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Cognitive-behavioral group therapy for girls victims of sexual violence in Brazil: Are there differences in effectiveness when applied by different groups of psychologists? Effectiveness of group therapy for girls victims of sexual violence

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Título: Terapia de grupo cognitivo-conductual para niñas víctimas de violencia sexual en Brasil: ¿Hay diferencia de efectividad al ser aplicada por distintos grupos de psicólogos?
Resumen: Se investigó la efectividad de un modelo de terapia de grupo cognitivo-conductual para el tratamiento de niñas víctimas de violencia sexual (VS) al ser aplicado por grupos distintos de profesionales: Investigadores/psicólogos que desarrollaron el modelo (G1) y psicólogos de la red pública de asistencia social entrenados por el primer grupo (G2). Se realizó un estudio *cuasi-experimental*, en el cual el modelo de terapia de grupo fue aplicado por los dos grupos. Fueron atendidas 103 niñas víctimas de violencia sexual (VS) con edades entre siete y 16 años (*M*=11,76 años, *DP*=2,02 años), siendo 49 atendidas por G1 y 54 por G2. Los resultados indican reducción significativa en los síntomas de depresión, ansiedad, estrés y TEPT. La comparación entre los resultados obtenidos por los dos grupos de profesionales en la aplicación del modelo indica que no hay diferencias significativas en los índices de mejora de las participantes. Estos resultados indican la efectividad del modelo de terapia de grupo cognitivo-conductual evaluado y la posibilidad de ser utilizado como una estrategia de atención por los profesionales de psicología que trabajan en servicios públicos.
Palabras clave: violencia sexual; tratamientos basados en evidencias; terapia de grupo cognitivo-conductual.

Abstract: The effectiveness of a cognitive-behavioral group therapy model for the treatment of girls victims of sexual violence (SV) was investigated when applied by different groups of practitioners: researchers/psychologists who developed it (G1) and psychologists from the public social care network trained by the first group (G2). A *quasi*-experimental study was carried out, in which the group therapy model was applied by the two groups. A total of 103 girls victims of sexual violence (SV), aged between seven and 16 years (M=11.76 years, SD=2.02 years) were included, with 49 attended by G1, and 54 by G2. The results indicated a significant reduction in the symptoms of depression, anxiety, stress, and PTSD. The comparison between the results obtained by the two groups of practitioners in the application of the model indicated no significant differences in the rates of improvement of the participants. These results indicate the effectiveness of the cognitive-behavioral group therapy model evaluated and the possibility of it being used as a care strategy by psychology practitioners working in public services.
Key words: Sexual violence; evidence-based treatments; cognitive-behavioral group therapy.

Introduction

At the end of the 1990s, the World Health Organization (WHO) recognized sexual violence (SV), along with other types of violence against children and adolescents, as a public health problem due to its prevalence, consequences and the economic costs that it entails. Its prevalence among children and adolescents was, over that decade, between 7% and 34% among girls and between 3% and 29% among boys (WHO, 1999). The meta-analysis developed by Stoltenborgh, Van IJzendoorn, Euser, and Bakermans-Kranenburg (2011) investigated the prevalence of sexual violence against children and adolescents in different countries from all continents. From the 217 articles analyzed, the total sample investigated in this study was 9,911,748 children and adolescents. The prevalence of the occurrence of sexual violence against children and adolescents was estimated to be 11.8%. Regarding gender, the estimate for female victims was 18%, while for males it was 7.6%. However, no Brazilian study was included in this meta-analysis, possibly due to a lack of systematization of the data from reported cases of SV in the country. The report of the national human rights violations notification service, published by the National Program to Combat SV against Children and Adolescents (2010), related to the services performed in 2010 (n = 160,933), indicated that 34% of the reports referred to cases of SV. Studies with the general population are scarce. Among 1,193 adolescent participants (aged 13 to 20 years) of a study performed in southern Brazil, 27 (2.3%) were victims of SV (Polanczyck, Zavaschi, Benetti, Zenker, & Gammerman, 2003).

The high prevalence of female sexual traumatization is related to gender violence (Walsh, Keyes, Koenen, & Hasin, 2015). The gender violence refers to all kinds of conduct (e.g. prejudice) or act (e.g. physical aggression) that causes or may harm women or girls just because their gender. The most common forms of gender violence are aggressions as sexual assault, interpersonal violence, sexual harassment, stalking, rape, prostitution and sex trafficking (Walsh et al., 2015). Furthermore, the relationship of sexual violence with gender is historically disseminated on cultural and social values (Castillo-Mayén & Montes-Berges, 2014; Chowdhury, 2014). The sexist values (e.g. objectification of women, patriarchy) expose women and girls to higher risks of aggression and to undesired sexual approaches, such as sexual abuse (Martínez & Paterna-Bleda, 2013; Santos-Iglesias, Vallejo-Medina, & Sierra, 2014). Because of that, is relevant to develop evidence-based interventions to treat the negative impact of sexual abuse that value and are adapted to the victims' gender, whether the victims are girls (Habigzang,

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Damásio, & Koller, 2013) or boys (Hohendorff, Salvador-Silva, Andrade, Habigzang, & Koller, 2014).

