

Differences in Trauma Symptoms and Family Functioning in Intra- and Extrafamilial Sexually Abused Adolescents

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This study investigated to what extent abuse-related symptoms and family functioning are related to intra- or extrafamilial sexual abuse. One hundred adolescents (12 to 18 years old) were recruited shortly after disclosure of the abuse. Information from the participants was obtained through self-report questionnaires and a semistructured interview. Fifty-three percent of the adolescents reported clinically significant symptoms. Data did not support the idea that intrafamilial sexually abused adolescents report more symptoms than extrafamilial sexually abused adolescents. Type of abuse did not account for the differences and variety of reported symptoms or for differences in family functioning. Family functioning—in particular, lack of cohesion—was an independent contributor to internalizing trauma-related problems.

Keywords: *intrafamilial; extrafamilial; sexual abuse; adolescents*

There is an increasing recognition that sexually abused adolescents show a heterogeneity of consequences (Bennett, Hughes, & Luke, 2000; Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003). Anxiety, depression, dissociative

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complaints, posttraumatic stress disorder (PTSD), anger, delinquency, and sexual problems are some of the most reported symptoms in these adolescents (Kendall-Tackett, Williams, & Finkelhor, 1993). Even though many sexually abused adolescents show trauma-specific symptoms, there also is a substantial group of adolescents (between 21% and 36%) that seem to be asymptomatic (Kendall-Tackett et al., 1993). One factor that may account for the diversity of symptoms is the type of victimization: victimization can be intrafamilial (perpetrator is a family member, e.g., father, stepfather, uncle, grandparent) or extrafamilial (perpetrator is a person outside the family, e.g., friend, teacher, stranger) (Fisher & McDonald, 1998). In their study with 92 sexually abused children and adolescents, McLeer, Deblinger, Atkins, Foa, and Ralphe (1988) found that 54%, 42%, and 10% met criteria for PTSD after they were abused respectively by natural fathers, trusted adults, and strangers. Not only the relationship of the abuser to the child but also the functioning of the family can contribute to symptom variety. Considerable evidence indicates that a cohesive, supportive family environment may serve as a buffer against the negative effect of sexual abuse (Ray & Jackson, 1997). Until now, little research focused on family functioning in families with an extrafamilial sexually abused adolescent. The aim of this study was to look at differences in trauma-specific symptoms and family functioning in intra- and extrafamilial sexually abused adolescents.

It has often been taken for granted that the effect of sexual abuse is more severe when the perpetrator is the father or a close family member (Browne & Finkelhor, 1986; Maynes & Feinauer, 1994). The fact that the majority of the studies have been concerned with intrafamilial abuse, and particularly with sexual activities between (step)fathers and daughters, may have confirmed the idea that intrafamilial abuse is more severe than extrafamilial abuse (Ray, Jackson, & Townsley, 1991). Several studies provide evidence that abuse by a family member, contrarily to a stranger, leads to long-term negative consequences and high levels of distress (Faust, Runyon, & Kenny, 1995; Wyatt & Newcomb, 1991). McLeer et al. (1988) found that 31 youngsters who were sexually abused by their fathers had a significantly higher frequency of PTSD symptoms than children abused by strangers, by older children, or by other adults. A possible explanation is that abuse by a relative often implies more frequent and longer-lasting abuse, which may result in more severe psychopathology (Beitchman et al., 1992; Bennett et al., 2000; DiLillo, Long, & Russell, 1994). Yet, other studies point to the severe effect of an extrafamilial perpetrator (Grosz, Kempe, & Kelly, 1999; Lucenko, Gold, & Cott, 2000). Feinauer (1989) found that victims abused by an extrafamilial perpetrator, compared to those abused by family members, reported higher levels of

symptomatology. Browne and Finkelhor (1986), as well as Gregory-Bills and Rhodeback (1995), found that young women abused by an extrafamilial perpetrator reported more extreme fear than women abused by a family member.

