulted at some point in their life. Another study conducted in the United States reported that approximately 20% to 27% of women describe being sexually abused as children or adolescents (Child Welfare Information Gateway, 2016). The U.S. Children’s Bureau (2013) also found that only 30% of child sexual assaults are reported, and yet in 2012, the staggering number of 62,936 new cases of childhood sexual abuse was documented. Additionally, current national statistics indicate that 35.85% of all sexual assaults occur when the victim is an adolescent. Thus, the data from a number of sources suggest general agreement on the numbers of women with a history of child and adolescent sexual abuse.

Definition of Childhood Sexual Abuse

The concept of child abuse is often differentiated into four categories; neglect, physical abuse, emotional abuse, and sexual abuse. While these four areas
are frequently co-occurring, the focus of this study is childhood sexual abuse. The United States Department of Health and Human Services definition of childhood sexual abuse is as follows: “Sexual abuse is the use, persuasion or forcing of a child [person under age of 18] to engage in sexual acts or imitation of such acts” (Child Welfare Information Gateway, 2016, p. 2).

This definition used by the Department of Health and Human Services was further expanded by Brown, Reyes, Brown, & Gonzenbach (2013) who refined their definition of childhood sexual abuse to include “any inappropriate sexual interaction with a child, including physical, or any attempts to exploit the child sexually” (p. 144). Briere and Rickards (2007) further defined childhood sexual abuse as “any physical sexual contact from an adult or someone 5 or more years older than the participant, or any peer sexual contact that was physically forced” (p. 498). Finkelhor (1979), designer of the Sexual Experiences Survey, defined childhood sexual abuse as “any sexual experience in which force/coercion was used and/or if there was a five-year age discrepancy for child victims or a ten-year age discrepancy for adolescent victims because adolescents may be involved in sexual relationships that are consensual” (p. 80). This inclusion of an age requirement for perpetrators was made in an effort to exclude consensual, age and developmentally appropriate sexual experiences from being mis-categorized as childhood sexual abuse.

For the purposes of the current study, the definition of childhood sexual abuse will combine the similar aspects of the definitions created by past researchers. In this
study, the following definition of childhood sexual abuse was used: the participant experienced unwanted touching, fondling, attempted intercourse, intercourse, and related sexual experiences between the ages of one and seventeen.

**Adult Mental Health Outcomes of Childhood Sexual Abuse**

Childhood sexual abuse has been correlated with several mental health difficulties in adult abuse survivors. Although many survivors do not develop mental health issues, and not all mental health issues can be causally linked to experiences of childhood sexual trauma, the current research suggests there are common diagnoses within the population of childhood sexual abuse survivors. The most common mental health diagnoses include Posttraumatic Stress Disorder, Depression, and Alcohol Abuse (Trask, Walsh & DiLillo, 2011; Horwitz et al., 2001; McCauley et al., 1997). Additionally, the psychological concept of Experiential Avoidance is a proposed mediator of long-term psychological outcomes (Hayes et al., 1996). As such, the connection between childhood sexual abuse and Posttraumatic Stress Disorder, Depression, Alcohol Abuse, and Experiential Avoidance is discussed.

**Posttraumatic Stress Disorder.** Posttraumatic Stress Disorder (PTSD) is one of the most commonly diagnosed disorders among child victims of sexual abuse (Trask, Walsh & DiLillo, 2011). The variables which impact the repercussions of childhood sexual abuse are numerous, but Beitchman et al. (1992) have identified several variables which are linked to higher incidence rates of the victims’ development of PTSD. The variables identified that predicted more negative
outcomes, include: an extended duration of abuse; the use or threat of force; and abuse involving a father or stepfather. (Beitchman et al., 1992). Researchers’ estimates suggest that approximately 37% to 53% of sexually abused children eventually develop PTSD, whether immediately following the trauma or during adulthood (Kendall-Tackett, Williams & Finkelhor, 1993; Fricker & Smith, 2001). The large majority of sexually abused children referred to treatment have been shown to experience at least partial PTSD symptoms (Deblinger, McLeer, Atkins, Ralphe & Foa, 1989; Fricker & Smith, 2001). Further research suggests that victims of childhood sexual abuse were significantly more likely than their non-abused counterparts to report symptoms related to PTSD including anxiety attacks, anger management difficulties, and sexual concerns (Beitchman et al., 1992; Browning, 1997; Fricker & Smith, 2001).

Deblinger, McLeer, Atkins, Ralphe, & Foe (1989) conducted a study to assess for trauma related symptomology. At the time of the study, the Deblinger et al. (1989) findings indicated 20% of sexually abused children also met diagnostic criteria for Posttraumatic Stress Disorder. Deblinger et al. (1989) also found that sexually abused children showed more avoidant and dissociative symptoms, common criteria of PTSD, than non-abused children. Adam, Everett, & O’Neal (1992) replicated this research study, collecting data from 98 children in an inpatient setting, aged four to 12. They found that 43% of sexually abused children had a diagnosis of Posttraumatic Stress Disorder.
Past research indicates that posttraumatic stress and hyperarousal difficulties in early and mid-adulthood are often correlated with a history of childhood sexual abuse. Cavanaugh et al. (2015) conducted a study in which they assessed the interpersonal and parenting concerns of 166 adult mothers, aged 20-58, from a non-clinical sample, with a history of childhood sexual abuse. The results from the Cavanaugh et al. (2015) study found that a majority of the participants experienced partial symptoms of Posttraumatic Stress Disorder in addition to interpersonal/marital trust difficulties.

Several research studies have identified that many survivors of childhood sexual abuse who do not meet full criteria for PTSD still experience significant amounts of trauma-related distress (Deblinger et al., 2001; Deblinger et al., 1989; Fricker & Smith, 2001; McCauley et al., 1997; Brancu et al., 2016). This “sub-threshold” PTSD can be a source of significant distress with symptoms of avoidance, hyperarousal, anxiety, and negative intrusive thoughts. There is not one standardized score for identifying subthreshold PTSD. This study evaluated posttraumatic distress as a continuous variable, with scores over twenty indicating some level of distress in this area.

**Depression.** An increased likelihood of adult depression has been correlated with the presence of childhood sexual abuse in women. In a study examining a number of outcomes associated with the lasting effects of childhood sexual abuse, Horwitz et al. (2001) reviewed the court-substantiated records of over 1500
participants from a 20 year period of time, and compared groups of those who reported childhood sexual abuse and those who did not. They found that being a female victim of childhood sexual abuse was significantly predictive of episodes of depression and dysthymia that can be recurrent over the course of the lifetime (Horwitz et al., 2001). In a similar research study, McCauley et al. (1997) studied the prevalence of childhood physical and sexual abuse in over 1900 women to assess physical and psychological symptoms associated with childhood abuse. Using the data gathered from primary care medical practices and self-report surveys, McCauley et al. (1997) found that women who reported physical or sexual abuse as children had higher scores for depression and lower scores for self-esteem when compared to women who had not experienced abuse.

Research indicated that there can be a delayed onset of trauma symptoms with childhood sexual abuse. Whiffen, Thompson & Aube (2000) surveyed 40 women regarding their experience of childhood sexual abuse occurring before age 14 and adulthood depression, in order to assess for a relationship between adult survivors of childhood sexual abuse and depressive symptoms. Whiffen et al. (2000) found that childhood sexual abuse was strongly associated with adult depression and interpersonal difficulties in women.

**Alcohol Use and Abuse.** Researchers of childhood abuse have linked childhood sexual abuse with an increased risk of adult alcohol and drug abuse (Davidson & Omar, 2014). In the previously cited Horwitz et al. (2001) study, the
researchers also found that female victims of childhood sexual abuse reported more symptoms of alcohol abuse or dependence than their control counterparts.

Furthermore, Widom, White, Czaja & Marmorstein (2007) studied the impact of childhood sexual abuse, childhood physical abuse, and childhood neglect on adult alcohol consumption. Widom et al. (2007) interviewed 892 survivors of court substantiated childhood abuse and found that when compared to their non-abused counterparts, female survivors of childhood abuse had a higher quantities of alcohol use over their lifetime. That is, the presence of childhood abuse was correlated with higher rates of alcohol problems during both young adulthood and middle adulthood.

The positive correlation between a history of childhood sexual abuse and increased adult alcohol use has been replicated multiple times over the last two decades. Boles, Joshi, Grella & Wellisch (2005) analyzed the effectiveness of substance abuse treatment outcomes on women who sustained childhood sexual abuse and found that the participants who had sustained childhood sexual abuse developed more severe substance abuse problems than women without histories of childhood sexual abuse. Furthermore, McCauley et al. (1997) studied the prevalence of childhood abuse in women to assess physical and psychological symptoms associated with childhood abuse and also found that women who reported childhood sexual abuse were more likely to currently abuse drugs or have a history of alcohol abuse when compared to women who had not experienced abuse.
**Experiential Avoidance.** Several common negative outcomes of childhood sexual abuse have been identified, including posttraumatic stress, depression, and alcohol abuse. Experiential avoidance, or the related construct of psychological flexibility, may serve as a mediator of long term psychological outcomes (Hayes et al., 1996). Current research finds experiential avoidance has a relationship between a history of abuse and the range of experienced symptoms. Hayes et al. (1996) describe experiential avoidance as “when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them” (p. 1154). Through review of the trauma-related literature, the use of avoidant coping strategies among survivors was found to be predictive of indicators of poorer psychological functioning (e.g., posttraumatic stress, depression, alcohol abuse) in trauma survivors (Batten, Follette & Aban, 2002).