In addition to the prevalence, the negative consequences on the development of the victims reinforce the comprehension of SV as a public health problem. Its occurrence carries short and long term repercussions for the victims, among them Posttraumatic Stress Disorder (PTSD), mood disorders, anxiety disorders, disruptive disorders, eating disorders, and personality disorders (Maniglio, 2009; Morelato, 2014).

Given the consequences that SV entails, it is necessary that psychological interventions are developed and empirically evaluated regarding their adequacy and effectiveness, with the aim of helping the practitioners provide treatments with a good cost/benefit relationship for victims of SV (WHO & International Society for the Prevention of Child Abuse and Neglect [ISPCAN], 2006). Among the therapeutic approaches, Cognitive-Behavioral Therapy (CBT) has been used with child and adolescent victims of SV Children and adolescents, between eight and 14 years, were randomly divided into two groups, according to the therapeutic modality to be received: CBT and child-centered therapy (Cohen, Deblinger, Mannarino, & Steer, 2004). Symptomatological evaluation instruments were used before and after the intervention, which was composed of 12 sessions. The group that received trauma-focused CBT presented significant improvements, compared to the other group, in PTSD symptoms; depression; interpersonal trust; perception of credibility; shame; and behavior problems. In another study, a meta-analysis was performed from the consultation of various databases (Hetzel-Riggin, Brausch, & Montgomery, 2007). A total of 28 studies, published in English between 1975 and 2004, were selected. The results indicated the effectiveness of any form of treatment compared to no treatment. The CBT was, however, more effective regarding problems of psychological stress, issues related to the self-concept, and social functioning (Hetzel-Riggin et al., 2007).

In Brazil, Habigzang et al. (2013) evaluated the effectiveness of a cognitive-behavioral group therapy model consisting of 16 semi-structured sessions focusing on psychoeducation, cognitive restructuring, stress inoculation training, and relapse prevention. Study participants were 49 girl victims of SV (aged 9 to 16 years) who were evaluated for symptoms of depression, anxiety, stress and PTSD, before and after the application of the model. The results showed a significant reduction in symptoms of anxiety, PTSD and stress. These results were maintained at follow-up, which was performed with 35 girls at 6 and12 months after the end of the intervention.

Evidence of effectiveness and efficacy of CBT for child and adolescent victims of SV therefore indicates its suitability for the psychological treatment of this public. The characteristics of CBT are consistent with the guidelines of the WHO and ISPCAN (2006) for the psychological treatment of victims of maltreatment. These guidelines indicate that psychological interventions should be based on empirical evidence of effectiveness, guided by goals, and have a structured approach. They should also include strategies for managing the emotional and behavioral consequences of the traumatic experience. Among them, strategies for identifying and regulating emotions, anxiety management and distorted perceptions were highlighted, as well as problem solving strategies. Thus, the aim of this study was to evaluate the effectiveness of a cognitive-behavioral group therapy model (Habigzang et al., 2013) in reducing symptoms of depression, anxiety, stress and PTSD in child and adolescent victims of SV In addition, its effectiveness was investigated when applied by trained practitioners and by the researchers/psychologists who developed it.

Method

Design

The effectiveness of cognitive-behavioral group therapy for girl victims of sexual violence was investigated by means of a *quasi*-experimental study (Rossi, Lipsey, & Freeman, 2004). The model was applied by two distinct groups of practitioners: the researchers/psychologists who developed it and psychologists from the public social care network trained by the first group. The victims were assessed for symptoms of depression, anxiety, PTSD and stress at the start of the cognitive-behavioral group therapy (pretest) and again at the end (post-test), with the comparison of the results achieved in the application by the two groups.

Participants

A total of 103 girl victims of SV aged between seven and 16 years (M=11.76 years, SD=2.02 years) participated. Among these participants, 49 were attended by the researchers/psychologists who developed the model, forming G1, and trained practitioners, constituting G2, attended 54.

The mean age of the participants of G1 was 11.43 years (SD=1.48), ranging from 8 to 16 years, in this group the mean age of onset of the occurrence of sexual violence was 8.93 years (SD=2.25 years) and the mean age of revelation was 10.02 years (SD=2.26 years). The sexual violence situations predominantly occurred within the family context. Cases involving multiple episodes of victimization had a higher frequency. The form of sexual violence with the highest incidence was “physical contact without penetration”. The majority of the participants of G1 waited between one and six months to receive psychotherapy due to SV and remained living with the family of origin after the revelation of the violence (See Table 1).

The mean age of the participants of G2 was 12.47 years (SD=2.13 years), with ages between 7 and 16 years, the mean age of onset of the occurrence of sexual violence was 10.35 years (SD=2.55 years), and the revelation of the violence took place when the participants had a mean age of 11.48 years (SD=2.44 years). A total of 22 groups were developed, 12 groups (G1) coordinated by the psychologists/researchers

who developed the model, and 10 groups (G2) by trained practitioners. The groups were formed of four to six children and adolescents, according to age and order of arrival of the participants at the care institution.