Because abuse-related symptoms cannot unequivocally be related to the perpetrator's relationship with the victim, demographic family variables and the functioning of the family can further clarify the severity of symptoms. Living with a single parent (which often causes stress due to a single income) or having a stepfather or an absent mother (as a result of work, depression, or drug abuse) are known to be potential risk factors that make families more vulnerable to abuse (Fisher & McDonald, 1998; Koverola, Proulx, Battle, & Hanna, 1996). Faust and colleagues (1995) found that certain demographic variables influence the victim's susceptibility to trauma-related psychopathology. In addition, the functioning of the family after the abuse has also been seen as an important variable in explaining the variable effects of sexual abuse. Long and Jackson (1994) found that adult victims who have been sexually abused, compared to a group of randomly selected nonvictims, reported more disorganized and less support-oriented family functioning. Compared to nonclinical groups who did not report sexual abuse, specific types of family dysfunction—such as higher familial disorganization, less cohesion, poor delineation of family roles, lower expressiveness, more conflict, and rigid control—are more frequently reported by intra- or extrafamilial sexually abused victims (Faust, Kenny, & Runyon, 1997; Long & Jackson, 1994; Ray & Jackson, 1997). Family functioning associated with intrafamilial sexual abuse has been studied much more than those associated with extrafamilial sexual abuse. Overall, incest families have been characterized as being chaotic, socially isolated, and exhibiting vague generational and role boundaries (Barnett, Miller-Perrin, & Perrin, 1997; Will, 1983). However, Ray and colleagues (1991) argued that intrafamilial victim families were not functioning significantly worse than extrafamilial victim families.

The purpose of this study was to investigate to what extent abuse-related symptoms and family functioning are related to intra- or extrafamilial sexual abuse. The objectives of this study were (a) to explore the variability of trauma-related symptoms in sexually abused adolescents, (b) to examine differences in abuse-related symptoms between intra- and extrafamilial abused adolescents, (c) to examine differences in family functioning between intra- and extrafamilial abused adolescents, and (d) to investigate whether characteristics of family functioning can be predictive for trauma-related symptoms.

METHOD

Participants

One hundred nine sexually abused adolescents participated in the study. Data from 100 adolescents were analyzed. Data from nine participants were excluded because the validity scales of the Trauma Symptom Checklist (see Briere, 1996) indicated that these adolescents had overresponded to the symptom items. The age of the adolescents varied between 11 and 18 years ($M = 14.34$, $SD = 1.82$). Fifty percent of the adolescents were between 11 and 14 years old, and the other 50% ranged in age from 15 to 18 years. Abusive experiences in the final test group were diverse: 63% of the adolescents reported intrafamilial sexual abuse, and 37% reported extrafamilial sexual abuse. The final group was 87% girls (Intrafamilial: $N = 61$; Extrafamilial: $N = 26$) and 13% boys (Intrafamilial: $N = 2$; Extrafamilial: $N = 11$). These data are comparable to official estimates and self-report surveys that indicate that the majority of child sexual abuse victims are female and that female compared to male adolescents are more often the victims of intrafamilial abuse (Barnett et al., 1997; Fisher & McDonald, 1998).

In the intrafamilial abused group, all perpetrators were family members, specifically the father (27%), the stepfather (19%), the brother (6%), the grandfather (13%), an uncle (16%), a nephew (10%), or another family member (9%). The offender in the extrafamilial group concerned an acquaintance (97%) or a stranger (3%). The reported acquaintances were a friend of the family (34%), a teacher (20%), a neighbor (11%), the father of a friend (11%), a friend of the adolescent (6%), the babysitter (1%), the general practitioner (1%), or a priest (1%). Five adolescents reported both intra- and extrafamilial abuse. These participants were divided in one of the two groups according to what they reported to be the most traumatic experience, the intra- or the extrafamilial abuse.

Adolescents were exposed to a wide variety of sexual behaviors, for example, sexual touching (clothes on) and kissing (Intrafamilial: 70%; Extrafamilial: 70%), breast or genital fondling (Intrafamilial: 75%; Extrafamilial: 60%), attempts at penetration (Intrafamilial: 52%; Extrafamilial: 27%), and penetration (Intrafamilial: 48%; Extrafamilial: 43%).

