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Bridging the Gap: Understanding non-offending parental responses to their children's sexual abuse.

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CERTIFICATE OF APPROVAL

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This is to certify that the Clinical Research Project of

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has been approved by the
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Abstract

The parental response to children's disclosure of childhood sexual abuse (CSA) is the most critical and important factor regarding the child's post trauma trajectory and overall trauma resolution. Understanding parental responses and the factors that prompt acceptance versus disbelief among the non-offending parent (NOP) is vital to children's success following disclosure given the weight of the NOPs response and its impact on long-term consequences of CSA. This literature review provides a comprehensive summary of what may deter the NOP from recognizing intrafamilial sexual abuse, factors that may contribute to the NOPs disbelief following disclosure, and possible clinical implications of such information. It was found that there may be several deterrents regarding recognizing CSA such as the child's presentation during periods of abuse, the perpetrator's grooming techniques, socioeconomic factors, and the presence of maladaptive coping skills among the NOP. Further, several possible factors that contribute to the NOPs disbelief following the child's disclosure were identified such as the NOPs relationship with the perpetrator, the NOP-child relationship, the NOPs mental health and degree of functioning, and the child's decision not to disclose.

Keywords: Childhood sexual abuse, non-offending parent, intrafamilial sexual abuse, disclosure, and maternal belief.

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Chapter I: Introduction

Childhood sexual abuse is a complex, multilayered form of trauma, which often prompts significant distress upon its victims. While children are viewed as innocent beings in need of adult care and protection, they continue to be abused, neglected, and violated at alarmingly high rates (Finkelhor, Shattuck, Turner, & Hamby, 2014; Stoltenborgh, van Ijzendorn, Euser, & Bakermans-Kranenburg, 2011). In order to strengthen protective factors among the youth of our country, society must develop safe-guards and deterrents for such abuse and victimization; however, until such acts are extinguished, bridging the gap between survivors of childhood sexual assault and their non-offending parent is vital.

Importance of bridging the gap. Quite often the offender of a child who experienced sexual abuse is the child's stepfather, the mother's partner, or other similar trusted male relative (van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2016; U.S. Department of Health and Human Services, 2012). Unlike physical accidents or medical illnesses, intrafamilial sexual assaults typically include an additional layer of betrayal or immorality, which requires a more complex approach to treatment (Freyd, 1996). Russell (1995) discussed the life story of Lara Newman who reported on-going childhood sexual abuse by her maternal grandfather and the lifelong effect of such experiences. During her interview, Lara indicated, "I hate my mother…I still believe she must have known about it…I don't know what I hate her more for – her stupidity or her naiveté" (pp. 85). Lara reported feelings of abandonment and worthlessness due her mother not recognizing that she was being abused by a close member of the family. Additionally, she indicated further resentment given that it was her mother's father that inflicted the trauma

(Russell, 1995). Understandably, such thoughts and affect prompt significant distress among sexual abused children, further distress the parent-child relationship, and jeopardize attachment during a period in which the relationship is of heightened importance. If left unaddressed, childhood sexual abuse (CSA) may lead to dysregulation of affect and behavior, disturbances of attention, interpersonal difficulties, and health risks in adulthood such as substance abuse, suicide attempts, or maladaptive behaviors that prompt physical illnesses (Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Felitti, et al., 1998; Hernandez et al, 2009). Furthermore, individuals who experience CSA are more prone to exhibit traits of post-traumatic stress and borderline personality disorders as well as experience long-term, maladaptive attachment styles, which exacerbates interpersonal deficits (Karakurt & Silver, 2014; van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2016).

Prior research results indicate that sexually abused girls who perceived higher levels of maternal acceptance and protection following disclosure had higher competency ratings and fewer behavioral problems as compared with victims who perceived higher levels of maternal rejection (Lovett, 1995; van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2016). As such, it is reasonable to conclude that it is necessary to explore all avenues that may aid in the strengthening of the parent-child relationship following disclosure, such as establishing a thorough understanding of what deters non-offending parents from recognizing that their child is being sexually abused. Children may view their parents as objects that are capable and willing to protect them from a variety of threats, particularly due to their affection and unconditional love for the child. However, for those children who experience intrafamilial sexual abuse, particularly when the offender is in a significant relationship with the family or non-offending parent, they may experience doubt regarding the non-offending parent's willingness or desire to intervene.

As such, psychotherapists must comprehend and provide psychoeducation in order to indicate how a parent may have not become aware of such transgressions, which requires substantial research and literature regarding the topic.

Childhood sexual abuse generally includes any sexual act between an adult and a minor, or between two minors, when one exerts power over the other (Townsend & Rheingold, 2013; Hernandez et al, 2009; Barker & Hodes, 2004). Forcing, coercing or persuading a child to engage in any type of sexual act is also considered abuse (Townsend & Rheingold, 2013; Barker & Hodes, 2004; WHO, n.d.). It should be noted that non-contact acts such as exhibitionism, exposure to pornography, voyeurism, and communicating in a sexual or provocative manner are also forms of sexual abuse (Townsend & Rheingold, 2013; Yancey & Hansen, 2010; Barker & Hodes, 2004); however, the definition of child sexual abuse will vary, both legally and in research.

Prevalence of childhood sexual abuse. Childhood sexual abuse is likely the most prevalent health problem among children, and also results in the most extensive array of consequences including long-term mental health issues (Townsend & Rheingold, 2013; Finkel, 2012; Yancey & Hansen, 2010; Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Hernandez et al, 2009). Approximately 30 to 40% of girls and 10% of boys will experience sexual abuse, involving physical sexual contact, prior to the age of 18 (Townsend & Rheingold, 2013; Finkel, 2012; Knott & Fabre, 2014; Hebert, Tourigny, Cyr, McDuff, & Joly, 2009; Yancey & Hansen, 2010; Finkelhor, Shattuck, Turner, & Hamby, 2014; Stoltenborgh, van Ijzendorn, Euser, & Bakermans-Kranenburg, 2011). Nearly 70% of all reported sexual assaults, including assaults that occur toward adults, occur to children aged 17 or under (Tebbutt, Swanston, Oates, & O'Toole, 1997). Further, 44% of rapes involving penetration occur to children under the age

of 18 and victims under the age of 12 account for 15% of those raped. Additionally, another 29% of rape victims are between 12 and 17 (Crimes against Children Research Center, 2002; Greenfield, 1997; Hernandez et al, 2009). Approximately 65 to 75% of children who experience sexual abuse also experience at least one additional form of mistreatment (Hebert, Langevin, & Oussaid, 2008; Felitti, et al., 1998) and one out of five were reported to experience *three* different types of mistreatment such as neglect, emotional abuse, exposure to violence, or exposure to drug use (Hebert, Langevin, & Oussaid, 2008; Felitti, et al., 1998; Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012).

Intrafamilial sexual abuse. Intrafamilial sexual abuse refers to child abuse that occurs between a child and a family member or member of the household (The National Child Traumatic Stress Network, 2009; Pintello & Zuravin, 2001). The family member may engage or expose the child to a sexual act. It should be noted that the term 'family members' is not confined to blood relatives as individuals who are considered a part of the family such as godparents or step-parents are included in this category. Nearly 50% of children who experience childhood sexual abuse are abused by an individual within the family unit (van Toledo & Seymour, 2013; The National Child Traumatic Stress Network, 2009; Finkelhor, 2012; Whealin, 2007). However, an estimated 90% of sexually victimized children know their abuser regardless of whether the perpetrator is a relative or an adult trusted by the family (van Toledo & Seymour, 2013; The National Child Traumatic Stress Network, 2009; Finkelhor, 2012; Whealin, 2007; Lalor & McElvaney, 2010).

Stigma of the NOP. The term 'non-offending parent' (NOP) refers to the parent or guardian who was not involved in the sexual assault of the child. Most commonly, the NOP refers to the mother of a child who was sexually assaulted by the other caregiver such as a father,

stepfather, or grandparent who actively participates in the upbringing of the child. Due to the significant levels or quantity of intrafamilial childhood sexual trauma, negative stigma developed regarding the NOP of the child experiencing such acts (Hooper, 1992; Hebert, Langevin, & Oussaid, 2008; Hooper & Humphrey, 1998; Toews, Cummings, & Zagrodney, 2016). Negative stigma, or 'mother-blaming,' pertains to an inability to accept that the NOP could remain unaware of the abuse and therefore must have known and ignored vital warning signs (Herbert, Langevin, & Oussaid, 2008; Hooper & Humphrey, 1998; Toews, Cummings, & Zagrodney, 2016). Prior literature regarding childhood sexual abuse notes negative views regarding the NOP such as an ideology that the NOP is indifferent or passive regarding the sexual abuse (Hooper, 1992; Tavkar, 2010). Furthermore, NOPs, mothers specifically, were subjected to beliefs that they were indirectly responsible for the abuse by parentifying the daughter or colluding with their spouse (Hooper, 1992; Tavkar, 2010).

