

**TESTING THE MATERNAL RESPONSE HYPOTHESIS IN CASES OF
SUSPECTED OR SUBSTANTIATED CHILD SEXUAL ABUSE:**

**SECONDARY DATA ANALYSIS OF THE CANADIAN INCIDENCE
STUDY OF REPORTED CHLD ABUSE AND NEGLECT, 1998**

By

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A thesis submitted in conformity with the requirements for the degree of Doctor
of Philosophy

Faculty of Social Work,
University of Toronto

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Abstract

Testing the maternal response hypothesis in cases of suspected or substantiated child sexual abuse: Secondary data analysis of the Canadian Incidence Study of Reported Child Abuse and Neglect, 1998

PhD, 2008

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Background and objectives

This dissertation's analyses examined the association of caregiver, child, abuse and investigation characteristics with maternal response and emotional harm among families for whom child sexual abuse (CSA) was suspected or substantiated.

Method

This study was based on secondary analysis of data collected in the Canadian Incidence Study of Report Child Abuse and Neglect 1998. The current analysis was limited to 373 CSA investigations for which there was a female non-offending caregiver and complete data on maternal response. Bivariate and hierarchical logistic regression analysis was conducted for two outcomes; maternal response and emotional harm.

Results

According to social worker assessment, the majority of female non-offending caregivers (87.1%) of children investigated for suspected or substantiated child sexual abuse responded with belief of the abuse disclosure, emotional support and protection of the child victim. The overall maternal response model was significant and accounted for 40.8% of the variance (Nagelkerke R^2). Factors significantly associated with maternal response in the multivariate

model included maternal mental health, age of the child, child's manifestation of sexualized behavior, child's relationship to the perpetrator, duration of abuse and co-occurring maltreatment. The overall emotional harm model was significant and accounted for 18.3% of the variance (Nagelkerke R^2). Age of the child at the time of investigation, inappropriate sexualized behavior and substantiation level were significant predictors in the final block of the emotional harm regression equation. Maternal response was no longer significantly associated with emotional harm when the analysis adjusted for child characteristics.

Conclusion

Consistent with previous research, the majority of non-offending mothers investigated as part of the CIS-98 responded to CSA disclosure with belief, emotional support and protection as determined by the social worker's assessment. The current study supports the cumulative evidence that caregiver mental health, age of the child and the child's relationship with the offender are significant predictors of negative maternal response and emotional harm. Although negative maternal response failed to predict emotional harm among children investigated for CSA, continued examination of the risk factors associated with maternal response is warranted to ensure the safety of a small, yet vulnerable segment of children.

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With infinite patience, Dr. Esme Fuller-Thomson so generously provided countless hours of methodological and statistical consultation, editorial guidance, and endless moral support.

It is my sincere hope that the results of this dissertation's analyses will contribute to social work intervention among the children and families with whom we are privileged to work.

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Chapter 1: Literature Review

Many survivors of childhood sexual abuse (CSA) experience short and long-term negative outcomes associated with abuse including depression, anxiety, Post-Traumatic Stress Disorder, diminished academic performance, social skill problems, sexual dysfunction, and somatic complaints. (For reviews see Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Beitchman, et al., 1992.) Despite these negative outcomes, this developmental trajectory of sexual abuse victims cannot be consistently predicted. Several studies have shown that the negative impact of CSA varies considerably among child victims (Caffaro-Rouget, Lang, & van Santen, 1989; Conte & Schuerman, 1987; Wolfe & Birt, 1995). In fact, there is a subgroup of survivors who do not exhibit any behavioural indication of CSA related distress. Considerable variability exists in published reports of victim symptomatology. For example, reports indicate that as many as 30% of survivors do not manifest symptoms directly associated with the experience of CSA (Kendall-Tackett, Williams, & Finkelhor, 1993). As a result of the varied response patterns, a distinct “CSA Syndrome” has not been identified in the research or clinical literature. Rather, a constellation of possible risk factors have been compiled and varied post-disclosure responses recorded.

A number of factors have already been identified as having an impact on child adjustment and well-being in the aftermath of CSA; frequency and severity of abuse (Fergusson, Horwood, & Lynskey, 1996; Friedrich, Urquiza, & Beilke, 1986), relationship to the perpetrator (Sedney & Brooks, 1984) and, more recently, presence and quality of maternal response to the child’s disclosure of sexual abuse (Elliot &

Carnes, 2001). Maternal response has been defined by child protective services as a) mother's belief of the child's disclosure, b) provision of emotional support, and c) protection from further abuse. Emotional support, typically from a non-offending mother, has been shown to play a mediating role in alleviating the short and long-term psychological impact of child sexual abuse (Elliot & Carnes, 2001; Esparza, 1993; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Spaccarelli & Kim, 1995). Although it is recognized that a minority of CSA perpetrators are women (Finkelhor & Russell, 1984), the focus of the existing study involves males as perpetrators of CSA and women as the non-offending mothers.

Purpose of study

The primary purpose of this study is to:

- Examine the association between maternal characteristics (e.g. mental illness, substance abuse, and domestic violence) and maternal response.
- Examine the association between child characteristics (e.g. age, inappropriate sexualized behavior, and developmental delay) and maternal response.
- Examine the relationship between CSA characteristics (e.g. type of CSA, duration of CSA, use of force, child's relationship to the perpetrator, co-occurring maltreatment and level of substantiation of the CSA investigation) and maternal response.
- Assess the relationship between maternal response and the development of emotional harm among sexually victimized children.

- Determine the relationship between child, abuse and investigation characteristics and children's emotional harm, independent of the effects of maternal response.

This study will not provide a model for intervention, nor will it endorse a causal trajectory explaining individual response to child sexual trauma. This study will, however, advance our understanding of the factors associated with maternal response in cases of CSA. Furthermore, it will help us understand the relationship between maternal response and the short-term outcomes for children who have experienced CSA.

The following research questions and hypotheses will be examined:

Research questions

1. What percentage of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were identified by their social workers as having a negative maternal response?
2. What characteristics are associated with maternal response?
 - 2.1 In particular, what maternal characteristics (e.g. substance abuse, mental health, and domestic violence) are associated with maternal response?
 - 2.2 What child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay) are associated with maternal response?

- 2.3 What abuse characteristics are associated with maternal response (duration of abuse, child's relationship to the perpetrator)?
- 2.4 What investigation characteristics (substantiation level, and co-occurring maltreatment) are associated with maternal response?
3. According to the investigating social workers assessment, what percentage of children investigated for sexual abuse in the CIS-98 experienced emotional harm?
4. What characteristics are associated with emotional harm?
 - 4.1 In particular, maternal characteristics (e.g. maternal response, domestic violence and mental health).
 - 4.2 Child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay).
 - 4.3 Abuse characteristics (duration of abuse, child's relationship to the perpetrator).
 - 4.4 Investigation characteristics (substantiation level, and co-occurring maltreatment).

Hypotheses

1. Maternal, child, abuse, and investigation characteristics are associated with maternal response among non-perpetrating caregivers of children investigated for sexual abuse.
2. Maternal, child, abuse, and investigation characteristics contribute to emotional outcome among children investigated for sexual abuse.

The importance of studying maternal response is two-fold:

Firstly, research data establishes a connection between maternal support and positive child outcome in cases of CSA (Corcoran, 2004; Elliot & Carnes, 2001). This knowledge is important for guiding evidence based clinical practice with survivors of child sexual abuse and their families.

Secondly, a child's placement following Child Protective Services (CPS) investigation is often dependent on the presence of poor maternal support and continued exposure to further abuse.

Terminology

Throughout this dissertation, results of the child sexual abuse investigation will be presented. All findings, including those on maternal response and emotional harm, are based on the interpretation of the investigating child welfare worker. Where it is noted that the non-offending mother, child or perpetrator made a report, it is more accurate to indicate that the report is that of the investigating child welfare worker and not the direct report of the subjects of the investigation. Investigations that were suspected or substantiated comprised this dissertation's study sample. Given that some investigations included in this sample were suspected, the CSA investigated should be considered alleged CSA and the perpetrators similarly, alleged perpetrators. The investigating child welfare worker made a determination of the non-offending

caregiver's response to the report of sexual abuse. From this point on, the term, "maternal response" will refer to the investigating child welfare worker's perception of the response of the female non-offending caregiver. It is important to note that 93% of these non-offending female caregivers were biological mothers and the other 7% were other female non-offending caregivers (e.g. stepmother). As will be identified throughout this dissertation, the term, "caregiver characteristics" refer to the characteristics of the non-offending female caregiver, which were identified by the investigating child welfare worker. Similarly, any and all determination of factors such as domestic violence, caregiver functioning, alleged perpetrators, child functioning, abuse characteristics, case characteristics were the perceptions of the investigating child welfare worker. The CIS-98 definition of maltreatment includes 22 forms reflecting four categories including physical abuse, sexual abuse, neglect and emotional abuse (CIS-98 Final Report, p. 5). Maternal caregiver refers to the female non-offending caregiver of the investigated child and maternal response refers to the belief, protection and support provided by the female non-offending caregiver of the investigated child. Negative maternal response refers to the female non-offending caregiver's disbelief of the child's disclosure of sexual abuse, and/or the absence of protection or emotional support. As will be addressed subsequently, biological mothers accounted for 93% of the female non-offending caregivers of children investigated for suspected or substantiated child sexual abuse in the CIS-98. The remaining 7% of the female non-offending caregivers were a common-law partner, grandparent, female foster parent, adoptive mother or a step-parent of the investigated child. Given that biological mothers represented the largest group of female non-offending caregivers in the CIS-

98, the term “maternal caregiver” and “mother” was used when referring to the study sample and when reviewing the maternal response literature. The conceptual issues surrounding the maternal response construct and a rationale for the operationalization of maternal response will be addressed in this dissertation.

Research significance

Substantial variability in maternal response exists with positive responses ranging from 27%-85% (Everson et al., 1989; Heriot, 1996; Faller, 1988; Sirles & Franke, 1989; Trocmé, et al., 2001). Varying definitions of maternal response and differences in study methodologies account for this wide variation.

Contextual factors existing in the lives of non-perpetrating mothers contribute to their response. For example, a mother’s response to her child’s allegation of sexual abuse may be affected by her own victimization by the same perpetrator, financial dependence on the perpetrator, and the mother’s own previous history of child sexual abuse. When considering the range of environmental characteristics non-perpetrating mothers are exposed to, their responses will naturally be dissimilar. Further examination of these topics will follow.

The operationalization of maternal response has historically involved use of dichotomous measures capturing either support or non-support. Recognizing fluctuation in response patterns, researchers have begun to examine a fourth component of maternal response; ambivalence. An ambivalent response is one which vacillates

between belief of a CSA disclosure to questioning the validity of a claim of child sexual abuse (Bolen & Lamb, 2004; Pintello & Zuravin, 2001). Bolen and Lamb (2004) summarize existing reviews and conclude that 25% of non-perpetrating mothers are not supportive, 31% are partially-supportive or ambivalent while 44% fully support their victimized child. Pintello and Zuravin (2001) also captured rates of ambivalence and indicate that, among their sample of 437 non-perpetrating mothers, 41.8% believed and protected their child, 27.3% responded in an ambivalent manner while 30.8% did not believe their child's disclosure and were unable to consistently demonstrate a protective response. Variation in study design and operationalization of the maternal response variable account for the different proportions of positive responses noted in the above studies.

Impact of maternal support on child outcome

Research on the outcomes of child sexual abuse has focused mainly on abuse characteristics. Characteristics such as duration and frequency of abuse (Friedrich, et al., 1986), relationship to the perpetrator (Sedney & Brooks, 1984), severity of abuse (Fergusson, Horwood, & Lynskey, 1996; Fromuth, 1986; Russell, 1986) and age at onset of the abuse (Kendall-Tackett, Williams, & Finkelhor, 1993) have been identified as factors contributing to the overall psychological outcome of survivors.

More recently, the clinical and research literature has identified maternal support as a protective factor in the adjustment of child victims. Children of responsive mothers manifest fewer mental health and behavioural problems (Adams-Tucker, 1982; Barker-

Collo, & Read, 2003; Bolen, & Lamb, 2004; Deblinger, Stauffer, & Landsberg, 1994; Deblinger, Steer, & Lipman, 1999; DeYoung, 1994; Elliott, & Carnes, 2001; Esparza, 1993; Everson, et al., 1989; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Heriot, 1996; Hiebert-Murphey, 1998; Leifer, Kilbane, & Grossman, 2001; Sirles & Franke, 1989; Spaccarelli, & Fuchs, 1997; Timmons-Mitchell, Chandler-Holtz, & Semple, 1996).

Inadequate maternal support has been associated with CPS involvement and apprehension of victimized children (Cross, Martell, McDonald, & Ahl, 1999; Hunter, Runyan, Coulter, Everson, 1990; Leifer, Shapiro, Martone, & Kassem, 1993; Pellegrin, & Wagner, 1990), children's difficulty in coping with the post-disclosure legal process (Leifer, Kilbane, & Grossman, 2001) and children's re-canting sexual abuse disclosure (Berliner & Elliot, 1996; Lawson & Chaffin, 1992).

Child sexual abuse and out of home placement

Apprehension of children in cases of CSA is less likely when mothers demonstrate compliance with CPS treatment planning and believe their child's disclosure (Pellegrin & Wagner, 1990). Of the 100 children investigated as part of a U.S. 1990 study, Hunter, Coulter, Runyan, and Everson found that at time of disclosure 50% of sexually victimized children were removed from their home and placed with family, or in foster, or institutional care. Of the 83 families remaining at 2 years follow-up, 73% of children were removed from their home. While these authors did not provide data on the number of children removed for whom maternal response was adequate, they did

state that apprehension was significantly less likely when appropriate maternal response was demonstrated. In fact, maternal response was determined to be the “most influential variable” in predicting child apprehension (Hunter et al., 1990, p.410). Combined with offender’s residential status, maternal support accounted for 25% of the variance in predicting out of home placement. Hunter and colleagues indicate that the high rates of removal can be explained by the inclusion of informal foster placements in this study, and the emphasis on apprehension in cases of child sexual abuse. These authors state, “Child protective services are presently under fire...perhaps some of the social workers in our study were practicing defensive social work” (Hunter, et al., 1997, p. 415).

Of the 58 case files of substantiated CSA examined by Pellegrin and Wagner (1990), 42% of the children were apprehended by CPS while the remaining 58% remained in the home. Finkelhor (1983), reporting on findings from the National Child Abuse and Neglect Data Systems (NCANDS), documents that only 17% of “molestation” victims were removed from their home. More recently, Canadian Incidence Study (2005) data indicate that only 6% of children for whom CSA was substantiated received placement in child welfare care (Trocmé, et al., 2005). Varying rates of removal may be due to the operationalization of placement type, and different sampling strategies¹.

Is the rate of removal in cases of CSA consistent with rates of apprehension across all maltreatment types? According to a 2000 U.S. report, 16% of all children for whom abuse and neglect was substantiated by the CPS during 1998 were removed from their

¹ Finkelhor, 1983 and Trocmé et al., 2001 both utilized a random sampling approach.

homes (Department of Health & Human Services Administration on Children, Youth and Families, 2000). Canadian reports document an overall apprehension rate of 13%, noting that this figure includes both child welfare and informal placement (Trocmé et al., 2005). Garbarino and Eckenroade (1997) remind us that adequate attention must be paid to ecological factors when attempting to understand the varying rates of removal.

As noted by Pintello and Zuravin (2001), in addition to the traumatic experience of CSA, children who are apprehended by CPS experience disruption in family attachments, and endure relocation to an unfamiliar school and community setting. There is some indication, as well, that children who do not receive maternal support and protection are at risk of recantation during court proceedings (Berliner & Elliot, 1996).

Practitioners suggest this early emphasis on child apprehension in cases of CSA amounts to punitive action directed towards victimized children and non-perpetrating mothers. Since this time, there has been a shift evident in practice with respect to recognizing that mothers are secondary victims in their own right and require support in coping with their grief response.

Advancement of social work knowledge

Social workers are among a group of professionals at the forefront of innovative service delivery in cases of CSA. However, the wealth of knowledge gained through direct practice has not been transferred into evidence based intervention with sexually

victimized families. A conceptual model guiding practice with families surviving CSA must examine the impact of various contextual factors. Yet, few models of conceptualizing the post-abuse responses of non-perpetrating mothers examine the complex interplay of maternal and child characteristics, family and abuse factors. This study will emphasize the importance of examining the maternal response dynamic, and as a result, contribute to an evolving body of social work research on the experiences of non-perpetrating mothers of sexually victimized children.

Definition of child sexual abuse

“Sexual abuse involves any sexual activity with a child where consent is not or cannot be given” (Berliner & Elliott, 2002, p.55). These same authors indicate that

Abuse involves sexual contact that is accomplished by force or threat of force, regardless of the age of the participants, and all sexual contact between an adult and a child, regardless of whether there is deception or the child reports to understand the sexual nature of the activity...sexual contact between an older and younger child also can be abusive if there is a significant disparity in age, development, or size, rendering the younger child incapable of giving informed consent. (Berliner & Elliott, 2002, p.55)

According to the CIS-98 (Trocmé et al., 2001), sexual contact includes anal or vaginal penetration, attempted penetration, oral sex, fondling, sex talk, voyeurism,

exhibitionism, and exploitation through prostitution or the production of pornographic materials. Perpetrators include biologically related and non-related individuals. Child welfare workers define CSA using the characteristics noted above.

Background information

Rates of child sexual abuse

Based on a review of existing American and Canadian retrospective surveys, Finkelhor (1994) estimates that between 20%-25% of women and 5%-15% of men in the general population have experienced child sexual abuse. In their meta-analysis, Polusny and Follette (1995) suggest that the CSA prevalence rate in North America is as high as 15-33% for females and 13-16% for males. When considering the clinical population, these same authors suggest that the CSA prevalence rate among female patients is 35-75% and 13-23% for males.

Recently, child welfare authorities in Canada and the United States have reported a substantial decline in reports of child sexual abuse (Jones & Finkelhor, 2003; Trocmé, Fallon, MacLaurin, & Copp, 2002). A Canadian report comparing rates of child welfare investigations between 1993 and 1998 documents a 44% reduction in cases involving substantiated child sexual abuse (Trocmé, et al., 2002). Results of the CIS-2003 cycle indicate that CSA accounts for 3% of all substantiated maltreatment investigations (Fallon, et al., 2005). Some speculate that similar to the public education efforts adopted in the 1980's to bring awareness to the sexual victimization of children;

existing prevention efforts may have resulted in a real decline in the occurrence of child sexual abuse. An alternate explanation is that more punitive legislative responses may have deterred accurate reporting of allegations of abuse (Jones & Finkelhor, 2003, p.11). Yet another explanation may be that reports of CSA are reduced due to a “backlash” against child welfare services as a result of negative publicity related to erroneous case findings and the perceived liability of professionals who report suspicions of CSA (Finkelhor & Jones, 2004). Finkelhor and Jones (2006) report that the decline in reported CSA is not a recent occurrence, but a trend evident beginning in the 1990’s and reflect “at least in part a real decline in sexual abuse” (p. 688). In addition, these authors review factors often cited as related to the decrease in CSA including reductions in violent crime particularly among youth, increase in economic prosperity, and vigilant policing.

Sequelae of abuse

Short and long term effects of CSA have been well documented (Beitchman et al., 1991; Beitchman et al., 1992; Tyler, 2002). Abuse characteristics such as duration of abuse (Caffaro-Rouget, et al., 1989; Kendall-Tackett et al., 1993), age at onset of abuse (Cohen & Mannarino, 1998b), and the occurrence of sexual penetration (Kendall-Tackett et al., 1993; Ruggerio, McLeer, & Kixon, 2000; Spaccarelli & Kim, 1995) have been identified as factors with predictive value in determining the developmental trajectory of victimized children. Other factors such as the degree of force used (Gomes-Schwartz, Horowitz, & Cardarelli, 1990), relationship to the perpetrator (Browne & Finkelhor, 1996), involvement of multiple perpetrators (Wolfe, 1998;

Wolfe & Birt, 1997) threats of harm to victim or family (Friedrich, Urquiza, & Beilke, 1986) and response of non-perpetrating caregivers (Barker-Collo, & Read, 2003; Bolen, 2002; Elliot & Carnes, 2001) have been investigated as factors contributing to the outcome of victimized children.

Short-term outcomes

The effects of child sexual abuse are broad in scope and severity. As was discussed earlier, Kendall-Tackett and colleagues (1993) suggest that the effects of CSA are not characterized by a distinct “CSA syndrome”. Rather, research evidence confirms a wide range of outcomes including interpersonal and psychosocial deficits among survivors of CSA when compared with non-CSA victims (Wolfe & Birt, 1995). When compared with their non-CSA counterparts, children exposed to CSA experience heightened emotional distress and behavioural problems, and more symptoms of depression and anxiety (Boney-McCoy & Finkelhor, 1996; Mannarino & Cohen, 1996; McLeer, et al., 1998; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). In addition, children with a history of CSA are more likely than non-CSA children to exhibit suicidality (Martin, Bergen, Richardson, Roeger, Allison, 2004; Molnar, Berkman, & Buka, 2001) and sexualized behaviour (Beitchman et al., 1991; Friedrich, et al., 2001; Hall, Mathews, & Pearce, 2002). Sexually victimized children display heightened behaviour problems when compared with their non-abused cohorts (Friedrich, 1988) and rank lower than non-CSA children in reports of self-esteem (Beitchman et al., 1991). Depending on the nature of CSA and post-abuse support, academic performance may be compromised among survivors of CSA (Rust & Troupe,

1991). CSA may contribute to the use of maladaptive coping strategies, resulting in cognitive distortions of self and others.

Severity of negative outcome is dependent on what is referred to as a “dose-response relationship” (Alexander, 1992). This means, CSA involving penetration, use of force, chronic abuse, threats of harm, and abuse involving a perpetrator close to the victim may lead to severe and long-term symptom presence.

The developmental stage and age of the child also contribute to symptom development among sexually abused children. Kitchur and Bell (1989) suggest that, when compared with children of other ages, children in the 7-13 year old age category demonstrate the greatest degree of psychopathology. It is suggested that older children have a more sophisticated cognitive capacity, which permits greater awareness of the violation that has occurred. While not conclusive, a variation in symptom response related to gender difference has also been noted. Most striking is the difference in post-abuse internalizing and externalizing behaviour among girls and boys. Bolton, Morris, and MacEachron (1989) and Finkelhor (1990) suggest that boys demonstrate more externalizing behaviours such as antisocial, sexualized and aggressive behaviour than do girls. Girls, however, tend to manifest more internalizing behaviours such as depressive symptoms and social withdrawal, than boys.

Friedrich and colleagues (1986) found that risk factors also differed among girls and boys. Retrospective studies of adults sexually abused as children reveals that there is a higher prevalence rate of CSA among females than males (Finkelhor, et al., 1990).

Risk factors for heightened symptom presence for girls include severe and frequent abuse in which there is a close relationship to the perpetrator. Risk factors predicting heightened symptomatology among boys include duration of abuse, time since last abuse, and close relationship to the perpetrator.

Incorporating gender into a model determining post-abuse functioning is complicated by differences in reporting trends between boys and girls. There are a disproportionate number of girls among reported cases of child sexual abuse. There are two reasons for this trend:

Firstly, Girls more frequently come to the attention of child welfare services than boys and are more likely to receive clinical intervention. This is so because girls are more likely to suffer intrafamilial abuse than are boys (Faller, 1989). Research confirms that intrafamilial abuse is associated with more severe effects than is extrafamilial abuse due to the experience of a profound violation of trust (Finkelhor, et al., 1990). For these reasons, girls are more likely to be overrepresented in the child welfare population (in terms of the reporting of CSA) and in the clinical population. Secondly, boys internalize the stigma associated with victimization and are less likely to disclose sexual abuse (Finkelhor, 1984). 3)

Long-term outcomes

Sexual abuse often functions as an antecedent to several problems later in life.

Emotional distress, including depression and anxiety, attributions of guilt associated with the abuse, deficits in interpersonal functioning, substance abuse, self-harm

behaviours, and sexual promiscuity may result (Beitchman et al., 1992; Browne & Finkelhor, 1986). Adopting a developmental life-span perspective, CSA symptomatology may manifest when survivors are required to negotiate various life stages such as intimate relationships, child rearing, and coping with loss. In some cases, the problems associated with an abuse history may develop into chronic impairments. Use of drugs and/or alcohol as a coping response, development of personality disorders and dissociative identity disorders have been linked to a history of child sexual abuse.

While several risk factors have been identified as contributing to long-term deficits, currently, a “typical” diagnostic presentation is unknown and a consistent developmental trajectory has not been identified. Finkelhor and colleagues, (1990), determined that, as a group, CSA survivors are clinically distinct from their non-abused cohorts in terms of their level of functioning, however, a precise developmental trajectory was not made explicit. Finkelhor’s study also revealed that varying levels of functioning are evident among survivors with some experiencing pervasive effects across several areas of functioning and others demonstrating an asymptomatic presentation.

Post Traumatic Stress Disorder²

Post-Traumatic Stress Disorder has been referred to as one of the most common negative sequelae of child sexual trauma (Barker-Collo & Read, 2003). The

² A DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders-IV) specific PTSD diagnosis presumes that a distinct, identifiable event occurred. However, chronic PTSD is characterized by repeated exposure to traumatic content over time. Chronic PTSD is referred to as DESNOS (Disorders of Extreme Stress Not Otherwise Specified) in the DSM-IV and is associated with higher levels of PTSD symptoms.

unpredictable nature of abuse and the fact that the event is beyond the control of the victim influences a characteristic traumatic response observed in CSA survivors.

Intrusive images, psychic numbing, phobic/avoidant behaviours and nightmares often characterize a PTSD response to child sexual abuse.

“Given the prevalence of CSA, abuse survivors may constitute the largest single group of PTSD sufferers” (Barker-Collo & Read, 2003, p.96).

A post traumatic stress response may include the following symptomatology:

Re-experiencing the trauma in nightmares, intrusive memories, or flashbacks, numbing of affect and avoidance of thoughts, acts, and situations that symbolize the trauma and symptoms of excessive arousal... a PTSD diagnosis requires the persistence of symptoms for at least 1 month and clinically significant distress or impairment. (Breslau, 2002, p. 923)

Concerned with the absence of a conceptual framework for understanding the various effects of CSA, Wolfe, Gentile and Wolfe, (1989), suggested that post sexual abuse distress is consistent with the diagnostic features of PTSD (American Psychiatric Association, 1987)³. Rates of PTSD prevalence among clinical and community samples range substantially across reports⁴. Kaysen, Resnick and Wise, (2003) report that overall rates of PTSD in clinical samples generally range between 21% to 74% with the

³ DSM IV, the current diagnostic classification system, uses consistent criteria for distinguishing PTSD as did the DSM-III-R edition.

⁴ Clinical samples refer to individuals recruited through mental health in or outpatient treatment while community samples refer to individuals who are recruited through other means (newspaper, media) and may or may not be receiving mental health treatment.

bulk of research studies citing between 40% and 50% of CSA survivors meeting the Diagnostic and Statistical Manual of Mental Disorders-IV criteria (DSM-IV).

McLeer, Deblinger, Atkins, Foa and Ralphe (1988) report that 48% of the 31 children in their sample manifested PTSD symptoms. Deblinger, McLeer, Atkins, Ralphe and Foa (1989) examined rates of PTSD among sexually abused, physically abused and non-abused psychiatrically hospitalized children. Twenty percent of the sexually abused children, 6.9% of physically abused children and 10.3% of non-abused children met criteria for PTSD.

Based on a community sample of women sexually abused as children, Saunders and colleagues (1992) found that 46% met diagnostic criteria for lifetime PTSD, and 13% met criteria for current PTSD. Kendall-Tackett, and others (1993) conducted a comprehensive review of 45 empirical studies of symptom presence among sexually abused children and reported that, in addition to other symptoms, sexually abused children exhibited symptoms of PTSD. After excluding victims of severe sexual abuse⁵, 32% of children were found to have symptoms of PTSD. These authors noted that this rate was similar to rates of other typical symptoms documented in this study such as compromised self-esteem (35%), promiscuity (38%) and general behaviour problems (37%).

Other studies document rates of PTSD much higher than those reported above (Owens & Chard, 2003). Variation in symptom presentation is explained by factors such as

⁵ Kendall-Tackett, Williams and Finkelhor (1993) reported PTSD rates after removal of severe ritualistic CSA cases as documented in the Los-Angeles Day Care allegations. These authors did not indicate the number of cases removed.

definition of CSA, chronicity of abuse, study methodology and instrumentation as well as recall bias in retrospective studies. Severity of PTSD symptoms is dependent on the frequency and duration of exposure to traumatic stimuli, in addition to factors such as the use of violence, relationship to the perpetrator, and attribution of blame. The issue of frequency vs. duration of trauma has been debated in the war trauma literature, and more recently among women suffering from chronic trauma. A diagnostic distinction regarding risk of post-abuse sequelae is made among survivors of single episode trauma vs. those who have been exposed to chronic trauma. Repeated exposure for extended periods of time is associated with heightened trauma symptomatology among victims when compared with victims subject to fewer incidents over a shorter time span.

Studies of adult survivors of CSA similarly reported an association between duration of abuse and PTSD symptom presence. In 1998, Rodriguez Van de Kemp, and Roy completed a comprehensive review of 33 empirical studies examining prevalence rates of PTSD among adults sexually abused during childhood. These authors found that, in clinical samples, current PTSD rates ranged from 69% to 72% and lifetime rates of PTSD range between 70% and 89%.

What do the results of these studies mean?

- Some children may develop symptomatology consistent with PTSD
- PTSD is not a distinctive CSA related syndrome
- Symptoms that may occur subsequent to CSA exist on a continuum ranging from mild to severe

- Duration, severity, relationship to the perpetrator, coercion and force contribute to symptom presence and intensity among survivors of CSA.
- Non-perpetrating mothers may similarly manifest PTSD-like symptomatology. Typologies of non-perpetrating mothers and the implications of a prior history of trauma among mothers will be discussed in a subsequent chapter.

PTSD and asymptomatic children

Kendall-Tackett, Williams, and Finkelhor (1993) reviewed 45 studies and found that, while abused children manifested more symptoms of PTSD and sexualized behavior as compared to non-abused children, one third of sexually abused children included in their meta-analysis demonstrated an asymptomatic response. In their 1995 review of the literature, Levitt and Pinnell indicated that, "the traditionally accepted link between childhood sexual abuse as an isolated cause of psychopathology in adulthood lacks empirical verification" (p.151). Beitchman and colleagues, (1992) documented the long-term effects associated with CSA, but cautioned against imposing a causal link between CSA and psychopathology indicating, "to what extent the sequelae are due to sexual abuse per se is still not known" (p. 115).

While controversial in its findings, a meta-analysis by Rind and Tromovitch (1997) found that child sexual abuse "is not associated with pervasive harm and that harm, when it occurs, is not typically intense" (p. 237). In their subsequent meta-analysis of several national probability samples Rind, Tromovitch, and Bauserman (1998) found that CSA is "non-causative." There are several hypothesized reasons for symptom absence among some CSA survivors.

These reasons are:

- Internalization of distress or repression of traumatic memories associated with abuse to the point that psychometric instruments are unable to detect subtle deficits in affect and functioning.
- Lack of understanding of the violation may contribute to inaccurate reporting of abuse events. However, negotiation of various developmental milestones (sexual intimacy, child birth, parenting, bereavement) may bring awareness of the abuse experienced, permitting the psychological processing of grief. Older children may have more capacity to understand the impact of the abuse event(s) given their more sophisticated cognitive functioning. However, this awareness may initiate symptom distress. Gomes-Schwartz, Horowitz, Cardarelli and Sauzier, (1990) report that 30% of previously asymptomatic children in their study developed symptoms at an 18th month follow-up assessment.
- Use of adaptive and cognitive coping strategies. Assistance of a social support network to address issues such as attribution of blame, guilt and self-esteem may contribute to an asymptomatic presentation. Resilient children manifest coping skills that contribute to improved outcomes.
- Varied study designs and definitions of child sexual abuse.

Should symptomatology be present at the time of assessment, researchers argue that caution should be used in making causal inferences. Sbraga and O'Donohue (2003) suggest that determining whether or not symptom presence at the time of assessment is directly associated with the occurrence of sexual victimization is a highly complex task. Given the innumerable confounding variables, identifying the psychological sequelae directly associated with CSA is a challenge.

Information on the risk factors associated with child sexual abuse and the short and long term adjustment problems linked to CSA have been presented in this chapter. The psychological sequelae as documented through empirical research and reported in this chapter provide some indication of the developmental trajectory of affected children. Short and long term adjustment problems associated with CSA may include substance abuse, mental health problems including somatoform disorders, suicidality, sleep and incontinence disorders, academic problems, poor self-esteem and behavioral problems including inappropriate sexualized behavior (Adams-Tucker, 1982; Beitchman et al., 1991; Beitchman et al., 1992; Boney-McCoy & Finkelhor, 1996; Briere & Elliot, 1994; Browne & Finkelhor, 1986; Finkelhor, 1979; Friedrich, et al., 2001; Hall, Mathews, & Pearce, 2002; Herman, 1981; Mannarino & Cohen, 1996; Martin et al., 2004; McLeer et al., 1998; Molnar, Berkman, & Buka, 2001; Rust & Troupe, 1991; Saunders et al., 1992).

These outcomes are dependent on factors such as abuse characteristics including duration and severity of abuse, age at onset of abuse and relationship to the perpetrator of abuse. The developmental pathway of victimized children is not predictive as manifestation of the above problems is mediated by the child's relationship with the non-offending caregiver, among other factors (Barker-Collo, & Read, 2003; Bolen, & Lamb, 2004; Deblinger, et al., 1994, 1999; DeYoung, 1994; Elliott, & Carnes, 2001; Esparza, 1993; Everson, et al., 1989; Gomes-Schwartz, et al., 1990; Heriot, 1996; Hiebert-Murphey, 1998; Leifer, et al., 2001; Sirles & Franke, 1989; Spaccarelli, & Fuchs, 1997; Timmons-Mitchell, et al., 1996).

An understanding of the short and long term effects of child sexual abuse is guided by an ecological theory orientation that focuses on the victimized child's immediate family environment as a source of support and healthy development. Employing ecological theory as a point of departure, this dissertation focuses on the child's relationship with the non-offending female caregiver as a crucial part of response to CSA. Following from this, attachment theory focuses more intimately on the dynamics of the parent-child relationship as it relates to the victimized child's psychological well being. Coping theory helps us understand the phases of coping with traumatic content and the ways in which coping responses contribute to post abuse psychological sequelae among victimized children and families. The subsequent chapter reviews, in detail, these theoretical perspectives and the analytic frameworks which guide this study.

Chapter 2: Theoretical Framework

This chapter examines the theoretical perspectives that influence the experience of childhood sexual abuse. Although researchers have measured maternal response and its impact on child functioning, few studies examine the theoretical contributions to the maternal response construct. In fact, much of the existing maternal response research aims to define behaviours associated with various response patterns and identify maternal response factors known to contribute to psychological adjustment in victimized children. The implications for service delivery and developing relevant best practice guidelines are considerable without a theoretical frame of reference. The concept of maternal response is not, at this time, grounded in a body of theoretical literature, but rather exists as a concept driven by the investigatory procedures of child welfare authorities.

Ecological theory provides an overarching framework for examining the effect of CSA on the child and their non-offending caregiver. Within this larger framework the thesis makes use of two significant theories: Coping theory and attachment theory. These theories are examined and the analytical models within each theory are presented in relation to CSA and maternal response. Factors known to influence the post-abuse response of children and caregivers are summarized and presented under each theory in Table 1. The remainder of the chapter provides an overview of these theoretical models and how they inform the analysis of maternal response and emotional harm.