**Treatment**

Several research studies have demonstrated the psychological impact of childhood sexual abuse is frequently long-standing and symptoms can last into adulthood (Hall et al., 1998; Horwitz, Widom, McLaughlin & White, 2001). Hetzel-Riggin, Brausch & Montgomery (2007) conducted a meta-analysis of the effectiveness of therapy for sexually abused children and adolescents and found that psychological treatment, regardless of modality, occurring after childhood or
adolescent sexual abuse, tended to result in better long-term outcomes than no treatment. The three most effective and evidence-based, childhood trauma treatments are included in this study; Trauma Focused – Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing therapy, and Child Centered Play Therapy (Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2013; Reyes & Asbrand, 2005). Following is a description of the identified treatment modalities for childhood sexual abuse and a review of these treatments’ effectiveness through literature review.

**Trauma Focused – Cognitive Behavioral Therapy (TF-CBT).** Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) is a highly effective, trauma-specific, treatment modality which has a family-focus. TF-CBT is a short-term, strengths-based treatment modality which focuses on the development of a client’s self-efficacy through psychoeducation and the development of coping and relaxation skills (Deblinger et al., 2011). TF-CBT is an adaptation of Cognitive Behavioral Therapy, and as such, the TF-CBT model identifies and treats the cognitive, emotional, and behavioral components of psychological distress. In addition to the treatment goals of replacing dysfunctional thought patterns, addressing interfamilial problems, adaptive expression and management of emotions, and changing traumatic behavior problems, a narrative of the client’s traumatic experience is developed and processed with the client and a chosen family member (Cohen, Mannarion & Deblinger, 2012). TF-CBT can be modified to suit a child’s specific needs, can be used with children aged 3 and up, and usually includes individual, group, and family
formats (Cohen, Mannarion & Deblinger, 2012). TF-CBT often incorporates therapeutic activities and games as therapeutic tools.

Several research studies, spanning multiple years, report Trauma Focused-Cognitive Behavioral Therapy as a superior method of treatment for children that experience negative psychological outcomes of childhood sexual abuse, specifically posttraumatic stress disorder and depression. A meta-analysis of the childhood sexual abuse treatment outcomes indicated that CBT, and its variation TF-CBT, produced more effective and longer lasting treatment gains than psychodynamic, supportive, Rogerian, EMDR, and solely pharmacological treatment modalities (Trask, Walsh & DiLillo, 2011). Additionally, the meta-analysis found there were no differences between individual and group treatment settings. They also report longer intervention lengths, 8-12+ weeks, were more effective than shorter interventions (Trask, Walsh & DiLillo, 2011). The CBT interventions were most beneficial with older children (aged 11-17,) which is hypothesized to be related to the fact that many existing CBT interventions rely heavily on cognitive components (e.g., the cognitive triad, cognitive distortions), which may be easier for older children to grasp (Trask, Walsh & DiLillo, 2011).

Deblinger, Mannarino, Choen & Steer (2006) conducted a study wherein they assessed 183 children, aged 8-14, and the children’s primary caregivers at a 6-month and 12-month interval following their completion of therapy to address childhood sexual abuse. The researchers tested the effectiveness of both Trauma Focused-
Cognitive Behavioral Therapy (TF-CBT) and Child-Centered Therapy (CCT) and found that the children treated with the TF-CBT intervention had significantly fewer symptoms of PTSD at the 6-month and 12-month intervals when compared to the CCT treated children. Deblinger et al. (2006) also found that the children’s caregivers treated with TF-CBT reported less abuse-specific distress during the follow-up period than those treated with CCT.

Deblinger, Steer & Lippmann (1999) conducted a follow-up study to determine the longitudinal effectiveness of TF-CBT in the treatment of PTSD in sexually abused children. Following the completion of the participants’ initial treatment, the researchers re-examined 100 mothers and their sexually abused children at a 3-month, 6-month, 12-month, and 24-month intervals. Deblinger, Steer & Lippmann (1999) found the three measures of psychopathology that had significantly decreased in the original study (i.e., externalizing behavior problems, depression, and PTSD symptoms) did not return to prior levels of symptomology at any posttreatment assessment. The data collected from the follow-up study conducted by Deblinger, Steer & Lippmann (1999) suggests that the effectiveness of TF-CBT for sexual abuse treatment is both significant and long-standing (as measured at 24-month follow up) as the children retained their treatment gains.

Eye Movement Desensitization and Reprocessing (EMDR). Treatment for sexual abuse survivors typically focuses on the sexual abuse experience because any emotional and behavioral disturbances are considered to have resulted from the
abuse. Therefore, the goal of treatment for the survivor is to eventually talk about or in some way address the trauma. Eye Movement Desensitization and Reprocessing (EMDR) is a treatment approach which addresses a traumatic experience through the targeting, desensitization, and reprocessing of three areas generally effected by trauma; past memories, current disturbances, and future actions. Through eight regimented stages of treatment, traumatic memories and negative self-beliefs are incrementally processed, emotional distress is decreased by desensitization, and positive and adaptive beliefs replace the maladaptive alternatives (Shapiro, 2001). Though most commonly used with adults, EMDR has been effectively used to treat children as young as 4 years old (Settle, 2016). EMDR is tailored to suit the client, and the client’s autonomy is important in personalizing the length of treatment phases. Specific to the child clients of EMDR, the treatment phases are adjusted to the child’s developmental stage, and typically, younger children require fewer phases of treatment (Chemtob, Nakashima & Carlson, 2002). EMDR is only used in individual treatment settings, and incorporates the use of visual stimulation, auditory stimulation, and tactile stimulation.

EMDR’s efficacy as a treatment of posttraumatic stress has been established by both controlled research and case studies. Chemtob, Nakashima, & Carlson (2002) assessed the effectiveness of EMDR in the treatment of 32 children, aged 6-12, with diagnosed Posttraumatic Stress Disorder. When comparing children who completed EMDR treatment to children with no treatment, Chemtob et al. (2002)
found that the EMDR treatment caused a substantial decrease in PTSD symptoms immediately following completion of therapy. In a six-month follow-up, symptoms remained in remission (Chemtob et al., 2002).

Meta-analysis of childhood psychological interventions have found that EMDR is effective within the adolescent population (Greyber, Dulmus & Cristalli, 2012). Ahmad, Larsson & Sundelin-Wahlsten (2017) compared the effectiveness of EMDR and no treatment intervention by comparing the treatment outcomes of 33 children, aged 6 to 16, with a DSM-IV diagnosis of PTSD. Ahmad et al. (2017) found EMDR was significantly more effective than no treatment, particularly regarding the reduction of intrusive, re-experiencing thoughts. These findings suggest that EMDR can be an effective tool to help adolescents and children recover from the effects of sexual abuse.

**Child Centered Play Therapy (CCPT).** Play therapy provides a means for children, aged 12 and under, to address sexual trauma using a variety of play media and through the relationship with the therapist. Because play is the natural expressive language of children, theoretically, play therapy provides the opportunity for sexually abused children to communicate that which cannot be articulated because of a lack of a cognitive framework for understanding their experiences (Griffith, 1997). Play therapy can be tailored to suit the child’s specific needs, including an individual or group format and directive or non-directive play. Group and directive play therapy are more appropriate for clients whose needs include normalization of
their experience and validation of their trauma-related emotions, as well as behavioral problems such as aggression and sexual reactivity (Sprunk et al., 2012). Play therapy incorporates psychoeducation, and though initially the child will be allowed to play freely, as treatment progresses more therapeutic tools and activities related to the child’s difficulties will be introduced. Play therapy commonly incorporates therapeutic toys, sandboxes, art materials, dolls, puppets, and other indoor games as therapeutic tools.

Multiple research studies indicate that play therapy is an effective treatment modality. Specifically, Child Centered Play Therapy is a common method of treatment for children that experience negative psychological outcomes of childhood sexual abuse, including posttraumatic stress, depression, and anxiety. Bratton, Ray, Rhine, and Jones (2005) conducted an extensive meta-analysis reviewing 93 controlled play therapy outcome studies (which were published 1953–2000) to determine factors that might impact its effectiveness. Results demonstrated that the overall treatment effect for play therapy interventions was more than three-fourths of a standard deviation better when compared to non-intervention, suggesting a strong effect for treatment (Bratton et al., 2005). Additional analysis revealed that treatment effectiveness was significant for both directive and non-directive play therapy, but non-directive play therapy showed a larger significance in overall treatment improvements (Bratton et al., 2005).
Although play therapy is usually used to treat children aged 12 and under, research has also found play therapy as an effective treatment for emotionally distressed older adolescents. Reyes & Asbrand (2005) conducted a study of the effectiveness of play therapy as the primary treatment for childhood sexual abuse for children aged 7 to 16. Reyes & Asbrand (2005) findings indicate that the use of play therapy significantly decreased the overall severity of trauma symptoms; anxiety, depression, and posttraumatic stress. However, concerns of sexual preoccupation or distress were not significantly changed by play therapy treatment (Reyes & Asbrand, 2005).

