

THE EFFECT OF A MATERNAL HISTORY OF SEXUAL ABUSE ON SUPPORT FROM
THE CHILD'S PERSPECTIVE FOLLOWING CHILD SEXUAL ABUSE

A thesis presented to the faculty of the Graduate School of Western Carolina University in
partial fulfillment of the requirements for the degree of Master of Arts in General Psychology.

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ABSTRACT

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Previous research has exhibited the impact that maternal support has on children following instances of child sexual abuse (CSA; Cyr, McDuff, & Hébert, 2013; Valentino, Berkowitz, & Stover, 2010). However, it remains unclear as to what degree a maternal caregiver's history of abuse effects their ability to provide support for their child following instances of CSA. Few previous studies have been able to draw consistent conclusions concerning the effect of a maternal history of abuse on support provided for CSA victims (Smith et al., 2017). The current study examined these factors using the Maternal Support Questionnaire- Child Report (MSQ-CR; Smith et al., 2017), an established measure of maternal support as indicated from the child's perspective. The MSQ-CR separates CSA-specific maternal support into the following three subscales: Emotional Support, Skeptical Preoccupation, and Protection/Retaliatio. Multiple correlations and hierarchical linear regressions were executed to examine the effect that maternal histories of childhood physical abuse, childhood sexual abuse, and/or romantic partner physical, sexual, and/or emotional abuse had on maternal support following cases of CSA. Additionally, variables supported by previous research as influencing maternal support following CSA were accounted for to gain a more accurate perspective on the potential impact of a maternal abuse

history on support (Cyr et al., 2003; Cyr et al., 2013; Smith et al., 2010). These variables included maternal relationship with the abuser, maternal relationship with parents, maternal-caregiver child relationship quality, child age, and child gender. Results from the study supported previous research exhibiting the impact of maternal caregiver relationship with the perpetrator of her child's abuse as well as maternal caregiver-child relationship quality on maternal support. Regarding variables related to a maternal history of abuse, childhood physical abuse, romantic partner physical abuse, and/or romantic partner sexual abuse histories were shown to be the largest predictors of various aspects of maternal support. Specifically, maternal caregivers within the study with a history of childhood physical abuse tended to provide increased levels of emotional support, leading to the increased overall perception of maternal support from the child's perspective. Maternal caregivers with a history of romantic partner physical abuse also tended to provide increased levels of emotional support, leading to increased overall support. However, caregivers with such a history additionally exhibited increased levels of skeptical preoccupation and protection and retaliation as measured by the MSQ-CR; thus, leading to decreased levels of overall perceived support. Maternal caregivers with a history of romantic partner sexual abuse tended to exhibit decreased levels of skeptical preoccupation, leading to an increase in overall maternal support. These results highlight previously overlooked factors impacting maternal support following CSA and exhibit the potential influence of a maternal history of abuse in childhood and/or adulthood. The results from the present study can be further utilized to refine clinical interventions to promote increased maternal support and improve child CSA victim outcomes.

INTRODUCTION

Previous research has exhibited the impact that parental support, in particular maternal support, has on children following instances of child sexual abuse (Cyr, McDuff, & Hébert, 2013; Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Malloy & Lyon, 2006; Valentino, Berkowitz, & Stover, 2010). Supportive and engaging maternal responses to their child following any type of traumatic event are associated with more positive outcomes and adjustment (Cyr et al., 2013; Everson et al., 1989; Malloy & Lyon, 2006). Conversely, negative parenting behaviors resulting from a traumatic event such as hostile, coercive, or blaming actions against the child are associated with negative child outcomes and an increase in psychopathology (Cyr et al., 2013; Moehler et al., 2007; DiLillo & Damashek, 2003). Conclusions can be drawn from previous research that in instances of child sexual abuse (CSA) maternal support can play a vital role in the child's coping and recovery. However, it remains unclear as to what degree a maternal caregiver's history of abuse and/or trauma effects their ability to provide support for their child following instances of CSA. Smith and colleagues (2017) noted that, although this topic has been examined previously, few studies have been able to draw consistent conclusions concerning the effect of maternal history on levels of support provided for CSA victims and only a handful have examined the maternal level of support provided from the child's viewpoint. The authors further questioned the validity and reliability of measures aimed at operationalizing maternal support. To aid in intervention efforts, it is important to establish both the predictors and outcomes of maternal support following CSA using well-validated measures. The current study will examine these factors as they are experienced by many survivors of CSA using an established measure of maternal support from the child's perspective.

Previous research has shown that abuse is more likely in families that carry with them a history of abuse (Jaffee et al., 2013; Moehler, Biringen, & Poustka, 2007). There are multiple theories as to why this phenomenon occurs: that children of parents who have been subjected to abuse are more likely to be exposed to situations in which abuse is more likely to occur, that individuals exposed to abuse and/or violence will imitate this behavior, or the influence of other outside factors (Baril, Tourigny, Paillé, & Pauzé, 2016). Nonetheless, previous research has repeatedly supported this repeated occurrence which unfortunately often applies to child sexual abuse in that many child sexual abuse victims also have a parent who themselves have a history of CSA or other violence or abuse (Baril et al., 2016; Jaffee et al., 2013; Leifer, Shapiro, & Kassem, 1993). Previous researchers have further theorized that mothers who have themselves been victimized through instances of abuse are less equipped to provide adequate support for their child following CSA due to repercussions of their own traumatic history (Jaffee et al., 2013; Moehler, Biringen, & Poustka, 2007).

Several previous research studies have found that if a nonoffending caregiver, particularly maternal caregivers, have a past experience of trauma or abuse, this has the high possibility to influence the amount of negative psychological impact that this caregiver experiences following the discovery of abuse with his/her own child (Chandler-Holtz, & Semple, 1996; Green, Coupe, Fernandez, & Stevens, 1995; Timmons-Mitchell, Parades, Leifer, & Kilbane, 2001). Mothers and maternal caregivers of child sexual abuse victims may experience second-hand trauma symptoms as a result of their child's abuse; however, maternal caregivers who themselves have experienced sexual abuse or other trauma are particularly susceptible to delayed posttraumatic stress symptoms as well as associations between their child's trauma and their own (Green et al., 1995; Parades et al., 2001; Timmons-Mitchell et al., 1996). This

association of trauma also has the possibility of negatively impacting the victimized child by limiting the amount of care available by the maternal caregiver and dictating the maternal caregiver's response to the abuse.

The proposed research will explore if and how a maternal history of trauma, amongst other predictors, influences maternal caregivers' response to her child's trauma in cases of CSA. The research will utilize a recently developed measure of maternal support as reported by the child victim to gain a unique view. The data collected from these measures will then be analyzed alongside data concerning nonoffending maternal caregivers' trauma history as well as CSA child victims' outcomes post disclosure. This will further be utilized to determine the relationship between nonoffending maternal caregivers' support and child outcomes and how a maternal history of trauma or violence impacts this relationship.

Child Sexual Abuse: Definition and Outcomes

One primary concern when researching factors associated with child sexual abuse is that there is no singular definition of what constitutes as CSA. CSA laws are state-driven in the United States and derive from the minimum definition standards created by the Child Sexual Abuse Prevention and Treatment Act (CAPTA) established in 1996 (Mitchell, & Rogers, 2003). According to the CAPTA, CSA is defined as, "[t]he employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct; or the rape, and in the cases of caretaker or other inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children or incest with children" (Child Welfare Information Gateway, 2016, p. 4). However, states may vary on the specific details, such as the age of consent.

In South Carolina, sex crimes against children are separated into three categories: crimes that involve touching or attempted touching, crimes of solicitation, and crimes involving photographs or other media (Children’s Law Center, 2010). Sexual crimes against children involving touching is further defined as follows: “sexual intercourse, anal intercourse, cunnilingus, fellatio, or any intrusion of any part of a person’s body or of any object into the genital or anal openings of another person’s body” (Children’s Law Center, 2010, p. 1). This definition is utilized in prosecuting criminal sexual conduct in the first degree if the perpetrator is found guilty of the sexual battery of a victim less than eleven years old or a victim under sixteen years old if the perpetrator has previously been convicted of such a crime or has previously been registered as a sex offender. For the purpose of the present study, South Carolina’s legal definition of child sexual abuse involving touching will be utilized as the broader definition of CSA due to the collection of the current data set being completed in South Carolina.

Childhood sexual abuse, as well as other forms of trauma and/or violence, can lead to multiple forms of maladaptive coping as well as numerous forms of emotional, psychological, and even physical symptoms that can span from childhood into adulthood (Labella et al., 2018; Levenson, 2016; Lindert et al., 2014; Newcomb & Locke, 2000; Runsten et al., 2014; Suzuki, Poon, Papadopoulos, Kumari, & Cleare, 2014). Because children’s brains are still developing, the physiological response to an adverse or stressful event through the rapid increase in corticosteroids can be overwhelming and dangerous (Suzuki et al., 2014). This type of overexposure to corticosteroids has been connected to depression as well as lower cortisol reactivity in adults with a history of childhood trauma. The large amount of stress experienced in childhood as a result of physical or sexual abuse are highly correlated with later depressive and anxiety symptomatology in adulthood; thus, leading to the term “toxic stress” in reference to

exposure to such maltreatment during childhood (Lindert, 2014). Adverse childhood experiences have also been linked to higher instances of other somatic and psychiatric illnesses, increased romantic violence perpetration and victimization, and increased substance abuse in adulthood (Labella et al., 2018; Levenson, 2016; Runsten et al., 2014). Therefore, instances of trauma in childhood such as sexual abuse often lead to immediate negative repercussions as well as harmful effects and outcomes that stem into adulthood. Maternal support is a factor that has been shown to moderate this relationship and lead to more positive adjustment outcomes for victims of CSA.

Importance of Maternal Support for Children following CSA

Previous research has found that parental support, specifically maternal support, for victims of CSA is critical in the child's emotional and psychological recovery (Cyr et al., 2013). Maternal support has been linked to child victims' increased healthy coping methods, higher self-esteem, secure relationship attachments, and positive emotional and behavioral adjustment following the abuse (Everson et al., 1989; Malloy & Lyon, 2006). Conversely, low levels or lack of maternal support from a primary maternal caregiver has been associated with increased emotional and psychological disturbance and increased likelihood of the child victim recanting their abuse accusation at some point during the CSA investigation (Everson et al., 1989; Malloy & Lyon, 2006). Additionally, children with maternal caregivers who display blaming or rejecting behavior following instances of trauma or abuse are also more likely to be removed from their homes, further disrupting their adjustment and attachments from other potentially supportive friends or family members (Everson et al., 1989).

Notably, in cases of CSA, maternal support levels prior to as well as following the abuse often influence whether or not the child willingly discloses the abuse occurrence, the timing of

their initial disclosure, who the child chooses to disclose to, and/or the child's willingness to maintain their disclosure over time (Malloy & Lyon, 2006). Malloy and Lyon (2006) found that in a group of prepubescent children presenting with various sexually transmitted diseases varied in terms of previous disclosure or nondisclosure. The nondisclosure rates among the sample were 37% for children with supportive caregivers and 83% with nonsupportive caregivers. This research also determined that nonoffending caregiver's lack of support was a significant predictor of whether the child victim recanted their disclosure at some point during the CSA investigation.

Additionally, previous research conducted by Valentino, Berkowitz, and Stover (2010) indicated that, as can be expected, hostile and coercive parenting styles following a potentially traumatic event such as CSA was strongly correlated with negative child-reported symptoms of posttraumatic stress, internalization, and negative adjustment. Alternatively, supportive and engaged parenting was correlated with positive personal adjustment for the child victim. This study again exhibits how parents' behaviors and attitudes following a potentially traumatic event such as childhood sexual abuse can impact a child victim's level of posttraumatic stress symptoms and overall recovery from the trauma. The study also argued that interventions following a traumatic event should include extensive parental interactions and focus on increasing the level of parental support and promoting more positive interactions between the caregivers and the child. However, it remains unclear as to what factors, such as personal history or attachment and parenting styles, contribute to a caregiver's ability to provide support for their child following a traumatic event such as CSA.

The amount of maternal support offered to children following instances of CSA varies due to a multitude of potential factors. Previous research has shown evidence of maternal support

in response to CSA ranging from 27-56% in cases of familial incest (Everson et al., 1989). In this study, Everson and colleagues (1989) determined that out of the 88 mothers or maternal figures evaluated less than one-half were classified as supportive of their children following familial incest. The study shed light on the role-conflict that is often present in nonoffending maternal caregivers of CSA victims in cases of familial incest or instances where the maternal caregiver's romantic partner is the perpetrator of the abuse. In such instances the maternal caregivers often report feeling torn between their relationship with their child and their relationship with their romantic partner or family member. This further results in an increase in unsupportive behaviors exhibited by the maternal caregiver such as disbelief, rejection, or blame. In Everson and colleagues' (1989) study, almost a quarter of the maternal caregivers sided with their spouse or partner as a response to the incest accusation from their child; however, the majority of the maternal caregivers at least offered some extent of uncertain support for their child. Children in such cases who have been abused by their fathers, father-figures, or other family members are especially at-risk for negative emotional repercussions resulting from feelings of betrayal that stem from lack of support.

Although a multitude of research has been conducted on the subject of CSA, specifically the importance of maternal support following instances of CSA, the data remains unclear as to the exact degree to which maternal support effects child outcomes as well as what factors influence maternal support. Based on previous research it is clear that parental and maternal support following any type of trauma can influence and promote various types of emotional, physical, and psychological child outcomes (Bolen & Lamb, 2007; Godbout, Briere, Sabourin, & Lussier, 2014; Zajac, Ralston, Smith, 2015). Previous research has also found that there are a number of factors that contribute to perceived levels of parental and maternal support,

particularly in cases of CSA (Godbout et al., 2014; Hershkowitz, Lanes, Lamb, 2007; Zajac et al., 2015). These include belief in the child, initial and later reactions to the abuse disclosure, exhibited distress levels, reporting to outside services, and continued interactions with the perpetrator. However, there is a gap in the previous research related to the topic of maternal support following CSA in that this research varies widely in definitions and outlines of maternal support. Additionally, previous studies often utilize measures that correlate with the maternal relationship with the child prior to the abuse occurring rather than specifically measuring the level of maternal support received by the child in light of the abuse disclosure. This has resulted in mixed results and inconsistent information as to the degree to which maternal support moderates the negative child outcomes associated with CSA.

These inconsistencies in the literature were confirmed through a meta-analysis conducted by Bolen and Gergely (2015). This study analyzed a total of 29 previous studies published prior to 2012 regarding the relationship between nonoffending caregiver support following CSA and post abuse disclosure functioning in the child victims. The meta-analysis exhibited minimal support for the relationship between nonoffending caregiver support of sexually abused children and children's post disclosure functioning. However, Bolen and Gergely (2015) recognized that this conclusion may not be accurate due to the multiple methodological weaknesses found in the studies that were analyzed, particularly regarding the definition and measurement of nonoffending caregiver support. A large portion of the studies (8 of the total 29) utilized the Parental Response to Incest Disclosure Scale (PRIDS) or the Parental Response to Abuse Disclosure Scale (PRADS). These scales examine nonoffending caregiver support in terms of three or four categories: emotional support, belief, action against the perpetrator, and in the PRADS, use of professional services. Although these are common dimensions utilized when

examining parental or caregiver support, both the PRIDS and the PRADS contains only a single-item measurement for each category of support. Another common measure utilized was the Parental Support Questionnaire (PSQ; 1996; 2000). Because this ten-item measure was developed and used exclusively by Cohen and Manarino in their 1996 and 2000 studies, it is not supported by outside researchers. Additionally, both the PRIDS and the PRADS as well as the PSQ only contains parent self-reports and lacks a child-report measure. Overall, a total of 14 different dimensions of nonoffending caregiver support was assessed between the 29 total studies. This discrepancy led to varied results and inconsistent data measurements making it impossible to determine an accurate extent to which nonoffending caregiver support moderates negative child outcomes associated with CSA.