Table 1: Constructs in Attachment, Coping and Ecological Theory

	THEORETICAL FRAMEWORK		
	Attachment theory	Coping theory	Ecological theory
HISTORICAL FACTORS			
Caregiver's experience of intergenerational violence	◆	◆	
Caregiver's development of parent-child attachment	◆	◆	
SYSTEMS INVOLVEMENT			
Police		◆	◆
Child protective services		◆	◆
SERVICE LEVEL INVOLVEMENT			
Psychosocial involvement	◆	◆	◆
Medical treatment		◆	
ENVIRONMENTAL FACTORS			
Community (isolation)		◆	◆
School involvement		◆	◆
Faith		◆	◆

HOUSEHOLD FACTORS			
Child residing with the perpetrator	◆	◆	
Involvement/isolation of extended family Members	◆	◆	◆
CONTEXTUAL FACTORS			
<i>Caregiver dependent on perpetrator of CSA/domestic violence</i>	◆	◆	
Emotional attachment to the perpetrator	◆	◆	
CAREGIVER FUNCTIONING			
<i>Caregiver's mental health functioning/addiction</i>	◆	◆	
<i>Physical health concerns</i>		◆	
Caregiver's compromised assessment of risk		◆	
ABUSE/CHILD CHARACTERISTICS			
<i>Severity</i>		◆	
<i>Duration</i>		◆	
<i>Physical Harm</i>			
<i>Child's relationship to perpetrator</i>	◆	◆	
<i>Child age</i>	◆	◆	
<i>Child's inappropriate sexualized behavior</i>	◆	◆	
<i>Non-offending caregiver's response</i>	◆	◆	

Note. Model used for analysis incorporates fewer factors than presented here. Italicized factors were examined in bivariate and multivariate analyses

Ecological Theory and Child Sexual Abuse

Research demonstrates that the environmental context underlies the process of post-abuse response in cases of child sexual abuse (Rind, Tromovich, & Baserman, 1998).

As such, ecological theory is a useful conceptual approach to help explain the variations in maternal response and emotional harm experienced by CSA survivors. In addition to this, ecological theory uncovers the limitations of examining CSA outcome solely within the context of psychoanalytic theory as seen through the use of attachment driven explanations.

As indicated by Bronfenbrenner (1986), ecological theory sheds light on the complex reciprocal relationships between an individual and her environment. Bronfenbrenner further determines that proximal characteristics (family, school, community) immediately influence child development to a greater degree than distal influences. Considering the individual, interpersonal, and systemic issues that operate in families for whom CSA is substantiated, an ecological conceptual framework helps to explain the effect of environmental factors.

An ecological model considers the dyadic relationship wherein the environment impacts the individual and the individual, in turn, influences the environment. In the case of CSA, little has been written about the independent effects of contextual factors. For example, at the initial family level of conceptualization domestic violence may influence child outcome as a result of mother's victimization and her potential negative

response to CSA. Not enough is known about the independent effects of family factors such as domestic violence with respect to its effect on child outcome. Also at the family level, mother's continued relationship with the perpetrator influences maternal response, and may contribute to heightened emotional harm among victimized children.

At the level of the community, there are neighbourhood-specific variations in maltreatment rates relative to macro-socioeconomic factors. Children in neighbourhoods highly influenced by low income, female single-parent households, with high population turnover, and large numbers of children per household are at greater risk for child maltreatment (Coulton, & Korbin, 2001; Coulton, Korbin, Su, & Chow, 1995; Sabol, Coulton, & Korbin, 2004). While this literature pertains most often to child neglect rather than child sexual abuse, the conceptualization of child maltreatment as a community level factor reflects an ecological theory approach to child development.

As indicated previously, the environmental context heavily influences the process of post-abuse adjustment subsequent to CSA. In an effort to protect the investigated child, CPS, as a community-level institutional entity, defines the parameters of state involvement in family life. The dynamic of interaction between the individual family and a state-level institution characterizes the influence of the exosystem on the post-abuse adjustment of the individual.

While ecological theory allows for the examination of contextual issues as they relate to child sexual abuse, it does not provide sufficient explanation of the individual's experience of abuse and subsequent coping response. Thus, coping theory and attachment theory are useful for a fuller understanding of child sexual abuse.

Coping Theory and Child Sexual Abuse

In an effort to understand the aftermath of sexual abuse, theorists have isolated factors which are generally understood to mediate post-abuse response among child victims. While abuse characteristics play a key role in contributing to psychological outcome, the body of CSA literature also reflects an interest in examining the impact of abuse perception and coping style.

Maladaptive coping style and noxious family environments have been identified in empirical research as factors contributing to the presence of psychological sequelae among survivors of sexual abuse. Researchers are also beginning to examine the ways in which victims cognitively process abuse events and the extent to which distortions in affective or cognitive interpretation occur. It is widely accepted that the degree to which the victim assumes responsibility for the abuse and internalizes guilt associated with abuse is predictive of maladaptive coping. In practice, defence mechanisms are invoked and self-blame utilized as a method of maintaining trust in the outside world. Use of self-blame in an uncontrollable situation acts as a mechanism to achieve a sense of control in a chaotic context. Naturally, utilizing self-blame as the only coping

response for a protracted period of time has a negative effect on the victim's sense of self-efficacy and this interpersonal dynamic should be examined in a clinical context. Given that some victims internalize a self-deprecating image, social workers should utilize a strengths based practice approach and reframe interpersonal processes typically labelled as "maladaptive" as behaviour aimed at achieving a sense of mastery in a chaotic environment.

While negative attributions regarding the abuse event(s) are associated with poorer outcomes (Mannarino & Cohen, 1996; Spaccarelli & Fuchs, 1997) research documents that most children do not blame themselves, but rather hold perpetrators responsible (Hunter, Goodwin, & Wilson, 1992). Cognitive reappraisal, changing one's perception of the stressful event, influences the coping process. Child victims of sexual abuse who demonstrate an adaptive post-abuse response are more likely to employ cognitive reappraisal. Trauma has the potential to overwhelm internal coping resources, particularly among individuals who do not have a sophisticated repertoire of responses from which to draw upon.

An adaptive coping style is described as "efforts made to master, tolerate, or reduce demands that exceed the person's resources" (Pearlin & Schooler, 1978, p.4). The cognitive processing of a stressful life event requires the effective management of internal stimuli, e.g., attributions of blame. When examining response patterns among CSA survivors it is evident that a series of cognitive, behavioral and affective mechanisms are triggered producing a myriad of interrelated responses. The association between coping style and psychological adjustment in individuals surviving

stressful life events has been empirically evaluated. In attempting to understand the relationship between sexual victimization and psychological adjustment, investigators have begun to explore coping style as a mediator of negative outcome (Chaffin, Wherry, & Dykman, 1997; Everson, Hunter, Runyon, Edelson, & Coulter, 1989; Spaccarelli & Kim, 1995).

Conceptual Models of Coping

Numerous conceptual models for understanding the effects of CSA on children and families have been developed. These models incorporate the person-in-environment conceptualization of family that is characteristic of social work, and are frequently cited in the child sexual abuse literature.

The Approach/Avoidance Model of Coping

Roth and Cohen (1986) classify coping responses into two distinct categories: approach and avoidance. Approach coping is well recognized as efficacious in processing stressful life events as it permits the “gathering of perceptual information regarding the event and facilitates taking action, and ultimately contributes to self-efficacy” (p. 813). Approach coping incorporates efforts made to problem solve and master distressing thoughts and emotions. Alternatively, avoidance coping is utilized to protect the individual from cognitively processing negative emotion associated with the stressful event and typically involves a process of filtering out content that may trigger a traumatic response. “While approach coping facilitates action, avoidant coping mechanisms generally do not encourage information seeking and action-oriented

response patterns” (Roth & Cohen, p. 819). For example, a child that has been victimized at the home of a relative may avoid all family gatherings in an attempt to protect themselves from a perceived negative experience. A response using an approach method may involve distinguishing between family members, isolating events which trigger distressful emotion, and seeking reassurance from a safe individual.

Moos (1986, p.138) distinguishes between appraisal-focused, problem-focused and emotion focused forms of coping. “Logical analysis”, and “cognitive redefinition”, characterize appraisal coping while “seeking information and support”, “taking problem-solving action”, and “identifying alternate rewards” are indicative of problem focused coping. Emotion focused coping involves “affect regulation,” “denial,” and “resigned acceptance”.

Implicit in emotion focused coping is what Moos (1986, p. 138) refers to as cognitive avoidance or suppression of stimuli related to a distressing event. Moos states: “conceptualized as a psychic defence mechanism, avoidance behaviours function as a self-protective response to trauma associated stress” (p. 138). Others refer to cognitive avoidance as the avoidance of thoughts, feelings and situations, detachment, and emotional numbing, which contributes to elevated rates of depression and anxiety among victimized children (Spaccarelli & Fuchs, 1997).

Similar to the Moos model of coping, Folkman and Lazarus (1988) integrate the mechanisms of the cognitive appraisal process into their conceptual framework. A conceptual distinction between primary and secondary appraisal is identified:

Primary appraisal: Refers to the conscious evaluation of a situation to determine if risk of harm exists (Folkman & Lazarus, 1988, p. 140)

Secondary appraisal: Refers to the evaluation of whether or not effort will be required to ensure one's safety (Folkman & Lazarus, 1988, p. 140).

Folkman and Lazarus (1988) identify several coping tasks including seeking more information, attempting to alter the situation, obtaining social support, avoidance of stimuli, confrontive coping and escape-avoidance (p.140). While other coping models establish a preference between various coping styles (e.g. approach/avoidance), the Folkman and Lazarus coping model does not appear to assign a hierarchy in terms of the benefits of employing one coping strategy over another.

The Cognitive Behavioural Model of Coping

The cognitive behavioral model of response to CSA integrates event stimuli (characteristics of the abusive event[s]) and personality type with event cognitions, event appraisals, coping strategies, emotional states, and crisis support (referred to as mediator variables). Joseph and colleagues (1995) suggest that event cognitions (thoughts about the sexually abusive incident) trigger cognitive activity in the form of intrusive thoughts, nightmares and flashbacks. Subsequent to this process, cognitive attributions occur and influence the coping process and ultimately initiate varied emotional states. Crisis support influences attributions, coping style and affect

response through mediation of cognitive appraisals. In cases when traumatic content is not processed and event stimuli is initiated, intrusive images, flashbacks and psychic numbing may occur resulting in repetitive cycles of negative cognitive appraisals. Survivors who experience less severe event cognitions, (less intense thoughts about the sexually abusive incident), typically experience fewer intrusive images and externalize blame associated with victimization.

The Model of Attachment and Coping

Aware of the absence of a comprehensive theoretical framework examining attachment and coping, Shapiro and Levendosky (1999) developed a conceptual model incorporating several coping mechanisms and attachment classifications. Insecure attachment is frequently noted as a risk factor for various forms of psychopathology among children who have experienced maltreatment while secure attachment often acts as a protective factor mediating the impact of CSA (Alexander, 1992). Shapiro and Levendosky (1999) have incorporated a second mediating factor, coping style. It is presumed that parent-child attachment has an indirect effect on psychological distress via coping style. It is generally understood that cognitive avoidance, a coping style characterized by conscious and unconscious avoidance of trauma related stimuli, heightens the risk of post-abuse mental health problems. Naturally, when reflecting on the concept of attachment, readers should be aware of the multiple insecure attachment classifications (avoidant/resistant/anxious/disorganized). A more comprehensive analysis of the impact of attachment on child outcome and maternal response will be discussed in a subsequent section.

The Main and Buffering Effect Model of Coping

The main and buffering effect models of coping examine the influence of family environment. As described by Cohen and Wills (1985) the main effect model of social support suggests that, during times of calm, “a cohesive and emotionally responsive home environment contributes to a perceived sense of support among children regardless of whether or not they are experiencing stress” (p. 310). The main effects model suggests that an adaptive home environment is beneficial regardless of a child’s level of stress and functions as the primary supportive mechanism. Not only does social support mitigate the harmful effects of stress, but according to the main effects model, the presence of a cohesive and responsive social network minimizes exposure to stressful events.

Among children exposed to heightened stress, the buffering effects model suggests that adaptive family relationships contribute to a sense of safety and stability and act as a protective factor preventing psychological distress. The buffering effects model may be characterized as:

Support provided to cope with specific stressful stimuli rather than general social support....the benefits of the buffering effect model will only be evident during times of exposure to heightened stress, and works to reduce the cumulative effects of prolonged exposure to stressful stimuli. (Cohen & Wills, p. 313)

These authors suggest that main and buffering effects do not typically co-occur.

Research on the influence of main and buffering effects in the child sexual abuse literature is limited.

Rutter (1981) examines the influence of family relationships on the stress reactions of adolescents coping with various life events and concludes that adolescent well-being is influenced by level of functioning among family members. Harter, Alexander, and Neimeyer (1988) attempt to determine the influence of family environment on the psychological outcome of sexually victimized children. These authors report that family cohesion, and a characteristic they refer to as “post-abuse adaptability,” account for greater variance in explaining coping among victimized children. Conte and Schuerman (1987) similarly indicate that a noxious family environment was associated with heightened symptom presence and difficulty coping among their sample of 369 sexually abused children.

Attachment Theory and Child Sexual Abuse

Attachment theory is examined as it relates to child sexual abuse and the non-perpetrating mother’s response. Factors that are known to influence parent-child attachment such as parenting behavior, mother’s history of trauma, mother’s relationship to the perpetrator, mother’s experience of domestic violence and mother’s perception of social support are examined in detail in Alaggia and Knott (2007).

Parent/Child Attachment

In the absence of a well defined theoretical construct, this author will consider the influence of attachment theory in informing maternal response. Parent-child attachment typologies include secure and insecure attachment with avoidant, ambivalent, and disorganized behaviors characterizing insecure attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990). Writing a comprehensive, integrated critical analysis of parent/child attachment is not the intention of this author. Rather, the purpose of this brief analysis is to establish a theoretical framework to explain the process of maternal response, incorporating attachment processes and several behavioral factors mentioned previously.

According to Goldberg (2000), securely attached infants seek proximity to their caregiver; demonstrate comfort in relating to the caregiver from afar, exploring the surroundings freely while the caregiver is present. Infants who demonstrate avoidant attachment behaviours will avoid contact with their caregiver and show little or no emotion when the caregiver departs. Ambivalent infants who are insecurely attached will avoid contact with strangers even when their caregiver is present. They will demonstrate substantial distress when their caregiver leaves and will respond resentfully upon return of their caregiver (Cassidy & Shaver, 1999). Disorganized attachment is evident when infants fail to demonstrate a consistent pattern of relating to their caregiver and others. These infants experience their caregiver as frightening. Interpersonal relationships are interpreted as inconsistent and the child is unable to establish a coherent pattern of relating to others. Disorganized attachment is often

evident in the most severe cases of child maltreatment (Greenberg, Cicchetti, & Cummings, 1990). The above attachment behaviors are identified through use of an exercise referred to as the strange situation wherein the “secure base” of the mother is utilized to assess the level of distress associated with proximity to one’s primary caregiver (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990).

The perception that parent/child relationships play a central role in the psychological, cognitive and social development of children is widely accepted. Compared with children who lack secure attachment bonds, children who have a fundamental sense of security are known to function more adaptively across contexts (Belsky & Vondra, 1989; Crittenden, 1995, Kolko, 1996). “The sense of safety inherent in attachment acts as a defence against stress and promotes resiliency” (Rutter, 1981, p.323). The attachment bond is the mechanism through which children perceive an internal working model of adaptive relationships. As an important function of attachment, children learn trust and reciprocity and this experience serves as a template for interpreting future relationships. Ability to self-regulate emotion is similarly a component of secure attachment and is essential to managing stressful encounters, particularly those associated with CSA.

Securely attached children anticipate a specific response to the disclosure of distressing information based on pre-existing attachment patterns. Crittenden (1995) indicates that both securely and non-securely attached infants (with the exception of resistant infants) predict caregiver behaviour and adjust their attachment seeking cues to the anticipated

responses of their caregivers. Infants submit cues to their caregivers in an attempt to illicit a caregiving response, and if responded to appropriately, this process forms the basis of secure attachment. However, “resistant infants cope with the unpredictable behaviour of their caregiver and subsequently learn to distrust cognition as a reliable source of information” (Goldberg, 2000, p.155).

Consistent with this process, many sexually victimized children exhibit help seeking cues to their non-perpetrating caregivers. These security-seeking patterns are intended to activate the existing attachment bond and promote a protective response. It is important to have an understanding of these early attachment mechanisms as they persist within families and are activated with the onset of stressful encounters. These attachment patterns function as a template for the management of distressing emotion between family members.

Diminished maternal support may be partially explained by examining the attachment behaviours of non-perpetrating parents at the time of CSA disclosure (Leifer, Kilbane & Grossman, 2001; Lewin & Bergine, 2001). Leifer and colleagues found that mothers of sexually abused children are more likely to have insecure attachments when compared with mothers of non-sexually abused children. This is not to say that mothers who are unable to provide protection and respond in an ambivalent manner fail to exhibit attachment behaviours. Much of the maternal response literature dichotomizes maternal response patterns into “good and bad,” with absence of full support perceived as negligent. Mothers who respond in an ambivalent manner do so

for a host of reasons including domestic violence, financial dependence on the perpetrator and concerns around placing other children at heightened risk. An ambivalent response does not preclude demonstration of subtle attachment cues, which psychometric instruments may not detect.

Parent Child Attachment and Maternal Response to CSA

Attachment relationships develop during childhood and persist into adulthood. The parent-child attachment relationship is considered the primary mechanism for interpretation of self, others and inform the negotiation of interpersonal relationships. As a result, a focus on the implications of attachment with respect to maternal response is critical.

Reporting on a subset of data from a 1987 survey (Zuravin & Taylor, 1987), Zuravin, McMillen, DePanfilis, and Risley-Curtiss (1996) indicated that the quality of non-perpetrating mothers' attachment relationships during her childhood predicted the occurrence of sexual abuse among her children. As documented by Alexander (1992), aspects of insecure parent-child attachment, including parentification, emotional rejection, fear and trauma often characterize the interpersonal dynamics among families wherein sexual abuse has occurred. Bolen (2002), in her descriptions of parent/guardian response to CSA, reported that mother's attachment style was the most influential predictor of emotional support. The complex interpersonal dynamic that influences maternal response within the context of mother's historical trauma is explored in detail in Alaggia and Knott (2007).

Adult Attachment and Response to CSA Disclosure

Hazan and Shaver (1987) and Feeney and Noller, (1992) document the persistence of early attachment patterns continuing into adulthood and influencing interpersonal relationships. Some ambivalent/preoccupied adults may experience intimate relationships as obsessions, have difficulty in regulating emotion, and experience jealousy (Bolen & Lamb, 2004). Feeney and Noller characterize ambivalent/preoccupied individuals as manifesting clingy behaviours, being emotionally volatile and demanding. In cases of CSA disclosure, non-perpetrating mothers who experience this intimate attachment pattern with their partner may demonstrate an ambivalent response to their victimized child, as the potential loss of their partner may initiate attachment related anxieties.

Psychosocial Intervention and Coping Response^{6, 7}

The post-disclosure psychological adjustment of victimized children is mitigated by the participation in and completion of treatment for problems associated with sexual abuse. Treatment is not limited to the participation of child victims, but often includes the non-perpetrating caregiver and this inclusion is found to result in fewer children developing long-term problems associated with abuse (Haskett, Nowlan, Hutcheson & Whitworth, 1991; Tingus, Heger, Foy & Leskin, 1996). Treatment for child sexual abuse involves a myriad of intervention models with children receiving individual or group therapy independent of the non-offending parent, or conjoint parent and child sessions. When

⁶ Although the term “caregiver” or “parents” is used often in this section, it is recognized by this author that the majority of non-perpetrating caregivers are mothers. Treatment outcome studies often use the language “parents” or “caregivers” to ensure that they are being inclusive despite the fact that a substantial majority of caregivers are non-offending mothers.

⁷ This section is based on Alaggia and Knott (2007).

non-offending parents receive treatment, this typically occurs in parallel groups with children and parents independently receiving group therapy.

Intervention with Victimized Children

Despite the substantial number of CSA survivors receiving services, there are noticeably few treatment outcome studies that rigorously evaluate the efficacy of intervention with victimized children. As a result, there is no single standard of empirically validated practice with this population although cognitive behavioral intervention is emerging as an effective treatment model (Corcoran, 2004).

Finkelhor and Berliner (1995) reviewed 29 treatment outcome studies and concluded that overall, symptom presence among victimized children declined after intervention when compared with children who received no treatment. These same authors indicated that when compared to supportive therapy, abuse focused therapy was more effective in reducing symptomatology. However, due to the absence of rigorous experimental studies included in this review, (results of simple pre/post test studies, quasi-experimental studies and 5 experimental studies were included) these authors confirmed that the effectiveness of clinical intervention with this population has not been established. Finkelhor and Berliner suggest that the elements of abuse-specific intervention should include a) encouraging ventilation of abuse-related feelings (anger, ambivalence, fear), b) clarifying erroneous beliefs that lead to negative attributions, c) teaching abuse prevention skills, and d) diminishing stigma and isolation through reassurance or exposure to other victims.

Treatment for Non-offending Mothers

Research findings conclude that greater symptom presence among non-perpetrating mothers is associated with emotional distress in children who have been sexually abused (Cohen & Mannarino, 1996). Therefore, to ensure a favourable post-abuse response in victimized children, non-offending mothers require help in coping with their own distress and assistance in providing their children with protection and much needed emotional support. The inclusion of non-offending parents in CSA treatment is derived from both clinical and research evidence which concludes that parents may experience emotional distress subsequent to the knowledge that their child has been victimized (Corcoran, 1998). Continued involvement between the non-offending mother and the perpetrator often confounds mothers' response to child sexual abuse and contributes to a complex set of emotions ranging from full support of the victimized child to ambivalence related to the veracity of the disclosure. Among a sample of 435 mothers of sexually victimized children, Pintello and Zuravin, (2001) found that mothers who continued to remain in a sexual relationship with the perpetrator were less likely to provide protection for their victimized child than in cases where mothers had ceased intimate involvement.

Parent involvement in treatment is critical to ensure the availability of emotional support for the victimized child and to provide an opportunity for the non-perpetrating caregiver to process grief and distress associated with their child's victimization. In addition, parental involvement in clinical intervention provides key information about symptom presence in children, and strategies for coping with problematic behaviours

(e.g. sexualized behaviour in children). It is not uncommon for parents to experience secondary trauma characterized by symptoms such as difficulty sleeping, intrusive thoughts, distress associated with attributions of blame, and anxiety (Corcoran, 1998; Manion, et al., 1996; Regehr, 1990). Therapeutic models for parents and children have evolved from treatment that formerly adopted a non-directive approach with a sole focus on reflective listening and empathy. More recently, intervention approaches incorporate a didactic approach with a focus on normalizing parental responses to disclosure of abuse, mitigating parental distress, and helping parents understand the short and long-term impact of CSA. Practice models include psycho-educational intervention and cognitive behavioral therapy (Cohen & Mannarino, 1998b, 1996b; Corcoran, 2004; Deblinger, McLeer & Henry, 1990, Deblinger, Stauffer & Steer, 2001; Stauffer & Deblinger, 1996; Winton, 1990).

Multiple treatment approaches have been developed to ameliorate the post-abuse sequelae among child victims and their families. Friedrich (1991a) suggests that family interventions incorporate a) abuse specific victim intervention, and b) family based intervention. Simultaneous intervention may occur as several treatment modalities are often adopted in direct service with families. Treatment modalities include:

Individual Therapy: Abuse specific intervention for the child and non-perpetrating caregiver. Non-abused siblings may be involved in individual therapy, if warranted.

Child: Individual treatment typically involves play, art or sand therapy. In addition, traditional psychotherapy for adolescents may focus on attributions of guilt, shame, self-harm, sexuality and intimacy.

Non-perpetrating caregiver: Provides a context to individually process traumatic reactions, and learn strategies to support the victimized child.

Group Therapy: Abuse specific intervention with multiple child victims or non-perpetrating family members. Aims to normalize the experience of abuse, provide concrete strategies for coping with symptoms, and mitigate the experience of isolation.

CBT group intervention for children or non-perpetrating parent and/or siblings

Client facilitated group: Adopts a mutual-aid approach

Art Therapy Groups: Expression and interpretation of trauma through the arts

Family Based Therapy: May involve non-perpetrating parents, victim and non-abused siblings. Aims to address attributions of blame while focusing on re-negotiating family relationships, and boundaries.

Marital Therapy: Couples therapy aims to process the experience of blame, reflect on intimacy issues and consider parenting strategies related to the victimized child and non-abused siblings.

Group Therapy for Perpetrators: Multiple offenders participate in abused focused group therapy with a concentration on developing insight into triggers for sexually abusive activity, and aims to reduce the risk of recidivism.

Group therapy has been identified as the preferred model of intervention for both children and parents as this approach helps to reduce the isolation experienced by many victimized children and parents, and counteracts the secrecy and shame often associated with CSA (Saxe, 1993, p. 93). Although, as indicated by Saxe (p.93), while individual therapy permits the building of trust with a single helping professional the privacy and

confidentiality inherent in individual approaches may inadvertently reinforce a sense of secrecy and isolation. “Group therapy seeks to normalize the experience of abuse and reduce the impact of stigma by identifying commonalities of the experience and post-abuse adjustment difficulties such as low self-esteem, shame, and guilt” (Saxe, p. 93).

Treatment Outcomes

Measurement of the efficacy of family intervention is complicated due to the multiple treatment approaches documented for use with families recovering from CSA, e.g. individual, family, and group therapy, in addition to various models of intervention, e.g. traditional psychotherapy, play therapy, art therapy, couples therapy and the various practice approaches; CBT, psychoeducation, and supportive counselling.

In the absence of a distinct developmental trajectory for CSA survivors, or a “sexual abuse syndrome,” multiple treatment approaches are often employed to target the diverse needs of the CSA survivor and her family. Complicating matters further, these interventions are often provided on a concomitant basis. For example, the child victim may be receiving both group intervention and family therapy while her mother may participate in a mothers support group and family therapy, while father is involved in an offender group. Clearly, measurement of the efficacy of multiple, and simultaneous interventions presents a methodological and research design challenge.

Treatment outcome research most frequently cited in the CSA literature are models developed by Cohen and Mannarino (1996a), and Deblinger, McLeer and Henry

(1990), Deblinger, Stauffer, and Steer (2001). Both models adopt a CBT approach; however, they vary in their length and inclusion of parents and children. Cohen and Mannarino, utilize a 12 week model of individual therapy involving 68 parents and children with randomization to either CBT or supportive therapy. The sample was comprised of 50% African-American participants and 50% Caucasian participants. The CBT intervention with parents dealt with issues such as ambivalence towards the perpetrator, impact of mother's history of victimization, encouraging maternal supportiveness, legal issues, attributions of blame, and teaching cognitive coping skills and parent training. Children randomized to the CBT group received treatment that focused on abuse prevention, attributions of blame, mitigating sexual acting out behaviors, and coping with fear and anxiety. CBT strategies for both parents and children included reframing, positive imagery, thought stopping, problem solving and assertiveness training (Corcoran, 2004, p.68). Results indicate that randomization to the CBT condition resulted in improvements in child behaviour; particularly sexual acting out behaviour, while gains were made across indexes for both parents and children randomized to CBT. These gains were maintained at follow-up. Of note, parental social support was the most significant predictor of positive outcome at 6 and 12 month intervals and parental distress was significantly related to child maladjustment.

Deblinger, Stauffer, and Steer (2001) examined the effect of an 8 session CBT group for 44 non-perpetrating parents and children. Parents and children received group therapy separately and were randomized to CBT or supportive therapy. Children and

parents in the CBT condition also received a 15 minute weekly joint activity. Parents and children in the CBT condition experienced overall improvement with most significant gains made in reducing parental distress.

Winton (1990) utilized a 13 week group for 27 non-perpetrating parents of CSA victims with a focus on parent skills training. Children's behavior problems were reportedly mitigated, but parents disclosed no significant improvement in parenting stress. These findings are based on a study employing a quasi-experimental design, small sample size and inclusion of families wherein both incest and extrafamilial abuse had occurred. These factors limited the study's generalizability and emphasized the need for rigorous empirical evaluation of parent support group intervention.

Despite the positive outcomes noted in research utilizing a CBT approach, generalizability is limited as many studies continue to use small sample sizes, utilize control groups involving "no treatment," have high drop out rates and confound parent and child treatment conditions.

Parenting Practices and Maternal Response to CSA

Maternal support exists within the framework of a family system, and therefore is influenced by the parenting practices utilized by caregivers. According to this model, parenting is partially influenced by the personal psychological resources of the parent. In studies examining the post-abuse adjustment of parents and children, findings

indicate that disclosure of sexual abuse is a traumatic stressor for both the victim and the non-perpetrating parent (Burgess, Hartman, Kelley, Grant, & Gray, 1990). Clinical observation confirms that, in many cases, the psychological resources of non-perpetrating mothers are compromised due to the trauma associated with disclosure.

Employing a “developmental lifespan model,” Manion, et al., (1998) measured the post-disclosure adjustment of both children and non-perpetrating parents, referred to as primary and secondary victims respectively. Among their sample of 56 children and 92 parents recruited through a hospital based child protection service, Manion and colleagues found that non-offending mothers’ experienced emotional distress subsequent to CSA disclosure, which diminished somewhat over time. At 12-month post-disclosure, 38% of mothers continued to report emotional distress in the clinical range.

Mothers who have experienced sexual trauma may have diminished capacity to experience satisfaction from their maternal role (Herman, 1981), may experience difficulty in negotiating discipline (DiLillo, Tremblay & Peterson, 2000; Gelinas, 1983) and may demonstrate heightened vigilance and responsibility in their parenting practices (Cohen, 1995). Among a clinical sample of 54 mothers with a history of CSA, Cohen reported that mother’s with a CSA background had more difficulty functioning in their parenting role when compared to non-CSA mothers, as measured by the Parental Skills Inventory. Cohen’s study incorporated a general sample of mothers whose children did not report CSA. Specific parenting challenges

experienced by mothers with a history of trauma included difficulties negotiating generational boundaries with children, permissive parenting, and increased use of physical discipline (DeLillo, & Damashek, 2003; Leifer, Kilbane, & Kalick, 2004).

Observational studies of CSA-mothers similarly document diminished parenting capacity. Burkett (1991) observed parenting interactions among a sample of 20 CSA-mothers recruited from both clinical and community settings. Results indicated that CSA-mothers demonstrated more self-focused behaviour during interactions with their children when compared with non-CSA mothers. Flat affect and decreased interaction were cited by Lyons-Ruth and Block (1996) during their observation of a group of 45 CSA mothers and their 18 month-old children. Lyons-Ruth and Block secondarily analyzed longitudinal data of families who received community support services (see Lyons-Ruth, Connell, Grunebaum, & Botein, 1990).

Zuravin (1999) refers to the cumulative risk model developed by Rutter (1987) and suggests that negative early relationships work to establish a context for future parenting problems. This model suggests that mothers' experience of sexual abuse in and of itself may not necessarily contribute to poor parenting; rather, it is the family context to which mother was exposed that mediates future parenting skill.

While maternal support has been found to mediate the negative effects of CSA, it is important to place CSA in the larger ecological context of the child's environment, which may include family dysfunction and socio-economic disadvantage, among other

factors. Individually, these factors may contribute minimally to the development of a psychiatric disorder; however, when examined collectively these factors may impact substantially on the recovery process.

Aversive Life Events and Effects on Later Parenting

While it has been documented that a mother's history of sexual abuse is related to diminished parenting efficacy, maternal capacity to protect and support may be a function of additional factors such as a mother's own experience of other aversive life events. Child sexual abuse often occurs in a context of heightened disadvantage and may co-occur with other forms of maltreatment such as physical and emotional abuse and neglect.

Few maternal support researchers control for the impact of other aversive events and focus solely on history of child sexual abuse as an antecedent to compromised parenting. Based on a sample of 430 women, Banyard (1997) identified predictive factors in determining parenting competency among women with a history of CSA. This study utilized secondary analysis of existing data involving low-income Baltimore mothers who received CPS intervention (see Zuravin, 1998). To determine the most powerful predictor of current parenting style this study examined CSA history, mother's perceived relationship with her own caregivers and mother's own history of physical abuse and neglect as a child. At the bivariate level, negative early relationships contributed the largest variance in predicting parent use of physical force over and above that accounted for by history of CSA and depression ($r=.20, .19, .18$).

However, at the multi-variate level, CSA predicted use of physical force and future parenting skill over and above that accounted for by aversive childhood events.

Mothers' history of substance abuse is also known to influence maternal response (Leifer, Shapiro, & Kassem, 1993; Rodriguez-Srednicki, 2001). Leifer, Kilbane and Kalik (2004) indicated that women with a history of CSA are more likely to abuse substances when compared with their non-CSA counterparts, and less likely to provide protection to their sexually victimized child. Zuravin and Fontanella (1999) also point to the impact of pre-disclosure maternal depression as a mediating factor in parenting. These authors suggest that, in light of the high prevalence rates of depression among women with a history of child sexual abuse, poor parenting may be a result of pre-existing depression exacerbated by the disclosure of their child's SA. The above study examined the complex interplay of several antecedents and findings demonstrated the influence of maternal depression on parenting capacity. For a review of parenting styles among women who have depression see (Downey & Coyne, 1990).

Effect of Cumulative Trauma on Capacity to Protect and Support

Given that young children may not appreciate the degree of violation associated with CSA, some suggest that disclosure of sexual victimization of a very young child may be more traumatic for the non-perpetrating mother than for the victimized child (McFarlane, 1986). A traumatic experience occurs when: "an event elicits fear, helplessness, and overstimulation and identified by the victim as traumatic" (Graham-Berman & Levendosky, 1998, p.1). Thus, not all women experience their child's

victimization as traumatic; however, for mothers with cumulative exposure to trauma, the effects of disclosure may compromise their response. For this reason, mothers' with their own history of CSA may demonstrate diminished capacity to provide emotional support.

Trauma theory suggests that victims of chronic trauma experience a diminished capacity to perform accurate risk assessments involving their proximity to danger and are at high risk for re-victimization (Arata & Lindman, 2002; Collins, 1998; Dietrich, 2003; Herman, 1992; Proulx, Koverola, Fedorowicz, & Kral, 1995). This is referred to in the trauma literature as having an extended latency. Repetition compulsion or re-enactment is also a factor that may occur among women with an abuse history (van der Kolk, 1989). This concept refers to an unconscious process wherein traumatized individuals attempt to master a previously traumatic event by exposing themselves to the harmful stimuli, in some cases, over and over again. Naturally, this process presents a host of risk factors for children under the care of an individual coping with severe and protracted trauma symptoms.

Social Support for Non-Perpetrating Mothers

Mothers' perception of the availability of social support is an important factor when considering non-perpetrating mothers responses to disclosure of CSA and is documented as a predictor of maternal support to the abused child (Hiebert-Murphey, 1998). In light of the demands placed on non-perpetrating mothers, perceived social

support naturally enhances maternal response and ultimately contributes to the improved psychosocial outcome of the victimized child. Given that the majority of sexually victimized children disclose abuse directly to their mothers (Sauzier, 1989), it is essential that mothers have access to appropriate post-disclosure support to ensure an effective response.

As in other stressful life events, the mechanism through which social support enhances coping is through the provision of a mutual aid system and assistance in problem solving. Literature examining the effectiveness of intervention with families of CSA victims documents the benefit of social support as a key element enhancing maternal response (DeVoss & Newlon, 1986; MacFarlane, 1986; Reyman, 1990). Although, when compared with cognitively based group intervention, social support groups were found to be less effective (Corcoran, 2004; Deblinger, Stauffer, & Steer, 2001). As a rationale for this finding, it is suggested that while social support provides an interpersonal context for the processing of grief, cognitively based intervention incorporates a didactic approach to understanding stages of recovery. Supporting mothers' in their coping response is critical, as a child's perception of her mother's ability to cope with the disclosure of abuse is likely to influence the child's internalization of blame.

Operationalization of Maternal Response

A narrow definition of maternal response exists with only 3 factors accounting for this complex and dynamic process. In light of this, how does one accurately measure maternal response? Bolen (2002) cogently raises this important issue with respect to the multiple and varied definitions of maternal response. Bolen reflected on this question: “How might one measure maternal response and ensure construct validity⁸ is met in the absence of a clear theoretical framework?”

- Maternal support is measured according to whether or not the caregiver believed the child and provided emotional support
- Ability to protect the victimized child is used as an indicator of maternal support, in addition to compliance with CPS
- Belief, protection and emotional support are reflected in the subscales of these clinician administered and self-administered maternal response instruments:

PRIDS: Is a clinician-completed Parental Reaction to Incest Disclosure Scale (Everson, Hunter, Runyon, Edelson, & Coulter, 1989), which provides a framework of parental reaction and support following the disclosure of sexual victimization. A score ranging from +5 (highest support) to -5 (least support) is obtained by summing three constructs: emotional support, belief of child, and action toward perpetrator (Leifer, et al., 2001, p.357).