Dispelling mother-blaming and the NOPs current mental state. Current literature has begun to dispel the erroneous belief that NOPs are to blame for the sexual trauma in which their children survived (Toews, Cummings, & Zagrodney, 2016; Thompson, 2017; Cromer & Goldsmith, 2010). A significant portion of such literature discussed the NOPs' mental state during the times in which their children are being abused (Collin-Vezina, Cyr, Pauze & McDuff, 2005; Deblinger, Hathaway, Lippmann, & Steer, 1993; Hernandez et al, 2009; Hooper & Humphrey, 1998). For example, NOPs are often physically and emotionally distressed due to socioeconomic stressors, their own personal experiences with trauma, or lack of social and familial support (van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2016; Chemtob & Carlson, 2004). Understanding that many NOPs of children who experience intrafamilial sexual abuse are also experiencing domestic violence and mental health issues themselves, or have a

significant history of abuse, prompted the theory that non-offending parents may experience maladaptive defense mechanisms, which may deter them from recognizing their child's abuse (Collin-Vezina, Cyr, Pauze & McDuff, 2005; Deblinger, Hathaway, Lippmann, & Steer, 1993; Hernandez et al, 2009; Hooper & Humphrey, 1998). For example, a mother who experienced intrafamilial sexual abuse as a child is more likely to be experiencing adult depression and health concerns (van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2016; Chemtob & Carlson, 2004), which may be deterring her from recognizing distress or warning signs among her child as her cognitive resources are significantly taxed by her own mental health symptoms. Furthermore, the same mother may have employed maladaptive coping skills, such as dissociation, during her own abuse and therefore is more likely to also dissociate during times of high stress during adulthood such as the presence of abuse toward her child within her home, particularly if such abuse is occurring by her spouse. Given the presence of such deterrents, children may build an understanding of what stopped their caregiver from recognizing and ending the abuse, which may be the initial step to repairing the NOP-child relationship following disclosure of CSA.

Betrayal theory. Another important aspect to consider and understand prior to further exploring the NOPs inability to recognize their child's abuse is the betrayal trauma theory, which applies to both the child victim and the NOP and may prompt the use of maladaptive coping skills that ultimately deter the NOPs' conscious awareness of CSA. Betrayal trauma theory (BTT) proposes that the way in which traumatic events are processed and stored in memory is directly related to the degree in which the negative event represents a betrayal by a trusted individual (Freyd, 1994, 1996, 1999; DePrince et al., 2012; Martin, Cromer, DePrince & Freyd, 2013). BTT argues that one fairly common effect of child sexual abuse, particularly the more it involves betrayal trauma, is some extent of forgetting or the isolation of specific knowledge

regarding the event (Freyd, 1994, 1996, 1999).Various levels of betrayal have been identified as trauma-related factors that best predict negative mental health outcomes (Martin, Cromer, DePrince & Freyd, 2013). For example, higher levels of betrayal are directly associated with increasingly negative mental health outcomes. It has also been noted that intrafamilial or interpersonal traumas are associated with greater negative psychological outcomes when compared to extrafamilial traumas (Martin, Cromer, DePrince & Freyd, 2013). In other words, intrafamilial abuse appears to have a higher degree of betrayal, which prompts more significant maladaptive psychological outcomes.

Research Questions for future Literature Review:

- What prevents non-offending parents from recognizing their child is being sexually abused?
- What deters the non-offending parent from accepting their child's disclosure regarding sexual abuse?
- Clinical Implications - How would such information impact the parent-child relationship following disclosure? In other words, could such information aid in the resolution of betrayal by increasing the child or adult survivor of CSA's comprehension regarding his or her mother's perceived lack of protection or subsequent negative reaction?

Hypotheses:

- Non-offending parents of children who experienced CSA experience symptoms related to traumatic dissociative amnesia as well as other mental health or socioeconomic difficulties that deters them from recognizing their child's abuse.

- Non-offending parents of children who endure sexual abuse also experience symptoms that are common to trauma survivors such as lowered self-esteem, depression, and anxiety, which interferes with their ability to accept their child's disclosure.
- Understanding the NOPs level of awareness and functioning during the time of abuse as well as following disclosure may be an initial step in repairing the rupture between the child and the NOP as it may diminish the negative effects of feelings related to betrayal.

Methods Section

Research Methods.

Existing research and theory will be obtained using a data base search (e.g. ProQuest Central, EBSCO, ScienceDirect, etc.), library catalogues (i.e. Argosy University and National Louis University), and subject-specific sites such as Researchgate.net. The following terms were utilized in order to search the above means for appropriate data: Childhood sexual abuse, intrafamilial sexual abuse, childhood trauma, incest, non-offending parents, mother-blaming, dissociation, disbelief following disclosure, maternal characteristics, trauma symptoms, betrayal theory, and traumatic dissociative amnesia.

Article Inclusion Criteria.

Articles must be directly related to the topic, be peer-reviewed, and approximately 10 years old or less; however, older articles were accepted in order to report original theorists, describe prior ideology related to the subject matter (e.g. mother-blaming versus modern views of the NOP), or indicate related, important statistics. For the purposes of this paper, qualitative and quantitative studies are included. While much of the data stems from studies conducted within the United States, some data from other countries are utilized as well (i.e. the United Kingdom and South Africa). Articles included must be written in or translated to the English language. It is

also noted that national and world organizations such as National Child Traumatic Stress Network, WHO, and the U.S. Department of Health and Human Services were utilized in order to report statistics or provide legal definitions of terms.

Ethical Issues.

Information utilized within the above journal articles must have been obtained lawfully and ethically and the information must have been accurately reported. Such ethical guidelines were also upheld within the present literature review.

The research methods will be employed in order to extensively review the existing literature regarding childhood sexual abuse, non-offending parents of children who are sexually abused, and outcomes regarding the parent-child relationship following disclosure. Additionally, the review of the literature will be used to develop a working theory regarding the proposed hypotheses and attempt to formulate a comprehensive understanding regarding what deters NOPs from recognizing their child's abuse and therefore bridge the gap between the child and the NOP following disclosure. It is also the goal to utilize such theories to help direct future research, particularly regarding the possible use of dissociation among NOPs as a means to cope with the traumatic events.

Chapter II: What Prevents the Non-Offending Parent from Recognizing Childhood Sexual Abuse?

As we continue to divert from placing blame on the NOP for their child's sexual abuse, we strive to then understand what deters the parent from protecting their child or being able to recognize that the abuse is occurring. Parents typically have an innate, evolutionary desire to protect their young and safeguard their future (Swain, Kim, Spicer, Ho, Dayton, Elmadih, & Abel, 2014); therefore, how do non-offending parents remain blind to the significant and common signs of sexual abuse? NOPs often report significant emotional distress due to their lack of awareness and are plagued with guilt regarding their perceived failure to protect their young. This chapter is designed to explore several deterrents of recognition regarding CSA that may account for such circumstances.

Child's presentation. Physical signs of sexual abuse are not necessarily common among children experiencing such abuse (WHO, n.d.; Finkel, 2012). In fact, while signs of child sexual abuse are often present, they may be indistinguishable from symptoms related to typical childhood stress or other forms of trauma such as bullying (WHO, n.d). The most common trauma symptoms associated with CSA are diminished self-esteem, depression, anxiety, anger, self-injurious behaviors, dissociation or somatic preoccupation (Lalor & McElvaney, 2010; Briere & Elliot, 2003). Unfortunately, such symptoms may remain unnoticed by the child's parent. Smith-Stover, Hahn, Im, and Berkowitz (2010) conducted a meta-analysis of 119 studies examining parent-child agreement regarding the symptoms that the child experienced following a traumatic event, particularly following a form of domestic violence. The researchers found that children reported significantly higher accounts of internalizing symptomology such as depression, anxiety, and lowered self-esteem while the parents over-reported externalizing

behaviors such as acting-out or non-compliance and failed to link such behaviors to the traumatic events (Smith-Stover, Hahn, Im, and Berkowitz, 2010). It was also noted that a study conducted by Meiser-Stedman et al. (2007) found that parents vastly underreported dissociative symptoms among their children, likely indicating that the parents had difficulty recognizing the common trauma symptoms.

Externalizing behaviors. Children who experience sexual abuse may exhibit behaviors such as non-compliance, physical aggression, or oppositionality as well as report headaches or stomach aches; however, such symptoms or behaviors are not necessarily atypical of children experiencing developmentally appropriate stressors, which may deter the NOP from comprehending the significance of their child's presentation (Lalor & McElvaney, 2010; Briere & Elliot, 2003; Prevent Child Abuse America, 2003; Broman-Fulks, et al., 2007; Noll, Trickett, & Putnam, 2003). This is particularly understandable when considering that children are most vulnerable for sexual abuse between the ages of seven and thirteen with the median age being nine years old (Putnam, 2003), which is a developmental stage where mild problem behavior is not viewed as uncommon.

Children who previously exhibited externalized problematic behavior, and are subsequently labeled 'troubled,' may also begin to exhibit common behavioral symptoms of CSA, such as acting-out, labile mood, exhibiting persistent anger or irritation, or becoming increasingly defiant (Spinazzola et al., 2014); however, the behaviors are incorrectly categorized as stemming from the prior behavioral issues. Misbehavior or isolation are often recognized as signs of sexual abuse (Broman-Fulks, et al., 2007; Noll, Trickett, & Putnam, 2003; Spinazzola et al., 2014); however, if a child previously exhibited such behavior, it is unlikely that there would be an immediate, noticeable change in behavior. As such, the perpetrator's decision to prey on

children with such characteristics may increase the odds that the NOP would not recognize the abuse given that the symptoms were pre-existing. Also, consider that externalizing behaviors are not uncommon among children who are experiencing bullying, chronic anxiety, or family dysfunction and such difficulties may prompt additional adults to become involved. Common examples may be religious leaders or recreational coaches within the community who assume roles within the lives of troubled youth. Similarly, extended family members such as grandparents or uncles may begin to take on guardianship roles for children exhibiting problem behaviors in order to assist mothers who may not be able to attend to their children due to extensive work schedules. Due to the pre-existing problematic behaviors, which were present prior to the offending adult's presence in the child's life, the link between the maintained problem behavior and CSA goes unseen and the perpetrators continue to have access to the child.

