The Association between Peer Victimization, PTSD, and Dissociation in Child Victims of Sexual Abuse

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Abstract

Background—Sexually abused children present a host of psychological difficulties, including dissociation and post-traumatic stress (PTSD) symptoms. Negative repercussions associated with sexual abuse may interfere with children's ability to interact competently with their peers, and might put them at risk for peer victimization. The aims of the study were 1) to describe peer victimization experiences of sexually abused children using a multi-informant approach (self, parents, teachers), and 2) to examine if peer victimization experiences are associated with clinical levels of PTSD and dissociation after controlling for relevant variables.

Method—Participants were 158 children (104 girls and 54 boys; Mean age = 9.10) and their non-offending parent consulting after the disclosure of sexual abuse. Children, parents, and teachers completed a measure assessing peer victimization (*Self-Report Victimization Scale*). Measures of trauma-related symptoms (PTSD and dissociation) were used as outcome variables.

Results—More than half (60%) of sexually abused children reported being picked on, 51% reported sustaining verbal victimization and a third (35%) physical victimization by peers in the school context. Inter-informant agreement was higher between parents and teachers than between self-reports and adults' reports. Peer victimization experiences increased the odds by up to threefold for clinical levels of dissociation and PTSD symptoms.

Limitations—Our findings are based on cross-sectional data, and therefore, causal relationships cannot be inferred. No control group was included in the study.

Conclusions—Results have significant relevance for prevention and intervention. Clinicians should include assessment of peer victimization experiences when evaluating sexually abused school-aged children. Prevention initiatives in terms of peer victimization could indirectly prevent worsening of symptoms in abused children.

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Author contributions

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Keywords

peer victimization; sexual abuse; PTSD; dissociation; cross-informant

Introduction

Child sexual abuse (SA) is an important public health problem that affects close to one out of five women and one out of ten men (Stoltenborgh et al., 2011). According to their parents, sexually abused children display higher levels of internalized and externalized behavior problems than their non-abused peers (Hébert et al., 2006). SA is also associated with a 4-fold increase in the odds of presenting clinical levels of post-traumatic stress disorder (PTSD), and with a 8-fold increase of clinical levels of dissociation in school-aged girls (Collin-Vézina & Hébert, 2005). Sexually abused children also appear to experience significant challenges in their social interactions with peers (Daignault & Hébert, 2008). Teachers rate sexually abused children as less socially skilled and as being more at risk of presenting clinically significant social difficulties than non-abused children (Blanchard-Dallaire & Hébert, 2014). These difficulties could place sexually abused children particularly at risk for peer victimization, another adverse childhood experience that could significantly add to the negative outcomes of sexually abused children. Exposure to one type of abuse has been found to be associated with higher odds of other types of victimization (Finkelhor et al., 2015). In addition, studies show a cumulative and sometimes synergetic effect on outcomes when more than one ACE is sustained (Putnam et al., 2013).

The American Psychological Association recognized peer victimization as a major public health issue in 2004 (APA, 2004). Peer victimization is associated with internalized and externalized behavior problems, academic dysfunction, as well as suicidal ideation (Rosen et al., 2009). Self-reports of peer victimization in elementary school are also found to be negatively associated with adjustment in adolescence (Smithyman et al., 2014).

Despite the wealth of studies on peer victimization, few studies have explored the potential links between negative experiences with peers and PTSD in school-aged children. One recent study has shown that children reporting peer victimization were twice as likely to show PTSD symptoms compared to children not victimized by their peers (Litman et al., 2015). Developing positive peer relationships is one of the major developmental tasks in middle childhood (Rubin et al., 2006). Indeed, friends come to play a more important role in youth's lives, and an important part of friendship is self-disclosure (Rubin et al., 2006). This role may be particularly salient for sexually abused children who may turn to their peers for support (Feiring et al., 1998). Children living in disharmonious homes may be more likely to rely on peers for emotional support, namely when the abuse involves an intra-familial perpetrator or when support is not readily available in the home environment. While positive peer relationships may play a protective role, peer relationships marked by victimization could also represent a risk factor for heightened distress in abused children.

