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# Evaluation of the therapeutic process in cases of sexual abuse

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## Evaluación del proceso terapéutico en casos de abuso sexual

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### Abstract

Sexual abuse can trigger cognitive and behavioral problems which require psychotherapeutic intervention. This study aimed to evaluate the therapeutic process of two clinical cases. Participants were two sexually abused girls who participated in cognitive behavioral group therapy. The cases were selected based on the different responses to group therapy. One of them showed a reduction in the symptoms of depression, anxiety, post-traumatic stress disorder, and stress while in other these same symptoms were not reduced. Results showed that factors influencing the therapeutic process and that were related to the different responses to group therapy included the onset age of sexual abuse; the form of abuse; the perception of the experience in the care institution; criminalization of the offender; and persistence of guilt when faced with stress inoculation techniques. Case studies can contribute to the understanding of individual responses to effective intervention models based on evidence.

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### Resumen

El abuso sexual puede provocar problemas cognitivos y conductuales que requieren intervención psicoterapéutica. Este estudio tuvo como objetivo evaluar el proceso terapéutico de dos casos clínicos. Los participantes fueron dos niñas víctimas de abuso sexual que participaron de un grupo de terapia cognitivo conductual. Los casos fueron seleccionados a partir de las respuestas diferenciadas a la terapia grupal. Una de las niñas presentó reducción de los síntomas de estrés, depresión, ansiedad y del cuadro de estrés post-traumático, mientras que la otra niña no presentó reducción de estos síntomas. Los resultados mostraron que algunos factores influyen el proceso terapéutico y que algunas variables estuvieron relacionadas con las respuestas diferenciadas a la terapia de grupo: la edad de inicio del abuso sexual, la forma del abuso, la percepción de la experiencia en la atención, la penalización del agresor, y la persistencia del sentimiento de culpa en la técnica de inoculación del estrés. Los estudios de casos pueden contribuir a la

*Keywords: Sexual Abuse; Child Abuse; Childhood; Cognitive-Behavior Therapy.*

comprensión de las respuestas individuales ante modelos de intervención efectivos basados en la evidencia.

*Palabras clave: Abuso sexual; abuso infantil; Infancia; Terapia cognitivo-conductual.*

Sexual abuse against children and adolescents is a universal phenomenon that occurs against boys and girls of all ages and socioeconomic levels (Pfeiffer & Salvagni, 2005). This form of violence can contribute towards serious psychological developmental problems such as disturbances in humor, anxiety, and eating as well as disruption, enuresis, encopresis, depression, and posttraumatic stress disorder (PTSD); the last two are the most common (Briere & Elliott, 2003; Holt, Buckley & Whelan, 2008; Maniglio, 2009). Sexual abuse can have a negative impact on the victims' cognitive, emotional, and social development, which can affect the rest of the person's life, damaging their interpersonal relationships and their perception of well-being (Cloitre, Cohen, Koenen, & Han, 2002; Ullman & Filipas, 2005).

Sexual abuse can be defined as any sexual act or game, heterosexual or homosexual, with the aggressor at a more advanced psychosexual stage than the victim. These erotic and sexual practices are imposed on children or adolescents through physical violence, threats, or force of will. It includes acts without physical contact (verbal harassment, voyeurism, exhibitionism, taking photos, and showing materials with pornographic content); acts with physical contact and without penetration (oral sex, groping, and touching genitals); and acts with penetration (with fingers or objects and genital or anal intercourse) (Ministério da Saúde, 2002). It is estimated that one in every four girls and that one in every six boys experience some form of sexual abuse before the age of 18 (Sanderson, 2005).

A national survey conducted in the United States between 2002 and 2003 with the general population about the victimization of children and adolescents aged between two and 17 years suggested, among their results, that one every twelve children or adolescents (82 in every 1000 participants) were victims of some form of sexual assault (Finkelhor, Ormrod, Turner & Hamby, 2005). Recently, a meta-analysis examined 217 articles published between

1980 and 2008 in different countries from all continents with results on the prevalence of sexual violence against children and adolescents. The total sample investigated was 748 9.911. The prevalence of sexual violence against children and adolescents estimated was 11.8. In relation to sex, the estimate for female victims was 18, while for the male victims was 7.6 (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011).