For example, consider a child who is exhibiting significant acting-out behavior who is then encouraged to develop and maintain a relationship with a community member who has volunteered to become the child's mentor. The individual in this position, such as a coach, music teacher, guidance counselor, or godparent, puts forth effort to spend time with the child, stating that they wish to oversee the child's behavior. They appear to be helping, however in reality they begin to coerce the child into a sexual relationship. Should the child be coerced, and the problem behaviors are strengthened or maintained, it is unlikely that the child's parent would recognize such behaviors as symptoms of the inappropriate sexual relationship with the mentor but rather as the continuation of previous areas of concern. Additionally, perpetrators frequently seek out children who are particularly trusting and may put forth great effort in order to establish a trusting relationship with the child prior to engaging in the abuse (De Bellis, Spratt, & Hooper, 2011). This trusting relationship may deter the child from disclosing the abuse. Karakurt and

Silver (2014) discussed a case study of a woman named Rosie who was adopted at the age of 6-years-old following her biological parents' death in a car crash. Having been raised by loving parents in a religious household, she was eager and happy to develop a relationship with her adoptive father who was also a priest. The adoptive father exhibited a strong desire to incorporate his adoptive daughter into their religious ceremony and developed a trusting relationship with the young girl. It was this trusting relationship that deterred Rosie from divulging the sexual abuse that began later as she believed she was betraying an adult that cared for her. Furthermore, having limited family or other significant relationships, she was unable to receive help for the mistreatment, abuse, and sexual misconduct that occurred throughout her childhood (Karakurt & Silver, 2014). The seemingly helpful adult may also simultaneously prompt trust within the NOP who believes the relationship maintains an appropriate adult-child dynamic. Such scenarios are examples of the grooming process often enacted by offenders. Through the grooming process, the perpetrators manipulate children with the use of coercion and deceit rather than force to engage them in sexual activity (Finkel, 2012; Bennett & O'Donohue, 2014) while skillfully gaining the trust of the NOP and further establishing a meaningful relationship within the family, therefore deterring the NOP from recognizing or accepting the possibility of CSA.

The grooming process. Grooming is a process by which an offender gradually draws a victim into a sexual relationship and maintains that relationship in secrecy (Finkel, 2012; Bennett & O'Donohue, 2014). Simultaneously, the offender may also hold roles within the victim's family, particularly with the NOP, such as the NOPs partner, helpful neighbor, or co-worker that allows the offender to develop into a trusted and valued member of the family system (Winters & Jeglic, 2016; Bennett & O'Donohue, 2014). Such predators often put forth significant effort in

order to appear helpful and charming in order to lure in the NOP and child (Winters & Jeglic, 2016; Bennett & O'Donohue, 2014). Consider a young boy who is singly cared for by his mother and begins to receive individual attention from a community coach. The young boy may appreciate the male role model as well as the direction and attention he is receiving from the coach, often going to practices and tournaments with the adult male. This coach, who often has unsupervised access to the child due to the mother working long hours, may engage in the grooming process to form a strong attachment with the child and the NOP as the mother believes the coach is helping keep her child involved in healthy extracurricular activities. Due to the seemingly positive relationship, the adult male requesting to spend extensive time with the child or being affectionate with the child would not initiate concern with the NOP or others. Additionally, the relationship between the child and the coach deters the child from disclosing as the child likely fears betraying the coach and believes that he has his best interest in mind given the assistance the child has received prior to the abuse.

Elliott, Browne, and Kilcoyne (1995) conducted an extensive study in which they interviewed child sexual assailants who were imprisoned, listed on the sex offender registry, currently on probation, or otherwise documented within a government agency for such illegal activities. The perpetrators reported that they typically sought passive, quiet, withdrawn, troubled, or lonely children (Elliott, Browne, & Kilcoyne, 1995), which contributed to the victim's diminished likelihood to disclose regarding the abuse. The decision to withhold the report of abuse increases with troubled or quiet youth as children who are aloof or withdrawn may experience difficulties forming open, trusting interpersonal relationships that incorporate communication of affectively charged information. Given the child's lack of confidants or unwillingness to discuss the emotional experience of CSA, the abuse goes unreported. Further,

child sexual offenders often target children of single parent homes or those in which the children receive less adult supervision (Elliott, Browne, & Kilcoyne, 1995; Winters & Jeglic, 2016; Finkelhor, Ormrod, & Turner, 2007; Ramirez, Pinzon-Rondon, & Botero, 2011). As such, the child may be more readily available for the offender to engage in grooming activities, which over time gain the child's trust and diminish the resistance to inappropriate sexual behaviors. It should be noted that while considering the grooming process as a deterrent to recognizing child sexual abuse, one should also recognize that grooming is utilized in approximately half of sexual abuse incidents towards children (Winters & Jeglic, 2016), therefore highlighting the common implementation of such manipulative techniques and the significant need to educate parents on such behaviors.

Socioeconomic factors. There are several factors that may increase the likelihood that grooming will occur as well as deter the NOPs ability to recognize the child's abuse. One such factor is the family's socioeconomic status (SES). It should be noted that a family's SES goes well beyond the household income and also refers to the family's social status, typical education attainment, overall financial security, and often impacts the family's access to a variety of means such as healthcare, psychoeducation, and childcare. The risk of CSA increases when children live within a single parent household (Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, and Li, 2010). Such economic stressors as well as an increased need to work additional hours may deter the NOP from witnessing the signs of abuse as well as negatively impact his or her ability to protect the child from visible danger due to their absence. Consider the prior example in which a child is being sexually abused by his coach. The mother, who is working long hours away from home while her child is spending a significant amount of time with the coach, may not be able to immediately recognize the child's change in mood, his tendency to withdraw from

others, or diminished self-esteem. Her absence as she attempts to provide sufficient income deters her ability to immediately witness the changes in her child that typically occur following sexual abuse. Additionally, her extensive work schedule likely deters her ability to spend time with both the coach and the child simultaneously, which may impact her ability to witness any inappropriate behaviors or odd occurrences. Furthermore, single-parents or homes with two working parents often rely on babysitters, extended family, school personnel, or coaches to attend to their children while they work, increasing the opportunities to engage in the grooming process or have private access to the child. Unfortunately, the unsupervised access to the child creates sufficient opportunity to coerce the child into the inappropriate sexual relationship.

Another component of a low SES household to consider is domestic violence. While domestic violence occurs across all socioeconomic statues, it has been found that those in low SES households are at higher risk of prolonged domestic violence (Crown, Juon, Ensminger, Burrell, McFarlane, & Duggan, 2011). Additionally, mothers of children sexually abused by their partner are more likely to indicate a significant history of domestic violence when compared to mothers of children abused by non-family members (Deblinger, Hathaway, Lippmann, & Steer, 1993). Similarly, children who witness or are the victim of other crimes, such as violence within the home environment, are significantly more likely to be sexually abused (Finkelhor, Ormord, & Turner, 2010; Knott & Fabre, 2014; Kellogg & Menard, 2003; Chemtob & Carlson, 2004). Parents who themselves are currently victims of domestic violence (DV) are often, as a result, under significant stress and themselves experience lowered self-esteem, anxiety, and depression, which collectively contribute to diminished attention and memory. As such, NOPs who are currently enduring domestic violence may be less sensitive to recognizing the signs of CSA or lack an ability to conduct adaptive risk assessments as their

cognitive resources are weakened or depleted (Finkelhor, Ormord, & Turner, 2010; Knott & Fabre, 2014; Kellogg & Menard, 2003; Chemtob & Carlson, 2004). Furthermore, women who experience DV are at higher risk for losing their jobs, endure prolonged unemployment, and exhibit instability in the job environment (Crown, Juon, Ensminger, Burrell, McFarlane, & Duggan, 2011). As such, women may become financially reliant on the abuser and cannot fathom that the individual is harming their child as doing so would greatly jeopardize the financial stability of the household. Overwhelming fear regarding the loss of the financial security may prompt maladaptive coping techniques such as severe denial of the possible abuse.

Regarding NOPs with *prior* history of domestic violence, it has been shown that such individuals who later experience symptoms related to post-traumatic stress disorder are also likely to experience difficulties sustaining work (Crown, Juon, Ensminger, Burrell, McFarlane, & Duggan, 2011; Chemtob & Carlson, 2004). Due to such difficulties, said population often become reliant on a spouse for financial security. Furthermore, the long-lasting psychological effects of past domestic violence can contribute to the NOPs current diminished mental capacities, which, as mentioned above, may deter the NOPs from recognizing the signs of abuse or accurately assessing circumstances.