In light of these considerations, this study's first aim is to describe peer victimization experiences of sexually abused school-aged children using a multi-informant approach (self, parent, teacher). Such an approach is now deemed essential to gain a more reliable

assessment of children's experiences (Kuppens et al., 2009). Children can report peer victimization experiences occurring in various contexts of their lives; being directly involved, they are good sources of information (Ladd & Kochenderfer-Ladd, 2002). However, biases can interfere with the validity of self-reports of peer victimization (e.g., interpretations, memory, social desirability) (Ladd & Kochenderfer-Ladd, 2002). Using additional informants, including teachers who are on the front line to observe peer interactions at school, and parents, could provide crucial complementary information (Ladd & Kochenderfer-Ladd, 2002). This study's second aim is to examine if peer victimization experiences, as assessed by self, teacher and parent reports, are related to PTSD and dissociation - two well-established correlates of SA - when other relevant variables, such as characteristics of the abuse (e.g., severity, duration, relationship with the abuser) and demographics (age, gender), are factored in.

Methods

Participants and procedure

Data for this study came from a larger project on developmental outcomes in sexually abused children. Children and their parents were recruited at treatment centers offering services to sexually abused children in the province of Quebec, Canada. Following parental consent, teachers were also invited to complete a questionnaire. This study was approved by the Ethics committees of the *Centre hospitalier universitaire Sainte-Justine* and of the *Université du Québec à Montréal*. All measures were administered in French by master's or doctoral-level research assistants.

The current study included 158 children (104 girls and 54 boys; 86% Canadian) aged 6–14 years ($M = 9.10$, $SD = 2.02$) and their non-offending parents (75.9% biological mother). Only 21% of children lived in an intact family, the remaining children lived in single-parent families, stepfamilies, or foster families. Approximately 50% of mothers had a high school diploma or less, and 65% had an annual income of less than 40,000\$ (CAN). The perpetrator was an immediate family member in 46% of cases, an extended family member in 24% of cases, and a known perpetrator in 29% of cases. Only 1% of the cases involved a stranger as the perpetrator. A total of 19% of children sustained one episode of SA, 44% reported episodes lasting less than 6 months while 37% of the children reported chronic abuse, spanning over more than six months. The majority of cases involved penetration or attempted penetration (65%), while one out of five children suffered unclothed touching, and one out of ten clothed touching.

Measures

Peer-victimization—Children completed the Self-Report Victimization Scale (SRVS; Kochenderfer & Ladd, 1996; Ladd & Kochenderfer-Ladd, 2002). The four items relate to situations involving peers experienced in the school context, and assess physical victimization, direct verbal victimization, indirect verbal victimization and general victimization. The same items and one additional item relating to teasing were in the parent and teacher versions (“*This child/My child is teased or made fun of by peers*”). Responses are coded on a 3-point frequency scale (1 = *never/seldom*, 2 = *sometimes*, or 3 = *a lot/often*).

The total score for each informant is obtained by averaging ratings across items. In the present study, the internal consistency of the total score derived from the self-report version was acceptable ($\alpha = .75$) and both the parent ($\alpha = .91$) and teacher version ($\alpha = .90$) showed high reliability.

Post-traumatic stress symptoms—PTSD symptoms were measured using the PTSD scale (46 items) of the Children's Impact of Traumatic Events Scale–II (CITES-II; Wolfe, 2002). The PTSD scale was designed to cover all symptoms identified in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (American Psychiatric Association, 1994), and diagnostic status can be calculated for the PTSD symptom criteria (Wolfe, 2007). The scale includes typical re-experiencing symptoms (e.g., nightmares), avoidant behaviors (e.g., social withdrawal), and hyperarousal symptoms (e.g., difficulty sleeping). Items are rated on a 3-point scale ranging from 0 (not true) to 2 (very true). The scale has been successfully used with children as young as 6 years old in previous studies (e.g., Hubel et al., 2014; Sawyer & Hansen, 2014; Yancey, Naufel, & Hansen, 2013). Studies have shown that the PTSD scale had good convergent validity with other measures including the Diagnostic Interview for Children and Adolescents – Revised (Chaffin & Shultz, 2001).