Research conducted by Smith and colleagues (2017) sought to address the problems in maternal support measurement with the creation of the Maternal Support Questionnaire- Child Report (MSQ-CR; Smith et al., 2017) and the Maternal Self-Report Support Questionnaire (MSSQ; Smith et al., 2017). Smith and colleagues' new child report, paired with the corresponding maternal self-report measure, was purposefully developed in order to promote more consistent and accurate data collection concerning maternal support specifically related to instances of CSA. The initial items of the MSQ-CR were developed to coincide with aspects of CSA-specific support as confirmed by previous research on the subject (Finkelhor & Browne, 1985; Spacarelli, 1994) as well as through coordination with CSA treatment experts. Following factor analysis items that had a loading of .40 or greater were kept and then further divided into three scales to represent three varying aspects of maternal support in response to CSA. These included Emotional Support, Skeptical Preoccupation, and Protection/Retaliation subscales. The correlations between each of the scales were significant and are described as follows: the

Emotional Support Scale and the Skeptical Preoccupation Scale ($r = .28, p < .01$), the Protection/Retaliation Scale and the Emotional Support Scale ($r = .38, p < .01$), and the Skeptical Preoccupation Scale and the Protection/Retaliation Scale ($r = .27, p < .01$). The internal consistencies of each scale were then confirmed through reliability analyses with Cronbach's α of .87 for the Emotional Support Scale, .71 for the Skeptical Preoccupation Scale, and .73 for the Protection/Retaliation Scale. Researchers then piloted this new child report measure with a sample of confirmed CSA survivors. Significant correlations were found between the MSQ-CR and the MSSQ to confirm the construct validity of the MSQ-CR. Additionally, there were significant correlations between all of the scales included in the MSQ-CR and the established Trauma Symptom Checklist for Children measure (TSCC; Briere, 1996). The MSQ-CR is unique in that it is reported by the child in terms of their viewpoint as to the quality and amount of maternal support they are receiving directly in response to their sexual abuse. The MSSQ measures similar components of support consisting of Emotional Support and Blame/Doubt. Once the psychometrics of the MSSQ and MSQ-CR were finalized the original data set utilized in the current study was collected.

Maternal Reaction to CSA in their Children

Nonoffending caregivers may experience a number of negative reactions as a result of the discovery of their child's sexual abuse and the resulting emotional impact. These symptoms commonly include, but are not limited to: depression, anxiety, posttraumatic stress symptoms, marital dissatisfaction, increased hostility, feelings of guilt and inadequacy, unresolved anger towards the perpetrator, psychotic behavior, and other secondary trauma-related symptoms (Davies, 1995; Manion et al., 1996; McCourt, Peel, & O'Carroll, 1998; Newberger, Gremy, Wateraux, & Newberger, 1993; Valentino et al., 2010). Research has repeatedly shown that

parents of child sexual abuse victims are more likely to experience numerous and severe levels of emotional distress when compared to parents of children who had not been sexually abused (Manion et al., 1996, Newberger et al., 1993). Both fathers and mothers of child sexual abuse victims have been shown to exhibit these types of notable distress symptoms. This emotional and psychological suffering has also shown to persist regardless of interventions from outside parties or whether the child in question continues to exhibit negative symptoms from the trauma or not (Davies, 1995). This creates the avenue for a cycle in which the parents' distress could possibly spark continued negative reactions from the child and influence the amount of support that the parent is able to offer their child.

The majority of marital or romantic relationships between nonoffending parents or caregivers of child sexual abuse victims are also negatively affected by the distress resulting from the abuse (Davies, 1995). Expressed lack of trust between nonoffending parents is a prominent feeling expressed by caregivers of sexually abused children (McCourt et al., 1998). This lack of trust and feelings of paranoia can easily cause a romantic partnership to come under pressure. Marital or relational strain following the discovery of a child's sexual abuse can also stem from the differing manners in which the paternal and maternal caregivers of sexual abuse victims typically express and confront their secondary symptoms (Manion et al., 1996; McCourt et al., 1998). There is also evidence of relationship dissatisfaction between the parents leaking into the larger aspect of family cohesion and negatively impacting the child in question. In Davies's (1995) study of parental distress following the disclosure of child sexual abuse, most parents reported their own distress and relationship problems interfering with familial relationships with the victimized child as well as other children or persons within the household. Often, the relationship with the child victim would be particularly strained. Stress such as that

from attachment and marital strain as well as the general stress experienced by the parents of CSA victims also negatively impacts the degree to which parental and maternal support is readily available to the child (Parades et al., 2001; Whitson & Kaufman, 2017). This then has the potential to lead to an increase in negative coping and maladaptive behaviors in the child.

On average, mothers have been shown to have more intense negative emotional and psychological distress following the discovery of their child's sexual abuse compared to fathers of child sexual abuse victims. Reported levels of pre-abuse maternal functioning, satisfaction with one's own parenting role and abilities, and perceived outside support following the abuse have all been shown to correlate with the levels of experienced emotional distress reported by mothers of sexually abused children (Manion et al., 1996). In Manion and colleagues' (1996) research evaluating the psychological distress in nonoffending parents following their child's sexual abuse the mothers in the study reported on average lower satisfaction with their own parenting when compared with the fathers in the study; this was shown to often further result in reported feelings of loss of control, negative feelings of self-worth, helplessness, and feeling ill-prepared to help their child deal with the emotional and psychological consequences of their abuse.

These reported symptoms are, on average, particularly prevalent throughout the initial stages of disclosure of the abuse; however, in Newberger and colleagues' (1993) research one-third of mothers who participated in a longitudinal study exhibited clinically significant negative symptoms twelve months following the initial interview for the study. Another study conducted by Kelley (1990) supports the prevalence of secondary traumatization symptoms over time in parents of child sexual abuse victims by finding significant levels of distress in a sample of mothers an average of two years following the sexual abuse of their child. These results show

that the negative implications from a child's abuse have the ability to remain a consistent factor in mothers' lives for a prolonged period of time. This distress interferes with the amount of support the nonoffending maternal caregiver is able to provide for the child victim following sexual abuse; thus, unintentionally promoting unfavorable outcomes and maladaptive coping strategies for the child (Paredes et al., 2001; Valentino et al., 2010; Whitson & Kaufman, 2017).

Although multiple studies have confirmed the secondary traumatization through various emotional and psychological means that child sexual abuse can have upon the parents (particularly mothers and maternal caregivers) of the victims, parents and families are rarely provided with appropriate support or crisis intervention resources following cases of child sexual abuse (Davies, 1995; Manion et al., 1996, McCourt et al., 1998; Newberger et al., 1993, Valentino et al., 2010). This secondary traumatization symptomology is theorized to be especially prevalent and damaging for both the parent and child victim if the parent has a previous history of sexual trauma or sexual abuse during childhood. Such a history has the potential to further damage the parents' functioning following the disclosure of their child's abuse and limit their ability to provide adequate support for their child due to their own emotional and psychological distress.

Effect of Maternal Response on Child's Processing of Trauma

Maternal distress levels as a response to their child's disclosure of CSA has also been shown to potentially impact the child victim's post-abuse functioning (Green et al., 1995; Newberger et al., 1993; Parades et al., 2001; Valentino et al., 2010). In studies concerning mothers' distress levels and the effects that this has upon child sexual abuse victims, it is often found that a mother's self-reported psychological distress and posttraumatic stress symptoms correlates with the mother-reported child distress symptoms; however, the parent-reports in these

cases often had higher ratings of all symptoms compared to the children's own self-reports (Newberger et al., 1993; Valentino et al., 2010). Due to the inconsistency between the maternal child symptomology reports and the child self-reports, the actual relationship between maternal distress and child post-abuse processing of trauma and functioning remain unclear.

Researchers in both Newberger and colleagues' (1993) and Valentino and colleagues' (2010) studies theorized that when the mothers in the dataset were highly distressed, their own emotional and psychological states may have affected their judgement of their own children's distress; therefore, making it difficult to separate their own emotional pain and suffering from that that they observed in their children. This phenomenon can be further theorized to extend to maternal caregivers who themselves have a history of sexual trauma or CSA as it would be increasingly difficult for these maternal figures to disconnect their own abuse history from their current suffering as a result of their child's abuse as well as their child's own current distress.

Parents who unintentionally skew their view of their child's reactions and stress due to their own symptoms or histories are potentially reducing the amount of aid they can provide their child due to their altered and inaccurate interpretations (Newberger et al., 1993; Valentino et al., 2010). For example, nonoffending parents may report their child experiencing increased or distorted negative outcomes following their sexual abuse due to the parent's own heightened distress. This could further lead to unhelpful clinical interventions for the child based on inaccurately reported maladaptive behaviors and distress symptoms. The prominence of incorrect perspectives specifically from mothers of sexual abuse victims is supported by various other research studies that state the need for child self-report measures as well as familial interventions when confronting child sexual abuse cases (Green et al., 1995; Manion et al., 1996; Newberger et al., 1993; Valentino et al., 2010).

Although the current research topic has not been examined extensively, based on previous studies it can be concluded that a parent's reaction and distress from their child's sexual abuse has the strong possibility of creating an adverse reaction for the child victim (in addition to the negative emotional and psychological distress that these victims are already experiencing from the trauma; Green et al., 1995; Newberger et al., 1993; Parades et al., 2001; Valentino et al., 2010). It is further theorized that a history of sexual trauma or childhood sexual abuse has the probability of further skewing caregivers' view of their child's CSA and increasing the amount of psychological and emotional distress experienced by parents. This skewed perspective and increased symptomology has the potential for limiting the amount of support that parents and caregivers are able to provide for the child victim and possibility increasing psychopathology in the child.

Influence of Maternal Trauma on Response to Child's CSA

Previous studies concerning the current research question have examined the impact that nonoffending mothers' psychological states and emotional responses to the disclosure of their child's sexual abuse has upon their child's processing and response to the abuse (Green et al., 1995; Newberger et al., 1993; Parades et al., 2001; Valentino et al., 2010). Maternal response and support following their child's abuse can also be strongly influenced by their own previous experienced trauma and/or sexual abuse history. The focus of a maternal history of trauma and/or CSA and its impact on maternal response to CSA in her child is relevant and needed due to the abundance of such occurrences; it has previously been reported that approximately 50% of mothers of child sexual abuse victims have also suffered sexual abuse as a child (Baril et al., 2016). This further suggests that a maternal history of abuse has the potential to effect child

sexual abuse victim outcomes due to levels of support and reactions to the disclosure of the abuse.

A study by Newcomb and Locke (2000) examined the relationship between various forms of child maltreatment and parenting practices. Within this study, there was a moderately strong effect found between general factors of childhood maltreatment and general factors of parenting practices for both mothers and fathers. For mothers, aspects of family neglect were correlated with poor overall parenting above that of general childhood maltreatment as well. Additionally, for mothers a history of CSA was correlated with particularly aggressive parenting. Conversely for fathers, a history of CSA was found to correlate with rejecting or avoidant parenting practices. These maladaptive parenting practices were attributed to attachment patterns learned through familial and parental relationships in childhood that have extended into adulthood. This study supports previous research suggesting that greater exposure to childhood maltreatment is correlated with increased parenting dysfunction and adverse parenting practices; thus, providing an avenue for continued instances of abuse.

In a separate study by Timmons-Mitchell and colleagues (1996) mothers of sexually abused children were evaluated in two separate study groups; mothers who had previously also been sexually abused as a child and mothers who had no such childhood history. Although the mothers from both groups reported significantly higher levels of multiple posttraumatic stress symptoms compared to a normative average, mothers who had themselves been sexually abused as children were more consistently negatively affected and reported higher levels of posttraumatic stress symptoms compared to the second group of mothers. It has been shown that in mothers of child sexual abuse victims who have themselves been subjected to sexual abuse or trauma, often the “original traumatic memories [are] brought into consciousness by subsequent

experiences that symbolized or actually resembled the original victimization [experienced by the mothers]...the sexual victimization of a [child] act[s] as a direct reminder of the mother's own childhood [abuse]" (Green et al., 1995, p.1280). Previously victimized mothers often report flooding of intrusive memories of their own abuse, depression, post sexual abuse trauma, and delayed symptoms of complex posttraumatic stress disorder; in extreme cases this has been noted as leading to suicidal or self-harm centered thoughts (Green et al., 1995).

This heightened reaction to the discovery of a child's sexual abuse also extends beyond mothers' past experiences with strict sexual abuse. It has been shown that a number of factors in a mother's history can dramatically affect her response to her child's abuse and the impact of experienced second-hand trauma (Parades et al., 2001). A mother's experience with familial relationship conflict, childhood physical abuse, instability in care as a child, and familial substance abuse history can all affect her response to her child's sexual abuse as well as impact her child's post-abuse functioning. Parades and colleagues' (2001) research also concluded that mothers who reported previous notable familial problems also reported their sexually abused children exhibiting increased aggressive behaviors compared to sexually abused children whose mothers did not have a traumatic familial history. The children in question also reported a poorer school experience, fewer friends, and poorer general functioning. There were also positive correlations between mothers who reported familial substance abuse during their childhood and their sexually abused children reporting less positive overall functioning and fewer friends; mothers who had instability of care during their childhood and their sexually abused children exhibiting symptoms of somatic complaints, anxiety, and depression; and others with a history of sexual abuse as a child and their sexually abused children exhibiting increased behavior problems.

It would be reasonable to conclude based on previous research that such secondary-victimization symptoms and intrusive reminders of their own abuse would hinder the amount of support that some mothers and maternal caregivers would be able to provide for their children following their own sexual abuse and lead to negative overall functioning outcomes for the child victims. Compared to populations of child sexual abuse victims whose mother has no history of CSA, child CSA victims whose mothers had also suffered sexual abuse as a child often report higher rates of problematic behaviors and are more likely to report being sexually abused by a trusted person versus a stranger or a person who was viewed as untrustworthy (Baril et al., 2016). It was also shown that sexually abused children whose mothers also have a history of CSA grow up with more psychosocial risk factors and report poorer overall adaption. The presenting question in such research is whether increased negative outcomes for CSA victims whose mother also has a history of CSA is due to the mothers' inability to provide adequate support and care following the disclosure of their child's abuse due to their own experiences, if mothers of victims with a CSA history themselves exhibit increased levels of distress which lead to increased negative functioning of their children, or if mothers with a history of CSA exhibit symptoms and causalities caused by their trauma that last into adulthood and lead to maladaptive parenting practices that furthers the negative impact on their child following CSA.