NOPs maladaptive coping and defense mechanisms. Dissociation within those who experience trauma may be defined as a phenomenon where an individual unconsciously diverts their conscious awareness away from an overwhelming traumatic event to other stimuli, which may be less threatening (Geraerts & McNally, 2008; Mauritz, Goossens, Draijer, & Achterberg, 2013; Martin, Cromer, DePrince & Freyd, 2013). For example, a woman who is being sexual assaulted may report an out of body experience where she does not feel pain or becomes hyper

focused on external stimuli such as a stain on the ceiling or a picture of the wall in order to divert her attention from the overwhelming and difficult circumstance she is enduring. During periods of dissociation, the mind can separate structures of psychological processing that would typically be integrated, such as one's thoughts, emotions, memory, and identity (Spiegel & Cardena, 1991; Collin-Vezina, Cyr, Pauze, & McDuff, 2005). Consider the example above, the woman separated her thoughts and emotions from the abuse, focusing on the external stimuli, which may later impact her memory or recollection of the event. While dissociation adaptively aided in her coping with the abuse in the moment, it may become maladaptive in the future as she may be unable to remember or process the trauma. The theory that trauma victims utilize the maladaptive technique of dissociation in order to cope with traumatic experiences has extensive empirical support (Lynn et al, 2014; Mauritz, Goossens, Draijer, & Achterberg, 2013; Martin, Cromer, DePrince & Freyd, 2013). This theory, often referred to as The Trauma Model, remains influential among clinicians and scholars, who indicate that traumatic experiences often prompt the development of dissociative symptoms. In fact, dissociation is often described as a core component of complex trauma or post-traumatic stress disorder (Lynn, et al, 2014; Mauritz, Goossens, Draijer, & Achterberg, 2013; Martin, Cromer, DePrince & Freyd, 2013). Research also supports the trauma theory of dissociation as a semi-typical response to intense fear or another extreme affect (Dalenberg, 2012; Mauritz, Goossens, Draijer, & Achterberg, 2013; Martin, Cromer, DePrince & Freyd, 2013). The use of dissociation initially acts as a protective factor, as it allows the individual to cope with the immediate overwhelming distress of the trauma.

Current research indicates that approximately 2 to 3% of the general population utilizes dissociation during a stressful event within their lifetime; however, when specifically examining

those who have had a severe traumatic experience, it is estimated that approximately 73% of survivors dissociate during the event as well as up to seven days following the incident (Martinez-Taboas & Guillermo, 2000). More specifically, there is extensive evidence that dissociative symptoms are most strongly related to intrafamilial sexual abuse (Chu & Dill, 1990; Plattner et al., 2003; Freyd, Klest, & Allard, 2005; DePrince, 2005; Chu & DePrince, 2006; DePrince et al., 2012). Furthermore, a study conducted by Hetzel-Riggin and Roby (2012) indicated that women who experience interpersonal trauma appear to have the highest rates of both short-term and long-term use of dissociation. It was noted that upwards of 58% of women who experience chronic interpersonal violence or abuse employ the use of dissociation in order to cope with the stressors (Hetzel-Riggin & Roby, 2012; DePrince et al., 2012). Also worthy of consideration is Banyard's (1997) study, which examined the parental practices of 518 low-income mothers and found that nearly 18% reported being sexually victimized before the age of 18 years. Fortier, DiLillo, Messman-Moore, Peugh, DeNardi, and Gaffey (2009) stated that women who experience re-victimization report higher levels of depression and dissociation in adulthood. Given such information and statistics, it may be reasonable to agree that discovering your child is being sexual abused is a form of trauma and therefore may act as a form of re-victimization, which may prompt maladaptive coping techniques such as dissociation among NOPs.

In summary, SES may play an important role in providing the opportunity for the grooming process to occur, low-income mothers are more likely to have experienced CSA when compared to high-income families, and a history of interpersonal violence is strongly linked to the use of long-term dissociation. Another consideration is how NOPs who have a history of

CSA or DV may employ previously acquired maladaptive coping skills during the time in which their child is being victimized.

NOP, their trauma history, and possible dissociative symptoms during child's sexual abuse. Researching and accurately identifying dissociative symptoms or trauma amnesia is often difficult as the individual may not be aware of their tendency to dissociate or simply cannot recall a memory that was never properly encoded (DePrince et al., 2012; Lindbolm & Gray, 2010). Such research often requires self-report strategies as well, which are not objective by nature and are difficult to verify. Such complications may impede the discovery of definitive information regarding the NOPs use of dissociation or presence of trauma amnesia during the child's sexual abuse within the home (DePrince et al., 2012). In fact, very few empirical studies have specifically examined the possibility that non-offending mothers of sexually abused children are employing dissociative techniques in order to cope with the presence of such abuse. However, numerous studies regarding the use of dissociation in order to cope with significant distress have found a connection between CSA and adult dissociative symptoms (Collin-Vezina, Cyr, Pauze, & McDuff, 2005; Chu & Dill, 1990; Gershuny & Thayer, 1999; Hall & Powell, 2000; Hartt & Waller, 2002; Rodriguez-Srednicki, 2001; Ross-Gower, Waller, Tyson, & Elliott, 1998). Additionally, individuals with pre-existing dissociative disorders display increased psychophysiological responses to stimuli that are reminiscent of their trauma or is personally relevant to their experiences (Dalenberg, et al., 2012; Reinders, et al., 2012), which increases the likelihood that future dissociation will occur if the adult experiences similar significant stressors. While dissociation is often described as a response of the individual experiencing sexual abuse, literature continues to explore the idea that NOPs may also experience a degree of dissociation during periods of time in which their children are being sexually abused as a means to cope with

the unbearable circumstances, particularly, if the abuse stems from a family member or spouse, which prompts significant feelings of turmoil, betrayal, and guilt (DePrince et al., 2012). Also consider that the disclosure of sexual abuse, particularly intrafamilial sexual abuse, often acts as a significant, traumatic stressor for the child as well as the NOP (Knott & Fabre, 2014; Lewin & Bergin, 2001). This is increasingly true if the sexual abuse is reminiscent of the NOPs trauma history (Dalenberg, et al., 2012; Reinders, et al., 2012).

Researchers have yet to conclusively identify the conditions under which a NOP may respond similarly to victims such as dissociating or partially forgetting abuse against their child. However, several studies indicate correlations among betrayal and dissociative symptoms (DePrince et al., 2012; Lindbolm & Gray, 2010) as well as the use of avoidant coping in adulthood during times of distress (Fortier, DiLillo, Messman-Moore, Peugh, & DeNardi, 2009). More specifically, sexual abuse was reported to prompt the highest degree of betrayal among children and adult survivors, which was correlated to the highest levels of forgetting (DePrince et al., 2012; Lindbolm & Gray, 2010).

The NOP may be experiencing negative mood symptoms or maladaptive coping skills, such as dissociation, as a result of experiencing betrayal trauma given that their spouse has subjected their children to sexual abuse (DePrince et al., 2012). In other words, the offending parent has betrayed the non-offending parent by sexually abusing their child. It has been found that there is a strong link between betrayal by an abusive intimate partner and higher levels of dissociation (Lindbolm & Gray, 2010). Generally speaking, dissociation appears to be the strongest and most prevalent among familial betrayals and abuse across age ranges, child or adult (DePrince et al., 2012; Lindbolm & Gray, 2010).

As previously mentioned, mental health issues such as depression, lowered self-esteem, and symptoms stemming from complex trauma, particularly from the NOPs possible prior experiences with CSA or DV, may interfere with their ability to recognize distress among his or her child. Such trauma history and current mental health functioning increases the likelihood that there is current use of dissociative symptoms among the NOPs where they compartmentalize their conscious awareness of their child's abuse, which may be occurring within the home. Overall, the NOPs childhood experiences of abuse, current dissociative symptoms, and dissatisfaction with social support are indicated as possible influences on parenting practices among non-offending mothers (Kim, Trickett, & Putnam, 2010; Chemtob & Carlson, 2004) and such factors are hypothesized to greatly impact the NOPs ability to recognize the presence of abuse. For example, the mother who endured chronic interpersonal abuse, employs long-term dissociative coping skills, and feels isolated or dependent may lack strong, positive, healthy parenting practices. Further, such difficulties and deficits can interfere with their cognitive ability to evaluate their child's mental health or recognize the signs of intrafamilial sexual abuse nor consciously accept that they must terminate their relationship with the abuser.

Given the prior research, it appears that several factors contribute to a NOPs inability to recognize or accept the sexual abuse of his or her child. Most interestingly, the NOP may be employing the use of dissociation in order to cope with the severe trauma of their child being sexually abused within the home or by a family member. The use of dissociation as a means to cope with their child's abuse becomes increasingly more feasible once risk factors for sexual abuse, the NOPs mental health, and the NOPs history of trauma are examined. The risk of CSA increases among low-income households as well as households that are maintained by single mothers, which are also two factors that increase the likelihood that the mother has experienced

significant physical or sexual interpersonal abuse. The presence of interpersonal abuse, or history of, also increases the likelihood that the mother has dissociated in the past, therefore, future dissociation then becomes more likely. It is known that dissociation may be acute, happening only during the traumatic event, or chronic; therefore, it is not improbable that such mothers continue to use dissociation during later years following their personal trauma, which would be triggered by intense, affectively charged situations. The presence of dissociative symptoms among NOPs of children experiencing intrafamilial sexual abuse is grossly under researched; however, it is a compelling theory, which deserves a thorough examination.