Recruitment and Procedure

Adolescents were recruited in six Confidential Centers for Child Abuse and Neglect¹ and six Child Guidance Centers. This study was approved by the ethical committees of Ghent University,² each participating Confidential

Center on Child Abuse and Neglect, and each participating Child Guidance Center. A strict recruitment and research protocol was designed according to the current ethical standards of the American Psychological Association. Sexual abuse was broadly defined as “contacts or interactions between a child and an adult whereby the child is being used for the sexual stimulation of the perpetrator or another person” (National Center on Child Abuse and Neglect [NCCAN], 1978, p. 2). The psychiatrist or clinical child psychologist at the center diagnosed the sexual abuse.

Inclusion in the study was based on the following criteria: (a) Only adolescents who for the first time in their life disclosed the sexual abuse to a professional caretaker (in our cases, the child psychiatrist or clinical child psychologist at the participating centers) could participate. (b) This implied that the adolescent had not had previous therapy related to the sexual abuse. (c) In order to be able to diagnose PTSD (American Psychiatric Association, 1994), at least 4 weeks must have elapsed since the first or only abuse incident had occurred, and (d) the adolescent had to be between 11 and 18 years old. Adolescents were excluded when they (a) went to a school for special education (the test battery was made up for children with an average intelligence level), (b) were referred to the center as a sexual offender, or (c) were referred as a sexually abused sibling of a participating adolescent. The rationale for this last exclusion criterion was that the study aimed at focusing on one victim within one family. The participating centers did not report how many out of all adolescents who met the eligibility criteria agreed to participate. Only when the adolescent was emotionally stable enough—that is, not suicidal or not in an extreme crisis situation—the child psychiatrist/clinical child psychologist asked the adolescent to participate. Based on conversations with the responsible therapists at the center, it was estimated that 10% of all adolescents did not participate. Research took place at the center and was carried out by the researcher. The adolescent was asked to fill in a standardized test battery. The guiding therapist was present at the center during the time of research.

Instruments

Sociodemographic characteristics of the family. Based on Draijer (1990), a short questionnaire concerning demographic variables was developed. Questions concerned the adolescent’s age, with whom they live, the type (intra- or extrafamilial) and the sexual behaviors involved in the abuse, relationship to the perpetrator, the parents’ previous psychiatric history, and education of the father as an inference of the socioeconomic status of the family.

So as not to overwhelm the adolescent with direct questions about abuse history, the guiding therapist filled out the instrument. Information was obtained from interviews with the adolescent, where the questionnaire was used as a semistructured interview, and from files on the family.

Family Environment Scale (FES) (Moos, 1974; Dutch version by Jansma & De Coole, 1996). The FES is a measure of the perception of family functioning. This questionnaire has been developed for families with children from 10 years of age and older. It is a 77-item, true-false, self-report instrument that contains seven subscales: Cohesion, Expressiveness, Conflict, Organization, Control, Norms, and Social Orientation. The questionnaire has been used several times in research on sexual trauma in families (see Wolfe & Birt, 1997). Several studies have emphasized the good psychometric qualities of this questionnaire (see Wilson & Kurtz, 1997). Within this research, the reliability of the subscales was sufficient to good. Cronbach alphas were Cohesion = .81, Expressiveness = .61, Conflict = .70, Organization = .72, Control = .42, Norms = .51, and Social Orientation = .49.