Research by Leifer, Kilbane, & Kalick (2004) examines conditions in which mothers with a history of CSA were able to prevent such abuse for their children. The research examined four groups of nonoffending mothers: a) sexually abused mothers of children who were not sexually abused, b) sexually abused mothers whose child was also sexually abused, c) mothers with no history of sexual abuse with children who also had no history of sexual abuse, and d) mothers with no history of sexual abuse who had a child who had been sexually abused. The

results of this study showed that mothers who had been sexually abused whose children did not experience such sexual abuse exhibited functioning that matched that of mothers who had not experienced sexual abuse. Contrastingly, mothers who had a history of sexual abuse whose children had also been sexually abused exhibited significantly more disturbed and negative functioning than the other three groups of mothers in the study, particularly in terms of attachment relationships. Insecure attachment relationships for mothers during childhood was shown to increase the probability of CSA for the children of mothers who were themselves sexually abused as children. The study ultimately suggests that mothers with a history of CSA may experience lasting symptoms associated with the CSA such as PTSD, depression, anxiety, cognitive distortions, and dissociation. These symptoms were theorized to lead to more negative events and parenting behaviors that allowed for future instances of abuse in their children as the mothers in the study who successfully discontinued this cycle exhibited significantly less trauma-related symptoms associated with their past abuse including sleep disturbance, dissociation, and anxiety. Ultimately, these mothers who had themselves experienced sexual abuse as a child but whose children did not were deemed as achieving better developmental outcomes than might be expected for adult CSA survivors. However, additional research concerning how a maternal history of sexual trauma influences maternal response to and support following the disclosure of her child's sexual abuse and how this further impacts the child victim is needed. The current study will address this research question along with the inconsistencies in the current literature surrounding this topic.

Previous research has shown that, even when not perpetrated directly by the caregiver, a child who has a parent that has experienced a form of abuse and/or maltreatment is much more likely to themselves experience a form of abuse and/or maltreatment (Baril et al., 2016; Jaffee et

al. 2013; Leifer, Shapiro, & Kassem, 1993; Moehler et al., 2007). A previous study by Leifer and colleagues (1993) examining the impact of maternal history on foster placement and adjustment in sexually abused girls noted that 52% of the mothers in the study themselves experienced CSA; a percentage considerably higher than the rate of CSA among females in the general population. These recurrences hold true even when parents with a history of abuse do not themselves transmit the abuse to their children. Instead, other associated risk factors such as social economic status, familial substance abuse, lasting psychopathology, and instable social attachments may increase the likelihood that their child will experience abuse (Baril et al., 2016; Bowman et al., 2009; DiLillo & Damashek, 2003; Leifer et al., 2004; Leifer et al., 1993; Moehler et al., 2007).

In particular, women with a history of CSA have been shown to be at increased risk for substance abuse, experiencing puberty and/or becoming pregnant at an earlier age, increased mental health psychopathology, increased anxiety surrounding intimacy, high risk sexual behaviors, and the tendency to be socially isolated and to emotionally distance themselves (Baril et al., 2016; Bowman, Ryberg, & Becker, 2009; DiLillo & Damashek, 2003; Leifer et al., 1993; Lyons-Ruth & Block, 1996; Roberts, O'Connor, Dunn, Golding, & The ALSPAC Study Team, 2004). It is further argued that these maladaptive outcomes in adults who have a childhood history of trauma promotes the transmission of abuse and trauma to their children through attachment disturbance, inappropriate or maladjusted parenting practices, and/or disassociation.

A model proposed by Baril and colleagues (2015) explains this phenomenon, specifically in cases where both a child and nonoffending mother have been subject to CSA. They propose that the traumatic experience of the CSA experienced by the mother combines with the increased likelihood of experiencing other forms of childhood abuse and adversities which are common in cases of CSA; thus, resulting in negative outcomes and adjustment in adulthood. These outcomes

serve to create a harmful environment for the child as well as increase the likelihood of maladaptive coping mechanisms by the mothers that potentially interfere with their parenting. These challenges serve to promote childhood difficulties and, when combined with adverse parenting practices, make the child more vulnerable to sexual abuse even when the abuse is not perpetrated directly by a caregiver.

Bearing this in mind, the current research seeks to investigate this repeated occurrence of abuse in terms of maternal response to her child's disclosure of CSA and how this, in turn, will affect the child victim's overall symptomatology and functioning post-disclosure. Previous research on the subject varies but suggests that nonoffending maternal caregivers will have increased adverse reactions to her child's abuse which will further promote maladaptive coping and adjustment by the child.

Current Study

Based on the results from previous research relevant to the current topic it can be concluded that, although notable progress has been made in the realm of child and parental reactions to childhood sexual abuse, additional research is needed in order to optimize treatment outcomes for those experiencing emotional repercussions of such sexual trauma. Maternal support plays a vital role in child victims' recovery from CSA; however, it is unclear what factors contribute to maternal support and what factors specifically influence maternal support and child outcomes despite advances in resources and care for victims of CSA and their families. Through the utilization of Smith and colleagues' (2017) unique measurement of child reported maternal support following CSA, the current study has endeavored to further solidify and expand upon this topic in order to address inconsistencies in the research. In particular, the current research addresses how a maternal history of trauma effects maternal support following the

sexual abuse in her child and further promotes various child victim outcomes and subsequent development.

A study by Sawyer, Smith, & Rooney (under review) investigated the relationship between maternal support and a maternal history of abuse/violence along with additional factors. However, this study has multiple limitations that hinder its ability to successfully find statistically significant results. The study utilized dichotomous variables to determine the aspects of the maternal caregivers' histories including CSA, child physical abuse, and relationship violence. Such utilization of dichotomous variables restricts the range of the variables as such reports of previous violence/abuse differ by each person's individual history and experiences; specifically, using dichotomous variables as opposed to continuous variables does not reflect the fact that individuals' experiences may differ in severity. The use of dichotomous variables also makes it increasingly difficult to find statistically significant results; consequently, the Sawyer et al., (under review) study found few significant results with these variables in reference to their research questions. Another limitation of the study is its grouping of all components of interpersonal violence (IPV) together into one dichotomous variable. This again limits the range of the variable and restricts the types of reported instances of IPV by the maternal caregiver and does not account for all of the various aspects of IPV. The present study addressed these limitations by analyzing the variables associated with a maternal history of abuse/violence as continuous through the creation of appropriate subscales relating to each separate aspect of experienced violence/abuse. The current study also separately analyzed maternal history of romantic relationship violence into three subscales to address emotional, sexual, and physical instances of interpersonal partner abuse which allowed for a more specified analysis of these variables. The present study additionally controlled for maternal caregiver's attachment

relationship with her parents in order to more accurately analyze and prioritize focus on the effect of a maternal history of abuse/violence on maternal support for her child following CSA disclosure.

The initial hypotheses concerning the relationship between a maternal history of trauma, violence, and/or CSA, and maternal support regarding her child post CSA were as follows:

Hypothesis I:

A maternal history of childhood sexual abuse will negatively impact maternal response to her child's current CSA; specifically, such a history will negatively correlate with maternal support as measured by the Emotional Support and Protection/Retaliation subscales of the MSQ-CR and positively correlate with the Skeptical Preoccupation subscale. This theory suggests that mothers with a history of CSA will tend to provide their children with less adequate support following their child's CSA. This hypothesis was analyzed through a correlation utilizing a continuous variable of maternal childhood sexual abuse history and child-rated maternal support levels as indicated by the MSQ-CR.

Hypothesis II:

The maternal caregiver's relationship quality with both of her parents will be positively correlated with the Protection/Retaliation and Emotional Support subscales and negatively correlated with the Skeptical Preoccupation subscale. This theory suggests that if the maternal caregiver has a negative relationship with one or both parents, resulting in an unhealthy attachment style, this will promote inadequate responses to the child's disclosure of sexual abuse; specifically a decrease in support offered. This was again analyzed through a correlation of a continuous variable of maternal relationship with her parents and child-rated maternal support as measured by the MSQ-CR.

Hypothesis III:

A maternal history of intimate partner physical violence will be negatively correlated with the Emotional Support and Protection/Retaliation subscales such that an increased history of romantic partner physical abuse will lead to decreased levels of emotional support and protective/retaliating actions. A maternal history of romantic partner physical abuse will conversely be positively correlated with the Skeptical Preoccupation subscale in that an increased history of romantic partner physical abuse will lead to increased levels of maternal skeptical preoccupation in response to her child's CSA. This was also analyzed through a correlation of a continuous variables of a maternal history of intimate partner physical violence and child-reported maternal support as measured by the MSQ-CR.

Hypothesis IV:

Variables related to a maternal history of abuse/violence will add predictive validity above and beyond what is accounted for by current and historical factors associated with child outcomes following CSA. To test this hypothesis multiple hierarchical linear regressions were performed. Step one of the hierarchical regressions included variables supported by previous research as influencing maternal support following CSA (Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013; Elliott & Carnes, 2001; Smith et al., 2010). These include maternal relationship with the abuser, maternal relationship with parents, maternal caregiver-child relationship quality prior to the abuse disclosure, child age, and child gender. Step two of the hierarchical regressions included, respectively, variables measured by the subscales created from the maternal caregiver interviews. These subscales include maternal history of childhood sexual abuse, childhood physical abuse, intimate partner sexual violence, intimate partner physical violence, and intimate partner emotional abuse.

Hypothesis V:

Previous research with the MSQ-CR have considered only linear relationships with predictor variables. With maternal history, it is possible that an interaction effect occurs such that in mothers who have experienced both past childhood abuse and abuse in adulthood by a romantic partner, their current level of support will be exponentially impacted. In order to test this interaction hierarchical linear regressions were performed using each subscale of the MSQ-CR. Step one of the hierarchical regression included variables previously shown to influence maternal support (maternal relationship with the abuser, maternal relationship with parents, maternal caregiver-child relationship quality, child age, and child gender; Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013; Elliott & Carnes, 2001; Smith et al., 2010) as well as a continuous variable of maternal experiences of child abuse (including both child physical and sexual abuse) and a continuous variable of maternal interpersonal violence (including physical, sexual, and emotional abuse by a romantic partner). Step two of the hierarchical regression added an interaction term between the maternal history of IPV and maternal history of child abuse variables.

METHODS

Participants

Participants in the current study included 106 mother-child dyads out of the total 146 mother-child dyads included in the original study completed by Smith and colleagues (2017). This decrease in sample size was largely due to many maternal caregivers choosing not to share information regarding a maternal history of abuse and violence through this component of the structured interview process. The participants included in the present study were referred for forensic interviews and evaluations at the Dee Norton Lowcountry Children's Center. These individuals were referred by a variety of sources including child protective services, medical professionals, schools, mental health professionals, law enforcement, or other social service agencies in the area. To be included in the study the maternal caregivers were required to be strictly nonoffending in regards to the sexual abuse, meaning that they were neither complicit nor involved in the abuse in any form. The mothers or maternal caregivers also had to be in a primary caregiving role for the child for at least 6 months prior to the initial CSA report.

Exclusion criteria for the original data collection included: either the child victim or nonoffending maternal caregiver exhibited psychotic behavior during the forensic evaluation, exhibited significant cognitive disabilities, or did not speak Spanish or English; however, no cases were excluded based on these criteria. To be included in the original study the initial report of the CSA must have been within six weeks prior to the physical forensic evaluation or have resulted directly from the evaluation findings. The final sample of participants represented a diverse sample that was similar to the area population. However, the participants gathered from the Dee Norton Lowcountry Children's Center (LCC; see below) cases cannot be considered

representative of all reported CSA cases in the area. On average, LCC cases of CSA involve younger victims compared to those not referred to LCC (Smith et al., 2017). Also, families involved in LCC cases are, on average, more socio-economically advantaged than the average population of reported CSA cases in the area. Because of these differences between the participant pool and the larger population of residents within the area, this limits the ability to generalize any findings to cases of CSA in this area as well as CSA cases in general. However, because these differences were recognized and considered when interpreting the present study's results, this data set remains useful for the current study and can be utilized in furthering the literature surrounding maternal support as related to CSA.

Descriptive statistics were utilized to initially analyze the frequencies of the variables within the data set that were relevant to the current study (See Appendix A). Out of the valid data from the 106 total cases, the children consisted of 15 males (14.2%) and 91 females (85.8%). The average age of the children was 11.6 (minimum = 7, maximum = 17). 60 of the children were Caucasian (56.6%), 44 were African American (41.5%) and 2 identified as Biracial (1.9%). The average age of the maternal caregivers was 37.60 (minimum = 22.67, maximum = 67.77). 61 of the maternal caregivers were Caucasian (57.5%) and 44 were African American (41.5%). One of the maternal caregivers in the data set chose not to provide information regarding their race. The majority of the children were sexually abused by a stranger (23.5%) followed by a trusted family member (21.7%), an acquaintance (15.1%), an individual who was married to their maternal caregiver (11.3%), another family member (8.5%), a trusted friend of their maternal caregiver (6.6%), an individual who was dating their maternal caregiver (4.7%), an individual who was divorced from their maternal caregiver (2.8%), another individual who did

not fit into any of the provided category options (2.8%), or an individual who was living with their maternal caregiver (0.9%). 2 participants (1.9%) chose not to provide this information.

Descriptive statistics were additionally utilized to analyze the maternal caregivers' history of various types of abuse within the study. Within the current data set, 72 of the maternal caregivers reported no history of intimate partner sexual abuse (67.9%) while 33 reported such a history (31.1%) and one chose not to answer (0.9%). Regarding intimate partner physical abuse, 41 maternal caregivers reported no history of physical IPV (38.7%) while 63 reported some history (59.4%) and 2 chose not to report (1.9%). 45 of the maternal caregivers reported no instances of intimate partner emotional abuse (42.5%), 60 reported such a history (56.6%), and 1 chose not to report (0.9%). Concerning a history of abuse during childhood, 82 of the maternal caregivers (77.4%) reported no history childhood physical abuse while 21 (19.8%) reported such a history and 3 chose not to answer (2.8%). 49 maternal caregivers further reported no history of CSA (46.2%), 53 (50.0%) reported a history of CSA, and 4 maternal caregivers chose not to report (3.8%). Maternal caregivers' levels of support as measured from the child's perspective utilizing the MSQ-CR were also analyzed utilizing descriptive statistics (See Appendix A).

Materials and Procedure

Clinical Interviews

The participants in the study completed structured clinical interviews in order to gain additional information from the maternal caregivers and child victims. The maternal caregivers and children were interviewed separately using a highly structured interview format. Through the structured child interviews the following information was obtained regarding the child's history: exposure to community violence, history of stressful or traumatic life events, sexual abuse history, physical abuse history, exposure to inter-parental violence, family relationships and

dynamics, legal and child protective service interventions, mental health concerns and treatment, and general demographic information. However, for the current study the majority of the variables of interest were documented during the maternal interviews. The maternal caregivers were also interviewed through a highly structured interview process to gain the following information: family history and family relationships, sexual abuse and assault history throughout childhood and adulthood, physical abuse and assault history throughout childhood and adulthood, intimate partner violence, information surrounding the reported CSA of their child, reaction to the discovery of the CSA of their child, the amount of social support they received regarding their child's CSA, social service intervention(s), and general demographic information.

The information gathered through the maternal caregiver interviews were then appropriately coded based on severity. The subsequent scales were then developed based on the interview questions: an 8-item Maternal Childhood Physical Abuse History subscale ($\alpha = .82$), a 6-item Maternal Childhood Sexual Abuse History subscale ($\alpha = .46$), a 6-item Maternal Intimate Partner Emotional Abuse subscale ($\alpha = .82$), an 11-item Maternal Intimate Partner Physical Violence subscale ($\alpha = .89$), a 2-item Maternal Intimate Partner Sexual Violence subscale ($\alpha = .80$), and an 8-item Maternal Closeness to Parents subscale ($\alpha = .87$).