**Individual, Group, and Family Therapy.** The research findings of Hetzel-Riggin et al. (2007) suggest that family therapy and individual therapy appear to be the most effective treatment for trauma specific psychological distress. Yet, group therapy appeared to be the most effective for treatment of clients’ low self-concept. As TF-CBT, EMDR, and Child Centered Play Therapy often include a combination of individual, group, and family therapies, these treatment modalities were also assessed in this study for effectiveness and participant preference.

**Present Study**

Though many survivors of childhood sexual abuse are resilient and experience no negative long-term mental health impact, connections have been established between childhood sexual abuse and its potential long-term psychological consequences through empirical studies. The consensus of these
studies is that childhood sexual abuse is correlated with several negative psychological and interpersonal difficulties which can occur throughout the victim’s lifespan (Deblinger et al., 1989; Adam et al., 1992; Cavanaugh et al., 2015; Hall et al., 1998; Gorcey et al., 1986; Beitchman et al., 1992; McCauley et al., 1997; Cheasty et al., 1998). TF-CBT, EMDR, and CCPT all have empirical support suggestive that they are effective in treating childhood sexual abuse and the disorders which are often associated with a history of childhood sexual abuse (e.g. PTSD, Depression, and Alcohol Abuse; Deblinger et al., 2006; Deblinger et al., 1999; Deblinger et al., 1996; Brown et al., 2013).

The aim of this study was two-fold. First, we compared the psychological functioning between the adult participants with a history of childhood sexual abuse who report a history of therapy as a child, therapy as an adult, or no history of therapy. Second, we assessed adult participants’ report of whether or not therapy was useful and their satisfaction with the psychological treatment. While treatment has shown to remain effective up to two years in multiple longitudinal studies, there is limited long term follow-up with adult survivors of childhood sexual abuse (Deblinger et al., 2006; Deblinger et al., 1999).

Exploratory Research

As this study is retrospective, there cannot be any direct assumptions about causality between participants’ treatment satisfaction and treatment outcomes. Causality cannot be determined in a retrospective cross-sectional study because of
the many possible intervening variables outside the control of this study. This study is intended to provide some exploratory research into long-term treatment outcomes and satisfaction of adult survivors of childhood sexual abuse as a step in advancing the literature in this area. No studies of these issues were found in the literature. Moreover, the study will provide a foundation for the feasibility of future research of this type in examining long-term treatment outcomes.

This study retrospectively assessed the variables of a history of childhood sexual abuse, psychological symptomology, satisfaction with treatment, rates of treatment for childhood sexual abuse, and the type of treatment that participants believe that they had received. Differences in those treated were compared to those not treated on the dependent variables of participants’ current symptoms of posttraumatic stress, depressive symptoms, alcohol use, and experiential avoidance.

**Hypotheses**

The hypotheses for the present study are as follows:

**H1:** Survivors of sexual abuse who report receiving treatment for that abuse will have fewer mental health problems than untreated survivors.

a) Survivors of childhood sexual abuse who report receiving treatment for that abuse will have lower symptoms of Posttraumatic Stress Disorder compared to individuals who report that they did not receive treatment.
b) Survivors of childhood sexual abuse who report receiving treatment for that abuse will have lower symptoms of Depression compared to individuals who report that they did not receive treatment.

c) Survivors of childhood sexual abuse who report receiving treatment for that abuse will have lower symptoms of Alcohol Abuse compared to individuals who report that they did not receive treatment.

d) Survivors of childhood sexual abuse who report receiving treatment for that abuse will have lower levels of Experiential Avoidance compared to individuals who report that they did not receive treatment.

**Research Question**

The second aim of the study is to provide a descriptive report of the types of therapy participants reported they received, and their satisfaction with that treatment. While we do not expect participants to have knowledge of the specifics of various treatment models, we provided a general description (suited for a lay audience) of the most common treatment modalities for childhood trauma. To our knowledge, there is no research that has examined sexual abuse survivors’ recollections of treatment and related outcomes. While we do not have specific hypotheses related to types of therapies and outcomes, this work will provide some preliminary data about participant recollection of treatment and their satisfaction with treatment.
Method

Eligibility Screen

Approval for this study was obtained by the Florida Institute of Technology Institutional Review Board (IRB) prior to the collection of data. Individuals who elected to participate in the study were administered an informed consent (Appendix A) and an initial screening assessment (Appendix C) to assess age, gender, sexual abuse history, and an attention check item. Participants passed this eligibility screening if they indicated they were 18 years or older, female, endorsed a history of childhood sexual abuse, and accurately responded to the attention check item. Of the 383 individuals who completed the informed consent and eligibility screen, 135 participants were disqualified from completing the remainder of the survey.

Participants

Participants were recruited via an online crowd-sourcing platform from throughout the United States using a brief study description (Appendix B). Only female participants with a history of childhood sexual abuse and over age 18 were recruited. Participants were recruited through Amazon Mechanical Turk (MTurk). Amazon MTurk is an online crowdsourcing platform where people can elect to perform tasks, called Human Intelligence Tasks (HITs), and earn money for their work. For the current study, we recruited only MTurk workers who were working within the United States and who had a 98% or higher HIT approval rating, meaning
that 98% or more of their work had been approved by employers (HIT requesters). The participants were given the incentive of $2.00 to complete at least 95% of all study items and provide accurate and effortful responses as measured by attention check items.

**Recruitment**

The recruitment study description (Appendix B) was listed on MTurk and titled, “Psychological study on childhood sexual abuse and treatment; Earn up to $2.00 if you qualify.” Prospective participants who choose to preview the HIT were presented with the information about eligibility, compensation, the amount of time required to participate, and the requirement of the participants’ effort and attention.

**Materials**

**Demographic questionnaire** (Appendix D). Participants were asked to complete a brief demographic questionnaire which asked them to indicate their sex, age, ethnicity, and educational status.

**Sexual and Physical Abuse Questionnaire (SPAQ)** (Appendix E). Participants were asked to complete a questionnaire assessing their experience of childhood sexual abuse. These questions were selected from a screening questionnaire developed by Kooiman, Ouwehand, & ter Kuile (2002) to assess the presence of sexual abuse and the age when the abuse first occurred.

In addition to the SPAQ, several complementary questions regarding sexual abuse were added to gain more specific information. The participants were asked
the following: *If you told someone about your abuse, how long after the abuse occurred did you tell them?* and *Was your abuse reported to legal authorities?*

**Center for Epidemiologic Studies Depression Scale - Revised** (Appendix F). The CESD-R (Eaton, Smith, Ybarra, Muntaner & Tien, 2004) is a commonly used 20-item self-report measure that was designed to detect the presence and severity of depression in adults. Each item is rated on a 5-point Likert scale, from 0 to 4, and participants are told to rate their symptoms which occurred during the past two weeks. To score and interpret the CESD-R, the scores are summed, and the higher total scores indicate more severe depressive symptoms. Cut-off scores on the CESD-R are 0 – 10 (no indication of depression), 10-15 (mild depression), 16-23 (moderate depression) and ≥24 (severe depression; Eaton et al., 2004). The standard cut-off point of 16 or more was used to classify participants with depressive symptoms. The internal consistency reliability of the CESD-R is .83 for the adult sample (Eaton et al., 2004). Also, the CESD-R shows good convergent validity as the correlation between the CESD-R and the original CESD was highly correlated (Eaton et al., 2004).

**Posttraumatic Stress Disorder Checklist for DSM 5 (PCL-5)** (Appendix G). The Posttraumatic Stress Disorder Checklist for DSM 5 (Blevins, Weathers, Davis, Witte & Domino, 2015) is a 20-item self-report questionnaire which assesses the presence and severity of criteria of PTSD. Each item is rated on a 5-point Likert scale, from 0 to 4. To score and interpret the PCL-5, the scores and summed and the
higher total scores indicate more severe posttraumatic symptoms. The total symptom severity scores range from 0-80, and the suggested cutoff range to indicate the presence of PTSD symptoms is 33. Internal consistency, assessed by Cronbach’s alpha, was high for the whole scale (0.94). PCL-5 scores were compared to previous versions of the PCL, and the PCL-5 exhibited strong test-retest reliability ($r = .82$), convergent validity ($r_s = .74$ to $.85$), and discriminant validity ($r_s = .31$ to $.60$; Blevins et al., 2015).

