Chapter 1

General Introduction
The impact of child sexual abuse (CSA) on short- and long-term mental health outcomes has been well-established (e.g., Chen et al., 2010; Maniglio, 2009). A growing body of research, however, highlights the importance of understanding the impact of CSA in an interpersonal context. CSA victims’ relationships with parents, friends, and romantic partners are found to both mediate and moderate the effects of CSA on mental health (e.g., Collishaw et al., 2007; Sperry & Widom, 2013). Currently, little is known about these relational processes among children and high-risk young adults (i.e., delinquent, antisocial). To address these gaps in the literature, the aim of this dissertation was to get a better understanding of the interpersonal context of CSA and the role of relational processes in the development of mental health problems among these understudied samples of abuse victims. Additionally, we examined the impact of CSA on non-offending mothers’ mental health, and risk factors associated with these mental health problems. The current chapter provides a background and outline of the studies described in this dissertation.

**Child sexual abuse: definition, prevalence, and risk factors**

CSA is defined by the Consultation on Child Abuse Prevention of the World Health Organization (WHO; 1999) as follows: “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society” (p. 15). This definition includes both adult and child/adolescent perpetrators, provided that the perpetrator overpowers and/or takes advantage of the child and the sexual activity satisfies the needs of the perpetrator (WHO; 1999). Furthermore, sexual activity may or may not involve physical contact.

Recent meta-analyses reveal that CSA is a global and large-scale problem affecting millions of children around the world (Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh, Van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011; Stoltenborgh, Bakermans-Kranenburg, Alink, & Van IJzendoorn, 2015). Females are particularly at risk for experiencing CSA, with global prevalence estimates ranging from 18%-19.7% (Pereda et al., 2009; Stoltenborgh et al., 2011). Among boys, global prevalence rates are significantly lower with estimates ranging from 7.6%-7.9% (Pereda et al., 2009; Stoltenborgh et al., 2011). However, these findings must be interpreted with caution in light of findings that boys are more hesitant and less likely to disclose CSA (O’Leary & Barber, 2008; for a review, see Paine & Hansen, 2002). In the Netherlands, 9.1% of youths (age 12-17) report having experienced CSA with equal prevalence rates for boys and girls (Alink et al., 2012). Among adults, 19% of women and 4% of males reported experiencing sexual violence before the age of 16 (Vanwesenbeeck, Bakker, & Gesell, 2010).
A number of risk factors are identified for experiencing CSA, with most factors being related to socio-economic status and family adversity. For example, a lower family income, parental drug and alcohol abuse, and parental discord are associated with a higher risk of CSA (e.g., Alink et al., 2012; Collishaw et al., 2007; Fergusson, McLeod, & Horwood, 2013; Putnam, 2003). Furthermore, children with intellectual and physical disabilities are particularly at risk (Fergusson et al., 2013; Putnam, 2003). In the Netherlands, the risk for CSA is higher among children in out-of-home care (i.e., residential and foster care) with a self-reported year prevalence rate of 24.8% as compared to 5.8% in the general population (Euser, Alink, Tharner, Van IJzendoorn, & Bakermans-Kranenburg, 2013).

Impact of CSA on victims

Abundant evidence shows that CSA is associated with a variety of short- and long-term negative mental health and developmental outcomes among children, adolescents, and adults. First, CSA is associated with an increased risk for lifetime diagnoses of several psychiatric disorders, including depression, anxiety disorder, posttraumatic stress disorder, and personality disorders (Chen et al., 2010; Cutajar et al., 2010; Fergusson et al., 2013). Other indications of mental health problems among CSA victims include higher levels of self-harm and suicide attempts (Chen et al., 2010; Trickett, Noll, & Putnam, 2011), and alcohol and drug abuse (Fergusson et al., 2013; Trickett et al., 2011). Second, victims of CSA are at risk for distortions in their psychobiological development (e.g., hypothalamic–pituitary–adrenal dysregulation) and diminished physical health (e.g., obesity and non-epileptic seizures) (Irish, Kobayashi, & Delahanty, 2010; Maniglio, 2009; Trickett et al., 2011).

Third, CSA is associated with maladaptive cognitive development and victims of CSA have lower educational outcomes than their non-abused peers (Trickett et al., 2011). To illustrate, CSA is associated with lower levels of language abilities and intelligence (Trickett et al., 2011). Fourth, CSA victims often engage in risky sexual behavior, including early age of onset of sexual activity and a lack of birth control usage (Fergusson et al., 2013). Also, they have been found to have more sexual partners and unplanned (teen) pregnancies than their non-abused peers (Fergusson et al., 2013; Trickett et al., 2011). Fifth, victims of CSA may have difficulties with fulfilling a variety of adult social roles, such as establishing and maintaining high quality romantic relationships, acquiring a well-paid job, and developing positive and effective parenting skills (for a review, see De Jong, Alink, Bijleveld, Finkenauer, & Hendriks, 2015). Finally, there is a high prevalence of severe child maltreatment, including CSA, among delinquent youth (e.g., Abram et al., 2004; Dixon, Howie, & Starling, 2004). Converging with these findings, CSA is found to be a risk factor for delinquency among adults (De Jong et al., 2015). In sum, CSA can have devastating
effects on developmental outcomes in childhood and adolescence, which may even persist well through adulthood.

