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Self-Blame, Shame, Avoidance, and Suicidal Ideation in Sexually Abused Adolescent Girls: A Longitudinal Study

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ABSTRACT

Depressive symptoms, posttraumatic stress disorder, and suicidal ideation are among the most prevalent problems associated with sexual abuse. Based on the Traumagenic dynamic of stigmatization model, the aim of this study was to investigate whether self-blame, shame, and maladaptive coping strategies predicted posttraumatic stress disorder, depressive symptoms, and suicidal ideation among sexually abused adolescent girls using a longitudinal design. A total of 100 adolescent girls completed a series of questionnaires at the initial visit at the intervention center (T1) and 6 months later (T2). Path analysis reveals shame at T1 predicted posttraumatic stress disorder symptoms at T2 whereas self-blame at T1 predicted depressive symptoms at T2. Furthermore, avoidance coping at T1 and depressive symptoms at T2 predicted suicidal ideation at T2 and accounted for 54% of the variance. These findings suggest that interventions designed for sexually abused adolescent girls should target shame, self-blame, and avoidance coping to foster recovery in this vulnerable population.

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Childhood sexual abuse (CSA) is a worldwide threat to women and girls physical and mental health. According to meta-analyses (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011), between 18% and 31% of girls have been sexually abused, with almost 40% of cases occurring during adolescence (Finkelhor, Shattuck, Turner, & Hamby, 2014). Mental health problems associated with CSA have been widely documented, with depressive symptoms, posttraumatic stress disorder (PTSD), and suicidal ideation among the most prevalent correlates (Paolucci, Genuis, & Violato, 2001). A meta-analytic review shows that women victims of CSA have more depressive and anxiety disorders than men victims and are five times more likely to meet the diagnostic criteria for depression and twice as likely to meet the diagnostic criteria for anxiety than women who are not victims (Amado,

Arce, & Herraiz, 2015). Furthermore, the comorbidity of major depressive episodes among epidemiological samples of people with PTSD is about 50%, and individuals with both disorders have a higher risk of suicide than those with PTSD only (Flory & Yehuda, 2015).

Among women, between 20% and 22% of suicide and suicide attempts could be imputed to CSA according to a meta-analysis (Devries et al., 2014). Furthermore, suicide appears to be the second leading cause of death worldwide among young people aged 10–29 years-old (World Health Organization, 2014) and among young people aged 10–25 years, sexual abuse is the adverse life event most consistently and strongly associated with suicide (Serafini et al., 2015). In fact, a review revealed significant associations between CSA and suicidal ideation or attempts in 49 out of 52 studies conducted with adolescents (Miller, Esposito-Smythers, Weismore, & Renshaw, 2013). Given this high co-occurrence rate, more studies are needed to identify the factors that can increase the risk of suicide among CSA victims during adolescence.

The different factors contributing to psychological distress among CSA victims have been studied for decades. In their 2005 review, Whiffen and MacIntosh concluded that shame, self-blame, and avoidant coping strategies mediated the association between CSA and psychological distress. However, few of the studies reviewed included these three factors simultaneously (self-blame, shame, and coping strategies) to examine their influence on depressive symptoms, PTSD symptoms, and suicidal ideation. Moreover, the majority of empirical reports analyzing outcomes in teenage girls have relied on cross-sectional studies and longitudinal designs have rarely been used.

Self-blame and shame

Self-blame is an internal attribution, a cognitive process by which an individual attributes the occurrence of a negative event to oneself. In the context of CSA, some victims attribute the abuse to an internal cause (Weiner, 1985). Shame refers to the feeling that is most likely to result from an internal attribution of a negative event (Lewis, 1992). Self-blame and shame are both included in the Traumagenic dynamic of stigmatization model proposed by Finkelhor and Browne (1985). According to these authors, a negative connotation about sexual abuse is transmitted to the victim by the aggressor, but also by her/his social network, and society at large. By integrating the stigma, the victim is likely to experience self-blame, shame, and guilt, to feel isolated, and engage in self-destructive behaviors, such as suicide attempts.