**Alcohol Use Disorders Identification Test (AUDIT)** (Appendix H). The AUDIT (Yee, Adlan, Rashid, Habil, & Kamali, 2015) is a widely used 10-item scale that measures the presence and severity of alcohol use disorders. Each item is rated on a 5-point Likert scale, from 0 to 4. To score and interpret the AUDIT, the scores and summed and the higher total scores indicate strong likelihood of alcohol use disorder. The total symptom severity scores range from 0-40. Scores between 0-7 indicate low risk of alcohol use disorder, scores between 8-15 indicate being at risk for alcohol use disorder and scores above 20 indicate serious alcohol abuse. The AUDIT shows good convergent validity as the correlation between the AUDIT and MAST was $r = .88$ ($p< .001$; World Health Organization, 2001). A high correlation coefficient (.78) was also found between the AUDIT and the CAGE. AUDIT also has a high test-retest reliability of $r = .86$ (World Health Organization, 2001).

**Acceptance and Action Questionnaire–II (AAQ-II)** (Appendix I). The AAQ-II is a 7-item self-report inventory that measures an individual’s willingness to
accept undesirable private events (e.g. emotions, thoughts, or sensations) and also act in a way which is congruent with their values and goals (Bond et al., 2011). Each item is rated on a 7-point Likert scale, from 1 to 7. Scores are the sum of item responses; higher scores indicate greater experiential avoidance and/or psychological inflexibility, whereas lower scores indicate greater experiential acceptance and/or psychological flexibility. The AAQ-II demonstrated excellent internal consistency ($\alpha = .94$; Bond et al., 2011). The AAQ-II maintains a high correlation ($r=.97$) with the AAQ-I and has improved psychometric consistency over the original measure. It has demonstrated convergent and criterion-related validity (Bond et al., 2011).

**Common & Efficacious Treatments of Childhood Sexual Abuse and Posttraumatic Stress Disorder** (Appendix J). A questionnaire with brief, layperson descriptions of the treatment modalities was created in an effort to determine the modality with which the participants were treated. (Foa, Keane, Friedman, & Cohen, (Eds.), 2008). Participants were asked to mark the treatment modality they recognize, or provide a description of their treatment. An “unknown” option was also provided.

**Client Satisfaction Questionnaire – 8** (Appendix K). The CSQ-8 (Attkisson, 1982) is an 8-item self-report measure that was designed to assess consumer satisfaction with mental health treatment. Each item is rated on a 4-point Likert scale, from 1 to 4. Total scores range from 8 to 32, with higher scores reflecting higher satisfaction with treatment. The internal consistency (coefficient a)
of the CSQ-18 was found to be .91, while the alpha value for the CSQ-8 was .93 (Attiksson, 1982).

**Procedure**

Participants were routed from the MTurk website to an online survey created in Qualtrics, an internet-based program for survey design and data collection. Participants began this online study by completing an informed consent (Appendix A). The study consisted of a series of questionnaires including: the Sexual and Physical Abuse Questionnaire (SPAQ) as a measure of childhood sexual abuse, the Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) as a measure of depression, the Posttraumatic Stress Disorder Checklist–5 (PCL-5) as a measure of posttraumatic stress, the Alcohol Use Disorder Identification Test (AUDIT) as a measure of alcohol abuse, the Acceptance and Action Questionnaire-II (AAQ-II) as a measure of experiential avoidance and psychological flexibility, and the Client Satisfaction Questionnaire-8 as a measure of treatment satisfaction. Also, participants completed a brief demographic questionnaire. A treatment questionnaire, with layperson descriptions of the treatment modalities, was also given to the participants.

Two attention check questions were inserted into the study. The first one was in the eligibility screener. The second was inserted at the end of the posttraumatic stress measure (PCL-5), and the participants were asked to leave this question blank. Fifty-four participants who responded incorrectly to the attention-check items were
disqualified from the survey and their data was not used in the analysis. These attention check items served to assess participants’ engagement, comprehension, and effort, as they are important to the validity of this study’s findings. Moreover, the placement of these items was aimed to prevent interference with the assessments.

**Preliminary Analyses**

The following preliminary analyses were completed on the collected data:

1) Examined data for accuracy and missing values.

2) Descriptive statistics of participant age, ethnicity, education status, and childhood sexual abuse (e.g., severity, treatment, disclosure, revictimization) were conducted.

**Plan of Analysis**

For the purpose of testing Hypotheses 1, a correlation table was developed in order to determine the relationships between the dependent variables (i.e., PTSD, Depression, Alcohol Abuse, and Experiential Avoidance) and to ascertain the suitability of a MANOVA. Once found suitable, a MANOVA was used to evaluate the differences between the treatment and non-treatment groups regarding the main dependent variables.

a) Evaluated the difference between treatment group and non-treatment group for outcomes of PTSD.
b) Evaluated the difference between treatment group and non-treatment group for outcomes of Depression.

c) Evaluated the difference between treatment group and non-treatment group for outcomes of Alcohol Abuse.

d) Evaluated the difference between treatment group and non-treatment group for outcomes of Experiential Avoidance.

Exploratory Analyses

For the purpose of testing the Research Question, the descriptive report of the types of therapy participants received and their satisfaction was reviewed for themes. Participants reported satisfaction was evaluated with both the satisfaction questionnaire (i.e. the CSQ-8) and the narrative comments. Participant’s narrative comments were reviewed for both qualitative and quantitative themes including type of treatment and treatment satisfaction.
Results

Descriptive Statistics of Participants

Three hundred eighty-three individuals participated in the screening portion of the study. One hundred and thirty-five participants were disqualified for not passing the eligibility screener, and an additional 54 participants were disqualified for not accurately responding to both attention check items. Screening the participants based on the inclusion criteria (e.g. passing the eligibility screen and accurate responses to both attention check items) yielded a total of 194 participants (N=194). There were no missing values in the data collection, as all study questions required participants to respond before continuing the study. Participants in this study were adult women who endorsed a history of childhood sexual abuse, ranging in age from 20 to 66 years old (M=33.05; SD=9.11).

In terms of the current sample’s (N=194) ethnic distribution, the majority of participants were Caucasian (n=122; 62.9%), followed by Asian (n=32; 16.5%), Hispanic (n=15; 7.7%), African-American (n=13; 6.7%), Native American (n=7; 3.6%), and Biracial (n=5; 2.6%). No participants identified themselves as Pacific Islander or Other.

The current sample’s educational status indicated that the majority of participants were college graduates (n=102; 52.6%), followed by 1-3 years of college or business school (n=42; 21.6%), high school graduates (n=25; 12.9%), professional degrees (n=20; 10.3%), and 10-11 years of schooling (n=5; 2.6%). No participants identified themselves as having less than 10 years of schooling.
To assess the severity of abuse experienced by the current sample, childhood sexual abuse was categorized as either *level 1* abuse (e.g. the experience of being sexually touched or forced to touch others sexually) or *level 2* abuse (e.g. the experience of rape or attempted rape; Myers et al., 2006). The majority of participants experienced *level 2* childhood sexual abuse (*n*=133; 68.6%), followed by *level 1* childhood sexual abuse (*n*=61; 31.4%).

The majority of participants indicated they did not receive treatment for childhood sexual abuse (*n*=119; 61.3%), while 75 participants (38.7%) indicated they had received treatment during childhood or adulthood. Of the 75 participants that reported treatment, 24 indicated they received treatment only during their childhood, while 34 reported they received treatment only in adulthood. Seventeen participants indicated they received treatment in both childhood and adulthood. The types of treatment reported by participants in the current study are described in Table 1. Over 3/4 of participants (79.4%) indicated their abuse had not been reported to legal authorities. The length of time between the onset of abuse and survivors’ abuse disclosures are described in Table 2.
Regarding the participants’ age at the onset of childhood sexual abuse, 11.9% of participants were first abused when they were younger than 6-years-old. Approximately half of participants (47.4%) were 6 to 12-years-old when first abused, and 40.7% of participants were 12 to 17-years-old when the sexual abuse first occurred. Additionally, approximately 1/3 of participants (36.6%) reported being abused over multiple age ranges. In terms of the current sample’s victimization, the

Table 1

*Types of Treatment Reported by Survivors of Childhood Sexual Abuse*

<table>
<thead>
<tr>
<th>Therapy Type</th>
<th>Yes</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF-CBT</td>
<td>57</td>
<td>17</td>
</tr>
<tr>
<td>EMDR</td>
<td>17</td>
<td>18</td>
</tr>
<tr>
<td>CCPT</td>
<td>23</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Individual</td>
<td>67</td>
<td>9</td>
</tr>
<tr>
<td>Group</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>Family</td>
<td>40</td>
<td>12</td>
</tr>
</tbody>
</table>

*Note:* Many participants reported they received multiple treatment types

Table 2

*Length of Time Between Onset of Abuse and Disclosure*

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately</td>
<td>16</td>
</tr>
<tr>
<td>&lt; 1 month after abuse occurred</td>
<td>26</td>
</tr>
<tr>
<td>&lt; 6 months after abuse occurred</td>
<td>7</td>
</tr>
<tr>
<td>&lt; 12 months after abuse occurred</td>
<td>10</td>
</tr>
<tr>
<td>≥12 months after abuse occurred</td>
<td>79</td>
</tr>
<tr>
<td>Did not disclose abuse</td>
<td>56</td>
</tr>
</tbody>
</table>
majority of participants reported they were abused only during their childhood
\((n=146, 73.3\%)\), while 48 participants \((24.7\%)\) reported being revictimized as an
adult.