Dissociation—Parents completed the Child Dissociative Checklist (CDC; Putnam et al., 1993). The scale consists of 20 items presented on a 3-point scale from 0 (*not true*) to 2 (*very true*). Items cover a wide range of behaviors, from adaptive functioning to pathological reactions. Total score range from 0 to 40, with a score of 12 or higher being the cut-off for the clinical range of dissociation (Putnam et al., 1993). The CDC was elaborated and validated with children aged 4 to 13 years old. The scale showed good test-retest reliability over 1 year with sexually abused and non-abused girls and had high discriminant validity among four samples (sexually abused girls, non-abused girls, and boys and girls with dissociative disorders). The scale has been used with children spanning a wide age range (preschool to adolescence) (Bernier, Hébert, & Collin-Vézina, 2013; Chae, Goodman, Eisen, & Qin, 2011; Putnam et al., 1993).

Socio demographic and abuse characteristics—Socio demographic characteristics of the children and their families were obtained through a questionnaire completed by the parents. Abuse characteristics were drawn from children's clinical case records using an adapted version (Parent & Hébert, 2000) of the History of Victimization Form (Wolfe et al., 1987). Characteristics of the abuse were binary coded for the analyses: type of abuse (0. *involving an extra-familial* vs. 1. *intra-familial perpetrator*), severity (0. *clothed or unclothed touching* vs. 1. *penetration or attempted penetration*) and duration (0. *less than 6 months* vs. 1. *more than 6 months*).

Results

Results showed a moderate correlation between parents' and teachers' reports of peer victimization ($r = .37, p < .001$), a significant but low association between children's self-report and parental reports ($r = .17, p < .05$). Children's self-reports of peer victimization did not correlate with teachers' reports ($r = .08, ns$). Peer victimization was positively correlated with age of the children in parental and teachers' reports, but not in self-reports ($r = .20$ and .

16, $p < .05$; $r = .01$, ns). Mean scores of peer victimization were as follows: $M = 1.66$ ($SD = 0.58$) for the child version, $M = 1.57$ ($SD = 0.62$) for the parent version and $M = 1.33$ ($SD = 0.47$) for the teachers' assessment of peer victimization.

Figure 1 illustrates the percentage of participants endorsing each item of the SRVS as occurring sometimes or often. Chi-square analyses revealed that both children (60.1%) and parents (56.3%) were more likely to endorse the item relating to general victimization than teachers (32.9%). The same pattern of results was apparent for verbal and physical victimization with children (verbal: 50.6%; physical: 34.8%) and parents (verbal: 41.8%; physical: 30.4%) reporting more victimization compared to teachers (verbal: 25.3%; physical: 15.2%). Parents reported teasing more often than teachers did (44.3% vs. 28.5%). Indirect verbal victimization was the only item for which no difference in endorsement by informant was noted (Children: 42.4%; parents: 44.3%; teachers: 36.9%).

Overall, 53.6% of sexually abused children reached clinical levels of PTSD while 16.6% reached clinical levels of dissociation. To ascertain associations between peer victimization and trauma-related outcomes, a dichotomous score of peer victimization was calculated following the guidelines provided by Ladd and Kochenderfer-Ladd (2002). A score of 1 SD of the mean was thus used to categorize children as experiencing victimization according to each informant. Figure 2 illustrates, for each informant, the percentage of children reaching clinical scores of PTSD and dissociation according to their experience of peer victimization. Bivariate analyses revealed that self-reported victimization was associated with a higher frequency of clinical levels of PTSD ($\chi^2_{(1, N=153)} = 8.87, p < .01$) and dissociation ($\chi^2_{(1, N=157)} = 5.71, p < .05$). Parental reports of peer victimization were significantly related to clinical levels of PTSD symptoms ($\chi^2_{(1, N=153)} = 3.71, p < .05$) and dissociation symptoms ($\chi^2_{(1, N=157)} = 9.89, p < .01$). Teachers' reports of peer victimization were linked to children's PTSD symptoms ($\chi^2_{(1, N=153)} = 3.74, p < .05$) but not to dissociation ($\chi^2_{(1, N=157)} = .82, ns$).