In youth and adult samples of women, self-blame following sexual abuse has been associated with PTSD (Arata & Burkhart, 1996; Cantón-Cortés, Cantón, & Cortés, 2012; Feiring, Taska, & Chen, 2002; Ullman, Filipas, Townsend, &

Starzynski, 2007), with depressive symptoms (Feiring & Cleland, 2007; Feiring, Taska, & Lewis, 1998; Frazier, 1990; Spaccarelli & Fuchs, 1997), and with suicidal ideation among women (Ullman & Najdowski, 2009). Shame has also been related to PTSD and depression among sexually abused women (DeCou, Cole, Lynch, Wong, & Matthews, 2017) and youth (Feiring & Taska, 2005; Feiring et al., 2002, 1998), and to suicidal ideation among adolescent girls (Alix, Cossette, Hébert, Cyr, & Frappier, 2017). Moreover, shame has been found to mediate the relationship between self-blame and PTSD symptoms among children and adolescents victim of CSA (Alix et al., 2017; Feiring et al., 2002).

A longitudinal study conducted by Candice Feiring and her colleagues has shown the long term impact of self-blame and shame on outcomes in CSA victims aged 8 to 15 years. High levels of shame were found to persist over time and to predict PTSD symptoms up to 6 years after the first assessment (Feiring & Taska, 2005), whereas self-blame tended to decrease over time but still predicted depressive and PTSD symptoms 6 years later (Feiring & Cleland, 2007). Persistence of shame and self-blame also predicted the use of avoidant coping strategies instead of constructive or approach coping strategies (Simon, Feiring, & Cleland, 2014). However, the authors did not examine the impact of self-blame, shame, and avoidant coping on suicidal ideation or attempts. Yet, sexual abuse is the adverse life event most strongly related to suicide among youth aged 10–25 years (Serafini et al., 2015). As Finkelhor and Browne (1985) have argued, the stigmatization experienced by the victim is likely to lead to internalized stigma and to self-blame and shame which may contribute to higher levels of psychological distress following CSA. Stigmatization could also lead to reliance on maladaptive coping strategies to deal with CSA, which can also contribute to psychological distress (Whiffen & MacIntosh, 2005).

Coping

Coping, as defined by Lazarus (1993), “consists of cognitive and behavioral efforts to manage psychological stress”. Coping strategies can be more or less adaptive. If an individual blames himself or herself for a perceived failure, this person is likely to feel shame or guilt (Weiner, 1985) and, maybe, use maladaptive coping strategies. The use of coping strategies by victims of CSA, either adaptive coping strategies such as problem-solving or seeking social support, or maladaptive coping strategies, such as avoidance, may therefore predict later outcomes.

A study among adolescent victims of CSA showed they tend to rely more on avoidance and social support seeking strategies than non-abused adolescents (Bal, Van Oost, De Bourdeaudhuij, & Crombez, 2003). Maladaptive coping strategies, including avoidance, substance use, and self-destructive behaviors, have been identified as strategies used by CSA

youth victims (Whiffen & MacIntosh, 2005). Avoidant coping has been related to the emergence of PTSD, depressive symptoms, or psychological distress among victims of CSA both in childhood (Alix et al., 2017; Bal et al., 2003; Hébert, Tremblay, Parent, Daignault, & Piché, 2006; Simon, Feiring, & McElroy, 2010; Spaccarelli & Fuchs, 1997; Tremblay, Hébert, & Piché, 1999) and adulthood (Walsh, Fortier, & DiLillo, 2010). Avoidant coping has also been shown to mediate the association between self-blame and PTSD among women victims of CSA (Cantón-Cortés, Cantón, Justicia, & Cortés, 2011). Ullman and Relyea (2016) in their study of women sexually abused in childhood or adulthood have shown that maladaptive coping strategies (denial, behavioral disengagement, substance use, and self-blame) were related to PTSD up to 3 years following the abuse. Maladaptive coping, but not self-blame, was also found to mediate the association between CSA severity and PTSD and depression (Ullman, Peter-Hagene, & Relyea, 2014).