The negative consequences on psychological development and the high epidemiological levels of sexual abuse indicate the need to develop effective psychological interventions. In Brazil, Habigzang et al. (2009) evaluated the effectiveness of a cognitive-behavioral group therapy model for girls victims of sexual abuse. This intervention was structured into 16 sessions had as its objectives the identification and restructuring of dysfunctional thoughts and behaviors related to the abuse; restructuring the traumatic memory; reducing the symptoms of depression, anxiety, stress, and PTSD; and building self-defense strategies to reduce the risk of revictimization. The results indicated a significant reduction in the symptoms of depression, anxiety, stress, and PTSD. Furthermore, this intervention contributed to the restructuring of beliefs related to the guilt over the sexual abuse and differences amongst the peers.

The evaluation of the cognitive-behavioral group therapy demonstrated the intervention's impact and noted its effectiveness (Habigzang et al., 2009). In view of these results, it is also relevant to analyze the intervention process in a qualitative manner. Studies evaluating the therapeutic process by verifying changes promoted by intervention, as well as when and how, can contribute to the understanding of mediators and the mechanisms involved in the patients' responses to psychotherapy (Kazdin, 2007). Some factors can influence the response to treatment, including ones related to: (1) the patient, such as their life history, symptoms and comorbidities, previous coping strategies for dealing

with stressful events, and motivation for treatment; (2) therapeutic alliance; (3) the therapist's characteristics, such as their empathy and technical competence; and (4) the treatment chosen, such as the employed techniques (Peuker, Habigzang, Koller, & Bizarro, 2009).

This study seeks to assess and compare the therapeutic process for two girls victims of sexual abuse who were treated according to the cognitive-behavioral group therapy model proposed by Habigzang et al. (2009) and who presented different responses to the treatment. The chosen cases presented, before and after the treatment, higher and lower symptom variations for depression, anxiety, stress, and PTSD.

### Method

There were two qualitative case studies with the objective of evaluating and comparing the cognitive-behavioral group therapy processes for girls who have been victims of sexual abuse. Two girls who were victims of intrafamilial sexual abuse participated in this study. They were 13 and 11 years old and presented different responses to the same cognitive-behavioral group therapy model. The description of the group therapy model is presented in Habigzang, Damásio and Koller (2013). Their responses to treatment were evaluated by comparing their scores on psychological instruments, thereby verifying the symptoms of depression, anxiety, stress, and PTSD before and after group therapy. One of the study's participants presented a good response to the treatment with a reduction in the symptoms of depression, stress, anxiety, and PTSD. On the other hand, the other participant presented an increase in the scores of depression and PTSD; maintained the same levels of stress; and had a reduction only in anxiety (the cases' complete description is in the results section).

This study's employed instruments were:

- (1) Initial Semi-Structured Interview (*The Metropolitan Toronto Special Committee on Child Abuse*, 1995, translated to Portuguese by Kristensen, 1996): to have a qualitative understanding of the cases' life histories and sexual abuse dynamics.
- (2) Clinical Record: the evolution of each case in the therapeutic process was recorded at the end of every cognitive-behavioral group therapy session. The clinical

record consisted of reports about the difficulties and therapeutic processes of each case as recorded by the therapists, as well as each girl's graphic creations (drawings and monitoring).

- (3) Children's Depression Inventory (CDI): developed by Kovacs (1992) and adapted from the *Beck Depression Inventory* for adults, the CDI is used to detect the presence and severity of depression. This inventory consists of 27 items, each one with three response options. The original's internal consistency revealed an  $\alpha$  of 0.86 with a cut-off point at 19 points. The instrument's internal consistency in the Brazilian validation was 0.85 ( $n= 951$ ; mean age= 11.95;  $SD=7.70$ ) (Wathier, Dell'Aglio, & Bandeira, 2008).
- (4) Child Stress Scale (CSS): developed to evaluate stress in children between the ages of 6 and 14 (Lipp & Lucarelli, 1998), this scale consists of 35 items related to the following kinds of stress reactions: physical, psychological, and psychological with depressive and psychophysiological components. Cronbach's alpha found in the study of Habigzang et al (2013) with victims of sexual violence was 0.82.
- (5) State-Trait Anxiety Inventory for Children (STAI-C): the inventory consists of two self-evaluation scales aiming to measure two distinct concepts of anxiety, trait and state. The instrument was adapted for use in Brazil by Biaggio and Spielberger in 1983. Each scale consists of 20 items, each one containing three affirmations representing different symptom intensities. Cronbach's alpha found in the study of Habigzang et al (2013) with victims of sexual violence was 0.88 for the state scale and 0.82 for the trait scale.
- (6) Structured interview based on DSM IV/SCID for evaluating PTSD: the diagnostic criteria established by the Diagnostic and Statistical Manual of Mental Disorders (DSM) was used as the basis for identifying PTSD symptoms (re-experiencing the traumatic event; avoiding stimulus associated with the trauma; and symptoms of increased excitability). The interview was based on the version translated to Portuguese by Del Ben et al (2001).