**Preliminary Analysis**

A correlational matrix was developed in order to determine the relationships
between the PTSD, Depression, Alcohol Abuse, and Experiential Avoidance. In
addition, the correlation table was examined for multiple collinearity to ascertain
suitability of a MANOVA for the main analyses which implies strong correlations
among the dependent variables as a basic assumption (see Table 3). As we expected
based on previous research, all variables were strongly and positively related.

Table 3

*Correlations of Dependent Variables*

<table>
<thead>
<tr>
<th>Measures</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PTSD</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2. Depression</td>
<td>.740*</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>3. Alcohol Abuse</td>
<td>.411*</td>
<td>.375*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>4. Experiential Avoidance</td>
<td>.753*</td>
<td>.718*</td>
<td>.348*</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: * Correlations are significant at the .05 level.
** Correlations are significant at the .01 level.

**Primary Analyses**

**Hypothesis 1.** It was hypothesized that participants who received therapy
specific to their childhood sexual abuse would endorse lower levels of PTSD,
Depression, Alcohol Abuse, and Experiential Avoidance when compared to
participants who did not receive treatment. While we asked participants to only report
their abuse-specific treatment experiences, we cannot be sure that participants did not include any other non-abuse related therapeutic experiences.

A MANOVA examined treatment group as an independent variable (with 2 levels: treatment and no treatment) and PTSD, Depression, Alcohol Abuse, and Experiential Avoidance outcome scores as dependent variables. The one-way MANOVA revealed no significant multivariate main effect of treatment for PTSD, Depression, Alcohol Abuse, or Experiential Avoidance based on participants’ treatment group, $F(4, 189) = .649, p = .628$; Wilk's $\Lambda = 0.986$, partial $\eta^2 = .031$. This finding suggests there is no significant difference between outcome scores based on the participants’ treatment group, and this is reported in Table 4.
Table 4

Differences in Mental Health Outcome Scores by Treatment Group

No Treatment vs. Received Treatment

- Depression
- Alcohol Abuse
- PTSD
- Bipolar Disorder

Error bars 95% CI
Research Question.

Treatment Satisfaction. Of the 75 participants that received treatment, 62 participants reported they were satisfied with their overall treatment experience, while 13 reported they were unsatisfied. Satisfaction scores ranged from 8 to 32 ($M=23.27$, $SD=6.34$). Participants’ overall satisfaction with their treatment experience is reported in Table 5.

Table 5

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>Satisfied</th>
<th>Unsatisfied</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Only</td>
<td>19</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>Adulthood Only</td>
<td>29</td>
<td>5</td>
<td>34</td>
</tr>
<tr>
<td>Both Childhood and Adulthood</td>
<td>14</td>
<td>3</td>
<td>17</td>
</tr>
</tbody>
</table>

Descriptively, 34 participants specifically described their treatment experience as “helpful,” “empowering,” or “positive;” whereas 9 participants described their treatment experience as unhelpful, negative, “cliché,” or “useless.”

Revictimization. Of the current sample, approximately one quarter of participants (24.7%; $n=48$) were revictimized as adults. An independent sample t-test was run comparing the groups of participants who only victimized as children and participants revictimized as adults with the dependent variables of PTSD, Depression, Alcohol Abuse, and Experiential Avoidance. Results indicated that there were significant differences in PTSD, Depression, and Experiential Avoidance
scores between the treatment and non-treatment groups. These findings indicate a relationship between participants who were revictimized as adults and elevated levels of PTSD, Depression, and Experiential Avoidance in adulthood. No statistical significance was found regarding participants’ Alcohol Abuse scores, however there was a trend in the data in the difference between victimization groups with regard to Alcohol Abuse scores ($p = .073$; See Table 6).

Of the 41 participants that received treatment in childhood (i.e. including participants who had treatment in both childhood and adulthood; n=41), approximately 30% (29.3%; n=12) of this sample were revictimized as adults while approximately 70% (70.7%; n=29) of participants were not revictimized in adulthood. Using the sample of participants that received treatment in childhood (n=41), an independent sample t-test was run comparing the groups of participants who were only victimized as children and participants revictimized as adults with the dependent variables of PTSD, Depression, Alcohol Abuse, and Experiential Avoidance. Results indicated a significant difference in PTSD scores between the childhood treatment revictimization groups (See Table 7). These findings indicate that within the childhood treatment group, there is a relationship between adulthood sexual abuse revictimization and an increase in adult PTSD scores.
Results of t-test for PTSD, Depression, Alcohol Abuse, and Experiential Avoidance by Revictimization Group

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Group</th>
<th>95% CI for Mean Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child Victim Only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Depression</td>
<td>17.78</td>
<td>16.22</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>5.63</td>
<td>6.99</td>
</tr>
<tr>
<td>Experiential Avoidance</td>
<td>21.79</td>
<td>10.95</td>
</tr>
</tbody>
</table>

*p < .05.

Table 6
Within the Childhood Treatment Group, Results of t-test for PTSD, Depression, Alcohol Abuse, and Experiential Avoidance by Revictimization Group

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Child Victim Only</th>
<th>Revictimized as Adults</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>PTSD</td>
<td>21.93</td>
<td>18.04</td>
<td>29</td>
<td>35.67</td>
<td>20.18</td>
</tr>
<tr>
<td>Depression</td>
<td>18.83</td>
<td>16.87</td>
<td>29</td>
<td>29.42</td>
<td>20.50</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>5.90</td>
<td>7.83</td>
<td>29</td>
<td>10.92</td>
<td>10.43</td>
</tr>
<tr>
<td>Experiential Avoidance</td>
<td>22.45</td>
<td>11.31</td>
<td>29</td>
<td>26.75</td>
<td>13.01</td>
</tr>
</tbody>
</table>

*p < .05.

Table 7
Abuse Severity. While analysis of abuse severity was initially unplanned at the initiation of the study, post hoc analyses regarding abuse severity were done to further explore the data. A MANOVA examined abuse severity as an independent variable [with 2 levels: level 1 severity abuse (e.g. the experience of being sexually touched or forced to touch others sexually) and level 2 severity abuse (e.g. the experience of rape or attempted rape)] and PTSD, Depression, Alcohol Abuse, and Experiential Avoidance outcome scores as dependent variables. The one-way MANOVA revealed a significant multivariate main effect of abuse severity for PTSD, Depression, and Experiential Avoidance based on participants’ severity group, \( F(4, 189) = 5.20, p = .001; \text{Wilk's } \Lambda = 0.901 \). This finding suggests there is a relationship between significant increases in PTSD, Depression, and Experiential Avoidance symptoms and high severity sexual abuse, and this is reported in Table 8. No statistical significance was found regarding participants’ Alcohol Abuse scores, however there was a trend in the data in the difference between abuse severity groups with regard to Alcohol Abuse scores (\( p = .063 \)).
Table 8

Differences in Mental Health Outcome Scores by Abuse Severity Group

Outcome Mean Score

High Severity Abuse

Low Severity Abuse

Error bars 95% CI
Participants’ Description of Treatment Experience

In response to the open-ended question regarding participants’ overall treatment experience, this author and an expert in the field reviewed all responses provided by the 75 participants that reported they had therapy. This treatment group consisted of all participants who received treatment during either childhood or adulthood. These responses were reviewed to find themes related to the participants’ experience of psychotherapy specific to their childhood sexual abuse.

Of those who reported receiving treatment for childhood sexual abuse (n=75), 6 participants described long-term treatment (i.e. lasting 12 months or longer), including participants who reported receiving treatment “for over 10 years,” “a few years,” and “ongoing for many many years.”

Participants were asked to report the type of treatment in which they were involved, and 10 participants reported they received treatment through multiple formats and/or models (e.g., family therapy and individual therapy, EMDR and TR-CBT). While participants had rated their treatment earlier in the survey, in written commentary they specifically mentioned Family Systems Therapy (n=1), Behavioral Therapy (n=1), Cognitive Therapy (n=1), and Dialectical Behavior Therapy (n=1). One participant described her experience with family therapy as “very successful to allow me to realize I did nothing wrong.” One participant reported individual, family, and play therapy, and described play therapy as “the most comfortable.” Many participants also discussed the caregivers involved in family therapy; mothers were the most commonly reported family member involved in family therapy.
Thirteen participants reported they “just talked” during their treatment, 3 participants reported “traditional talk therapy,” and 1 participant reported “simply talking it out.” One participant described her “traditional talk therapy” as “we talked about what happened in my past extensively and found ways to deal with the pain and memories.” Three participants specifically reported drawing or playing games during treatment (e.g., “rock em sock em robots” and “Frogger”), and 2 participants identified both play and talk incorporated into their treatment experience. One participant described the combination of talk and play in treatment as “during the therapy I talked to the psychologist about my experience… when I was little [the] psychologist used many games to learn more about me.”

Eight participants reported they were diagnosed with additional mental health disorders (e.g., Generalized Anxiety Disorder, agoraphobia, Borderline Personality Disorder, “anger issues”) while in treatment specific to their childhood sexual abuse; one of these participants directly linked her mental health diagnosis (i.e. panic attacks) with her history of childhood sexual abuse.