PRADS: Parental Reaction to Abuse Disclosure Scale (Runyon, Hunter, & Everson, 1992). This scale is a modified version of the Parental Reaction to Incest Disclosure

⁸ Rubin and Babbie (1997, p. 179) indicate that construct validity refers to the way a measure relates to other variables within a system of theoretical relationships...whether [or not] a measure fits theoretical expectations.

Scale. The indicators for PRADS include the following: belief in the child's report, emotional support offered to the child, choice of the child over the perpetrator, attitudes towards professional services. These subscales are rated from -2 (least supportive) to +2 (most supportive) with a total range of -8 to +8. A score of +4 on the PRADS classified mothers as supportive to their children (Leifer, et al., 2001, p.357).

Ultimately, whether the scale is clinician administered, or self-administered the factors used to determine evidence of maternal response remain concepts driven by CPS investigatory practices. The absence of a clear theoretical framework remains as few authors have put forth an explicit theory informing their understanding of maternal response. Spaccarelli and Kim, (1995) and Shapiro and Levendosky, (1999) are among a handful of researchers who articulate a theoretical framework that situates maternal response in a larger theoretical model - Attachment Theory. These researchers explore the nature of mother-child attachment and suggest that attachment theory is critical in explaining the process of maternal response.

Integration of Constructs

The model below incorporates the concept of cumulative risk, in that, with multiple exposures to contextual stressors, there is increased risk of negative maternal response and emotional harm to children. CSA, naturally, is the antecedent event that triggers a coping response, which ultimately informs mother's reaction to disclosure. This process is determined by various risk and protective factors including historical factors such as mother's history of trauma, household factors, contextual factors such as

mother's victimization by the CSA perpetrator, caregiver functioning factors including mother's mental health and abuse characteristics such as duration and severity of abuse.

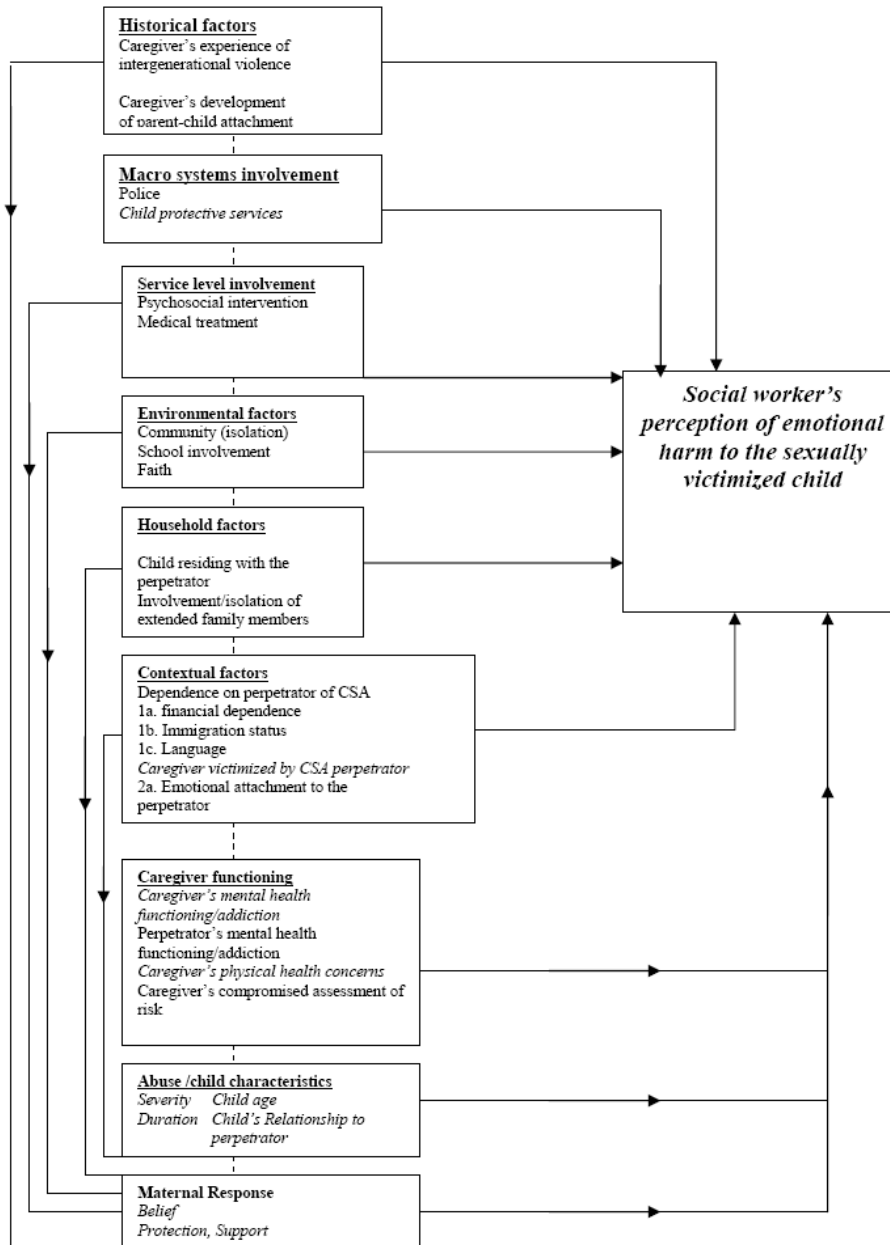
Model of Maternal Response and Child Outcome: Figure 1

Figure 1, model of maternal response, depicts the direct relationship between the predictor variables and the maternal response outcome. As indicated, maternal stressors have a direct impact on maternal response defined as belief, protection and emotional support. CSA characteristics similarly have a direct influence on maternal response as do child characteristics and maternal resources. In addition to determining the relative importance of each successive category of predictor variables, this study will assess the estimated interaction effect of independent factors. Overall, the above model suggests that when contextual factors such as availability of social support, history of trauma, current depression/anxiety, and drug use are considered, maternal coping resources may be depleted and maternal response compromised.

This model assumes that predictor variables have both a direct and indirect influence on child outcome, mediated by maternal response. In addition to this, Figure 1 suggests that maternal response is associated with child outcome when other risk factors are controlled. This study will identify the relative influence of maternal response in predicting child outcome when, for example, domestic violence is controlled.

Only italicized factors were used in analyses

Integrated model of child outcome



The above model suggests a more comprehensive method of examining maternal response by incorporating various aspects not previously included in a single

conceptualization. Historically, the clinical and research literature has focused on strategies of optimizing maternal response with the objective of improving the outcome of victimized children. Unfortunately, little emphasis has focused on mother's health and well-being as a distinct entity separate from her victimized child. While it is important to isolate predictive factors contributing to improved outcomes of victimized children, more emphasis on the experience of mothers is needed. In many cases, mothers are similarly victimized by abusive partners and should receive adequate attention in their own right.

Chapter 3: Design and Methods

Empirical research examined in chapters one and two support the research questions and hypotheses noted below. The research questions and hypotheses are influenced by an ecological approach to understanding the effects of child sexual abuse. An ecological approach conceptualizes maternal response and emotional harm within the context of the child's environment. Beginning with the non-perpetrating mother as the primary source of support, the characteristics of the female non-offending caregiver were assessed. Factors associated with the investigated child were examined for relevance in predicting maternal response and emotional harm. The household context is critical in understanding the process of maternal response and emotional harm subsequent to CSA, and related characteristics were examined in bivariate and multivariate analyses. Following this, the characteristics of the reported CSA were assessed as abuse characteristics influence the developmental trajectory of children investigated for sexual abuse.

It is recognized that the inclusion of the predictors below was based on theoretical validity of the concepts in relation to maternal response and emotional harm, in addition to the results of bivariate analyses.

Research Questions

1. What percentage of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were identified by their social workers as having a negative maternal response?
2. What characteristics are associated with maternal response?
 - 2.1 In particular, what maternal characteristics (e.g. substance abuse, mental health, and domestic violence) are associated with maternal response?
 - 2.2 What child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay) are associated with maternal response?
 - 2.3 What abuse characteristics are associated with maternal response (duration of abuse, child's relationship to the perpetrator)?
 - 2.4 What investigation characteristics (substantiation level, and co-occurring maltreatment) are associated with maternal response?
3. According to the investigating social workers assessment, what percentage of children investigated for sexual abuse in the CIS-98 experienced emotional harm?
4. What characteristics are associated with emotional harm?
 - 4.1 In particular, maternal characteristics (e.g. maternal response, domestic violence and mental health).

- 4.2 Child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay).
- 4.3 Abuse characteristics (duration of abuse, child's relationship to the perpetrator).
- 4.4 Investigation characteristics (substantiation level, and co-occurring maltreatment).

Hypotheses

1. Maternal, child, abuse, and investigation characteristics are associated with maternal response among non-perpetrating caregivers of children investigated for sexual abuse.
2. Maternal, child, abuse, and investigation characteristics contribute to emotional outcome among children investigated for sexual abuse.

The theoretical approaches presented in chapters one and two provided a rationale for the inclusion of the questions and hypotheses noted above. See previous chapters for a review of the following theoretical frameworks: Traumagenic framework (Finkelhor, 1988), transactional model of coping (Spaccarelli, 1994), cognitive behavioral model (Joseph, William and Yule, 1995), model of attachment and coping (Shapiro & Levendosky, 1999), and the child sexual abuse accommodation syndrome (Summit, 1983). While characteristics of abuse help influence child outcome, more attention needs to be paid to the environmental context in which victimized children live. In brief, literature on the outcomes of child sexual abuse has focused primarily on child

and abuse characteristics (Fergusson, Horwood, & Lynskey, 1996; Friedrich, et al., 1986; Fromuth, 1986; Kendall-Tacket, et al., 1993; Russell, 1986; Sedney & Brooks, 1984). More recently, caregiver and household characteristics have been identified as factors that mediate the adjustment of sexually abused children (Alaggia & Turton, 2005; Bolen, & Lamb, 2004; Elliott, & Carnes, 2001; Esparza, 1993; Everson, et al., 1989; Hiebert-Murphey, 1998; Leifer, Kilbane, & Grossman, 2001). With this in mind, the above research questions and hypotheses were developed around an ecological model that examined post-abuse adjustment within the context of a person-in-environment conceptualization.

CIS-98 Sample

This study was based on secondary analysis of data collected in the Canadian Incidence Study of Reported Child Abuse and Neglect - 1998 (Trocmé, et al., 2001).

Maltreatment was divided into 4 categories in the CIS-98: physical abuse, neglect, emotional abuse and sexual abuse. In 1998, physical abuse was the primary reason for investigation in 31% of all investigated maltreatment, a further 40% of investigations were primarily motivated by neglect, and emotional abuse accounted for 19% of all investigated maltreatment. Child sexual abuse as the primary reason for investigation accounted for 10% of all maltreatment reports. This dissertation's analyses utilized unweighted data as there was no intention to generalize findings of the current study to the entire population of sexually abused children.

Further distinctions were made between cases which were substantiated, suspected or unsubstantiated. Only cases which were suspected or substantiated were included in the present study. Substantiation refers to cases wherein, “the balance of the evidence indicates that abuse or neglect has occurred” (Trocmé et al., 2001, p. 26). Suspected refers to a case “where there is not enough evidence to substantiate maltreatment, but there nevertheless remains a suspicion that maltreatment has occurred” (Trocmé et al., 2001, p. 26). Unsubstantiated indicates that “there is sufficient evidence to conclude that the child has not been maltreated” (Trocmé et al., 2001, p. 26).

Study Sample

The research questions in this study sought to determine the level of maternal response and emotional harm and the characteristics that contributed to each.

The dataset for this study’s analysis restricted those cases where an allegation of CSA was suspected or substantiated. Only CSA investigations for which a female non-perpetrating caregiver was identified were retained in the study sample (i.e. biological mother, grandmother, stepmother, foster mother, and adoptive mother).

The following was the rationale for limiting the study sample to those investigations with a female non-perpetrating caregiver:

- a) Limiting the study sample to investigations with a female non-offending caregiver reflects the existing research literature on maternal response (Elliot

& Carnes, 2001; Esparza, 1993; Everson, Hunter, Runyon, Edelson, & Coulter, 1989).’

- b) The utility of comparing dissertation findings against previous studies where the most common family configuration involves mothers as the non-perpetrating caregiver.

Operationalization of the non-offending caregiver

When completing the CIS-98 data collection instrument workers were asked to complete information on caregiver A and caregiver B. If caregiver A was the perpetrator, the investigation involving B was included if caregiver B identified as female and non-offending. If caregiver B was the perpetrator, the investigation involving caregiver A was included as long as caregiver A identified as female and non-offending. If caregivers A and B were both perpetrators of CSA, this investigation was not included in this study’s sub sample.

From this point on, when referring to the overall CIS-98 study sample, the term non-offending caregiver is utilized. Although, when referring to the dissertation study sample the terms mother or maternal non-offending caregiver, or female non-offending caregiver may be used.

As previously mentioned, dissertation analyses sought to isolate cases of CSA wherein only female non-offending caregivers were identified by the investigating child welfare worker. Investigations that were suspected or substantiated were included because of the preponderance of guilt associated with both child welfare dispositions.

The unit of analysis in this study was the investigated child. The investigating child welfare worker completed the CIS-98 data collection instrument (in appendix 1) identifying the response of the non-offending caregiver subsequent to the investigated child's report of CSA. As depicted in Table 2 below, although there were 524 investigations of suspected or substantiated child sexual abuse in the CIS-98 dataset, the total sample of child sexual abuse investigations for which there was a female non-perpetrating caregiver was 373. As my focus is on the role of maternal response, my sample was restricted to these 373 investigations.

**Table 2: Description of final CIS-98 sample of child sexual abuse investigations
n= 373**

Number of CIS-98 child maltreatment investigations	Number of CIS-98 child sexual abuse investigations	Number of suspected or substantiated child sexual abuse investigations	Number of suspected or substantiated child sexual abuse investigations for which a female non-perpetrating caregiver was identified
N=7672	n=883	n=524	n=373*

*Indicates sample of female non-offending caregivers utilized for data analyses.

This study utilizes the term, “maternal non-offending caregiver,” although a small minority of investigations involved women in a caregiving role who were not biological mothers. Of the 373 female non-offending caregivers, there were 349 (93.6%) children

whose non-offending caregiver was a biological mother, 12 (3.2%) other female caregivers, 8 (2.1%) foster mothers, 3 (.8%) adoptive mothers, and 1 (0.3%) step-mother.

Table 3: Description of the female non-perpetrating caregiver’s relationship to the investigated child

N= 373

Number of suspected or substantiated child sexual abuse investigations for which a female non-offending caregiver was identified	Biological Mother	Other	Foster mother	Adoptive mother	Step-mother
N=373	n=349 (93.6%)	n=12 (3.2%)	n=8 (2.1%)	n=3 (0.8%)	n=1 (0.3%)

The majority of investigations involved sexual abuse (86.3%) as the only reason for the report. The remaining 13.7% of CSA cases were investigated for child sexual abuse and another form of co-occurring maltreatment. The variable, “co-occurring maltreatment” was entered into the regression model to determine the influence of multiple alleged maltreatment types on negative maternal response and emotional harm.

The CIS-98 did not track the following: (a) incidents that were not reported to child protection authorities, (b) reported cases that were screened out by child protection workers before being fully investigated, (c) new reports on cases already open by child protection authorities, (d) cases that were only investigated by the police, and (e) cases involving separated parents who proceeded through the family courts without having a

full child welfare investigation (Trocmé, MacMillan, Fallon, & De Marco, 2003, p. 911).

Data Analysis

Procedures

Bivariate analyses (cross-tabs) and multivariate analyses (logistic regression) were used to determine the factors that contributed to social workers perception of negative maternal response. Due to the power limitations in this study, only those variables statistically significant at the bivariate level ($p=.05$) were included in the multivariate regression model. This process was repeated for the outcome “social workers perception of emotional harm of the investigated child.”

Logistic regression

Logistic regression analysis was used to predict the likelihood that a female non-offending caregiver demonstrated negative maternal response. In the present study, the target group was “negative maternal response, “NMR”. A hierarchical regression model was employed with the four categories noted below representing each successive block. Blocks representing each of the categories were compared to determine their relative contribution and inclusion in the target group. Investigations with missing information were not included in the analyses. Multicollinearity tests were conducted to determine if there was a high degree of correlation between the multiple independent variables.

Block 1: Characteristics of the female non-perpetrating caregiver

- Caregiver domestic violence
- Caregiver mental health

Block 2: Child characteristics

- Age
- Inappropriate sexualized behaviour
- Developmental delay

Block 3: Abuse characteristics

- Duration of abuse
- Relative perpetrator

Block 4: Investigation characteristics

- Sexual abuse and other co-occurring maltreatment

Logistic regression was similarly used to predict the likelihood that emotional harm was experienced by the investigated child. If the investigating worker reported no emotional harm the outcome was coded 0 and if the worker reported that the child experienced emotional harm the outcome was coded 1. A hierarchical regression

model was utilized with the above four categories representing each successive block. Blocks representing each of the above categories were compared to determine their relative contribution and inclusion in the target group. Investigations with missing information were not included in the analyses. In light of the research question attempting to determine the relative contribution of negative maternal response in predicting emotional harm, maternal response was retained in block 1 of the emotional harm model.

Block 1: Characteristics of the female non-perpetrating caregiver

- Negative maternal response
- Caregiver domestic violence
- Caregiver mental health

Block 2: Child characteristics

- Age
- Inappropriate sexualized behavior
- Developmental delay

Block 3: Abuse characteristics

- Duration of abuse
- Relative perpetrator

Block 4: Investigation characteristics

- Sexual abuse and other co-occurring maltreatment
- Substantiation level

Statistical Power and Effect Size

Using the software, Sample Power, the power for maternal response and emotional harm at the bivariate level was determined to be .86. Therefore, this study had 86% power to detect a medium effect for the two outcome variables (Effect size $\phi = .30$). For domestic violence and maternal response there was 77% power to detect a small effect (Effect size $\phi = .14$). Hence, the key variables had sufficient power to detect a medium effect size and in some cases were also sufficiently powerful to detect a small effect size in bivariate analyses.

In one example, the variables gender of the child and maternal response had insufficient power. In this scenario, there was 25% power to detect a small effect. In general, with the key variables utilized there was sufficient power to detect a medium effect and in some cases a small effect.

Measures

Dependent variables

Consistent with the research questions noted above, the child welfare worker's determination of the female non-offending caregiver's response to her child's disclosure of sexual abuse was identified as "negative maternal response" and child outcome was identified as "emotional harm".

Maternal response

In this analysis, maternal response was measured using the CIS-98 non-offending caregiver response items. The maternal response construct was based on the variable, “Response to Sexual Abuse,” question 25 on the CIS-98 data collection instrument (see appendix 1). The CIS-98 study guide provided the following guidance for the investigating child welfare worker’s completion of item #25 on the CIS-98 data collection instrument: “for cases of suspected or substantiated sexual abuse, please describe the response of the non-offending caregiver/caregivers to the allegations of abuse” (Trocmé et al., 2001, p. 148).

More specifically, the CIS-98 study guide indicates the following:

- 25a) Indicate if the non-offending caregiver believed the child’s sexual abuse, or was the allegation discounted.
- 25b) Indicate if the non-offending caregiver provided emotional support to the child following the report and during the [CAS] investigation.
- 25c) Identify if the non-offending caregiver demonstrated the ability to prevent further incidents of sexual abuse.

For the purpose of the current investigation, only items 25a, 25b, and 25c were included in analyses as these items focused on the worker’s perception of the response of the non-offending caregiver, which was the primary factor under examination.

Responses to each of 25a, 25b, and 25c were collapsed to produce a single dichotomous (yes/no) derived variable hereafter referred to as “negative maternal response”. A yes to 25a, 25b, and 25c resulted in a positive indication of maternal response; while a no to any of 25a, 25b, or 25c resulted in a negative indication of maternal response. Cases with missing or unknown responses to each of 25a, 25b, and 25c were discarded from the dataset. However, when paired with a negative response, missing and unknown responses were classified as negative maternal response. There were 18 cases where an unknown response occurred with a no response. After analyses it was determined that unknown cases did not function any differently than known cases with respect to emotional harm.

The rationale for the coding strategy above rests in the distinction made by Child Protective Services in determining level of risk assumed when children remain in the home with a perpetrator present. When evaluating risk, CPS requires evidence of maternal belief, protection and emotional support in order to ensure the safety of the investigated child. In the absence of any of these factors, workers’ perception of risk of harm to the child is elevated and child apprehension may occur.

Maternal response was a nominal variable and was dummy coded 0, no negative maternal response; 1, negative maternal response.

Emotional harm

The emotional harm construct was derived from the variable, “mental or emotional harm,” question 19 on the CIS-98 data collection instrument (see appendix 1). Workers were asked to identify whether or not the investigated child exhibited signs of mental or emotional harm at the time of the investigation. This nominal level variable was coded: 0, no emotional harm noted; 1, emotional harm noted. To determine the seriousness of the emotional harm, workers were subsequently asked if therapeutic treatment was required and if the child’s mental/emotional health or capabilities were significantly impaired. In this study, only the variable, ‘emotional harm’ was used and the sub-items related to severity of harm were excluded from analyses.

Mental or emotional harm, as measured in the CIS-98, was not reflective of a clinical diagnosis. CAS workers made a determination of mental or emotional harm based on existing/historical data and were not trained to conduct psychological assessments. Given that these data are cross-sectional, historical information on the existence of emotional problems prior to the CIS-98 study was not accessible. Study findings indicated that emotional harm occurred in 40.2% (150) of investigations of suspected or substantiated child sexual abuse in the CIS-1998.

Predictor Variables

Inclusion of the predictive variables below is characteristic of an ecological conceptualization of child sexual abuse. The rationale for this plan involved the recognition that individual, family and environmental factors, (as indicated in chapter 2

– ecological Theory), impact maternal response. Critical analysis of these factors has been conducted and reported in previous chapters, and therefore justify inclusion of these variable groupings.

Table 4
Theoretical Importance of Predictor Variables

Predictor Variable	Theoretical Relevance	Support in the Literature
CAREGIVER CHARACTERISTICS		
Age	Age of the caregiver may be related to level of maturity and ability to respond appropriately to a CSA disclosure. Although, age of the caregiver has not been investigated as a factor contributing to negative maternal response, child maltreatment literature has documented a relationship between age of the caregiver and child maltreatment. This study seeks to determine the association between a) age of the caregiver and negative maternal response and b) age of the caregiver and emotional harm.	Brenner, Overpeck, Trumble, DerSimonian, & Berendes, 1999; Siegel, et al., 1996
Education	Although, the educational level of the caregiver has not been investigated as a factor contributing to negative maternal response, child maltreatment literature has documented the relationship between parental education and child maltreatment.	Brenner, Overpeck, Trumble, DerSimonian, & Berendes, 1999; Kotch, Browne, Dufort, Winsor, Catellier, 1999
Race	Once controlling for caregiver, child, abuse and investigation characteristics racial identity of the caregiver should not be related to negative maternal response.	Sedlak & Broadhurst, 1996
	Although disproportionate representation of racialized minority families is evident in child welfare, there is no indication that racialized minority groups are more likely to be abusive. Rather, a plethora of systemic issues contribute to the overrepresentation of minority families.	Knott & Donovan, 2008
Caregiver Functioning	Caregivers with mental health and substance abuse problems are less likely to respond with belief, protection and support subsequent to their children's disclosure of CSA. Compromised parenting capacity, as a result of mental illness, is associated with poor maternal response.	Berger, 2005; Berg-Nielsen, Vikan, & Dahl, 2002; Gladstone, Boydell, & McKeever, 2006; Leifer, Shapiro, & Kassem, 1993; Rodriguez-Srednicki, 2001; Zuravin & Fontanella, 1999.
	While there is no direct link between caregiver criminal involvement and negative maternal response, the relationship between child maltreatment and "social impoverishment" including high crime, high poverty neighbourhoods has been established.	Garbarino & Sherman, 1980; Ménard & Ruback, 2003
	Caregivers with low perceived social support are more likely to exhibit a negative maternal response.	Hiebert-Murphey, 1998
Abused as a Child	Non-offending mothers with a history of child sexual abuse are more likely to experience depression, and exhibit trauma symptoms. As a result, parenting capacity may be diminished and poor maternal response may result. In addition, some mothers with a history of child sexual abuse may have diminished perception of high-risk situations and may be unable to provide appropriate protection.	Burgess, Hartman, Kelley, Grant, & Gray, 1990; Corcoran, 1998; Corcoran, 2004
	Alternatively, there is some indication that a non-offending mother with a history of CSA may have a heightened sense of empathy towards her sexually victimized child.	Morrison & Clavenna-Calleroy 1998
Domestic Violence	Mother's who report domestic violence are more likely to exhibit a negative maternal response as a result of the fear associated with providing protection to the victimized child, financial dependence on the perpetrator, and in some cases an insecure attachment to the perpetrator.	Alaggia & Turton, 2005; Heibert-Murphy, 2001; Kellogg and Menard, 2003
CHILD CHARACTERISTICS		

Age	Adolescent girls are more vulnerable to exposure to maternal disbelief subsequent to CSA disclosure. This is due to the avoidant coping response of the adolescent (secretive behaviors and externalizing behaviors), which may be perceived by the non-offending mother as culpability. As a result of poor maternal response the adolescent may be at risk of protracted victimization and continued emotional harm	Heriot, 1996; Sirls & Franke, 1989
Sex	Alleged CSA among girls is more likely to come to the attention of child welfare authorities due to a greater likelihood for females to experience incest. In the current study, 76.3% of suspected or substantiated CSA investigations involved girls. There are inconsistent findings regarding whether or not girls are more likely to be exposed to negative maternal response.	Girls are more likely than boys to be exposed to negative maternal response: Lyon & Kouloumpou-Lenares, 1987; Salt et al., 1990 No relationship between child gender and maternal response: DeJong, 1988; Everson et al., 1989 Some indication that girls are at increased risk of negative maternal response, although this relationship was not significant throughout the regression procedure: Pintello & Zuravin, 2001
Inappropriate sexual behavior of child	As a child functioning issue, inappropriate sexual acting out may contribute to negative maternal response. Sexual acting out is mediated by the severity of abuse. Severe abuse involving penetration and physical injury is more likely to lead to sexually inappropriate behavior and subsequently poor maternal response.	Heriot, 1996
Child's depression	Although an association between mental illness among children, behavior problems and poor maternal support has not been established, children with difficult temperaments and functioning problems, including mental illness are more vulnerable to child maltreatment. This study seeks to determine the association between child functioning factors and negative maternal response and emotional harm.	Belsky & Vondra, 1989; Shaw, Vondra, Dowdell-Hommerding, Keenan, & Dunn, 1994.
Child's use of self-harm	As noted above children with difficult temperaments and functioning problems, including mental illness are more vulnerable to child maltreatment. This study seeks to determine the relationship between child functioning factors and negative maternal response and emotional harm among children for whom CSA is suspected or substantiated.	Belsky & Vondra, 1989; Shaw, Vondra, Dowdell-Hommerding, Keenan, & Dunn, 1994.
Child's developmental delay	Children with developmental delay are at increased risk of maltreatment and negative maternal response.	Bottoms et al., 2003; Verugo and Bermejo, 1997
HOUSEHOLD CHARACTERISTICS		
Home Tenure	Home tenure is often used as a proxy measure of poverty with home rental an indicator of low SES. While there is no direct link between home tenure and negative maternal response, the relationship between child maltreatment and poverty is well established.	Belsky & Vondra, 1989; Berger, 2005; Coulton, & Korbin, 2007; Coulton, Korbin, Su, & Chow, 1995; Garbarino & Sherman, 1980; Gelles, 1992; Pecora, Whittaker, Maluccio, & Barth, 2000.
Income	As previously indicated, the relationship between child maltreatment and poverty is well established. Poverty is most often a risk factor for neglect.	Belsky & Vondra, 1989; Berger, 2005; Coulton, & Korbin, 2007; Coulton, Korbin, Su, & Chow, 1995; Garbarino & Sherman, 1980; Gelles, 1992; Pecora, Whittaker, Maluccio, & Barth, 2000.
Family Structure	Single parent status has been identified as a risk factor for child maltreatment as a result of stress and economic deprivation.	Berger, 2005; Sack, Mason, & Higgins, 1985

ABUSE CHARACTERISTICS

Abuse type	<p>Severity of child sexual abuse defined as completed sexual victimization (vaginal/anal penetration) has been identified as a factor contributing to the manifestation of psychological sequelae among victimized children.</p> <p>Emerging evidence has established an association between severe abuse (physical harm) and poor maternal response.</p>	<p>Beitchman et al., 1991; Beitchman, et al., 1992; Fergusson et al., 1996; Ruggerio, McLeer, & Kixon, 2000; Spaccarelli & Kim 1995</p> <p>Heriot, 1996</p>
Duration	<p>Protracted sexual abuse has been identified as an abuse characteristic associated with emotional harm among victimized children.</p> <p>Negative maternal response is more likely when sexual abuse occurs for a protracted period of time. It is thought that a longer duration of abuse is associated with an entrenched pattern of maltreatment in the home and the non-offending mother may be unable to respond due to the stress associated with a chaotic family environment.</p>	<p>Barker-Collo & Reid, 2003; Beitchman et al., 1991; Beitchman, et al., 1992; Friedrich, et al., 1986; Kendall-Tackett et al., 1993</p> <p>Heriot, 1996</p>
Child's relationship to the perpetrator	<p>Perpetrator identity (immediate or extended family member) has been identified as a factor contributing to emotional harm and children's use of internalizing behaviors, such as avoidant coping.</p>	<p>Browne & Finkelhor, 1996; Heriot, 1996; Sedney & Brooks, 1984; Tremblay, Hebert, and Piche, 1999</p>
Case previously open	<p>Children for whom a previous child welfare case opening exists may be more at risk of subsequent maltreatment and potential emotional harm.</p> <p>Families compliant with CPS service are less likely to have a recurrent child welfare investigation.</p>	<p>U.S. Department of Health and Human Services, 2002.</p> <p>DePanfilis & Zuravin,, 2002.</p>
Maltreatment co-occurrence	<p>While an evolving body of literature has documented the influence of co-occurring maltreatment on emotional harm the effects of co-occurring maltreatment on maternal response has not been examined.</p> <p>There exists inconsistent evidence regarding the relationship between co-occurring maltreatment and emotional harm.</p>	<p>Clemmons, DiLillo, Martinez, DeGue, & Jeffcott, 2003; Higgins & McCabe, 2001</p> <p>De Marco, Tonmyr, Fallon, and Trocmé. 2007</p>
Level of substantiation	<p>Debate exists in the literature around the conceptualization of unsubstantiated cases and the distinction between unsubstantiated and substantiated cases and whether or not suspected allegations should be classified as substantiated reports.</p>	<p>King, Trocmé and Thatte, 2003; Leiter, Myers & Zingraf, 1994.</p>
Physical harm	<p>Sexual abuse resulting in physical harm to the investigated child is more likely to result in negative maternal response.</p>	<p>Heriot, 1996</p>
Emotional harm	<p>An effective maternal response to disclosure of CSA acts as a mediator of emotional harm among children for whom sexual abuse has occurred.</p>	<p>Elliot & Carnes, 2001; Esparza, 1993; Everson, Hunter, Runyon, Edelson, & Coulter, 1989; Spaccarelli & Kim, 1995</p>

The table below lists the independent variables utilized in the prediction of a) maternal response and b) emotional harm.

Table 5
Independent variables used to predict maternal response and emotional harm in logistic regression analysis.
Source: 1998 CIS

	Predictive Variables by Level of Characteristic			
Dependent Variables	Characteristics of the Maternal Non-Perpetrating Caregiver(s)	Child Characteristics	Abuse Characteristics	Investigation Characteristics
Negative Maternal Response	a) Domestic violence b) Mental health	a) Age of child b) Sexualized behaviour c) Developmental delay	a) Duration b) Relative perpetrator	a) Sexual abuse and other co-occurring maltreatment
Emotional harm	a) Negative maternal response b) Domestic violence c) Mental health	a) Age of child b) Sexualized behaviour c) Developmental delay	a) Duration b) Relative perpetrator	a) Sexual abuse and other co-occurring maltreatment b) Substantiation level

Description of predictive variables

The following is a description of each level of predictive variables. Note that for each independent variable responses were isolated to reflect only cases that involved suspected or substantiated CSA investigations. Cases with missing or unknown responses were not included in the bivariate and logistic regression analysis.

Caregiver characteristics

Caregiver age

Caregiver age was the age of the female non-offending caregiver at the time of the investigation. For the purpose of this analysis, age was an ordinal variable: <30, 31-40, 41-50, 51-70. Caregiver age was coded: 1, <30; 2, 31-40; 3, 41-50; 4, 51-70.

Caregiver education

Caregiver education was the education of the female non-offending caregiver as reported by the child welfare worker at the time of the investigation. Education was an ordinal level variable: elementary or less, secondary or less, college/university or less. Education was coded: 1, elementary or less; 2, secondary or less; 3, college/university or less.

Race of the caregiver

Race of the caregiver was the ethno-racial identity of the female non-offending caregiver as reported by the child welfare worker at the time of the investigation. Workers were asked to identify one of up to 12 categories of ethno-racial identity based on the 1996 Statistics Canada Census racial groupings. For the purpose of this dissertation's analysis, race was collapsed to reflect white and non-white caregivers. This variable was a nominal level variable and dummy coded: 0, white; 1, non-white.

Caregiver employment

Employment of the caregiver was the employment status of the female non-offending caregiver as reported by the child welfare worker at the time of the investigation.

Workers were asked to identify up to 9 income sources. For the purpose of the current study, employment was collapsed into no employment and some employment.

Employment is a nominal level variable and dummy coded: 0, no employment; 1, some employment.

Caregiver functioning concerns

Literature examining the relative influence of caregiver characteristics such as mental health status, substance abuse and domestic violence has been identified throughout chapters one and two. In light of this empirical evidence, the relative influence of caregiver variables in predicting maternal response and emotional harm was explored. As mentioned above, maternal response researchers typically analyze the responses of female non-offending caregivers only. However, due to the structure of the CIS-98 dataset, a positive response to a caregiver functioning item may reflect the characteristics of a male or female caregiver and may similarly reflect the functioning of a perpetrator of CSA. It is not clear whether the child welfare worker obtained a response to the caregiver functioning items from a female or male caregiver, nor is it possible to determine if the response was obtained from an offending or non-offending caregiver. As such, caution is recommended in interpreting results of the “caregiver functioning” items.

Investigating child welfare workers were asked to assess the presence of up to 8 caregiver functioning concerns and whether or not the functioning concern was confirmed, suspected, or not noted. Functioning concerns that were suspected and confirmed by the investigating child welfare worker were collapsed. For the purpose of this dissertation's analyses, only caregiver alcohol abuse, drug abuse, mental health, physical health, criminal activity and few social supports were examined. Alcohol and drug abuse were collapsed into a single variable, and will hereafter be referred to as substance abuse. Each of substance abuse, mental health, physical health, criminal activity and few social supports were nominal level variables and the dummy coding for each was 0, not noted; 1, noted.

Caregiver abused as a child

Caregiver abused as a child was the non-offending caregiver's history of child maltreatment. Investigating child welfare workers were asked to identify whether or not the maltreatment of the caregiver during childhood was confirmed, suspected or not noted. For the purpose of the current analysis, confirmed and suspected cases were collapsed. This variable was a nominal level variable and dummy coded: 0, not noted; 1, noted.

Caregiver report of domestic violence

Domestic violence was the report by the child welfare worker that the female non-offending caregiver experienced domestic violence at the time of the investigation. Child welfare workers were asked to identify whether or not the domestic violence was

confirmed, suspected or not noted. For the purpose of the current analysis, confirmed and suspected cases were collapsed. This variable was a nominal level variable and dummy coded: 0, not noted; 1, noted.

Child characteristics

Literature reviewed in chapters one and two indicated that maternal response is mediated by the effects of child age. Less is known about the effects of gender of the child vis a vis the presence of negative maternal response and emotional harm among children with suspected or substantiated CSA.