The psychological evaluation were developed over three meetings in which the interview and other psychological

instruments were individually applied. Each evaluation session lasted an hour and occurred on a weekly basis. After the evaluation, the girls were sent to cognitive-behavioral group therapy, following the model by Habigzang et al. (2009). The group therapy consisted of 16 weekly sessions. Each meeting was semi-structured and lasted one hour and 30 minutes. The group was coordinated by two female therapists, trained in cognitive-behavioral therapy and experience in the care of child victims of sexual abuse. The girls were individually reevaluated after the group therapy (16 weeks interval between pre and post-test). After the reevaluation, which occurred over two meetings, instruments were applied by research group members who had not participated as therapists in the group. This study was approved by the Research Ethics Committee, ensuring the necessary ethical care. The participants were included in the study by signing the consent form by their caretakers and the girls themselves.

To understand the patients' different responses to the same psychotherapeutic processes, the cases were analyzed and compared according to the following factors: (1) life history and symptoms before group therapy; (2) therapeutic alliance; (3) diligence and adherence to activities; (4) stressful events during group therapy; (5) responses to the employed techniques; and (6) self-evaluation after group therapy. These factors were understood according to the history and dynamics of the abuse suffered by each of the participants (Initial Semi-Structured Interview) and to the clinical record.

## Results and Discussion

The clinic case description will be presented first, followed by the analysis of the defined factors (see Methods), in order to understand each girl's therapeutic process.

### Case Descriptions

**Case 1.** This girl is 13 years old. She was shy during the initial interview but responded to all the questions. She said she had been in the care institution for a few months and was repeating the fifth grade. She said she had failed because she skipped a lot of classes and missed tests, needing to stay at home helping her grandparents. After a while she was visited by the Guardianship Council which warned her grandparents that she could not skip school any longer.

The adolescent said that she had nine siblings and that all of them were in care institutions, but only two sisters were in the same one as her. The girl is the fourth of ten children. She said that they were sheltered for the first time because her "dad has problems with alcohol and my oldest brother with crack." She said that her younger siblings, her mom, and she herself were physically abused by their dad and that he was very aggressive, particularly when drinking. Her father was constantly unemployed and her family went through financial difficulties. When she lived with her parents, she and her siblings also skipped school a lot because they needed to help their mom earn money by selling candy on the street.

The school denounced the family's situation to the Guardianship Council because the children came to class with precarious hygiene and marks of physical violence. She and her siblings went to different care institutions of the municipality. After a few months, the paternal grandparents requested guardianship over three granddaughters and two grandsons, alleging that they could not take care of them all. The girl, 11 years old at the time, the two sisters with her in the same institution, and two of her brothers went to live with their grandparents. The adolescent revealed that after living a while with her grandparents, she realized that her grandfather "went too far" with her and her sisters. According to her, "the first time grandpa went too far was with my eight year old sister, she was sleeping and he started to run his hand over her body. I saw and called grandma. Grandma got very angry and hit him, saying that next time she'd return us to the Guardianship Council because she wouldn't stand an affront like this." She also said that he asked them to help in the work of "collecting things for the junk yard" and that he took advantage of her grandmother's absence to run his hand over her and her sisters' bodies. She said that her grandfather used a "lash, a rope with fine tresses, to beat her and her sisters."