The situations of sexual violence occurred in the intrafamilial context as well as the extrafamilial context. The cases of sexual violence involving multiple episodes were predominant, and the form of sexual violence with the highest frequency was "physical contact without penetration". It was observed that among the participants of G2, 44.4% waited between one and six months for psychotherapy and 83.3% remained living with the family of origin after the revelation of violence (See Table 1).

Table 1. Sociodemographic characteristics of G1 and G2.

Variable	G1 (*n* = 49)	G2 (*n* = 54)
Age (*M* (*SD*))	11.43 (1.48)	12.47 (2.13)
Age at onset of SV (*M* (*SD*))	8.93 (2.25)	10.35 (2.55)
Age at revelation (*M* (*SD*))	10.02 (2.26)	11.48 (2.44)
Context of the SV		
Intrafamilial (% (*n*))	75.5% (37)	58.5% (32)
Extrafamilial (% (n))	14.3% (7)	34.0% (18)
Intrafamilial and extrafamilial (% (*n*))	10.2% (5)	7.5% (4)
Episodes of SV		
Single episode (% (*n*))	20.4% (10)	22.2% (12)
Multiple episodes (% (*n*))	79.6% (39)	77.8% (42)
Type of SV		
Without physical contact (% (*n*))	8.2% (4)	9.3% (5)
With physical contact and without penetration (% (*n*))	61.2% (30)	55.6% (30)
With physical contact and with penetration (% (n))	30.6% (15)	35.2% (19)
Length of time waiting for attendance		
Immediate (% (*n*))	26.5% (13)	38.9% (21)
1 to 6 Months (% (*n*))	49.0% (24)	44.4% (24)
More than 6 Months (% (*n*))	24.5% (12)	16.7% (9)
Institutional care		
Sent to the care institution	38.8% (19)	14.8% (8)
Resides with the extended family	6.1% (3)	1.9% (1)
Resides with the family of origin	55.1% (27)	83.3% (45)

Instruments

- Initial semi-structured interview (*The Metropolitan Toronto Special Committee on Child Abuse*, 1995, translated and adapted to Portuguese by Kristensen, 1996): used to obtain the report of the sexually abusive experience, regarding the frequency, duration, scope, dynamics of the abusive episodes, risk and protective factors, and protective measures adopted.
- Children's Depression Inventory (CDI - Kovacs, 1992): instrument developed by Kovacs (1992), adapted from the *Beck Depression Inventory* for adults (BDI, Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). It aims to identify depressive symptoms in children and adolescents between 7 and 17 years of age and is composed of 27 multiple-choice items with three corresponding response alternatives. The child/adolescent should choose the option that best describes their recent state (days). The options are scored 0 to 2. The internal consistency described by Kovacs (1992) was adequate (α=0.86), and the cutoff of the CDI was set at 19, i.e., a result above this number can be consider an indicator of depression. The CDI was adapted for use in Brazil by Gouveia, Barbosa, Almeida and Gaião (1995) demonstrating adequate psychometric characteristics.
- Childhood Stress Scale (ESI - Lipp & Lucarelli, 1998): composed of 35 items related to physical reactions, psychological reactions, psychological reactions with depressive component, and psychophysiological reactions to stress in children between 6 and 14 years. The instrument received authorization for use from the Federal Council of Psychology in 2003. The response to the item is made on a five-point scale, in which the child or adolescent fills in parts of a circle, divided into four, according to the frequency (Never, A little, Sometimes, Often, and Always) that the participant experiences the symptoms indicated in the item. It can be considered that the child/adolescent assessed has significant stress indicators when seven or more completely filled circles are presented for the total scale, or when the score is equal to or higher than 27 points in any of the three following subscales: physical reactions, physiological reactions, psychological reactions with depressive component, or when the score is equal to or higher than 24 points in the psychophysiological reactions subscale. A total score greater than 105 points is also indicative of the presence of stress.
- State-Trait Anxiety Inventory for Children (STAI-C - Biaggio & Spielberger, 1983): developed by Spielberger in 1970, and adapted for use in Brazil by Biaggio & Spiel-

berger, 1983): consists of two scales, each with 20 self-assessment items aimed at measuring indicators of two distinct anxiety concepts: trait and state. Each scale consists of 20 items. Each item consists of three statements that represent varying intensities of the symptom. Higher scores indicate a greater presence of anxiety in both scales. In the study by Habigzang (2010), the Cronbach's alpha was 0.88 for the State scale and 0.82 for Trait scale.

- Structured interview based on the DSM IV/ SCID (Del Ben, Vilela, Crippa, Hallak, Labe, & Zuardi, 2001, adapted by Habigzang, 2006 - Annex D): the diagnostic criteria established by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR - *American Psychiatric Association*, 2003) are used as the basis for identifying the presence of symptoms that comprise PTSD (re-experiencing the traumatic event, avoidance of stimuli associated with the trauma, and symptoms of increased excitability). The Cronbach's alpha in the study by Habigzang (2010) was 0.51 for re-experiencing, 0.37 for avoidance, and 0.56 for increased excitability.