The questions on the Maternal Childhood Physical Abuse History subscale measured the amount of physical abuse the maternal caregiver had experienced during childhood with a higher score indicating increased severity of abuse (See Appendix B). Such items included "Did your mother or father grab you around the neck and choke you?" and "Did your mother or father beat you up, hit you with a fist, or kick you hard?" These items were coded on a scale of 0 (*no*) and 1 (*yes*) and summed. The first two items of the subscale were then additionally analyzed to determine if physical abuse had occurred based on the maternal caregiver then being asked to

indicate whether they experienced physical injury as a result of this instance. This was again coded as 0 (*no*) and 1 (*yes*). If the maternal caregiver indicated that they had experienced physical injury as a result of these instances then these indications were then added to their total amount of childhood physical abuse as indicated by the Maternal Childhood Physical Abuse History subscale. These two items read “Did your mother or father slap or spank you?” and “Did your mother or father hit you with something like a belt, hairbrush, a stick, or some other hard object?”

The questions on the Maternal Childhood Sexual Abuse History subscale measured the maternal caregiver’s CSA history according to severity with a higher score indicating an increased severity of sexual abuse (See Appendix C). Such items included “Has a man or boy ever put his penis inside your vagina, rectum, or mouth when you didn’t want him to?” and “Has anyone, male or female, ever made you touch their private sexual parts when you did not want to?” Each of the six questions included in this scale were appropriately assigned a weighted coding of 1-6 (*yes*) according to the severity of the incident if the maternal caregiver indicated that they had experienced this type of sexual abuse. Items were coded 0 (*no*) if the maternal caregiver indicated that they had not experienced this type of sexual abuse. If the participant answered yes they were then asked to indicate if this happened on more than one occasion, how old they were the first time this happened and the last time this happened, how the perpetrators of the CSA were related to them, if they told anyone about the instance, and (if applicable) how supportive the first person was that they told about the instance. For the current research agenda, only data from sexual abuse experienced under the age of 18 were included in this scale.

The questions on the Maternal Intimate Partner Emotional Abuse subscale measured the maternal caregiver’s experienced emotional relationship abuse according to severity with a

higher score indicating an increased severity of emotional abuse experienced (See Appendix D). Such items included “Did any romantic partner ever restrict your use of the telephone?” and “Did any romantic partner ever call you demeaning or insulting names (e.g. ugly, stupid, bitch, etc.?)” These items were coded on a scale of 0 (*no*) and 1 (*yes*).

The questions on the Maternal Intimate Partner Physical Violence subscale measured the maternal caregiver’s experienced physical IPV in terms of severity with a higher score representing increased severity of physical IPV experienced (See Appendix E). Such items included “Did any romantic partner ever burn or scald you on purpose?” and “Did any romantic partner ever push, shove, or grab you?” These items were also coded on a scale of 0 (*no*) and 1 (*yes*).

The questions on the Maternal Intimate Partner Sexual Violence subscale concerned the severity of romantic partner sexual abuse experienced by the maternal caregiver in adulthood with higher scores representing increased severity of romantic sexual violence (See Appendix F). The questions included “Did any romantic partner ever use force or the threat of force to make you have any type of sex?” and “Did any romantic partner ever verbally pressure you to have sex?” Questions again were measured on a scale of 0 (*no*) and 1 (*yes*).

Although the Cronbach’s alphas reported above indicate some consistency in how participants responded to these items, it could be argued that using Cronbach’s alpha may not be appropriate for items that indicate the occurrence of past events. However, previous research regarding cumulative risk hypothesis indicated the utility of combining dichotomously coded historical risk experiences into a continuous cumulative risk scales (Appleyard, Egeland, van Dulmen, & Sroufe, 2005). Thus, the scales used in the current study represent the accumulation of multiple negative experiences within specific domains, and thus more closely approximate

indications of abuse severity than the coding method used for the Sawyer and colleagues' (under review) study. It should additionally be noted that the utilized scale regarding maternal caregivers' history of CSA had the lowest level of internal reliability ($\alpha = .46$). The manner in which the present data set was coded based off of the maternal caregiver interview questions was not ideal in that the subsequent scale looked only at the total severity of experienced CSA events by the maternal caregiver. However, the field is currently severely lacking a more appropriate measure of previous child sexual abuse experiences recalled in adulthood; thus adding increased difficulty to the current research topic. If an improved measure of the recall of child sexual abuse experiences and severity of these experiences could have been utilized, it is possible that the present study would have yielded differing results. However, the use of the current created scale of severity of a maternal caregiver history of CSA is acceptable and appropriate for the present study utilizing an archival data set.

The questions concerning the Maternal Closeness to Parents subscale measured the attachment relationship that the maternal caregiver had with her own caretakers (See Appendix G). The six questions included those such as "Was your mother (or mother figure) tender and affectionate to you?" and "Did your father (or father figure) take an interest in how you felt?" These items were coded on a scale consisting of 2 (*Often*), 1 (*Sometimes*), and 0 (*Never*). Higher scores indicate more positively reported attachment relationships between the maternal caregiver and her own parents or caregivers. These scales were then utilized for the current study's analyses.

Parenting Satisfaction Scale

The Parenting Satisfaction Scale (PSS; Guidubaldi & Cleminshaw, 1996) was utilized in the current study to measure the current maternal caregiver-child relationship. The PSS is a 45-

item questionnaire used to assess parent self-reports of satisfaction with parenting according to three separate domains: Parenting Performance of Spouse/ex-spouse, Parent-Child Relationship, and Own Parenting Performance. Only the Parent-Child Relationship and Own Parenting Performance subscales were administered to the participants and only the Parent-Child Relationship subscale ($\alpha = .86$) was utilized in the current study (Guidubaldi & Cleminshaw, 1985). Such questions from the Parent-Child Relationship subscale included “I am satisfied with the way my children treat me” and “I think that my children do not like me very much which upsets me”. Previous research has additionally confirmed the internal validity of this measure as well as predictive validity through previous custody evaluations as well as family therapy settings. The Parent-Child Relationship subscale of the PSS was not included in the appendices of this document due to the measure containing copyrighted material.

Maternal Support Questionnaire- Child-Report

The Maternal Support Questionnaire- Child Report (MSQ-CR; Smith et al., 2017) was developed and utilized to gain a unique view of maternal support relating to instances of CSA from the child’s perspective. The MSQ-CR is a 20-item questionnaire assessing the child’s view of his/her maternal caregiver’s attitudes, behaviors, and responses since the disclosure of their CSA (See Appendix H). The MSQ-CR was developed to accompany the MSSQ in order to gain a more accurate perspective as to the level of maternal support being provided to the child following CSA and how this support is being received by the child. The MSQ-CR consists of three scales of perceived abuse-specific maternal support including Emotional Support, ($\alpha = .87$), Skeptical Preoccupation, ($\alpha = .71$), and Protection/Retaliation, ($\alpha = .73$; Smith et al., 2017). The higher the child-rated scores on the Skeptical Preoccupation scale, the higher the degree to which the child indicates that his/her maternal caregiver questions and/or doubts his/her abuse

allegations. Such questions included “My mother asked me if I am telling the truth about what happened to me,” and “My mother tried to make sure I was telling the truth about what happened to me.” Alternatively, the higher the child-rated scores on the Emotional Support scale, the more the child reports the maternal caregiver displaying empathy for the child’s distress. Such questions included “My mother cared about my feelings,” and “My mother seemed to know when I was feeling upset about what happened to me.” The questions from the Protection/Retaliation scale concerned the degree to which the child reported the maternal caregiver taking actions to protect the child. A higher score on the Protection/Retaliation scale indicated multiple actions from the maternal caregiver being recognized by the child as attempts to protect him/her from further harm and keep him/her safe. Such items included “My mother said she wants to do something to harm the person who hurt me,” and “My mother tries to keep the person who hurt me away from me.” The children rate the degree to which each item describes their maternal caregiver’s behavior towards them since the disclosure of their sexual abuse on a Likert-type scale ranging from 0 (*not at all*) to 3 (*very much*). The MSQ-CR items were developed with consultation from experts in the CSA treatment field and were developed rationally. With this development, it is believed that the MSQ-CR scales yield psychometrically sound results similar to other scales previously developed on the current topic.

Procedure

The current research was part of a larger study on maternal support following child sexual abuse and the analysis of a new measure of maternal support following CSA through comparison of a maternal self-report (MSSQ) and a child-report (MSQ-CR; Smith et al., 2017). Participants were recruited from the Lowcountry Children’s Center (LCC), a child advocacy center in the Southeastern United States. LCC provides a variety of resources including forensic

interviewing and evaluation, advocacy, and family and individual counseling for victims of suspected or confirmed CSA and their families. Multiple measures were completed by both the maternal caregiver and the child victim in addition to those described and utilized in the current study. However, for the current study, only the data collected from the Maternal Self-Report Support Questionnaire, the Maternal Support Questionnaire- Child Report, the Parenting Satisfaction Scale, and the child and maternal caregiver interviews from the Time 1 assessments were necessary.

The data was gathered by Smith and colleagues (2017) over a 3.5 year period. Both caregiver and child participants were compensated for their participation in the study. The original study included 146 maternal caregiver-child pairs as participants which represented 46% of the eligible participants gathered from LCC. Throughout the entire data collection the maternal caregivers and children were interviewed and assessed separately.

Analytic Plan

The data gathered by Smith and colleagues (2017) was analyzed to test Hypotheses I, II, and III in order to see which aspect(s) of maternal caregivers' histories had the strongest relationship with maternal caregivers' current support for her child following his/her sexual abuse. Specifically, the data from the subscales created from the maternal caregivers' interviews concerning maternal history of childhood sexual abuse, relationship with parents, and romantic partner physical violence was analyzed through a correlation with the three subscales of the MSQ-CR. Hypotheses IV and V were then tested utilizing hierarchical linear regressions in order to examine variables that influence maternal support in the aftermath of child sexual abuse disclosure. Specifically, Hypothesis IV utilized three hierarchical linear regressions examining maternal emotional support, skeptical preoccupation, and protection and retaliation respectively.

These specified aspects of abuse-specific maternal support were utilized to determine if variables related to a maternal history of abuse added predictive validity above and beyond what was accounted for by the initial model of variables supported by previous research as influencing maternal support following CSA. Similarly, Hypothesis V utilized three hierarchical linear regressions examining the same aspects of measured maternal support following CSA to determine if an interaction effect occurred in that maternal caregiver support was exponentially affected if the maternal caregiver had experienced abuse in both childhood and adulthood.

RESULTS

Pearson correlations were completed in order to test Hypotheses I, II, and III (See Appendix I). Firstly, the relationship between the maternal caregivers' history of childhood sexual abuse and current maternal caregivers' support for her child following the disclosure of CSA relating to maternal emotional support, maternal skeptical preoccupation, and maternal protection and retaliation was investigated in accordance with Hypothesis I. Specifically relating to maternal history of CSA and maternal emotional support, there was a no significant relationship, $r = -.01$, $n = 98$, $p = .93$. There was also no significant relationship between maternal history of CSA and maternal skeptical preoccupation, $r = .02$, $n = 98$, $p = .88$, or maternal history of CSA and maternal protection and retaliation, $r = -.04$, $n = 100$, $p = .67$. Therefore, results did not support the association between a maternal history of CSA and any of the measured aspects of maternal support; thus, Hypothesis I was not supported in the current study.

Hypothesis II was then tested in which the associations between the maternal caregivers' relationship with her parents and the various aspects of maternal support including emotional support, skeptical preoccupation, and protection and retaliation were analyzed. None of the aspects of measured maternal support following CSA was significantly related to the maternal caregivers' relationship with her parents. Maternal caregivers' relationship with her parents and maternal emotional support had no significant relationship, $r = -.05$, $n = 97$, $p = .63$. Additionally, neither maternal caregivers' relationship with her parents and maternal skeptical preoccupation, $r = -.003$, $n = 97$, $p = .97$, or maternal caregivers' relationship with her parents and maternal protection and retaliation, $r = .11$, $n = 99$, $p = .30$, exhibited a significant

relationship. Furthermore, there does not appear to be an association between maternal caregivers' relationship with her parents and the various measured aspects of maternal support following her child's CSA disclosure within the present study. Consequently, based on the present data set and analyses, Hypothesis II was not supported.

Hypothesis III was analyzed in the same manner in which the potential relationship between maternal history of romantic partner physical violence in adulthood and aspects of maternal support including emotional support, skeptical preoccupation, and protection and retaliation were included. Within this analysis maternal history of romantic partner physical violence did not exhibit a significant relationship with either maternal skeptical preoccupation, $r = .13$, $n = 100$, $p = .19$, or maternal protection and retaliation, $r = .15$, $n = 102$, $p = .14$. However, maternal caregivers' history of romantic partner physical violence did display a small, positively significant relationship with maternal emotional support regarding the disclosure of CSA, $r = .22$, $n = 100$, $p < .05$. Therefore, within the current data set, it was found that maternal caregivers who reported having a history of romantic partner physical violence typically provided their child with increased levels of perceived emotional support following their child's CSA disclosure. These did not support Hypothesis III in the present study.

Thereafter, three hierarchical linear regressions were executed utilizing maternal emotional support, maternal skeptical preoccupation, and maternal protection and retaliation as the dependent variables, respectively, to test Hypothesis IV. To control for variables supported by previous research as influencing maternal support following instances of CSA, the following were included in Step one of the analyses: maternal caregiver's relationship to the abuser, maternal relationship with parents, maternal caregiver-child relationship quality prior to the abuse disclosure, child age, and child sex. (Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013;

Elliott & Carnes, 2001; Smith et al., 2010). For Step two of the analysis, variables measured by the subscales relating to the maternal caregivers' histories were added. These include maternal history of childhood sexual abuse, childhood physical abuse, intimate partner sexual violence, intimate partner physical violence, and intimate partner emotional abuse.

Concerning maternal emotional support (See Appendix J), results indicated that the variables included in Step one of the model accounted for 16.1% of the variance, $R^2 = .16$, $F(5, 80) = 3.08$, $p < .05$. Within this First step, the maternal caregiver relationship with the perpetrator was significantly associated with maternal emotional support following CSA, $B = -3.97$, $\beta = -.27$, $t(80) = -2.59$, $p < .05$. The addition of Step two of the analysis accounted for an additional 13.7% of the variance, which was a significant increase, $\Delta R^2 = .16$, $F(5, 75) = 3.19$, $p < .05$. This resulted in Step two of the model accounting for a total 29.8% of the variance, $R^2 = .30$, $F(5, 75) = 3.19$, $p < .01$. In this second step, maternal caregiver relationship with the perpetrator was again significant, $B = -4.14$, $\beta = -.28$, $t(75) = -2.56$, $p < .05$. Maternal childhood physical abuse history was also significantly associated with maternal emotional support following CSA, $B = 1.01$, $\beta = .25$, $t(75) = 2.34$, $p < .05$. Additionally, maternal intimate partner physical abuse history in adulthood was significantly associated with maternal emotional support, $B = .52$, $\beta = .27$, $t(75) = 2.11$, $p < .05$.

