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PSYCHOLOGICAL WELL-BEING IN MALTREATED CHILDREN
AND
CAREGIVER PERSPECTIVES OF SUPPORT

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A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Clinical Psychology, The University of Auckland, 2013

Abstract

Understanding the patterns of referral to child protection services can inform decision makers about the services needed for the prevention and treatment of child abuse. This research consisted of three linked studies, the first of which aimed to describe demographic, abuse, authority involvement, and family characteristics of 307 children who presented over a four month period to a multi-service agency for maltreated children. The second study involved a subsample of 180 children, and employed correlations, Chi-square tests, and MANOVA tests to investigate factors related to psychological well-being, as assessed by the Strengths and Difficulties Questionnaire. The third study employed qualitative methods to explore perceptions of 22 non-offending parents and caregivers, with regard to experiences of support following presentation to Puawaitahi. Key findings were that a large proportion of children presented due to more than one form of maltreatment, there were often delays in abuse identification, and many children were repeatedly victimised. Emotional, behavioural, and peer difficulties were common for these children. Children who were male, older at the time of referral, and had experienced multiple home placements were found to be particularly vulnerable to difficulties following maltreatment. Whilst parents and caregivers considered support helpful, many said attempts to access counselling or therapy following presentation had been too difficult or involved delays.

**This thesis is dedicated to my family, with gratitude for your
love and support**

Acknowledgements

I would firstly like to thank my supervisor Professor Fred Seymour, whose help, support, and calm guidance has been invaluable throughout the process of this thesis. I would also like to thank my secondary supervisor, Dr. Suzanne Barker-Collo, for her amazingly fast feedback and much appreciated statistical support.

I am thankful for the staff in the Clinical Psychology Programme and my clinical supervisors for their time, knowledge, and support. Sheryl Robertson, thank you for always looking after the clinical psychology students so well. Thank you to the clinical crew for the fun and peer support over the last four years; I will miss seeing everyone on a regular basis.

Thanks to Dr. Gjurgjica Badzakova for answering my statistical queries, Dr. Erana Cooper for her guidance, Tania Gilchrist for her help conducting interviews, and Jan Rhodes for her help with transcription.

I am highly appreciative of the help provided by staff at Puawaitahi, who gave out consent forms and participant information sheets, and readily assisted me in finding the information I needed despite having plenty of other work to do. In particular, thank you to Dr. Patrick Kelly, Sue Hutchinson, Kathrine Newell, Victoria LARBalestier, and Richard Corbidge; without their support for this project it would never have started let alone be completed.

I would like to express my heartfelt thanks and love to my family for their warmth, belief, and continuous encouragement. James, completing this would have been immeasurably more difficult without your steady support and love.

I would also like to acknowledge the funding I received through the University of Auckland Doctoral Scholarship.

Finally, thank you to the parents and caregivers who generously agreed to share their experiences and views during a particularly difficult time for their family.

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Chapter One: Introduction

As part of my clinical psychology training I have taken a specific interest in child and adolescent mental health. Given that experiences of childhood abuse and neglect can have a significant impact on the psychological well-being of children, I was particularly interested in studying maltreatment.

Potential thesis topics were discussed with staff at Puawaitahi, an Auckland based multi-agency service which investigates alleged abuse of children and adolescents and provides links with other services in cases where treatment or therapy needs are identified. It was highlighted that many children who presented to Puawaitahi displayed psychological and behavioural difficulties, but did not go on to access appropriate support services. Therefore, the original study design involved a file audit to investigate what demographic, abuse, authority involvement, and family characteristics were related to well-being for children who experienced maltreatment, followed by telephone interviews with non-offending parents and caregivers to discover which children had received support following presentation to Puawaitahi. It was thought that this design would enable the exploration of characteristics related to child well-being, as well as characteristics associated with service access. Puawaitahi staff also indicated that there had been no studies evaluating their service, so it was agreed that questions related to parent/caregiver experience of Puawaitahi would be included in the follow-up telephone interviews.

Ethical approval was obtained for both studies from the Ministry of Health Regional X Health and Disabilities Ethics Committee, the Auckland District Health Board Research Review Committee, the Police Research and Evaluations Steering Committee, and the Child, Youth and Family (CYF) Research Access Committee. However, delays in obtaining ethical approval and related implementation issues resulted in fewer non-offending parents and caregivers being approached to take part in the follow-up telephone interview study. Thus, only 22 follow-up telephone interviews were conducted, and this number was too small to allow statistical analyses for this part of the research. Nevertheless, the information obtained from the telephone interviews was considered valuable, so a qualitative approach was used to analyse information regarding access to support following presentation to Puawaitahi, and parent and caregiver experience of Puawaitahi services.

Consequently, the thesis is divided into three parts: the first examines characteristics of children presenting to Puawaitahi, the second investigates what characteristics are related to psychological well-being for children presenting to Puawaitahi, and the third involves an exploration of the support received following presentation to Puawaitahi, as well as an evaluation of services received at Puawaitahi, via a thematic analysis of parent and caregiver telephone interviews.

Relevant literature is presented in the current chapter. The second chapter presents study one, a file audit in which demographic, abuse, authority involvement, and family characteristics of all children who presented to Puawaitahi over a four month period are described. The third chapter details study two, which describes the psychological wellbeing of children who presented to Puawaitahi, and examines what characteristics are associated with psychological and behavioural difficulties following maltreatment. The fourth chapter presents the thematic analysis of non-offending parent and caregiver telephone interviews, and explores what support services were desired and received following presentation to Puawaitahi, as well as parent and caregiver experience of Puawaitahi services. The final chapter of the thesis considers conclusions that can be drawn, recommendations, limitations, and potential avenues for future research.

