

CORRESPONDENCE OF PARENT AND CHILD REPORTS ON CHILD'S EMOTIONAL ADJUSTMENT FOLLOWING DISCLOSURE OF SEXUAL ABUSE

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Introduction

Child sexual abuse is not considered a disorder or syndrome; however, it appears to be associated with a wide range of symptoms evident in child psychopathology. Short-term correlates of childhood sexual abuse have been relatively well explored. Sexual abuse may be associated with a number of internalizing behaviors (e.g., anxiety, depression, problems with self esteem, suicidal ideation, somatic complaints, post-traumatic symptoms), externalizing behavior problems (e.g., self-abusive behaviors, delinquency, sexual behaviors), and problems with school performance, relationships and social competence. Despite this array of symptoms, there is no one clinical profile apparent in the majority of sexually abused children and adolescent. Therefore, it is important to understand each child's symptoms during the assessment before engaging in the treatment.

Traditionally, multiple informants (e.g., child, parent, teacher, peers, clinician) have been used to gather critical information about an identified child in both the research and clinical arenas. Research has shown that agreement between informants and child self-reports are generally modest to low (e.g., Achenbach, McConaughty, & Howell, 1987; Phares, Compas, Howell, 1989). Despite the relative lack of agreement, researchers and clinicians have developed conventions for determining the reliability of information from different informants. Parental reports are considered to be more accurate than child reports for younger children although older children are viewed as more reliable reporters about themselves than are their parents. In general, children appear to be better reporters about their internal states (e.g., self-esteem, anxiety, depression) whereas parents and teachers are better reporters on externalizing behaviors (e.g., acting-out behaviors; Edelbrock et al., 1986; Herjanic & Reich, 1982; Kolko & Kazdin, 1993).

Child self-report has been the primary method of assessing internalizing aspects because many aspects of an individual's psychological state are subjective and require direct assessment of the child's self-reported feelings. However, in cases of child sexual abuse as well as other child clinical presentations, parental reports of internalizing behaviors continue to be gathered and utilized as reliable information. Parents are the common informants of children's functioning following disclosure of sexual abuse. Although their perceptions are very important, it is imperative to obtain the child's perspective, which may differ substantially. This is especially important for older children who can validly report their internal states. A combination of behavioral and self-report measures is crucial, particularly in children and adolescents who do not exhibit overt behavioral problems, but who experience difficulties in areas such as self-blame and poor self-image instead. Furthermore, disclosure of child sexual abuse is likely to have a distressing, emotional impact on the parents, which in turn can affect their perceptions and expectations about their children's functioning. Therefore, it is important to ascertain both the parent and child's reports of child's functioning after disclosure of sexual abuse.

The purpose of the current study is to examine the correspondence between child and parent reports of the child's internalizing behaviors and to identify whether abuse characteristics (e.g., relationship to perpetrator, severity of abuse) or respondent variables (e.g., gender of the child, age of parent) are related to parent and child correspondence in reporting child's internalizing symptoms.

Methods

Participants

Participants were 94 sexually abused children and adolescents and their nonoffending parents (i.e., 47 child-parent dyads) who were seeking cognitive-behavioral group treatment at an outpatient

clinic. The average children's age was 11.9 (SD = 2.9; range of 6.1 to 17.0) with 93.6% ages between 7 and 16. There were 11 boys (23.4%) and 36 girls (76.7%). The ethnic backgrounds for the children included 34 Whites (72.3%), 2 Mexican American (4.3%), 8 Bi-racial youths (17%), and 2 Multi-racial youths (4.3%); one child's ethnic background was unidentified. The majority of the nonoffending primary caregivers were biological mothers ($N = 38$, 80.9%). The mean age for the parents was 36.4 (SD = 6.07; range of 25 to 48 with three parents' age unknown) and majority of the parents were White ($N = 43$, 91.5%).

The alleged perpetrators were identified by the non-offending parents; 27 (57.4%) had an intrafamilial relationship with the child (e.g., sibling, biological parent, step-parent) while 20 (42.6%) had an extrafamilial relationship with the child (e.g., neighbor, adult or child family friend). The majority of the alleged perpetrators were men ($N = 40$, 85.1%) and ranged in age from 10 to 69, with a mean of 26.4 years (SD = 13.5). Thirty of the child victims in this sample experienced digital penetration or intercourse (vaginal, anal, or oral) (63.8%) and ten were sexually assaulted by multiple perpetrators (i.e., two or three). The mean duration of the sexual abuse was 12.7 months (SD = 16.5; range of 1 to 90 months).

Procedures

As part of parent and child participation in Project SAFE, a group treatment for children age 7 to 16 and their nonoffending caregivers, participants were asked to complete questionnaires selected to assess various domains of functioning. The intake data collected prior to the initiation of treatment was used for the present study.