Chapter III: NOPs Disbelief following the Child's Disclosure of CSA

The NOPs response following disclosure includes the parent's belief regarding the presence of sexual abuse, the resulting emotional support given to the child, and protection from additional maltreatment (Knott & Fabre, 2014; Pintello & Zuravin, 2001). For the purposes of this paper, parental belief refers to the NOPs acknowledgment and acceptance of the child's allegations regarding abuse. Protection, therefore, refers to the steps that the NOP then takes in order to keep the child safe and remove the perpetrator from having access to the child. For example, this may include removing the perpetrator from the home, notifying the school that the offender may not pick up the child from the academic setting, or refusing to allow the perpetrator to attend family events or activities. Further, emotional support is also an important protective barrier and refers to the empathic support that the NOP provides the child in order to ease the psychological turmoil they are facing. The NOP may provide a safe space for the child to discuss their abuse, how it made them feel, how they are currently coping with the distress, how they feel towards the perpetrator, or their residual fears stemming from the abuse as well as fears for the future.

The response of the NOP following the child's disclosure is the greatest predictive factor when considering the trajectory of the child's post-trauma adjustment and recovery (Knott & Fabre, 2014; Finkel, 2012; Tavkar, 2010; Yancey & Hansen, 2010; Pintello & Zuravin, 2001; O'Leary, Coohey, & Easton, 2010). In other words, the NOPs response following disclosure will likely direct the child's future functioning in a substantial manner. In a study conducted by Pintello and Zuravin (2001) that examined approximately 500 non-offending mothers of children who had experienced intrafamilial sexual abuse, 41.8% of mothers both believed the abuse claim and engaged in protective behaviors towards their children, 30.8% denied the allegations and

failed to engage in protective behaviors, and 27.3% had ambiguous responses, which involved either believing but not protecting their child or denying the allegations but then engaging in protective behaviors despite their non-belief. In other words, 58.1% of the victimized children within the study did not receive *both* the acceptance and protective factors that were likely to positively impact their future psychological well-being and adjustment post abuse (Pintello and Zuravin, 2001). Similar results were found by Rakovec-Felser and Vidovic (2016) who examined 73 families and found that 51% of mothers did not believe their children nor did they engage in protective behaviors following disclosures. It should be noted that Rakovec-Felser and Vidovic (2016) produced far less generalizable results when compared to other research studies utilized in this section as their study incorporated several limitations. Limitations included pooling subjects from court-referred cases, limiting subjects to female victims with male perpetrators, and geographical location as the study was conducted in Slovenia. Potential cultural differences and the exclusion of male victims should be considered when examining clinical implications and when attempting to apply such findings in additional settings.

Positive responses stemming from the NOP following disclosure, such as believing the allegations and engaging in protective measures, are strongly linked to adaptive coping, positive adjustment, and fewer mental health issues among children who survived CSA (Knott & Fabre, 2014; Yancey & Hansen, 2010; Pintello & Zuravin, 2001; Rakovec-Felser & Vidovic, 2016). Oppositely, negative responses or lack of emotional support from the NOP, such as denying the allegation and keeping the perpetrator in the child's environment, are linked to increased anxiety and depressive symptoms as well as lowered self-esteem and increased risk for re-victimization or exploitation (Knott & Fabre, 2014; Yancey & Hansen, 2010; Pintello & Zuravin, 2001). Children who disclose but are not affectively supported or prompted to fully discuss and process

their abuse within one year following disclosure are significantly more likely to experience severe pathology in adulthood, particularly if the abuse stemmed from a family member (O'Leary, Coohey, & Easton, 2010). Furthermore, empirical data have not found disclosure alone to be a reliable predictor of positive long-term outcomes for the child (Hebert, Tourigny, Cyr, McDuff, & Joly, 2009). This may be due to, in large part, the NOPs' negative response to the disclosure or lack of emotional support following the abuse. Literature also extensively reviews the betrayal theory, which indicates that children exposed to CSA often develop intense feelings of betrayal toward the NOP who 'failed' to protect them, which further exacerbates maladjustment following CSA regardless of disclosure (DePrince et al., 2012; Martin, Cromer, DePrince & Freyd, 2013). It should be noted that children who experience sexual abuse are most likely to disclose to the NOP, specifically the mother (Knott & Fabre, 2014; O'Leary, Coohey, & Easton, 2010; McElvaney, Greene, & Hogan, 2014), which further demonstrates the significance of comprehending what prompts mothers to accept or deny the child's reports of abuse as it directly affects their future functioning and quality of life. Several possible factors may contribute to the NOPs denial of CSA allegations, which may prove to be useful regarding understanding NOP negative responses and subsequent attempts to bridge the gap between the NOP and the survivor.

Factors Contributing to the Denial of Disclosure.

Relationship with the perpetrator. Children who live with a single parent that has a live-in partner are at the highest risk of CSA (Sedlak, et al., 2010; Knott & Fabre, 2014; van Toledo & Seymour, 2013). Statistically, children living with a single parent that has a live-in partner are 20 times more likely to be a victim of CSA than children living with both biological parents (Sedlak, et al., 2010). Live-in partners of single parents often offer emotional and

monetary support, which may prompt a strong, emotional attachment given the NOPs perceived need for the partner (Yancey & Hansen, 2010). Additionally, such heightened emotions may prompt denial among NOPs as they may be unconsciously unwilling or unable to accept their partner's unfathomable behavior such as sexually abusing their child (Pretorius, Chauke, Morgan, 2011; Bux, Cartwright, & Collings, 2015). Pintello and Zuravin (2001) found that NOPs who were not in a relationship with the perpetrator were four times more likely to believe their child's abuse allegations and follow-through with protective behaviors when compared to those who were romantically involved with the offender. Ambivalence was also noted among NOPs who sensed that abuse was occurring but did not fully intervene or confront their spouse due to the intense fear of confirming their suspicions (Pretorius, Chauke, Morgan, 201; Bux, Cartwright, & Collings, 2015). For example, consider a mother who fears her child is being abused and therefore prompts the child to remain in her supervision, limiting the step-father's access, but does not verbally confront the step-father or report the suspicion to other family members or authorities due to fear of confirmation or legal ramifications.

This may be particularly true when the NOP experiences significant guilt given the NOPs decision to introduce the partner into the household, therefore exposing their child to danger despite being unaware of the live-in partner's proclivities. In such situations, it is reasonable to believe that accepting the disclosure of abuse simultaneously prompts perceived responsibility for the abuse. Such acceptance has been linked to significant guilt and grief that mirrors the grief experienced following the death of a loved one (Pretorius, Chauke, Morgan, 2011; Bux, Cartwright, & Collings, 2015), which may indicate the psychological need to deny such allegations in order to deter the resulting bereavement. Furthermore, the NOP may fear the reaction of extended family given the NOPs introduction of the offender into the home. Guilt

coupled with the fear of family discord regarding the presence of the offender are certainly factors in the reluctance of accepting accounts of sexual abuse (Pretorius, Chauke, Morgan, 2011; Bux, Cartwright, & Collings, 2015). Regardless of residency, the presence of an intimate relationship between the NOP and the perpetrator significantly increases the likelihood of a negative response following disclosure (Pintello & Zuravin, 2001). Particularly, if the NOP fears the consequences of the allegations, such as the offender being incarcerated or otherwise punished for the crime (McElvaney, Greene, & Hogan, 2014). Also, consider the prior data discussed regarding the grooming process. While offenders may put forth great effort to groom a child in order to decrease the likelihood that the child will disclose the sexual abuse, it is also reasonable to conclude that the offender will engage in similar tactics in order to gain the trust and confidence of the NOP to ensure the continuance of their romantic relationship and prompt disbelief should the sexual abuse be reported. Pretorius, Chauke, and Morgan (2011) conducted a study in order to evaluate the experiences of non-offending mothers post-disclosure and reported that one participant stated, "I could not believe that my husband did it, because I remember how he always said in front of the television that he cannot think that a man can do that to a little girl," (pp. 4). Such statements had instilled a level of trust within her spouse, which impacted the mother's ability to initially accept the report of abuse.

Parent- child relationship. McElvaney, Greene, & Hogan (2014) highlighted the benefits of functional communication among the NOP and their children because explicitly asking a child about abuse appears to be a significant factor that contributes to disclosure. The NOP recognizing and addressing the changes within their child, such as changes in mood or behavior, and expressing concern may be an indicator of a positive parent-child relationship in which a child would be more likely to disclose. As previously mentioned, Rakovec-Felser and

Vidovic (2016) conducted a study including 73 families of children who experienced CSA and found that children who viewed their mothers as supportive typically disclosed their abuse within nine months while those who did not perceive their mothers as supportive typically required approximately seven years to report the abuse. It should be noted that approximately 70% of the children included in Rakovec-Felser and Vidovic's (2016) study experienced intrafamilial sexual abuse and therefore results should be examined and applied under similar circumstances when attempting to generalize to NOPs and CSA. However, it would appear that the NOPs supportive relationship coupled with their direct inquiry and verbalized concerns appears to increase the likelihood that the NOP will be receptive to the reports of abuse as he or she has cognitively recognized possible issues with the child's presentation and therefore recognizes that unknown negative events are likely occurring within the child's life (McElvaney, Greene, & Hogan, 2014).