Trauma Symptom Checklist for Children (TSCC) (Briere, 1996; Dutch translation by Bal, 1998, unpublished). The TSCC assesses trauma symptoms among adolescents. For this study, the questionnaire was translated into Dutch, with the consent of the original authors, according to a strict translation protocol. On a 4-point scale (*never, sometimes, lots of times, almost all of the time*), the adolescent indicates how often a thought, feeling, or behavior occurs. The scale is made up of 54 items and six subscales: Anxiety, Depression, Posttraumatic Stress, Dissociation, Anger, and Sexual Problems. The questionnaire has two validity scales: One examines the tendency to deny symptoms, and the second the tendency to overreport. The data of nine participants were excluded from statistical analyses based on the strong tendency to overreport. The questionnaire has been frequently used in research on trauma in adolescents (Singer, Anglin, Song, & Lunghofer, 1995). Several studies confirmed the good psychometric qualities of this questionnaire (see Nader, 1997). The reliability of the subscales within this research was good to very good. Cronbach alphas were Anxiety = .84, Depression = .87, Posttraumatic Stress = .87, Dissociation = .79, Anger = .89, and Sexual Problems = .77.

Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-C) (Nader et al., 1996; Dutch translation by Bal, 1998, unpublished). The CAPS-C is a semistructured clinical interview for children and adolescents aged 8 to 18 years. The scale permits the assessment of DSM-IV PTSD diagnosis (17

items) and includes nine additional questions concerning associated symptoms and exposure variables (including symptoms found for more complex PTSD). Questions are answered on a 5-point scale. The scale provides a method for evaluating the frequency and intensity of individual symptoms, the effect of symptoms on social and occupational functioning, degree of improvement since an earlier rating, validity of ratings obtained, and overall intensity of symptoms (Nader, 1997). Psychometric testing has not yet been conducted for this instrument, although it has been used with success in clinical settings with sexually abused children and adolescents (see Nader, 1997).

DATA ANALYSIS

Multivariate analyses of variance were performed to look at differences of symptoms between adolescents abused by an intra- or an extrafamilial perpetrator.

To investigate the relative contribution of family determinants in the prediction of trauma-specific symptoms, we first examined zero-order correlations (see Table 4) between the hypothesized predictors (variables of family functioning) and each of the outcome variables (trauma-specific symptoms). Second, we performed a series of hierarchical multiple regression analyses. Types of abuse and family variables were entered in step one. In the second step, all predictors with significant zero-order correlations ($p < .05$) with the dependent variable were entered using a stepwise inclusion method.

RESULTS

PTSD Diagnosis and Clinical Scores on Trauma-Specific Scales

Fifty percent of the adolescents were diagnosed with PTSD. For the TSCC, Briere (1996) considered T-scores at or above 65 (except for the sexual problem scale T-scores, which have to be at or above 70) as clinically significant. Fifty-three percent of the adolescents had one or more clinical outcomes on a TSCC subscale (another 14% had outcomes in the borderline range). Compared to a nonclinical norm group, 38% had clinical scores for Anxiety, 29% for Depression, 28% for PTS-related symptoms, 20% for Dissociation, 8% for Anger, and 20% for Sexual Problems. Thirty-three percent of the adolescents did not have any clinically significant outcome on the TSCC.

TABLE 1: Differences on Symptoms Between Intra- and Extrafamilial Abuse

	<i>Intrafamilial Sexual Abuse</i>		<i>Extrafamilial Sexual Abuse</i>	
	M	SD	M	SD
Trauma symptoms				
Anxiety	11.79	5.80	11.78	4.81
Depression	12.06	6.20	10.25	4.88
PTS	15.56	6.27	13.83	4.98
Dissociation	10.65	5.73	10.56	5.10
Anger	8.11	5.10	8.00	5.83
Sexual problems	5.57	4.27	6.17	4.10
PTSD diagnosis	27%		23%	

NOTE: PTSD = posttraumatic stress disorder.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Differences on Trauma-Specific Symptoms Between Adolescents Sexually Abused by an Intra- or Extrafamilial Perpetrator

Multivariate analyses of variance did not show pronounced differences between adolescents sexually abused by an intra- or extrafamilial perpetrator concerning trauma-specific symptoms such as Anxiety, Depression, PTS, Dissociation, Anger, or Sexual Problems, $F(6,93) = 1.94, p = .08$. Because the multivariate analyses did approach significance, univariate analyses were conducted. No univariate significant differences were found: Anxiety, $F(1,98) = .00, p = .97$, Depression, $F(1,98) = 2.14, p = .15$, PTS, $F(1,98) = 1.98, p = .16$, Dissociation, $F(1,98) = .00, p = .99$, Anger, $F(1,98) = .02, p = .89$, or Sexual Problems, $F(1,98) = .69, p = .41$. The mean scores are shown in Table 1.