Procedures

Training in the Application of the Cognitive-Behavioral Group Therapy

A training program was developed to train psychologists from the public social care network for the use of the cognitive-behavioral group therapy model (Freitas & Habigzang, 2014; Habigzang, Damásio, Hohendorff, & Koller, 2011). Four editions of this program were performed between 2009 and 2012, training 51 practitioners.

The training program consisted of four modules, held monthly, totaling 34 hours. The first three modules aimed to discuss aspects related to the assessment and treatment of victims of SV. In the fourth module, the practitioners performed the care for child and adolescent victims of violence according to the cognitive-behavioral group therapy model, under the supervision of the team of psychologists/researchers that developed it.

Initial and Final Psychological Assessment (Pre and post-test)

The participants of this study were referred for care by the institutions of the protection network (e.g. Guardian Council, Childhood and Youth Court, Social Care Services, Primary Health Units). They were evaluated individually over three weekly sessions, each with one hour duration. The instruments used in the evaluation were applied randomly in order to avoid possible order effects. At the end of the intervention the psychological instruments were reapplied.

Cognitive-Behavioral Group Therapy Model for Girl Victims of SV

The cognitive-behavioral group therapy model created by Habigzang et al. (2009) consists of 16 semi-structured sessions with an average duration of one hour and thirty minutes, and a weekly frequency. It is divided into three steps: (1) Psychoeducation and Cognitive Restructuring (six sessions), with the aim of providing psychoeducation about SV and the cognitive-behavioral model, as well as the identification and restructuring of the participants' dysfunctional beliefs about themselves, the perpetrators, the reactions of the family members and the violence; (2) Stress Inoculation Training (four sessions), with the aim of restructuring the traumatic memory and developing cognitive and behavioral strategies for its management; (3) Relapse Prevention (six sessions), aiming to conduct workshops on sexuality, body expression, the rights of children and adolescents, social skills training to prevent possible revictimization, and to discuss expectations for the future and life project (Habigzang et al ., 2013).

The therapeutic groups were constituted according the girls' age. Girls between 9 and 12 years old and girls between 13 and 16 years were addressed to different groups. This division by age was adopted concerning developmental issues. Furthermore, therapeutic groups could be constituted by extra and intrafamilial cases of sexual abuse. Even though when cases of extrafamilial sexual abuse were addressed to therapeutic groups with intrafamilial cases, the perpetrators were someone known by victims like neighbors who usually frequented victims' home. If cases of sexual exploitation were addressed, these cases would not include in the same groups of extra and intrafamilial cases because of its distinct dynamics.

Statistical Analysis

The effectiveness of the cognitive-behavioral group therapy model was evaluated through its impact on symptoms of depression, anxiety, PTSD, and stress, comparing pre and post-test results. Due to the non-normality of the data, the *Wilcoxon-Signed-Rank* test and exact probability tests (Field, 2005) were used. Specifically for the PTSD diagnosis variable, *McNemar's* test was used, as this is a dichotomous variable (1-yes, 2-no; Field, 2005).

The comparison of the impact of the treatment between G1 and G2 in the post-test was performed using the *Mann-Whitney* U test and exact probability tests due to the non-normality of the data. Whether G1 and G2 presented differences regarding the presence of the PTSD diagnosis at post-test was also evaluated, and, since this variable is dichotomous (1-yes, 2-no), the Chi-square was applied (χ^2; Field, 2005).

Results

The results of the *Wilcoxon-Signed-Rank* test, exact tests probability and *McNemar's* test showed that there was a significant reduction ($p \leq 0.001$) between the pre-test and post-test in all the symptoms evaluated (depression, anxiety, stress, and PTSD - See Table 2) in the total sample (*n* = 103). The symptoms reduction demonstrate the effectiveness of the cognitive-behavioral group therapy model for the treatment of girl victims of SV.

Table 2. Longitudinal analysis of symptoms of depression, anxiety, stress, and PTSD at T1 and T2 (n = 103).

Variable (Instrument)	Subscale	Application of Instruments		*Wilcoxon Signed-Rank*	*McNemar's*
		Pre-test (*M* (*SD*))	Post-test (*M* (*SD*))		
Depression (CDI)		14.4 (8.7)	11.2 (8.4)	- 3.4*	
Anxiety (STAI)	State	35.0 (7.4)	31.2 (7.1)	-3.9*	
	Trait	40.0 (7.1)	35.8 (7.1)	-5.1*	
Childhood Stress(ESI)	Total	46.3 (20.0)	37.7 (21.4)	-4.1*	
	Physical Reactions	8.8 (4.9)	7.4 (5.3)	-2.8*	
	Psychological Reactions	15.2 (7.2)	11.3 (7.0)	-4.8*	
	Psychological Reactions Depressive Depres.	10.6 (7.0)	9.3 (7.1)	-2.0*	
	Psychophysiological Reactions	11.4 (5.1)	9.4 (5.3)	-3.9*	
Posttraumatic Stress Disorder (DSM-IV Interview)	Re-experiencing	2.9 (1.3)	1.9 (1.3)	-5.7*	
	Avoidance	3.2 (1.6)	1.9 (1.4)	-5.8*	
	Hypervigilance	3.2 (1.4)	2.6 (1.5)	-5.7*	
	Presence of diagnosis (*n* (%))	72 (70%)	28 (27%)		33.2*
	Absence of diagnosis (*n* (%))	31 (30%)	74 (73%)		