Although no clear themes were identified across all participant descriptions, common topics appeared, including participants’ struggle to cognitively distance themselves from their history of abuse. Also present in many descriptions were the participants’ feelings of vulnerability, both regarding their memories of sexual abuse and discussing their abuse with others. Self-blame was a common topic; participants
reported an influential part of their treatment was “learning not to blame myself” and “working through the events and figuring out how to not blame myself.”
Discussion

Summary of Findings

This study has assessed the long-term effects of childhood sexual abuse, including an assessment of how therapy for the abuse was related to long-term outcomes. While some survivors of abuse do not report long-term problems associated with the abuse, it is clear that many survivors of abuse report a number of psychological problems associated with that abuse. Through literature review, the most common symptoms associated with sexual abuse were identified (e.g., Posttraumatic Stress Disorder, Depression, and Alcohol Abuse), as well as Experiential Avoidance as a mediator of long-term psychological outcomes (Trask, Walsh & DiLillo, 2011; Horwitz et al., 2001; McCauley et al., 1997). In order to identify the most commonly used treatments in treating abuse, the literature was reviewed and several treatments were chosen for inclusion (e.g. Trauma Focused – Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing therapy, and Child Centered Play Therapy; Gillies, Taylor, Gray, O’Brien, & D’Abrew, 2013; Reyes & Asbrand, 2005). As such, the connections between psychological treatment for childhood sexual abuse and adult abuse survivors’ Posttraumatic Stress Disorder, Depression, Alcohol Abuse, and Experiential Avoidance scores were reviewed. In this study, it was hypothesized that participants who received therapy specific to their childhood sexual abuse would endorse lower
levels of PTSD, Depression, Alcohol Abuse, and Experiential Avoidance when compared to participants who did not receive treatment.

Participants for the current study were recruited through MTurk, and after screening participants based on the inclusion criteria, 194 met criteria. The sample raged in age from 20 to 66 years old and the majority of participants were Caucasian and college graduates. Approximately half of participants were 6 to 12-years-old when first abused. The majority of participants experienced childhood rape or attempted rape (68.6%) and did not receive treatment for childhood sexual abuse (61.3%; Myers et al., 2006). Over 3/4 of participants (79.4%) indicated that their abuse was not reported to legal authorities. The majority of participants identified TF-CBT and Individual therapy as the treatment model/format they experienced, though many participants indicated they received multiple treatment models and formats. Approximately 70% of participants who received treatment as a child were not sexually revictimized in adulthood.

As expected, our dependent variables were correlated (e.g., PTSD, Depression, Alcohol Abuse, and Experiential Avoidance). As Experiential Avoidance is thought to be a mechanism related to developing trauma symptoms, it is not surprising that Experiential Avoidance is highly correlated to the symptoms assessed in the sample of childhood sexual abuse survivors.

The data from this survey did not detect that those participants who had therapy for their abuse were lower in symptomology for PTSD, Depression,
Alcohol Abuse, or Experiential Avoidance. Our data did not indicate a difference in outcome scores between participants who received treatment and those who did not receive treatment. These findings do not support our hypothesis that participants who received therapy specific to their childhood sexual abuse would endorse lower levels of PTSD, Depression, Alcohol Abuse, and Experiential Avoidance when compared to participants who did not receive treatment. However, this finding is limited by both the methodology of this study and the length of time since participants’ received treatment.

Regarding the impact of sexual abuse revictimization, current findings indicate a relationship between participants who were revictimized as adults and elevated levels of PTSD, Depression, and Experiential Avoidance in adulthood. Additionally, within the sample of participants who received trauma-specific therapy during their childhoods, this study’s findings suggest a relationship between participants who were revictimized as adults and higher levels of adulthood PTSD scores (without significant differences between victimization groups regarding Depression, Alcohol Abuse or Experiential Avoidance scores). It is the interpretation of this author that a recency and/or severity effect (e.g., the potential recency/severity of the participants’ revictimization) may be confounding the relationship of higher PTSD scores and participants who received childhood treatment and were revictimized as adults. Further exploration of the effect of childhood sexual abuse
treatment on potential revictimization and mental health symptomology in adulthood is an important and needed research area.

The participants with the most severe abuse histories also had significantly higher scores of PTSD, Depression, and Experiential Avoidance in adulthood. This finding is consistent with similar research (Beitchman et al., 1992). Given our data, and findings from many other studies on long-term problems associated with sexual abuse, it is also important to consider this issue in treatment for childhood sexual abuse survivors.

Although unsolicited by the researchers, the majority of participants reported additional details regarding their childhood sexual abuse (e.g., relationship to perpetrator, environment where abuse occurred, societal/familial response to abuse, etc.). There are many possible interpretations regarding the participants’ general eagerness to disclose personal and painful memories, including the possible therapeutic experience of simple self-disclosure. The majority of participants in the current study reported they did not receive therapy related to their sexual abuse. The urge to share/process their stories, combined with the anonymity provided by the online survey, allowed participants an opportunity to share their stories and release emotions. As researchers have identified a link between repeatedly disclosing stressful/traumatic experiences and reduced psychological symptoms, it is possible that this self-disclosure in itself may have been a therapeutic experience for some participants. (Pérez, Peñate, Bethencourt, & Fumero, 2017). As such, future online
public health or psychological interventions may be designed with spaces for individuals to anonymously disclose stressful or traumatic experiences, therefore increasing the availability and opportunity of individuals to receive positive therapeutic effects even without traditional psychotherapy.

**Limitations and Future Directions**

As this study is retrospective, there cannot be any direct assumptions about causality between participants’ treatment satisfaction and treatment outcomes. Causality cannot be determined in a retrospective cross-sectional study because of the many possible intervening variables outside the control of this study. In future research, it would be beneficial to conduct longitudinal studies of mental health outcomes of adult survivors of abuse, so that causal assumptions can be made.

A limitation of this study was the difficulty in treatment identification types, as we relied on participants’ self-report and memories. While we asked participants to only report their abuse-specific treatment experiences, we cannot be sure that participants did not include any other non-abuse related therapeutic experiences.

In future research, it is also important to examine the experiences of men with a history of childhood sexual abuse. Also, future research should include semi-structured, in-person interviews with the participants, as this may draw more reliable data than relying exclusively on self-report surveys. Additionally, semi-structured, in-person interviews would likely reveal more information regarding overall themes
regarding participants treatment/abuse experience, as the open-ended questions used in this online survey did not identify clear overall themes.

Conclusion

Despite the increasing availability of therapy for childhood sexual abuse, the majority of the current sample reported they did not receive therapy. These findings point to an important, 3-part public health crisis; a need to increase the availability of treatment, to let the public know about treatment availability, and to remove barriers to treatment accessibility. In the current study, approximately 25% of the participants were revictimized in adulthood and the revictimized participants reported higher levels of mental health symptoms. The primary goals of childhood therapy for sexual abuse survivors is often to prevent the development of later symptoms and to reduce the rates of revictimization. However, current research has not yet provided solid evidence for the efficacy of childhood treatment as a protective factor against revictimization. Additionally, there is a need for long-term follow-up with adult survivors of childhood sexual abuse. These longitudinal data collections would help researchers better identify and understand any causal relationship between childhood sexual trauma, trauma-specific childhood/adulthood treatment, and the absence or development of trauma-related psychological symptomology in adulthood. It is the hope that through these efforts, childhood sexual abuse survivors of all ages will receive timely and research-based treatment or support.
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Appendix A

Informed Consent

Please read this consent document carefully before you decide to participate in the study.

Purpose of Study:
You are being asked to participate in a study that will examine the impacts a history of childhood sexual abuse and therapy on psychological outcomes in adults.

Procedures:
The survey will take approximately 30 minutes. The goal of this research is to determine the effects treatment of childhood sexual abuse during childhood, adult depression, adult posttraumatic stress, and adult substance use. You will be asked to complete a series of questionnaires that asks questions about demographic information (i.e., age, gender, ethnicity), questions about your childhood experiences, your current psychological well-being, and current substance use.

Potential Risks of Participating:
Your participation will not subject you to any foreseeable risks other than possible mild discomfort when answering survey questions. The National Sexual Assault Hotline at 800.656.HOPE (4673) is a resource you can call if you do experience discomfort and would like to talk to a trained support specialist.

Potential Benefits of Participating:
It is possible that there may be no direct benefits to you during or following the completion of this study. However, the results of this study may provide useful information about adult survivors of childhood sexual abuse.

Compensation:
Following completion of the survey, you will receive $2.00 in your MTurk account.

Confidentiality:
Your name will not be recorded. Responses will be given an anonymous participant identification number, and no identifying information will be recorded with your responses. Thus, all information will be kept confidential.

Voluntary Participation:
Your participation in this study is voluntary. There is no penalty for not participating.