Sociodemographic Characteristics of the Family

Results showed that the majority of the extrafamilial abused adolescents live with their biological parents (65%). The living situation of the intrafamilial abused adolescents was more diverse: 35% were living with their biological parents, 25% with their mother, and 16% with their mother and stepfather. Significantly more parents are divorced in families with an intrafamilial perpetrator (62%) than in families with an adolescent abused by an extrafamilial perpetrator (32%), $\chi^2(1) = 8.10, p < .01$. Socioeconomic status, determined by the education of the father, was significantly lower in families with an intrafamilial perpetrator, $\chi^2(3) = 9.90, p < .05$. In addition, drug

TABLE 2: Family Characteristics of the Families With a Sexually Abused Adolescent (in percentages)

	<i>Intrafamilial Abuse</i>	<i>Extrafamilial Abuse</i>
Living situation		
Biological parents	35	65
Mother	25	11
Mother & stepfather	16	14
Father & stepmother	3	5
Foster parents	3	0
Home/institution	8	0
Parents divorced	62	32
Socioeconomic status		
Low	50	31
Middle	15	45
High	26	24
Parental problems ^a		
Depression	44:22	28:14
Drugs/alcohol	8:21	0:11
History of abuse ^a		
Sexual	24:10	24:3
Other kind	26:21	22:22
Sexual abuse siblings ^b	17:9	14:16

a. Mother:Father.

b. Sister:Brother.

TABLE 3: Differences on Family Functioning Between Intra- and Extrafamilial Abuse

	<i>Intrafamilial Sexual Abuse</i>		<i>Extrafamilial Sexual Abuse</i>	
	M	SD	M	SD
Cohesion	7.03	3.04	7.54	2.64
Expressiveness	5.52	2.38	5.65	2.45
Conflict	5.75	2.66	5.49	2.77
Organization	7.07	2.54	7.59	2.40
Control	7.16	1.96	7.35	1.58
Norms	8.07	1.69	8.14	2.06
Social orientation	4.74	2.25	5.81	4.11

NOTE: Subscales range from 0 to 11.

abuse by the father, $\chi^2(2) = 6.71, p < .05$, was significantly more frequently found in families with an intrafamilial perpetrator than in families with an

TABLE 4: Zero-Order Correlations Between Predictor and Outcome Variables in the Study

<i>Predictor Variable</i>	<i>Outcome Variables</i>					
	<i>Anxiety</i>	<i>Depression</i>	<i>PTS</i>	<i>Dissociation</i>	<i>Anger</i>	<i>Sexual Problems</i>
Cohesion	-.37***	-.33***	-.35***	-.35***	-.19	-.09
Expressiveness	-.30**	-.18	-.27**	-.17	-.12	-.05
Conflict	.29**	.31**	.31**	.29**	.30**	.17
Organization	-.15	-.24*	-.21*	-.24*	-.17	-.06
Control	.01	-.01	-.03	.02	-.08	-.03
Norms	-.12	-.09	-.02	-.14	-.02	-.00
Social orientation	-.02	-.16	-.05	-.03	-.18	-.01

NOTE: PTS = posttraumatic stress.

* $p < .05$. ** $p < .01$. *** $p < .001$.**TABLE 5: Results of Hierarchical Regression Analysis of Adolescent-Reported Symptoms on Significant Zero-Order Predictors**

<i>Criterion Variable</i>	<i>Step</i>	<i>Predictor</i>	<i>Beta</i>	Δr^2	<i>Adj. r^2</i>
Trauma symptoms					
Anxiety	1	Intra/Extra	.01	.00	-.01
	2	Cohesion	-.37***	.14	.12
Depression	1	Intra/Extra	-.13	.02	.01
	2	Cohesion	-.32***	.10	.11
PTS	1	Intra/Extra	-.13	.03	.02
	2	Cohesion	-.35***	.12	.13
Dissociation	1	Intra/Extra	.02	.00	-.01
	2	Cohesion	-.35***	.12	.10
Anger	1	Intra/Extra	.03	.00	-.01
	2	Conflict	.31**	.09	.07

NOTE: PTS = posttraumatic stress.