The adolescent's teacher noticed the injuries on her legs and asked what was happening. The girl then revealed the abuses to the teacher. The school denounced the situation to the Guardianship Council and she and her siblings were once again sent to care institutions. During the interview, the adolescent became emotional when talking about her parents and cried, saying how much she missed her mother who rarely visits her at the care institution. She also said that she likes having friends and plays basketball well.

**Case II.** This 11 year old girl started the evaluation on the same day that she was sent to a care institution with her sister. She was in the fifth grade and had good performance in school. She said that until then, she had lived with her mother, father, and seven year-old sister. The girl said that the guardianship councilor went to get her in school, together with her sister, and that they were unable to say goodbye to their mother.

When asked about why she was taken in, the girl said that “some things happened with my dad.” According to her, her father abused her since she was eight years old. She said that at first “he passed his hand over me and made me touch his penis.” She informed us that she tried “to tell her mom what was happening, but she didn’t believe it.” However, in the last weeks the abuse became more frequent and aggressive. The girl said that “dad forced me to have sex with him and it hurt. He wanted it every day.” She said that her father threatened to burn her if she told anyone what happened between them. She also revealed that he beat her “when she didn’t behave well.”

So the girl ran away from home and asked for help from a neighbor, telling her what was happening. The neighbor denounced the situation to the Guardianship Council, which took the children from school and sent them to a care institution.

The girl seemed frightened by the whole situation. She said that she no longer trusted her father but that she did not want to be away from her mother. She also said that her sister was no longer speaking to her, since she was angry over being in the institution. She said that her father did not abuse her sister because she “made sure she would prevent it from happening. The forensic medical examination confirmed the rape and the father was imprisoned after a few months (during the group therapy). The mother visited the daughters in the institution. The guardianship councilor accompanying the case said that the whole neighborhood learned about the abuse and that the “mom put the house on sale because she and the girls’ father were almost lynched.” Table 1 summarizes the information about the abuse the two participants experienced.

Before (Pre-Test) and after (Post-Test) the cognitive-behavioral group therapy, psychological instruments were applied to evaluate depression, anxiety, stress, and PTSD. The obtained results are presented in Table 2.

**Table 1**  
*Information about the Sexual Abuse of the Clinical Cases I and II*

Information	Case I	Case II
Current age	13	11
Onset age of abuse	11	08
Age when abuse was revealed	11	11
Aggressor	Paternal grandfather	Biological father
Number of episodes	Multiple	Multiple
Form of abuse	Physical contact without rape	Physical contact with rape
Presence of other forms of violence	Physical and psychological	Physical and psychological
Presence of threats	Yes	Yes
Person to whom they revealed the abuse	Teacher	Mother
Belief in the abuse	Yes	No
Measures adopted after the revelation	School notified the Guardianship Council	The mother did not take any protective measures and the girl ran from home asking for help from a neighbor who denounced the situation to the Guardianship Council
Taken in	Yes	Yes
Criminal punishment of the aggressor	No	Yes
Waiting time for psychological treatment	5 months	Immediate

**Table 2**  
*Instrument Scores Before (Pre-Test) and After (Post-Test) Group Therapy*

Symptoms	Instruments	Case I		Case II	
		Pre-Test	Post-Test	Pre-Test	Post-Test
Depression	CDI	21	04	10	16
Stress	CSS – Total score	46	04	45	44
Anxiety	STAI - State	29	24	41	33
	STAI – Trait	36	24	43	39
PTSD	Reliving	05	01	02	03
	Avoidance	05	01	05	04
	Excitability	05	01	02	04

**Evaluation of the Group Therapy Process.** The two presented cases participated in a cognitive-behavioral group therapy process focusing on sexual abuse and its cognitive, emotional, and behavioral consequences. The two girls participated in the same therapeutic group, coming to all the group sessions and presenting different responses to the intervention, as presented in Table 2. The two cases will now be analyzed, through comparison, in terms of factors that may be related to the different responses to treatment.

**Life history and symptoms before group therapy.** Life history refers to familial aspects and the sexual abuse experience. Cases I and II are identified as having suffered intrafamilial sexual abuse. However, some significant differences were verified. In case I, the girl was the victim of sexual abuse with physical contact, but there was no rape. In case II, the girl was raped by her father. Another difference between the two cases was their age when the abuse started and how long the violence lasted. Case II, with a weaker response to treatment, was exposed to violence for longer, starting from the age of eight and ending at 11. On the other hand, the girl from case I, presenting a better response to treatment, was sexually abused by her grandfather at the age of 11, with the violence lasting less than a year.