In a cross-sectional study (Alix et al., 2017) showed a high prevalence of distress among CSA adolescent girls, with almost half of them reporting suicidal ideation in the last 3 months. Shame and depression were found to partially mediate the association between self-blame and suicidal ideation. Shame was also found to partially mediate the association between self-blame and PTSD symptoms. These findings highlight the need to further examine the impact of self-blame and shame on psychological distress and suicidal ideation by means of a longitudinal design.

Aim and hypotheses

The aim of the present study was to investigate the impact of self-blame, shame, and coping strategies on symptoms of PTSD, depression, and suicidal ideation among sexually abused adolescent girls using a longitudinal design. We first hypothesized that self-blame, shame, and coping strategies at first assessment (T1) would predict symptoms of PTSD and depression and suicidal ideation 6 months later (T2). We also hypothesized that depressive and PTSD symptoms at T2 would contribute to the prediction of suicidal ideation.

Method

Participants and procedure

Participants were recruited as part of a larger study from four different CSA intervention centers in the province of Quebec: the Clinique de l'adolescence of the Center Hospitalier Universitaire (CHU) Sainte-Justine, Parent-Unis Repentigny (PURL), The Center d'Intervention en Abus Sexuels pour la

Table 1. Sociodemographic characteristics.

Characteristics	Participants (%)
Age	
14	26.0
15	28.0
16	24.0
17	20.0
18	2.0
Nationality	
Born in Canada from parents born in Canada	69.7
Born in Canada with one or two parents born outside Canada	19.2
Born outside of Canada	11.1
Parents' nationality	
Canadian	76.0
Caribbean	13.0
Other	11.0
Language at home	
French	89.0
English	3.0
Other	8.0
Family structure	
Intact family	20.0
Single-parent family	48.0
Recomposed or foster family	32.0

Famille (CIASF), and the Center Jeunesse de la Mauricie et du Center du Québec (CJMCQ). A sample of 100 adolescent girls, aged 14 to 18 years, was assessed twice, at recruitment (T1) and 6 months later (T2).

A research assistant explained the purpose of the study, obtained written consent, and provided assistance in the completion of the survey if required. Participants then received a gift card and a list of relevant resources available in their district. The study was approved by the Ethics Committee of the Center Hospitalier Universitaire Sainte-Justine. Sociodemographic characteristics of the sample are presented in [Table 1](#).

Measures

Abuse characteristics

The History of Victimization Form (HVF) (Wolfe, Gentile, & Bourdeau, 1987) was used to assess characteristics of the abuse. The questionnaire was completed by the caseworker. The data collected included number of reported lifetime CSA situations, severity of the abuse (1: exhibitionism, voyeurism, kisses, exposition to pornographic material or physical contact over clothing, 2: physical contact under clothing, 3: oral, vaginal or anal penetration or penetration attempt or oral-genital contact), duration of the abuse (1: one episode, 2: many episodes, 3: repetitive or chronic, i.e. over 6 months), and relationship to abuser (family member, partner, friend or acquaintance, stranger).

Self-blame

Participants completed the Abuse Attribution Inventory (AAI) (Feiring, Simon, & Cleland, 2009), consisting of 8 items rated on a three-point scale: not true, somewhat true, and very true. Sample items include: “It happened to me because I am not a cautious person.” and “It happened to me because I was to blame for what happened”. Internal consistency was acceptable in the original study ($\alpha = .75 - .80$; Feiring et al., 2009) and ordinal Cronbach’s alpha was good in the present study (ordinal $\alpha = .88$).