Oppositely, parent-child relationships that are characterized by maladaptive communication, chronic argumentative behaviors, and are generally strained may prompt disbelief following disclosure (Finkelhor, Ormrod, & Turner, 2007; Ramirez, Pinzon-Rondon, & Botero, 2011). NOPs may believe that the child is misbehaving as means to receive attention or purposefully prompt discord within the family due to such behavior being present prior to the abuse, which previously stemmed from the strained, negative parent-child relationship. For example, consider a strained parent-child relationship between a single-mother and her daughter, which has been characterized by persistent arguing, non-compliance, and general disagreements regarding household rules for an extended period of time. Should the mother introduce a live-in partner, which ultimately results in the disclosure of sexual abuse toward the daughter, the NOP may attribute the accusation as another form of misbehavior and therefore deny the report. Due to the prior experiences with maladaptive problem solving and communication as well as a

chronic disruption between the mother and daughter within the home, the NOP ultimately does not have confidence in the child's report. Pintello and Zuravin (2001) found that NOPs were twice as likely to deny their children's allegations of sexual abuse if there was prior problem behavior or perceived sexual acting out by the child.

Child's decision not to disclose. Individuals who experience CSA often indicate significant fear regarding disclosing such information as they may be rejected or accused of lying (Cromer & Goldsmith, 2010; McElvaney, Greene, & Hogan, 2014; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Priebe & Svedin, 2008; Morrison, Bruce, & Wilson, 2018). In fact, a review of numerous studies regarding the percentage of those who disclose sexual abuse found that approximately 30% of children do not disclose to any individual regarding the traumatic events during their childhood (Cromer & Goldsmith, 2010; London, Bruck, Ceci, & Shuman, 2005; McElvaney, Greene, & Hogan, 2014; Rakovec-Felser & Vidovic, 2015). It was also noted that children who experience intrafamilial sexual abuse often take longer to disclose and engage in higher rates of recanting (van Toledo & Seymour, 2013; Rakovec-Felser & Vidovic, 2015; Hebert, Tourigny, Cyr, McDuff, & Joly, 2009; Finkel, 2012). Such reluctance to disclose interferes with others belief that CSA is a prevalent crime and therefore deters the likelihood of automatic acceptance of disclosures given the misperception that such acts are fairly uncommon and unlikely (Cromer & Goldsmith, 2010). This is particularly true for the NOPs who wholeheartedly believe that their child would seek their help if he or she were truly enduring such traumatic acts.

However, children fail to report their abuse for a number of reasons, which typically relates to concerns regarding how the information will be perceived and how the information will impact their family (Morrison, Bruce, & Wilson, 2018). Victims of CSA involving a family

member often experience the greatest degree of apprehension regarding disclosure due to a feeling of disloyalty toward a member of their own family (Hebert, Tourigny, Cyr, McDuff, & Joly, 2009; Jonzon & Lindblad, 2004; McElvaney, Greene, & Hogan, 2014; Morrison, Bruce, & Wilson, 2018; Rakovec-Felser & Vidovic, 2015). Additionally, child victims often report fears of 'breaking up the family,' fear that the perpetrating family member will become incarcerated, or fear emotionally hurting other members of the immediate family due to the uncomfortable nature of the abuse such as siblings discovering that their father has been molesting a sibling (McElvaney, Greene, & Hogan, 2014; Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003; Morrison, Bruce, & Wilson, 2018). For example, McElvaney, Greene & Hogan (2014) identified a research participant who discussed her fear regarding reporting her father's sexual abuse. The 16-year-old girl stated, "I didn't want them to grow up with no Dad . . . I felt like I was taking their Dad away from them but at the same time I didn't want anything to happen to them . . . I knew that was the right thing to do but at the same time I felt like 'What am I doing? It's their Dad . . . I can't let them live without their Dad" (pp. 937). The victim went on to explain the pain she experienced when her younger siblings would inquire regarding why their father had left and often asking why he was no longer in the home setting (McElvaney, Greene, & Hogan, 2014). Further, children may perceive the abuse as being their fault, fear that they will be in trouble for 'allowing' the abuse to continue, or may have received threats from the abuser that severe consequences will come from their decision to disclose (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003, Quas et al., 2003, McElvaney, Greene, & Hogan, 2014; Priebe & Svedin, 2008; Morrison, Bruce, & Wilson, 2018). It should also be noted that sexual abuse often prompts significant shame within the victim, which undoubtedly deters their desire to inform others that they have been subjected to such intimate violence or mistreatment.

McElvaney, Greene, & Hogan (2014) discuss the nature of disclosing versus secrecy as "the truth being longer than the lie" (pp. 931). The quote indicates the significant internal struggle regarding coping with the truth being uncovered and the subsequent consequences versus holding the secret and avoiding reprieve as well as backlash. Explicitly understanding what deters a child from reporting sexual abuse may significantly decrease a NOPs doubt regarding their decision not to disclose as well as prompt empathy regarding the vast sea of reasons why they would choose to maintain the secrecy of the coercive sexual molestation.

NOPs mental health and degree of functioning during the time of abuse. NOPs of sexually victimized children report heightened symptoms of depression and anxiety (Lewin & Bergin, 2001; Yancey & Hansen, 2010; van Toledo & Seymour, 2013), which may prompt the utilization of common defense mechanisms such as denial or avoidance. Therefore, denial may more accurately represent the NOPs attempt to defend themselves against the pain and distress of the disclosure rather than indicate a true disbelief regarding the child's report. Additionally, nearly 75% of non-offending mothers have also experienced a form of sexual or physical victimization in their lifetime, therefore experience pre-existing symptoms such as depression, diminished self-esteem, and sexual dysfunction (Tavkar, 2010; Knott & Fabre, 2014; Yancey & Hansen, 2010). Further, those who were abused following the age 12 are ten times more likely to experience significant post-traumatic stress disorder as an adult (Schoedl, et al., 2010). Due to the prior experience with sexual trauma, non-offending mothers may be triggered by the disclosure, further prompting maladaptive coping skills or defense mechanisms. In fact, women, or non-offending mothers, who experienced CSA often exhibit increased adrenocorticotropic (ACTH) response following psychological stress in adulthood (Schoedl, et al., 2010; Heim, et al., 2000). Simply put, adult victims of CSA neurologically respond to significant stress

differently than the general population (Schoedl, et al., 2010; Heim, et al., 2000). As such, the NOPs maladaptive reaction to disclosure may partially stem from a biological reaction to stress prompted by their own CSA or abuse.

NOPs may also experience diminished capacity for adaptive coping or maintain a compromised emotional availability as a result of DV (Knott & Fabre, 2014; Kellogg & Menard, 2003). As a result, mothers of DV are less likely to recognize mental health difficulties and seek services for their children (Chemtob & Carlson, 2004). Consider the fear that such violence may prompt within the NOP as well. DV victims who fear the physical and emotional backlash of addressing reports of sexual abuse towards their child may further exacerbate maladaptive coping techniques such as denial, avoidance, or repression. In addition to prior mental health distress, victimization, or the presence of domestic violence, current literature has begun to document compromised responses to CSA disclosure as a result of drug or alcohol use (Knott & Fabre, 2014; Knott, 2008). While substance use may deteriorate the NOPs ability to accurately assess the situation, it may also prompt impaired judgement such as denying the disclosure or continuing to allow the perpetrator access to the child (Knott & Fabre, 2014; Knott, 2008).

Current literature also commonly identifies non-offending mothers as hidden victims, which opposes prior stigmatization that described said parents as collusive (Hebert, Langevin, Oussaid, 2018; Knott & Fabre, 2014; McElvaney, Greene, & Hogan, 2014). Furthermore, current research indicated that the NOP may also be a primary victim when childhood sexual abuse stems from the second paternal figure or spouse due to significant distress stemming from their child's abuse as well as simultaneous loss of the spouse (Hebert, Langevin, & Oussaid, 2018; Knott & Fabre, 2014; van Toledo & Seymour, 2013). Consider the example provided above from

Pretorius, Chauke, and Morgan (2011), the mother indicated that she trusted her husband, which therefore impacted her ability to initially accept the report of abuse but then also prompted significant distress as the trust she once had in her spouse was shattered and the relationship was lost. Following their child's disclosure, NOPs may experience post-disclosure trauma including symptoms such as depression, anxiety, PTSD, somatic symptoms, anger, psychoticism, and paranoid ideation as well as increased risk for suicidal ideation and attempts (Tavkar, 2010; Knott & Fabre, 2014; Hebert, Langevin, & Oussaid, 2018; van Toledo & Seymour, 2013). McElvaney, Greene, & Hogan (2014) discussed the emotional and overwhelming reaction of a NOP following their child's disclosure quoting, "for me it was the end of the world … it was the worst thing that ever happened and it killed me, really, really ate me up . . . for the first 8 months I thought this was the worst thing that ever happened. Nothing worse could ever happen now" (pp. 938). It was noted that the NOP may experience such symptoms for approximately two years following the child's disclosure regarding enduring sexual abuse (Tavkar, 2010). Non-offending fathers may also experience similar levels of distress; however, such symptoms may have a delayed response as fathers typically attempt to avoid affect when compared to non-offending mothers (Tavkar, 2010). Conclusively, it may be reasonable to believe that a NOPs denial following a child's disclosure regarding sexual abuse may stem from their own mental health difficulties and employment of maladaptive defense mechanisms rather than a genuine disbelief.