Logistic regression analyses were performed first with the clinical score of PTSD, and then dissociation as dependent variables. Independent variables were entered in two steps: 1) sex and age of the child, and characteristics of SA including type, severity and duration of abuse, 2) all three informants' reports of peer victimization. The analyses yielded significant results (see Table 1). Results indicated that younger children were more likely to reach clinical levels of PTSD. In addition, self- and teachers' reports of peer victimization were associated with a higher likelihood of presenting clinical levels of PTSD. Self-reports of peer victimization increased the odds of reaching clinical levels of PTSD by threefold ($OR = 3.17$) and teachers' reports by twofold ($OR = 2.53$). As for dissociation, both self-reports ($OR = 2.85$) and parents' reports ($OR = 3.26$) were independently associated with clinical levels. Abuse-related characteristics did not independently contribute to either PTSD or dissociation.

Discussion

This study's first aim was to describe peer victimization experiences of sexually abused school-aged children using a multi-informant approach. Results indicated that an important

proportion of these children experienced at least one incidence of peer victimization. Indeed, 60% of SA children endorsed experiencing general victimization sometimes or often, while verbal victimization, indirect victimization and physical victimization were experienced by 51%, 42% and 35% of children, respectively. In a nationally representative sample of American children, 13.3% of children were identified as being bullied in the last year, while 19.2% of them had been teased or emotionally bullied (Finkelhor et al., 2009). While differences in measures used preclude direct comparison, it would appear that sexually abused children in our sample are at greater risk for peer victimization than children in the general population. Symptoms associated with SA as well as the sense of stigmatization, betrayal, and issues in trust may hinder the development of children's social competence and/or make them vulnerable targets for victimization by peers. Our results are in line with past reports that suggest that experiences of victimization are often inter-related (Dong et al., 2004; Finkelhor et al., 2015).

Inter-rater agreement between reports of peer victimization from parents and teachers was moderate, while it was significant but low between parents and children, and non significant between children and teachers. These results appear congruent with the idea that informants who have similar roles will make similar evaluations (Achenbach et al., 1987). The higher child/parent agreement compared to child/teacher agreement may be attributable to the fact that parents' reports of peer victimization rely mostly on what children tell them about their experiences (Demaray et al., 2013), while teachers' evaluations may rely on what they directly witnessed in the school environment (Ladd & Kochenderfer-Ladd, 2002). Peer victimization may also occur in contexts where teachers are not necessarily present (e.g., school yard or bus) (Ladd & Kochenderfer-Ladd, 2002), which could explain why children report acts of peer victimization to a greater extent.

Results of our bivariate analyses show that experiences of peer victimization were positively associated with trauma symptoms in sexually abused children. Rates of clinical levels of PTSD were significantly higher when children sustained peer victimization be it in accordance with self-, teacher- or parents reports. Rates of clinical dissociation were close to 3 times higher when either children or parents reported peer victimization.

In multivariate analysis, peer victimization remained a significant factor above and beyond demographics and characteristics of the SA experienced. Indeed, both self-reports and teachers' reports of peer victimization were associated with an increased risk of reaching clinical levels of PTSD (by three and two-fold respectively) even after controlling for type of SA, severity of the acts involved or duration of the SA. When either the child or the teacher reported negative peer experiences, children were more prone to endorse re-experiencing, hyperarousal and avoidance behaviors typical of PTSD.

Both self-reports and parental reports of peer victimization were linked with clinical levels of dissociation once demographics and SA characteristics were controlled for. Thus, when children or parents reported experiences of peer victimization in the school context, children were close to 3 times more likely to achieve clinical levels of dissociation. It appears that each informant's report of peer victimization is differently associated with PTSD and dissociation, underlining the relevance of a multi-informant approach to gather a more valid

evaluation. Thus reports from different informants appears to explain unique variance in trauma-related symptoms in SA children.

Analyzing data from the 2014 National Survey of Children's Exposure to Violence, Finkelhor et al. (2015) found that adding peer victimization to the original Adverse Childhood Experiences (ACE) Scale (Felitti et al., 1998) adds a substantial contribution to the prediction of mental health symptoms. This is coherent with our results, and with those of other studies that have identified peer victimization as a risk factor for developing a host of mental health symptoms (Litman, et al., 2015; Rosen et al., 2009; Smithyman et al., 2014).