The purposes of the current chapter are to review the impact of child maltreatment on mental health, and the factors that influence therapy uptake following child maltreatment. Child abuse and neglect prevalence, and psychological impacts of child maltreatment are presented. Then, factors that mediate and moderate psychological outcome following abuse and neglect, the effectiveness of interventions for child maltreatment, potential facilitators and barriers to accessing support services, and current practice in New Zealand, are discussed. The research presented is more comprehensive for child sexual abuse (CSA) and child physical abuse (CPA) compared to neglect and exposure to domestic violence (DV). This is because there is not the same depth of literature for neglect and exposure to DV, and there is a greater focus on sexual and physical abuse in this research.

Definitions of Maltreatment

The World Health Organization (WHO) defines CSA to be the subjection of a child to sexual acts that they do not totally understand, they cannot give informed consent to, they are not

at a developmentally appropriate stage for, or that transgress laws or social taboos (WHO, 1999). The abuse may occur between a child and an individual, be they an adult or another young person, who is in a position of power or responsibility.

The WHO defines CPA as any contact or lack of contact that is within limits of control, which leads to actual or potential bodily harm to a child (WHO, 1999). This harm may be inflicted by a parent or another individual who is in a position of power, or who is entrusted with the care of the child, and may occur on single or multiple occasions.

Neglect is considered to be the failure of a caregiver to act in ways that provide what is necessary to meet their child's developmental needs (Straus & Kantor, 2005), and protect their child from harm (Atwool, 2011). This includes inadequate provision of food, clothing, and housing, not seeking medical assistance when required, not ensuring that a child attends school most of the time, failing to provide a safe environment (Gilbert et al., 2009) and not meeting their emotional development needs (WHO, 1999).

Edleson (2006) defined exposure to DV as the multiple experiences of children who live in households in which there is an adult who is physically violent towards a romantic partner. Currently, the word "exposure" tends to be used as opposed to "witnessing" DV, as it is considered to be more inclusive; encompassing what a child sees, hears, and is involved in (Øverlien, 2010). Exposure to DV may involve the child witnessing the violence, being victimised themselves, or being hurt whilst trying to protect the parent who is being abused (Briere & Jordan, 2009).

Prevalence and Incidence of Child Maltreatment

The term prevalence refers to the overall number of individuals who have experienced child maltreatment, whereas incidence relates to the number of new cases during a specified time period, such as a year (Fallon et al., 2010). Child abuse prevalence rates are often researched by way of population surveys, where adults are asked to report whether they experienced child maltreatment (Finkelhor, 1994a). The argument in support of such retrospective reports is that many cases of child abuse are not disclosed at the time of maltreatment (Finkelhor, 1994a). Conversely, some authors suggest that this method may not obtain accurate prevalence rates due to memory distortion and the data being reflective of rates of abuse when the sample was young, rather than current child maltreatment rates (Briere & Elliot, 2003).

Since many cases of abuse are not disclosed, and even those that are disclosed may not be officially reported, the recorded incidence of child maltreatment will be much lower than prevalence records (Finkelhor, 1994a). For instance, Finkelhor concluded that if rates of CSA were similar to those reported in adult general population surveys, then North American incidence figures captured less than a third of all cases. Accordingly, this section focuses primarily on prevalence estimates, with some New Zealand incidence figures to follow.

It is important to consider that children who have experienced one type of abuse are often subjected to other forms of abuse (Gilbert et al., 2009). For instance, Briere and Elliot (2003) found a co-occurrence rate of 20.9% for physical and sexual abuse during childhood. Other research on an abused sample of children aged between 7 and 13 found that close to 17% had experienced both sexual and physical abuse (Ackerman, Newton, McPherson, Jones, & Dykman, 1998).

Prevalence figures stated in studies are probably conservative due to under-reporting of child maltreatment (Gilbert et al., 2009). For example, New Zealand longitudinal research has shown that reports of child sexual and physical abuse are relatively unstable due to the provision of false negative reports by abuse victims (Fergusson, Horwood, & Woodward, 2000). Using a test-retest paradigm, Fergusson and colleagues found that approximately half of the people who reported subjection to CSA or CPA at age 18 did not report it at age 21, and around half of the people who reported experiences of CSA or CPA at age 21 did not report it at age 18. Consequently, they concluded that prevalence rates of CSA and CPA based on cross-sectional studies may substantially underestimate true prevalence rates.

As a group, Māori children are socio-economically disadvantaged compared to non-Māori and face greater family adversity, both of which are linked to child maltreatment (Marie, Fergusson & Boden, 2009). Results of a longitudinal study showed that, compared to non-Māori, Māori adults reported significantly higher rates of childhood exposure to severe types of physical punishment and regular physical punishment, and significantly greater rates of childhood exposure to DV (Marie et al., 2009). However, there were no significant differences in rates of reported CSA.

Child sexual abuse

Prevalence studies nevertheless report high CSA prevalence rates. A meta-analysis of 217 studies found a global CSA prevalence rate of 11.8%, and showed that CSA rates were higher for

girls than boys (Stoltenborgh, van Ijzendoorn, Euser & Bakermans-Kranenburg, 2011). A review by Gilbert et al. (2009) found rates of CSA to be between 15 and 30% for girls, and between 5 and 15% for boys. Penetrative sexual abuse rates were 5 to 10% for girls and 1 to 5% for boys. Another review of 38 international CSA prevalence studies showed rates that varied between 0 to 53% for females and 0 to 60% for males, with the highest number of studies finding prevalence rates of 10-20% for women and up to 10% for men (Pereda, Guilera, Forns, & Gomez-Benito, 2009). Thus, Pereda and colleagues concluded that CSA is a highly prevalent, international problem.