The interpersonal context of CSA

Victims’ interpersonal relationships may moderate and mediate the impact of CSA on mental health (e.g., Collishaw et al., 2007; Sperry & Widom, 2013). The most consistent protective factor against the negative effects of CSA is a stable and supportive family environment (for reviews, see Marriott, Hamilton-Giachritis, & Harrop, 2014; Yancey & Hansen, 2010). For example, a supportive parent-child relationship is linked to a variety of mental health outcomes among CSA victims, including lower levels of depression, anxiety, and posttraumatic stress (e.g., Deblinger, Steer, & Lippman, 1999; Godbout, Briere, Sabourin, & Lussier, 2014; Musliner & Singer, 2014). Importantly, among child victims of CSA, parental support is found to be an even stronger predictor of children’s adjustment than abuse-related factors (for a review, see Elliott & Carnes, 2001).

Despite the importance of parents in children’s adjustment to CSA, only a few studies examined the quality of parent-child relationships among child CSA victims as compared to non-abused children. Nevertheless, these studies reveal links between CSA and difficulties in the parent-child relationship. For example, sexually abused children report a lower overall parent-child relationship quality (Boney-McCoy & Finkelhor, 1996; Hotte & Rafman, 1992) and a more negative perception of their mother (Stern, Lynch, Oates, O’Toole, & Cooney, 1995) as compared to non-abused children. To date, key aspects of the parent-child relationship that may be of particular importance for sexually abused children have remained unexamined. To address this gap in the literature, Chapters 2 and 3 report on studies examining parent-child emotional communication and secrecy in the parent-child relationship. Importantly, we put effort in more fully capturing relational processes by including both parents’ and children’s perspectives on the parent-child relationship as well as by observing both parent and child contributions in dyads’ communication about emotions.

As victims of abuse grow up, other sources of social support, beside parental support, may become increasingly important. As such, supportive relationships with friends and romantic partners are associated with resiliency among victims of abuse (e.g., Collishaw et al., 2007; DuMont et al., 2007). However, these relationships may not fully reflect the scope of the interpersonal context. Social networks at the workplace may be an important source of social support among victims of abuse, because abuse is associated with difficulties in establishing and maintaining stable and positive intimate relationships (Colman & Widom, 2004; De Jong et al., 2015). In the absence of positive intimate relationships, social contacts at the workplace may be an alternative source of social support, which, in turn, increases mental health (Selenko, Batinic, & Paul, 2011).
Yet, researchers have not examined employment as a protective factor against the negative effects of abuse on mental health. Chapter 5 addresses this issue by examining associations between employment, as well as romantic relationships, and depression among victims of abuse. Importantly, we studied these associations in a sample of formerly institutionalized females, who have, despite the high prevalence of child abuse in this group (Abram et al., 2004; Dixon et al., 2004), received relatively little attention in abuse literature.

The impact of CSA on non-offending parents

Although an extensive body of research suggests that CSA is associated with negative outcomes, much less is known about the impact of CSA on non-offending parents of abused children. Research does reveal that CSA has short- and long-term consequences for parental mental health. Mothers often exhibit high levels of psychopathology (e.g., depression, anxiety, posttraumatic stress) following disclosure of their child’s CSA (Cyr, McDuff, & Hébert, 2013; Elliott & Carnes, 2001; Hébert, Daigneault, Collin-Vézina, & Cyr, 2007). Furthermore, mothers report feelings of shame, guilt, and self-blame for not being able to stop the abuse from happening (Kilroy, Egan, Maliszewskab, & Sarma, 2014; Plummer & Eastin, 2007). To date, little is known about risk factors for these problems among non-offending parents. This gap is surprising, given the negative association between parental mental health problems and parental support after CSA (Cyr et al., 2013). Chapter 4 of this dissertation fills this gap in the literature by examining predictors of posttraumatic stress symptoms among non-offending mothers.

Aims and outline

Given the crucial role of non-offending parents in the adjustment of children to CSA (Elliott & Carnes, 2001; Yancey & Hansen, 2010), we examined two key aspects of the parent-child relationship (Chapter 2 and 3) and predictors of parental mental health (Chapter 4) in the aftermath of CSA. Specifically, we investigated general mother-child emotional communication patterns by studying mother-child dialogues about children’s emotional experiences (Chapter 2). We examined the quality of mother-child emotion dialogues among dyads with CSA victims as compared to dyads with children who have not experienced CSA. Furthermore, we examined whether mother’s own experiences of childhood maltreatment and maternal psychopathological symptoms were associated with the quality of mother-child emotion dialogues.