The characteristics of sexual violence are associated with the impact of the experience on the victims' development and show that they are related to the treatment responses. Factors that can exacerbate the consequences of sexual violence include the onset age of abuse; duration, frequency, and degree of violence; difference in age and emotional closeness between the aggressor and victim; the level of secrecy and threats; the absence of protective parental figures; receiving rewards; and the perpetrator denying that the abuse occurred (Furniss, 1993; Ullman & Filipas, 2005). Case II, with a weaker response to group therapy, was exposed to sexual abuse for three years, starting from when she was eight, and was raped by her father. Furthermore, her mother did not believe her. On the other hand, case I, with a better response to group therapy, was victimized for less than a year and was not raped.

Physical and psychological abuses associated with the family were identified in both cases. With case I, it is evident that aside from sexual abuse, the father's physical abuse was a significant traumatic event. Another aspect the two girls have in common was their need to ask for

help outside the family in order to stop the violence. In case I, the grandmother was present during the abuse and did not take adequate protective measures. In case II, the mother did not believe the revelation about the abuse. The negative and non-protective reactions from their caretakers when faced with the revelation is a factor that can potentiate the abuse's effects (Elliot & Carnes, 2001; Jonzon & Lindbland, 2004; Santos & Dell'Aglío, 2009) and may consequently be related to the girls' responses to group therapy.

Being taken into a care institution as a protective measure was something both cases experienced. However, in case I, the girl demonstrated "adaptation" to being taken in since she had already experienced this situation earlier in her life due to her father's physical violence. For the girl from case II, being taken in was new and stressful, especially because her younger sister blamed her for their situation. The effects of being taken in as a protective measure have been discussed when considering the consequences on the victims' development. Some point out that separating the child from living with their family is negative and can potentiate the symptoms of depression and anxiety. On the other hand, the care institution can become a source of support for the children and adolescents given that their still existing familial ties and relationships are very weak and do not provide them with the needed security and protection (Habigzang, Cunha, & Koller, 2010; Siqueira, Betts, & Dell'Aglío, 2006).

The symptoms presented by the girls before group therapy showed that case I had indications of depression and diagnostic criteria for PTSD. Case II also presented diagnostic criteria for PTSD; however, she had fewer experiences of reliving and hypervigilance. On the other hand, case II also presented higher scores in anxiety symptoms than case I. Given the girls' previous experiences with abuse, characteristics were identified in case II that may have contributed to the weaker response to group therapy, such as the precocious age at which the abuse started and the presence of more intrusive and violent forms of abuse, like rape.

Of the aspects related to the life history and abuse, the process analysis indicated that the longer exposure to abuse, the precocious age at which the violence starts, the presence of rape, the association of negative meanings with being taken in, and a mother's negative reaction to the revelation

may influence the response of children and adolescents to the group therapy model. Thus, these aspects should be observed throughout group therapy when identified in the initial evaluation. Individual accompaniment may be necessary concomitant to the group therapy or after the group process.

**Therapeutic alliance.** The term therapeutic alliance (TA) comprises the relationship of trust between a therapist and patient as well as the pair's capability of accomplishing psychotherapeutic tasks (Safran, 2002). The formation of a secure therapeutic link should be the first goal of interventions for children and adolescents victims of sexual abuse. An environment of safety, trust, and acceptance must be created. The results of a psychotherapeutic intervention depends, amongst other variables, on the work relationship established between the therapist and patient. TA has been considered an important predictor of therapeutic results in different psychotherapeutic approaches, including cognitive-behavioral therapy (Peuker et al., 2009; Safran, 2002).