Regarding maternal skeptical preoccupation following CSA (See Appendix K), the analysis indicated that Step one of the model accounted for 9.2% of the variance, $R^2 = .09$, $F(5, 80) = 1.63$, $p = .16$. Surprisingly none of the individual variables were significant predictors in this first step of the analysis. Step two of the analysis accounted for an additional 11.9% of the variance, which was approaching significance, $\Delta R^2 = .12$, $F(5, 75) = 2.01$, $p = .06$. This resulted in Step two accounting for 21.1% of the total variance, $R^2 = .21$, $F(5, 75) = 2.01$, $p < .05$. When

the variables included in Step two of the model were added, maternal romantic partner sexual abuse history in adulthood was significantly associated with maternal skeptical preoccupation following CSA, $B = -1.47$, $\beta = -.32$, $t(75) = -2.04$, $p < .05$. Maternal romantic partner physical abuse history in adulthood was additionally significantly associated with maternal skeptical preoccupation, $B = .50$, $\beta = .37$, $t(75) = 2.76$, $p < .01$.

The final hierarchical regression within Hypothesis IV regarding maternal protection and retaliation in relation to overall support for her child following CSA (See Appendix L) indicated that Step one of the model accounted for 12.5% of the variance, $R^2 = .13$, $F(5, 82) = 2.35$, $p < .05$. Within this first step, the maternal relationship with the abuser was significant, $B = -2.31$, $\beta = -.22$, $t(82) = -2.05$, $p < .05$. Additionally within Step one of the model, maternal caregiver-child relationship was also significant, $B = .17$, $\beta = .24$, $t(82) = 2.22$, $p < .05$. Step two of the analysis accounted for an additional 11.2% of the variance, which was approaching significance, $\Delta R^2 = .11$, $F(5, 77) = 2.40$, $p = .06$. Therefore, Step two accounted for 23.7% of the total variance, $R^2 = .24$, $F(5, 77) = 2.40$, $p < .05$. Within Step two of the analysis, maternal caregiver-child relationship was significant, $B = .17$, $\beta = .24$, $t(77) = 2.16$, $p < .05$. Maternal history of intimate partner physical violence in adulthood was also significant within this second step, $B = .57$, $\beta = .39$, $t(77) = 2.94$, $p < .01$.

Within the analyses regarding Hypothesis IV, the hierarchical regression analyzing maternal emotional support saw a significant increase in overall variance from Step one to Step two with the inclusion of variables related to a maternal history of abuse. Similarly, the hierarchical regressions analyzing maternal skeptical preoccupation and protection and retaliation saw an increase in variance that was approaching significance with the inclusion of variables related to a maternal history of abuse. Within the variables associated with a maternal

history of abuse, a maternal history of childhood physical abuse, a maternal history of romantic partner physical abuse and a maternal history of romantic partner sexual abuse were shown to be individually significant within the second steps of the analyses. Specifically, a maternal history of childhood physical abuse was shown to be significantly associated with increased levels of maternal emotional support following instances of CSA. Additionally, a maternal history of romantic partner physical abuse was also shown to be significantly associated with increased levels of maternal emotional support as well as increased levels of skeptical preoccupation and protection and retaliation. A maternal history of romantic partner sexual abuse was shown to be significantly associated with decreased levels of skeptical preoccupation as perceived by the child CSA victim in regards to their maternal caregiver. It can be concluded that within the utilized data set the inclusion of variables related to a maternal history of abuse in childhood and adulthood as a whole add predictive validity above and beyond what is accounted for by current and historical factors associated with child outcomes following CSA. Therefore, the current research serves to partially support Hypothesis IV.

Hypothesis V was then analyzed using three separate hierarchical regressions to see if an interaction effect occurs such that maternal caregiver support is affected exponentially if the maternal caregiver has experienced abuse in both childhood and adulthood. This was accomplished through the combination of childhood sexual and physical abuse variables as well as the blend of romantic partner emotional, physical, and sexual violence in adulthood into two continuous variables. These continuous variables were then analyzed for a possible interaction effect through separate hierarchical regressions with each of the three utilized components of maternal caregiver support.

Within the first step of the model regarding maternal emotional support (See Appendix M), the variables included accounted for 22.6% of the variance, $R^2 = .23$, $F(7, 78) = 3.25$, $p < .01$. Within this first step, maternal relationship with the abuser was significant, $B = -4.28$, $\beta = -.29$, $t(78) = -2.84$, $p < .01$. Additionally, the continuous variable for maternal history of romantic partner abuse in adulthood was positively significant, $B = .35$, $\beta = .30$, $t(78) = 2.55$, $p < .05$. However, the continuous variable for maternal history of childhood abuse proved not to be significant within this first step. The addition of Step two of the analysis accounted for an additional 0.3% of the variance, $\Delta R^2 = .003$, $F(1, 77) = 2.86$, $p = .56$. Step two of the analysis accounted for 22.9% of the total variance which was significant, $R^2 = .23$, $F(1, 77) = 2.86$, $p < .01$. Within this second step, maternal relationship with the abuser was again significant, $B = -4.38$, $\beta = -.30$, $t(77) = -2.88$, $p < .01$. Additionally, maternal history of romantic partner abuse was also significant, $B = .37$, $\beta = .32$, $t(77) = 2.60$, $p < .05$, and maternal history of childhood abuse was not significant. The interaction effect between the continuous variables of child abuse and romantic partner abuse was also not significant, $B = -.01$, $\beta = -.06$, $t(77) = -.59$, $p = .56$. Therefore, there was no evidence of an interaction effect between the continuous variables of child abuse and romantic partner abuse as relating to perceived maternal emotional support.

Skeptical preoccupation was then examined as a component of maternal support following CSA (See Appendix N). The first step of the model accounted for 14.0% of the variance, $R^2 = .14$, $F(7, 78) = 1.82$, $p = .10$. Within this first step, maternal history of romantic partner abuse was significant, $B = .20$, $\beta = .25$, $t(78) = 2.05$, $p < .05$. However, maternal history of childhood abuse was not significant within this first step. Additionally, maternal relationship with the perpetrator was also approaching significance, $B = -2.04$, $\beta = -.22$, $t(78) = -1.96$, $p = .054$. Step two of the analysis accounted for an additional 1.3% of the variance, $\Delta R^2 = .01$, $F(1,$

77) = 1.73, $p = .29$. Therefore, Step two accounted for 15.3% of the total variance, $R^2 = .15$, $F(1, 77) = 1.73$, $p = .10$. In Step two of the model maternal relationship with the perpetrator, $B = -2.21$, $\beta = -.23$, $t(77) = -2.10$, $p < .05$, and maternal history of romantic partner abuse, $B = .22$, $\beta = .28$, $t(77) = 2.26$, $p < .05$, were again significant. Additionally, there was no evidence of an interaction effect between the continuous variables of child abuse and romantic partner abuse pertaining to skeptical preoccupation as these results were found to not be significant, $B = -.02$, $\beta = -.12$, $t(77) = -1.07$, $p = .29$. Therefore, there was no evidence of an interaction effect between the continuous variables of child abuse and romantic partner abuse as relating to perceived maternal skeptical preoccupation.

Regarding maternal protection and retaliation (See Appendix O), the first step of the model accounted for 15.6% of the variance, $R^2 = .16$, $F(7, 80) = 2.11$, $p = .052$. Within this first step maternal relationship with the abuser, $B = -2.42$, $\beta = -.23$, $t(80) = -2.11$, $p < .05$, and maternal caregiver-child relationship, $B = .17$, $\beta = .24$, $t(80) = 2.20$, $p < .03$, were significant. The addition of the second step accounted for an additional 0.2% of the variance, $\Delta R^2 = .002$, $F(1, 79) = 1.86$, $p = .64$. Step two of the model subsequently accounted for 15.8% of the total variance, $R^2 = .16$, $F(1, 79) = 1.86$, $p = .08$. Within the second step, maternal relationship with the abuser, $B = -2.51$, $\beta = -.23$, $t(79) = -2.15$, $p < .05$, and maternal caregiver-child relationship, $B = .17$, $\beta = .24$, $t(79) = 2.21$, $p < .05$, were again significant. Within either step of the model the continuous variables of maternal history of childhood abuse and maternal history of romantic partner abuse were not significant. Furthermore, the added interaction term between a maternal history of childhood abuse and a maternal history of abuse experienced in adulthood was not significant, $B = -.01$, $\beta = -.05$, $t(79) = -.48$, $p = .64$. Therefore, there was no evidence of

an interaction effect between the continuous variables of child abuse and romantic partner abuse as relating to perceived maternal protection and retaliation.

Within the present study there was no significant increase in variance in any of the executed hierarchical linear regressions concerning aspects of maternal support with the addition of an interaction effect between a maternal history of child abuse (sexual and/or physical) and a history of IPV in adulthood (emotional, physical, and/or sexual). Therefore, results did not support the existence of an interaction effect between these two continuous variables related to the measured aspects of abuse-specific maternal support from the child's perspective.

Subsequently, Hypothesis V was not supported in the current study. However, the present analyses serve to further support the impact of a maternal history of romantic partner abuse in adulthood on various aspects of maternal support. Specifically, within the current study, the continuous variables of maternal history of romantic partner abuse was significantly associated with increased emotional support and skeptical preoccupation from the child's perspective following instances of CSA.

DISCUSSION

The purpose of the present study was to build upon previous research regarding maternal support for her child following instances of child sexual abuse and the various factors that were hypothesized to impact maternal support as analyzed from the child's perspective. The current research was developed and executed based on the design and results of previous research regarding similar topics (Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013; Elliott & Carnes, 2001; Sawyer et al., under review; Smith et al., 2010; Smith et al., 2017). Specifically, the present study worked to examine the possible influence of a maternal history of abuse/violence in childhood and/or adulthood on three specified aspects of CSA-related maternal support: emotional support, skeptical preoccupation, and protection and retaliation.

Regarding the utilized data set, a large number of maternal caregivers within the study had themselves experienced child sexual abuse (53 participants out of 106, or 50.0%). Although these figures are consistent with the literature regarding the increased likelihood of maternal caregivers with a history of CSA also having children who experience CSA (Baril et al., 2016; Bowman et al., 2009; Leifer et al., 2004; Leifer et al., 1993; Moehler et al., 2007; Timmons-Mitchell et al., 1996) this statistic is still alarming. The large number of sexually abused children with maternal caregivers who have experienced CSA themselves indicates that this is a vital subfield within the larger realm of child sexual abuse research. Additionally, this is an area of focus for the development of future clinical implications regarding ways to support maternal caregivers of child sexual abuse victims with a history of abuse themselves. Moreover, specific clinical implications regarding preventative measures to break this continuation of experienced abuse through generations should continue to be pursued through informed research initiatives.

Within the current research agenda and utilized data set, the maternal caregivers' history of childhood sexual abuse did not significantly impact any aspect of measured maternal support for her child following the child's own sexual abuse. However, the variability within the utilized data sample should be considered when drawing conclusions from the current study. Considering the overall range of 18.00 of the Maternal Childhood Sexual Abuse History subscale, the mean was fairly low at 3.85; thus, indicating that the majority of the maternal caregivers within the data set reported lower levels of CSA through the clinical interviews. Such a low mean regarding the maternal caregivers' reported histories of childhood sexual abuse could have impacted the analyses results. However, with a large standard deviation of 4.74, the results within the subscale provide sufficient variance for the subsequent analyses. Therefore, the results from the present study provide some evidence that such maternal caregivers who have themselves been sexually abused as a child can provide support for her child following their sexual abuse similar to maternal caregivers with no such history. This provided support is possible despite the many negative emotional and psychological consequences associated with the reliving of such an experience as CSA. Due to the lack of a significant relationship between a maternal history of CSA and any of the analyzed aspects of maternal support following her child's CSA, Hypothesis I is not currently supported within this research study. Such results conflict with previous research that concluded that a maternal history of child maltreatment and/or abuse on average led to poorer overall parenting practices as well as the maternal caregivers being more strongly and negatively affected by the disclosure of their child's sexual abuse (Leifer, Kilbane, & Kalick, 2004; Newcomb & Locke, 2000; Timmons-Mitchell et al., 1996). This phenomenon was previously speculated to further hinder maternal caregivers with a history of CSA's ability to provide adequate support for their child following sexual abuse. It is possible that maternal

caregivers who have themselves experienced sexual abuse in childhood have normalized this experience as an emotional coping strategy. Therefore, the various aspects of support provided by the maternal caregivers within the study with a history of CSA were not significantly impacted neither positively nor negatively as their normalization of this experience muted any such influence.

The current data set also exhibited a lack of association between the maternal caregivers' relationship with her parents and the various measured aspects of maternal caregiver support in response to her child's CSA. These results exhibit the possibility for maternal caregivers who were not close to their parents as still having the potential to be similarly supportive towards their child following such trauma compared to maternal caregivers who were close with their parents. This can be further interpreted in that it is possible that maternal caregivers who reportedly did not have a healthy attachment style in childhood are additionally able to provide adequate support for their child following their child's sexual abuse. Due to a lack of a significant relationship between maternal caregivers' relationship with her parents and the aspects of maternal support explored within the current data set, Hypothesis II was not supported within this research study. These results contradict previous research studies which found attachment disturbance in maternal caregivers to be a primary factor influencing the likelihood of a child experiencing maltreatment and/or abuse and the response from the child to such abuse (Baril et al., 2016; Leifer, Kilbane, & Kalick, 2004; Newcomb & Locke, 2000). A possible explanation for this contrast in results is that the data set utilized for the current study primarily included maternal caregivers who experienced positive paternal responses and support regarding any past experiences of trauma, violence, or abuse. Thus, this possibly allowed for attachment

style to have less of an impact on the maternal caregivers' current responses to her child's sexual abuse.

Regarding a maternal history of intimate partner physical violence and the various aspects of maternal support following their child's CSA, such a history had no significant effect on maternal skeptical preoccupation or protection and retaliation in the current study. However, a maternal history of romantic partner physical abuse positively impacted maternal emotional support following CSA. Consequently, within the current sample, maternal caregivers who had a history of romantic partner physical abuse were generally more emotionally supportive of their child following the disclosure of their sexual abuse. Therefore, Hypothesis III is partially supported within the current study. These results are similar to previous research conducted by Coohey and O'Leary (2008) which found that a maternal caregiver history of physical domestic violence positively impacted maternal caregivers' protectiveness of her child following instances of child sexual abuse. It is possible that such a protective component could additionally be related specifically to aspects examined within the current study regarding maternal emotional support which further led to increased overall maternal support following CSA from the child's perspective. However, additional research specifically within this area of maternal emotional support following instances of CSA is needed to confirm this theory.

Maternal caregiver relationship with the perpetrator and maternal caregiver- child relationship quality prior to the abuse disclosure are variables supported by previous research as impacting aspects of maternal support following instances of childhood sexual abuse (Bolen & Lamb, 2002; Coohey & O'Leary, 2008; Everson et al., 1989; Leifer, Kilbane, & Grossman, 2001). This held true for the current study as maternal caregiver relationship with the perpetrator was a significant predictor of maternal emotional support, maternal skeptical preoccupation, and

maternal protection/retaliation. The current study showed that, within the present data sample, the maternal caregiver having an intimate relationship with the perpetrator of her child's sexual abuse led to decreased levels of maternal emotional support. This further resulted in less overall maternal support following CSA as viewed by the child victim. This negative impact on emotional support is supported by previous research examining the role-conflict that is often experienced by maternal caregivers of CSA victims in instances of familial incest or when the perpetrator of the abuse is a romantic partner to the maternal caregiver (Bolen & Lamb, 2002; Coohy & O'Leary, 2008; Everson et al., 1989; Leifer, Kilbane, & Grossman, 2001). Such role-conflict often results in unsupportive or blaming behaviors exhibited by maternal caregivers. Conversely, in the present study the maternal caregiver having a relationship with the perpetrator also led to decreased levels of maternal skeptical preoccupation and protection and retaliation; factors associated with decreased perceived maternal support. Such results suggest that, within the current study, when the maternal caregiver had a relationship with the perpetrator of her child's sexual abuse her response and support towards her child, both positive and negative, were muted. This is perhaps a coping mechanism in response to the maternal caregivers' conflicting relationships between her child and the perpetrator. However, additional research is needed regarding to what extent maternal caregiver relationship with the perpetrator impacts various aspects of maternal support following instances of CSA.