Right to withdraw from study:
You have the right to withdraw from the study at any time without consequence.
Whom to contact if you have questions about the study:
Dr. Victoria Follette
150 W. University Blvd.
Melbourne FL 32901
Email: vfollette@fit.edu Phone: 321.674.8105

Whom to contact about your rights as a research participant in the study:
Dr. Lisa Steelman, IRB chairperson
150 W. University Blvd.
Melbourne, FL 32901
Email: lsteelma@fit.edu Phone: 321.674.8104

Agreement:
Pressing the accept button below indicates that you agree to participate in this research and that:
1) You have read and understand the information provided above;
2) You are over 18 years old; 3) You understand that participation is voluntary and that refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled; and 4) You understand that you are free to discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

1. Yes, I consent
2. No, I do not consent
Appendix B

Recruitment Description

Dear Participant,

We are specifically seeking women, 18 years of age and older, who have experienced childhood sexual abuse. You must reside in the United States and be fluent in English. We would like to extend an invitation to you to participate in this current study. The questionnaires used in this study are brief and this entire survey takes approximately 30 minutes to complete. We are aware of time constraints in your daily schedule but ask that you consider taking the 30 minutes needed to participate. As an additional incentive, you will receive $2.00 in your M-TURK account following your completion of the study. Thank you in advance for your time and participation in this study.

Sincerely,

Victoria Follette, Ph.D.; Principal Investigator; Florida Institute of Technology

Tarila Abbott, M.S.; Co-Investigator, Florida Institute of Technology
Appendix C

Eligibility Screen

Read the questions through carefully. If you are unsure of the answer, fill in the answer which you feel is most applicable to you.

1. Are you 18-years-old or older?
   - Yes
   - No
     - If no, participant was redirected to end-screen

2. Are you a female?
   - Yes
   - No
     - If no, participant was redirected to end-screen

3. Do you have a history of childhood sexual abuse?
   - Yes
   - No
     - If no, participant was redirected to end-screen

4. Did you read and answer the above questions to the best of your ability?
   - Yes
   - No
     - If no, the participant was re-administered the question.
Appendix D

Demographic Questionnaire

Please fill out the following questions about yourself:

1. What is your gender?
   - Female
   - Other Specify (_____

2. How old are you, in years? ______

3. What is your race/ethnicity?
   - White
   - Black
   - Hispanic
   - Asian
   - Pacific Islander
   - Native American
   - Biracial
   - Other Specify (____

4. Please select the description that most applies to you.
   EDUCATIONAL SCALE
   - Professional (Master's degree, doctorate or professional degree).
   - College graduate.
   - 1-3 years college or business school.
   - High school graduate.
   - 10-11 years of schooling.
   - 7-9 years of schooling.
   - Under 7 years of schooling.
Appendix E
Sexual and Physical Abuse Questionnaire (SPAQ)
(Kooiman, Ouwehand, & ter Kuile, 2002)

Read the questions through carefully. If you are unsure of the answer, fill in the answer which you feel is most applicable to you.

Example: Have you ever fallen off a bicycle?

- No
- Yes, if yes, how old were you when it first happened?
  - Less than 6 years old
  - 6 years old or older, but less than 12 years old
  - 12 years old or older, but less than 18 years
  - 18 years old or older

This example shows that the person had already fallen from a bicycle before she was 6 years old. This could have happened just once, or it could also have happened more often, and it could still have happened after her 6th year of life.

1. Has anyone ever touched your sex organs in a sexual manner and against your will?

- No
- Yes, if yes, how old were you when it first happened?
  - Less than 6 years old
  - 6 years old or older, but less than 12 years old
  - 12 years old or older, but less than 18 years
  - 18 years old or older

2. Has anyone ever forced you to touch his or her sex organs in a sexual manner and against your will?

- No
- Yes, if yes, how old were you when it first happened?
  - Less than 6 years old
  - 6 years old or older, but less than 12 years old
  - 12 years old or older, but less than 18 years
  - 18 years old or older
3. Has anyone ever tried to force you to have sexual intercourse against your will?
   - No
   - Yes, if yes, how old were you when it first happened?
     - Less than 6 years old
     - 6 years old or older, but less than 12 years old
     - 12 years old or older, but less than 18 years
     - 18 years old or older

4. Has anyone ever had sexual intercourse with you against your will?
   - No
   - Yes, if yes, how old were you when it first happened?
     - Less than 6 years old
     - 6 years old or older, but less than 12 years old
     - 12 years old or older, but less than 18 years
     - 18 years old or older

5. Have you ever had another unwanted or threatening sexual experience that is not named above?
   - No
   - Yes, if yes, can you identify what it involved?
     - Date rape
     - Exposure to pornography
     - Unwanted exposure of others’ sexual organs
     - Sexual harassment
     - Other (please describe)
   - And, how old were you when it first happened?
     - Less than 6 years old
     - 6 years old or older, but less than 12 years old
     - 12 years old or older, but less than 18 years
     - 18 years old or older

6. If you have had one of the above experience, have you ever discussed it with anyone?
   - No
   - Yes, if yes, with whom?
     - With a relative
     - With boyfriend(s) or girlfriend(s)
With non-medical workers (for example: teacher, church elder, minister, priest)
With medical workers (for example: GP, specialist, social worker, psychologist)

7. If you told someone about your abuse, how long after the abuse occurred did you tell them?

- I did not tell anyone/Not Applicable
- I disclosed the abuse
  - Immediately
  - Less than 1 month after abuse occurred
  - Less than 6 months after abuse occurred
  - Less than 1 year after abuse occurred
  - 1 year or longer after abuse occurred

8. Was your abuse reported the legal authorities (example: police)?

- No
- Yes

9. Have you ever intentionally been treated by someone in such a way that you suffered physical injury (for example: beaten, stamped on, kicked, or pushed)? (Physical injury means, for example: bruises, welts, broken bones, broken teeth, cuts, burns, and loss of consciousness).

- No
- Yes, if yes, how old were you when it first happened?
  - Less than 6 years old
  - 6 years old or older, but less than 12 years old
  - 12 years old or older, but less than 18 years
  - 18 years old or older
10. Have you experienced something that is not listed above and which you have perceived as violent?

- No
- Yes, if yes, can describe it briefly? And, how old were you when it first happened?
  - Less than 6 years old
  - 6 years old or older, but less than 12 years old
  - 12 years old or older, but less than 18 years
  - 18 years old or older

11. If you have ever experienced one of these things (question 6 and 7), have you ever discussed it with anyone?

- No
- Yes, if yes, with whom?
  - With a relative
  - With boyfriend(s) or girlfriend(s)
  - With non-medical workers (for example: teacher, church elder, minister, priest)
  - With medical workers (for example: GP, specialist, social worker, psychologist)
Appendix F

**Center for Epidemiologic Studies Depression Scale - Revised**

(Eaton et al., 2004)

Instructions: Below is a list of statements dealing with your general feelings about yourself. For each statement, please indicate how often you have felt this way recently by selecting the option you most agree with.

<table>
<thead>
<tr>
<th>No.</th>
<th>Response</th>
<th>Not at all or less than 1 day last week (0)</th>
<th>One or two days last week (1)</th>
<th>Three to four days last week (2)</th>
<th>Five to seven days last week (3)</th>
<th>Nearly every day for two weeks (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My appetite was poor.</td>
<td></td>
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<tr>
<td>2.</td>
<td>I could not shake off the blues.</td>
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<td>3.</td>
<td>I had trouble keeping my mind on what I was doing.</td>
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<td>4.</td>
<td>I felt depressed.</td>
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<td>5.</td>
<td>My sleep was restless.</td>
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<td>6.</td>
<td>I felt sad.</td>
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<td>7.</td>
<td>I could not get going.</td>
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<td>8.</td>
<td>Nothing made me happy.</td>
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<td>9.</td>
<td>I felt like a bad person.</td>
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<td>10.</td>
<td>I lost interest in my usual activities.</td>
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<td>11.</td>
<td>I slept much more than usual.</td>
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<td>12.</td>
<td>I felt like I was moving too slowly.</td>
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<td>13.</td>
<td>I felt fidgety.</td>
<td></td>
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<td>14.</td>
<td>I wished I were dead.</td>
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<td>15.</td>
<td>I wanted to hurt myself.</td>
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<td>16.</td>
<td>I was tired all the time.</td>
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<td>17.</td>
<td>I did not like myself.</td>
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<td>18.</td>
<td>I lost a lot of weight without trying to.</td>
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<td>19.</td>
<td>I had a lot of trouble getting to sleep.</td>
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<td>20.</td>
<td>I could not focus on the important things.</td>
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Appendix G

**Posttraumatic Stress Disorder Checklist- for the DSM 5 (PCL-5)**

(Blevins et al., 2015)

Instructions: Considering your history of childhood sexual abuse, below is a list of problems that people sometimes have in response to childhood abuse. Please reach each problem carefully, then circle one to the numbers to indicate how much you have been bothered by that problem in the past month.

- If it bothered you *not at all*, circle 0.
- If it bothered you *a little bit*, circle 1.
- If it bothered you *moderately*, circle 2.
- If it bothered you *quite a bit*, circle 3.
- If it bothered you *extremely*, circle 4.