Note: * $p \leq .001$.

In order to assess differences in the impact of the cognitive-behavioral group therapy model when applied by trained practitioners and the researchers/psychologists that developed it, it was investigated whether G1 and G2 could be considered homogeneous when the groups started treatment (pre-test). There were no differences between G1 and G2 in the variables analyzed in the pre-test using the *Mann-Whitney* U test and exact probability tests. The variables analyzed were: age ($Z = -2.84$; $p > .05$), depression symptoms ($Z = -1.54$; $p > .05$), trait anxiety symptoms ($Z = -1.71$; $p > .05$), state anxiety symptoms ($Z = -1.02$; $p > .05$), total stress level ($Z = -2.78$; $p > .05$), symptoms stress with physical reactions ($Z = -0.42$; $p > .05$), stress symptoms with psychological reactions ($Z = -2.08$; $p > .05$), stress symptoms with reactions with depressive components ($Z = -0.70$; $p > .05$), stress symptoms with psychophysiological reactions ($Z = -1.38$; $p > .05$) and PTSD symptoms (re-experiencing, $Z = -1.27$, $p > .05$; avoidance, $Z = -1.41$, $p > .05$; and hypervigilance $Z = -1.26$, $p > .05$).

Next, the scores in the symptoms assessed at the end of the intervention obtained from the application of the model with G1 (*n* = 49) and G2 (*n* = 54) were compared. It was found that the groups did not show significant differences (see Table 3), i.e., that the intervention model was equally effective when applied by trained practitioners or by the researchers/psychologists that developed it. It was also observed that the presence of PTSD diagnoses was similar between G1 (*n* = 49) and G2 (*n* = 54), therefore not being associated with the group of practitioners who attended the victims (See Table 3).

Table 3. Comparison of symptoms of depression, anxiety, stress, and PTSD in G1 (n = 49) and G2 (*n* = 53) at T2.

Variable (Instrument)	Subscale	G1 (*M* (*SD*))	G2 (*M* (*SD*))	*Mann-Whitney U*	*df*
Depression (CDI)		11.2 (8.4)	10.7 (8.1)	- 0.80	
Anxiety (STAI)	State	31.0 (7.2)	31.5 (7.2)	- 0.31	
	Trait	35.7 (6.3)	35.8 (7.8)	- 0.10	
Childhood Stress (ESI)	Total	40.8 (8.0)	35.5 (19.2)	- 1.0	
	Physical Reactions	8.0 (5.9)	6.8 (4.6)	- 0.85	
	Psychological Reactions	11.5 (7.2)	11.1 (7.0)	- 0.42	
	Psychological Reactions Depressive Comp.	10.0 (7.2)	8.7 (7.2)	- 0.90	
	Psychological Reactions	10.0 (6.1)	8.8 (7.8)	- 1.0	
PTSD (DSM Interview)	Re-experiencing	1.9 (1.3)	1.9 (1.3)	- 0.10	
	Avoidance	1.8 (1.4)	2.1 (1.5)	- 1.12	
	Hypervigilance	2.5 (1.4)	2.7 (1.6)	- 0.47	
	Presence of diagnosis (n (%))	12 (25%)	16 (30%)		0.41 (1)
	Absence of diagnosis (n (%))	37 (75%)	38 (70%)		

Note: * $p \leq .05$.

Discussion

This study sought to verify the effectiveness of the cognitive-behavioral group therapy model (Habigzang, et al., 2013) in reducing different symptoms commonly displayed by victims of SV, and to verify its effectiveness when applied by trained practitioners and by the researchers/psychologists that developed it. The results indicate its effectiveness in reducing symptoms for the total sample of victims enrolled (n = 103), and in the comparison between the groups of practitioners (researchers/psychologists that developed the model and practitioners trained for its application) who applied it. This is in agreement with evidence obtained in previous studies (see Habigzang et al., 2013) and the results allow the model evaluated to be considered an effective evidence-based practice for the treatment of girl victims of sexual violence. Seeking evidence of the effectiveness of psychotherapeutic treatments is one of the current challenges that researchers and clinicians face. Given the importance of this search, the American Psychological Association (APA), in 2008, created a task force to study evidence-based practices for children and adolescents (APA Task Force on Evidence-Based Practice for Children and Adolescents, 2008). Psychotherapeutic interventions are considered evidence-based practice when they are developed from empirical data obtained from previous research, combined with the clinical experience of practitioners about the contextual and cultural characteristics and the values of the patients (American Psychological Association [APA], 2002).