Chapter IV: Clinical Implications

CSA is a complex and multilayered offense that causes a unique form of trauma and interpersonal as well as intrapersonal difficulties. Based on the information collected in the previous chapters, CSA has the potential for prompting intergenerational trauma as CSA can prompt maladaptive behaviors within the NOP that simultaneously increases the risk of CSA for their children. Additionally, such intergenerational trauma may also impact the NOPs response to their child's disclosure of abuse, which also prompts an array of possible difficulties that were previously discussed. The repercussions of a NOPs negative response following disclosure as well as effective therapeutic modalities for the child have been examined in great depth; however, literature regarding the implications of resolving feelings of betrayal among the children exposed to sexual abuse as well as the NOP are lacking. Research and theoretical underpinnings regarding the parental responses to their child's sexual abuse have been reviewed. As mentioned, intrafamilial sexual abuse may prompt physical and emotional turmoil as well as intense feelings of betrayal among the child victim as well as psychological distress for the NOP, which often requires periods of bereavement and recovery in order to process the trauma.

Resolving the Betrayal Trauma.

As previously discussed, betrayal trauma theory (BTT) proposes that the way in which traumatic events are processed and recalled is often related to the degree of betrayal involved in the traumatic event (Freyd, 1994, 1996, 1999; DePrince et al., 2012; Martin, Cromer, DePrince & Freyd, 2013). Given the discussion in previous sections regarding the traumatic nature of discovering your child is being sexually abused by a member of the family, it is also reasonably understandable that a NOP may experience some degree of forgetting during the time in which their child is being offended against as a defense mechanism (DePrince et al., 2012; Martin,

Cromer, DePrince & Freyd, 2013). This is specifically due to the abuse representing a severe and significant form of betrayal by the perpetrator. Therefore, although not addressed thoroughly in literature, both the child and the NOP are at jeopardy for experiencing significant betrayal trauma stemming from such traumatic acts as well as traumatic amnesia. It is certainly necessary for the NOP to recognize the feelings of betrayal that their child is likely experiencing, however, would it also be impactful for the child to become aware of the betrayal that the NOP experiences as means of building an understanding of the parental responses to their abuse and linking their experiences?

While research has shown the effectiveness of individual trauma counseling for the child who survived sexual abuse (van Toledo & Seymour, 2013; Karakurt & Silver, 2014), there remains significant gaps in the literature regarding how to clinically support the NOP during their personal crisis following the child's disclosure (van Toledo & Seymour, 2013). However, the limited research that is available indicated that providing interventions for the NOP likely has a positive emotional impact on the parent as well as the child. NOPs may recognize that the child requires affective support following disclosure, however parents are often unaware of what to expect or how to respond to the child (van Toledo & Seymour, 2013; Karakurt & Silver, 2014). van Toledo and Seymour (2013) conducted an extensive review of the current research regarding the ability of the NOP to cope with and intervene following their child's disclosure of sexual abuse and reported that the NOPs confidence regarding coping with the crisis increased if they received significant psychoeducation following disclosure, such as identifying the consequence of CSA, common behavioral and emotional symptoms to be expected following disclosure, and the long-term impact of such abuse (van Toledo & Seymour, 2013). Support groups have also been found to improve NOPs' self-esteem and ability to process the betrayal trauma, which

therefore better allows the NOP to become involved with the child's therapeutic process in a healthy manner (van Toledo & Seymour, 2013; Hill, 2001; Hernandez et al, 2009). It appears that the NOP putting forth effort to resolve their personal betrayal trauma positively impacts the therapeutic process for their child; however, further research is required to definitively conclude such hypothesis.

Children and NOPs may seek individual counseling following disclosure, which may be effective during the crisis stage; however, it is likely that they will also require joint psychotherapy in order to address maladaptive thoughts, residual feelings of betrayal, or to identify adaptive manners in which they can engage in positive communication (Karakurt & Silver, 2014; van Toledo & Seymour, 2013). Joint psychotherapy may be particularly helpful when considering intrafamilial sexual abuse, as the offender may have purposefully created divisions between the child and the non-offending parent in order to minimize the risk of exposure. Furthermore, it is reasonable to conclude that debriefing between the child and the NOP in a safe, empathic setting will likely increase positive aspects of the parent-child relationship. Unfortunately, joint therapy has not become the norm following such disclosures and the lack of such interventions may impede the resolution of trauma (Karakurt & Silver, 2014; van Toledo & Seymour, 2013). As previously mentioned, there is an added layer of betrayal, fear, and shame when abuse stems from a member within the family system; Therefore, the added layer of distress may prompt unique challenges for identification and treatment following disclosure as the victims are less likely to disclose, often take longer to disclose when they chose to do so, are more likely to recant, and demonstrate less improvement in therapy (Lalor & McElvaney, 2010; Finkelhor, Ormrod, & Turner, 2007; Hetzel-Riggin, Brausch, & Montgomery, 2007). Such issues undoubtedly interfere with the implementation of joint therapy

following disclosure and therefore impact the resolution of the multilayered betrayal for both the child and the NOP.

Clinical Implications Furthered.

While accurate data is available regarding the prevalence and real nature of CSA, many individuals remain blind to such abuse, its risk factors, and the related symptoms (Cromer & Goldsmith, 2010; Cheit, 2003). Such lack of awareness allows CSA myths to remain robust and therefore negatively impact the protection of children and increases disbelief following disclosure. Myths include the belief that perpetrators are easily identifiable and are most often strangers, that the child must have willingly participated in the sexual misconduct or prompted the abuse via wearing revealing clothing or acting provocatively, or that CSA is rare (Cromer & Goldsmith, 2010; Cheit, 2003). Such myths may act as deterrent for CSA recognition as well given the inaccurate lens that NOPs utilize when caring for their children. For example, believing that perpetrators are typically strangers may interfere with the NOPs ability to critically examine others and identify the skilled perpetrators that are engaging in the grooming process. Similarly, if NOPs believe that CSA is rare, they may be less likely to consider the possibility that their children are at-risk and therefore may not cognitively interpret presenting concerns through a trauma lens. It should be noted that research regarding the impact of myths on the perpetuation of CSA is lacking.

Research regarding CSA, including information reviewed within this paper, must be consumed readily and spread throughout society in order to extinguish inaccurate information or beliefs regarding CSA in order to prevent such maladaptive acts, protect future children, and help those who have survived CSA. Such avoidance and perpetuation of CSA myths can be seen in

literature and popular media, which often discuss and provide education on the dangers presented by strangers but do not discuss intrafamilial sexual abuse, despite its significant occurrence around the world (Cromer & Goldsmith, 2010; Cheit, 2003; Lalor & McElvaney, 2010). Readily available psychoeducation regarding CSA, its long-term impact, and possible role in prompting intergenerational trauma may also increase individuals' understanding of early intervention for all members of the family in order to fully process the trauma as well as feelings of betrayal. For example, comprehending that a child who survives sexual trauma may continue to experience significant mental health difficulties into adulthood, which may simultaneously increase their children's chances of abuse, may empower clients to consistently utilize interventions that will improve their functioning and mental health prior to having children that are at high-risk for victimization. In other words, theoretically, comprehending the significant impact of CSA and engaging in services to process the multilayered trauma may prompt adaptive trauma resolution that will aid in ceasing the intergenerational trauma cycle. However, it should be noted that further research is required prior to conclusively stating such theories.

As stated in previous chapters, socioeconomic factors, such as living in a poor or low-income household, appear to increase the likelihood of CSA and mental health difficulties; however, low income households are also less likely to have access to mental health services that often aid in recognizing the signs of CSA, processing such experiences, and addressing the resulting interpersonal betrayal trauma (Hodgkinson, Godoy, Beers, & Lewin, 2017). In other words, the factors that appear to make children and families at higher risk for CSA, also significantly decreases their access to the necessary mental health services that would be recommended in order to address the trauma and improve functioning across the lifespan. Such families and children are more likely to have access to primary care physicians and counseling

services that are provided in the academic setting, which further highlights the need to provide trauma informed care across professions (Hodgkinson, Godoy, Beers, & Lewin, 2017; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). Approximately three fourths of children who receive mental health services, access such services in the academic setting; however, many social workers or school counselors do not receive specific training in identifying or addressing sexual trauma nor do they have the ability to address such concerns in a family systems approach (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010), leaving additional family members without means to process the trauma that is occurring within their family. Ideally, CSA victims and NOPs should access high-quality mental health care in order to decrease the likelihood of long-term maladaptive trauma responses; however, until issues pertaining to accessing such services are resolved, strengthening the training related to trauma informed care across professions that work with children and families may aid in decreasing these affects.

Current information and data should be critically examined when addressing sexual abuse that has already occurred as intrafamilial sexual abuse is quite unique when compared to other forms of trauma. Intrafamilial sexual abuse involves physical violations, significant betrayals of trust, and prompts psychological discord, which often then prompts both externalizing and internalizing symptoms. As such, clinicians are often tasked with examining multiple modalities of treatment that will address the interpersonal relationship issues, intrapersonal difficulties, externalizing problematic behaviors, and family system conflicts (Lalor & McElvaney, 2010; Hetzel-Riggin, Brausch, & Montgomery, 2007). For example, play therapy with children may be effective for addressing internal struggles and social concerns as well as aids in the processing of trauma while individual and family cognitive-behavioral techniques are likely better suited to address problematic behaviors across settings and decrease family psychological distress (Lalor

& McElvaney, 2010; Hetzel-Riggin, Brausch, & Montgomery, 2007). Such considerations should be examined in order for clinicians to employ affective trauma informed care.