Additionally, maternal caregiver-child relationship quality prior to the abuse disclosure was found to be a significant predictor of maternal protection and retaliation. Specifically, more positively rated maternal caregiver-child relationships led to increased levels of protective and retaliating actions by the maternal caregiver. This is additionally supported by previous research by Bolen and Lamb (2007) that found a correlation between the maternal caregiver-child

relationship quality and child victims' overall adjustment and functioning following the disclosure of CSA. However, Smith and colleagues (2017) determined that such protective actions/retaliation in response to her child's sexual abuse led to less perceived maternal support from the child victims' perspective as measured by the Protection/Retaliation subscale of the MSQ-CR. Consequently, with the current data set, increased maternal caregiver-child relationship quality prior to the abuse disclosure ultimately led to decreased overall maternal support from the child's perspective. This is possibly due to the well-intended heightened responses from maternal caregivers who reported a higher relationship quality with their children. Such responses conceivably consisted of extensive protective measures and retaliation and threats directed towards the perpetrator and any other person(s) involved with their child's abuse. Such actions would lead to decreased feelings of overall maternal support from the child's perspective as measured by the MSQ-CR. This area of maternal support regarding protective and retaliating actions as relating to maternal caregiver-child relationship quality requires additional, specified research in order for more solidified conclusions to be drawn.

Variables related to the maternal caregivers' history of multiple types of abuse experienced in both childhood and adulthood by a romantic partner were also shown to significantly predict various aspects of measured maternal support. Specifically regarding maternal emotional support, maternal childhood physical abuse history and maternal intimate partner physical abuse history were significant predictors. Maternal romantic partner physical abuse history was also a significant predictor of maternal skeptical preoccupation and protection and retaliation. Additionally, a maternal history of romantic partner sexual abuse was shown to be a significant predictor of skeptical preoccupation as it relates to maternal support following instances of CSA. Furthermore, within the current data set, a maternal history of physical abuse

either in childhood and/or adulthood as well as a maternal history of sexual abuse by a romantic partner were shown to be the largest predictors of maternal support. Thus, a maternal history of romantic partner physical abuse led to increased emotional support, skeptical preoccupation, and protective/retaliating actions while a maternal history of childhood physical abuse led to increased maternal emotional support. A maternal history of romantic partner sexual abuse was shown to lead to decreased levels of skeptical preoccupation exhibited by the maternal caregiver. Such increases in maternal emotional support and decreases in skeptical preoccupation led to increases in perceived overall support following the disclosure of the abuse from the child's perspective. Conversely, increases in protection/retaliation and skeptical preoccupation as exhibited in a maternal history of romantic partner physical abuse additionally led to a decrease in perceived maternal support. These results serve to partially support Hypothesis IV in that a maternal history of abuse in either childhood or adulthood has the potential to impact all aspects of maternal support following CSA as evaluated within the current study. Such findings coincide with previous research that has found other types of abuse outside of strict childhood sexual abuse to be influential on maternal caregivers' responses to her child's sexual abuse (Newcomb & Locke, 2000; Parades et al., 2001). Parades and colleagues (2001) specifically evaluated childhood physical abuse as well as other factors relating to familial and childhood instability and found these to be significant predictors for maternal responses to her child's CSA. Additionally, these factors were seen to influence child outcomes following the disclosure of the abuse. Additionally, research by Symes, Maddoux, McFarlane, Nava, and Gilroy (2014) examined the impact of a maternal history of intimate partner physical and sexual violence on both maternal and child outcomes. Symes and colleagues found that a maternal history of intimate partner physical abuse was associated with increased maternal anxiety and child

externalization outcome scores. Similarly, a maternal history of intimate partner sexual abuse was associated with increased maternal somatization and PTSD symptomatology as well as child internalization and total problems outcome scores. It can therefore be concluded that maternal histories of sexual, physical, and emotional abuse experienced in childhood and/or adulthood have the potential to influence multiple aspects of perceived maternal support following her child's CSA as well as overall child outcomes.

Interestingly, within the current study, a maternal history of childhood sexual abuse and intimate partner emotional abuse were not significantly related to perceived maternal support as measured by the three subscales of the MSQ-CR. This conflicts with previous research specifically regarding maternal caregivers with a history of CSA themselves (Baril et al., 2016; Green et al., 1995; Newcomb & Locke, 2000; Timmons-Mitchell et al., 1996). Such a history has been previously shown to influence maternal responses to the abuse of their children as well as their children's adjustment and overall outcomes post-disclosure. Conversely, within the current study, such effects were limited to maternal caregivers with a history of physical violence in childhood and/or adulthood and/or a history of romantic partner sexual abuse experienced in adulthood. Additional research examining the effects of maternal histories of abuse in childhood and/or adulthood on maternal responses and support following the disclosure of her child's CSA is necessary to ensure that the current findings are not limited to the employed data set. The effects of physical abuse and instances of sexual abuse in adulthood should be further explored as the current findings suggest that such a history could have a more pronounced effect on maternal caregiver support following the discovery of her child's CSA.

As previous research has shown (Baril et al., 2016; Coohy & O'Leary, 2008; Green et al., 1995; Leifer & Kilbane, 2001; Leifer, Kilbane, & Kalick, 2004; Newcomb & Locke, 2000;

Parades et al., 2001; Timmons-Mitchell et al., 1996) multiple aspects of a maternal caregiver's history of abuse has the potential to impact maternal levels of support for her child following CSA. However, within the current study sample physical abuse either in childhood or adulthood or sexual abuse by a romantic partner are maternal histories shown to be particularly influential regarding later levels of maternal support. A similar research initiative conducted by Sawyer, Smith, & Rooney (under review) found maternal history of childhood physical abuse to be associated with child reports of increased provided maternal emotional support following their sexual abuse. Sawyer and colleagues found no such results regarding maternal romantic partner physical and/or sexual abuse history. However, the previous study by Sawyer and colleagues utilized maternal history of IPV as a singular, dichotomous variable; therefore, limiting the study's ability to find statistically significant results regarding this variable. Conversely, the present study separated a maternal history of IPV into three appropriate subscales, evaluating romantic partner physical abuse, romantic partner emotional abuse, and romantic partner sexual abuse individually. In this manner, the present study was able to reveal a significant relationship between both a maternal history of romantic partner physical abuse as well as a history of romantic partner sexual abuse as it relates to various aspects of perceived maternal support from the child's perspective. Therefore, it can be concluded that a maternal history of physical abuse in childhood and/or adulthood and/or a history of romantic partner sexual abuse had the most impact out of all of the examined variables relating to a maternal history of abuse within the present study.

Within the final set of analyses, a maternal history of abuse experienced in childhood combined with abuse experienced in adulthood were not shown to exponentially impact the effect that such histories had upon various aspects of maternal support following CSA. These

results therefore served to not support Hypothesis V within the present study. However, these analyses served to confirm the impact of a maternal history of romantic partner abuse as a separate variable. The presence of a history of maternal history of intimate partner violence (emotional, physical, and/or sexual abuse) led to increased levels of emotional support, leading to an increase in overall perceived maternal support. However, such a history of abuse by a romantic partner conversely additionally led to increased levels of skeptical preoccupation; thus, leading to a decrease in perceived overall maternal support. It can be hypothesized that, because such violence/abuse is experienced in adulthood and closer to the event of her own child's sexual abuse, such a history leads to conflicting feelings of both emotional support and skepticism following the disclosure of her child's sexual abuse. Such results conflict with previous research that has shown a maternal history of IPV to be associated with decreased emotionally supportive behavior, and increased harsh parenting practices (Gustafsson & Cox, 2012; Loucks & Shaffer, 2014). However, recent research conducted by Guyon-Harris, Ahlfs-Dunn, and Huth-Bocks (2017) exhibited individualized differences and variability in maternal caregivers' responses to their own abuse histories and parenting practices. These results further exhibit the potential impact that a maternal history of romantic partner violence experienced in adulthood can be regarding maternal caregiver support. Consequently, such a maternal history can also drastically effect child victim outcomes following instances of CSA.

Clinical Applications

These results support the potential benefits to be had by increasing focus on parental/caregiver histories and reactions to CSA within the clinical settings as these have the ability to further effect child outcomes and perceived support. Specifically, a maternal history of physical abuse either in childhood or adulthood and/or a history of romantic partner sexual abuse

should be a target for future clinical interventions. Such histories are shown within the current research as having the most noteworthy impact on various perceived aspects of maternal caregiver support following instances of CSA as viewed from the child's perspective. Previous research has found that parental support, specifically maternal support, for child victims of sexual abuse is imperative for successful and healthy coping and psychological recovery (Cyr et al., 2013; Everson et al., 1989; Malloy & Lyon, 2006). Therefore, it would be best practice to develop specified interventions for cases of CSA utilizing information regarding maternal caregiver abuse history in order to improve the outcomes for child victims. With this, in moving forward with treatment and clinical implications for cases of CSA, examining maternal caregivers' own trauma histories is a reasonable and effective method for positive change and more targeted interventions for CSA victims and their families. In particular, it would be useful to add to existing screening measures regarding maternal caregiver histories of physical abuse and/or romantic partner sexual abuse as these are seen within the current study as having the most noteworthy impact on perceived maternal support.

Limitations

The current research had several limitations that should be noted. Firstly, the present study had a limited overall sample size at 106 maternal caregiver-child pairings. Although the original study by Smith and colleagues (2017) included 146 total participant dyads, only 106 pairs completed the necessary measures included in the present study regarding maternal caregivers' abuse histories and child-rated maternal support. Out of these 106 maternal caregiver participants, 33 (31.1%) reported a history of intimate partner sexual abuse, 63 (59.4%) a history of intimate partner physical abuse, and 60 (56.6%) a history of intimate partner emotional abuse according to the maternal IPV subscales. Regarding abuse during childhood, 21 (19.8%)

maternal caregivers within the study reported a history of childhood physical abuse while 53 (50.0%) reported a history of childhood sexual abuse. Out of these maternal caregivers who reported an abuse history, some additionally chose not to answer certain questions regarding the details of their abuse. Therefore, within the analyses utilized in the current study, statistical power was limited due largely to the lack of variability in the employed sample.

Additionally, the present study sought to account for outside variables supported by previous research as influencing aspects of maternal support following CSA (Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013; Elliott & Carnes, 2001; Smith et al., 2010). With this, the current study attempted to isolate and more accurately examine the influence of maternal caregivers' histories of various forms of abuse. However, with this method, a large number of predictor variables were consequently included. In such hierarchical regressions, the ratio of sample size to predictor variables impacts the power of the analyses. Because of the large number of variables included in these hierarchical regressions, a larger sample size and/or less predictor variables would have led to more reliable statistical results. Specifically, the statistical power within the multiple hierarchical linear regressions performed to examine Hypotheses IV and V was affected by such small sample sizes of less than 100 maternal caregivers. With a small original sample size, a small portion of maternal caregivers that reported an abuse history and completed the abuse history subscales, and a large number of included predictor variables, it is possible that the results from the present study were consequently altered. Therefore, the results from the present study should be interpreted with caution and not be utilized to discredit any differing results found in previous studies within the field. Additionally, none of the variables found not to be statistically significant within the current study should be excluded from future research based solely on the present results. For future research initiatives relating to the present topic, obtaining

a larger sample size as well as limiting the number of predictor variables should be primary considerations.

Furthermore, the scale utilized in the current research study was created from the maternal caregiver interviews conducted by Smith and colleagues (2017) and focused solely on maternal experiences of sexual abuse in adulthood as perpetrated by a romantic partner. This prevents the inclusion of any experiences of sexual abuse by strangers or other known individuals to the maternal caregivers; thus, limiting the ability to generalize the results to all maternal histories of sexual violence in adulthood. Experiences of sexual abuse in adulthood by strangers or known individuals other than romantic partners have been shown to lead to a wide range of negative outcomes (Culbertson & Dehle, 2001; Ellis, Atkeson, & Calhoun, 1981; Ullman, Filipas, Townsend, & Starzynski, 2006). If the measures utilized in the present study would have included evaluations of other forms of sexual abuse and violence experienced by the maternal caregivers as adults outside of that perpetrated by a romantic partner, the results of the present study could have been impacted. Although the inclusion of added measures for the current research agenda was impossible due to the use of an archival data set, information regarding other maternal experiences of adult sexual abuse should be included in future research initiatives on the present topic.

The current study utilized the Parent-Child Relationship subscale of the Parenting Satisfaction Scale (Guidubaldi & Cleminshaw, 1996) as a measure of maternal caregiver-child relationship quality. This variable was accounted for within the regression analyses as maternal caregiver-child relationship quality has been shown through previous research to influence maternal support following child sexual abuse (Cyr et al., 2003; Cyr et al., 2013). Although the use of this measure serves to account for the reported relationship between the maternal

caregiver and the child, this measure does not account for overall attachment. Attachment style between the child victim and maternal caregiver could influence maternal response to her child's abuse and overall child outcomes differently than that accounted for by the caregiver-child relationship. Attachment style could also potentially be further impacted by various maternal maltreatment histories and produce differing results regarding the effect of a maternal history of abuse on maternal support in response to her child's sexual abuse. Therefore, a measure of attachment style between the child victim and their maternal caregiver would be useful to include in future studies relating to this topic.

Additionally, the data sample used in the current study did not accurately represent the demographic region from which the data was collected nor cases of reported CSA in general (Smith et al., 2017). According to the original grant proposal by Smith (2017), on average, cases of CSA that are referred to the Lowcountry Children's Center (LCC) involve younger child victims than other CSA cases within the demographic area that are not referred to the LCC. Families and children impacted by CSA with LCC involvement are also, on average, more socio-economically advantaged than the average population of CSA cases in the area. These notable differences between the employed data pool and the larger demographic area from which the data was collected is an important limitation for the current study to be noted. Moreover, the utilized sample was also not fully representative regarding race, socio-economic status, child age, or child sex. Due to such differences between the participant pool, the residents in the data collection area, and the larger population of families impacted by CSA, the results from the present study should be cautiously generalized to cases of CSA in this geographical area and CSA cases in general. Increased representation within the sample should be a primary consideration by future research agendas regarding the current topic.

It should additionally be noted that, within the original study by Smith and colleagues (2017) a total of 317 maternal caregiver-child dyads met full criteria and were eligible to complete the study. Out of this total, 46 pairs declined to participate, 105 pairs were unable to be contacted, and 20 pairs were excluded after they failed to attend scheduled appointments regarding the study. The final sample included in Smith and colleagues (2017) research initiative included 46% of the total eligible participants within the recruitment period. Out of the total 146 dyads within the original study, 106 were included within the present research. Because less than half of the eligible participants completed the original study, it is possible that self-selection bias occurred. This limitation should additionally be considered when interpreting the results of the present study.