The creation of a good connection with the therapist and the other girls in the group was identified, considering the cases analyzed. Both demonstrated trust in their therapists, sharing their thoughts and feelings. The girl from case I managed to overcome her shyness and shame and came to present greater self-confidence during group therapy. She stopped hiding her face behind sheets or her own arms to reveal her experiences. The girl from case II found in the group a space of support for her suffering, identified through verbalizations like "It's good to be able to count on the group. I feel well here." Furthermore, the two girls performed the proposed tasks and activities during group therapy. The girl from case I presented leadership behavior in the group during many of the proposed activities. In this way, no differences were identified between the cases in terms of therapeutic alliance. The fact that the therapists were the same in both cases excludes aspects related to the therapist's style and experience, which are also predictors of the response to treatment. Therefore, the therapeutic alliance does not seem to have influenced the girls' different responses to the group therapy process.

**Diligence and adherence to activities.** The two girls participated diligently in group therapy, coming to all the meetings punctually. Both were engaged in the activities, actively participating in the process and doing all the

homework. The girls shared their experiences, doubts, and strategies for dealing with stressful situations. The good connection with the therapists can also be evaluated through their adherence to the treatment. The girls did not abandon the group, not even after the familial reinsertion.

The two girls demonstrated daily use of the techniques they learned in the group in order to deal with their memories of abuse, reporting their use of relaxation techniques, image substitution, and "emergency button" in quotidian situations. Thus, the indicator of diligence and adherence does not explain the girls' different responses to the group therapy. Moreover, group therapy was appealing enough to keep them connected to the treatment.

**Stressful events during group therapy.** In terms of this indicator, what can be emphasized is the imprisonment, during the last group therapy stage, of the father of the girl from case II due to the violence he perpetrated against her. The girl experienced this event in an ambivalent manner: she said she blamed herself for her father's fate although she felt rage. According to her, "I just wanted him away from the family, but not that he would be imprisoned." The paternal family pressured the girl to say she had lied about the abuse in order to release the father from jail, generating stress and anguish in her. The sister's negative reaction to the imprisonment emphasized the perception of guilt for the abuse. This event and the separation from the mother by the care institution were negative aspects that presented a connection to the sadness and suffering of the girl in case II, which seemed to become more heightened throughout group therapy.

No stressful events during the group therapy were identified for case I. The adolescent's routine remained the same throughout the group process without any changes in the family. The girl was not called for testimonies in this period, nor was her grandfather criminally punished. She reported feeling better in the care institution than at home since she experienced the shelter as a protective factor.

Stressful events that occur during the psychotherapeutic process can generate regression or relapses. Such events and their effects cannot be controlled in a research, which can affect the results. In case II, the father's imprisonment contributed to the girl re-experiencing feelings of guilt and intense suffering. The process of change for case I during group therapy was not damaged by external life events.

**Responses to the employed techniques.** The techniques employed in the first phase, psychoeducation and cognitive restructuring, were experienced by the girls in a positive manner. The session in which they built figures of their aggressors out of modeling clay stirred strong feelings in the girl from case II, provoking crying and anxiety. The two girls demonstrated an understanding of the cognitive-behavioral model and the relationship between the sexual abuse and the differences in behavior that they presented. One difference identified amongst the participants was the restructuring of the perception and attribution of guilt. The girl from case I demonstrated an understanding that her grandfather was responsible for the abuse and its consequences for her and her sisters. On the other hand, the girl from case II did not demonstrate the same response to the cognitive restructuring techniques, presenting a belief of guilt until the end of the group therapy process.

The techniques from the second phase, inoculation training, received a better reaction from case I. The girl from case II demonstrated intense and negative emotional reactions to the gradual exposure of memories of the abuse and building narratives about the traumatic event. The substituting images technique was difficult for the case II girl: the self-instruction, according to her, presented a better result for self-control. Gradual exposure to memories of abuse technique may not be the best therapeutic instrument for patients with intense symptoms of reliving trauma or of dissociation, which were identified in case II. The girl demonstrated the need for more space to talk about her suffering from being taken away and living apart from her mother as appears in her narratives, which emphasize how much she misses her mother and home. Aside from the first narrative, which expressed some details of the abuse, the others focused on the relationship with her mother; how the mother did not believe and support her; and how much she missed home and her other relatives. This suggests that the girl from case II could have benefited from individual sessions, concomitant to the group, to focus on these issues that seem to have contributed to her depressed mood, which intensified during this group therapy phase.