Through this study, it was possible to verify the effectiveness of the model evaluated in reducing the symptoms investigated, even when applied by different groups of practitioners, considering the absence of significant differences between G1 and G2. Thus, it is possible to conclude that the effectiveness of the model is due to the techniques used, not being exclusively associated with the practitioners who apply it.

This result indicates that the brief, structured model, with previous evidence of effectiveness (Habigzang et al., 2013) can be replicated by trained practitioners in the public care network for victims of sexual violence. Certainly there is a need to invest in training practitioners so that they are adequately prepared for the application of these techniques. Furthermore, this study indicates that investment in theoretical and practical training with a clearly defined focus (in this case, the treatment of victims of sexual violence) can contribute to professional development. Specifically in Brazil, the Federal Council of Psychology (CFP, 2009) demonstrated that psychology practitioners assessed themselves as not having professional qualifications suitable for attending cases of sexual violence, indicating the need for investment in this area. It was verified that practitioners do not have sufficient theoretical and practical knowledge to carry out assessments and effective interventions (Freitas, Habigzang, & Koller, 2015). In Brazil, evidence-based practices are scarce in the public mental health field and this study revealed the possibility of a strong connection between research and practice, as well as the proximity between scientific knowledge and the public service network to better serve high risk populations, such as cases of sexual violence.

Although the results of this study indicate the effectiveness of the cognitive-behavioral group therapy model evaluated, the method used must be considered. Ideally, the randomized clinical trial is the most appropriate design when the aim is to evaluate a treatment. This is constituted by an experimental design in which the different factors that could affect the final result are controlled. Thus, participants are randomly assigned to two different conditions: treatment and control group. However, when performing the evaluation of treatments for victims of sexual violence, in addition to aspects related to the method, ethical aspects should also be taken into consideration. In these cases, the use of a control groups is impossible (or limited), since depriving some participants of the treatment can be considered unethical. Despite this methodological limitation of the study, it was possible to obtain results, which indicate the effectiveness of the model evaluated respecting the ethics of research with human subjects.

Another limitation of this study was related to the inclusion of intra and extrafamilial cases of sexual abuse in the same therapeutic groups. Distinct therapeutic groups for distinct forms of sexual abuse (i.e., intra and extrafamilial) can fit better with the subsequent consequences of each form. In the other hand, the low frequency of sexual abuse case referrals to therapy related to sub notification, the need of faster composition of groups to not leave girls victims waiting for therapy for a long time and the necessity to match schedules of each girl (e.g., school turn) increase the challenges to compose groups. Practitioners need to make decisions about how face these challenges even though when the decision is not totally appropriate. In this way, the option adopted in this study was to include intra and extrafamilial cases in the same therapeutic groups as a way to guarantee their faster formation.

The subsequent consequences of sexual abuse are influenced by different mediators since intrinsic ones (e.g., victims' temperament, age, history of mental disease) to extrinsic ones (e.g., type of sexual abuse, caregivers' reactions related to disclosure). So, victims of intra and extrafamilial sexual abuse can develop similar symptoms. The same can occur to cases of sexual abuse with or without contact physic (Hébert, Lavoie, & Blais, 2014; Morelato, 2014; Ullman & Filipas, 2005). The practitioners need to analyze all these issues to better understand each case and form therapeutic groups.

When the challenges to group formation might negatively affect its beginning a possible solution is the individual setting. Schneider and Habigzang (2014) adapted the cognitive-behavioral group therapy for girls' victims of sexual violence to an individual setting. The victims showed reductions on their levels of depression, anxiety and PTSD symptoms (Schneider & Habigzang, 2014). The results indicated that

the evidence-based intervention was effective to treat children victims of sexual violence in an individual setting.

Finally, the results of this study confirm the results of previous studies (e.g, Cohen et al., 2004; Hetzel-Riggin et al., 2007; Hohendorff et al., 2014; Macdonald et al., 2012), which indicate the cognitive-behavioral approach as the most effective and efficient treatment for child and adolescent victims of sexual violence. Taken together, these studies indicate that the cognitive-behavioral approach presents empirical evidence of adequacy and effectiveness, as indicated in the guidelines of the WHO & ISPCAN (2006).

References

American Psychiatric Association. (2003). *Manual Diagnóstico e Estatístico dos Transtornos Mentais (DSM-IV-TR)* [Diagnostic and Statistical Manual of Mental Disorders] (4. ed. rev.). Porto Alegre: Artmed.

American Psychological Association. (2002). *Criteria for evaluating treatment guidelines*. *American Psychologist*, *57*(12), 1052-1059. doi: 10.1037//0003-066X.57.12.1052

American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents. (2008). *Disseminating evidence-based practice for children and adolescents: A systems approach to enhancing care*. Washington, DC: American Psychological Association. Retrieved from http://www.apa.org/practice/resources/evidence/children-report.pdf

Beck, A. T.; Ward, C. H.; Mendelson, M.; Mock, J., & Erbaugh, G. (1961). An inventory for measuring depression. *Archives of General Psychiatry 4*, 53-63.