Shame

The Abuse Specific Shame Questionnaire (ASSQ) (Feiring et al., 1998) comprises the following items rated on a three-point scale: not true, somewhat true, and very true: 1. “I feel ashamed because I think that people can tell from looking at me what happened”, 2. “When I think about what happened I want to go away by myself and hide”, 3. “I am ashamed because I feel I am the only one in my school who this has happened to”, and 4. “What happened makes me feel dirty.” The internal consistency was high in the original study ($\alpha = .85$) (Feiring et al., 2002) as well as in the present study (ordinal $\alpha = .85$).

Coping strategies

The brief version of the Ways of Coping Questionnaire (WCQ) (Folkman & Lazarus, 1988) was adapted to assess abuse-specific coping strategies. The adapted version comprises 12 items rated on a four-point scale: does not apply or not used, used somewhat, used quite a bit, and used a great deal. Three subscales were used: social support seeking (ordinal $\alpha = .79$), problem-solving (ordinal $\alpha = .83$), and avoidance coping (ordinal $\alpha = .70$).

Posttraumatic stress disorder

The global PTSD score ($\alpha = .95$) of the Children’s Impact of Traumatic Events Scale II (CITES II) (Wolfe, 2002) was used. This scale was designed to cover all symptoms identified in the DSM-IV (American Psychiatric Association [APA], 1994). The global PTSD score (46 items) was used in the analyses (ordinal $\alpha = .96$).

Depressive symptoms

The Affective Problems Scale from the Youth Self Report (YSR) (Achenbach & Rescorla, 2001) was used to assess depressive symptoms. This scale was found to be a better measure of major depressive disorder than the anxiety/depressive scale (Ferdinand, 2008; Nakamura, Ebesutani, Bernstein, & Chorpita, 2009). Clinical scores can be derived from the YSR (T scores >70). The original scale comprises 13 items. In order to analyze the relationship between depressive symptoms and suicidal ideation, item 91 “I think

about killing myself” was removed from the measure of depressive symptoms in the analyses. The revised scale contains 12 items (ordinal $\alpha = .87$).

Suicidal ideation

The item 91 (“*I think about killing myself*”) from the Affective Problems Scale of the YSR was used to assess suicidal ideation in the last three months. Rating is on a three-point scale: not true, somewhat or sometimes true, and very true or often true. A dichotomized score of suicidal ideation (true or not true) was used in the analyses.

Results

Our data indicate that 50.0% of participants experienced the last episode of sexual abuse in the last month while 18.8% experienced it within the last two to six months. A total of 13.5% of participants reported that the last episode of SA occurred within the last 7 to 18 months, while 17.7% reported it occurred more than 18 months before their initial visit to the intervention center.

Concerning the characteristics of the abuse incurred by our sample, 84.4% of adolescents reported severe sexual abuse including penetration or penetration attempt. Concerning the frequency of the sexual abuse, the majority of adolescents (57.1%) reported a single episode, while 10.2% reported more than one episode, and 32.7% reported chronic abuse that lasted over 6 months. A little more than a third (36.4%) of those adolescents were abused by a family member, 47.4% by a partner, friend, or acquaintance, and 16.2% by a stranger.

There were no significant correlations between characteristics of CSA and self-blame, shame, coping strategies, or outcomes. Six months after initial assessment, 48.0% of the sample reported PTSD symptoms in the clinical range, 37.4% reported symptoms of depression in the clinical range, and 30.3% reported seriously thinking about suicide.

Self-blame at T1 and outcomes at T2 were all significantly and positively correlated. Shame and avoidance at T1 were positively correlated with PTSD symptoms and suicidal ideation at T2, but not with depressive symptoms. Problem-solving coping at T1 was positively correlated with PTSD symptoms at T2 and social support seeking coping at T1 was not correlated with outcomes at T2 and, therefore, was removed from further analysis. Correlations among variables, means, and standard deviations are presented in [Table 2](#).

Table 2. Intercorrelations, means, and standard deviations for self-blame, shame, and coping strategies at T1 and PTSD symptoms, depressive symptoms, and suicidal ideation at T2.