The final phase techniques and workshops, relapse prevention, were experienced by the two girls in a positive manner. Both responded positively to these sessions, actively participating in the activities, especially in the workshop about sexual education and body expression.

The group modality was a positive experience for the girls since it contributed to their perception that they were not alone and offered support and emotional relief. The group made it possible for both cases to elaborate on their feelings of isolation and stigmatization, as they pointed out in their self-evaluations.

**Self-evaluation after group therapy.** The case I self-evaluation revealed changes in the symptoms of reliving the sexual abuse and improvements in school. She even recovered activities like playing. The girl affirmed that she changed her behavior, being no longer “weird” and saying “things that make people laugh.” The change was visible in the group. At first shy, the adolescent started using the space and expressing her thoughts and feelings without demonstrating shame. She came to hold eye contact while speaking instead of looking at the floor or hiding behind the sheets they had used during the activities. The girl from case II also revealed that she could concentrate more in class and was more open to sharing her experiences and opinions with people, including her mother. Although the instruments did not point to a reduction in all the evaluated symptoms, the girl identified aspects in which she felt benefited by the group. She noticed how important it was for her to speak amid the group, and revealed her concern about the group’ finishing.

## Conclusions

Cognitive Behavioral Therapy has been shown to be effective for the treatment of children and adolescents victims of sexual violence (Cohen, Mannarino, & Knudsen, 2005; Habigzang et al., 2013). The group therapy format has brought cost benefit (McCrone et al., 2005). However, there is a need to understand the factors that may be related to the different responses that the patients may present effective treatment models.

Of the factors employed in evaluating the responses to group therapy, the following can be emphasized: onset age of abuse; the form of abuse (whether or not there was rape); perception of the experience at the care institution; criminalization of the aggressor; and persistent belief of guilt and anxiety when faced with stress inoculation techniques. These factors influenced the therapeutic process and were related to the different responses to group therapy in the cases analyzed. The results of this study should not be generalized, as they were identified only in two cases clinical analysis.



Heterogeneity of the cases was purportedly sought, including girls with different histories and severity of sexual abuse, even though it would represent a challenge for discussing the results of this research. The objective was to assess the therapeutic process which, for this reason, was applied in a setting with conditions similar to the “real world.” Studies like these seek to reproduce treatment conditions in routines of psychotherapists as much as possible, with greater use for public health and clinical fields (Coutinho, Huf, & Bloch, 2003).

The evaluation of the process revealed that the employed group therapy model can generate different results in different girls who have been victims of sexual abuse. This study examined only two cases treated in group therapy, each with their own idiosyncrasies and with different responses to the intervention. The evaluated model proved effective for most of the already treated cases when quantitatively evaluated by Habigzang et al. (2009; 2013). However, it may not be appropriate for all girls who have been victims of sexual abuse. Intervention protocols are instruments which guide the psychotherapist's work, but they should be adequate for special cases when necessary. No treatment is effective for all cases and when the response to treatment is not positive; other intervention strategies should be included. In cases such as case II, having concomitant individual sessions, or after group therapy (or even a higher number of group sessions) may be needed to guarantee better results. The appropriate number of sessions for the treatment of sexual abuse victims is still a factor to be researched. Moreover, the combination with psychopharmacological treatments could potentiate the group therapy effects. In this study the girls did not utilize psychopharmacological medicine due to difficulties in accessing evaluations and psychiatric accompaniment within the network. Moreover, intrinsic individual aspects should be considered, such as their temperament and internal resources for dealing with stressful events that interfere with their responses to psychotherapeutic intervention; the therapist's characteristics; and the patient-therapist relationship (Kazdin, 2007).

The group therapy model activities and techniques proposed in this study were formed considering general themes related to abuse as well as the symptoms frequently presented by sexual abuse victims. However, they certainly do not cover all the individual issues that should be considered for effective treatment. When adopting this group therapy model, the therapists should evaluate the necessity of

psychiatric accompaniment for the group members as well as the necessity of additional sessions apart or with the group in order to broach emergent issues not covered in the 16 programmed sessions. This group therapy's results could also be potentiated by focused interventions with the caretakers with the following objectives: strengthening the emotional connection with the child; learning protective behaviors; improving credibility and communication; and learning about the developmental aspects of children and adolescents.

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