The variable “sexualized behaviour” is retained in the maternal response and emotional harm models in light of research cited in previous chapters that documented the impact of sexualized behaviour on child outcome via its influence on the non-perpetrating caregiver. The variable, “developmental delay” is included in the maternal response model as not enough is known about the effects of developmental delay in contributing to a non-perpetrating mothers’ belief in the validity of a CSA disclosure. See chapter two for a discussion of the effects of developmental delay within the context of child sexual abuse and the responses of caregivers.

Child age

Child age was the age of the investigated child at the time of the investigation. For the purpose of this analysis, age was an ordinal level variable: ages <1-7, 8-11, 12-15.

Child age was coded: 1, <1-7; 2, 8-11; 3, 12-15.

Child gender

Gender of the investigated child was identified by the investigating child welfare worker. Child gender was a nominal level variable and dummy coded: 0, male, 1, female.

Child functioning concerns

Investigating child welfare workers were asked to assess the presence of up to 18 child functioning concerns and whether or not the functioning concern was confirmed, suspected, or not noted. For the purpose of this dissertation's analyses, only child developmental delay, depression/anxiety, self-harming behavior and inappropriate sexualized behavior were examined. In this analysis, suspected and confirmed responses were collapsed. Each of developmental delay, depression/anxiety, self-harming behavior, and inappropriate sexualized behavior were nominal level variables and the dummy coding for each was 0, not noted; 1, noted. For example, the variable developmental delay was coded, 0, no delay noted; 1, developmental delay noted.

Household characteristics⁹

Theoretical literature and empirical support examining the impact of ecological characteristics in determining the developmental trajectory of CSA survivors has been presented in chapters one and two. In keeping with this, dissertation analyses have similarly determined the relative influence of household characteristics in predicting maternal response and emotional harm (i.e. household structure).

⁹ Analysis of household characteristics was limited to the bivariate level. Household characteristics were not entered into either of the maternal response or emotional harm regression models.

Home tenure

Home tenure was housing accommodation at the time of the CSA investigation.

Workers could identify up to 8 forms of housing accommodation. For the purpose of this analysis, responses to public housing, rental apartment, rental townhouse, rental house, and shelter/hotel were defined as ‘rental.’ Purchased home was referred to as, ‘purchased.’ The dummy coding of this nominal level variable was: 0, purchased home; 1, rental/other home.

Household structure

Investigating child welfare workers were asked to identify a household structure that involved up to 7 different groupings of caregivers. For the purpose of the current study, three caregiver groupings were disaggregated into individual variables. The variable ‘both biological parents’ was a nominal level variable and dummy coded: 0, not noted; 1, noted. The variable ‘lone female parent’ was a nominal level variable and dummy coded: 0, not noted; 1, noted. The variable ‘common-law/step/adoptive parent’ was a nominal level variable and dummy coded: 0, not noted; 1, noted.

Abuse characteristics

Characteristics of abuse including type and duration of abuse, relationship to the perpetrator and physical injury are factors that often influence the emotional availability of the non-perpetrating caregiver and may compromise her efforts to protect the investigated child. This study aims to build on research evidence regarding CSA

characteristics and their influence on maternal response patterns and emotional harm associated with sexual abuse.

Abuse type

The CIS-98 data collection instrument had 23 possible maltreatment codes and child welfare workers were asked to identify up to 3 forms of investigated maltreatment. The maltreatment types were physical abuse, sexual abuse, neglect and emotional maltreatment and their corresponding sub-typologies. This study isolated only investigations involving suspected or substantiated child sexual abuse¹⁰. Sexual abuse referred to an investigation of a child who has been or is at substantial risk of being sexually molested or sexually exploited. As a result, only 7 sub-types of CSA were included and were disaggregated into 7 individual dichotomous variables. Completed sexual abuse included oral, vaginal or anal sexual activities. Completed CSA was a nominal variable and dummy coded: 0, no; 1, yes. Attempted CSA included attempted oral, vaginal, or anal sexual activities. Attempted CSA was a nominal variable and dummy coded: 0, no; 1, yes. Touching/fondling genitals was a nominal variable and dummy coded: 0, no; 1, yes. Exposure of genitals refers to an adult exposing genitals to the investigated child. Exposure was a nominal level variable and dummy coded: 0, no; 1, yes. Voyeurism included activities where a child was encouraged to exhibit himself/herself for the sexual gratification of the alleged perpetrator. Voyeurism was a nominal level variable and was dummy coded: 0, no; 1, yes¹¹. Exploitation: Pornography/prostitution included situations where an adult allegedly sexually

¹⁰ In 13.7% of investigations, sexual abuse and other co-occurring maltreatment was identified by the child welfare worker.

¹¹ Voyeurism was removed given the limited number of investigations of this type in the CIS-98.

exploited a child for the purpose of financial gain or other profit. It was coded: 0, no; 1, yes. Sexual harassment included a proposition, encouragement or a suggestion of a sexual nature. Sexual harassment was a nominal variable and dummy coded: 0, no; 1, yes.

In cases where there was more than one type of child sexual abuse recorded, the most invasive type of CSA was identified. Completed sexual abuse was the most invasive, followed by attempted sexual abuse, touching/fondling, exposure, exploitation, and sexual harassment. Once the most severe type of CSA was identified the corresponding perpetrator type and duration of abuse was determined.

Perpetrators of abuse

Investigating child welfare workers were asked to identify up to 8 perpetrators of suspected or substantiated CSA. The CIS-98 data collection instrument provided the following 8 potential perpetrators: biological mother, biological father, step-father/common-law, step-mother/common-law, sibling, other, stranger, and unknown. In an effort to remain consistent with current maternal response empirical literature, all investigations with an alleged female CSA offender were not included in this study. Based on the original CIS-98 perpetrator categorization, perpetrator type was disaggregated into 3 individual dichotomous variables. The variable, 'biological father, adoptive father, father and other' was a nominal level variable and was dummy coded: 0, no; 1, yes. The variable, 'other relative' was a nominal variable and was dummy coded: 0, no; 1, yes. The variable, 'stranger,

unknown, other acquaintance, other multiple perpetrators' was a nominal level variable and was dummy coded: 0, no; 1, yes.

Duration of maltreatment

The CIS-98 data collection instrument had five possible duration of maltreatment codes and child welfare workers were asked to identify only one duration for each of the three maltreatment types. The CIS-98 data collection instrument provided the following five potential duration of maltreatment types: not applicable (maltreatment unfounded), single incident, less than six months, more than six months, and unknown duration. Based on the original CIS-98 duration of maltreatment categorization, less than six months, more than six months and unknown duration were collapsed and not applicable was eliminated from the dataset. In the current study duration of abuse was a nominal level variable. This variable was dummy coded: 0, single incident; 1, greater than a single incident and unknown.

Previous child welfare opening

The investigating child welfare worker identified whether or not the investigated child was the subject of a previous child welfare case opening. This variable was a nominal level variable and was dummy coded: 0, no previous opening; 1, yes previous opening. Unknown responses were discarded from the dataset.

Investigation Characteristics

There are inconsistent findings on whether or not maltreatment co-occurrence contributes to heightened psychological sequelae among children subject to child maltreatment investigations. In addition, there is a debate regarding the variations in outcomes among children who have received an unsubstantiated, suspected or substantiated maltreatment disposition. In light of this, maltreatment co-occurrence and substantiation level will be entered into the regression models.

Co-occurring maltreatment

As previously noted, workers were asked to identify up to 3 forms of investigated maltreatment from up to 23 possible maltreatment codes. Among the 373 suspected or substantiated child sexual abuse investigations included in this study, 51 (13.7%) of investigations involved child sexual abuse and other co-occurring maltreatment. The variable, co-occurring maltreatment was a nominal level variable and dummy coded: 0, sexual abuse only; 1, sexual abuse and other co-occurring maltreatment.

Substantiation level

Investigating child welfare workers were asked to identify 1 of up to 3 levels of substantiation (unfounded, suspected, or substantiated) for each of the 3 maltreatment categories noted. In this study, unfounded investigations were excluded from the dataset. The variable, level of substantiation was a nominal level variable and dummy coded, 0, suspected CSA; 1, substantiated CSA.

Physical harm

Workers were asked to identify up to 7 types of physical harm suspected or known to have occurred as a result of the investigated maltreatment. The categories of physical harm were: no harm, bruises/cuts/scrapes, burns and scalds, broken bones, head trauma, fatal, and other health condition. For the purpose of this analysis, responses to bruises/cuts/scrapes, burns and scalds, broken bones, head trauma, fatal, and other health condition were collapsed into one category. As a result, the nominal level variable, physical harm was dummy coded, 0, no harm noted; 1, physical harm noted.

Police investigation

The variable, police investigation is the child welfare worker's identification of police involvement at the time of the investigation. If police involvement was noted, workers were subsequently asked to indicate if a charge was laid, considered or not laid. In this study, only the variable 'police involvement' was utilized and the sub-items related to the extent of police involvement were excluded from analyses. Police involvement was a nominal level variable and coded: 0, no police involvement; 1, police involvement.

Dissertation analyses determined the relative importance of each of the above predictor variables in contributing to a) negative maternal response and b) emotional harm.

Generating empirical evidence on the factors that promote maternal responsivity is critical to the development of evidence based interventions for sexually victimized children and their families and for supporting the continued development of a CSA research agenda.

Presentation of Findings

In an effort to assist the reader in examining the results and given the relative complexity of the model, the variables used in this analysis have been described in detail. In the results chapter, these variables have been repeated throughout the tables. The progression of the results chapter involves an initial description of the study sample followed by a separation of maternal response results and emotional harm results. Maternal response bivariate results (cross-tabs), and multivariate results (logistic regression) have been presented first followed by emotional harm bivariate results (cross-tabulations) and multivariate results (logistic regression).

Limitations

The CIS-98 dataset includes variables that are cross-sectional. As a result, any change in the condition of the children and families reported by the CIS-98 was not represented in this dataset.

The items on the CIS-98 data collection instrument were completed by child protective workers. As mentioned throughout, due to the structure of the CIS-98 dataset, dissertation analyses are unable to determine who the investigating child welfare worker was referring to when completing the “caregiver functioning” items. In cases where a positive indication of a caregiver functioning item occurred it is unclear who the subject of the caregiver functioning item was.

Several items referred to in dissertation analyses as, “caregiver characteristics” and “child characteristics” (such as caregiver mental health, and child with a developmental delay) required clinical knowledge of mental health status and cognitive capacity. It was not expected that child welfare workers would provide a diagnosis. They generally relied on independent observation, case histories and first hand information from physicians and mental health workers in determining a response. When child protection workers were aware of the existence of a formal diagnosis, they indicated a “confirmed” response. Otherwise, “suspected” or “no” was indicated.

The sexual abuse investigations included in the CIS-98 dataset reflected predominantly children and families affected by incest. Incest involves the perpetration of sexual abuse by a member of the immediate or extended family. This dataset also included a relatively large proportion of child sexual abuse cases that involved children and families investigated for extrafamilial child sexual abuse. Extrafamilial abuse occurs when someone outside of kin related family is the perpetrator of abuse. For example, a stranger, teacher, or babysitter may act as a perpetrator of extrafamilial child sexual abuse. In light of this, there may be lower levels of emotional harm detected in this sample when compared to a CSA sample involving children for whom incest is the only investigated abuse type. Research documents that children who experience extrafamilial abuse have less severe psychological sequelae when compared with children who disclose incest (Finkelhor, et al., 1990). One may consider that diminished emotional harm is due to the positive effect of maternal response, when in fact, the proportion of cases of extrafamilial abuse may act as an independent variable

contributing to less emotional harm in children who have experienced child sexual abuse.

Management of Missing data

The following series of analyses were conducted with variables having substantial missing data. Chi-square analyses were conducted with predictive variables having substantial missing data to ensure no systematic bias in reporting demographic characteristics relative to negative maternal response.

Caregiver Education

A substantial number of responses to the caregiver education item were unknown. As a result, chi-square analyses incorporating the unknown education data were conducted to ensure no systematic bias in reporting education relative to negative maternal response. After determining no significant association between unknown caregiver education and negative maternal response ($p=.36$), the unknown items were removed from the analyses.

Income

A substantial number of the responses to the income item were unknown. As a result, chi-square analyses incorporating the unknown income data were conducted to ensure no systematic bias in reporting income relative to negative maternal response. After determining no significant association between unknown income and negative maternal response ($p=.53$), the unknown items were removed from the analyses. A derived

income variable was created with 4 categories ($\$ < 15,000$; $\$15,000-24,999$; $\$25,000-40,999$; $\$41,000-80,000$).

Ethno-Racial Heritage

A substantial number of the responses to the ethno-racial heritage items were unknown. As a result, chi-square analyses incorporating the unknown ethno-racial data were conducted to ensure no systematic bias in reporting ethno-racial heritage relative to negative maternal response. After determining no significant association between unknown ethno-racial heritage and negative maternal response ($p = .21$), the unknown items were removed from the analyses. A derived ethno-racial variable 'race' was created with 2 levels (white and non-white).

Employment

A substantial number of the responses to the employment status item were unknown. As a result, chi-square analyses incorporating the unknown employment data were conducted to ensure no systematic bias in reporting employment relative to negative maternal response. After determining no significant association between unknown employment and negative maternal response ($p = .10$), the unknown items were removed from the analyses. A derived employment variable 'employment' was created with 2 levels (some employment, no employment).

Non-parallel treatment of missing data with respect to maternal response

There were 54 missing responses on the maternal response variable. Of these 54 responses, these analyses determined that 30 had at least one positive response in addition to missing responses. As a result, it is not clear what may result from the non-parallel treatment of missing data in this circumstance, but the proportion of missing data is small and that the regression model retained sufficient power in the bivariate analysis.

As evident in the description of the study sample, given the small sample size (n=373) and relatively crude measures the possibility of non-findings is present.

Chapter 4: Results

The research questions that guided this study involved identifying the prevalence of negative maternal response among non-perpetrating mothers and determining the characteristics that were associated with negative maternal response. The secondary purpose of this study was to document the level of emotional harm among children investigated for sexual abuse and to identify the characteristics that were associated with emotional harm (research questions originally presented in chapters 1 and 3).

When considering suspected or substantiated sexual abuse cases for which a female non-offending caregiver was identified by the investigating worker, the final sample of CSA investigations was 373. The majority of cases involved only alleged sexual abuse (86.3%). The remaining 13.7% of CSA cases were investigated for child sexual abuse and another form of co-occurring maltreatment. Of the 373 suspected or substantiated CSA investigations, 87.1% (325) of non-perpetrating mothers responded positively to the CSA disclosure according to the investigating child welfare worker while 12.9% (48) of non-perpetrating mothers responded negatively.

Sequence of results chapter

The results of univariate, bivariate, and multivariate analyses for both the negative maternal response and emotional harm models have been presented herein. The characteristics of the child sexual abuse sample at each of four predictor levels were initially described followed by a report of bivariate results with respect to maternal response and emotional harm. Multivariate analysis was subsequently employed to

determine the association between each independent variable and each block of variables in predicting a) negative maternal response and b) emotional harm.

Univariate Results

Female non-perpetrating caregiver characteristics¹²

The following univariate findings are related to the female non-offending caregiver. As noted in Table 6, the majority of female non-offending caregivers were 31-40 years old (54.3%) and had a secondary school education (41.6%); approximately half had some form of employment (39.9%). Only a minority of caregivers experienced problems with substance abuse (14.2%), had a history of criminal involvement (7.5%), or a mental or physical health problem (12.1% and 5.9% respectively). Less than one-third of caregivers reported a history of maltreatment in their family of origin (18.2%), a minority reported a history of domestic violence (14.2%) and 18% reported having few social supports.

Domestic violence

Almost fifteen percent of the female non-perpetrating caregivers (53 of the 373) were identified by the worker as having experienced domestic violence. Further analyses were conducted to determine whether the female non-perpetrating caregiver was the victim or the offender of domestic violence. Only 35 of these 53 reports of domestic violence had complete data on whether the worker believed the maternal caregiver was

¹² See chapter 3 for a description of female non-offending caregivers.

a victim or the perpetrator of domestic violence. According to the investigating child welfare worker's perception, all but one of the 35 was a victim of domestic violence.

Investigating child welfare workers were asked to investigate whether male partners were victims of perpetrators of domestic violence. When examining the child welfare worker's perception of the male caregivers, it was determined that only 27 of 373 (7.2%) were allegedly involved in domestic violence. Only 22 of these 27 had complete data on the question related to involvement as a victim or perpetrator. Investigating workers found that 21 out of 22 (95%) male partners were alleged perpetrators of domestic violence.

Table 6
Description of female non-offending caregiver characteristics of those with suspected or substantiated sexual abuse
 Source: CIS-1998

Variable	Total N=373 ^a	Valid %
Age of caregiver		
<30	101	28.3%
31-40	194	54.3%
41-50	54	15.1%
51-70	8	2.2%
Education		
Elementary or less	17	4.6%
Secondary or less	155	41.6%
College/university or less	41	11%
Race		
White	192	51.5%
Non-white	48	12.9%
Employment		
No employment	150	40.2%
Some employment	149	39.9%
Substance abuse		
No	320	85.8%
Yes	53	14.2%
Mental health problem		
No	328	87.9%
Yes	45	12.1%
Physical health problem		
No	351	94.1%
Yes	22	5.9%
Abused as a child		
No	192	51.5%
Yes	68	18.2%
Domestic violence		
No	320	85.8%
Yes	53	14.2%
Criminal activity		
No	345	92.5%
Yes	28	7.5%
Few social supports		
No	306	82%
Yes	67	18%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/- 0.1%.

^a Missing data: of the total sample of 373 the number of missing data varies. There are 16 missing responses to the variable age of caregiver, 160 missing responses to caregiver education, 133 missing responses to race of caregiver, 74 missing responses to caregiver employment, and 113 missing responses to caregiver abused as a child.

Child characteristics:

As shown in Table 7, children most frequently investigated were those in the <1-7 age category, followed by children aged 12-15 years and 8-11 years. Girls accounted for the majority of CSA cases (76.3%). A minority of children reportedly experienced depression/anxiety (14.5%), had a developmental delay (7%), and displayed self-harming and sexually inappropriate behaviour (5.4% and 9.9% respectively).

Table 7

Description of child characteristics of those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N=373 ^a	Valid %
Age of child		
<1-7	169	45.4%
8-11	89	23.9%
12-15	114	30.6%
Sex		
Boy	88	23.7%
Girl	284	76.3%
Developmental Delay		
No	347	93%
Yes	26	7%
Depression/anxiety		
No	319	85.5%
Yes	54	14.5%
Age inappropriate sexual behavior		
No	203	54.4%
Yes	37	9.9%
Self-harming behavior		
No	220	94.6%
Yes	13	5.4%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/-0.1%.

^aMissing data: of the total sample of 373 the number of missing data varies. There is 1 missing response to the variable age of child, 1 missing response to the variable sex of child, 133 missing responses to the variable age inappropriate sexual behavior, 140 missing responses to the variable self-harming behavior.

Household characteristics

As demonstrated in Table 8, most families rented rather than owned their own home, and the majority of investigated children lived with a single female caregiver (40.4%).

One-third of the caregivers reported a household income of <\$15,000 while an equal proportion disclosed a household income of between \$15,000 and \$24,999.

Table 8

Description of household characteristics of those with suspected or substantiated child sexual abuse
Source: CIS-1998

Variable	Total N=373	Valid %
Home tenure ^b		
Purchased	128	34.3%
Rental/other	200	53.6%
Household income		
<\$15,000	77	30.1%
\$15,000-\$24,999	76	29.7%
\$25,000-\$40,999	57	22.3%
\$41,000->\$80,000	46	18%
Household structure		
Both biological parents		
No	251	67.2%
Yes	122	32.7%
Household structure		
Single female parent		
No	222	59.5%
Yes	151	40.4%
Household structure		
Common-law/step/adoptive		
No	296	79.3%
Yes	77	20.6%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/-0.1%.

^aMissing data: of the total sample of 373 the number of missing data varies. There are 45 missing responses to the variable home tenure and 117 missing responses to the variable household income.

^b Home tenure refers to rental home vs. purchased home. Rental includes public and private rental, shelter and hotel.

Abuse characteristics

As indicated in Table 9, touching/fondling was the CSA type investigated in more than half of the reports (50.9%) followed by sexual activity attempted (20.4%) and sexual activity completed (16.6%). Exposure of genitals accounted for 5.9% of investigations while exploitation and sexual harassment represented a marginal difference (1.9% and 2.9% respectively). Sexual activity not otherwise specified was the least frequent type of CSA investigation (1.3%).

Table 9
Investigated abuse type of those with suspected or substantiated child sexual abuse
 Source: CIS-1998

Variable	Total N=373	Valid %
Sexual activity completed		
No	311	84.2%
Yes	62	16.6%
Sexual activity attempted		
No	297	79.6%
Yes	76	20.4%
Touching/fondling		
No	183	49.1%
Yes	190	50.9%
Exposure of genitals		
No	351	94.1%
Yes	22	5.9%
Exploitation: Pornography/ Prostitution		
No	366	98.1%
Yes	7	1.9%
Sexual harassment		
No	362	97.1%
Yes	11	2.9%
Sexual abuse not otherwise specified		
No	368	98.7%
Yes	5	1.3%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/-0.1%.

As shown in Table 10, perpetrators of CSA most frequently were a stranger, unknown, other acquaintance, or other multiple perpetrators (43.2%), followed by other relative (33.5%). Biological father, adoptive father and father and other were the least frequent perpetrators of alleged CSA (23.3%).

Table 10
Description of alleged perpetrators of suspected or substantiated child sexual abuse
 Source: CIS-1998

Variable	Total N=373	Valid %
Perpetrator: Biological father, adoptive father, father and other		
No	286	76.7%
Yes	87	23.3%
Perpetrator: Other relative ^a		
No	248	66.5%
Yes	125	33.5%
Perpetrator: Stranger, unknown, other acquaintance, other multiple perpetrators		
No	212	56.8%
Yes	161	43.2%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/-0.1%.

^aAs noted above, other relative refers to any other relative, adult or child, who sexually abused the investigated child (i.e. Grandparent, aunt/uncle, sibling, cousin, and common-law partner) excluding the biological mother, biological father, stepmother, stepfather, foster parent or adoptive parent. Other refers to parent's boyfriend/girlfriend, family friend, child's friend or peer, babysitter, babysitter's family, neighbor, boarder, recreational staff, maintenance staff, daycare provider, teacher, or other professional.

As demonstrated in Table 11, alleged CSA greater than a single incident or for an unknown duration accounted for the largest proportion of sexual abuse investigations. One third of sexual abuse investigations in the CIS-98 involved cases that were previously opened, while 86.3% of CSA investigations involved alleged sexual abuse only and the remaining 13.7% of investigations involved alleged sexual abuse and other alleged co-occurring maltreatment.

Table 11

Description of the alleged abuse characteristics associated with suspected or substantiated child sexual abuse

Source: CIS-1998

Variable	Total N=373 ^a	Valid %
Duration of abuse ^b		
Single incident	150	40.3%
>single incident & unknown duration	222	59.7%
Case previously open		
No	251	67.3%
Yes	122	32.7%
Maltreatment co-occurrence ^c		
No	322	86.3%
Yes	51	13.7%
Level of substantiation		
Suspected	127	34%
Substantiated	246	66%
Physical harm		
No	337	90.3%
Yes	36	9.7%
Emotional harm		
No	223	59.8%
Yes	150	40.2%
Police investigation		
No	111	29.8%
Yes	261	70.2%

Note. Adding down should equal 100% in each cell. This is true for each of the descriptive tables. Due to rounding error, some cells vary from 100.0% by +/-0.1%.

^a Missing data: of the total sample of 373 the number of missing data varies. There is 1 missing response to the variable duration of abuse and 1 missing response to the variable police investigation.

^b Of the 373 investigations, 77 investigations resulted in suspected or substantiated CSA lasting a duration of less than six months, 93 greater than six months, and 52 were of an unknown duration.

^c Among the 13.7% of investigations that involved child sexual abuse and other co-occurring maltreatment, the most severe CSA type was identified and included in the study sample.

In 60% of the investigations, the alleged CSA occurred for more than 6 months or for an unknown duration (see Table 12). Fondling was the most frequently investigated child sexual abuse type.

Table 12
Description of the type of suspected or substantiated sexual abuse investigation by duration of CSA^a
 Source: CIS-1998

Abuse type ^b	Single incident		>Single incident and unknown		Total	
	n (150)	40.3%	n (222)	59.6%	N (372)	100%
Completed	25	16.7%	37	16.7%	62	16.7%
Attempted	40	26.7%	36	16.2%	76	20.4%
Fondling	69	46%	120	54.1%	189	50.8%
Exposure	11	7.3%	11	5%	22	5.9%
Exploitation	0	0%	7	3.2%	7	1.9%
Sexual harassment	3	2%	8	3.6%	11	3%
Sexual abuse not specified	2	1.3%	3	1.4%	5	1.3%
Total N	150	100%	222	100%	372	100%

Note. Although adding down should equal 100% in each cell due to rounding error some cells vary from 100.0% by +/-0.1%.

^aMissing data: Total number of cases included in analyses is 372 as there is one missing response to the variable duration of abuse.

^bVoyeurism has been excluded as there are fewer than 5 cases.

Maternal Response Hypothesis

Maternal, child, abuse and investigation characteristics are associated with maternal response among non-perpetrating caregivers of sexually abused children.

1. *What percentage of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were identified by their social workers as having a negative maternal response?*

Results of CIS-98 data indicated that a minority of non-perpetrating mothers (12.9%) demonstrated a negative response to disclosure of child sexual abuse (see chapter 3 for a discussion on the formulation of the derived maternal response variable).

Bivariate Results: Maternal Response

2. *What characteristics are associated with maternal response?*
 - 2.1 *In particular, what maternal characteristics (e.g. substance abuse, mental health, and domestic violence) are associated with maternal response?*
 - 2.2 *What child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay) are associated with maternal response?*
 - 2.3 *What abuse characteristics are associated with maternal response (duration of abuse, child's relationship to the perpetrator)?*

2.4 *What investigation characteristics (substantiation level, and co-occurring maltreatment) are associated with maternal response?*

Maternal non-offending caregiver characteristics associated with maternal response

As indicated in Table 13, the relationship between maternal response and eleven maternal non-offending caregiver characteristics was examined. Maternal non-offending caregivers aged 30 years and younger had lower rates of negative response than older mothers (0% versus 25%), although this variable failed to meet the level of significance. Mothers with an elementary education or less were more likely to exhibit negative maternal response compared with mothers who had a higher level of education (35.3% versus 7.3%). Caregivers with alcohol or drug addictions were much more likely to have a negative response to a CSA disclosure than caregivers without an addiction issue (20.8% versus 11.6%). Caregivers with mental and physical health problems were similarly much more likely to demonstrate negative maternal response than their healthy counterparts (mental health: 35.6 % versus 9.8%; physical health: 36.4% versus 11.4%). Negative maternal response was more likely to occur in homes where domestic violence existed compared with homes without such concerns (24.5% versus 10.9%). Non-perpetrating caregivers with a history of criminal involvement were substantially more likely to respond negatively to their child's disclosure of CSA than their counterparts without criminal involvement (42.9% versus 10.4%).

Cases where the worker reported that there was inadequate social support had a significantly higher prevalence of negative response to the disclosure of CSA (20.9%) in comparison to those with adequate support (11.1%). Age, race, and employment, were not found to be significantly associated with negative maternal response.

Table 13

Percentage with negative maternal response by caregiver characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% negative maternal response (12.9%)	χ^2	p-value
Age of caregiver				
<30	101	8.9%	3.16	p=.36
31-40	194	14.9%		
41-50	54	14.8%		
51+	8	25%		
Education of caregiver				
Elementary or less	17	35.3%	8.89	p=.03
Secondary or less	155	12.9%		
College/university or less	41	7.3%		
Race of caregiver				
White	192	14.6%	4.49	p=.10
Non-white	48	18.8%		
Caregiver employment				
No employment	150	12%	4.75	p=.09
Some employment	149	10.1%		
Caregiver substance abuse				
No	320	11.6%	3.42	p=.06
Yes	53	20.8%		
Caregiver mental health problem				
No	328	9.8%	23.49	p<.001
Yes	45	35.6%		
Caregiver physical health problem				
No	351	11.4%	11.51	p=.01
Yes	22	36.4%		
Caregiver abused as a child				
No	192	13%	6.04	p=.04
Yes	68	20.6%		
Domestic violence				
No	320	10.9%	7.49	p=.01
Yes	53	24.5%		
Caregiver involved in criminal activity				
No	345	10.4%	24.28	p<.001
Yes	28	42.9%		
Few social supports				
No	306	11.1%	4.69	p=.03
Yes	67	20.9%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

Child characteristics associated with maternal response

As shown in Table 14, chi-square analyses were conducted with six child characteristics. Children with developmental delay were much more likely to receive a negative maternal response to CSA disclosure than children without developmental delay (38.5% versus 11%). Similarly, children who exhibited inappropriate sexual behaviour were substantially more likely to experience negative maternal response than children who did not (32.4% versus 12.3%). Children who reported depression and involvement in self-harming behaviour were more likely to be exposed to negative maternal response than children who were not dealing with these issues (depression: 25.9% versus 12.7%; self-harming behaviour: 46.2% versus 13.7%). Subsequent to CSA disclosure, older children more frequently received a negative maternal response (22.8% versus 4.7%). In fact, children aged 12-15 years were most likely to be exposed to negative maternal response followed by children aged 8-11 years and 0-7 years. The child's gender was not associated with negative maternal response.

Table 14
Percentage with negative maternal response by child characteristics among those with suspected or substantiated sexual abuse
 Source: CIS-1998

Variable	Total N ^a (373)	% negative maternal response (12.9%)	χ^2	p-value
Age of child ^b				
0-7	169	4.7%	20.61	p<.001
8-11	89	15.7%		
12-15	114	22.8%		
Sex				
Male	88	13.7%	1.31	p=.25
Female	284	9.1%		
Developmental delay				
No	347	11%	16.32	p<.001
Yes	26	38.5%		
Depression/anxiety				
No	319	10.7%	9.6	p=.01
Yes	54	25.9%		
Age inappropriate sexual behavior				
No	203	12.3%	15.19	p=.01
Yes	37	32.4%		
Self-harming behavior				
No	227	13.7%	9.95	p=.01
Yes	13	46.2%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

^b Mean and SD cannot be computed for child age given the ordinal nature of the child age variable in the CIS-98 public dataset.

Household characteristics associated with maternal response

The relationship between maternal response and five household characteristics were examined and presented in Table 15.

Children from common-law/step-parent households were more likely to receive a negative maternal response than children from homes with other family structures (26%

versus 8.2%). Home tenure approached significance in terms of its association with negative maternal response ($p=.06$) as did single parent households ($p=.08$).

Table 15

Percentage with negative maternal response by household characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% with negative maternal response (12.9%)	χ^2	p-value
Home tenure				
Purchased	128	7.8%	5.43	p=.06
Rental/other	200	14.5%		
Household income				
\$<15,000	77	15.6%	3.54	p=.43
\$15,000-24,999	76	9.2%		
\$25-40,999	57	15.8		
\$41-80,000	46	6.5		
Household structure: both biological parents				
No	251	15.1%	3.52	p=.06
Yes	122	8.2%		
Household structure: single female parent				
No	222	15.3%	2.92	p=.08
Yes	151	9.3%		
Household structure: common law/ Step/adoptive partner/ other				
No	296	9.5%	14.86	p<.001
Yes	77	26%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

Abuse characteristics associated with maternal response

As indicated in Table 16, the relationship between maternal response and seven abuse type characteristics was examined. There was no abuse type found to be associated with negative maternal response.

Table 16

Percentage with negative maternal response by investigated abuse type among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% with negative maternal response (12.9%)	χ^2	p-value
Sexual activity completed				
No	311	11.9%	1.57	p=.20
Yes	62	17.7%		
Sexual activity attempted				
No	297	12.8%	.01	p=.93
Yes	76	13.2%		
Touching/fondling				
No	183	14.2%	.57	p=.44
Yes	190	11.6%		
Exposure of genitals				
No	351	12.3%	2.02	p=.15
Yes	22	22.7%		
Exploitation: Pornography/ prostitution				
No	366	13.1%	1.05	p=.30
Yes	7	0%		
Sexual harassment				
No	362	13.3%	1.67	p=.19
Yes	11	0%		
Sexual abuse not otherwise specified				
No	368	13%	.74	p=.38
Yes	5	0%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

The relationship between maternal response and three perpetrator characteristics was examined and shown in Table 17. Alleged abuse by a biological father, adoptive father, a father and another perpetrator was found to be strongly associated with negative maternal response ($p < .001$). There was a statistical trend ($p = .09$) indicating

that if the alleged abuser was an “other relative” there was a lower prevalence of negative maternal response. If the investigated sexual abuse was by a stranger, other acquaintance, other multiple perpetrators or an unknown perpetrator there was a significantly lower prevalence of negative maternal response ($p=.03$).

Note, other relative was not a biological father or mother, step-father, adoptive parent or foster family.

Table 17

Percentage with negative maternal response by alleged perpetrator characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% with negative maternal response (12.9%)	χ^2	p-value
Perpetrator: Biological father, adoptive father, father & other				
No	286	8.7%	18.62	p<.001
Yes	87	26.4%		
Perpetrator: Other relative				
No	248	14.9%	2.77	p=.09
Yes	125	8.8%		
Perpetrator: Stranger, unknown, other acquaintance, other multiple perpetrators				
No	212	16%	4.40	p=.03
Yes	161	8.7%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

Table 18 portrays the relationship between six abuse characteristics and maternal response. A higher level of negative maternal response was found when children were allegedly abused on more than one occasion when compared with a single incident of

abuse (16.7% versus 7.3%). The presence of maltreatment co-occurrence was highly associated with negative maternal response ($p < .001$).

Table 18

Percentage with negative maternal response by investigated abuse characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% with negative maternal response (12.9%)	χ^2	p-value
Duration of abuse				
Single incident	150	7.3%	6.93	p=.05
>single incident & unknown duration	222	16.7%		
Case previously open				
No	251	11.9%	1.18	p=.27
Yes	122	15.6%		
Maltreatment co-occurrence ^b				
No	322	8.7%	48.27	p<.001
Yes	51	43.1%		
Level of substantiation				
Suspected	127	13.4%	.04	p=.83
Substantiated	246	12.6%		
Physical harm				
No	337	12.5%	1.05	p=.47
Yes	36	16.7%		
Police investigation				
No	111	9.9%	1.06	p=.30
Yes	261	13.8%		

Note. The overall prevalence of negative maternal response is 12.9%. Thus, the noted prevalence should average to that number. Adding down should not equal 100 in each cell. If maternal response is not noted to be negative, it should be considered positive.

^a Missing data: of the total sample of 373 the number of missing data varies.

^b Among the 13.7% of investigations that involved child sexual abuse and other co-occurring maltreatment, the most severe CSA type was identified and included in the study sample.

Multivariate Results: Maternal Response

Logistic Regression Procedure

Logistic regression analysis was utilized to predict the likelihood that a non-offending caregiver would demonstrate negative maternal response to a sexually abused child. In the present study, the outcome was coded 0 for positive maternal response and 1 for negative maternal response. A hierarchical regression model was employed with the four categories noted above representing each successive block (e.g. caregiver, child, abuse, and investigation characteristics)¹³. Due to the relatively small number of cases with negative maternal response (n=48), the logistic regression analyses had insufficient power to include all theoretically valid variables. The variables included in the logistic regression analyses from each category were based on the level of significance achieved in the bivariate analyses. Blocks representing each of the above categories were compared to determine their relative contribution to the variance in outcome. Cases with missing data were not included in the analyses. Table 19 below, which first appeared in chapter 3, is the 4-step hierarchical regression model with maternal response as the outcome variable. Caregiver characteristics were entered at step 1, child characteristics were added at step 2, abuse characteristics added at step 3, and investigation characteristics added at step 4. Theoretical relevance and statistical significance at the bivariate level determined the variables for inclusion in the regression analyses.

¹³ As a result of bivariate analyses, household characteristics were excluded from logistic regression procedures. Given the presence of multicollinearity among the variables physical injury and domestic violence, physical injury was excluded from the multivariate model.

Table 19: Independent variables used to predict negative maternal response in logistic regression analysis.