Biaggio, A. & Spielberger, C. D. (1983). *Inventário de Ansiedade Traço-Estado-Idate-C Manual*. Rio de Janeiro: CEPA.

Castillo-Mayén, R., & Montes-Berges, B. (2014). Análisis de los estereotipos de género actuales [Analysis of current gender stereotypes]. *Anales de Psicología*, *30*(3). doi: 10.6018/analesps.30.3.138981

Chowdhury, E. H. (2014). Rethinking patriarchy, culture and masculinity: Transnational narratives of gender violence and human rights advocacy. *Journal of Women of the Middle East World and the Islamic World*, *12*, 79-100. doi: 10.1163/15692086-12341253

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A (2004). A multisite, randomized controlled trial for children with sexual abuse–related PTSD symptoms. *Journal American Academy of Child and Adolescent Psychiatry, 43*(4), 393-402. doi: 10.1097/01.chi.0000111364.941169.f9

Del Ben, C. M., Vilela, J. A., Crippa, J.A., Hallak, J. E., Labate, C. M., & Zuardi, A. W. (2001). Confiabilidade da entrevista estruturada para o DSM-IV - versão clínica traduzida para o português [Interview reliability structured for DSM-IV - Clinical version translated into Portuguese]. *Revista Brasileira de Psiquiatria, 23*(3), 156-159. doi: 10.1590/S1516-44462001000300008

Field, A. (2005). *Discovering Statistics Using SPSS*. 2nd Ed. London: Sage.

Freitas, C. P. P., & Habigzang, L. F. (2013). Percepções de psicólogos sobre a capacitação para intervenção com vítimas de violência sexual [Psychologists' perceptions about training for intervention with victims of sexual violence]. *Psicologia Clínica*, *25*(2), 215-230. doi: 10.1590/S0103-56652013000200013

Freitas, C. P. P., & Habigzang, L. F. (2014). Tecnologia Social de Capacitação Profissional para Intervenção com adolescentes vítimas de violência sexual [Social Technology Professional Training for Intervention with adolescent victims of sexual violence]. In L. F. Habigzang, E. Diniz, & S. H. Koller (Eds.), *Trabalhando com adolescentes: Teoria e Pesquisa* (pp. 309-327). Porto Alegre: Artmed.

Freitas, C. P. P., Habigzang, L. F., & Koller, S. H. (2015). Avaliação de uma capacitação para profissionais de psicologia que trabalham com vítimas de violência sexual [Evaluation of a training for psychology professionals working with victims of sexual violence]. *Psico, 46*(1), 40-47. doi: 10.15448/1980-8623.2015.1.16718

Gouveia, V. V., Barbosa, G. A., Almeida, H. J. F., & Gaião, A. A. (1995). Inventário de Depressão Infantil - CDI: Estudo de adaptação com escolares de João Pessoa [Inventory Child Depression - CDI: Study adaptation with João Pessoa students]. *Jornal Brasileiro de Psiquiatria, 44*, 345-349.

Hetzel-Riggin, M., Brausch, A. M., & Montgomery, B. S. (2007). A meta-analytic investigation of therapy modality outcomes for sexually abused children and adolescents: An exploratory study. *Child Abuse & Neglect, 31*, 125–141. doi: 0.1016/j.chiabu.2006.10.007

Habigzang, L. F. (2006). *Avaliação e intervenção clínica para meninas vítimas de abuso sexual intrafamiliar* [Assessment and clinical intervention for girls victims of domestic abuse]. Unpublished master's dissertation. Graduate school in Developmental Psychology at the Federal University of Rio Grande do Sul. Porto Alegre: UFRGS.

Habigzang, L. F. (2010). *Avaliação de impacto e processo de um modelo de grupoterapia cognitivo-comportamental para meninas vítimas de abuso sexual* [Impact assessment and process a model of cognitive behavioral group therapy for sexually abused girls]. Unpublished doctoral's dissertation. Graduate school in Developmental Psychology at the Federal University of Rio Grande do Sul. Porto Alegre: UFRGS.