Because of missing or incomplete data relating to the variables utilized within the study, a complete case analysis approach was implemented; thus, such incomplete or missing cases were excluded from the current research. This resulted in a decrease in participants compared to the original study by Smith and colleagues (2017). Missing or incomplete data that resulted in case exclusion primarily regarded maternal caregivers' self-reports of abuse histories gathered from the original structured interviews. Although this method is frequently utilized to address missing or incomplete data, the utilization of a complete case analysis approach additionally promotes statistical concerns and limitations. Use of complete case analysis assumes that the included complete cases represent a statistically random sample from the original data set; thus, providing analytic results nearly identical to the results that the original sample would have produced with complete cases. However, this is rare as complete cases are often systematically different from the data sample as a whole. With the present study, the majority of unanswered portions leading to the exclusion of cases regarded the maternal caregivers' reported abuse

experiences. It is possible that maternal caregivers who chose not to answer these questions regarding past experiences of abuse had differing abuse histories or experiences than those who completed these questions; therefore, exhibiting a possible bias within the research results. This limitation should be considered when generalizing the results from the study and when conducting future research on this topic.

Future Research

Multiple research projects have been conducted that solidify the pronounced effect that maternal support has on child outcomes following instances of CSA, (e.g. Bolen & Lamb, 2007; Cyr et al., 2013; Everson et al., 1989; Godbout, Briere, Sabourin, & Lussier, 2014; Malloy & Lyon, 2006; Zajac, Ralston, Smith, 2015) as well as various factors that have the potential to influence parental support following traumatic events (e.g. Godbout et al., 2014; Hershkowitz, Lanes, Lamb, 2007; Zajac et al., 2015). However, the realm of research concerning how a maternal history of trauma and/or abuse influences aspects of provided support for her child following instances of sexual abuse remains limited with vastly inconsistent results. The present research topic provides multiple opportunities for the expansions of such research and the resulting academic literature. Specifically, various components that contribute to how a maternal caregiver experienced their own history of abuse and how this subsequently effects the support they provide to their child following instances of sexual abuse should be further examined. It is possible that any effect that maternal caregivers' experiences of past abuse has on maternal support, although important, is outweighed by coping mechanisms in regards to their past experiences of abuse. With this, an interaction effect may occur such that maternal caregivers who effectively coped with their abuse histories may not be impacted in terms of how they react to their child's abuse; however, further research within the field would be necessary to confirm

this. Such components to research as relating to coping following abuse could include variables relating to maternal social supports, relationship with their abuser, and the experienced intensity and violence of their abuse.

It is also possible that maternal caregivers who have experienced both sexual abuse and physical abuse (in either in childhood and/or adulthood) additionally experience increased negative symptomatology as a result of these traumas. Previous research has highlighted the likelihood of victims of childhood sexual abuse being at increased risk for physical, sexual, and/or emotional abuse in adulthood (Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996; Gobin, & Freyd, 2009; Messman & Long, 1996; Schaaf, & McCanne, 1998) Additionally, a previous study by Schaaf and McCanne (1998) found that in a sample of adult women, individuals who reported both sexual and physical abuse additionally reported higher rates of PTSD and trauma symptoms compared to those who only reported sexual or physical abuse. Therefore, it is possible that such increase in trauma symptomatology could further impact maternal caregivers' support provided for her child following her child's own sexual abuse. With this, an interaction effect may occur such that with maternal caregivers who have experienced both sexual and physical abuse, their current level of provided maternal support in response to their child's sexual abuse may be exponentially impacted. The present research examined the potential interaction effect regarding a maternal history of past childhood abuse and abuse in adulthood as perpetrated by a romantic partner. However, these analyses failed to examine the proposed potential interaction regarding a maternal history of sexual abuse and physical abuse experienced either in childhood and/or adulthood. Such would be a beneficial expansion upon the present research to further confirm the impact of a history of both physical and sexual abuse as well as the impact of such a combined history on maternal support following instances of CSA.

The present study examined maternal adult experiences of abuse only in terms of abuse perpetrated by a romantic partner, as outlined by the maternal caregiver interviews. However, research has shown that sexual abuse and assault in adulthood, particularly by strangers or known individuals who are not romantic partners, can consequently result in a wide range of negative psychological, social, and emotional outcomes for the survivor (Culbertson & Dehle, 2001; Ellis, Atkeson, & Calhoun, 1981; Ullman, Filipas, Townsend, & Starzynski, 2006). Research by Ullman and colleagues (2006) showed that such sexual assaults by strangers and relatives were associated with increased PTSD symptoms than assaults by acquaintances and romantic partners. Therefore, future research on the present topic should widen the span of maternal experiences of sexual abuse and assault in adulthood to include such instances perpetrated by strangers, family members, and acquaintances in addition to romantic partners. Such inclusion would allow for more comprehensive and inclusive results regarding the effect of a maternal history of such sexual abuse or assault in adulthood on her response to her own child's sexual abuse.

Additionally, it would be beneficial for future research studies regarding the impact of a maternal history of abuse on aspects of abuse-specific maternal support to further refine measures of maternal abuse histories. Specifically, abuse severity and total number of abuse occurrences should be calculated independently to further identify individual differences in abuse experiences. Such would additionally promote more specified and accurate results regarding the impact of such experiences on maternal support. Previous research has shown that both the severity and the total number of abuse occurrences have the potential to significantly impact individuals' perception of their abuse experience(s) as well as resulting trauma-related symptomatology (Feinauer, Mitchell, Harper, & Dane, 1996; Lesserman et al., 1997; Melville,

Kellogg, Perez, & Lukefahr, 2014). The inclusion of a more specified measure of maternal abuse histories focusing on abuse severity and total abuse occurrences would consequently lead to improved clinical interventions based on more accurate research results.

The current research agenda utilized a new measure of maternal support as examined from the child CSA victims' perspective (MSQ-CR; Smith et al., 2017). The use of the MSQ-CR yielded differing results than that from previous research studies that primarily utilized maternal caregiver self-reports and/or clinical observations. Smith and colleagues created this measure to more accurately examine the effects of maternal support on child outcomes by asking the children themselves how supported they felt by their maternal caregivers in various abuse-specific areas. Such practices of examining the child's perspective should be continued in future research studies regarding maternal support following differing aspects of experienced abuse/violence. Such reports provide a more accurate and usable measurement than that of maternal self-reports which are more subject to bias and desire to conform to socially acceptable parenting norms.

With the successful usage of the MSQ-CR and accompanying MSSQ within the current and previous research agendas, continued usage of these measures would be beneficial for the research field regarding maternal support and child outcomes following instances of CSA. Such continued use of these measures in future research initiatives would help standardize research practices in this area of study as well as provide an avenue for more specified results. As previous research within this area has often utilized inconsistent measures and methods, the continued use of the MSQ-CR and MSSQ would allow for results to be better directly compared and analyzed. This would therefore serve to increase the accuracy of conclusions that can be

drawn from the research results. With this progression, more accurate clinical interventions can be developed and implemented.

Conclusion

Recent clinical practice has moved towards a trauma-informed model over recent years in response to research exhibiting both the prominent occurrence of childhood trauma as well as the resulting epidemic-sized impact that such trauma has on later adult functioning and health (Champine, Matlin, Strambler, & Tebes, 2018; Hanson & Lang, 2016; Saunders & Adams, 2014). Previous research has additionally shown the importance of maternal support following trauma and/or abuse in child victims (Bolen & Lamb, 2007; Cyr et al., 2013; Everson et al., 1989; Malloy & Lyon, 2006; Valentino, Berkowitz, & Stover, 2010; Zajac, Ralston, Smith, 2015) as well as many factors that have been shown to influence provided maternal support (Alaggia, 2002; Cyr et al., 2013; Elliott & Carnes, 2001; Godbout et al., 2014; Smith et al., 2010; Zajac et al., 2015). The present research findings serve to add to this discussion and promote additional avenues to be explored regarding this research topic.

Within the current study, results supported previous research findings regarding the influence of maternal caregivers' relationship with the perpetrator and maternal caregiver-child relationship quality as predictors of maternal support following instances of CSA (Alaggia, 2002; Cyr et al., 2003; Cyr et al., 2013; Everson et al., 1989; Malloy & Lyon, 2006). Findings additionally corroborated previous statistics regarding the increased likelihood of maternal caregivers of CSA victims also experiencing sexual abuse during their childhood, with 50.0% of maternal caregivers in the study reporting a history of CSA (Baril et al., 2016; Bowman et al., 2009; Leifer et al., 2004; Leifer et al., 1993; Moehler et al., 2007; Timmons-Mitchell et al., 1996). Furthermore, the current research agenda highlighted previously overlooked factors of

maternal caregivers' histories that could have a significant influence on maternal support provided following CSA: physical abuse in childhood, romantic partner physical abuse, and romantic partner sexual abuse. Such information is useful in addressing specific aspects of maternal support that is affected by these maternal histories. Specifically in cases of CSA in which the maternal caregiver has experienced romantic partner physical abuse, clinicians should additionally address the increased risk of skeptical preoccupation and protective/retaliation statements exhibited by the maternal caregiver. Such increased risk can be identified through brief clinical interviews regarding the maternal caregiver's history of abuse and addressed through direct clinical interventions targeting exhibited unsupportive behavior and statements by the maternal caregiver. Additionally, in cases of CSA in which the maternal caregiver reports such a history, interventions can also include the further promotion of emotionally supportive behavior as such a maternal history was shown to lead to increased perceived emotional support. Similarly, maternal histories of childhood physical abuse and romantic partner sexual abuse were shown to lead to increased perceived overall maternal support through increased emotional supportive behaviors and decreased skeptical preoccupation respectively. Interventions could additionally be implemented for maternal caregivers with such histories to further increase these behaviors and encourage the continued support for the child sexual abuse victim. Targeted interventions for nonoffending maternal caregivers of children who have experienced sexual abuse can further lead to lessened PTSD symptoms and other negative child outcomes following the abuse.

Maternal physical abuse histories and sexual abuse histories should be further evaluated and utilized to further the research field in the study of maternal support in response to child sexual abuse. Such research initiatives would lead to more specified clinical interventions

regarding maternal caregiver histories and better care and support for both child victims of CSA and their families. Future research initiatives that further specify factors that influence maternal support following CSA could additionally promote preventative action regarding the current widespread prominence of child sexual abuse.

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Appendix A

Case Descriptive Statistics

Demographics	<i>n</i>	<i>M</i> age	% Caucasian	% females
Maternal Caregiver	106	37.6	57.5	N/A
Child	106	11.5	56.6	85.8

Maternal caregiver abuse history	<i>n</i>	% of cases
History of intimate partner sexual abuse	33	31.1
History of intimate partner physical abuse	63	59.4
History of intimate partner emotional abuse	60	56.6
History of childhood physical abuse	21	19.8
History of childhood sexual abuse	53	50.0

*Out of 106 cases in study.

Maternal caregiver abuse history scale scores	Range	<i>M</i>	<i>SD</i>
History of intimate partner sexual abuse	2.00	.50	.79
History of intimate partner physical abuse	11.00	2.44	2.98
History of intimate partner emotional abuse	6.00	1.57	1.88
History of childhood physical abuse	7.00	.56	1.33
History of childhood sexual abuse	18.00	3.85	4.74

Maternal caregiver support scale scores	Range	<i>M</i>	<i>SD</i>
Maternal Emotional Support	24.00	20.62	5.44
Maternal Skeptical Preoccupation	15.00	6.67	3.73
Maternal Protection/Retaliation	18.00	9.77	4.18

Appendix B

Maternal Childhood Physical Abuse History Subscale

Now still thinking back to the time when you were growing up, did your (mother/figure) or (father/figure) ever do anything of the following:

0 = No

1 = Yes

For each item to which the person responds “yes”, ask the following three questions:

- b. How old were you the first time your mother/father [insert item]?
- c. How old were you the last time your mother/father [insert item]?
- d. Did you receive any physical injury when your mother/father [insert item]? 0 (No) 1 (Yes)
- e. Did you fear that you would be seriously harmed or killed when your mother/father [insert item]? 0 (No) 1 (Yes)

Did your mother or father:

1. Slap or spank you?
2. Hit you with something like a belt, hairbrush, a stick, or some other hard object?
3. Beat you up, hit you with a fist, or kick you hard?
4. Grab you around the neck and choke you?
5. Burn or scald you on purpose?
6. Lock you in a closet or tie you up?
7. Threaten you with a knife, gun or any other weapon, or object used as a weapon?
8. Use a knife or fire a gun on you on purpose?

Appendix C

Maternal Childhood Sexual Abuse History Subscale

Let's talk about sexual experiences you have had with others, starting with experiences you had as a child. Sometimes a person may do sexual things to a young person that the young person does not want. People who try to do unwanted sexual things to young people are not always strangers. They can be someone you know well like a friend, neighbor, teacher, coach, counselor, baby-sitter, minister, or priest. They can even be a parent, a boyfriend, or a family member. People who try to make young people do unwanted sexual things are not always men or boys- they can also be women or girls. I would like for you to think about any experiences you've had where someone tried to make you do something sexual that you did not want to do, no matter who did it, how long ago it happened, or whether or not it was reported to the police or other authorities.

1. Has a man or boy ever put his penis inside your vagina, rectum, or mouth when you didn't want him to?
 - a. (0) _____ No
(1) _____ Yes
 - b. If yes: Did this happen: (1)___one time
(2)___more than one time
 - c. If yes: How old were you the first time this happened? _____
How old were you the last time this happened? _____
 - d. If yes: How were the people who did this related to you?
Perpetrator 1: _____ Perpetrator 3: _____
Perpetrator 2: _____ Perpetrator 4: _____
 - e. If yes: Did you tell anyone about this?
(0) _____ No--If no, skip
(1)_____ Yes--If yes, go on
If yes: How supportive was the first person you told about this?

Perpetrator 1: _____ Perpetrator 3: _____

Perpetrator 2: _____ Perpetrator 4: _____

e. If yes: Did you tell anyone about this?

(0) _____ No--If no, skip

(1) _____ Yes--If yes, go on

If yes: How supportive was the first person you told about this?

(0) _____ Not at all supportive

(1) _____ Somewhat supportive

(2) _____ Very Supportive

4. (Not counting any incidents you already told me about), has anyone, male or female, ever touched any of your private sexual parts when you didn't want them to?

a. (0) _____ No

(1) _____ Yes

b. If yes: Did this happen: (1) _____ one time

(2) _____ more than one time

c. If yes: How old were you the first time this happened? _____

How old were you the last time this happened? _____

d. If yes: How were the people who did this related to you?

Perpetrator 1: _____ Perpetrator 3: _____

Perpetrator 2: _____ Perpetrator 4: _____

e. If yes: Did you tell anyone about this?

(0) _____ No--If no, skip

(1) _____ Yes--If yes, go on

If yes: How supportive was the first person you told about this?

(0) _____ Not at all supportive

(1) _____ Somewhat supportive

(2) _____ Very Supportive

(1)_____ Yes--If yes, go on

If yes: How supportive was the first person you told about this?

(0)_____ Not at all supportive

(1)_____ Somewhat supportive

(2)_____ Very Supportive

Appendix D

Maternal Intimate Partner Emotional Abuse Subscale

No matter how well two people get along in a romantic relationship, there are times when they disagree, get annoyed with the other person, want different things from each other, or have fights because they are in a bad mood, are tired, or for some other reason. This is a list of things that might have happened between you and a romantic partner.