Source: 1998 CIS

	Predictive Variables by Level of Characteristic			
Dependent Variables	Characteristics of the Maternal Non-Perpetrating Caregiver(s)	Child Characteristics	Abuse Characteristics	Investigation Characteristics
Negative Maternal Response	a) Domestic violence b) Mental health	a) Age of child b) Sexualized behaviour c) Developmental delay	a) Duration b) Relative perpetrator	a) Sexual abuse and other co-occurring maltreatment

Note. The predictors above were significant at the bivariate level.

Characteristics of the Maternal Non-offending Caregiver

Selected characteristics of the maternal non-offending caregiver were examined in block one of the maternal response logistic regression procedure: caregiver mental health problems and domestic violence.

Table 20 presents the model building process employed in the logistic regression procedure. Categories of variables were utilized in this analysis beginning with caregiver characteristics, as shown in step 1. The inclusion of caregiver characteristics in step 1 yielded a statistically significant result (Block 1 X^2 23.21, $p < .001$). A history of caregiver mental health problems resulted in significantly higher odds of negative maternal response in all four steps of the logistic regression. In the final step of the logistic regression, caregivers with a mental health problem were two times more likely to demonstrate a negative response to CSA disclosure compared with those without mental health issues.

Presence of caregiver domestic violence resulted in significantly higher odds of negative maternal response in the first, second and third step of the logistic regression analysis. With the addition of co-occurring maltreatment in the fourth step of the regression procedure caregiver domestic violence ceased to be a statistically significant predictor of negative maternal response ($p=.94$).

Table 20: Logistic regression: Factors associated with negative maternal response among those with suspected or substantiated child sexual abuse (N=373)

Source: 1998-CIS

Level of Characteristic	Step 1 a). Caregiver characteristics		Step 2 a). Caregiver characteristics b). Child characteristics		Step 3 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics		Step 4 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics d). Investigation characteristics	
	Odds ratio	Sig.	Odds ratio	Sig.	Odds ratio	Sig.	Odds ratio	Sig.
CAREGIVER CHARACTERISTICS								
Mental illness	4.92	.001***	3.98	.001***	4.19	.001***	2.63	.04*
Caregiver domestic violence ^a	2.49	.01**	2.53	.03*	2.17	.07*	1.03	.94
CHILD CHARACTERISTICS								
Age 8-11 ¹⁴			4.52	.01**	4.74	.01**	4.99	.01**
Age 12-15			6.37	.001***	7.69	.001***	8.53	.001***
Sexualized behaviour			3.48	.01**	2.72	.03*	3.23	.02*
Developmental delay			2.14	.14*	3.08	.04*	3.57	.02*
ABUSE CHARACTERISTICS								
Duration ¹⁵ :>1 incident/unknown					2.87	.02*	3.02	.02*
Relative as perpetrator ¹⁶					2.39	.02*	2.60	.02*
INVESTIGATION CHARACTERISTICS								
Sexual abuse and other co-occurring maltreatment ¹⁷							8.43	.001***

Note. $p<.05^*$, $p<.01^{**}$, $p<.001^{***}$ ^a Caregiver domestic violence approached statistical significance in step 3 of the logistic regression procedure ($p=.07$).

¹⁴ Reference category for age was 0-7 years.

¹⁵ Reference category for duration was single incident abuse.

¹⁶ The reference category for relative perpetrator is non-relative, or non-kin perpetrator

¹⁷ Reference category for sexual abuse and other co-occurring maltreatment was sexual abuse only.

Child characteristics

Selected child characteristics were examined in block two of the maternal response logistic regression procedure. These characteristics were age of child, presence of sexualized behaviour, and developmental delay.

Table 21 demonstrates that the inclusion of child characteristics in step 2 yielded a statistically significant result (Block 2 $X^2=32.48$, $p<.001$). Children aged 8-11 years and 12-15 years had significantly higher odds of exposure to negative maternal response than children 0-7. In the final step of the logistic regression, children aged 12-15 years were over eight times more likely to experience negative maternal response to CSA disclosure compared with children in other age categories. Presence of sexualized behaviour was significantly ($p=.02$) associated with higher odds of negative maternal response in step 2, and continued to maintain a significant p-value throughout all steps of the regression procedure.

Abuse characteristics

Two selected abuse characteristics were examined in the third block of the maternal response logistic regression procedure: duration of abuse and relative perpetrator.

Table 21 indicates that the inclusion of abuse characteristics in step 3 yielded a statistically significant result (Block 1 X^2 13.29, $p=.001$). Abuse occurring on more than one occasion resulted in significantly higher odds of negative maternal response than did abuse that occurred only one time. Children abused by a family member were

over two times more likely to experience negative maternal response when compared with children not abused by a family member.

Investigation characteristics

Table 21 demonstrates that the inclusion of co-occurring maltreatment in step 4 yielded a statistically significant result (Block 2 $X^2=22.79$, $p<.001$). Investigations involving child sexual abuse and other co-occurring maltreatment yielded significantly higher odds of negative maternal response when compared with investigations of suspected or substantiated child sexual abuse only. In fact, children for whom an investigation involved co-occurring maltreatment were over eight times more likely to experience negative maternal response than those who had no co-occurring maltreatment.

When the block of variables related to co-occurring maltreatment was added to the equation, duration of abuse and abuse by a relative continued to be significant predictors of negative maternal response at the fourth step of the regression procedure.

As shown in Table 21, the caregiver characteristic block explained 11.3% of the variance in the outcome variable maternal response (Pseudo $R^2=11.3\%$). Child characteristics explained an additional 14.7% of the variance (Pseudo $R^2=26\%$). Abuse characteristics contributed an additional 5.6% to the variance in the third step (Pseudo $R^2=31.6\%$). Finally, co-occurring maltreatment explained an additional 9.2%. Overall, the cumulative effect of the model explained a total of 40.8% of the variance and was significant at $p<.001$.

Table 21: Summary of the negative maternal response model (N=373)
Source: 1998 - CIS

	Step 1 a). Caregiver characteristics	Step 2 a). Caregiver characteristics b). Child characteristics	Step 3 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics	Step 4 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics d) Maltreatment co-occurrence
Block χ^2	23.217 (p<.001)	32.485 (p<.001)	13.297 (p<.001)	22.799 (p<.001)
Model χ^2	23.217 (p<.001)	55.702 (p<.001)	68.999 (p<.001)	91.79 (p<.001)
Nagelkerke R ² (Change in R ² Nagelkerke)	11.3%	26% (26 -11.3=14.7%)	31.6% (31.6-26=5.6%)	40.8% (40.8-31.6=9.2%)
-2 log likelihood	262.606	230.121	216.824	194.025

3. *According to the investigating social workers assessment, what percentage of children investigated for sexual abuse in the CIS-98 experienced emotional harm?*

Social workers reported that approximately 40.2% of children investigated for suspected or substantiated child sexual abuse experienced emotional harm.

Bivariate Results: Emotional Harm

4. *What characteristics are associated with emotional harm?*
- 4.1 *In particular, maternal characteristics (e.g. maternal response, domestic violence and mental health).*

- 4.2 *Child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay).*
- 4.3 *Abuse characteristics (duration of abuse, child's relationship to the perpetrator).*
- 4.4 *Investigation characteristics (substantiation level, and co-occurring maltreatment).*

Maternal non-offending caregiver characteristics associated with emotional harm among children investigated for sexual abuse

As reflected in Table 22, the relationship between emotional harm and eight maternal non-offending caregiver characteristics was examined. Negative maternal response, caregiver mental health problems, domestic violence and caregiver criminal activity were found to be significantly associated with emotional harm among children investigated for sexual abuse. The caregiver variables substance abuse, physical health, maltreatment as a child, and few social supports were not significantly associated with emotional harm among this sample of children with suspected or substantiated CSA.

Approximately sixty percent (60.4%) of children whose maternal non-offending caregiver responded negatively to disclosure of CSA were emotionally harmed in comparison to 37% (37.2%) whose caregivers responded positively.

Children were significantly more likely to experience emotional harm subsequent to CSA when their maternal non-offending caregivers had a mental health problem

compared with children of caregivers without a mental health issue (53.3% versus 38.4%). When domestic violence was reported by the investigating child welfare worker children were significantly more likely to have experienced emotional harm when compared with investigations where workers did not report the presence of domestic violence (52.8% versus 38.1%). Children were significantly more likely to experience emotional harm when the social worker reported that the caregiver was involved in criminal activity as compared to investigations where this involvement was not noted (57.1% versus 38.8%).

Table 22

Percentage with emotional harm by female non-offending caregiver characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	χ^2	p-value
Maternal response				
No	325	37.2%	9.35	p=.01
Yes	48	60.4%		
Caregiver substance abuse				
No	320	38.8%	2.00	p=.15
Yes	53	49.1%		
Caregiver mental health problem				
No	328	38.4%	3.66	p=.05
Yes	45	53.3%		
Caregiver physical health problem				
No	351	39.9%	0.26	p=.60
Yes	22	45.5%		
Caregiver abused as a child				
No	192	32.8%	2.92	p=.14
Yes	68	42.6%		
Domestic violence				
No	320	38.1%	4.09	p=.04
Yes	53	52.8%		
Caregiver involved in criminal activity				
No	345	38.8%	3.60	p=.05
Yes	28	57.1%		
Few social supports				
No	306	39.9%	0.08	p=.77
Yes	67	41.8%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

Child characteristics associated with emotional harm among children investigated for child sexual abuse

Table 23 reflects the relationship between emotional harm and six child characteristics: sex of the child, age of child, depression/anxiety among investigated children, inappropriate sexualized behaviour, self-harming behaviour, and developmental delay were found to be significantly associated with emotional harm. Gender of the investigated child was not significantly associated with emotional harm.

Older children (ages 12-15 years) were significantly more likely to experience emotional harm than younger children (0-3 years) (55.3% versus 30.2%). Children who utilized self-harming behaviour and those who exhibited inappropriate sexual behaviour were significantly more likely to experience emotional harm compared with those who did not display self-harming and sexualized behaviour (76.9% versus 33% and 56.8% versus 31.5% respectively). Children with anxiety/depression and developmental delay were significantly more likely to experience emotional harm than those who did not identify with these mental health issues (81.5% versus 33.2% and 61.5% versus 38.6% respectively).

Table 23

Percentage with emotional harm by child characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	X^2	p-value
Age of child				
0-7	169	30.2%	17.86	p<.001
8-11	89	39.3%		
12-15	114	55.3%		
Sex				
Male	284	40.1%	0.004	p=.95
Female	88	39.8%		
Depression/anxiety				
No	319	33.2%	11.51	p<.001
Yes	54	81.5%		
Age inappropriate sexual behavior				
No	203	31.5%	14.73	p=.01
Yes	37	56.8%		
Self-harming behavior				
No	227	33%	10.35	p<.001
Yes	13	76.9%		
Developmental delay ^b				
No	347	38.6%	5.28	p=.02
Yes	26	61.5%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

^b Disability may involve behavior disorders, learning disabilities, mental retardation, speech/language difficulties, mental illness, orthopedic problems, hearing and visual disabilities, and autism.

Household characteristics associated with emotional harm among children investigated for child sexual abuse

Table 24 portrays the relationship between emotional harm and four household characteristics. Home tenure, biological parents in the home, common-law or step/adoptive partner in the home were not significantly associated with emotional harm.

There was a statistical trend ($p < .06$) indicating that sexually abused children from single parent homes more frequently experienced emotional harm compared with their counterparts from homes without this family structure (44.1% versus 34.4%).

Table 24

Percentage with emotional harm by household characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	X^2	p-value
Home tenure^b				
Purchased	128	46.9%	3.62	p=.16
Rental/other	200	37%		
Household structure: both biological parents				
No	251	40.2%	0.00	p=.98
Yes	122	40.2%		
Household structure: single female parent				
No	222	34.4%	3.52	p=.06
Yes	151	44.1%		
Household structure: common law/ Step/adoptive partner/ other				
No	296	38.2%	2.47	p=.11
Yes	77	48.1%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

^b Home tenure refers to rental home vs. purchased home. Rental includes public and private rental, shelter and hotel.

Abuse characteristics associated with emotional harm

Table 25 reflects the relationship between emotional harm and seven characteristics of abuse type. Bivariate analyses identified no characteristics of abuse that were

significantly associated with emotional harm among children investigated for sexual abuse.

Table 25

Percentage with emotional harm by type of investigated abuse among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	χ^2	p-value
Sexual activity completed				
Purchased	311	38.6%	2.06	p=.15
Rental/other	62	48.4%		
Sexual activity attempted				
No	297	41.1%	0.45	p=.50
Yes	76	36.8%		
Touching/fondling				
No	183	41.5%	0.25	p=.61
Yes	190	38.9%		
Exposure of genitals				
No	351	40.2%	0.005	p=.94
Yes	22	40.9%		
Exploitation: Pornography/ Prostitution	366 7	40.7% 14.3%	1.99	p=.15
No Yes				
Sexual harassment	362	40.1%	0.12	p=.71
No Yes	11	45.5%		
Sexual abuse not specified	368	39.9%	0.82	p=.36
No Yes	5	60%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

The relationship between emotional harm and three perpetrator characteristics was investigated (Table 26). Abuse by a biological father, adoptive father, and father and other was associated with a higher prevalence (57.5% versus 35%) of emotional harm than was abuse by a non-father figure ($p < .001$). Alleged abuse by strangers resulted in lower levels of emotional harm than abuse by non-strangers (33.5% versus 45.36%, $p = .02$). Investigated abuse by an “other relative” was not significantly associated with emotional harm. Other relative is not a biological father, mother, step-father, adoptive parent or foster family.

Table 26
Percentage with emotional harm by alleged perpetrators of CSA among those with suspected or substantiated sexual abuse
 Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	χ^2	p-value
Perpetrator: Biological father, adoptive father, father & other				
No	286	35%	14.05	p<.001
Yes	87	57.5%		
Perpetrator: Other relative				
No	248	41.9%	0.91	p=.34
Yes	125	36.8%		
Perpetrator: Stranger, unknown, other acquaintance, other multiple perpetrators				
No	212	45.3%	5.24	p=.02
Yes	161	33.5%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

The relationship between emotional harm and six abuse characteristics is reflected in Table 27. When compared with children investigated for single incident abuse, there

was a statistical trend ($p=.10$) indicating that children for whom CSA was alleged to occur on more than one occasion and children with investigated CSA of an unknown duration more frequently experienced emotional harm (43.7% versus 35.3%). Maltreatment co-occurrence (13.7%) and level of substantiation were significantly associated with emotional harm ($p=.02$ and $p=.01$ respectively). Co-occurring maltreatment was associated with a higher prevalence of emotional harm when compared with sexual abuse as the only reason for investigation (54.9% versus 37.9%). Substantiation of a CSA investigation was associated with a higher prevalence of emotional harm when compared with investigations that were suspected (45.9% versus 29.1%).

The remaining abuse characteristics, case previously opened, police investigation and physical injury were not significantly associated with emotional harm among children investigated for sexual abuse.

Table 27

Percentage with emotional harm by investigated abuse characteristics among those with suspected or substantiated sexual abuse

Source: CIS-1998

Variable	Total N ^a (373)	% of children with emotional harm (40.2%)	χ^2	p-value
Duration of abuse				
Single incident	150	35.3%	2.60	p=.10
>single incident & unknown duration	222	43.7%		
Case previously open				
No	251	41.1%	0.47	p=.49
Yes	122	37.7%		
Maltreatment co-occurrence ^b				
No	322	37.9%	5.30	p=.02
Yes	51	54.9%		
Level of substantiation				
Suspected	127	29.1%	9.83	p=.01
Substantiated	246	45.9%		
Physical harm				
No	337	38.9%	2.61	p=.10
Yes	36	52.8%		
Police investigation				
No	111	39.6%	0.01	p=.91
Yes	261	40.2%		

Note. The overall prevalence of emotional harm is 40.2%. This is true for each of the emotional harm descriptive tables. Thus, the noted prevalence should average to approximately that number. Adding down should not equal 100 in each cell. If emotional harm is not noted, there should be considered no emotional harm.

^a Missing data: of the total sample of 373 the number of missing data varies.

^b Among the 13.7% of investigations that involved child sexual abuse and other co-occurring maltreatment, the most severe CSA type was identified and included in the study sample.

Multivariate Results: Emotional Harm

Logistic Regression Procedure

As in the prior regression procedure, the present analysis involved four categories of predictor variables: caregiver, child, abuse and investigation characteristics. Variables within these levels of characteristics were derived from the results of bivariate analyses.

As a result of bivariate analyses, household characteristics were excluded from logistic

regression procedures. The comprehensive literature review cited in chapters one and two supported the inclusion of variables with predictive value in terms of explaining emotional harm in cases of CSA. In addition to bivariate analyses and published literature driving the inclusion of the above categories of predictor variables, selected categorical predictor variables with significant chi-square values ($p < .05$) were also included in the subsequent multivariate model.

The second logistic regression procedure determined the effect of negative maternal response on emotional harm and assessed the likelihood of an association of child, abuse, and investigation characteristics on emotional harm, independent of the effects of negative maternal response. Logistic regression analysis was utilized to predict the likelihood that negative maternal response would be associated with emotional harm to the investigated child. In the present study, the target group was “emotional harm, EH.” A hierarchical regression model was employed with caregiver, child, abuse and investigation characteristics representing each successive block. These blocks were compared to determine their relative contribution and inclusion in the target group, emotional harm. As above, cases with missing data were excluded from the analyses.

Published literature examining the emotional outcome of CSA victims focuses on child characteristics (age, gender) abuse characteristics (duration, relationship to the perpetrator, use of force) and more recently contextual characteristics (presence of domestic violence, maternal response) (see Beitchman et al., 1991; Beitchman et al., 1992; Corcoran, 2004; Poulsney & Follette, 1995).

Table 28 below, which first appeared in chapter 3, is the 4-step hierarchical regression model with emotional harm as the outcome variable. Caregiver characteristics were entered at step 1, child characteristics were added at step 2, abuse characteristics added at step 3, investigation characteristics added at step 4. Theoretical relevance and statistical significance at the bivariate level determined the variables for inclusion in the regression analyses.

Table 28: Independent variables used to predict emotional harm in logistic regression analysis.

	Predictive Variables by Level of Characteristic			
Dependent Variables	Characteristics of the Maternal Non-Perpetrating Caregiver(s)	Child Characteristics	Abuse Characteristics	Investigation Characteristics
Emotional harm	<ul style="list-style-type: none"> a) Negative maternal response b) Domestic violence c) Mental health 	<ul style="list-style-type: none"> a) Age of child b) Sexualized behaviour c) Developmental delay 	<ul style="list-style-type: none"> a) Duration b) Relative perpetrator 	<ul style="list-style-type: none"> a) Sexual abuse and other co-occurring maltreatment b) Substantiation level

Note. The predictors above were significant at the bivariate level.

Characteristics of the Maternal Non-Perpetrating Caregiver

Selected characteristics of the maternal non-offending caregiver were examined in block one of the emotional harm logistic regression procedure. These characteristics were negative maternal response, domestic violence.

The inclusion of caregiver characteristics in step 1 yielded a statistically significant result (Block 1 X^2 13.18, $p=.01$). In cases where there was a negative maternal response the odds of contributing to emotional harm were twice that of cases with positive maternal response ($p=.01$). With the inclusion of other variables in subsequent steps the maternal response-emotional harm association was no longer significant. Domestic violence and caregiver mental health were not significantly associated with emotional harm in step 1, nor were these variables related to emotional harm at any subsequent step in the regression procedure.

Table 29: Logistic regression: Factors associated with emotional harm among those with suspected or substantiated child sexual abuse (N=373).

Source: 1998-CIS

Level of Characteristic	Step 1 a). Caregiver characteristics		Step 2 a). Caregiver characteristics b). Child characteristics		Step 3 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics		Step 4 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics d). Investigation characteristics	
	Odds ratio	Sig.	Odds ratio	Sig.	Odds ratio	Sig.	Odds ratio	Sig.
CAREGIVER CHARACTERISTICS¹⁸								
Negative maternal response	2.21	.01**	1.58	.19	1.39	.35	1.29	.50
Caregiver domestic violence	1.62	.11	1.65	.12	1.52	.19	1.39	.33
Caregiver mental illness	1.47	.24	1.60	.19	1.62	.18	1.49	.29
CHILD CHARACTERISTICS¹⁹								
Age 8-11			1.41	.23	1.48	.18	1.36	.30
Age 12-15			2.88	.001***	3.06	.001***	2.93	.001***
Sexualized behaviour			2.51	.02*	2.35	.03*	2.49	.02*
Developmental delay			1.45	.42	1.61	.31	1.60	.32
ABUSE CHARACTERISTICS								
Duration ²⁰ : >1 incident/unknown					1.20	.44	1.21	.41
Relative as perpetrator ²¹					1.59	.05*	1.54	.07
INVESTIGATION CHARACTERISTICS								
Sexual abuse and co-occurring maltreatment ²²							1.40	.35
Substantiation of CSA ²³							1.69	.04*

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

¹⁸ Additional analysis (not shown) was conducted to determine the influence of including the variable type of caregiver (biological mother, other) into the regression equation. In the sample utilized for this study, the bulk of caregivers were biological mothers (93%). When the remaining 7% of caregivers were collapsed into an “other caregiver” variable, this caregiver variable failed to reach the level of significance in both the maternal response and emotional harm regression equations.

¹⁹ Reference category for age was 0-7 years.

²⁰ Reference category for duration was single incident.

²¹ Reference category for relative perpetrator is non-relative/non-kin perpetrator.

²² Reference category for sexual abuse and co-occurring maltreatment was sexual abuse only.

²³ Reference category for substantiation of CSA was suspected CSA.

Child characteristics

Selected child characteristics were examined in block two of the emotional harm logistic regression procedure: age, sexualized behavior and developmental delay.

Table 30 demonstrates that the inclusion of child characteristics in step 2 yielded a statistically significant result (Block 2 $X^2=31.05$, $p<.001$). The odds that the investigating worker would report emotional harm for children aged 12-15 years was approximately three times higher when compared to children aged 7 and under. Children who exhibited inappropriate sexualized behaviour were over two times more likely to experience emotional harm. Developmental delay was not significantly associated with emotional harm among children with suspected and substantiated CSA.

Abuse characteristics

Selected abuse characteristics were examined in the third block of the emotional harm logistic regression procedure: duration of abuse and relative perpetrator.

Table 30 indicates that the inclusion of abuse characteristics in the third step of the regression procedure yielded a statistically significant result (Block 1 $X^2 4.66$, $p=.09$).

Social workers had more than 50% higher odds of reporting that the investigated child experienced emotional harm when the alleged abuse was by a relative as compared to abuse by a non-relative. This association reached statistical significance in step 3

($p=.05$), but was only a statistical trend in block 4 ($p=.07$). Duration of abuse was not statistically significant in any step.

Investigation characteristics

Co-occurring maltreatment and substantiation level were examined in step four of the emotional harm logistic regression procedure. Table 30 indicates that the inclusion of co-occurring maltreatment and substantiation level in block 4 of the regression equation yielded a statistically significant result (Block 1 X^2 4.99, $p=.08$).

As shown in Table 30, the caregiver characteristic block explained 4.7% of the variance in the outcome variable emotional harm (pseudo $R^2=4.7\%$). With the addition of child characteristics the shared variance was enhanced by 10.5% (pseudo $R^2=15.2\%$). Abuse characteristics contributed an additional 1.5% to the variance in the third step of the regression equation while investigation characteristics accounted for an additional 1.6% (pseudo $R^2=18.3\%$). Overall, the cumulative effect of the model produced a final X^2 value of 18.3%, $p<.001$.

Table 30: Summary of the emotional harm model (N=373)**Source: 1998-CIS**

	Step 1 a). Caregiver characteristics	Step 2 a). Caregiver characteristics b). Child characteristics	Step 3 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics	Step 4 a). Caregiver characteristics b). Child characteristics c). Abuse characteristics d). Investigation characteristics
Block χ^2	13.18 (p=. 01)	31.05 (P<.001)	4.66 (p=.09)	4.99 (p=.08)
Model χ^2	13.18 (p=. 01)	44.23 (P<.001)	48.89 (P<.001)	53.89 (P<.001)
Nagelkerke R ² (Change in R ² Nagelkerke)	4.7%	15.2% (15.2-4.7=10.5%)	16.7% (16.7-15.2=1.5%)	18.3 (18.3-16.7=1.6%)
-2 log likelihood	486.67	455.62	450.95	445.96

Chapter 5: Discussion

The results of this dissertation confirmed that social workers reported that the majority of non-offending mothers (87.1%) of children with suspected or substantiated child sexual abuse (CSA) demonstrated positive maternal response. Perhaps the most remarkable finding was that despite the substantial number of risk factors involved, the vast majority of mothers nevertheless responded to CSA disclosure with belief, emotional support and protection, an outcome consistent with published research that illustrates positive responses among non-perpetrating mothers of sexually abused children (Bolen, 2002; Elliot & Carnes, 2001; Leifer, Kilbane & Grossman, 2001; Sirles & Franke, 1989). This dissertation's analyses focused on the minority of mothers (12.9%) who exhibited a negative maternal response to their child's disclosure of alleged CSA. The intension of analyses was not to reinforce the perception of non-perpetrating mothers as collusive and enact surveillance on this small minority. Rather, examining the risk factors associated with negative maternal response will work towards ensuring the safety of a small, yet vulnerable segment of children exposed to the negative reactions of non-offending mothers.

Two empirical models were subject to logistic regression analyses: a) the first model examined factors associated with negative maternal response; b) the second model explored factors associated with emotional harm. The findings of this study confirmed that according to the social workers assessment, a large minority of suspected or substantiated CSA cases resulted in emotional harm to the investigated child (40.2%), a result that is consistent with previous research (Beitchman et al., 1991; Beitchman et

al., 1992). Informed by ecological theory, this dissertation examined the characteristics among reported families that may be associated with maternal response and emotional harm. The ensuing discussion integrates the dissertation's findings with previous research and examines the implications for social work practice and policy development.

The present study documented the caregiver, child, abuse and investigation characteristics of cases for which CSA was suspected or substantiated. This dissertation's analyses examined the association of various characteristics with negative maternal response and with emotional harm, and subsequently explored the implications for clinical practice. In particular, analyses confirm earlier studies that demonstrate the vulnerability of adolescents vis a vis their exposure to negative maternal response (Heriot, 1996; Sirles & Franke, 1989).

The format of this chapter incorporates the research questions articulated in chapter one with a focus on maternal response, followed by discussion of outcomes related to emotional harm. The significance of descriptive and multivariate findings is summarized and facilitates discourse on the implications for future research and practice in the area of child sexual abuse.

The following research questions and hypotheses have been examined:

Research Questions

1. What percentage of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were identified by their social workers as having a negative maternal response?
2. What characteristics are associated with maternal response?
 - 2.1 In particular, what maternal characteristics (e.g. substance abuse, mental health, and domestic violence) are associated with maternal response?
 - 2.2 What child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay) are associated with maternal response?
 - 2.3 What abuse characteristics are associated with maternal response (duration of abuse, child's relationship to the perpetrator)?
 - 2.4 What investigation characteristics (substantiation level, and co-occurring maltreatment) are associated with maternal response?
3. According to the investigating social workers assessment, what percentage of children investigated for sexual abuse in the CIS-98 experienced emotional harm?
4. What characteristics are associated with emotional harm?
 - 4.1 In particular, maternal characteristics (e.g. maternal response, domestic violence and mental health).

- 4.2 Child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay).
- 4.3 Abuse characteristics (duration of abuse, child's relationship to the perpetrator).
- 4.4 Investigation characteristics (substantiation level, and co-occurring maltreatment).

Hypotheses

1. Maternal, child, abuse, and investigation characteristics are associated with maternal response among non-perpetrating caregivers of children investigated for sexual abuse.
2. Maternal, child, abuse, and investigation characteristics contribute to emotional outcome among children investigated for sexual abuse.

Of note, hypothesis one was explored in model one (maternal response) and hypothesis two in model two (emotional harm). Table 2, previously depicted in chapter three, provides a detailed breakdown of the variables utilized in the first of the two regression models.

Study limitations

Regression analyses were conducted to determine the predictive ability of four categories of independent variables in contributing to negative maternal response and emotional harm. Study findings were reported and their relevance to practice and

policy documented. As with any study this investigation was subject to certain methodological constraints that should be noted.

Although results of this dissertation's analyses demonstrated a small to medium effect size²⁴, a small sample and consequently a lack of power may have contributed to non-significant findings. The precision of measurement, particularly the determination of the caregiver functioning characteristics (e.g. substance abuse, and mental health problems) was indefinite. Given the small sample size (n=373) and relatively crude measures the possibility of non-findings is present.

Findings for each category of characteristics were restricted to the responses of the female non-offending caregivers. The responses of male and female perpetrators of suspected or substantiated child sexual abuse were excluded. However, a limitation of the CIS-98 data collection instrument was that it did not distinguish between caregiver A and caregiver B in the caregiver functioning items: caregiver substance abuse, mental health issues, physical health problem, criminal activity and perception of few social supports. Furthermore, as it is not clear if a "yes" response was specific to the female non-offending caregiver or another caregiver in the home, results of the caregiver functioning items should be interpreted with caution.

²⁴ Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Earlbaum Associates.

The variable physical harm was indicated by the investigating child welfare worker if harm occurred as a result of any alleged abuse. Therefore, it is not possible to determine if the report of physical harm was associated with the alleged child sexual abuse or another form of alleged maltreatment.

The CIS-98 study guide instructs CPS workers to document the presence of an established medical diagnosis if available (e.g. mental or physical health problem in caregivers, depression or a developmental delay in investigated children). Workers indicated “suspected” when there was a disclosure of a mental/physical problem not accompanied by a formal diagnosis. In this dissertation’s analyses, the suspected and confirmed responses to the above adult and child characteristics were collapsed and accepted as a positive response. Consequently, there is the potential of over-inclusion of confirmed diagnosis.

Several demographic variables had substantial missing data (e.g. employment, education, and household structure). Consequently, the power to detect a significant finding for these variables is diminished. Furthermore, non-responders may differ systematically from responders.

Data obtained from the CIS-98 is cross-sectional in nature and as a result does not report potential shifts in the responses of non-perpetrating mothers over time. Most importantly, cross-sectional data do not allow a determination of causality. Future research could employ a comparative research design that incorporates multiple time

points to monitor changes in maternal response patterns. Another limitation of utilizing the data from the CIS-98 is that it is not inclusive of undisclosed cases of CSA and CSA cases not reported to Child Protective Services, which are therefore not reflected in the analyses.

With multiple observations for several households (e.g. two or more children with the same mother), these analyses are potentially jeopardizing the assumption of independence. However, it is likely that the effect is minimal because only 102 (27.3%) of the 373 families examined had more than one investigated child in the family.

Given that multicollinearity among the variables physical injury and domestic violence was identified, physical injury was excluded from multivariate analysis, however, it was retained in univariate and bivariate analyses.

Model 1: Maternal Response

Table 31: Independent variables used to predict caregiver response in logistic regression procedures

Source: CIS-1998

	Predictive Variables by Level of Characteristic			
Dependent Variables	Characteristics of the Female Non-Perpetrating Caregiver(s)	Child Characteristics	Abuse Characteristics	Investigation Characteristics
Caregiver Response	a) Domestic violence b) Mental health	a) Age of child b) Sexualized behaviour c) Developmental delay	a) Duration b) Relative perpetrator	a) Sexual abuse and other co-occurring maltreatment

*Note: The household characteristic block was eliminated after the initial round of bivariate analyses was conducted. Given the presence of multicollinearity among the variables physical injury and domestic violence, physical injury was excluded from the multivariate model, but remained at the bivariate level. The predictors above were significant at the bivariate level.

Overview

According to the reports of investigating social workers, the vast majority of non-perpetrating mothers in the CIS-98 responded with belief, protection and support when CSA was disclosed (87.1%). The overall maternal response model was significant and accounted for 40.8% of the variance (Nagelkerke R^2). Multivariate results support a model where child and caregiver characteristics provided the greatest explanatory value in predicting negative maternal response, contributing 14.7% and 11.3% respectively of the variance. The predictors child age (years 12-15), sexualized behavior among children, and caregiver mental health, yielded significant results at the multivariate level ($p < .001$, $p = .02$, and $p = .04$ respectively). Other predictors representing abuse characteristics, such as child's relationship to the perpetrator and duration of abuse, were also found to be associated with negative maternal response ($p = .02$ and $p = .02$).

respectively). Social worker's identification of caregiver domestic violence was significantly associated with negative maternal response in steps 1-3, but failed to yield a significant response in the 4th and final step of the regression equation ($p=.94$).

The emotional harm model documented that less than one half of children investigated for suspected or substantiated sexual abuse experienced emotional harm (40.2%). The overall emotional harm model was significant and accounted for 18.3% of the variance (Nagelkerke R^2). Child and caregiver characteristics contributed most substantially to the emotional harm regression model, accounting for 10.5% and 4.7% respectively of the variance. At the multivariate level, the age of the child at the time of investigation (12-15 years) and inappropriate sexualized behavior were significant predictors in the final stage of the regression equation. Inconsistent with previous CSA research, the variables negative maternal response, caregiver domestic violence, and duration of abuse failed to contribute significantly to the emotional harm model. Substantiation level of CSA investigations was a significant predictor of emotional harm ($p=.04$) while co-occurring maltreatment did not meet the level of significance ($p=.35$). These and other findings are addressed in the upcoming discussion.

1. *What percentage of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were identified by their social workers as having a negative maternal response?*

This dissertation's findings concluded that social workers identified only a small minority of non-perpetrating mothers who responded negatively to the disclosure of

alleged CSA (12.9%). Despite the multiple risk factors non-perpetrating caregivers are exposed to, the vast majority (87.1%) of caregivers in the CIS-98 demonstrated positive maternal support, believed their child's disclosure and provided protection from further abuse, a rate slightly higher than that reported in previous studies. Sirles and Franke (1989) found that 78% of non-offending mothers believed their child's claim of abuse, while Leifer, Kilbane and Grossman (2001) found that 61.7% of 99 non-offending mothers were emotionally supportive. Elliot and Carnes (2001) summarized existing maternal response studies and concluded that although many non-offending mothers believed their child's disclosure, and provided emotional support and protection, they noted substantial variability in response patterns. Included in this summary, Pintello and Zuravin (2001) reported that only 41.8% of 435 non-perpetrating mothers both believed and protected their victimized child, while Adams-Tucker (1982) found that only 27% of 28 non-offending caregivers were very supportive.

Methodological considerations that may contribute to these diverse findings include the operationalization of maternal response. As noted by Elliot and Carnes, (2001, p.316) maternal response involves "constructs that overlap (belief, protection and support) and are difficult from a practice and measurement perspective to separate." Maternal response studies differ in the employment of standardized measures, the inclusion of intrafamilial and extrafamilial samples and duration since CSA disclosure (Elliot & Carnes). There was considerable variation with respect to the severity of the cases in these studies due to recruitment of samples from different settings. Recruitment of samples from clinical settings (e.g. recruitment from hospital or mental health clinics),

community (e.g. newspaper or other media), or mandated populations (e.g. referral from child welfare or police services) may have accounted for the differences between CIS-98 findings and previous research outcomes.

Recognizing that only a minority of non-perpetrating mothers exhibited negative response to CSA disclosure, intervention should aim to engage families in a minimally intrusive way. Commitment to ensure the protection needs of this population is critical. While continued CAS investigation is essential, it would be advantageous for protective services to re-evaluate its investigatory protocol to acknowledge the strengths of non-perpetuating mothers and emerging data that indicates most non-offending mothers respond appropriately to disclosure of CSA.

2. *What characteristics are associated with maternal response?*

2.1 *In particular, what maternal characteristics (e.g. substance abuse, mental health, and domestic violence) are associated with maternal response?*

Dependent Variables

Substance abuse

Although only 14.2% of non-perpetrating mothers had an alcohol and/or drug problem, those who did have addiction issues more frequently exhibited negative maternal response toward their victimized child (20.8% versus 11.6%) than did those without an

alcohol and/or drug problem. Often employed as a coping mechanism, empirical data suggests that addiction to drugs or alcohol may compromise a mother's capacity to adaptively respond to CSA disclosure and may impair her judgment regarding proximity to danger (Leifer, Kilbane & Kalik, 2004; Leifer, Shapiro, & Kassem, 1993). Coping theories presented in chapter two (approach/avoidance model by Roth & Cohen, and the Cognitive Appraisal model by Lazarus & Folkman) suggest that avoidance of stressful stimuli, often through use of substances, acts as a defence mechanism to protect the non-perpetrating mother against emotionally charged content.