Some prevalence research differentiates contact and non-contact CSA. For instance, in a sample of 2,869 young adults from the United Kingdom, approximately 6% of male and 15% of female participants met the criteria for contact sexual abuse, and a further 4% of male and 7% of female participants met the criteria for non-contact sexual abuse (May-Chahal & Cawson, 2005). With regard to occupation, of those who had experienced CSA, 14% were in professional, managerial, and skilled non-manual roles, and a slightly higher 18% were in skilled, semi-skilled and unskilled manual roles. This implies that whilst CSA may be slightly more likely to occur in families of low socio-economic status, it is a problem that affects children from all socio-economic contexts.

Prevalence rates of CSA in New Zealand appear to be similar to those found in the international literature. Flett et al. (2012) found that 13% of women in a community sample reported that they had been sexually abused as a child. In another study, approximately 23.5% of women living in an urban area (Auckland) and 28.2% of women living in a rural area (Waikato) reported unwanted sexual experiences before the age of 15 (Fanslow, Robinson, Crengle & Perese, 2007). Furthermore, 23% of women who reported CSA indicated that it had occurred multiple times. The median age of abuse onset was 9 years for both regions. Thus, this study indicates that a large proportion of New Zealand women have been victims of CSA (Fanslow et al., 2007).

Another New Zealand study followed a birth cohort for 25 years and investigated child maltreatment rates by means of retrospective report at ages 18, 21, and 25 (Fergusson, Boden, & Horwood, 2008). At age 18, 10.2% of the sample reported having experienced any form of CSA, 4.2% reported CSA consisting of indecent exposure and suggestions, 7.5% reported contact sexual abuse such as fondling, and 5.6% reported actual or attempted intercourse

(Fergusson, Horwood, & Lynskey, 1997). At age 21, 8.5% of the sample said that they had experienced CSA; 7.1% identified contact sexual abuse and 4.4% identified abuse that involved attempted or completed penetration (Fergusson et al., 2000). Combined results indicate that, at either age 18 or 21, 14% of the cohort reported having experienced some form of CSA, within which 11.1% reported contact sexual abuse at some point, and 6% attempted or actual intercourse (Fergusson et al., 2000). At age 25, 14.1% of the cohort said they had been sexually abused as a child; 2.7% reported non-contact sexual abuse, 5.1% contact sexual abuse that did not consist of sexual penetration and 6.3% sexual abuse that involved actual or attempted sexual penetration of any type (Fergusson et al., 2008).

Results from the New Zealand Youth 2000 survey found that 22.2% of female students and 11.3% of male students said that they had at some point in their life been touched in an unwanted sexual manner or been made to do unwanted sexual acts (Adolescent Health Research Group, 2003). However, the Youth 2007 survey found lower percentages for the same item, with 19.9% of female students and 5.4% of male students reporting unwanted sexual touches or acts (Adolescent Health Research Group, 2008). Of those reporting unwanted sexual encounters, approximately 70% of male students and 57% of female students had never told anyone.

Child physical abuse

With regard to CPA specifically, a recent review indicated that between 5 and 35% of children were victims of severe parental violence and between 4 and 16% were physically abused yearly (Gilbert et al., 2009). Studies included in this review were from high-income countries including the United Kingdom, United States, New Zealand, Finland, Italy, and Portugal.

A study by Briere and Elliot (2003) revealed high prevalence rates within an American sample; 22.2% of males and 19.5% of females indicated that they had experienced some form of physical abuse by a parent or caregiver prior to age 18. Another American study showed that 28.4% of people from a sample size of 15,197 had been physically assaulted by a parent or other adult caregiver during their childhood, and half of these people said it occurred three or more times (Hussey, Chang, & Kotch, 2006). However, the question used to determine physical assault was how often they had been slapped, hit, or kicked by a parent or other adult caregiver. As respondents answered independently by way of computer-assisted self-interviewing, it is possible that they may have interpreted the word “hit” to include light smacks that are used by

parents as a form of punishment. This definition would not fit with the much stronger meaning associated with the term “physical assault”, and so this may have contributed to the high rate of 28.4%.

People are more likely to under-identify as having been abused, as personal definitions of child abuse can vary widely (Berger, Knutson, Mehm, & Perkins, 1988). For instance, a study of more than 4500 students found that of all individuals who had received burns, lacerations, dental damage, or head injuries as a result of parental discipline, only 35 to 38% considered themselves to have been physically abused as a child (Berger et al., 1988). Moreover, only 43% of people who had received broken bones at the hands of a parent described themselves as victims of CPA (Berger et al., 1988).

Studies outside of America have also identified substantial rates of CPA (Fergusson et al., 2008; May-Chahal & Cawson, 2005). One study conducted on young adults in the United Kingdom found that 6% of male respondents and 8% of female respondents had childhood experiences that could be classified as serious physical abuse (May-Chahal & Cawson, 2005). While the study classified 7% of the young adults to have been seriously abused, only 5% self-identified as having been physically abused as a child, and the majority were in semi-skilled and unskilled vocations. An additional 15% of male and 12% of female respondents met the criteria for physical abuse of an intermediate extent, but unlike those who had experienced serious physical abuse, no differences in proportions were found based on occupation (May-Chahal & Cawson, 2005).

In New Zealand, research with a Christchurch birth cohort of 1265 individuals studied to the age of 18 indicated that 7.6% of people were often physically punished by their parents, and 3.9% were physically punished “too often or too severely”, or were treated “in a harsh and abusive way” (Fergusson & Lynskey, 1997). When the same birth cohort was questioned at age 25, 4.5% of the sample stated that they had endured “frequent or severe punishment” or had been treated in a “harsh or abusive manner” (Fergusson et al., 2008).