Habigzang, L. F., Damásio, B. F., Hohendorff, J. V., & Koller, S. H. (2011). Intersections between scientific research and public policies for sexual abuse. *International Society for the Study of Behavioural Development (ISSBD Bulletin)*. Retrieved from http://www.issbd.org/resources/files/JBD_Nov11.pdf

Habigzang, L. F., Damásio, B. F., & Koller, S. H. (2013). Impact Evaluation of a Cognitive Behavioral Group Therapy Model in Brazilian Sexually Abused Girls. *Journal of Child Sexual Abuse*, *22*(2), 173-190. doi: 10.1080/10538712.2013.737445

Habigzang, L. F., Stroeher, F., Hatzenberguer, R., Cunha, R. C., Ramos, M., & Koller, S. H. (2009). Grupoterapia cognitivo-comportamental para crianças e adolescentes vítimas de abuso sexual [Cognitive behavioral group therapy for children and adolescents victims of sexual abuse]. *Revista de Saúde Pública, 43*, 70-78. doi: 10.1590/S0034-89102009000800011

Hébert, M., Lavoie, F., & Blais, M. (2014). Post Traumatic Stress Disorder/PTSD in adolescent victims of sexual abuse: Resilience and social support as protection factors. *Ciência & Saúde Coletiva*, *19*(3), 685–694. doi: 10.1590/1413-81232014193.15972013

Hohendorff, J. V., Salvador-Silva, R., Andrade, R., Habigzang, L. F., Koller, S. H. (2014). Adaptação e avaliação de uma intervenção cognitivo-comportamental para meninos vítimas de violência sexual [Adaptation and evaluation of a cognitive-behavioral intervention for children victims of sexual violence]. *Psicologia: Reflexão e Crítica*. doi: 10.1590/1678-7153.201427302

Kovacs, M. (1992). *Children's Depression Inventory Manual*. Los Angeles: Western Psychological Services.

Kristensen, C. H. (1996). *Abuso sexual em meninos* [Boys victims of sexual abuse]. Unpublished master's dissertation. Graduate school in Developmental Psychology at the Federal University of Rio Grande do Sul. Porto Alegre: UFRGS.

Lipp, M. E. & Lucarelli, M. D. M. (1998). *Escala de stress infantil – ESI: Manual* [Stress scale for children - SSC: Manual]. São Paulo: Casa do Psicólogo.

Macdonald, G., Higgins, J. P. T., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P. … Taylor, M. (2012). Cognitive-behavioural interventions for children who have been sexually abused. *Cochrane Database of Systematic Reviews 2012(5)*, CD001930. doi: 10.1002/14651858.CD001930.pub3.

Martínez, C., & Paterna-Bleda, C. (2013). Ideología masculina e igualdad de género: Valorando el neosexismo [Masculine ideology and gender equality: Valuing neosexism]. *Anales de Psicología*, *29*(2), 558-564. doi: 10.6018/analesps.29.2.141311

Maniglio, R. (2009). The impact of child sexual abuse on health: A systematic review of reviews. *Clinical Psychology Review, 29*, 647-657. doi: 10.1016/j.cpr.2009.08.003

Morelato, S. G. (2014). Evaluación de factores de resiliencia en niños argentinos en condiciones de vulnerabilidad familiar [Evaluation of resilience factors in Argentine children living in household vulnerability]. *Universitas Psychologica, 13*(4), 1473-1488. doi: 10.11144/Javeriana.UPSY13-4.efrn

Polanczyck, G. V., Zavaschi, L., Benetti, S., Zenker, R., & Gammerman (2003). Violência sexual e sua prevalência em adolescentes de Porto Alegre, Brasil [Sexual violence and its prevalence in adolescents from Porto Alegre, Brazil]. *Revista de Saúde Pública*, 37(1), 8-14. doi: 10.1590/S0034-89102003000100004

Programa Nacional de Enfrentamento da Violência Sexual Contra Crianças e Adolescentes (2010). *Relatório disque denúncia nacional* [Report dial national reporting]. Brasília: Secretaria de Direitos Humanos da Presidência da República. Retrieved from http://www.direitosdacrianca.org.br/midiateca/publicacoes/relatorio-geral-do-disque-100-2010

Rossi, P. H., Lipsey, M. W., & Freeman, H. E. (2004). *Evaluation: A systematic approach* (7th ed.). Thousand Oaks: Sage.

Schneider, J. A., & Habigzang, L. F. (2014). Aplicação do programa cognitivo-comportamental Superar para atendimento individual de meninas vítimas de violência sexual: Estudos de caso [*Application of "Superar" cognitive-behavioral program for girls victims of sexual violence: Case studies*]. *Submitted article.*

Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment*, *16*(79), 79-101. doi: 10.1177/1077559511403920

The Metropolitan Toronto Special Committee on Child Abuse (1995). *Child Sexual Abuse Protocol* (3rd. ed.). Toronto: Author.

Ullman, S. E. & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse & Neglect, 29*, 767- 782. doi:10.1016/j.chiabu.2005.01.005

Walsh, K., Keyes, K. M., Koenen, K. C., & Hasin, D. (2015). Lifetime prevalence of gender-based violence in US women: Associations with mood/anxiety and substance use disorders. *Journal of Psychiatric Research*, *62*, 7–13. doi: 10.1016/j.jpsychires.2015.01.002

World Health Organization (1999). *WHO recognizes child abuse as a major public health problem*. Retrieved from http://www.who.int/inf-pr-1999/en/pr99-20.html

World Health Organization & International Society for Prevention of Child Abuse and Neglect (2006). *Preventing child maltreatment: A guide to taking action and generating evidence*. Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf

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