Leifer, Kilbane and Kalik, (2004) examined this topic from an intergenerational perspective recognizing that some mothers of CSA victims often have their own history of CSA and may engage in substance abuse as a coping strategy. Poor maternal protection of victimized children was conceptualized as a factor of mother's use of alcohol and/or drugs secondary to her historical CSA trauma. Although the data presented by Leifer and colleagues confirmed that non-perpetrating mothers with a history of CSA more frequently engaged in alcohol and/or drug use compared with mothers who abstained, it did not address the proportion of such cases wherein negative maternal response was found.

Elliott and Carnes' (2001) comprehensive review of research on maternal response also conceptualized response within the context of maternal history of sexual trauma. Reliance on substances as a means of coping was identified as a characteristic of non-perpetrating mothers with historical trauma and linked to poor maternal response.

Leifer, Shapiro and Kassem (1993) measured the level of functioning among non-perpetrating mothers and children's perception of maternal response among 68 sexually victimized children and found that current substance abuse predicted poor maternal response and more extensive abuse of children.

Alternatively, Morrison and Clavenna-Calleroy (1998) reported that non-perpetrating mothers with a history of sexual trauma responded more empathically than mothers without a personal history of CSA when faced with the disclosure that their child was a victim of CSA. These authors investigated 50 adolescent female CSA survivors recruited through a hospital setting and though their findings represent an anomaly in terms of the existing data, they may be understood within the context of attachment theory. Mothers' subjective experience of abuse may heighten her sense of empathy and emotional engagement towards her victimized child and thus promote an improved coping response.

In the general population, 37% of those with a substance abuse problem have a concomitant mental health problem at some point in their life (Reiger, Farmer, & Rae, 1990). Other studies have examined caregiver factors from a multivariate perspective incorporating maternal response, substance abuse and mother's previous trauma (Leifer, Kilbane and Kalik, 2004), but this author has not identified a study that focuses on maternal response, substance abuse and mental health. It remains ambiguous whether the relationship between maternal response and substance abuse is too closely

related to mental health for the effects of substance abuse to be detected. Examination of the interaction of these variables is an important area for future research.

At the bivariate level, dissertation findings indicated that negative maternal response to disclosure of CSA occurred more frequently among non-perpetrating mothers who abused alcohol and/or drugs than in those who abstained. Regrettably, CIS-98 data did not permit an examination of the interaction between mothers' historical experiences of child sexual abuse and substance abuse and its influence on maternal response.

Mental health

Although only 12.1% of non-perpetrating mothers had a mental illness, those with mental illness more frequently had a negative maternal response than those without mental health issues (35.6% versus 9.8%). In the current study, mental illness was found to significantly predict the presence of negative maternal response in multivariate analyses. Children whose parents had a mental illness were four times more likely to be exposed to negative maternal response than children of parents without mental health issues.

Ample literature documents the influence of various mental health disorders on parental response to CSA. Depression, either pre-existing or post-abuse, may diminish the parenting capacity of the victimized mother and place her at risk of exhibiting a negative response to disclosure of CSA (Zuravin & Fontella, 1999). Manion and

colleagues' (1996) study involving a sample of 93 non-offending parents of children investigated by Canadian child welfare authorities for extrafamilial CSA found that post-traumatic stress disorder symptomatology was heightened among non-offending mothers compared with non-offending fathers. Subsequent to disclosure of CSA, non-perpetrating mothers also reported heightened symptoms related to psychosis, hostility and phobia. Elevated emotional distress was also documented among 30 non-offending parents of victimized children where 46% of mothers and 22% of fathers self-reported depressive and post-traumatic symptomatology (Davies, 1995). Lewin (2001) indicated that subsequent to CSA disclosure, non-offending mothers reported heightened levels of depression, and vacillating attachment behaviors compared with matched controls. DeLillo and colleagues (2003) reviewed existing research on parenting capacity among non-offending caregivers who reported emotional distress subsequent to their child's CSA disclosure and concluded that parents of sexually victimized children evidenced permissive and authoritarian parenting styles and parentification (i.e. role reversal).

Parenting challenges among persons with a serious mental illness have been linked to internalizing and externalizing behaviors in children (Beardslee, Versage, & Gladstone, 1998; Berg-Nielsen, Vikan, & Dahl, 2002; Gladstone, Boydell, & McKeever, 2006; Hall, 2004; Rutter, 1990; Rutter & Quinton, 1984). Compromised parenting due to mental illness diminishes parents' ability to ensure the child's protection from further abuse and may pose significant risks for sexually victimized children. Although empirical data links mental illness with compromised parenting, an alternative body of research refutes this finding (see Gladstone, et al., 2006 for review). For example,

Aldridge (2006) assessed the parenting capacity of 40 parents with depression and bipolar disorder recruited from a community mental health centre and concluded that with appropriate intervention the deleterious effects of mental illness were not evident in child psychosocial outcomes.

A subset of literature examines mental illness and parenting capacity from the context of parental trauma, with a particular focus on the impact of trauma on subsequent parenting style. In cases involving non-perpetrating mothers' of CSA victims who have their own history of sexual abuse, trauma symptoms may resurface at the time of the victimized child's disclosure and compromise maternal responses (Burgess, Hartman, Kelley, Grant, & Gray, 1990; Corcoran, 1998; Corcoran, 2004).

While this dissertation did not specifically investigate mental illness and parenting capacity, bivariate analyses identified an association between mental illness and poor maternal response insofar as maternal response is conceptualized as an aspect of parenting.

As noted in chapter 3, the interpretation of data generated from the caregiver functioning items (caregiver substance abuse and mental health) was constrained by limitations in the CIS-98 data set. For example, a "yes" response to the caregiver functioning items could pertain to the female non-offending caregiver or another caregiver in the home.

Domestic violence

The current investigation found that a small minority of non-perpetrating mothers experienced domestic violence at the time of CSA disclosure (14.2%). Negative maternal response occurred more frequently in homes experiencing domestic violence when compared with homes without such history (24.5% versus 10.9%). In the multivariate model, domestic violence was not a significant predictor of negative maternal response in the final block of the regression equation. These findings are contrary to accumulating research evidence where poor maternal response is cited in many cases where domestic violence is present (Alaggia & Turton, 2005; de Young, 1994; Hiebert-Murphy, 2001; Kellogg & Menard, 2003).

Among 481 children recruited through a university based health clinic, Bowen (2000) found that over one half (54%) of CSA victims experienced concurrent CSA and domestic violence in the home. Based on a retrospective chart review of 164 children and adolescents recruited from a community treatment setting, Kellogg and Menard (2003) indicated that 58% of the 83 offenders residing in the home with the sexually victimized child were perpetrators of concurrent domestic violence. Hiebert-Murphy (2001) reported that concurrent domestic violence and CSA compromised positive maternal response as evidenced in mothers' use of avoidant coping strategies. Furthermore, the author found that both physical and emotional abuse experienced by the non-offending mothers negatively affected their maternal response to CSA disclosure. In a similar study that examined the influence of concurrent domestic violence and CSA in terms of its impact on maternal response, Alaggia and Turton

(2005) found that emotional or psychological abuse resulted in negative maternal response to disclosure of CSA.

The current study's findings were inconsistent with previous literature, as only 24.5% of non-perpetrating mothers who disclosed current domestic violence exhibited a negative response to a CSA report. This may be explained by the inclusion of both incest and extrafamilial abuse investigations in a single sample in the CIS-98. A substantial proportion of CIS-98 sexual abuse investigations included in this study were extrafamilial CSA. Non-perpetrating mothers, influenced by proximity to the offender, may respond differentially than mothers distanced from the immediate threat of the offender. Consequently, the inclusion of both incest and extrafamilial abuse may have contributed to the absence of an association between domestic violence and negative maternal response in the current study. In addition, the operationalization of the independent and/or dependent variables in dissertation analyses may have contributed to the relatively small percentage of negative maternal response among mother's who workers identify as experiencing domestic violence. In particular, the operationalizing of the derived CIS-98 maternal response variable involved collapsing worker responses to three items; belief, emotional support and protection into a single dichotomous variable.

Another contributing factor to the incongruent finding of this investigation is that belief, emotional support and protection are overlapping constructs (Elliot & Carnes,

2001, p.315) and not all studies report on the provision for measuring response patterns (such as use of PRIDS – Parental Response to Incest Disclosure Scale).

Inconsistency with published research may be partially explained by the operationalization of the domestic violence variable in the CIS-98 dataset and resultant limitations. Question 6 “Caregiver A: Domestic Violence” on the CIS-98 data collection instrument was utilized for dissertation analyses where 53 of 373 (14.2%) non-perpetrating mothers disclosed current domestic violence. Further examination to distinguish between the alleged victim and the perpetrator revealed that not all alleged female victims were abused by the child’s secondary caregiver, i.e. caregiver b as defined in chapter 3, which suggests that the CIS-98 solicited information on violence among intimate partners as well as residents of the same household who may not be intimately involved. As a consequence, the effects of domestic violence vis a vis maternal response are mitigated by instances where the non-offending mother resided apart from the perpetrator of domestic violence.

The employment of a national child welfare dataset may also account for the inconsistent results emanating from this investigation when compared with existing research. The potential risk of child apprehension entailed with involvement with the Children’s Aid Society may have deterred some mothers from truthfully reporting the presence of domestic violence to the investigating child welfare worker and consequently research outcomes may not accurately reflect the co-occurrence of CSA and domestic violence. Data generated from participants recruited through a clinical

treatment setting may hold greater validity where disclosure of co-occurrence of CSA and domestic violence is not restrained by the direct threat of child apprehension.

In addition to reviewing empirical data, theoretical perspectives may be examined to help explain negative maternal response patterns within the context of co-occurring domestic violence. Dutton and Painter (1981) address the phenomenon of traumatic bonding, which encompasses an inherent imbalance of power, intermittent exposure to domestic violence and the development of a strong reliance on the perpetrator of violence for safety. Traumatic bonding theory (Dutton & Painter) is not intended to pathologize the individual; rather, it focuses on psychological manipulation that occurs as a result of intermittent abuse and results in emotional bonding of the victim to the offender. In its application to CSA and domestic violence, a mother's diminished psychological resources and compromised emotional support, belief and protection of the sexually victimized child may be a reflection of traumatic bonding. As described by Herman (1981), mother's fear of abandonment by the offender, who is both the initiator of, and rescuer from abuse, eventuates in insecure attachment to the perpetrator and mother's anxious clinging behavior. This has critical implications for the child's safety. Mother's financial dependence on the perpetrator could result in an ambivalent or negative response pattern and thereby leave the child at risk of ongoing abuse; exposure of children to risk of protracted abuse increases the potential for apprehension by CPS (Pellegrin & Wagner, 1990). Furthermore, it could promote continued or more severe domestic violence and subsequently compromise maternal response and inadvertently expose the abused child to continued sexual victimization.

Bivariate analysis indicated that children whose mothers experienced domestic violence were more frequently exposed to negative maternal response. Although the block containing caregiver characteristics explained 11.3% of the variance in predicting negative maternal response, domestic violence failed to emerge as a significant variable.

2.2 *What child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay) are associated with maternal response?*

Child age

Dissertation findings revealed that child characteristics accounted for 14.7% of the variability in the logistic regression analysis and was overall the strongest group of predictors of negative maternal response. Of these child characteristics, child age was the strongest predictor of negative maternal response ($p < .001$). Although only 30.6% of all CIS-98 child sexual abuse investigations involved adolescent survivors, the current study found that adolescent children aged 12-15 years were most likely to be exposed to negative maternal response (as noted in chapter 4, 22.8% of adolescents experienced negative maternal response compared to 4.7% of children aged 0-7 years).

Published findings on maternal response document that disclosures of abuse from pre-school children are more frequently believed by non-perpetrating mothers compared

with adolescent disclosures (Heriot, 1996). Among 118 non-perpetrating mothers of children incestuously victimized and recruited from Baltimore CPS, Heriot (1996) reported that sexually abused adolescents were least likely to have their disclosure believed by their non-perpetrating mother compared with children in other age groups. An avoidant coping response by the adolescent CSA survivor may invoke a negative response from the non-perpetrating mother. In keeping with the process of avoidant coping evident in the child sexual abuse accommodation syndrome discussed in chapter 2, sexually victimized children often exhibit secretive behaviors in response to threats of harm from the perpetrator of abuse (Summit, 1983). These behaviors may be interpreted by the non-offending mother as culpability and propel maternal disbelief. Externalizing behaviors and running away are frequently evident among adolescent survivors of CSA and may trigger a negative maternal response (Johnson & Kenkel, 1991; Shapiro & Levendosky, 1999; Spaccarelli, 1994). In expelling the myth of the “collusive mother,” Salt and colleagues (1990) note the concern often expressed by non-perpetrating mothers for younger victims and suggest that adolescent victims are most often subjected to parental disbelief and punishment for disclosing abuse.

Pintello and Zuravin (2001) similarly reported a significant effect of child age in relation to maternal response. However, contrary to the findings of this dissertation, their hierarchical regression model, which involved 435 non-perpetrating mothers recruited through CPS, was unable to maintain the significant effect of child age following the addition of other variables in their regression procedure. Nevertheless,

the import of child age is dependant on the other variables entered into the analyses and perhaps there was no variability from a regression perspective left to explain.

This dissertation's analyses confirmed previous study findings that demonstrate the vulnerability of adolescents vis a vis their exposure to negative maternal response (Heriot, 1996; Sirles & Franke, 1989). Despite the enhanced ability of adolescents to engage in therapeutic treatment due to more sophisticated cognitive skills, they more frequently employ avoidant coping strategies (Johnson & Kenkel, 1991; Shapiro & Levendosky, 1999; Spaccarelli, 1994). Comparatively, younger children (preschool/school-age) are more likely to be believed by their non-offending mother and have any post-abuse behaviors mediated by parent training. Maternal support, particularly when the perpetrator is the mother's intimate partner, is recognized as the most significant predictor of emotional harm in adolescents.

Sex of the child

In concert with published findings, a large majority of suspected or substantiated cases of child sexual abuse investigated as part of the CIS-98 involved female children (76.3%). While girls were disproportionately represented among reports of CSA, gender was not found to be significantly associated with negative maternal response in bivariate analyses. The relationship between gender and the likelihood of exposure to negative maternal response in existing literature remains tenuous. DeJong (1988) and Everson et al., (1989) identified no relationship between gender of the victimized child and maternal response. Yet, other research documents an increased likelihood of

negative maternal response in the context of female disclosures (Salt et al., 1990; Lyon & Kouloumpos-Lenares, 1987). Pintello and Zuravin (2001) found male disclosures more frequently resulted in belief and protective action, however, the effect of gender was not maintained at each step of the regression procedure.

The overrepresentation of female CSA reports does not denote that males are less likely to be sexually victimized. The gender discrepancy in the CPS and clinical population may be attributed to a greater likelihood for females to experience incest (Faller, 1989). Comparatively, incest is more frequently reported to CPS compared with suspected extrafamilial abuse (Sedlak & Broadhurst, 1996; Trocmé et al., 2001) and may contribute to more severe post-abuse sequelae than extrafamilial abuse (Finkelhor, et al., 1990), resulting in increased contact with mental health professionals and authorities. Boys tend to internalize the stigma associated with CSA and are less likely to disclose abuse (Finkelhor, 1984). Retrospective studies of adults sexually abused as children reveals that there is a higher prevalence rate of CSA among females than males (Finkelhor, et al., 1990), which may be indicative of gender differences in reporting.

Inappropriate sexualized behavior

Although only 10% of children exhibited inappropriate sexual behavior, those who did were much more likely to be exposed to negative maternal response (32.4% versus 12.3%). The findings of this dissertation revealed that the proportion of children who

manifested sexually explicit behavior was substantially less than that portrayed in previous research (Kendall-Tackett, Williams, & Finkelhor, 1999), which may be a result of use of a non-clinical sample.

Maternal belief in the veracity of the child's disclosure may be compromised when a victimized child's disclosure is accompanied by age inappropriate sexual knowledge and behaviors. Sexually explicit behaviors may be misperceived by a non-perpetrating mother as provocative and result in blame directed towards the victimized child for inciting the abusive incident(s).

Empirical literature has explored the occurrence of inappropriate sexual behavior among sexually victimized children and identified its negative effect on maternal response (Cohen & Mannarino, 1993; Friedrich, 2007; Wolfe & Birt, 1997). In a comparison study involving 195 victims of both physical and sexual abuse recruited from a series of three clinical settings, Goldston, Turnquist, and Knutson (1989) reported that overt sexualized behavior was evident more frequently among the sexually victimized participants compared with those physically abused. Einbender and Friedrich (1989) similarly reported that 52% of 46 sexually victimized children recruited from a clinical setting engaged in sexualized behaviors within 4 years post-disclosure. The occurrence of sexualized behaviour in the current study is restricted to the 30 days of initiating the investigation based on child welfare protocol requiring workers to file a deposition within this timeframe; evidence of sexualized behaviour thereafter could not be captured in this data.

Although Alexander (1992) argues that manifestation of sexualized behavior and age inappropriate sexual knowledge is not “typical” of a child’s post-abuse presentation, other researchers suggest that its presence is more common than not (Cohen & Mannarino, 1988; Friedrich et al., 1992; Friedrich, 2007; Friedrich, Beilke, & Urquiza, 1988; Kendall-Tackett et al., 1999). In their review, Kendall-Tackett et al., (1999) indicated that inappropriate sexualized behavior was “by far the most commonly studied symptom...often considered the most characteristic symptom of sexual abuse” (Kendall-Tackett et al., 1999, p.165). Beitchman and colleagues (1991; 1992) reviewed CSA research and concluded that sexualized behavior was among the short and long-term sequelae evident in the behaviors and language of victimized children. Although the current study documented the presence of inappropriate sexualized behavior, only 10% of investigated children responded in this way.

The relatively low proportion of children who exhibited sexually inappropriate behavior as found in the CIS-98 dataset may be explained by the collection of CIS-98 data by child welfare workers who may not have appropriately assessed the presence of sexually inappropriate behavior. Sexually explicit behaviors may not be evident among all victims of CSA (Beitchman et al., 1991) and it is not known whether specialized training was provided to CAS workers to accurately identify this CSA characteristic.

Drawing on the theoretical conclusions of Finkelhor (1979), examination of the traumagenic dynamics suggests that inappropriate sexualized behavior may be indicative of a sexually abusive incident(s). Victimized children may re-enact sexual

content in an effort to gain the attention, rewards and affection initially afforded during the abusive period. As indicated in chapter two of this study, sexually inappropriate behavior may be an expression of the child's confusion regarding sexual norms and difficulty in distinguishing between sex and love (Friedrich, 2007). Dissertation analyses revealed that children for whom sexualized behavior was present were over three times more likely to be exposed to a negative response from a non-perpetrating mother when compared with children not exhibiting this behavior.

The variables, sexualized behavior coupled with age of the child, were both strong predictors of negative maternal response among families for whom CSA was suspected or substantiated in the CIS-98. Corcoran (2004) reviewed 15 CSA studies that focused on parent-child interaction and concluded that both age and sexualized behavior, among other variables, predicted negative maternal response. The current investigation similarly demonstrated that child age contributed to poor maternal response, particularly when coupled with sexualized behavior. From a bivariate perspective both age and sexualized behavior were significant in the current study, and from a multivariate perspective, both age and sexualized behavior contributed substantially to the variance in negative maternal response.

Developmental delay

Although only 7% (n=26) of children investigated as part of the CIS-98 had a developmental delay, those who did were more frequently exposed to negative maternal response (38.5% versus 11%). In the current study, developmental delay was strongly

associated with negative maternal response in the bivariate analysis. From a multivariate perspective, the variable developmental delay was similarly a significant predictor of negative maternal response ($p=.02$).

Despite the strong evidence for heightened risk of abuse among children with a disability (Goldman, 1994; Sullivan, & Knutson, 1998; Sullivan & Knutson, 2000; Westat, 1993; Westcott & Jones, 1999; Zirpoli, 1990), success in identifying a study that specifically measured maternal response to CSA among children with a disability proved elusive. While children with intellectual and developmental delay are at increased risk of CSA, they are less likely to have their disclosures believed by professionals and have their cases prosecuted in court when compared with children without developmental delay (Bottoms, Carris, Harris, & Tyda, 2003; Tharinger, Horton, & Millea, 1990; Verdugo & Bermejo, 1997). Assumptions regarding “basic memory deficits and suggestibility” are offered as reasons why the abuse disclosures of children with disabilities may not be considered credible and thus discounted (Bottoms et al., 2003, p. 206). Questioning the credibility of abuse claims may lead to delay or failure to report abuse and expose the victimized child to continued maltreatment (Tharinger, Horton, & Millea). Tharinger and colleagues suggest that the person to whom the disclosure is made may internalize pressure to disbelieve the child in light of the perceived incapacity of children with a developmental or intellectual disability to accurately report abuse. Within a climate where credibility of the victimized child influences the decision to prosecute a CSA offender, a myth regarding the asexuality of

persons with a disability continues to surface and impact the decision to believe a CSA disclosure and report the allegation(s) (Tharinger, Horton, & Milea).

In the absence of research that specifically measures maternal response among children who have a developmental or intellectual disability, it is useful to draw on theoretical literature that conceptualizes the experience faced by non-perpetrating mothers of children diagnosed with a cognitive deficit. Coping theory postulates that a stressful event is characterized as, “pressure that exceeds one’s perceived ability to cope” (Lazarus & Folkman, 1984, p.141). The stress associated with coping, together with the competing demands of accounting for the veracity of the child’s disclosure and negotiating with professionals around the child’s credibility, may contribute to poor maternal response. As previously indicated, non-perpetrating parents often experience symptoms of trauma associated with the disclosure of CSA (DiLillo, 2003; Lewin et al., 2001). Bottoms and colleagues (2003) and Verugo and Bermejo (1997) found that the stress of coping with the disclosure of CSA in the face of doubt from professionals and authorities may contribute to heightened stress and compromise maternal response to the victimized child. Further research that examines the complex experiences of non-perpetrating mothers of sexually victimized children with developmental or intellectual disability is recommended.

Parental belief is one of the three components of the derived CIS-98 variable, negative maternal response. Developmental delay may have emerged as highly correlated with parental disbelief had dissertation analyses disaggregated the negative maternal

response variable and examined maternal belief in isolation from the other factors emotional support and protection.

Of note, general reference to “disability” in research studies encompasses a comprehensive spectrum of diagnoses including behavior disorders, learning disabilities, mental retardation, speech/language difficulties, mental illness, orthopaedic problems, hearing and visual disabilities, and autism. An inherent limitation in the CIS-98 data set is the lack of distinction between intellectual and developmental delay.

What household characteristics are associated with maternal response (e.g. household structure)?²⁵

Home tenure

The majority of families of children with suspected or substantiated sexual abuse rented, as opposed to owned their home (53.6% versus 34.3%). Results of bivariate analyses indicated that the relationship between home tenure and negative maternal response approached statistical significance ($p=.06$).

To this author’s knowledge, no CSA study has examined the predictive influence of home tenure on negative maternal response. Household characteristics, including home tenure, were excluded from the multivariate model given the lack of statistical significance at the bivariate level. Home tenure provides a cautionary proxy

²⁵ Household characteristics were included in bivariate analysis and not in multivariate analysis. To avoid confusion, household characteristics were eliminated from the numbered research questions that guided this study.

measure of poverty, recognizing that home ownership does not necessarily equate with material resource. Home tenure as a measure of socio-economic status is commonly used among health researchers who examine the correlation between SES and health (Guillford, Sedgwick, & Pearce, 2003; Wannamethee & Shaper, 1997; Wardle, Robb, & Johnson, 2002). Mother's social status may have an effect on negative maternal response secondary to the stress associated with limited financial resource. Additionally, low socio-economic status may influence mothers' access to and utilization of community services (Hayward & Rootman, 2001). Future research integrating both home tenure and annual income would provide a more reliable measure of poverty and further explain the effects of SES on negative maternal response.

Household structure

In the present investigation, 20.6% of children for whom CSA was suspected or substantiated resided in a common-law/step-parent/adoptive partner/other family structure. Negative maternal response occurred more frequently among families for whom this family structure was present when compared with families with two biological parents (26% versus 8.2%). Results of bivariate analyses indicated a statistically significant ($p < .001$) relationship between the common-law/step/adoptive partner/other family household structure and negative maternal response.

Research literature documents the presence of poor maternal response in cases of CSA wherein non-perpetrating mothers continue to remain in an intimate relationship with

the perpetrator (Pintello & Zuravin, 2001). Among a sample of 435 non-offending mothers of children investigated for CSA, Pintello and Zuravin found that protection from abuse was compromised when mothers remained in an intimate relationship with the perpetrator. Faller (1988) and Salt and colleagues (1990) reported similar findings among families that continued to maintain contact with the offender.

2.3 *What abuse characteristics are associated with maternal response (duration of abuse, child's relationship to the perpetrator)?*

Duration of abuse

Bivariate findings revealed that unknown duration of CSA more frequently resulted in negative maternal response compared with abuse that occurred on only one occasion (19.2% versus 7.3%). Unknown duration could potentially represent any length of abuse. To maximize the power of the analysis, duration of abuse was entered into a multivariate model as a dichotomous variable with two possible responses; single incident of CSA (40.3%) or CSA in excess of a single incident; unknown duration was collapsed into CSA in excess of a single incident (59.7%). When entered into a regression equation after caregiver and child characteristics were already in the negative maternal response model; duration of abuse was found to be a significant predictor of negative maternal response (odds ratio=3.02). In fact, children whose mothers responded negatively were three times more likely to have experienced abuse

for an unknown duration or duration greater than six months compared with children whose mothers responded positively. Naturally, if the non-perpetrating mother believes the disclosure of CSA she is more likely to prevent further abuse.

Longer duration of abuse could result in more severe post-abuse symptomatology in children and greater potential for the child's physical injury (Barker-Collo & Reid, 2003; Beitchman et al., 1991; Beitchman et al., 1992; Fergusson et al., 1997; Friedrich, Urquiza, & Beilke, 1986). This author is not aware of a study that examines the association between duration of CSA and maternal response, and as a result the dynamic between duration of abuse and maternal response is not known. Theoretically, chronic CSA may precipitate the enactment of trauma symptomatology in the non-offending mother (or re-enacted if mother has her own history of CSA), resulting in compromised emotional availability and poor maternal response. Protracted abuse may reveal an entrenched pattern of victimization in the home and negative maternal response may be an avoidant coping response to chronic child sexual abuse.

Regarding entrenched patterns of dysfunction in the home, Garbarino and Eckenrode (1997) postulate that "an unclear separation of parental, spousal and child roles," in addition to "economic deprivation of fathers" and lack of emotional engagement may be present among families where CSA is suspected or substantiated (Garbarino & Eckenrode, 1997, p. 122-123). Abuse within these confines may not be detected and may result in continued exposure to an adverse environment and prolonged victimization. Within the context of chronic family dysfunction, symptoms of abuse

(behavioral acting out, running away) may be misperceived by the non-offending mother and professionals as externalizing behavior symptomatic of a compromised living environment rather than a response to sexual victimization.

While it is not this author's intention to blame mothers for non-protective behavior, mothers' compromised ability to detect and report sexual abuse to CPS may inadvertently result in continued victimization and poor psychosocial outcomes for children. CPS investigative responses aim to diminish the duration of abuse and psychological sequelae associated with victimization. Fortunately, most non-offending mothers believe, support and protect their children from continued sexual victimization (Bolen & Lamb, 2004; Briere & Elliot, 1994; Everson et al., 1989; Heriot, 1996; Faller, 1988; Pintello & Zuravin, 2001; Sirles & Franke, 1989; Trocmé, et al., 2001).

Child's relationship to the perpetrator

Bivariate findings demonstrated that abuse perpetrated by a father figure most often resulted in negative maternal response when compared with abuse perpetrated by any other individual. Similarly, when abuse by a relative was added to the final step of the regression equation, this variable yielded a statistically significant result. Relative perpetrators were grandparent, aunt/uncle, cousin, sibling, and the non-perpetrating caregiver's common-law partner. It was not determined if the relative perpetrator lived in the family home at the time of the abuse as one-third of CSA cases involved extra-familial abuse.

Child's relationship to the perpetrator:

Tremblay, Hebert, and Piche (1999) reported that among 50 children with substantiated CSA recruited from a Canadian hospital setting, perpetrator identity (immediate or extended family member) was the only abuse related variable that significantly predicted children's use of internalizing behaviors, such as avoidant coping.

Research indicates that incest victims experience more severe psychological sequelae when compared with those subjected to extra-familial abuse (Finkelhor, et al., 1990; Beitchman et al., 1991; Beitchman, 1992; Kendall-Tackett et al., 1999).

Attachment and object relations theories help explain the poor outcomes among CSA survivors victimized by a close relative. The profound violation of trust associated with abuse by a relative is experienced by the victimized child as a fracture to the attachment bond and challenges the child's existing notions of her internal working model (see chapters one and two for a description of attachment theory within the context of CSA). Object relations theory (Bacal & Newman, 1990) suggests that self-representation (one's inner representation of self often referred to as "ego-self") develops only in relation to significant others. Two contradictory images of a significant other may result in the experience of "splitting" (a Freudian term to characterize a dissociative experience wherein the individual, presented with traumatic content, utilizes a psychic defence to "split" the ego), contribute to inadequate ego development and confusion between self and others (see Bacal & Newman for a detailed description of these concepts). The confusion of having a relative who enacts both protectiveness and

degradation may contribute to the use of cognitive defences (as above) and instil a profound distrust in those with whom an intimate family bond is shared.

Mother's ongoing relationship to the perpetrator:

In cases where the mother's intimate partner is the perpetrator of CSA, research supports the likelihood of negative maternal response to the victimized child (Heriot, 1996). Heriot suggests that mother's continued relationship with the perpetrator of CSA is the strongest predictor of post-abuse adjustment among adolescent victims. Pintello and Zuravin (2001) found that among 435 biological non-offending mothers recruited through CPS, those in a current relationship with the perpetrator of CSA were much more likely to respond negatively to disclosure of CSA; in fact, mothers were 4.3 times more likely to disbelieve their child's CSA disclosure.

In the current study, multivariate results indicated that negative maternal response more frequently occurred in cases where the perpetrator was a family member compared with a non-family offender(s). Consistent with published research, this dissertation's analyses revealed that children allegedly victimized by a relative had twice the odds of exposure to negative maternal response.

Theorists employ attachment theory to help explain the complex interpersonal dynamic involving negative maternal response within the context of mother's relationship with the perpetrator. As previously noted, insecure attachment between the non-perpetrating mother and offender may negatively impact mother's emotional availability subsequent

to disclosure of CSA. As discussed in chapter two of this study, adult attachment patterns closely approximate those developed in childhood and are invoked later in life when exposed to interpersonal vulnerability related to loss of an attachment figure. Any indication of loss of relationship with the perpetrator may activate mother's insecure attachment to the offender and lead to the absence of support, belief and protection for the victimized child. As well, non-perpetrating mothers may be financially dependent on the perpetrator and thus exhibit a negative or ambivalent response to the child's CSA disclosure.

Leifer and colleagues (2004) reported that in comparison to their non-abused counterparts, non-offending mothers with their own history of CSA demonstrated significantly more psychological sequelae associated with their child's disclosure of sexual victimization. The authors theorize that insecure attachment between mother and child occurs more frequently among mothers with their own history of abuse than mothers without such history. The nature of the attachment relationship with the CSA offender is addressed in the coming paragraph.

The concept of cumulative trauma experienced by non-offending mothers of children for whom CSA was suspected or substantiated was introduced in chapter 2 and incorporated into discourse on traumatic bonding (see Herman, 1981, 1992 for details). The ambivalent attachment to the offender that forms the basis of traumatic bonding may affect the degree of emotional support, belief and protection afforded to the victimized child subsequent to disclosure of CSA. In the current study, the exploration

of this concept was limited to the variable, “mother’s experience of childhood abuse” (20.6%). In the absence of a robust measure of cumulative trauma this variable was excluded from the regression equation.

Bell (2002) references an ideological construct regarding normative parenting and suggests that perceptions of mothers as protective and all-knowing imply that non-offending mothers of sexually victimized children should “just know” if their child is being abused. Bell challenges the notion that mothers fail to respond when presented with the knowledge that their child is being victimized. In some cases, the presence of domestic violence may contribute to “a loss of a sense of self as an autonomous capable individual; women’s lives become focused on avoiding and minimizing violence to the extent that they cease to assert themselves (Bell, 2002, p.350).” The behaviors of their victimized children may be misinterpreted as typical of children exposed to domestic violence rather than suggestive of sexual victimization. Breckenridge (2006) suggests that non-offending mothers of children investigated for suspected or substantiated CSA are poorly portrayed in CSA literature, particularly those with their own history of abuse. Expectations regarding the protectiveness of mothers are premised on an ideological assumption that mother’s have an inherent ability to detect the occurrence of abuse in the home. Not only are these assumptions evident in the CSA literature, they are also integrated in CPS practice, and in doing so allude to the non-offending mother as failing to protect her child when incidents of abuse occur. Nonetheless, analyses of CIS-98 data demonstrated that the majority of non-offending mothers of children investigated for suspected or substantiated CSA responded positively to the

investigated child (87.1%) even within the context of a number of risk factors as previously noted; these findings are consistent with published literature which has revealed supportive responses among non-perpetrating mothers (Bolen, 2002; Elliot & Carnes, 2001; Leifer, Kilbane & Grossman, 2001; Sirles & Franke, 1989).

Physical injury

At the bivariate level, analysis of the CIS-98 data demonstrated that children who were identified by the investigating worker as physically injured were more often exposed to negative maternal response compared with children who did not sustain injury (16.7% versus 12.5%), however this variable failed to reach the level of significance. Physical injury was not retained in the multivariate model as multicollinearity prevented its inclusion.

Evidence in the form of physical injury or forensic evidence in CSA cases could potentially substantiate abuse claims and advance the non-perpetrating caregiver's belief of the allegation. Such manifestation, however, is relatively uncommon and conversely could detract from the credibility of the abuse claim and contribute to ambivalent maternal response.

Abuse characteristics such as severity of abuse (Fergusson, Horwood, & Lynskey, 1996; Fromuth, 1986; Russell, 1986), degree of force used (Gomes-Schwartz, Horowitz, & Cardarelli, 1990), threats of harm to victim or family (Friedrich, Urquiza, & Beilke, 1986) and sexual penetration (Kendall-Tackett et al., 1993; Ruggerio,

McLeer, & Kixon, 2000; Spaccarelli & Kim 1995) have been identified as factors predicting post-abuse sequelae. Post-abuse behaviors such as sexual acting out, running away, depression and suicidality are mediated by the severity of abuse (Beitchman et al., 1991; Beitchman et al., 1992). Alexander (1992) references the concept of the “dose-response relationship,” where the severity of abuse has direct implications for psychological outcome and post-abuse behaviors. In the event that severity of abuse is extreme and results in physical harm, behaviors such as inappropriate sexual acting out may surface. Within this framework of post-abuse behaviours, Heriot (1996) identified an association between severity of abuse involving physical harm and negative maternal response. Severe abuse involving penetration resulted in less protective action among non-perpetrating mothers of children investigated for CSA. The results of this dissertation were inconsistent with the research identified above.

2.4 *What investigation characteristics (co-occurring maltreatment) are associated with maternal response?*

Co-occurring Child Maltreatment

In the current study, co-occurring maltreatment (sexual abuse and other abuse and neglect) was entered into the regression equation at the final step. After controlling for caregiver, child and abuse characteristics, children for whom suspected or substantiated co-occurring maltreatment was documented were over eight times more likely to experience negative maternal response when compared with children for whom

suspected or substantiated sexual abuse only was indicated. While an evolving body of literature has documented the influence of co-occurring maltreatment on emotional harm to the investigated child (Clemmons DiLillo, Martinez, DeGue, & Jeffcott; Higgins & McCabe, 2001), the effects of co-occurring maltreatment on maternal response have not been examined. Dissertation findings may reflect what Briere and Runtz (1988, p.334) refer to as “generalized parental abusiveness” suggesting children’s simultaneous exposure to multiple forms of abuse and neglect. As the non-offending caregiver in this scenario, the mother may experience distress related to the multiple maltreatment events occurring in the home thereby preventing her from demonstrating positive maternal response to any form of maltreatment.