Furthermore, in the New Zealand national secondary school youth health survey, more than 50% of male students and more than 40% of female students answered that they had been hit or physically hurt by someone intentionally within the last year (Adolescent Health Research Group, 2003). However, the relationship between the students and the person who inflicted the physical harm was not clear.

In the more recent Youth 2007 survey, close to 48% of male students and 33% of female students said that they had been hit or physically harmed in the last year, and around 18% of these male students and 33% of these female students said that this was pretty bad, really bad, or terrible (Adolescent Health Research Group, 2008).

Neglect

Overall, between 6 and 11.8% of children are thought to experience neglect (Gilbert et al., 2009). A meta-analysis of neglect prevalence studies found overall self-reported child neglect rates of 13.3% for physical neglect, and 18.4% for emotional neglect (Stoltenborgh, Bakermans-Kranenburg & van Ijzendoorn, 2013). However, Stoltenborgh et al. concluded that neglect continued to be a neglected form of maltreatment, due to the relatively small number of prevalence studies they found for their meta-analysis, and the absence of studies focussing solely on neglect. In an international study, 9% of New Zealand adults reported experiencing three or more neglectful behaviours by their parents (Straus & Savage, 2005).

Prevalence of exposure to domestic violence

Between 8% and 25% of children are estimated to be exposed to DV (Gilbert et al., 2009). Results from the Dunedin Multidisciplinary Health and Development Study showed that just less than one quarter of those interviewed at age 26 reported that they had witnessed violence or threats of violence between their parents before age 18 years (Martin, Langley & Millichamp, 2006). Of individuals who reported exposure to DV, 55% said it had been father to mother directed, 16% reported that it had been mother to father directed, and 28% said it had involved both parents. It is unsurprising that rates of child exposure to DV are so high given that so many New Zealand adults are victims of DV. In one sample lifetime prevalence of intimate partner sexual and physical violence was 57.6% for Māori women, 32.4% for Pacific women, 34.3% for European women, and 11.0 % for Asian women (Fanslow, Robinson, Crengle & Perese, 2010).

Differences in prevalence rates

As evident in the literature summarised above, estimates for prevalence rates of child maltreatment can vary widely (Finkelhor, 1994a). A further example of this can be found in a review of sexual abuse prevalence research across countries: rates of female CSA were concluded to be between 7% and 36%, and rates of male CSA between 3% and 29% (Finkelhor, 1994b). Finkelhor (1994b) acknowledges that these results may not reflect true differences in

prevalence rates across countries, since differences in definitions and methodology mean that they are not directly comparable.

A number of factors can influence estimates of prevalence rates, including definitions, the population surveyed, and methods of data collection. With regard to definitions of child abuse, variations include the age range used (Goldman & Padayachi, 2000). For example, some prevalence studies on CSA have employed an upper age limit of 16 years, whereas others have increased this to 17 years, and such differences have been shown to affect prevalence estimates (Wyatt & Peters, 1986). Age also affects the issue of consent in cases of CSA, as consent becomes complicated when individuals reach adolescence and engage in consensual sexual behaviours with older partners (Wyatt & Peters, 1986). Variations also arise from the behaviours that are included under the umbrella terms of child abuse (Wyatt & Peters, 1986). In terms of CPA, the line that differentiates physical discipline from child abuse can sometimes be difficult to determine (Kolko, 2002). With regard to CSA, definitions may include both contact and non-contact types of abuse, or exclude non-contact sexual abuse (Wyatt & Peters, 1986). The age of the perpetrator is another element to consider in the definition of child abuse, as studies may vary with regard to the age discrepancy or whether they include an age discrepancy at all. The argument behind the inclusion of an age discrepancy may relate to factors such as the idea that physical harm inflicted by a peer or sibling does not constitute physical abuse, and the belief that consensual sexual behaviour between children is a normal part of development (Wyatt & Peters, 1986). However, most researchers concur that the exertion of power over the child, such as the use of threats or exploitation, should be incorporated in the definition of CSA regardless of the age of the perpetrator (Duffy et al., 2006).

The population surveyed may also affect prevalence estimates. For instance, it is likely that compared to general population samples, prevalence rates would be lower for research conducted with university students, and higher for studies conducted with people in the mental health system. Furthermore, sample characteristics such as age, gender, and ethnicity can impact on prevalence estimates as well (Wyatt & Peters, 1986).

Finally, differences in employed methodologies account for some of the variance found in prevalence studies (Finkelhor 1994a). For instance, mailed-out surveys could obtain different prevalence rates than face-to-face interviews, anonymous reports of abuse could lead to different rates compared to reports in which the subject is known to the researcher, and one general

screening question could result in different prevalence rates than several specific questions (Finkelhor, 1994b).

New Zealand incidence of child maltreatment

With regard to incidence rates of child maltreatment within New Zealand, a statistics fact sheet by the New Zealand Family Violence Clearinghouse (NZFVC, 2009) shows that between 2007 and 2008, 89,461 notifications were received by Child, Youth and Family (CYF), New Zealand's child protection service. Of these, 40,739 required further action, and 4,522 children were placed in CYF care (NZFVC, 2009). Furthermore, in 2010 there were 4,047 adults in New Zealand prosecuted by Police as a result of child abuse or neglect, and CYF confirmed 21,000 cases of child maltreatment between 2009 and 2010 (New Zealand Government, 2011). Between June 2011 and June 2012, following investigation CYF identified 1,396 cases of sexual abuse, 3,249 cases of physical abuse, 4,766 cases of neglect, and 12,114 cases of emotional abuse, which primarily consisted of exposure to DV (New Zealand Government, 2012).