Given the complexity of CSA and its consequences, the clinical implications of establishing a comprehensive understanding of what deters a NOP from recognizing their child's sexual abuse as well as what prompts a NOP to engage in disbelief following disclosure are broad. Accurate and readily available information regarding risk factors and the extensive impact of CSA as well as its role in the cycle of intergenerational sexual trauma likely have significant clinical implications; however, such possible impacts require further research in order to accurately identify the aspects that will impact the field of childhood sexual trauma. Further, given the continued difficulties among those that experience poverty, such as increased risk for trauma and diminished access to mental health services, all professions that work with families and children should receive adequate training regarding trauma informed care. Additional professions may include primary care physicians, school counselors, teachers, social workers, occupational therapists, and speech pathologists due to their consistent access to children and potential ability to decipher typical problem behavior from symptoms of CSA or recognize other warning signs that increase a child's risk.

Chapter V: Discussion and Future Research

The purpose of this paper was to critically examine the current literature regarding CSA in order to understand the parental responses of NOPs of children who have been sexually abused. The lack of recognition of CSA among NOPs was hypothesized to impact the NOP-child relationship, contribute to the betrayal trauma felt by the child, and the NOPs response following disclosure, therefore possible deterrents of recognition were identified utilizing current literature. It appears that the NOP may not fully comprehend the symptoms of CSA and therefore are not linking the child's presentation to the trauma. For example, CSA often prompts internalized symptoms such as diminished self-esteem, anxiety, depression, and dissociation, which appear to be difficult symptoms for the NOP to recognize and therefore does not prompt suspicion of abuse. Additionally, NOPs often fail to link externalizing behaviors such as non-compliance, aggression, or somatization to the possibility of abuse as such symptoms may be developmentally appropriate reactions too many other common stressors such as peer conflict, increased academic demands, or typical parent-child relationship issues.

The grooming process also likely deters the NOPs recognition of CSA as the perpetrator may have put forth great effort to establish a trusting relationship with the child and NOP in order to conceal the inappropriate sexual relationship and significantly decreases the likelihood the child will disclose. Further, SES was also examined and appears to be a significant factor in the NOPs lack of recognition of CSA. Low SES is often associated with single-parent homes, increasing the NOPs need to work longer hours, and increasing the need for additional adults to become involved in the child's life, which may then create greater opportunities for grooming and abuse to occur undetected. A NOP maintaining a lower SES may also increase the likelihood that they do not have adequate access to healthcare, which decreases the NOPs access to

psychoeducation regarding common symptoms of CSA or to services that may address their own mental health needs.

The importance of the NOPs mental health and degree of functioning should not be underestimated as it appears to have a significant impact on the likelihood the child will be exposed to sexual abuse, deters the NOP from recognizing the abuse, and directly impacts the NOPs ability to accept and protect their children following disclosure of abuse. NOPs with their own history of trauma or current mental health difficulties greatly impacts their cognitive resources, which when depleted impacts their ability to interpret their environment and adaptively cope with stressors. Additionally, mental health difficulties among the NOP may prompt maladaptive coping skills such as dissociation, denial, or substance use as well as increases their tolerance of domestic violence as they are not cognitively able to address the situation, nor do they have the means to escape safely. Further, low SES and diminished functioning may impact one's ability to maintain a strong, positive support system and is associated with poor parenting practices, which can negatively impact the parent-child functional communication skills and overall parent-child relationship.

The information gathered within this paper highlights the distressful cycle of abuse and trauma. Individuals who experienced sexual trauma or domestic violence as a child and enter into adulthood with unprocessed abuse appear to struggle with a great deal of difficulties such as depression, maladaptive coping skills, diminished self-esteem, and economic hardship. Such long-term difficulties appear to then negatively impact their ability to engage in positive parenting skills, may impair judgement, and increases their children's risk of exposure to sexual abuse, perpetuating the cycle of trauma. It appears that an important factor of addressing the

CSA epidemic within the United States is to provide comprehensive trauma informed care in order to aid those who have already experienced CSA as a means to stop the cycle. It is hypothesized that providing trauma informed care to the current CSA survivors would decrease long-term consequences of the abuse, improve their functioning in adulthood, and therefore decrease the risk of continuing the cycle with their children.

Limitations of Current Research.

It was noted that the majority of research utilized within this paper included subjects that identified as Caucasian, African American, or Hispanic, which highlights the need to further examine what deters NOPs of additional ethnic minorities from recognizing or reporting CSA. Additionally, current research also tends to utilize non-offending mothers while many non-offending fathers remain unincorporated in the studies, therefore research on fathers continues to be minimal. As western societies continue to broaden their ethnic make-up and alter the 'typical' family structure, it is critical to examine cultural factors that impact behaviors and put forth effort to refrain from inappropriately generalizing data from the majority group to others without due process and definitive data. Additionally, Lalor and McElvaney (2010) indicated that an examination of various studies around the world maintained a typical 70% response rate as it pertained to sexual assault victims participating or following through with proposed studies. Further, as previously mentioned, approximately 30% of children do not disclose their abuse to any individual during their childhood (Cromer & Goldsmith, 2010; London, Bruck, Ceci, & Shuman, 2005; McElvaney, Greene, & Hogan, 2014), which indicates that a great deal of the CSA victims have not been assessed and are not included in current research.

Similarly, although there is thorough research regarding the effectiveness of providing psychoeducation to parents on prevention of general maltreatment or abuse of children, specific research is still needed to determine how such practices will deter CSA (Lalor & McElvaney, 2010). In other words, research is required in order to determine what preventative strategies will effectively decrease the risk that a child will be exposed to intrafamilial sexual abuse. It has been noted throughout research that individuals who suffered from intrafamilial sexual abuse are less likely to engage in research studies when compared to other sources of sexual misconduct (Goodman-Brown, Edelstein, Goodman, Jones, & Gordon, 2003). Therefore, while information regarding childhood sexual abuse may be available, it is often not specifically geared towards those who have been abused by a family member, which as mentioned above, constitutes additional layers of concerns and consideration regarding post-abuse recovery. Unfortunately, the landscape of current research is sparse and therefore definitive conclusions cannot be made. While the current research is meaningful and provides a foundation for future research, generalizations and clinical implications must be formulated cautiously as the studies often exhibit small sample sizes, a lack of diversity among participants, and are qualitative in nature. However, the qualitative information has provided initial insight into the viewpoints of non-offending mothers and their children regarding CSA, which undoubtedly will aid in the development of hypotheses and will assist in guiding future, meaningful research studies.

Future Research.

Several gaps remain within the literature regarding childhood sexual abuse. Such gaps may prove useful for directing future research and could potentially aid in further bridging the gap between NOPs and their children who survived CSA. Research is certainly required in order

to examine the NOPs memory during the time of their child's sexual abuse. Additionally, future research may identify specific factors that potentially diminish the NOPs memory during such periods such as the NOPs mental health symptoms, substance abuse, or trauma symptoms. More specifically, information regarding NOPs with dissociative amnesia type symptoms during periods in which their child is being abused could potentially provide meaningful data. Such information may prove useful in developing a thorough understanding of what truly deters NOPs from recognizing their child's abuse when such abuse happens in the home via a family member such as a stepparent or live-in partner.

Further, understanding the possible influences of the NOPs feelings of betrayal, due to their own betrayal trauma, following disclosure could lend important therapeutic information regarding the post-disclosure joint-therapy trajectory for the NOP and survivor; however, research is required in order to definitively conclude such theories. Similarly, research is necessary in order to assess the impact of understanding the NOPs betrayal trauma on the child's adjustment trajectory following CSA. It may also prove beneficial to explore the impact of strengthening CSA trauma informed care across professions that work with children regarding improving their ability to recognize and intervene with victims. It is unclear whether such information would be beneficial to the child and as such should be researched prior to being utilized in therapeutic settings in order to prohibit further trauma or maladjustment of the child.

Conclusion

CSA remains a source of significant concern and occurs at a high rate. More concerning is the deep and possible long-term effects of CSA as well as its impact on perpetuating the cycle of intergenerational trauma and mental health difficulties. Further, the betrayal trauma that

occurs among the child survivors as well as the NOPs creates unique therapeutic barriers and increases the complexity of processing and adaptively coping with such experiences. While the limitations in current research coupled with the sparse landscape of definitive data regarding CSA may appear disheartening as it pertains to decreasing such types of trauma, it is important to note that general awareness regarding trauma and mental health difficulties is increasing (American Psychological Association, 2019). Additionally, there is currently a strong sense of empowerment across countries towards the de-stigmatization of receiving psychological interventions for a wide variety of mental health difficulties and issues. For example, 87% of adults believe that having a mental health disorder is nothing to be ashamed of and that individuals with disorders can become better through the use of psychological intervention (American Psychological Association, 2019). As society continues to increase awareness of trauma, awareness of mental health difficulties, and improves accessibility of services, significantly more individuals are receiving the necessary assistance in order to process and cope with their struggles (Hodgkinson, Godoy, Beers, & Lewin, 2017; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010; American Psychological Association, 2019). Further, providing psychoeducation regarding CSA continues to occur across settings such as among mandated reporters and in mental health facilities. Given the improvement in awareness of mental health difficulties and the decreased stigmatization of common disorders, theoretically, such awareness of the high rate of CSA may also follow similar trajectories. Interventions and preventative strategies appear to have been effective regarding decreasing various other forms of maltreatment of children such as physical and emotional abuse (Lalor & McElvaney, 2010), therefore there is hope that the current strive to decrease CSA will also be effective. As with

many issues, simply improving awareness and disseminating correct data may lead to further research, effective preventative strategies, and empirically supported interventions.

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