There is also an evolving body of literature that has examined domestic violence as a co-occurring maltreatment type, particularly among families for whom child sexual abuse is alleged (Alaggia & Turton, 2005; de Young, 1994; Hiebert-Murphy, 2001; Kellogg & Menard, 2003; Tamaraz, 1996). In general, these findings suggest that the non-offending mother’s response to her child’s allegation of sexual abuse is compromised as a result of her own experience of domestic violence by the same alleged offender.

Further examination of dissertation findings as they relate to the body of literature on co-occurring maltreatment will be examined in the emotional harm section of this dissertation.

Model 2: Emotional Harm

The association between negative maternal response and emotional harm among children for whom child sexual abuse was suspected or substantiated was documented in chapters one and two. A positive maternal response from a non-offending caregiver has been shown to alleviate the short and long-term psychological impact of CSA (Elliot & Carnes, 2001; Esparza, 1993; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Spaccarelli & Kim, 1995). This study also sought to identify the characteristics associated with emotional harm among children investigated for suspected or substantiated CSA.

Overview

The findings of this dissertation revealed that social workers reported that 40.2% of cases of suspected or substantiated CSA resulted in emotional harm to the investigated child. Selected child and abuse characteristics were highly correlated with emotional harm. Multivariate analyses supported a model where caregiver and child characteristics provided the greatest explanatory value in predicting emotional harm. The overall emotional harm model, however, accounted for only 18.3% of the variance (Nagelkerke R^2), consistent with multivariate models in other research analyses. Spaccarelli and Kim (1995) found that parental support and child's experience of stress as measured by the Checklist of Abuse and Related Stressors (C-SARS) were the greatest predictors of emotional harm among 43 female survivors of CSA. The overall emotional harm model noted by these researchers accounted for 16.5% of the variance in outcome (Nagelkerke R^2), however, they did not indicate if this estimate reflected an

adjusted R^2 . If based on a non-adjusted r-square, with 43 participants and 7 measures in the regression equation, this finding may be driven by sample size limitations.

An important variable utilized in Spaccarelli and Kim's (1995) study that may have improved the R-Square value in their findings was a global measure of post-abuse stress. A limitation of the current study was the inability to capture responses through use of psychometric measures as the CIS-98 data collection schedule was not intended to reflect the properties of a psychometric instrument.

Results of the current analyses are consistent with published literature on the characteristics associated with post-abuse adjustment and provide clinical utility in understanding the experience of emotional harm subsequent to suspected or substantiated CSA. However, the results of the emotional harm model do not themselves lend confidence to implementing clinical practice initiatives to promote post-abuse adjustment without further conclusive research.

Table 36 illustrates the caregiver, child and abuse factors that significantly contributed to the emotional harm model and those found to be statistically significant in bivariate and multivariate analyses. As previously indicated, multivariate analyses revealed that while the emotional harm model produced a small overall effect, the group of caregiver and child characteristics contributed the greatest predictive value to the model.

Model 2: Emotional Harm

Table 32: Independent variables used to predict emotional harm in logistic regression analysis.

	Predictive Variables by Level of Characteristic			
Dependent Variables	Characteristics of the Female Non-Perpetrating Caregiver	Child Characteristics	Abuse Characteristics	Investigation Characteristics
Emotional harm	a) Negative response b) Domestic violence c) Mental health	a) Age of child b) Sexualized behaviour c) Developmental delay	a) Duration b) Relative perpetrator	a) Sexual abuse and other co-occurring maltreatment b) Substantiation level

*NOTE: The Household Characteristic block was eliminated after the initial round of bivariate analyses was conducted. Given the presence of multicollinearity among the variables physical injury and domestic violence, physical injury was excluded from the multivariate model, but retained at the bivariate level.

3. *According to the investigating social workers assessment, what percentage of children investigated for sexual abuse in the CIS-98 experienced emotional harm?*

The current study (CIS-98) found that 40.2% of allegedly sexually abused children were noted by the investigating child welfare worker to have experienced emotional harm. These findings are consistent with existing research evidence documenting the presence of emotional harm subsequent to child sexual abuse. CSA may result in varying types of emotional harm (Adams-Tucker, 1982; Beitchman et al., 1991; Beitchman et al., 1992; Briere & Elliot, 1994; Browne & Finkelhor, 1986; Finkelhor, 1979; Herman, 1981) including, but not limited to depression (Boney-McCoy & Finkelhor, 1996; Mannarino & Cohen, 1996; McLeer, et al., 1998; Saunders, Villepontoux, Lipovsky, Kilpatrick, & Veronen, 1992), diminished school performance (Rust & Troupe, 1991), sexualized behaviors (Beitchman et al., 1991;

Friedrich, et al., 2001; Hall, Mathews, & Pearce, 2002) and suicidality (Martin, Bergen, Richardson, Roeger, & Allison, 2004; Molnar, Berkman, & Buka, 2001). Although many survivors experience some component of the above sequelae, the developmental trajectory of CSA survivors cannot be uniformly predicted. Alexander (1992) proposed that a single “CSA syndrome” is unlikely given the diverse risk and protective factors that influence child outcome. In fact, it is estimated that as many as 30% of CSA survivors do not report any abuse related symptomatology (Kendall-Tackett, Williams, & Finkelhor, 1993).

CIS-98 analyses revealed that 59.8% of children reported for CSA were not identified by social workers as having experienced emotional harm. Given that the majority of non-offending mothers in the CIS-98 responded appropriately to the investigated child’s disclosure, this finding may be evidence of the benefits of positive maternal response. Alternatively, there is the likelihood that in some instances child welfare workers were unable to detect emotional health problems. In the absence of a disclosure of an emotional health issue by the child’s guardian or a diagnosis from the child’s physician, child welfare workers were left to interpret the child’s behavioral cues and respond accordingly²⁶. Therefore, without psychometric instruments to evaluate behavior, CAS workers may have missed manifestations of CSA sequelae.

²⁶ The CIS-98 code book provided instructions of how to respond to the emotional harm items: Describe the mental or emotional harm or trauma that was suspected or known to have been caused by the investigated maltreatment. This question requires evidence that the harm was likely caused by the suspected or substantiated maltreatment, as opposed to questions in Section 13 (Child Functioning). Include changes in the child’s development (regression, withdrawal), self-regulation (sleep patterns, elimination); or emotions (child is crying, clinging, or anxious), that are apparent for at least 48 hours and are suspected to have been caused by the investigated maltreatment.

Emotional harm may be characterized in different ways. The current study utilized the objective determination of the investigating child welfare worker regarding presence of emotional harm as well as reports from professionals and caregivers. Other studies have employed psychometric and diagnostic tools to measure the presence of internalizing and externalizing behaviors. For example, Johnson and Kenkel (1991) utilized the Brief Symptom Inventory (Derogatis, 1975) and the SCL-90-R (Derogatis & Melisaratos, 1976) to determine DSM-III diagnosis. Another study by Spaccarelli and Kim (1995), utilized the CDI – Child Depression Inventory (Kovacs, 1981) to assess post-abuse depression levels and the CBCL – Child Behavior Checklist (Achenbach, 1991) to measure the presence of internalizing and externalizing behaviors. As in the previous studies, the current investigation found that a significant proportion of cases of suspected or substantiated CSA resulted in emotional harm to the investigated child.

4. What characteristics are associated with emotional harm?

4.1 In particular, maternal characteristics (e.g. maternal response, domestic violence and mental health).

Negative Maternal Response:

As expected, negative maternal response was found to be significantly associated with emotional harm in bivariate analyses ($p=.01$); children whose mothers responded negatively more frequently experienced emotional harm (60.4% versus 37.2% - $p=.01$) compared with children whose mothers responded positively. These findings are

reflective of the accumulating research evidence that documents emotional harm subsequent to negative maternal response (See Elliot & Carnes, 2001 for review).

As noted in previous chapters, existing research on the psychological sequelae associated with CSA has focused primarily on abuse characteristics such as severity of abuse (Fergusson, Horwood, & Lynskey, 1996; Fromuth, 1986; Russell, 1986), age at onset of abuse (Kendall-Tackett, et al., 1993), duration and frequency of maltreatment (Friedrich, et al., 1986) and relationship to the perpetrator (Sedney & Brooks, 1984).

Contemporary CSA research has documented the positive effects of post-disclosure maternal support, belief and protection in preventing mental health and behavioral problems among survivors of CSA (Adams-Tucker, 1982; Barker-Collo, & Read, 2003; Bolen, & Lamb, 2004; Deblinger, Stauffer, & Landsberg, 1994; Deblinger, Steer, & Lipman, 1999; DeYoung, 1994; Elliott, & Carnes, 2001; Esparza, 1993; Everson, et al., 1989; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Heriot, 1996; Hiebert-Murphey, 1998; Leifer, Kilbane, & Grossman, 2001; Sirles & Franke, 1989; Spaccarelli, & Fuchs, 1997; Timmons-Mitchell, Chandler-Holtz, & Semple, 1996). Aspelmeier, Elliot, and Smith (2007) found that among 324 college students, parent-child attachment moderated (although weakly) the negative effects of CSA and the presence of trauma symptoms.

Tremblay, Hebert, and Piche (1999) found that non-offending parental support significantly predicted post-disclosure externalizing behaviors and self-worth among 50

victims of substantiated CSA recruited from a Canadian paediatric hospital.

Spaccarelli and Kim (1995, p.1178) reported that among 43 female CSA survivors and 34 non-offending mothers recruited through a community mental health clinic, parental support “was the best predictor of [child] resiliency” and significantly contributed to the variance in predicting internalizing and externalizing behaviors among children.

Among their sample of 45 adolescent female survivors of CSA recruited from a clinical setting, Johnson and Kenkel (1991) found that mothers’ reaction to disclosure of CSA significantly predicted symptom presence among study participants and explained 22.7% of the variance in overall adolescent outcome.

Absence of maternal support has been associated with apprehension of victimized children by Child Protective Services (Cross, Martell, McDonald, & Ahl, 1999; Hunter, Runyan, Coulter, Everson, 1990; Leifer, Shapiro, Martone, & Kassem, 1993; Pellegrin, & Wagner, 1990). Pellegrin and Wagner found that among the 58 CPS case files reviewed, 42% of sexually victimized children were apprehended and placed in a foster care setting; although 65% of non-perpetrating mothers believed their child’s CSA disclosure, the authors indicated that children were more likely to be removed from their home in cases of maternal disbelief. Hunter and colleagues investigated 100 children, for whom CSA was substantiated; immediately following CPS assessment 50% were apprehend and placed in formal and informal foster care and institutional settings. The authors concluded that, “maternal response was the most influential variable in predicting child apprehension” (Hunter et al., 1990, p. 410). This dissertation’s analyses did not examine the rates of apprehension among children

investigated for suspected or substantiated CSA, however, reports of CIS-98 data document an overall apprehension rate of approximately 13%, including both child welfare and informal placements (Trocmé et al., 2005).

Bivariate findings in the current study identified a correlation between poor maternal response and emotional harm. Multivariate findings revealed that children exposed to negative maternal response had two times the odds of experiencing emotional harm when entered into the regression equation at the first step ($p=.01$). However, in the final step of the regression model, negative maternal response did not emerge as a significant predictor of emotional harm. The vacillation between significance to non-significance may be explained by the previously noted methodological limitations of the maternal response variable, and correlation between negative maternal response and variables subsequently entered into the regression equation, such as caregiver domestic violence.

Domestic violence:

Social workers identified domestic violence in the homes of 14.2% of non-perpetrating mothers of children investigated for suspected or substantiated CSA. Social workers reported that 52.8% of children in these homes suffered emotional harm. According to social work assessment, children exposed to domestic violence more frequently experienced emotional harm compared with those who were not exposed to domestic violence (52.8% versus 38.1%). The current model revealed that, at the bi-variate level, domestic violence was significantly associated with emotional harm among children for

whom CSA was investigated ($p=.04$). When entered into a regression model, however, domestic violence did not significantly predict emotional harm, ($p=.33$).

The results demonstrating a significant association between domestic violence and emotional harm at the bivariate level are congruent with research evidence that supports the presence of emotional harm among families for whom domestic violence is indicated. Results of Wolfe and colleagues' (2003) meta-analysis similarly revealed that domestic violence is strongly associated with emotional and behavioral sequelae among victimized children; heightened internalizing and externalizing behaviors were evident among children exposed to domestic violence as measured by the CBCL, Youth Self-Report, Behavior Problem Checklist, and Eyberg Child Behavior Inventory (see Wolf et al., 2003 for details). Nevertheless, the authors conclude that not enough is known about the mitigating factors that influence children's emotional and behavioral response to domestic violence. In light of the increased reports of domestic violence (CIS-2003), further investigation of the factors that influence domestic violence would contribute to the development of an enhanced model to better understand domestic violence and improve service response.

Operationalization of the CIS-98 maternal response variable may have prevented the detection of a significant association between domestic violence and emotional harm at the multi-variate level. This may have occurred as the derived maternal response variable was attained by collapsing responses from three CIS-98 items; belief, emotional support and protection into a single dichotomous variable. It is also

recognized that the inclusion of both alleged incest and extrafamilial abuse victims in a single sample presents a methodological limitation; the developmental outcomes of incest are more severe than the outcomes associated with extrafamilial abuse (Finkelhor, et al., 1990). As previously noted, many characteristics of domestic violence are common to households with caregiver mental health issues, such as inappropriate sexual behavior, and therefore there may be no variability from a regression perspective left to explain.

The bivariate findings of this dissertation are reflective of research evidence which documents emotional harm among children who have been exposed to domestic violence (see Wolfe, Crooks, Lee, McIntyre-Smith, and Jaffe, 2003 for review). The co-occurrence of CSA and domestic violence has been established in research and evident in the works of Alaggia and Turton (2005), Bowen (2000), Hiebert-Murphy (2001), Kellogg and Menard (2003) and others.

4.2 *Child characteristics (e.g. age, gender, sexualized behaviour, and developmental delay).*

Age of the investigated child

Only one-third (30.6%) of children investigated for CSA were adolescents, however, emotional harm more frequently occurred in this age group compared with other age groups. Adolescents aged 12-15 years were significantly more likely to experience

emotional harm when compared with preschool/school age children aged 0-7 years (55.3% versus 30.2%).

Divergent opinions are expressed in CSA literature regarding the degree of emotional harm experienced relative to the age of the child victim. Some contend that children with a younger age of onset experience heightened post-abuse symptomatology (Cohen & Mannarino, 1998b; Nash, Zivney, & Husley 1993) given their exposure to abuse over a prolonged period of time. Kitchur and Bell (1989), on the other hand, found that children with an older age of onset manifested more severe post-abuse sequelae than younger children given their more sophisticated cognitive recognition of the degree of violation that has occurred. In the opinion of Heriot (1996), adolescent female victims are least likely to receive positive maternal support but require countenance at this developmental stage, just as at any other stage. Durlak, Fuhrman, and Lampman (1991) report that adolescents have more capacity to engage in therapeutic intervention compared with any other age group. The current study has examined the correlation between child's age at the time of CSA investigation rather than the child's age at the time of CSA onset.

Corcoran's (2004) review of CSA treatment outcome research reveals that preschool, school age and adolescent children consistently demonstrate improved post-abuse symptomatology with the employment of the cognitive behavioral model of intervention (see Corcoran, 2004 for review) which targets typical age specific behavior patterns among sexually victimized children. For example, among preschool and

school age survivors, treatment focuses on diminishing sexualized behavior and regaining competency in social spheres, while for adolescent victims, intervention models target avoidance behaviors commonly exhibited by victimized teens.

Multivariate findings of CIS-98 analyses revealed that age of the investigated child was a significant predictor of emotional harm; children aged 12-15 years had almost three times the odds of experiencing emotional harm in comparison to children within other age categories (ages 0-7 years and 8-11 years). Regression analysis confirmed that adolescent age predicted the manifestation of emotional harm, just as adolescence was associated with negative maternal response in the first regression model. These findings are consistent with the previously mentioned research outcomes and suggest that adolescent children investigated for sexual abuse are at increased risk of post-abuse emotional harm.

Gender of the investigated child

Notwithstanding the fact that girls were overrepresented in the sample of children investigated for CSA in the CIS-98, both boys and girls were reported by the investigating child welfare worker to have experienced similar rates of emotional harm (girls 41.9% and boys 40.9%, $p=.86$). Research findings denote a variance in symptom presence among girls and boys with regard to post-abuse internalizing and externalizing behaviors. As reported in chapter one, victimized boys tend to exhibit more externalizing behaviors such as aggressive, antisocial and inappropriate sexualized behavior, whereas victimized girls display more internalizing behaviors such as social

withdrawal and depressive symptomatology (Bolton, Morris & MacEachron, 1989; Chandy, Blum, & Resnick, 1996; Finkelhor, 1990; Friedrich, Urquiza, & Beilke, 1986). Chandy and colleagues (1996) found that sexually victimized males demonstrated poor school performance and involvement in delinquent behaviors, while females exhibited elevated rates of suicidality and disordered eating.

Risk factors for emotional harm differ according to the gender of the victimized child. In a study by Friedrich and colleagues (1986), the relationship to the perpetrator and severity of abuse were risk factors that predicted heightened symptom presence among girls, while duration and frequency of abuse were factors significantly associated with emotional harm among boys. As noted in chapter one, incorporating gender as a predictive variable in both the maternal response and emotional harm models is complicated by the differences in reporting trends of victimized girls and boys. As girls are more likely to be reported for incest than are boys, a disproportionate number of girls come to the attention of CPS (Faller, 1989) and incest is associated with poorer psychological outcomes than outcomes of extrafamilial abuse. Boys are more reluctant than girls to disclose abuse due to the internalization of shame associated with abuse that is typically inflicted by a same-sex perpetrator (Finkelhor, 1984).

Household characteristics (e.g. household structure)²⁷.

The majority of families (40.4%) in the CIS-98 investigated for suspected or substantiated child sexual abuse were headed by a single female parent. Of all of the household structures examined in the current study, single parent families were the only household structure found to be significantly associated with emotional harm.

Mother's stress of coping with the disclosure of CSA and the demands of single parenthood, as well as lack of access to resources may have affected the quality and availability of her post-abuse emotional support and thereby influenced the presence of emotional harm among victimized children. An ecological theory approach suggests that children's developmental trajectory may be influenced by stressors such as socioeconomic disadvantage if the family is unable to provide consistent and adequate care (Bronfenbrenner, 1986). In an effort to determine the characteristics associated with resilience among maltreated children, the study by Jaffee and colleagues (2007) reported that children with multiple risk factors including socio-economic disadvantage, residential crime and poor social cohesion were less resilient than children from families where these characteristics were not evident. In their assessment of cumulative risk among 102 sexually victimized children and teens, Nash, Zivney, and Husley (1993) concluded that two-parent homes mitigated the negative effects of child sexual abuse and recommended intervention strategies that target not only alleviation of symptomatology but also the victimized child's home and community environment.

²⁷ Household characteristics were included in bivariate analysis and not in multivariate analysis. To avoid confusion, household characteristics were eliminated from the numbered research questions that guided this study.

This dissertation's analyses isolated suspected or substantiated child sexual abuse cases and assessed the presence of emotional harm. The findings revealed that allegedly sexually abused children from single parent families were most at risk for emotional harm compared with children from other family structures. The study by Jaffee and colleagues (2007) examined the effects of CSA from an ecological perspective and found that children's developmental trajectory was affected by family disruptions, socioeconomic circumstance and neighbourhood effects, among other environmental factors. These findings, coupled with the work of Rutter (1990) on resilience among abused children provide relevance for the interpretation of this dissertation's results. To the extent that cumulative risk is present among sexually abused children, isolating the external emotional effects of CSA from exposure to adversity remains a challenge.

4.3 *Abuse characteristics (duration of abuse, child's relationship to the perpetrator).*

Duration of abuse

As in the previous model, abuse characteristics accurately predicted the presence of emotional harm among children investigated for suspected or substantiated sexual abuse. Duration of abuse in the CIS-98 refers to the length of time in months that the child was allegedly exposed to sexual abuse²⁸. CIS-98 analyses at the bivariate level

²⁸ Severity of PTSD symptoms is dependent on the frequency and duration of exposure to traumatic stimuli, in addition to, factors such as the use of violence, relationship to the perpetrator, and attribution of blame. The issue of frequency vs. duration of trauma has been debated in the war trauma literature, and more recently among women suffering from chronic trauma (DESNOS, see footnote 1). A diagnostic distinction regarding risk of post-abuse sequelae is made among survivors of single episode trauma vs. those who have been exposed to chronic trauma. Repeated exposure for extended periods of time is associated with heightened trauma symptomatology among victims when compared with victims subject to fewer incidents over a shorter time span.

demonstrated that children who were reportedly abused for more than six months more frequently experienced emotional harm compared with children who endured alleged abuse for a shorter duration. Consistent with the literature that chronicles the psychological sequelae associated with CSA, this study confirmed empirical knowledge related to the negative emotional effects of protracted abuse²⁹ (Beitchman et al., 1991; Beitchman et al., 1992; Caffaro-Rouget, Lang, van Santen, 1989; Friedrich, et al., 1986; Wolfe et al., 1989). From a multivariate perspective, however, the significant association of duration of abuse on emotional harm among children investigated for CSA was not retained; inadequate power in the current study may have prevented the detection of a significant association.

Wolfe and colleagues (1989, 1994) measured emotional harm by examining levels of PTSD among victimized children subsequent to disclosure of CSA. They found that in CSA cases where abuse extended beyond one year, 73% of the 90 children in their sample met the criteria for PTSD. Thirty-seven percent of children for whom abuse lasted less than one year exhibited symptoms associated with PTSD. In contrast, Sauzier, Salt and Calhoun (1990) found that duration of abuse was not associated with negative outcomes among sexually victimized children, while Nash and colleagues (1993) suggest that the frequency of abusive incidents, rather than duration of abuse, affects outcome among children. Dissertation research did not examine PTSD among victimized children; rather, variability in emotional harm is explained by factors such as

²⁹ Single incident abuse accounted for 40.3% of all CSA investigations while 59.7% of CSA investigations were CSA occurring for longer than a single incident or unknown duration.

severity of abuse (attempted or completed abuse), use of force and the child's relationship to the perpetrator.

Child's relationship to the perpetrator:

The intimacy associated with abuse by a relative has been shown to influence the presence of emotional harm among sexually abused children (Faller, 1988; Leifer et al., 2004; Pintello & Zuravin, 2001; Salt, et al., 1990). As previously indicated, 40.2% of children in the CIS-98 for whom CSA was suspected or substantiated were determined by the investigating child welfare worker to have experienced emotional harm. The current research found that alleged abuse by a relative occurred in over 50% of suspected or substantiated sexual abuse investigations while the variable, "relative perpetrator" was determined to be a significant predictor of emotional harm in the multivariate regression equation.

Traumatic bonding theory has been previously referenced as a theoretical explanation for emotional harm among children sexually victimized by a close relative. Traumatic bonding occurs through violation of trust, when the victimized child is emotionally and physically dependent on the abuser for care and the abuser vacillates between caregiver and offender. Children victimized by a close relative may develop empathy for the offender and internalize blame associated with abuse. In their review of CSA literature, Browne and Finkelhor (1986) reported that children abused by a father or stepfather were at greater risk for post-abuse adjustment problems compared with children abused by other offenders. Kendall-Tackett's (1993) meta-analysis confirmed the presence of

heightened victim symptomatology among children abused by a close family relative. More recently, Bulik, Prescott, and Kendler (2001) found that abuse by a relative accurately predicted major depressive disorder and generalized anxiety disorder among adult twins sexually victimized as children. Consistent with published literature, this dissertation's findings revealed that children allegedly abused by a relative more frequently experienced emotional harm than children abused by a non-relative while the strong association between relative perpetrator and emotional harm was maintained in both bivariate and multivariate analyses.

Physical injury

As previously reported, 9.7% of children in the CIS-98 investigated for suspected or substantiated CSA experienced physical injury. Bivariate findings confirmed that 52.8% of the physically harmed children manifested psychological sequelae as documented by the investigating child welfare worker, however, this association failed to meet statistical significance ($p=.10$). Physical injury was not retained in the multivariate model as multicollinearity prevented its inclusion.

The findings of this investigation are similar to those in published literature which demonstrates that physical injury among those investigated for CSA contributes to heightened levels of emotional harm (Hanson, et al., 2001; Kilpatrick & Resnick, 1993; Mullen et al., 1993; Spacarelli 1994; Spacarelli & Kim, 1995). Among their sample of 406 adults who were sexually victimized as children, Hanson and colleagues found that

psychological sequelae was associated with the presence of physical injury as a result of childhood rape and aggravated assault.

Emotional harm is the consequence of fear associated with the use of force and threat to physical integrity. Victims may perceive severe abuse involving physically injurious acts as a threat of violence, and may present with manifest symptoms of anxiety related to fears of bodily harm. Although the CIS-98 did not measure PTSD, the presence of PTSD among those whose physical integrity was compromised through injurious acts of sexual abuse has been substantiated (Herman, 1992).

Children who experience severe abuse involving physical harm are less likely to disclose their victimization compared with those who do not suffer physical harm (Sinclair & Gold, 1997). Withholding disclosure presupposes that abuse may remain undetected for an unknown period of time and result in continued emotional harm to the child. Thus, physical injury both directly and indirectly contributes to emotional harm through failure to disclose abuse possibly protracting potential abuse.

4.4 *Investigation characteristics (substantiation level, and co-occurring maltreatment).*

Co-occurring Child Maltreatment

As indicated previously, co-occurring maltreatment was associated with emotional harm at the bivariate level among children for whom sexual abuse was suspected or

substantiated ($p=.02$). At the multi-variate level, however, co-occurring maltreatment was not a significant predictor of emotional harm ($p=.35$). While it may be intuitive that multiple forms of concomitant maltreatment may contribute to heightened trauma symptomatology among survivors of abuse research has not demonstrated consistent findings to support this perception (Clemmons DiLillo, Martinez, DeGue, & Jeffcott, 2003; De Marco, Tonmyr, Fallon, and Trocmé, 2007). De Marco and colleagues found that co-occurring maltreatment (sexual abuse occurring with other maltreatment) was not significantly associated with emotional harm among 5,143 suspected or substantiated maltreatment investigations in the CIS-2003. While sexual abuse and other co-occurring maltreatment was not found to be a significant predictor of emotional harm, suspected or substantiated sexual abuse only was associated with emotional harm in the CIS-2003. These authors cite the taboo associated with sexual abuse as contributing to emotional harm among children investigated in the CIS-2003. Clemmons, DiLillo, Martinez, DeGue, and Jeffcott (2003) indicated that among 112 study participants, those who disclosed co-occurring maltreatment (29%) reported heightened trauma symptomatology and more severe victimization when compared with those without co-occurring maltreatment. In their review of 29 retrospective studies on co-occurring maltreatment, Higgins and McCabe (2001) found that simultaneously occurring abuse and neglect was associated with emotional harm among children; however, these authors cite several methodological problems with this body of literature. Many studies failed to measure the effects of all maltreatment types (sexual, physical, and psychological abuse, neglect and children's exposure to domestic violence) with a focus on physical and sexual abuse co-occurring and had inconsistent

definitions of child abuse and neglect. Higgins and McCabe differentiate between “multi-type maltreatment,” which refers to multiple co-occurring abuse and “multiple victimization,” which suggests “multiple experiences of the same type of maltreatment” (p.548). Further, determining the exact cause of emotional harm and the influence of co-occurring maltreatment is complicated by extraneous factors such as the influence of caregiver characteristics (substance abuse, mental health), characteristics of the abuse (severity, duration and relationship to the perpetrator) and maternal response to disclosure of abuse (belief, protection and support).

When entered into the regression equation after child, caregiver and abuse characteristics co-occurring maltreatment was not found to be a significant predictor of emotional harm in the current study. The emotional harm regression model only accounted for 18% of the variance in outcome. Therefore, there may not have been any variation left to predict as co-occurring maltreatment was entered into the final block of the regression equation.

Substantiation Level

Substantiation level of the child sexual abuse investigation was a significant predictor of emotional harm ($p=.04$). More specifically, sexual abuse investigations that were substantiated had 69% higher odds of resulting in emotional harm to the investigated child. Presumably, a substantiated abuse allegation demonstrates an increased likelihood that the investigated abuse occurred and is more likely to result in emotional harm when compared with an investigation that only reached the level of suspicion.

Synopsis of findings

In summary, this dissertation's findings determined that social workers identified only a minority of non-offending mothers who exhibited a negative response to the disclosure of investigated CSA (12.9%). At the bivariate level, maternal mental illness and domestic violence were significantly associated with negative maternal response ($p < .001$; $p = .01$ respectively), among other variables. Age of the child at the time of investigation, evidence of developmental delay and inappropriate sexual behavior were also significantly associated with negative maternal response ($p < .001$; $p < .001$; $p = .01$ respectively). At the multivariate level, mother's mental health, age of the child at the time of investigation, child's sexualized behavior, child's developmental delay, duration of abuse, child's relationship to the perpetrator and alleged co-occurring maltreatment were the factors that significantly contributed to the overall negative maternal response model.

In the emotional harm model, less than one half of children investigated for suspected or substantiated sexual abuse experienced emotional harm according to the child welfare worker (40.2%). For these children, negative maternal response and mother's domestic violence were significantly correlated with emotional harm at the bivariate level ($p = .01$; $p = .04$ respectively). Additionally, in bivariate analyses age of the investigated child, inappropriate sexual behavior, child's developmental delay, duration of abuse, having a relative as the perpetrator, co-occurring maltreatment, and substantiation level was also significantly associated with emotional harm among investigated children ($p < .001$; $p = .01$; $p = .02$; $p < .001$; $p < .001$, $p = .02$; $p = .01$

respectively). At the multivariate level, age of the child at the time of investigation (ages 12-15 years), sexualized behavior, and substantiation level provided the greatest explanatory value in predicting the presence of emotional harm.

Implications for social work practice

Social work professionals are uniquely situated at the forefront of direct practice to intervene with children and families impacted by CSA. This section addresses the findings of this dissertation in relation to existing social work interventions and offers recommendations for enhancing social work practice within the context of outcomes from the negative maternal response model and the emotional harm model.

This dissertation's findings confirmed that social workers identified that the majority of non-perpetrating mothers responded positively to their child's disclosure of CSA (87.1%), results that are consistent with published research (Bolen, 2002; Elliot & Carnes, 2001; Leifer, Kilbane & Grossman, 2001; Sirles & Franke, 1989). These findings are encouraging, however, when maternal support is not adequate the likelihood of emotional harm to the victimized child increases. Therefore, it is critical that CPS, upon whom it is incumbent to determine the presence of a wide range of risk factors among families, continue its efforts to protect victimized children.

The current study contributes to the body of the CSA literature which links the mental health of the non-perpetrating caregiver to the presence of negative maternal response. Impaired mental health compromises adaptive coping, therefore, interventions that

stabilize the mental health of non-perpetrating caregivers are recommended, followed by didactic intervention to support mothers in fulfilling their parenting role. CPS investigations involve screening for mental health issues at the outset of the intake process; in cases where mental illness is severe and supports inadequate, apprehension by CPS may be an option to prevent further episodes of maltreatment.

CPS intervention may be strengthened by recognizing the parenting capacity of mothers despite mental illness, and adopting a strengths approach to treatment planning, once the safety of the child is secured. A strengths approach would lend credence to the personal skills of mothers within the context of a supportive system and avoid labelling individuals or behaviors solely in terms of a psychiatric diagnosis.

Mothers' perception of social support contributes to the quality of her post-disclosure response, as well as improving the psychosocial outcome of victimized children (Hiebert-Murphey, 1998). Given the knowledge that CSA disclosures are most often made directly to the child's non-perpetrating mother (Sauzier, 1989), mother's access to timely and appropriate post-disclosure support is critical to ensure an emotionally supportive and protective response. In an analysis of effective social work intervention strategies for mothers with mental illness, Alakus and colleagues (2007) found that mothers identified a need for improved interagency collaboration and access to mutual aid support groups. Mothers also expressed a desire for an improved relationship with child welfare staff to avoid child apprehension, and parenting skills education. While the authors did not measure the impact of mental health services on post-disclosure

maternal response, the vulnerability of mentally ill mothers and their struggles to liaise with child welfare were evident.

CSA literature identifies substance abuse as one of several predictive variables that help to explain the maternal response dynamic (Leifer, Shapiro, & Kassem, 1993; Rodriguez-Srednicki, 2001). While this dissertation's findings failed to yield a significant multivariate result between substance abuse and negative maternal response, bivariate results imply that social workers need to be aware of the presence of substance abuse, which may suggest a cluster of at-risk characteristics requiring further investigation.

As noted in the current study as a critical factor, age of the victimized child has similarly been identified in CSA research as a significant variable associated with negative maternal response. Research studies document the vulnerability of adolescent survivors of child sexual abuse in terms of their exposure to negative maternal response (Heriot, 1996; Sirles & Franke, 1989). Adolescent disclosures of child sexual abuse are less likely to be believed compared with disclosures of pre-school children (Heriot, 1996). Recruited from a Baltimore area CPS, Heriot (1996) interviewed 118 non-perpetrating mothers of children for whom CSA was substantiated; in comparison with other age groups, the author found that adolescent survivors of child sexual abuse were the least likely to have their CSA disclosures believed.

Results of this dissertation's analyses revealed that 45.4% (n=169) of CIS-98 investigations of suspected or substantiated CSA involved children aged 0-7 years, 30.6% (n=114) aged 12-15 years and the remaining 23.9% (n=89) children aged 8-11 years. At the bivariate level, adolescent children aged 12-15 years experienced heightened negative maternal response and emotional harm when compared with their younger counterparts. Furthermore, adolescent age significantly predicted the presence of negative maternal response ($p < .001$) and emotional harm ($p < .001$) in the final block of regression analyses.

The age of non-perpetrating mothers was also examined as a caregiver characteristic influencing the presence of negative maternal response and emotional harm among investigated children in the CIS-98. Interestingly, younger non-offending mothers of children investigated for CSA were identified as more positively responsive than older mothers. This finding is compromised by the high presence of older mothers in this sample of suspected or substantiated CSA investigations. Further research is recommended to investigate whether younger mothers are more likely to seek out mainstream support services, and by virtue of their age, avoid exposure to the cumulative effects of an adverse environment that often accompanies child sexual abuse.

Consistent with published literature, this dissertation found that the manifestation of sexualized behavior among children investigated for sexual abuse contributed to the presence of negative maternal response. The introduction of behavioral interventions to

ameliorate sexualized behavior among victimized children has met with success (see Corcoran, 2004). Behavioral interventions are informed by cognitive and behavioral theories that are integrated as a component of abuse focused CBT intervention; non-sexual behavior is rewarded and inappropriate sexual content is diminished. Didactic components of intervention (age dependent) explain the aetiology of sexualized behaviors among victimized children and adolescents. Research conducted by Cohen and Mannarino (1996a, 1996b), Deblinger, Steer, and Lippman (1999), Deblinger, Stauffer and Steer (2001) provide strong evidence that CBT interventions are effective in minimizing externalizing behavior. Deblinger and colleagues (1999) assessed the effectiveness of individual treatment for 90 children and their non-offending parent utilizing a 12 session CBT intervention protocol. Their findings revealed mitigation of psychiatric symptomatology and improved self-reported parenting capacity. Social work practitioners should recognize that the findings of these intervention studies are somewhat compromised by methodological limitations such as small sample size, confounding parent and child interventions, inclusion of samples involving both intrafamilial and extra-familial abuse and lack of comparison/control groups (Corcoran, 2004). These limitations have been discussed in chapter two and will be addressed briefly in the section, “directions for future research”.

This study identified a factor not extensively addressed in existing child sexual abuse literature: developmental disability. Children for whom a developmental disability was diagnosed or reasonably suspected were more likely to be exposed to negative maternal response compared with children without a developmental disability. Literature

examining CSA among developmentally disabled populations suggests that the veracity of CSA disclosures by impaired children may be questioned by professionals and non-perpetrating caregivers (Tharinger, Horton, & Millea, 1990). Further, Tharinger and colleagues suggest that disclosures of CSA from developmentally disabled children are subject to atypical scrutiny during the investigatory process to establish credibility. It is critical for social work practitioners to be cognizant of this dynamic in order to respond more effectively by validating disclosures and providing appropriate post-disclosure interventions for children and families impacted by developmental delay. Clinical practice literature suggests that intervention among families affected by developmental delay should reflect the same focus offered to children and families not impacted by developmental delay. For example, while accommodations may be made for visual, auditory and cognitive deficits, the target of intervention must remain to diminish symptom presence, address self-blame, promote adaptive coping and focus on the family system. As far as is known, the current study is the first to specifically measure the association between negative maternal response and developmental delay among children investigated for CSA. These findings strengthen the maternal response body of literature, however, there is a clear need for further research before clinically relevant social work interventions may be designed and implemented for this population.