In summary, despite the definitional and methodological differences that pervade child abuse and neglect prevalence research, one overarching conclusion can be drawn: child abuse is present within many families, regardless of nationality, ethnicity, or socioeconomic status. New Zealand is no exception, which makes the proposed research worthwhile in that it will contribute to the child abuse knowledge base and have practical implications for responding to the many New Zealand children who are victims of abuse.

Consequences of Child Maltreatment

Child maltreatment can lead to a variety of detrimental psychological, behavioural, and social sequelae (Briere & Elliot, 2003). Exposure to child abuse is a key risk factor in the development of negative short and long-term outcomes, and there is often a dose-response relationship between severity of maltreatment and likelihood of later dysfunction (Arnow, 2004). It is thought that exposure to violence and abuse can lead to detrimental physiological changes in the central nervous system, such as changes to the functioning of the hypothalamic pituitary adrenal axis (Neigh, Gillespie & Nemeroff, 2009). Changes to this axis result in either an under or over-active stress responses, leaving people susceptible to the development of psychological and physical problems (Neigh et al., 2009). Whilst there is a notion that child abuse and neglect begets child abuse and neglect, most research studies that support this have been considered

methodologically flawed, and therefore it is difficult to determine whether victimisation as a child leads to perpetration as an adult (Thornberry, Knight & Lovegrove, 2012).

Child sexual abuse

Outcomes of CSA can be numerous and diverse due to the wide range of harmful acts sexual abuse includes and an array of influential personal and contextual factors (Putnam, 2003). For instance, sexual abuse can range from genital exposure, to fondling, to attempted intercourse or completed penetration (Wyatt & Peters, 1986). Furthermore, outcome can be influenced due to child characteristics such as age and personality, abuse characteristics including severity of abuse and concurrent neglect, and relationship factors such as attachment and reaction to disclosure (Barker-Collo & Read, 2003).

A review of the impacts of sexual abuse on children highlights that post-traumatic stress disorder (PTSD) is a common consequence in substantiated cases (Nurcombe, 2000). In addition, children who have been sexually abused on multiple occasions frequently have problems with impulse control, such as aggressiveness, hyperactivity, and sexualised behaviour, as well as emotional difficulties including fear, depression, anxiety, and somatic pain (Nurcombe, 2000). It is thought that processes such as affect regulation, impulse control, and managing interpersonal relationships are influenced by what happens at important developmental periods in terms of brain maturation (Putnam, 2003). As brain development is continuously influenced by factors external to the child, brain functioning can be altered in response to stress caused by sexual abuse (Glaser, 2000). Consequently, there may be a physiological basis for some of the symptoms seen following sexual abuse, including hyper-arousal, dissociation, aggression, poor impulse control and affect regulation, and poor academic functioning.

Other reviews of the CSA literature indicate that sexualised behaviour in children is frequently associated with CSA (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Putnam, 2003), especially in young children and in children who have been recently abused (Putnam, 2003). Furthermore, CSA has been linked to symptoms of dissociation and is often associated with low self-esteem in children (Nurcombe, 2000).

In adolescence, the effects of CSA can manifest in substance use and violent behaviour (Hussey et al., 2006). For example, Hussey and colleagues revealed that, relative to non-maltreated adolescents, adolescents who had experienced contact sexual abuse prior to age 11 were 1.8 times more likely to smoke cigarettes, 1.6 times more likely to frequently drink or binge

drink, 2 times more likely to use marijuana, and 1.67 times more likely to have used illicit inhalants. In terms of increased violence, the subsample of adolescents who had been sexually abused were 1.5 times more likely to have been in a serious fight, and 1.55 times more likely to have hurt someone to an extent that required medical help.

Moreover, New Zealand research indicates that females who have experienced CSA are more likely to engage in sexual risk-taking behaviours and be sexually re-victimised as teenagers (Fergusson et al., 1997). In this study, young adult females who had experienced contact CSA that did not include intercourse were significantly more likely to have had unprotected sex and have been raped or sexually assaulted between the ages of 16 and 18. Furthermore, females who reported experiences of CSA that included attempted or actual intercourse had the highest levels of unprotected sexual relations, adolescent pregnancy, early sexual activity, sexually transmitted infections, and sexual re-victimisation.

Jonas et al. (2011), with a UK sample, revealed that CSA was strongly linked with all of the following in adulthood: depression, mixed anxiety and depression, generalised anxiety disorder, PTSD, panic disorder, specific phobia, obsessive compulsive disorder, drug dependence, alcohol dependence, eating disorders, and sexual abuse re-victimisation in adulthood. Reviews also indicate that borderline personality disorder is commonly associated with CSA victimisation (Beitchman et al., 1992; Putnam, 2003). There is a particularly strong association between major depression and CSA; it is three to five times more prevalent in women who have experienced CSA than those who have not (Putnam, 2003). Flett et al. (2012) found that adult females who were sexually abused in childhood reported more physical symptoms, psychological distress, and stressful life events than women who were not victimised. Research by Briere and Elliot (2003) revealed elevated rates of sexual dysfunction in a sample of adults with a history of CSA victimisation. Also, there is evidence that CSA may play a causal role in the development of psychosis (Bebbington et al., 2011).