Variables	1	2	3	4	5	6	7	<i>M</i>	<i>SD</i>
1. Self-blame T1	-							5.38	3.76
2. Shame T1	.474**	-						3.96	2.53
3. Avoidance coping T1	.265**	.451**	-					7.93	2.94
4. Social support seeking T1	.051	-.092	-.001	-				6.38	3.25
5. Problem solving T1	.049	.186	.241*	.441**	-			6.21	3.49
6. PTSD symptoms T2	.325**	.444**	.209*	-.100	.237*	-		42.69	19.13
7. Depressive symptoms T2	.258**	.180	.114	-.163	-.034	.562**	-	9.07	5.26
8. Suicidal ideation T2	.374**	.314**	.264**	-.154	.029	.358**	.573**	0.39	0.65

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

Path analysis

Preliminary analyses showed that all variables were normally distributed, except for shame (kurtosis = -3.31). Because the skewness was not problematic, scores were not transformed. Path analyses were performed using *Mplus* (Muthén & Muthén, 2007). A path analysis including all the variables correlated to the outcomes was first carried out. Initial model had poor fit, $\chi^2(5) = 22.79$, $p > .001$; CFI = .63, TLI = .11, RMSEA = .19 [90% CI = .12, .27]. Problem-solving coping ($\beta = .14$, SE = 0.78, $p = .143$) was removed from the model since it did not significantly predict PTSD symptoms when self-blame, shame, and avoidance were included in the model. Self-blame ($\beta = .16$, SE = 0.80, $p = .132$) and avoidance ($\beta = -.03$, SE = -0.20 , $p = .767$) also failed to predict PTSD symptoms when shame was included into the model. Self-blame ($\beta = .22$, SE = .30, $p = .026$) was the only predictor of depression whereas avoidance coping ($\beta = .30$, SE = .12, $p = .030$), along with depression symptoms ($\beta = .54$, SE = .13, $p < .001$), predicted suicidal ideation. PTSD symptoms ($\beta = .25$, SE = .02, $p = .055$) failed to predict suicidal ideation when all the variables were included into the model.

We used the model modification indices suggestions to identify possible relations that could enhance the model fit, and the prediction of outcomes. *Mplus* suggested that we link PTSD symptoms and depression symptoms. As shown in Table 2, the correlation between both variables was high. PTSD symptoms were then included as a predictor of depressive symptoms into the final model.

The final model showed an excellent fit, $\chi^2(7) = 7.12$, $p = .417$; CFI = 1.00, TLI = 1.00, RMSEA = .01 [90% CI = .00, .12]. Figure 1 presents the results of the path analysis. Post-hoc modifications were not carried out because of the good fit of the data to the model. Shame at T1 significantly predicted PTSD symptoms at T2 ($\beta = .34$, SE = 2.44, $p = .014$) whereas self-blame at T1 ($\beta = .28$, SE = .39, $p = .006$) and PTSD symptoms at T2 ($\beta = .46$, SE = .14, $p < .001$) were significant predictors of depressive symptoms at T2. Avoidance coping at T1 ($\beta = .29$, SE = .11, $p = .044$) and depressive

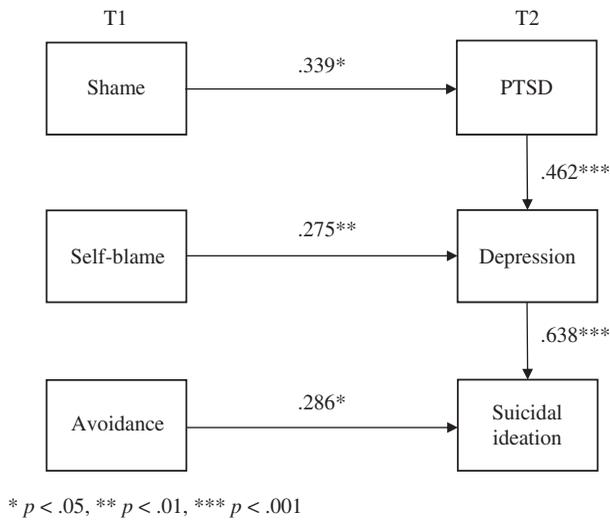


Figure 1. Path analysis with standardized beta coefficients.