Did any romantic partner ever:

0 = No

1 = Yes

1. Decide how all of the money was spent in your family, with no regard to your opinion?
2. Refuse to allow you to get or keep a job?
3. Restrict your use of the telephone?
4. Not allow you to leave the house or see certain people?
5. Threaten to take your children away from you?
6. Call you demeaning or insulting names (e.g., ugly, stupid, bitch, etc.)?

Appendix E

Maternal Intimate Partner Physical Violence Subscale

No matter how well two people get along in a romantic relationship, there are times when they disagree, get annoyed with the other person, want different things from each other, or have fights because they are in a bad mood, are tired, or for some other reason. This is a list of things that might have happened between you and a romantic partner.

Did any romantic partner ever:

0 = No

1 = Yes

1. Throw something at you?
2. Push, shove, or grab you?
3. Slapped or hit you with an open hand?
4. Threaten you with a knife, gun, or other weapon?
5. Beat up, kick, or punch you with a fist?
6. Hit you with something that could hurt?
7. Burn or scald you on purpose?
8. Threaten to kill or have someone else kill you?
9. Cause you to have a broken nose, broken bone, serious cut or wound, or cause you to pass out (from a fight with your partner)?
10. Cause you to have other injuries, like bruises, scrapes, a black eye, or anything else we haven't mentioned yet (from a fight with your partner)?
11. Cause you to need to see a doctor (because of a fight with your partner, whether you actually went to the doctor or not)?

Appendix F

Maternal Intimate Partner Sexual Violence Subscale

No matter how well two people get along in a romantic relationship, there are times when they disagree, get annoyed with the other person, want different things from each other, or have fights because they are in a bad mood, are tired, or for some other reason. This is a list of things that might have happened between you and a romantic partner.

Did any romantic partner ever:

0 = No

1 = Yes

1. Verbally pressure you to have sex- meaning intercourse, oral sex, or any other type of sex?
2. Use any force or the threat of force to make you have any type of sex?

Appendix G

Maternal Closeness to Parents Subscale

For the next several questions about your relationships with your parents, please indicate whether these things happened often, sometimes, or never.

2 = Often

1 = Sometimes

0 = Never

1. Was your mother (or mother figure) tender and affectionate to you?
2. How about your father (or father figure)?
3. Would you go to your mother (or mother figure) for help when you felt upset or had a problem or when you really needed someone to talk to?
4. How about your father (or father figure)?
5. Did your mother (or mother figure) take an interest in how you felt?
6. How about your father (or father figure)?

Appendix H

Maternal Support Questionnaire- Child Report (MSQ-CR; Smith, et al., 2017)

When mothers find out that their children have been abused, they do many different things. How much has your mother done each of these things during the past month?

0 = Not at all 1 = A little bit 2 = A lot 3 = Very much

My mother:

1. Believed everything I said happened.
2. Asked what she can do to help me feel safe.
3. Talked about wanting the person who hurt me to get in trouble.
4. Got really upset about what happened to me.
5. Asked me if I am telling the truth about what happened to me.
6. Tried to get me to talk about what happened to me.
7. Tried to keep the person who hurt me away from me.
8. Said she wants to do something to harm the person who hurt me.
9. Tried to make sure I was telling the truth about what happened to me.
10. Said what happened to me is the abuser's fault.
11. Told me that she loves me.
12. Has done things to make me feel safe at home.
13. Really listened to me if I talked about what happened to me.
14. Helped me feel better about what happened to me.
15. Cared about my feelings.
16. Thought about what happened to me a lot.
17. Seemed to know when I was feeling upset about what happened to me.

18. Seemed to want to “get back at” the person who hurt me.
19. Knew how to calm me down when I was upset about what happened to me.
20. Tried to get more information (from the library, Internet, doctors) to learn about what happened to me.

Scales:

Emotional Support: 1, 2, 11, 12, 13, 14, 15, 17, 19

Skeptical Preoccupation: 5, 6, 9, 16, 20

Protection/Retaliation: 3, 4, 7, 8, 11, 18

Appendix I

Correlation Matrix of Predictor Variables

Predictor Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Maternal emotional support	-															
2. Maternal skeptical preoccupation	.27**	-														
3. Maternal protection/retaliation	.41**	.23*	-													
4. Maternal relationship with abuser	-.29**	-.19	-.20*	-												
5. Maternal relationship with parents	-.05	-.003	.11	-.04	-											
6. Maternal-child relationship	.17	.03	.20*	-.04	.29**	-										
7. Child age	-.20*	-.20	.16	.07	.13	-.09	-									
8. Child sex	-.14	-.17	.07	.11	-.02	-.16	.12	-								
9. Maternal history of childhood sexual abuse	-.01	.02	-.04	-.08	-.44**	-.17	-.17	-.12	-							
10. Maternal history of childhood physical abuse	.25*	-.02	.14	-.04	-.35**	-.08	-.08	.11	.13	-						
11. Maternal history of intimate partner sexual abuse	.07	-.09	.001	.04	-.33**	-.06	.19	.08	.32**	.22*	-					
12. Maternal history of intimate partner physical abuse	.22*	.13	.15	.01	-.31**	-.12	.06	.18	.22**	.16	.58**	-				
13. Maternal history of intimate partner emotional abuse	.07	-.01	-.04	.28**	-.31**	-.14	.16	.10	.15	.16	.63**	.59**	-			
14. Maternal history of childhood abuse total	.06	.03	-.01	-.08	-.50**	-.20	-.19	-.08	.97**	.38**	.37**	.25*	.19	-		
15. Maternal history of romantic partner abuse total	.17	.06	.07	.12	-.35**	-.14	.14	.16	.24*	.20*	.76**	.92**	.84**	.28**	-	
16. Interaction between maternal history of childhood abuse and romantic partner abuse	-.03	-.03	.05	-.09	-.10	-.01	.11	.05	.20	.07	.27**	.16	.10	.20*	.18	-

* $p < .05$

** $p < .01$

Appendix J

Hierarchical Linear Regression Predicting Maternal Emotional Support Following CSA

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-3.97	1.53	-.27	-2.59	.01*	-7.02 - -.92
Maternal relationship with parents	-.07	.07	-.12	-1.06	.29	-.20 - .06
Maternal-child relationship	.16	.10	.17	1.56	.12	-.04 - .36
Child age	-.34	.23	-.16	-1.51	.14	-.79 - .11
Child sex	-.94	1.74	-.06	-.54	.59	-4.41 - 2.53
<i>Step 2</i>						
Maternal relationship with abuser	-4.14	1.61	-.28	-2.56	.01*	-7.35 - -.92
Maternal relationship with parents	.02	.08	.04	.32	.75	-.13 - .17
Maternal-child relationship	.15	.10	.16	1.52	.13	-.05 - .34
Child age	-.36	.22	-.17	-1.65	.10	-.80 - .08
Child sex	-2.50	1.73	-.15	-1.45	.15	-5.94 - .94
Maternal history of childhood sexual abuse	-.11	.14	-.10	-.82	.42	-.38 - .16
Maternal history of childhood physical abuse	1.01	.43	.25	2.34	.02*	.15 - 1.87
Maternal history of intimate partner sexual abuse	-.74	1.02	-.10	-.72	.47	-2.76 - 1.29
Maternal history of intimate partner physical abuse	.52	.25	.27	2.11	.04*	.03 - 1.00
Maternal history of intimate partner emotional abuse	.38	.46	.12	.82	.42	-.54 - 1.29

* $p < .05$

** $p < .01$

Appendix K

Hierarchical Linear Regression Predicting Maternal Skeptical Preoccupation Following CSA

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-1.70	1.04	-.18	-1.64	.11	-3.76 - .37
Maternal relationship with parents	.02	.05	.04	.32	.75	-.08 - .10
Maternal-child relationship	-.02	.07	-.03	-.26	.80	-.16 - .12
Child age	-.22	.16	-.15	-1.39	.17	-.54 - .10
Child sex	-1.47	1.20	-.14	-1.22	.23	-3.86 - .92
<i>Step 2</i>						
Maternal relationship with abuser	-2.17	1.13	-.23	-1.92	.06	-4.42 - .08
Maternal relationship with parents	.02	.05	.04	.30	.77	-.09 - .12
Maternal-child relationship	-.02	.07	-.03	-.25	.80	-.16 - .12
Child age	-.18	.16	-.12	-1.10	.27	-.49 - .14
Child sex	-2.00	1.21	-.18	-1.65	.10	-4.41 - .41
Maternal history of childhood sexual abuse	-.04	.10	-.05	-.42	.68	-.23 - .15
Maternal history of childhood physical abuse	-.11	.35	-.04	-.31	.76	-.81 - .59
Maternal history of intimate partner sexual abuse	-1.47	.72	-.32	-2.04	.045*	-2.90 - -.04
Maternal history of intimate partner physical abuse	.50	.18	.37	2.76	.007**	.14 - .85
Maternal history of intimate partner emotional abuse	.30	.33	.15	.93	.36	-.35 - .95

* $p < .05$

** $p < .01$

Appendix L

Hierarchical Linear Regression Predicting Maternal Protection/Retaliation Following CSA

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-2.31	1.13	-.22	-2.05	.04*	-4.56 - -.07
Maternal relationship with parents	-.003	.05	-.01	-.07	.95	-.10 - .10
Maternal-child relationship	.17	.08	.24	2.22	.03*	.02 - .33
Child age	.27	.17	.17	1.61	.11	-.06 - .60
Child sex	1.47	1.31	.12	1.12	.27	-1.14 - 4.08
<i>Step 2</i>						
Maternal relationship with abuser	-1.75	1.22	-.16	-1.43	.16	-4.18 - .69
Maternal relationship with parents	.05	.06	.11	.87	.39	-.06 - .16
Maternal-child relationship	.17	.08	.24	2.16	.03*	.01 - .32
Child age	.32	.17	.20	1.91	.06	-.01 - .66
Child sex	.70	1.33	.06	.53	.60	-1.94 - 3.34
Maternal history of childhood sexual abuse	.04	.11	.04	.37	.71	-.17 - .25
Maternal history of childhood physical abuse	.54	.33	.18	1.61	.11	-.13 - 1.20
Maternal history of intimate partner sexual abuse	-.97	.77	-.19	-1.26	.21	-2.51 - .57
Maternal history of intimate partner physical abuse	.57	.19	.39	2.94	.004**	.18 - .95
Maternal history of intimate partner emotional abuse	-.20	.36	-.09	-.55	.58	-.91 - .51

* $p < .05$

** $p < .01$

Appendix M

Hierarchical Linear Regression Analyzing Maternal History of Childhood and Adulthood Abuse

Relating to Maternal Emotional Support

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-4.28	1.51	-.29	-2.84	.006**	-7.27 - -1.28
Maternal relationship with parents	-.01	.08	-.02	-.14	.89	-.16 - .14
Maternal-child relationship	.15	.10	.16	1.49	.14	-.05 - .34
Child age	-.43	.22	-.20	-1.91	.06	-.87 - .02
Child sex	-1.83	1.74	-.11	-1.05	.30	-5.29 - 1.63
Maternal history of childhood abuse	-.07	.13	-.07	-.56	.58	-.34 - .19
Maternal history of romantic partner abuse	.35	.14	.30	2.55	.01*	.08 - .62
<i>Step 2</i>						
Maternal relationship with abuser	-4.38	1.52	-.30	-2.88	.005**	-7.40 - -1.35
Maternal relationship with parents	-.01	.08	-.01	-.11	.92	-.16 - .14
Maternal-child relationship	.15	.10	.16	1.52	.13	-.05 - .35
Child age	-.40	.23	-.19	-1.79	.08	-.86 - .05
Child sex	-1.79	1.75	-.11	-1.03	.31	-5.27 - 1.69
Maternal history of childhood abuse	-.06	.13	-.06	-.47	.64	-.33 - .20
Maternal history of romantic partner abuse	.37	.14	.32	2.60	.01*	.09 - .66
Interaction between maternal history of childhood abuse and romantic partner abuse	-.01	.02	-.06	-.59	.56	-.06 - .03

* $p < .05$

** $p < .01$

Appendix N

Hierarchical Linear Regression Analyzing Maternal History of Childhood and Adulthood Abuse

Relating to Maternal Skeptical Preoccupation

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-2.04	1.04	-.22	-1.96	.054	-4.11 - .03
Maternal relationship with parents	.03	.05	.08	.63	.53	-.07 - .14
Maternal-child relationship	-.03	.07	-.05	-.47	.64	-.17 - .11
Child age	-.27	.16	-.18	-1.69	.10	-.58 - .05
Child sex	-2.02	1.22	-.19	-1.66	.10	-4.45 - .40
Maternal history of childhood abuse	-.08	.10	-.11	-.86	.39	-.27 - .11
Maternal history of romantic partner abuse	.20	.10	.25	2.05	.04*	.01 - .39
<i>Step 2</i>						
Maternal relationship with abuser	-2.21	1.05	-.23	-2.10	.04*	-4.30 - -.11
Maternal relationship with parents	.04	.05	.09	.70	.49	-.07 - .14
Maternal-child relationship	-.03	.07	-.05	-.42	.68	-.17 - .11
Child age	-.24	.16	-.16	-1.50	.14	-.56 - .08
Child sex	-1.96	1.22	-.18	-1.61	.11	-4.39 - .46
Maternal history of childhood abuse	-.07	.10	-.09	-.70	.49	-.26 - .13
Maternal history of romantic partner abuse	.22	.10	.28	2.26	.03*	.03 - .42
Interaction between maternal history of childhood abuse and romantic partner abuse	-.02	.02	-.12	-1.07	.29	-.05 - .02

* $p < .05$

** $p < .01$

Appendix O

Hierarchical Linear Regression Analyzing Maternal History of Childhood and Adulthood Abuse

Relating to Maternal Protection/Retaliation

Predictor	<i>B</i>	<i>SE B</i>	β	<i>t</i>	<i>p</i>	95% CI
<i>Step 1</i>						
Maternal relationship with abuser	-2.42	1.15	-.23	-2.11	.04*	-4.70 - -.14
Maternal relationship with parents	.04	.06	.09	.72	.48	-.07 - .15
Maternal-child relationship	.17	.08	.24	2.20	.03*	.02 - .33
Child age	.24	.17	.15	1.43	.16	-.10 - .58
Child sex	1.21	1.33	.10	.91	.37	-1.44 - 3.86
Maternal history of childhood abuse	.05	.10	.06	.44	.66	-.16 - .25
Maternal history of romantic partner abuse	.15	.10	.18	1.48	.14	-.05 - .36
<i>Step 2</i>						
Maternal relationship with abuser	-2.51	1.17	-.23	-2.15	.04*	-4.83 - -.19
Maternal relationship with parents	.04	.06	.09	.74	.46	-.07 - .16
Maternal-child relationship	.17	.08	.24	2.21	.03*	.02 - .33
Child age	.26	.17	.16	1.48	.14	-.09 - .60
Child sex	1.24	1.34	.10	.92	.36	-1.43 - 3.91
Maternal history of childhood abuse	.05	.10	.06	.50	.62	-.15 - .26
Maternal history of romantic partner abuse	.17	.11	.19	1.54	.13	-.05 - .38
Interaction between maternal history of childhood abuse and romantic partner abuse	-.01	.02	-.05	-.48	.64	-.05 - .03

* $p < .05$

** $p < .01$