* $p < .05$. ** $p < .01$. *** $p < .001$.

adolescent abused by an extrafamilial perpetrator. Percentages of family characteristics are shown in Table 2.

Differences on Family Functioning Between Adolescents Sexually Abused by an Intra- or Extrafamilial Perpetrator

With regard to family functioning, $F(7,90) = .47$, $p = .86$, multivariate analyses of variance did not show significant differences between adoles-

cents abused by an intra- or an extrafamilial perpetrator. Means and standard deviations are reported in Table 3. Compared to a nonclinical norm group (Jansma & De Coole, 1996), no adolescents had clinically significant outcomes.

Influence of the Functioning of the Family on Trauma-Specific Symptoms

In all of the multiple regressions (see Table 5), type of abuse was not a predictor for trauma-specific symptoms. Less cohesion had a significant influence on more Anxiety (Adj. $R^2 = .12$, $F(2,97) = 7.43$, $p < .001$), on more Depression (Adj. $R^2 = .11$, $F(2,98) = 6.74$, $p < .01$), on more PTS (Adj. $R^2 = .13$, $F(2,97) = 7.98$, $p < .001$), and on more Dissociation (Adj. $R^2 = .10$, $F(2,98) = 6.59$, $p < .01$). Higher conflict had a significant influence on more anger (Adj. $R^2 = .07$, $F(2,99) = 4.96$, $p < .01$).

DISCUSSION

The purpose of this study was to examine the variability of trauma-related symptoms in sexually abused adolescents, to study differences in abuse-related symptoms and in family functioning between adolescents who have been sexually abused by an intra- or extrafamilial perpetrator, and to investigate whether characteristics of family functioning can be predictive for trauma-related symptoms.

Consistent with previous research, these findings gave evidence for the variability of abuse-related symptoms in adolescents. Fifty percent of all adolescents met the criteria for the DSM-IV diagnosis of PTSD, and 53% of the adolescents reported clinically significant trauma-specific symptoms. These results demonstrate that adolescent victims of sexual abuse suffer a variety of immediate, severe, negative consequences. Moreover, and in line with other research, our results show that approximately one third of the victims are asymptomatic at initial assessment (Barnett et al., 1997; Kendall-Tackett et al., 1993). There are several possible explanations why these adolescents appeared to be asymptomatic. The effect of the abuse could be masked, meaning that these adolescents are suppressing their feelings or that they have not yet processed their experiences. Symptom manifestation may then occur at a later point in time. Gomes-Schwartz, Horowitz, Cardarelli, and Sauzier (1990) found that 30% of asymptomatic sexually abused children developed severe symptoms 18 months after the initial assessment. On the other hand, it may as well be that these adolescents are truly less trauma-

tized and that they are the most resilient adolescents, with the most psychological and social resources to cope (Kendall-Tackett et al., 1993).

Multivariate analyses approached a significant effect of type of abuse on reported symptoms, but type of abuse could not unequivocally be related to symptom development. Similar to findings by Ray et al. (1991), no significant symptom differences were found between adolescents abused by an intra- or extrafamilial perpetrator. Nevertheless, our findings provide empirical support for further research to focus on the victim-perpetrator relationship. It could be that the concept of intra- or extrafamilial sexual abuse might be too unspecific. It is well known that family relatedness can imply very close as well as rather distant relationships. Likewise, a good family friend might have a more severe effect than a distant uncle might. Future studies should take the subjective perception of proximity to the perpetrator further into account.