symptoms at T2 ($\beta = .64$, $SE = .13$ $p < .001$) predicted suicidal ideation at T2. A total of 11% of the variance of PTSD symptoms at T2 was explained by shame at T1. Regarding depressive symptoms at T2, 33% of its variance was explained by self-blame at T1 and PTSD symptoms at T2, and a total of 54% of the variance of suicidal ideation at T2 was explained by avoidance at T1 and depressive symptoms at T2.

Discussion

The aim of this study was to investigate the impact of self-blame, shame, and coping strategies on symptoms of PTSD, depression, and on suicidal ideation among sexually abused adolescent girls using a longitudinal design. Based on past studies and on the Traumagenic dynamic model (Finkelhor & Browne, 1985), the first hypothesis was that self-blame, shame, and coping strategies at first assessment (T1) would predict symptoms of PTSD and depression and suicidal ideation 6 months later (T2). The second hypothesis was that depressive and PTSD symptoms at T2 would contribute to the prediction of suicidal ideation.

In bivariate analyses, self-blame, shame, avoidance coping, and problem solving coping at first assessment were all significantly correlated with PTSD symptoms at T2. The positive association between problem-solving and PTSD symptoms was somewhat unexpected, but has already been documented in a meta-analysis focussing on victims of interpersonal violence or severe injury (Littleton, Horsley, John, & Nelson, 2007). Tiet et al. (2006) suggested that patients with PTSD may rely on approach coping in an effort to lessen the negative impact of symptoms. In other words, given the high levels of PTSD, individuals rely on

problem-solving in an effort to deal with the experienced distress. However, our results show that problem-solving at first assessment is significantly correlated with later PTSD, which is difficult to explain, but the correlation was small and problem-solving was not a predictor of later PTSD in the path analysis.

In our multivariate analyses, when all correlated variables at T1 were included in a path analysis, shame was the only factor contributing to the prediction of PTSD symptoms 6 months later. Comparison with past studies is somewhat hazardous since none of them used the same predictors or measures, but shame was identified as a long-term predictor of PTSD either alone (Feiring & Taska, 2005), or along with self-blame (Feiring et al., 2002). This finding is interesting because exaggerated self-blame following a traumatic event is now part of Criterion D in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association [APA], 2013). However, in the present study shame was the only predictor of PTSD while self-blame was the only predictor of depressive symptoms. These results could be explained by the fact that self-blame and shame are correlated, and because self-blame often leads to shame (Lewis, 1992). Furthermore, at first assessment, shame partially mediated the association between self-blame and PTSD symptoms among the same population (see Alix et al., 2017). These findings therefore lead us to conclude that shame might be a better predictor of PTSD than self-blame among adolescent girls victim of CSA. Further studies should be conducted to ascertain this hypothesis.

Avoidance coping at T1 failed to predict PTSD at T2 when shame was included in the prediction. This finding is unexpected given that avoidance is a required criterion for PTSD (DSM-5, APA, 2013) and is identified as a factor contributing to maintain symptoms in different conceptual models (Ehlers & Clark, 2000; Mowrer, 1960). Our results show that avoidance loses its predictive capacity once shame is considered, suggesting that shame may be a critical element to target when assessing CSA victims.

Self-blame at T1 and PTSD symptoms at T2 were both predictors of depressive symptoms. Previous studies showed that both self-blame and shame were correlated to depressive symptoms among children or adolescent victims of CSA (Alix et al., 2017; Feiring et al., 2002, 1998). There is a strong correlation between self-blame and shame, but self-blame is a cognitive construct, while shame is an emotion. Depression is characterized by a depressive mood and, among other symptoms, excessive or inappropriate guilt, self-depreciation, and critical attitude toward oneself (APA, 2013; Beck, Steer, & Brown, 1996). In guilt, in contrast to shame, the behavior, rather than the self, is the focus of a negative evaluation (Lewis, 1971). Self-blame following CSA could lead in the long run to the cognitive symptoms of depression.