Although significant in bivariate analysis, domestic violence was not determined to be a significant predictor of negative maternal response in the multivariate analysis of the current study. Given the accumulating empirical evidence, it is reasonable to consider

domestic violence as a potential risk factor. From a research perspective, it should be recognized that domestic violence is also associated with a cluster of other risk factors that explain more of the total variance in the negative response model.

As explained in chapter two, an evolving body of literature on family violence documents the concomitance of CSA and domestic violence. Generalist social work practitioners may wish to adopt screening procedures to identify the presence of domestic violence subsequent to disclosure of CSA similar to that carried out in a child welfare context or a primary health care setting. Caution is warranted, however, as screening could be perceived as a policing approach to intervention. While the priority of CPS is to protect vulnerable children, it is recommended that the social work profession avoid enacting surveillance on non-perpetrating mothers and recognize that they constitute a vulnerable population in their own right.

This dissertation's findings support existing literature related to abuse characteristics and the presence of poor maternal response. Abuse characteristics such as duration of CSA, and relationship to the perpetrator not only compromise the developmental trajectories of victimized children (Beitchman, et al., 1991, Beitchman, et al., 1992), but also contribute to poor maternal response. As previously referenced, the experience of cumulative exposure to trauma reinforces the need for interventions that target PTSD symptomatology among non-perpetrating mothers. Mothers with their own personal CSA history often re-experience trauma symptoms subsequent to their child's CSA disclosure.

Co-occurring maltreatment was found to be associated with eight times the odds of negative maternal response. While emerging research on the effects of co-occurring maltreatment appears to indicate no evidence of heightened emotional harm, this author is not aware of any study that examines the effect of co-occurring abuse on negative maternal response. Continued research on the complex dynamic involved in co-occurring maltreatment is needed prior to the development and implementation of practice strategies that target the effects of this type of abuse.

Analysis of CIS-98 data at the bivariate level revealed that social workers perception of negative maternal response was strongly correlated with emotional harm among children for whom CSA was suspected or substantiated ($p=.01$). As noted throughout, the absence of emotional support, belief and protection has been identified as a risk factor for the onset of psychological sequelae associated with CSA (Elliot & Carnes, 2001) with parent-child attachment the likely intervening variable. Research literature supports the influence of parent-child attachment as a factor contributing to the response pattern of non-offending mothers and the presence of emotional harm among children (Alexander, 1992; Leifer et al., 2002); practice strategies that target parent-child attachment dynamics may therefore ameliorate the emotional harm associated with CSA.

Results of this study confirmed an association between domestic violence and emotional harm among children for whom child sexual abuse was suspected or

substantiated in the CIS-98 ($p=.04$). Throughout this dissertation, empirical evidence corroborating the co-occurrence of CSA and domestic violence was presented (Bowen 2000; Kellogg & Menard, 2003). While associated at the bivariate level, domestic violence failed to predict emotional harm at the multivariate level in CIS-98 analysis. Nonetheless, an association between domestic violence and emotional harm was evident among children for whom sexual abuse was suspected or substantiated. This finding, coupled with the cumulative evidence linking domestic violence and emotional harm warrants screening for the presence of domestic violence at the intake stage of clinical intervention and child welfare investigation.

Research evidence suggests that adolescent CSA reports are more likely to be disbelieved by non-perpetrating mothers when compared with disclosures from preschool or school age children (Heriot, 1996). As previously noted, adolescents may demonstrate avoidant coping and externalizing behaviors in response to CSA disclosure, which may be interpreted as culpability by the non-offending mother (Johnson & Kenkel, 1991; Shapiro & Levendosky, 1999; Spaccarelli, 1994). It is through this dynamic that the investigated child may be blamed for contributing to the abuse and may suffer emotional harm. Analysis of CIS-98 data revealed that adolescence was strongly correlated with emotional harm among investigated children at the bivariate level ($p<.001$) and was the strongest predictor of emotional harm in multivariate analysis ($p<.001$). From a practice perspective, these findings support continued utilization of age appropriate specialized treatment strategies that meet the developmental, cognitive and emotional needs of the victimized child.

Treatment outcome studies

Treatment approaches designed to mitigate the negative effects of CSA may involve individual therapy for victimized children and non-perpetrating mothers, and family intervention or group therapy for children and non-offending caregivers. Intended to ameliorate the experience of isolation among victimized families, group therapy has proven to be effective in addressing the shame and secrecy associated with abuse (Saxe, 1993). Involvement of the non-offending parent in group or individual treatment encourages parents to process the grief and trauma associated with disclosure of abuse. Parental treatment typically involves a psycho-educational component to address the potential symptom presentation of victimized children and strategies for responding to their behavioral reactions (e.g. inappropriate sexualized behavior).

Considered best practice with sexually victimized families, CBT treatment outcome studies have allowed for the development of evidence based intervention strategies of varied lengths and focus to target the diverse needs of victimized children, adolescents and non-perpetrating caregivers (Cohen & Mannarino, 1996a, 1996b; Deblinger, Stauffer & Steer, 2001; Deblinger, Steer, & Lippman, 2001).

Specialized treatment is warranted for preschool children given the significant proportion of CSA cases within this age group (Cohen & Mannarino, 1993). Building on existing practice (see Corcoran, 2004), continued application of cognitively based intervention is essential to address the issues relevant to victimized preschoolers, such as sexualized behavior (Kendall-Tackett et al, 1993), with a focus on parent support and

parenting skill development. Child age influences the interpretation of abuse events and must direct post-abuse treatment approaches. Research findings document that adolescent children and families similarly benefit from cognitively based intervention, often between 8 to 13 weeks in duration (although King et al., 2000 have utilized a 20 session structure), which involves both conjoint parent-child sessions and group intervention.

Barker-Collo and Read (2003) and Cohen, Deblinger and Mannarino (2004) examined the effectiveness of treatment programs that targeted CSA related symptomatology. They found that the psychological sequelae associated with abuse exist within the context of attachment violations and are mitigated by trauma focused CBT which targets symptoms of PTSD as well as feelings of self-blame, interpersonal trust and feelings of safety. Of the 229 sexually abused children interviewed in their multi-site randomized control trial, Cohen and colleagues (2004) discovered that trauma focused CBT was more effective in alleviating symptoms of PTSD, depression, behavior problems, internalization of shame and improving interpersonal trust than was supportive psychotherapy. These findings underscore the importance of attachment with the non-perpetrating mother as a mediator of post-abuse adjustment in child victims. In the absence of a secure attachment bond, the violation of trust inherent to CSA may result in the internalization of blame associated with the experience of abuse and global distrust of others.

This dissertation's research was not intended to develop a model for intervention with families. Rather, this study was intended to develop a more critical understanding of the factors associated with negative maternal response and the experience of emotional harm among children investigated for CSA. Continued development of treatment outcome research should focus on addressing methodological limitations such as small sample size, confounding parent and child treatment, and inclusion of subjects where both incest and extrafamilial abuse has occurred. It would also be beneficial for treatment outcome studies to include non-offending male caregivers and document the demographic profile of study participants to identify the racial and ethnic groups that utilize abuse focused intervention.

Implications for policy development

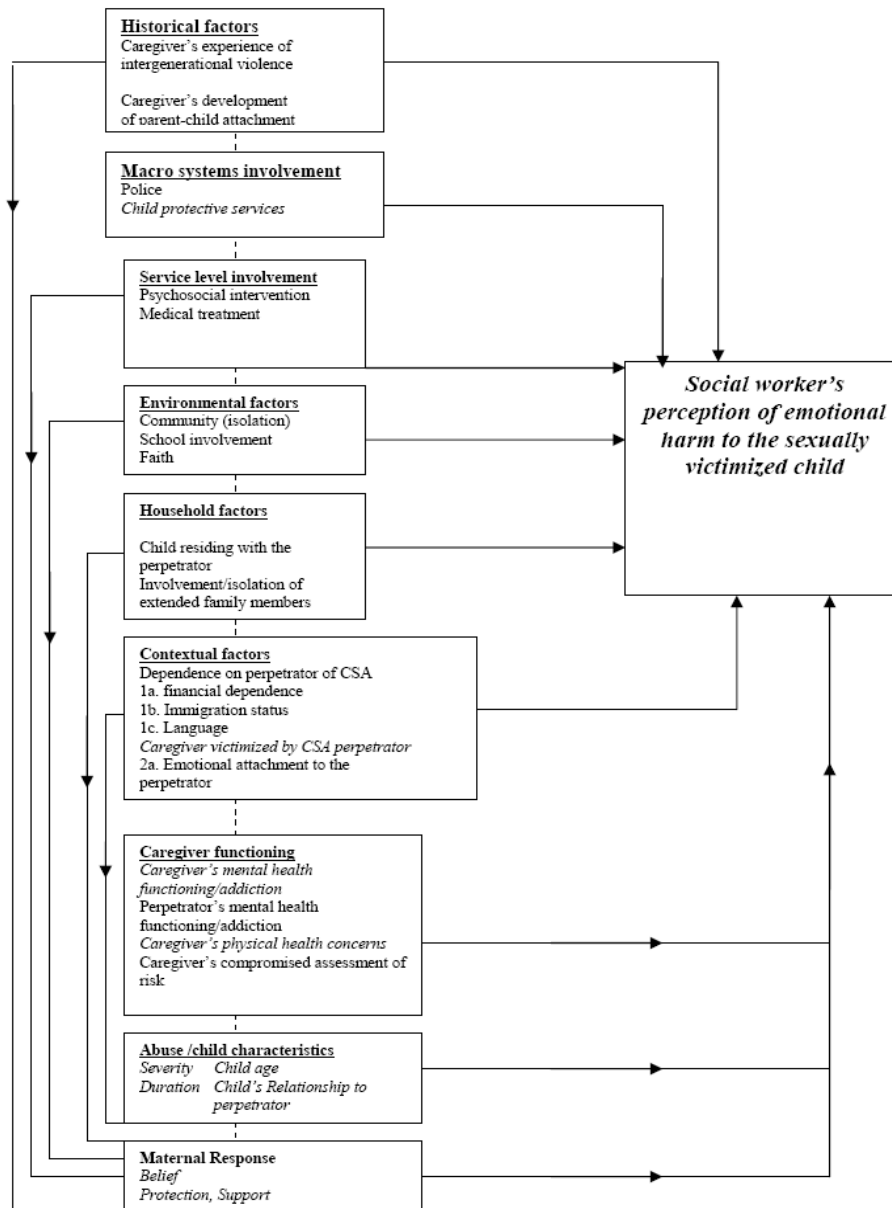
Dissertation analyses sought to address the absence of a theoretically driven maternal response construct in child sexual abuse literature by conducting a thorough analysis of the conceptual factors contributing to the maternal response dynamic. Through systematic examination of several theoretical frameworks and conducting exploratory quantitative analyses, dissertation findings have provided clarity to this construct and promoted critical analyses of the factors that impact the response of non-perpetrating mothers.

Dissertation analyses also afforded the opportunity to explore the association between the factors identified by theory as important to maternal response, some of which have

not previously been examined with empirical data. The figure below identifies the larger macro system influences as well as the caregiver, child, household, abuse and investigation characteristics that potentially contribute to maternal response and depicts the interactive quality of the characteristics.

Only italicized factors were used in analyses

Integrated model of child outcome



While an enhanced understanding of the factors that are associated with maternal response was achieved, this study precluded examination of the nuances of the various

manifestations of maternal response. For example, what psychological sequelae do children experience when exposed to an ambivalent maternal response, and what are the circumstances within which ambivalence occurs? Is the vacillation of non-perpetrating mothers between belief of CSA disclosure and questioning the validity of the CSA claim a product of concomitant domestic violence or the result of insecure adult attachment? How may child protective services incorporate these interpersonal dynamics into their investigatory procedure, or is the negotiation of these dynamics outside the purview of CPS?

Recommending a shift in policy was not an intended outcome of this study, however, a response that transcends the current dichotomous approach to child welfare involvement in cases of child sexual abuse is warranted. The findings of this study bring to the forefront the relevance of the current CPS custom of incorporating a dichotomous positive/negative maternal response distinction into practice decisions. If belief of CSA disclosure and provision of emotional support are evident, but the context precludes protection, is there an alternative approach to child apprehension just as successful in abating risk or is there exclusive dependence on conventional practice which may involve the surveillance of women in the enforcement of failure to supervise dispositions?

It may be anticipated that greater focus on the practice of CPS and its related investigatory procedures, would result in a better refined and increasingly relevant maternal response construct and accompanying practice. Given the gaps in research

related to maternal response, the scope of a potential shift in policy remains undetermined. A potential change in CPS investigatory procedure involving a more relevant child welfare response to sexually victimized children and non-perpetrating mothers is contingent upon evidence based data.

Broadening the knowledge base around the dynamics of maternal response is critical for the establishment of clinically appropriate social work engagement. However, a solitary focus on the non-offending mother may reinforce the perception of women as collusive agents in the victimization of children. The role of helping professionals should be to promote a shift in clinical and child welfare practice that recognizes the complex interplay of mothers' experience of cumulative trauma as a factor in her response to CSA. In light of this, a renewed focus on the perpetrators of violence is clearly warranted.

Directions for Future Research

This section will consider the utility of supplementary investigation examining maternal ambivalence, in addition to CPS apprehension, developmental delay and domestic violence within the context of negative maternal response. The limits of the current study prevented the exploration of maternal ambivalence, while the subsequent factors elicited findings that incite further empirical investigation.

Maternal Ambivalence

“Many mothers who exhibit an ambivalent response are nonetheless able to take actions to protect their children” (Elliot & Carnes, 2001 p.316). In the study by Lyon and Kouloumpos-Lenares (1987), close to one-half of the mothers in their sample provided their children with active support, while another 26% provided protection but demonstrated some form of ambivalence (e.g. denying the child needed treatment).

Maternal ambivalence subsequent to CSA disclosure is a concept that demands empirical investigation in light of findings that vary dramatically between negative and positive support. As noted in chapter two, an ambivalent response is one which vacillates between belief of a CSA disclosure and questioning the validity of a claim of child sexual abuse. Maternal response has historically been articulated as a dichotomous process involving either a positive or negative response from a non-perpetrating caregiver, however, recognizing the fluctuating responses; researchers have now begun to investigate the concept of ambivalence.

This topic gained greater relevance given the increased scrutiny of child welfare decision making and the role ambivalence plays in contributing to the apprehension of sexually abused children. As previously noted, the absence of belief, support and protection may warrant apprehension subsequent to CSA investigation. Consequently, conceptualization of maternal response has the potential to impact child protection policy and direct its practice.

Bolen and Lamb (2004) concluded that over one-third of non-perpetrating mothers in their study exhibited an ambivalent response immediately after disclosure of CSA (31% ambivalent). Pintello and Zuravin (2001) similarly reported that almost one-third of their random sample of 437 non-perpetrating mothers demonstrated an ambivalent response to CSA disclosure (27.3% ambivalent).

This investigation was unable to examine the impact of maternal ambivalence as defined above, “a response which vacillates between belief of a CSA disclosure and questioning the validity of the CSA claim.” The measure of maternal response utilized in the current study determined whether the non-perpetrating mother believed the CSA claim, but did not protect her child, or whether the mother believed the CSA claim but did not provide emotional support.

Objectives for further ambivalence research include the following:

- a) Identify whether an ambivalent response is associated with emotional harm among children for whom sexual abuse is investigated. The current study examined the impact of negative maternal response and its effects on emotional harm, but was unable to measure the influence of maternal ambivalence in relation to emotional harm.
- b) Delineate the role of parent-child attachment as a potential factor contributing to maternal ambivalence. In 1994, Spaccarelli examined the interaction between coping style and attachment among sexually victimized children; Alexander (1992) measured

the attachment behaviors present among victimized girls; and Leifer, Kilbane, and Skolnick (2002) examined adult attachment and maternal support. However, no study could be identified that assesses maternal ambivalence as a function of parent-child attachment. Future research is required to more precisely measure whether insecure parent-child attachment contributes to maternal ambivalence.

- c) Examine the role domestic violence plays in maternal ambivalence. While a link has been established between CSA and the presence of domestic violence (Alaggia & Turton, 2005; Kellogg & Menard, 2003) there is dearth of knowledge about the nature of ambivalent responses within the context of domestic violence. Pintello and Zuravin (2001) found that mothers who remain in an intimate relationship with the perpetrator are less likely to ensure protection for their victimized child compared with mothers who terminate an abusive relationship. While the cited research is helpful in guiding future analyses, there is a need for a more robust understanding of the dynamics that produce ambivalent responses. For example, do non-perpetrating mothers believe disclosures of CSA but not protect their children due to the threat of violence, and how might this dynamic be addressed from a treatment perspective? What influence does co-occurring maltreatment play in the dynamic of maternal ambivalence?

As previously reported, small sample size prevented the measurement of maternal ambivalence. Answers to each of the maternal response items in the CIS-98 dataset were collapsed to establish a single dichotomous negative maternal response variable (see chapter 3 for further detail on this derived variable). A maternal response variable

with a positive, negative and ambivalent maternal outcome would have facilitated further clarification of this complex construct.

Child apprehension in the context of negative maternal response

Given that the results of this dissertation's analyses indicated that only a small minority of non-offending mothers exhibited poor maternal response, further research should explore the utility of conventional child welfare practice that dichotomizes positive and negative maternal response potentially resulting in child apprehension. In examining the rate of apprehension among families for whom negative maternal response is detected subsequent analyses should clarify whether apprehension in cases of CSA is due to negative maternal response, or a result of the constellation of risk factors often present among families for whom suspected or substantiated CSA is determined.

Developmental Disability

Results of this dissertation's analyses indicated that the variable developmental delay maintained statistical significance in the final block of the maternal response regression equation. As indicated earlier, the presence of developmental delay among investigated children may contribute to negative maternal response through perceptions of the child's level of capacity and likelihood of a fallible report. Although dissertation research established a strong association between developmental delay in investigated children and negative maternal response, the gap in literature precludes comparison

with current findings. A substantial body of evidence exists linking developmental delay with risk of child maltreatment; however, no study specifically examines the correlation between disability and negative maternal response among children investigated for child sexual abuse. These preliminary findings merit further investigation and it is hoped that the current study may stimulate subsequent analyses.

Domestic violence

Results of this dissertation's analyses failed to yield a significant association between domestic violence and negative maternal response and emotional harm in the multivariate models. As previously indicated, there is considerable variability in CSA literature with respect to the documented co-occurrence of domestic violence and child sexual abuse. Supplementary analyses should ensure a multivariate model not encumbered by methodological limitations in order to accurately determine the association of these two factors.

Conclusions

This dissertation's findings were inconsistent with existing maternal response research, (see maternal response review by Elliot & Carnes, 2001) as only a small proportion of non-offending mothers (12.9%) demonstrated negative maternal response. In addition, poor maternal response was not significantly associated with emotional harm in the final regression model.

Dissertation analyses examined the maternal response construct with the expressed goal of developing a more balanced understanding of the experience of non-offending mothers and to ameliorate the perceptions of mothers as collusive agents while also promoting relevant intervention for families affected by CSA. Further empirical investigation should examine the characteristics of resilient children and avoid focusing solely on the minority of children for whom a symptomatic response to child sexual abuse is evident.

In summary, the vast majority of non-perpetrating mothers of children investigated for sexual abuse in the CIS-98 were emotionally supportive, protective and believed the CSA disclosure. Even in situations where non-offending mothers were found to have demonstrated negative maternal response, there were not any dramatic, visible effects with respect to the investigated children. Despite this, substantial emphasis in social work literature and practice is directed towards identifying negative maternal response and examining the detrimental impact of poor maternal response on sexually victimized children. One may have expected that even with a small sample size and crude measures utilized, maternal response may have been more evidently associated with noted emotional problems. Instead, poor maternal response and emotional problems are not the most striking features among families investigated for child sexual abuse in the CIS-98. Notwithstanding the limitations of this dissertation's analyses, negative maternal response was not a critical factor in the emotional wellness of sexually victimized children.

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CIS Maltreatment Assessment: Household Information

CIS Office Use Only:
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<p>1. Caregiver A: <input type="radio"/> Biological Parent <input type="radio"/> Foster Parent <input type="radio"/> Common-Law Partner <input type="radio"/> Adoptive Parent <input type="radio"/> Step-parent <input type="radio"/> Grandparent <input type="radio"/> Other (Specify): _____</p> <p>Age: <input type="radio"/> <16 <input type="radio"/> 16-18 <input type="radio"/> 19-21 <input type="radio"/> 22-25 <input type="radio"/> 26-30 <input type="radio"/> 31-40 <input type="radio"/> 41-50 <input type="radio"/> 51-60 <input type="radio"/> 61-70 <input type="radio"/> >70</p> <p>Gender: <input type="radio"/> Male <input type="radio"/> Female</p> <p>2. Primary Income Source: (Fill in only one) <input type="radio"/> Full Time <input type="radio"/> Seasonal <input type="radio"/> Other Benefits <input type="radio"/> Part Time <30 hrs <input type="radio"/> Unemployment <input type="radio"/> Unknown <input type="radio"/> Multiple Jobs <input type="radio"/> Social Assistance <input type="radio"/> None</p> <p>3. Educational Level: <input type="radio"/> Elementary or less <input type="radio"/> College/University <input type="radio"/> Secondary or less <input type="radio"/> Unknown</p> <p>4. Ethno-Racial Group: Based on Statistics Canada 1996 Census <input type="radio"/> White <input type="radio"/> Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan) <input type="radio"/> Aboriginal <input type="radio"/> South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan) <input type="radio"/> Chinese <input type="radio"/> Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese) <input type="radio"/> Latin American <input type="radio"/> Black (e.g. African, Haitian, Jamaican) <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Other: _____</p> <p>If Aboriginal, please check all that apply: <input type="radio"/> On Reservation <input type="radio"/> Non-Status <input type="radio"/> Métis <input type="radio"/> Inuit <input type="radio"/> Off Reservation <input type="radio"/> Status <input type="radio"/> Other: _____</p> <p>Primary Language: <input type="radio"/> English <input type="radio"/> French <input type="radio"/> Other: _____</p>	<p>1. Caregiver B: <input type="radio"/> No Other Caregiver <input type="radio"/> Caregiver in Home <input type="radio"/> Other Adult (not in household)</p> <p><input type="radio"/> Biological Parent <input type="radio"/> Foster Parent <input type="radio"/> Common-Law Partner <input type="radio"/> Adoptive Parent <input type="radio"/> Step-parent <input type="radio"/> Grandparent <input type="radio"/> Other (Specify): _____</p> <p>Age: <input type="radio"/> <16 <input type="radio"/> 16-18 <input type="radio"/> 19-21 <input type="radio"/> 22-25 <input type="radio"/> 26-30 <input type="radio"/> 31-40 <input type="radio"/> 41-50 <input type="radio"/> 51-60 <input type="radio"/> 61-70 <input type="radio"/> >70</p> <p>Gender: <input type="radio"/> Male <input type="radio"/> Female</p> <p>2. Primary Income Source: (Fill in only one) <input type="radio"/> Full Time <input type="radio"/> Seasonal <input type="radio"/> Other Benefits <input type="radio"/> Part Time <30 hrs <input type="radio"/> Unemployment <input type="radio"/> Unknown <input type="radio"/> Multiple Jobs <input type="radio"/> Social Assistance <input type="radio"/> None</p> <p>3. Educational Level: <input type="radio"/> Elementary or less <input type="radio"/> College/University <input type="radio"/> Secondary or less <input type="radio"/> Unknown</p> <p>4. Ethno-Racial Group: Based on Statistics Canada 1996 Census <input type="radio"/> White <input type="radio"/> Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan) <input type="radio"/> Aboriginal <input type="radio"/> South Asian (e.g. East Indian, Pakistani, Punjabi, Sri Lankan) <input type="radio"/> Chinese <input type="radio"/> Southeast Asian (e.g. Cambodian, Indonesian, Laotian, Vietnamese) <input type="radio"/> Latin American <input type="radio"/> Black (e.g. African, Haitian, Jamaican) <input type="radio"/> Filipino <input type="radio"/> Japanese <input type="radio"/> Korean <input type="radio"/> Other: _____</p> <p>If Aboriginal, please check all that apply: <input type="radio"/> On Reservation <input type="radio"/> Non-Status <input type="radio"/> Métis <input type="radio"/> Inuit <input type="radio"/> Off Reservation <input type="radio"/> Status <input type="radio"/> Other: _____</p> <p>Primary Language: <input type="radio"/> English <input type="radio"/> French <input type="radio"/> Other: _____</p>																																				
<p>5. Contact with Caregiver: <input type="radio"/> Co-operative <input type="radio"/> Not co-operative <input type="radio"/> Not contacted</p> <p>6. Was Caregiver maltreated as a child? <input type="radio"/> Confirmed <input type="radio"/> Suspected <input type="radio"/> No/Unknown Is Caregiver in a violent relationship? <input type="radio"/> Confirmed <input type="radio"/> Suspected <input type="radio"/> No/Unknown Was this Caregiver the: <input type="radio"/> Victim <input type="radio"/> Perpetrator</p>	<p>5. Contact with Caregiver: <input type="radio"/> Co-operative <input type="radio"/> Not co-operative <input type="radio"/> Not contacted</p> <p>6. Was Caregiver maltreated as a child? <input type="radio"/> Confirmed <input type="radio"/> Suspected <input type="radio"/> No/Unknown Is Caregiver in a violent relationship? <input type="radio"/> Confirmed <input type="radio"/> Suspected <input type="radio"/> No/Unknown Was this Caregiver the: <input type="radio"/> Victim <input type="radio"/> Perpetrator</p>																																				
<p>7. Other adults in the home: <input type="radio"/> None <input type="radio"/> Grandparent <input type="radio"/> Children > 19 yrs <input type="radio"/> Other Relative <input type="radio"/> Boy/Girl-friend <input type="radio"/> Boarder <input type="radio"/> Other: _____</p> <p>a) Are you aware of a Caregiver outside of the home involved with any of the children? <input type="radio"/> None <input type="radio"/> Mother <input type="radio"/> Father <input type="radio"/> Other: _____</p> <p>b) Is there an ongoing child custody dispute at this time? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p>																																					
<p>8. Family Income Estimate: <input type="radio"/> < \$15,000 <input type="radio"/> \$15-24,999 <input type="radio"/> \$25-40,999 <input type="radio"/> \$41-57,999 <input type="radio"/> \$58-80,000 <input type="radio"/> > \$80,000 <input type="radio"/> Unknown</p>																																					
<p>9. Housing Accommodations: <input type="radio"/> Public Housing <input type="radio"/> Rental Apartment <input type="radio"/> Rental Townhouse <input type="radio"/> Rental House <input type="radio"/> Purchased Home <input type="radio"/> Shelter/Hotel <input type="radio"/> Unknown <input type="radio"/> Other: _____</p> <p>Unsafe housing conditions? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p> <p>Does family share a home? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p> <p>Approximate number of moves in past 6 months? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 or more <input type="radio"/> Unknown</p>																																					
<p>10. Caregiver Functioning (Do any of the following apply to Caregivers in this household?) <input type="radio"/> No caregiver concerns for the household</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"></td> <td style="width:10%; text-align: center;">Confirmed</td> <td style="width:10%; text-align: center;">Suspected</td> <td style="width:25%;"></td> <td style="width:10%; text-align: center;">Confirmed</td> <td style="width:10%; text-align: center;">Suspected</td> </tr> <tr> <td>Alcohol Abuse</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Cognitive Impairment</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Drug Abuse</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Mental Health Issues</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td>Criminal Activity</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> <td>Physical Health Issues</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Few Social Supports</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td>Other: _____</td> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>			Confirmed	Suspected		Confirmed	Suspected	Alcohol Abuse	<input type="radio"/>	<input type="radio"/>	Cognitive Impairment	<input type="radio"/>	<input type="radio"/>	Drug Abuse	<input type="radio"/>	<input type="radio"/>	Mental Health Issues	<input type="radio"/>	<input type="radio"/>	Criminal Activity	<input type="radio"/>	<input type="radio"/>	Physical Health Issues	<input type="radio"/>	<input type="radio"/>				Few Social Supports	<input type="radio"/>	<input type="radio"/>				Other: _____	<input type="radio"/>	<input type="radio"/>
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			Few Social Supports	<input type="radio"/>	<input type="radio"/>																																
			Other: _____	<input type="radio"/>	<input type="radio"/>																																
<p>11. Case Status: a) Was this case previously open? <input type="radio"/> Never <input type="radio"/> 1 time <input type="radio"/> 2-3 times <input type="radio"/> > 3 times <input type="radio"/> Unknown b) If case was previously open, how long was it closed before current opening? <input type="radio"/> < 3 mo <input type="radio"/> 3-6 mo <input type="radio"/> 7-12 mo <input type="radio"/> 13-24 mo <input type="radio"/> >24 mo c) Will case stay open for ongoing child welfare services? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Other: _____</p>																																					
<p>12. Referral(s) for any family member: (Fill in all that apply) <input type="radio"/> No referral made</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;"><input type="radio"/> Family Preservation/Reunification</td> <td style="width:25%;"><input type="radio"/> Welfare/Social Assistance</td> <td style="width:25%;"><input type="radio"/> Psychiatric/Psychological Services</td> <td style="width:25%;"><input type="radio"/> Victim Support Program</td> </tr> <tr> <td><input type="radio"/> Parent Support Program</td> <td><input type="radio"/> Food Bank</td> <td><input type="radio"/> Special Education Placement</td> <td><input type="radio"/> Medical/Dental Services</td> </tr> <tr> <td><input type="radio"/> Other Family/Parent Counseling</td> <td><input type="radio"/> Shelter Services</td> <td><input type="radio"/> Recreational Services</td> <td><input type="radio"/> Other Child Counseling</td> </tr> <tr> <td><input type="radio"/> Drug/Alcohol Counseling</td> <td><input type="radio"/> Domestic Violence Counseling</td> <td colspan="2"><input type="radio"/> Other Child/Family Referral: _____</td> </tr> </table>		<input type="radio"/> Family Preservation/Reunification	<input type="radio"/> Welfare/Social Assistance	<input type="radio"/> Psychiatric/Psychological Services	<input type="radio"/> Victim Support Program	<input type="radio"/> Parent Support Program	<input type="radio"/> Food Bank	<input type="radio"/> Special Education Placement	<input type="radio"/> Medical/Dental Services	<input type="radio"/> Other Family/Parent Counseling	<input type="radio"/> Shelter Services	<input type="radio"/> Recreational Services	<input type="radio"/> Other Child Counseling	<input type="radio"/> Drug/Alcohol Counseling	<input type="radio"/> Domestic Violence Counseling	<input type="radio"/> Other Child/Family Referral: _____																					
<input type="radio"/> Family Preservation/Reunification	<input type="radio"/> Welfare/Social Assistance	<input type="radio"/> Psychiatric/Psychological Services	<input type="radio"/> Victim Support Program																																		
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CIS Maltreatment Assessment: Child

First Name: _____ Male Female Age:

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13. Child Functioning: (Are you aware if any of the following apply to this child at this point in time?) No child functioning issues at this time

	Confirmed	Suspected		Confirmed	Suspected
Developmental Delay	<input type="radio"/>	<input type="radio"/>	Running (One incident)	<input type="radio"/>	<input type="radio"/>
Physical/Developmental Disability	<input type="radio"/>	<input type="radio"/>	Running (Multiple incidents)	<input type="radio"/>	<input type="radio"/>
Other Health Condition	<input type="radio"/>	<input type="radio"/>	Involvement in Prostitution	<input type="radio"/>	<input type="radio"/>
Substance Abuse Related Birth Defects	<input type="radio"/>	<input type="radio"/>	Age-inappropriate Sexual Behaviour	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>	Psychiatric Disorder	<input type="radio"/>	<input type="radio"/>
Self-harming Behaviour	<input type="radio"/>	<input type="radio"/>	Criminal/YOA Involvement	<input type="radio"/>	<input type="radio"/>
Negative Peer Involvement	<input type="radio"/>	<input type="radio"/>	Special Education Class	<input type="radio"/>	<input type="radio"/>
Substance Abuse	<input type="radio"/>	<input type="radio"/>	Irregular School Attendance	<input type="radio"/>	<input type="radio"/>
Behaviour Problem (Home/Community)	<input type="radio"/>	<input type="radio"/>	Other (Specify): _____	<input type="radio"/>	<input type="radio"/>
Violence Towards Others	<input type="radio"/>	<input type="radio"/>			

14. Maltreatment Codes: (Enter primary form of maltreatment first)

Physical Abuse	(1) Shaken Baby Syndrome (2) Inappropriate Punishment (3) Other Physical Abuse
Sexual Abuse	(4) Sexual Activity Completed (5) Sexual Activity Attempted (6) Touching/Fondling Genitals (7) Exposure of Genitals (8) Exploitation: Pornography/Prostitution (9) Sexual Harassment (10) Voyeurism
Neglect: (Failure to Provide)	(11) Failure to Supervise/Protect (12) Failure to Supervise/Protect: Sexual (13) Physical Neglect (14) Medical Neglect (15) Failure to Provide Treatment: Psych. (16) Maladaptive Behaviour (17) Abandonment (18) Educational Neglect
Emotional Maltreatment	(19) Emotional Abuse (20) Non-organic Failure to Thrive (21) Emotional Neglect (22) Exposed to Family Violence
Other Abuse	(23) Other: _____

CIS Office Use Only:

15. Alleged Perpetrator: (Fill in all those that apply)

	1st	2nd	3rd
Mother (biological)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father (biological)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stepfather/Common-law	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stepmother/Common-law	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sibling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stranger	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

CIS Office Use Only:

16. Substantiation: (Fill in only one per column)

	1st	2nd	3rd
Unfounded	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suspected: Insufficient Evidence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Substantiated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If unfounded, was report a malicious referral?
 Yes No Unknown

17. Duration of Maltreatment: (Fill in only one per column)

	1st	2nd	3rd
Not Applicable (Maltreatment Unfounded)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Single Incident	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Less than Six Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
More than Six Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Describe harm suspected or known to be caused by investigated maltreatment.

18. Physical Harm: (Fill in all that apply)

No Harm Bruises/Cuts/Scrapes Burns and Scalds
 Broken Bones Head Trauma Fatal
 Other Health Condition: _____

a) Medical treatment required for injury. Yes No
 b) Health or safety seriously endangered by suspected or substantiated maltreatment. Yes No
 c) History of undetected or misdiagnosed injuries. Yes No

19. Mental or Emotional Harm:

a) Child exhibits signs of mental or emotional harm. Yes No
 b) Exhibited harm requires therapeutic treatment. Yes No
 c) If maltreatment suspected/substantiated, is it probable that the child's mental or emotional health or capabilities have been significantly impaired? Yes No

20. Out of Home Placement: (Fill in only one)

No Placement Required Foster Placement
 Placement to be Considered Group Home Placement
 Informal Placement Residential/Secure Treatment

If this sheet is for an additional child, check here to indicate Sections 21 to 25 are the same as for the 1st child recorded in the family.

21. Child Welfare Court:
 Application Made Application Considered No Court Considered

22. Previous Reports to Child Welfare: (For this child)
 Was child previously reported to Child Welfare for suspected maltreatment? Yes No Unknown

23. Criminal Court: (Regarding the child maltreatment)
 Was there a Police Investigation? Yes No
 If yes, were criminal charges: Laid Considered Not Laid

24. Alleged Perpetrator Description: (If not, caregiver A or B)

Age: < 12 13-15 16-20 21-30
 31-40 41-50 51-60 > 60

Gender: Male Female

25. Response to Sexual Abuse:

a) Non-offending caregiver(s) believes the child. Yes No Unknown
 b) Caregiver(s) provide emotional support. Yes No Unknown
 c) Caregiver(s) protect child from further incidents of sexual abuse. Yes No Unknown
 d) Alleged perpetrator is a known offender. Yes No Unknown
 e) Did he/she live in same home as child? Yes No Unknown
 f) Is he/she still living in same home as child? Yes No Unknown