Limitations

There are several limitations to the current study that need to be considered. The design of the study was cross-sectional precluding any conclusion about causality and the temporality of associations. The absence of a comparison group of non-sexually abused children limits our interpretation of the prevalence rates obtained for sexually abused children. While relying on a dichotomous score of PTSD ensured clinical relevance of the findings, developmental issues related to the DSM-IV PTSD diagnosis might lead to an underestimation of the number of children affected by this disorder in our sample (Cohen & Scheeringa, 2009). Other variables that were not considered in the present study (for e.g., other forms of child maltreatment or adverse life events) may contribute to the prediction of trauma-related symptoms. Our results failed to identify abuse-related variables as associated with PTSD and dissociation. It is possible that other characteristics of the abuse (e.g., nature of threats involved, use of force, etc.) not evaluated in the present study contribute to PTSD and dissociation and/or that the salience of these variables may be associated with long-term outcomes. While reliance on multiple informants in our study offered a more comprehensive approach to delineate children's experience of peer victimization, our measure was limited to peer victimization in the school context. Yet, there is some evidence attesting that a significant proportion of peer victimization occurs outside the school context (Turner et al., 2011). Despite these limitations, our results suggest that more than half of sexually abused children are experiencing peer victimization in the school context and that these experiences contribute to a higher risk of clinical levels of PTSD and dissociation.

Future studies will need to explore potential mediators that may explain the greater vulnerability of sexually abused children to peer victimization (e.g., hostile intent bias, interpersonal trust). In addition, reliance on a longitudinal design would offer means to ascertain the sequencing of variables and explore whether the experiences of peer victimization in abused children are maintained over time.

Implications and contributions

Our findings highlight some important implications for clinical practice. Characteristics of the SA endured do not allow identifying which children are most in need for treatment; thus orientation to services should not be based upon the nature of the SA. Clinicians need to include an evaluation of possible experiences of peer victimization in their assessment of

sexually abused children, in addition to trauma-related symptoms. Prevention initiatives regarding peer victimization in school settings may offer a viable means to prevent distressing symptoms in sexually abused children. As school-aged children evolved in a social network that has the potential to either support or undermine their adaptation following adverse childhood experiences such as sexual abuse, parents and teachers should be informed of the potential additional harm caused by peer victimization. An increased awareness may serve to mobilize teachers and parents to intervene more quickly when faced with such situations.

Acknowledgments

Role of funding source

This research was supported by a grant from the Canadian Institutes of Health Research (CIHR # 77614) awarded to Martine Hébert.

The authors would like to thank the families who participated in this study and members of the participating agencies. Our thanks are also extended to Manon Robichaud for database management and assistance in preparation of the manuscript.

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Figure 1.
Percentage of Endorsement (sometimes or often) for the Different Peer Victimization Items by Informant

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

Figure 2.
 Percentage of SA Children Achieving Clinical Scores of PTSD and Dissociation by
 Informant Reports of Peer Victimization.
 Note. * $p < .05$, ** $p < .01$, *** $p < .001$

Table 1

Logistic Regression Analyses

Dependent variable						
	Independent variable	<i>B</i>	<i>SE</i>	Wald	<i>p</i>	<i>OR</i>
PTSD		$\chi^2_{(8)} = 19.35, p = .01$				
Step 1	Sex of the child	-.41	.38	1.14	.29	.67
	Age of the child	-.02	.01	4.21	.04	.98
	Intra-familial sexual abuse	-.18	.39	.22	.64	.84
	Chronic	.29	.40	.54	.46	1.34
	Severe sexual abuse	.36	.39	.83	.36	1.43
Step 2	Self-reported peer victimization	1.15	.49	5.48	.02	3.17
	Parent-reported peer victimization	.62	.51	1.51	.22	1.87
	Teacher-reported peer victimization	.93	.47	3.91	.05	2.53
Dissociation		$\chi^2_{(8)} = 16.22, p = .04$				
Step 1	Sex of the child	-.19	.52	.13	.72	.83
	Age of the child	.01	.01	1.38	.24	1.01
	Intra-familial sexual abuse	-.57	.49	1.33	.25	.57
	Chronic	.09	.52	.03	.87	1.09
	Severe sexual abuse	-.03	.53	.00	.95	.97
Step 2	Self-reported peer victimization	1.05	.51	4.31	.04	2.85
	Parent-reported peer victimization	1.18	.52	5.20	.02	3.26
	Teacher-reported peer victimization	.16	.56	.08	.78	1.17

Note. OR = Odds ratio.