As hypothesized, self-blame, shame, and avoidance coping strategies at first assessment were all significantly correlated to suicidal ideation 6 months later and symptoms of PTSD and depression were also both correlated with suicidal ideation. However, only depressive symptoms and avoidance coping predicted suicidal ideation and both of these factors accounted for 54% of the variance of suicidal ideation. The fact that PTSD did not predict suicidal ideation contrast with past findings. In their systematic review on the relationship between PTSD and suicidal ideation and attempt, Krysinska and Lester (2010) concluded that PTSD was associated with higher prior and current suicidal ideation and that while controlling for depression and other psychiatric disorders weakened the association, it was still significant. Furthermore, Brabant, Hébert, and Chagnon (2014) assessed this relationship among adolescent victims of CSA and showed that PTSD predicted suicidal ideation even after controlling for depression and past suicide attempts. However, this study is the first to assess a variety of factors as predictors of suicidal ideation among CSA adolescent girls using a longitudinal design. In this study, PTSD symptoms did not explain a significant unique part of the variance of suicidal ideation that depressive symptoms and avoidance already explained. Although avoidance coping did not predict PTSD as expected, it predicted suicidal ideation 6 months later whereas PTSD at T2 did not. This result might suggest that avoidance coping should be assessed not only as part of PTSD symptoms, but also considered alone in order to prevent suicidal ideation among this population.

Briere (2002) suggested that PTSD symptoms and avoidant coping are inborn self-healing strategies in response to maltreatment and might be adaptive on the short term. Indeed, in our previous study conducted with a larger sample of adolescent girls, avoidance did not predict suicidal ideation at first assessment when shame, self-blame, and depressive symptoms were considered (Alix et al., 2017). The fact that avoidance coping was a predictor of suicidal ideation 6 months later seem to confirm the negative impact of avoidance on victims of CSA. This negative impact has been reported in many studies (Cantón-Cortés et al., 2011; Hébert et al., 2006; Ullman et al., 2007; Whiffen & MacIntosh, 2005). Our findings show that avoidance, in the long term, does not seem to be useful to attenuate the most severe symptoms associated with CSA.

To our knowledge, this longitudinal study is the first to assess the impact of self-blame, shame, and coping strategies on three major outcomes associated with CSA among adolescent girls. Our results revealed the prevalence of suicidal ideation to be high as close to one of three girls reported and that it could be predicted not only by depressive symptoms, but also by avoidance coping at initial assessment.

Some limitations of the present study should however be mentioned. Our sample of adolescents may not be representative of all sexually abused adolescent girls since the vast majority (85%) of them reported severe CSA

including penetration or attempt. Those girls were probably more inclined to seek clinical help and, therefore, to be recruited in this study. Another limitation is that suicidal ideation was measured with only one item. Finally, the present study did not evaluate the impact of adolescents' social network. Yet, in accordance with the Traumagenic dynamic of stigmatization model (Finkelhor & Browne, 1985), the reactions of their family and peers after disclosure may have a significant impact on the victims' tendency to experience self-blame and shame.

In conclusion, our findings seem to confirm the effect of self-blame, shame, and avoidance on later PTSD and depressive symptoms, and suicidal ideation among adolescent girls victim of CSA. Psychological distress was high six months after the first assessment. Almost half of our sample reported PTSD symptoms in the clinical range, more than one third reported symptoms of depression in the clinical range, and one third reported seriously thinking about suicide. Future studies and clinicians should assess suicidal distress among this population, along with PTSD and depressive symptoms. Interventions should target self-blame, shame, and avoidance coping as they predict later distress in this vulnerable population.

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