A study that employed a New Zealand birth cohort of more than 1,000 people showed that CSA was significantly associated with many mental health disorders in young adulthood (Fergusson et al., 2008). Fergusson and colleagues illustrated that at ages 18, 21, and 25, the experience of CSA was significantly associated with total number of psychological disorders (Fergusson et al., 2008). Participants who had experienced CSA involving attempted or actual sexual penetration reported a mean of 1.52 psychological disorders when 25 years old, compared

to a mean of 0.60 reported by those who had not experienced CSA. Other New Zealand research provides evidence of associations between CSA victimisation and increased risk of suicide attempt, depression, alcohol abuse, and eating disorders (Mullen, Martin, Anderson, Romans & Herbison, 1993; Mullen, Martin, Anderson, Romans & Herbison, 1996; Romans, Gendall, Martin, & Mullen, 2001).

With regard to anxiety, analysis of data from a New Zealand birth cohort of young adults illustrated that, compared to people who had not experienced CSA, those with a history of CSA were four times more likely to have suffered from panic attacks and 2.2 times more likely to meet the criteria for panic disorder (Goodwin et al., 2005).

Compared to non-victims, victims of sexual abuse in childhood have been found to be significantly more likely to be charged with all different types of criminal offences, and sexual and violent offences were particularly elevated (Ogloff, Cutajar, Mann & Mullen, 2012). They were also significantly more likely to be victims of violence and future sexual assaults.

Child physical abuse

Physical abuse in childhood has been linked to interpersonal, cognitive, emotional, and behavioural issues (Kaplan, Pelcovitz, & Labruna, 1999). A review by Trickett and McBride-Chang (1995) illustrated that non-compliance and aggression were common in children who had been physically abused. Furthermore, the experience of CPA appeared to negatively affect peer relations, due to disruptiveness and aggression resulting in rejection by peers. Kaplan et al. (1999) posited that children who experience physical maltreatment may show high levels of aggression due to heightened impulsivity and irritability, hyper-vigilance, and a reduced awareness of inflicted and experienced pain. Trickett and McBride-Chang (1995) also concluded that there was consistent support that infants and children who are victims of physical abuse experience developmental delays for cognitive milestones, as well as academic problems.

Rogosch, Cicchetti, and Aber (1995) demonstrated that children who had been exposed to physical abuse were more likely to have problems socially and experience avoidance, isolation, and rejection by their peers. These difficulties in social relationships were shown to go beyond factors such as intelligence level and socioeconomic status (Rogosch et al., 1995), and they seemed to be present throughout all stages of childhood, including adolescence (Trickett & McBride-Chang, 1995). The underlying reason for the relationship between interpersonal difficulties and CPA may relate to insecure attachment, as children who live in violent homes

often experience their relationships with caregivers as threatening, unstable, and volatile in nature (Rogosch et al., 1995). Consequently, an insecure attachment may form and the child's ability to understand emotions and interpersonal events can be compromised. Additionally, they may retreat from others in order to maintain their own security, or have problems controlling negative emotions and therefore display externalizing behaviours, which thereby lead to social problems.

Kaplan et al. (1999) found that CPA was commonly associated with increased levels of aggressiveness, and greater engagement in adolescent risk-taking behaviours such as smoking, drug use, and unprotected sexual relations. Furthermore, they found that CPA enhanced the likelihood of psychological problems such as anxiety disorders, conduct disorder, oppositional defiant disorder (ODD), attention deficit hyperactivity disorder (ADHD), and in extreme cases PTSD.

Hussey et al. (2006) found that adolescents who experienced CPA before age 11 were 1.75 times more likely to be depressed, and 1.57 times more likely to use marijuana, compared to non-maltreated youths. Furthermore, they were significantly more likely to be overweight, use cigarettes and illicit inhalants, and consume alcohol frequently and binge-drink. Finally, adolescents were 1.5 times more likely to get into a physical fight, and 1.41 times more likely to hurt someone to a degree that necessitated medical attention. This is consistent with other research which has shown that adolescents who have experienced CPA are at an increased risk of displaying violent behaviour, especially if they are male (Malinosky-Rummell & Hansen, 1993).

Long term effects for individuals who have experienced CPA are also evident (Fergusson et al., 2008). A review by Malinosky-Rummell and Hansen (1993) illustrated that negative effects of CPA seen in childhood can continue into adulthood. They summarised that, in the long term, CPA was associated with increased levels of aggressive and violent behaviour, non-violent criminal activities, drug use, self-harm and suicidality, emotional difficulties, interpersonal issues, and academic and occupational problems. Furthermore, a general population study of 935 randomly selected USA adults revealed that, taking potential confounds into account, a history of exposure to CPA was associated with heightened scores on 7 of the 10 clinical scales of the Trauma Symptom Inventory (Briere & Elliot, 2003)

New Zealand research showed that exposure to CPA was significantly associated with increased rates of major depression, anxiety, conduct and antisocial personality disorder,

substance abuse, suicidal thoughts, and suicidal behaviour (Fergusson et al., 2008). Overall, participants who had experienced severe physical punishment as a child reported a mean of 1.41 psychological disorders, compared to a mean of 0.59 psychological disorders reported by participants who had not experienced CPA.

In the same New Zealand longitudinal study in which retrospective reports of over 1000 18 year olds were analysed, Fergusson and Lynskey (1997) found a positive association between degree of physical maltreatment in childhood and rates of youth offending, substance abuse, major depression, conduct disorder, and anxiety disorders. More specifically, individuals who had experienced frequent or harsh and abusive physical punishment whilst growing up had rates on the above factors that were between 1.5 to 3.9 times that of individuals who reported no physical punishment during childhood.

Mullen et al. (1996) found that New Zealand adults exposed to CPA had an attempted suicide rate of 15.4%, which was significantly higher in relation to the no-abuse control group rate of 3.7%. They also demonstrated that people who had been physically abused in childhood were more likely to have an eating disorder, experience depression and low self-esteem, become separated or divorced, and have sexual problems.