Sociodemographic characteristics—such as divorce, previous parental abuse, and so on—of the participating families were comparable to those in former studies (Faust et al., 1997). Our results support the idea that specific family characteristics can be associated with intra- or extrafamilial sexual abuse (Ray et al., 1991). Compared to families with an extrafamilial abused adolescent, families with an adolescent abused by an intrafamilial perpetrator reported more divorce, more drug abuse by the father, and an overall lower socioeconomic status. Compared to the Flemish population, socioeconomic status was significantly lower in families with an adolescent abused by an intrafamilial perpetrator.

A remarkable finding in our study was that results did not show differences in perception of family functioning between sexually abused families and a nonclinical norm group. There are no indications that the functioning of families with a sexually abused adolescent is pathologic. Moreover, intrafamilial victim families were not significantly less well functioning than extrafamilial victim families. Adolescents abused by an intra- compared to an extrafamilial perpetrator did not report significant differences in the functioning of their families. Possibly the families in this sample were more support seeking and less rigid than average abused families because these studied adolescents voluntarily sought help. The designs of previous studies, in which victims had to make recollections about how they perceived their family years ago, may have led abuse victims (of an intrafamilial perpetrator) to exaggerate about the functioning of their family (see Boney-McCoy & Finkelhor, 1996). In these studies, sexually abused victims might have overrated the degree of disruption in their family precisely because they were

abused (Conte, 1986, in Nash, Hulsey, Sexton, Harralson, & Lambert, 1993). However, another explanation might be that self-report questionnaires are not sensitive enough to measure the complete functioning of the family. Because family functioning is a complex and multidetermined construct, other investigation techniques or content-specific measurements are recommended in addition to the use of self-report measures, which only assess a limited number of aspects of total family functioning. In the study of Barrett, Rapee, Dadds, and Ryan (1996), for example, specific sequences of problem-solving discussions between parents and children were examined. The study of Stevens, De Bourdeaudhuij, and Van Oost (2002) showed that the analysis of more specific, potentially deviant aspects of family functioning can reveal more overt data on family functioning.

The final objective of this study was to investigate whether family characteristics were related to trauma-specific symptoms. Less cohesion appeared to be the most consistent predictor of more internalizing symptoms such as anxiety, depression, PTS, and dissociation. As former studies revealed, many parents do not recognize the majority of internalizing problems of their children (Kendall-Tackett et al., 1993).

Some limitations are important to note in interpreting these results. First, the participating families all searched for help and, therefore, they could be characterized as a selective group. Generalization of findings to a larger group of adolescents might be limited by the nature of this sample. Second, the study was cross-sectionally designed, and our effects must not be confused with causal effects. Only longitudinal studies can show the direction of the relation between the different variables, as well as of the stability of the measured variables. Third, by only using generic self-reports to measure family functioning, some specific aspects of this construct may not have been assessed thoroughly. Fourth, failure to find differences between groups on some factors may be due to limited power.

In conclusion, this study showed that differences in abuse-related symptoms and in perception of family functioning are not related to type of abuse. Independent of the type of abuse, the adolescents reported a variety of symptoms, with 53% of them suffering from severe trauma-specific symptoms, and 33% showing no symptoms at all. In this study, the functioning of families with a sexually abused adolescent did not differ from nonclinical families. Yet, a lack of cohesion in the family was a determinant for more internalizing symptoms in abused adolescents. As for clinical implications, family therapy should therefore focus on increasing cohesion in families with sexually abused adolescents.

NOTES

1. This study and the informed consent forms were approved by the Ethical Review Committee of Ghent University on November 24, 1998.
2. The Flemish Confidential Centers on Child Abuse and Neglect have the task of coordinating and/or setting up therapy for children, adolescents, and families, where abuse has or may have occurred, without recourse to any civil or criminal proceedings. Confidential Centers on Child Abuse and Neglect work with multidisciplinary teams and guarantee a 24 hours permanency. Many people will first report child abuse to a Confidential Center on Child Abuse and Neglect because direct psychological help is guaranteed and direct juridical intervention is avoided at this stage.

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