Measures

In addition to abuse-related and demographic information, the Child Behavior Checklist (CBCL; Achenbach, 1991) was completed by the parent. The CBCL - Parent Report Form is a 113-item checklist used for the assessment of parents' perceptions of social competence and behavioral problems of their children ages 4 to 18 years. The withdrawal, somatic complaints, and symptoms of anxiety and depression subscales were selected for use in this study.

Child report measures selected for this investigation included the following:

Children's Depression Inventory (CDI or CD Inventory; Kovacs, 1992). The CDI is a 27-item measure used to assess recent cognitive and somatic symptoms of depression.

Children's Fears Related to Victimization (CFRV). The CFRV is a 27-item subscale of the Fear Survey Schedule for Children – Revised (FSSC-R; Ollendick, 1983; Wolfe & Wolfe, 1986). The CFRV lists situations that sexually abused children seem to find particularly distressing (e.g., people not believing me, being lied to by someone I trust, people knowing bad things about me) and children rate how afraid he or she is of the situation.

Children's Impact of Traumatic Events – Revised (CITES-R; V.V. Wolfe, Gentile, Michienzi, Sas, & D.A. Wolfe, 1991). The CITES-R is a 78-item semi-structured interview developed to measure the impact of sexual abuse from the child's perspective across areas of Post-Traumatic Stress, Abuse Attributions, Social Reactions, and Eroticism. The Post-Traumatic Stress subscale was selected for this study.

Children's Loneliness Questionnaire (CLQ; Asher & Wheeler, 1985). The CLQ is a 24-item questionnaire that assesses children's feelings of loneliness, social adequacy, and subjective estimations of peer status.

Children's Manifest Anxiety Scale - Revised (CMAS-R; Reynolds & Richmond, 1985). The CMAS-R is a 37-item measure that assesses general anxiety with a Total Anxiety score comprising physiological, subjective, and motor symptoms of anxiety.

Self-Esteem Inventory (SEI; Coopersmith, 1981). The SEI contains 58 items that measure children's attitudes about themselves in social, academic, family, and personal areas of experience.

Results

Child internalizing behaviors were assessed both by parent report and by child self-report. Tables 1 and 2 reflect the univariate statistics for both the parents' and children's scores. A composite score for both the parents' report of their children's behaviors, and the children's self-report of internalizing problems was calculated. The parent's composite score ($M = 62.20$, $SD = 8.16$) resulted from averaging the CBCL Withdrawn, Somatic, and Anxious/ Depressed subscales resulting in one

mean internalizing score for each child as described by the parent. The children's composite score ($M = 43.79$, $SD = 9.41$) was calculated by averaging their self-report total T scores on the RCMAS, CLQ, CFRV, CDI, and the PTSD subscale scores of the CITES. As Figure 1 suggests and a Pearson's correlation revealed, these two scores have a significant linear relationship ($r = .484$, $p = .002$).

A regression analysis was conducted using the parent composite score as the criterion and the child composite scores along with gender and age of child, age of parent, perpetrator relationship to child, duration of sexual abuse, and sexual abuse type as predictors. Categorical variables (perpetrator relationship, gender of child, type of abuse) were recoded into effect codes. The resulting model had $R^2 = .608$ ($F(7,32) = 2.679$, $p = .027$), with a significant regression weight for only the children's composite score. Table 3 shows the regression weights and t-tests results.

Conclusions

Contrary to the existing literature on the low correspondence between parent and child reports of child's emotional adjustment, current findings support a convergence of sexually abused children's and their nonoffending parents' reports of child internalizing symptoms. One possible explanation for these results is the sample consisting of parents who are seeking interventions for their children may be attuned to their children's level of distress and were able to report it with a high degree of sensitivity.

Future research with a larger sample will allow researchers to examine parent-child dyads who have similar perceptions versus those who have dissimilar perceptions, as this difference may reflect upon the quality of the parent-child relationship. In addition, an examination of child versus adolescent self-reports will be possible with a larger sample. Parental distress and familial stress are variables to consider in future studies to explore relative contributions of child symptoms ratings and informant discrepancies. Furthermore, it would be important to expand current research findings to a different symptom domain (i.e., externalizing behaviors), child samples (e.g., nonpatient, inpatient), and between different informants (e.g., teacher-child, therapist-child).

Results from this study are promising and strengthen the need to obtain information about child symptomatology from multiple sources because each informant can provide a unique perspective of the child's functioning. This assessment data from multiple informants can also guide valuable treatment planning and identify specific interventions for the youth. One goal for future interventions is to directly address parent and child communication and improve the parents' ability to gauge their children's internalizing behaviors.

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Figure 1.

Child Self-Report by Parent Report of Child's Internalizing Behaviors