With regard to intergenerational impacts of CPA, Malinosky-Rummell and Hansen (1993) estimated that one third of people who were victims of CPA would go on to abuse their own children. Furthermore, they may be more vulnerable to abuse victimisation in romantic relationships, as well as more likely to be violent towards a romantic partner.

Neglect

The consequences of neglect are pervasive, and impacts can be more severe than the consequences of abuse (Hildyard & Wolfe, 2002). Neglected children tend to present with internalising difficulties, whereas physically abused children may be more likely to exhibit externalising difficulties such as defiance and aggression (Hildyard & Wolfe, 2002). The impacts of neglect can also manifest in impeded development, risky behaviours, early pregnancies, drug abuse, criminal behaviour, and death (Atwool, 2011).

Manly, Kim, Rogosch and Cicchetti (2001) found that physically neglected children showed greater externalising problems and aggression than children who were not maltreated. They also found that internalising symptoms and withdrawal were particularly related to the experience of physical neglect, with a dose-response relationship in terms of severity of neglect and

internalising symptoms. The authors posited that from an attachment perspective, these children may have learnt that people were not responsive to their needs and therefore withdrew from relationships since they were not helpful. Hussey et al. (2006) found that a lack of parental supervision and neglect of physical needs in childhood left young adults vulnerable to depression. With regard to cognitive development, it has been consistently shown that children who are neglected tend to experience cognitive delays and academic progress below that of their peers (Trickett & McBride-Chang, 1995).

Exposure to domestic violence

Young children exposed to DV are almost four times more likely to experience internalising or externalising problems than children not exposed to DV (Martinez-Torteya, Bogat, von Eye & Levendosky, 2009). Furthermore, a longitudinal study conducted by Johnsona et al. (2002) showed that exposure to DV was a predictor of child aggression, anger, depression, and anxiety.

There is evidence that children exposed to marital violence have heart rates and salivary cortisol levels that are significantly higher than other children, as well as higher trauma symptomatology, even when controlling for other forms of abuse (Saltzman, Holden & Holahan, 2005). The authors conjectured that this reflected an ongoing state of hyper-vigilance which left these children more susceptible to the development of anxiety disorders.

Children exposed to DV are frequently abused themselves by the same perpetrator, and the combination of exposure to DV and being the victim of physical violence has been linked with greater detrimental impacts (Edleson, 1999). Furthermore, female children exposed to intimate partner violence are at greater risk of being victimised in future relationships, and male children are at greater risk of becoming perpetrators of DV (Whitfield, Anda, Dube & Felitti, 2003).

To conclude, an array of negative psychological, behavioural, and social outcomes have been associated with child maltreatment victimisation. Hence, a need for therapeutic services is highlighted so that efforts can be made to attenuate the harmful consequences of child maltreatment.

Mediators and Moderators of the Impact of Child Maltreatment

Whilst child abuse has been associated with many short and long-term negative sequelae, the experience of abuse does not necessarily lead to psychological or functional impairments (Finkelhor & Berliner, 1995; Nurcombe, 2000; Putnam, 2003). For instance, one review showed

that when standard clinical instruments were used at initial assessment, up to 40% of children who had experienced CSA had few symptoms or were asymptomatic (Finkelhor & Berliner, 1995). Furthermore, other research found that 22% of people who had experienced child abuse or neglect met the criteria for resilience in adulthood across domains including employment, psychological disorder, criminal behaviour, and education (McGloin & Widom, 2001).

Consequently, researchers have suggested that both short and long-term impacts of abuse are mediated and moderated by multiple variables, such as abuse characteristics, responses to disclosure (Briere & Elliot, 2003), and individual differences in resilience and coping styles (Putnam, 2003). Mediators are variables that arise from an antecedent and then alter the relationship with the effect variable, whereas moderators are pre-existing variables that can influence the strength or direction of an effect (Wu & Zumbo, 2008).

Victim characteristics

Factors that relate to the individual, such as age, coping and attachment style, and personality can moderate and mediate the effects of child abuse. Age of the victim may influence the impact of child maltreatment on psychological health, although there have been some disparate findings. For example, one study found that child physical or sexual abuse at an older age was predictive of mental health symptoms (Briere & Elliot, 2003), whereas a review by Barker-Collo and Read (2003) found that with regard to CSA, younger age was associated with poor psychological outcome. Ogloff et al. (2012) found that compared to males who were 12 years or younger when sexually abused, males who were older than 12 years were significantly more likely to be charged with a sexual assault in the future, even when confounds such as severity and duration of abuse were taken into account. Thus, the influence of age on psychological outcome appears to be questionable. Other child characteristics that promote resilience following maltreatment include high intelligence, positive self-concept, and a high level of commitment to education (Herrenkohl et al., 2008).

Briere and Elliot (2003) found that a greater extent of emotional upheaval at the time of the abuse was associated with poor psychological outcome for children who had been physically or sexually abused. A meta-analysis of studies involving children exposed to traumatic events found that greater posttraumatic stress symptoms in the short term, symptoms of depression, and symptoms of anxiety, were predictive of developing posttraumatic stress in the long-term (Alisic, Jongmans, van Wesel & Kleber, 2011). In addition, mental health appears to be influenced by

coping and attachment style for people who have experienced CSA, with emotion-focussed coping and avoidant or anxious attachment associated with a poor outcome (Barker-Collo & Read, 2003).

Facets of the victim's personality also appear to moderate the psychological consequences of child abuse. For instance, individuals who have been physically or sexually abused in childhood are more likely to be resilient to the effects of child maltreatment if they have a personality that is low in neuroticism (Barker-Collo & Read, 2003; Collishaw et al., 2007). For victims of CSA, other protective factors against low self-esteem and psychological issues in adulthood include enjoyment of secondary school, a good social life in adolescence, and being good at sport (Romans, Martin, Anderson, O'Shea & Mullen, 1995).