<table>
<thead>
<tr>
<th>No.</th>
<th>Response</th>
<th>(0)</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Repeated, disturbing, and unwanted memories of the stressful experience?</td>
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<td>2.</td>
<td>Repeated, disturbing dreams of the stressful experience?</td>
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<td>3.</td>
<td>Suddenly feeling or acting as if a stressful experience were actually happening again (as if you were actually back there reliving it)?</td>
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<td>4.</td>
<td>Feeling very upset when something reminded you of the stressful experience?</td>
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<td>5.</td>
<td>Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?</td>
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<td>6.</td>
<td>Avoiding memories, thoughts, or feelings related to the stressful experience?</td>
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<td>7.</td>
<td>Avoiding external reminders of the stressful experience (for example, people, places,</td>
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<td></td>
<td>conversations, activities, objects, or situations?</td>
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<td>8.</td>
<td>Trouble remembering important parts of the stressful experience?</td>
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<td>9.</td>
<td>Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?</td>
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<td>10.</td>
<td>Blaming yourself or someone else for the stressful experience or what happened after it?</td>
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<td>11.</td>
<td>Having strong negative feelings such as fear, horror, anger, guilt, or shame?</td>
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<td>12.</td>
<td>Loss of interest in activities that you used to enjoy?</td>
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<td>13.</td>
<td>Feeling distant or cut off from other people?</td>
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<td>14.</td>
<td>Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?</td>
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<td>15.</td>
<td>Irritable behavior, angry outbursts, or acting aggressively?</td>
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<tr>
<td>16.</td>
<td>Taking too many risks or doing things that could cause you harm?</td>
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<tr>
<td>17.</td>
<td>Being “superalert” or watchful or on guard?</td>
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<td>18.</td>
<td>Feeling jumpy or easily startled?</td>
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<tr>
<td><strong>19.</strong></td>
<td>Having difficulty concentrating?</td>
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<tr>
<td><strong>20.</strong></td>
<td>Trouble falling or staying asleep?</td>
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<tr>
<td><strong>21.</strong></td>
<td>Please leave this response blank.</td>
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</tbody>
</table>
Appendix H

Alcohol Use Disorder Identification Test
(Yee, Adlan, Rashid, Habil, & Kamali, 2015)

Instructions: Below is a list of statements dealing with your general drinking behaviors during the past 1 year. Select the box that best describes your answer to each question.

<table>
<thead>
<tr>
<th>No.</th>
<th>Response</th>
<th>(0)</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How often do you have a drink containing alcohol?</td>
<td>Never</td>
<td>Monthly or less</td>
<td>2-4 times a month</td>
<td>2-3 times a week</td>
<td>4 or more times a week</td>
</tr>
<tr>
<td>2.</td>
<td>How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>1 or 2</td>
<td>3 or 4</td>
<td>5 or 6</td>
<td>7 to 9</td>
<td>10 or more</td>
</tr>
<tr>
<td>3.</td>
<td>How often do you have six or more drinks on one occasion?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>4.</td>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>5.</td>
<td>How often during the last year have you failed to do what was normally expected from you because of drinking?</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td>6.</td>
<td>How often during the last year have you needed a first drink in the morning to get yourself going after</td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
</tr>
<tr>
<td></td>
<td>a heavy drinking session?</td>
<td>7. How often during the last year did you have feelings of guilt or remorse after drinking?</td>
<td>8. How often during the last year have you been unable to remember what happened the night before because you had had been drinking?</td>
<td>9. Have you or someone else been injured as a result of your drinking?</td>
<td>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</td>
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<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>Less than monthly</td>
<td>Monthly</td>
<td>Weekly</td>
<td>Daily or almost daily</td>
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<tr>
<td></td>
<td>No</td>
<td>Yes, but not in the last year</td>
<td>Yes, during the last year</td>
<td>Yes, during the last year</td>
<td>Yes, during the last year</td>
<td></td>
</tr>
</tbody>
</table>
Appendix I

Acceptance and Action Questionnaire-II
(Bond et al., 2011)

Instructions: Below is a list of statements. Please rate how true each statement is for you by circling a number next to it. Use the scale below to make your choice.

   If it is never true, circle 1.
   If it is very seldom true, circle 2.
   If it is seldom true, circle 3.
   If it is sometimes true, circle 4.
   If it is frequently true, circle 5.
   If it is almost always true, circle 6.
   If it is always true, circle 7.

<table>
<thead>
<tr>
<th>No.</th>
<th>Response</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
<th>(7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>My painful experiences and memories make it difficult for me to live a</td>
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<td></td>
<td>life that I would value.</td>
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<tr>
<td>2.</td>
<td>I’m afraid of my feelings.</td>
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<td>3.</td>
<td>I worry about not being able to control my worries and feelings.</td>
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<tr>
<td>4.</td>
<td>My painful memories prevent me from having a fulfilling life.</td>
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<td></td>
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<td>5.</td>
<td>Emotions cause problems in my life.</td>
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<td>6.</td>
<td>It seems like most people are handling their lives better than I am.</td>
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<td>7.</td>
<td>Worries get in the way of my success.</td>
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</tbody>
</table>
Appendix J

Common & Efficacious Treatments of Childhood Sexual Abuse and Posttraumatic Stress Disorder

Following are the additional Childhood Sexual Abuse questions developed by evaluator.

Please fill out the following about yourself.
1. As a child, did you ever receive therapy related to the abuse? Yes/No/I don’t know
   1a. If yes, how long did treatment last?
       Less than 10 sessions
       10 – 20 sessions
       20+ sessions

2. As an adult, did you ever receive therapy related to the abuse? Yes/No/I don’t know
   2a. If yes, how long did treatment last?
       Less than 10 sessions
       10 – 20 sessions
       20+ sessions

Instructions: There are many different kinds of treatment for survivors of childhood sexual abuse. Below is a list of common therapy types that are used to treat survivors of childhood sexual abuse. Please read each description carefully, then indicate if you recognize the treatment from your experience.

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Layperson Treatment Description</th>
<th>Yes</th>
<th>No</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Trauma-Focused</td>
<td>This treatment focuses on a child’s strengths and includes learning self-calming skills,</td>
<td></td>
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<tr>
<td>Cognitive Behavioral Therapy (TF-CBT)</td>
<td>talking about the traumatic experience, and sharing your trauma story with a trusted adult. This therapy treats the child’s upsetting emotions, thoughts, and actions that resulted from abuse.</td>
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<tr>
<td>2. Eye Movement Desensitization and Reprocessing (EMDR)</td>
<td>This treatment focuses on the child’s past trauma memories, current problems, and future goals. This treatment helps children rethink and replace negative thoughts about themselves. This therapy uses eye movements, hand-tapping, and listening to noisy sounds. Commonly, children alternate their focus between relaxation and bad memories while watching a flickering</td>
<td></td>
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</tbody>
</table>
3. **Child Centered Play Therapy**

   This treatment focuses on allowing the child to express herself through playing. This therapy includes some psychological teaching, free-play time, and playing with the therapist. This therapy uses many toys including, art supplies, dolls, sandboxes, puppets, and games.

4. **Other/Unknown**

   Please describe.

---

Instructions: There are many different ways to administer treatment for survivors of childhood sexual abuse. Below is a list of common therapy administrations that are used to treat survivors of childhood sexual abuse. Please reach each description carefully, then indicate if you recognize the treatment from your experience.

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Layperson Treatment Description</th>
<th>Yes</th>
<th>No</th>
<th>I Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>Individual</td>
<td>Client has one-on-one treatment interactions with her therapist.</td>
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<tr>
<td></td>
<td>Therapy</td>
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<tr>
<td></td>
<td>Group Therapy</td>
<td>Treatment is a group setting, consisting of therapist, child, and at least one non-relative member.</td>
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<tr>
<td>7.</td>
<td>Family Therapy</td>
<td>Treatment is a group setting, consisting of therapist, child, and at least one family member.</td>
<td></td>
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</tbody>
</table>

8. Please comment on your overall treatment type and experience:
## Appendix K

### Client Satisfaction Questionnaire (CSQ-8)

(Attiksson, & Zwick, 1982)

Instructions: Below is a list of statements dealing with your general feelings about your past therapy treatment.

- If you are **highly satisfied**, circle 4.
- If you are **mostly satisfied**, circle 3.
- If you are **somewhat satisfied**, circle 2.
- If you are **unsatisfied**, circle 1.

<table>
<thead>
<tr>
<th>No.</th>
<th>Response</th>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>How would you rate the quality of therapy you received?</td>
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<tr>
<td>2.</td>
<td>Did you get the kind of service you wanted?</td>
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<td>3.</td>
<td>To what extent did the therapy meet your needs?</td>
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<td>4.</td>
<td>How satisfied are you with the amount of help you received?</td>
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<td>5.</td>
<td>Did what you received help you to deal more effectively with your problems?</td>
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<tr>
<td>6.</td>
<td>If you were to seek help again, would you seek the same therapy program?</td>
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<tr>
<td>7.</td>
<td>If a friend were in need of a similar help, would you recommend the same therapy program?</td>
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<td>8.</td>
<td>In an overall sense, do you think your therapy was helpful?</td>
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<td></td>
<td>Are there any additional comments that you would like to make about this study? Please comment below:</td>
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</tbody>
</table>