Chapter 3 zooms in on sexually abused children’s secrecy toward their mothers. We examined children’s general tendency to keep secrets as well as children’s secrecy of CSA-specific information. Specifically, we examined whether, as compared to children who have not experienced CSA, CSA victims have a greater tendency for secrecy
as reported by mothers and children. Furthermore, we tested a mediation model in which CSA victims’ higher levels of secrecy explained the association between CSA and psychopathology (i.e., internalizing and externalizing behavior problems).

Shifting our focus to the non-offending mothers, Chapter 4 describes a study into the role of disgust sensitivity in the development of posttraumatic stress symptoms among non-offending mothers of sexually abused children. We examined whether mothers who reported higher levels of disgust sensitivity had higher levels of posttraumatic stress symptoms. Also, we examined whether mothers’ own CSA experiences and biological relatedness of the perpetrator to the child predicted posttraumatic stress symptoms.

Finally, Chapter 5 adopts a broader perspective on the interpersonal context of CSA. To study a broader scope of social connections, we examined the protective effects of employment and romantic relationships on depressive symptoms among adult victims of childhood maltreatment (i.e., physical abuse, sexual abuse, neglect, and exposure to domestic violence). To this end, we examined associations between childhood maltreatment, employment, romantic relationships, and depressive symptoms over time among high-risk females, who were institutionalized in their youth and followed-up in adulthood.

Chapter 6 summarizes and integrates findings from all four studies to provide new insights into the impact of sexual abuse on children and their families. Given that the presented data in Chapters 2, 3, and 4 are derived from a larger study, overlap in the Method sections across articles was inevitable to ensure that all chapters can be read as separate articles.

Research project
The studies described in Chapter 2, 3, and 4 of this dissertation were conducted within the Academic Collaborative Centre Child Abuse (Academische Werkplaats aanpak Kindermishandeling). This large-scale project aimed to (a) develop and implement a multidisciplinary child abuse center, in which the police, the justice department, youth care, and physicians work together in severe cases of child abuse to ensure a quick and family-centered approach; (b) develop, implement, and examine the effectiveness of treatments for children exposed to domestic violence and sexual abuse; and (c) provide professionals with education and training to boost their knowledge about best-practices in the field of child abuse.

The data presented in Chapter 2, 3, and 4 of this dissertation was collected within two concurrent studies of the research project. We examined characteristics of families with sexually abused children as compared to families without sexually abused children (Study 1). Furthermore, we examined the effectiveness of the Horizon group therapy (Lamers-Winkelman, 2000; Lamers-Winkelman & Bicanic, 2000) for
sexually abused children and their parents (Study 2). The participant flow in both studies that comprise the final sample of families with sexually abused children (N = 84) is presented in Figure 1.

In Study 1, sexually abused children aged 4-16 and their families referred for treatment of CSA to the Child and Youth Trauma Center Haarlem, Fier Fryslân, De Rading, and Accare were approached for our study. The final sample of 84 participating families with children exposed to sexual abuse consisted of 81 mothers, 24 fathers, and 84 children. Families participated in the study before the start of treatment. To compare characteristics of families with abused children to families without abused children, a comparison group was recruited from Dutch primary schools and through the social network of research assistants. A total of 63 comparison families participated in the study consisting of 61 mothers, 45 fathers, and 76 children. For more information about the participants, procedure, and measures we refer the reader to Chapter 2, 3, and 4.

In Study 2, sexually abused children and their families referred to the Horizon group therapy were approached to participate in a multicenter randomized controlled trial. The Horizon therapy is partly based on the principles of trauma-focused cognitive therapy (Cohen, Mannarino, & Deblinger, 2006) supplemented with components derived from psychomotor therapy. The Horizon group therapy consists of 14 weekly parallel sessions for children (aged 4-12) and their non-offending parents. For more detailed information about the Horizon therapy, please see Martens, Van Delft, and Visser (2012). An important component of the Horizon therapy is the trauma narrative, in which children disclose the abuse by talking, writing, and/or drawing about what happened to them, guided by a therapist. Our research specifically focused on examining the impact of sharing this trauma narrative with parents. To this end, we compared two conditions in which the child either shared the trauma narrative with

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**Figure 1.** Participant flow of families with sexually abused children.

Note. Numbers of accepted and participating families differ due to attrition and post-hoc exclusion.
their therapist only or shared the trauma narrative also with their parent(s). Treatment outcomes were measured before the start of the intervention, during the intervention, one week after the intervention, and at follow-up after six months. In this dissertation, we were only able to present data collected before the start of the intervention.
References