Attribution of blame

Attribution of blame is another mediating factor which has been shown to influence mental health outcome following child sexual and physical abuse (Barker-Collo & Read, 2003; McGee, Wolfe, & Olson, 2001). For example, in research that investigated the impact of attributions on psychological outcome following child abuse, self-blame for exposure to family violence contributed 4% unique variance to self-reported internalising problems (McGee et al., 2001). In addition, self blame for sexual abuse added 19 and 10% unique variance to self-reported internalising and externalising problems respectively (McGee et al., 2001). These results are congruent with other research in which adult survivors of CSA who blamed themselves for the abuse reported lower levels of self-esteem and life satisfaction, compared to adult survivors who attributed the abuse to the offender's personality (Lev-wiesel, 2000).

Abuse characteristics

Severity, frequency, and duration of abuse can influence whether a person develops psychological symptoms following child maltreatment. A review by Briere and Jordan (2009) explored variables that influenced outcome following child maltreatment. Influential variables identified in this review included the age of the child at the start of maltreatment, whether or not the abuse was perpetrated by a family member, the frequency and duration of maltreatment, the invasiveness of sexual abuse, and whether a physical injury was sustained following physical abuse. Briere and Elliot (2003) found that a greater frequency of abuse incidents and more than one abuser were predictive of mental health symptoms following CSA or CPA. The finding that

a greater frequency of sexual abuse events is associated with poorer psychological outcome is also supported by New Zealand research (Romans et al., 1995). Moreover, a review by Herrenkohl et al. (2008) indicated that abuse that occurred once in a while, in the context of otherwise positive parenting, was associated with better outcomes than frequent and ongoing abuse.

Not surprisingly, the severity of CSA has been found to influence whether psychological symptoms develop (Barker-Collo & Read, 2003). One study found that sexual abuse which included vaginal, anal, or oral penetration was predictive of psychological symptomatology (Briere & Elliot, 2003). Furthermore, sexually abused individuals are more likely to develop psychopathology in adulthood if force and threats are used during the abuse (Bulik, Prescott, & Kendler, 2001). Indeed, the link between use of force and poor psychological outcome has consistently been found in sexual abuse research, probably because of the additive trauma that violent assaults pose (Beitchman et al., 1992).

With regard to CPA specifically, a review illustrated that a longer duration of abuse and a greater level of violence was related to later psychological symptomatology in women (Briere & Jordan, 2009). Moreover, the concurrent experience of physical abuse and neglect has also been associated with negative psychological outcomes (Barker-Collo & Read, 2003).

An earlier onset of neglect is particularly detrimental for children, probably because there are cascading effects in which milestone achievements are delayed, resulting in neglected children being challenged by developmental tasks that other children would have already mastered (Hildyard & Wolfe, 2002). Naturally, these children would be unable to master more complex developmental tasks without having learnt the foundational skills required.

Children exposed to DV as well as another form of abuse tend to experience greater difficulties than those exposed to only one form of maltreatment (Herrenkohl et al., 2008). Martinez-Torteya et al. (2009) found that young children exposed to intermittent family violence probably had better outcomes than those exposed to chronic DV due to comparatively better family functioning and time periods in which family stress levels were lower. A review by Carlson (2000) indicated that children exposed to a greater intensity and duration of DV experienced more distress and may have become sensitised to future episodes of conflict. In addition, Rossman (2001) found that children who had been exposed to DV for a greater

percentage of their life had a greater number of PTSD symptoms, as well as more severe PTSD symptoms.

Relationship to perpetrator

Whether intrafamilial CSA has a greater impact on psychological functioning than extrafamilial abuse is contentious. For instance, Briere and Elliot (2003) did not find any difference between intrafamilial and extrafamilial abuse with regard to impact on psychological symptomatology. However, one review concluded that close proximity to the abuser was predictive of poor outcome (Barker-Collo & Read, 2003), and another review suggested that impacts on psychological functioning were greater if the offender was a father or step-father (Beitchman et al., 1992). Beitchman et al posit that this may be because abuse by a father-figure involves a high degree of betrayal and trust violation, and may be indicative of substantial family disturbance and low levels of emotional support for the child. Furthermore, when abuse is perpetrated by a father or step-father the family may become fragmented, the child may not be believed, and the abuse may have occurred over an extended period of time, thus leading to a greater detrimental impact on the victim.

Reaction to disclosure and authority involvement

Reaction to sexual abuse disclosure is an important mediator of psychological health following CSA, with negative reactions or low support after disclosure leading to poorer outcomes (Barker-Collo & Read, 2003; Beitchman et al., 1991; Bulik et al., 2001). Draucker et al. (2011) illustrated that blame and disbelief following disclosure of CSA often prevents children from making further disclosures. However, if disclosure of the abuse successfully stops victimisation this acts as a protective factor against later psychopathology (Bulik et al., 2001).

The involvement of authorities such as the Police and child protection services is also associated with negative outcomes, possibly because of the detrimental effects of service delays, inadequate interagency collaboration, and lack of support (Barker-Collo & Read, 2003) that have been identified in previous research (Davies, Seymour, & Read, 2001). Alternatively, perhaps authority involvement is associated with poor psychological outcome because a greater severity or duration of abuse leads to an increased likelihood of notifications being made to authorities. Authority involvement may also result in greater disruption to the child's life in terms of displacement of family members, separation of the child from their parents and siblings, and

changes in living situation and consequent disruption to peer, teacher, and extended family relationships. Furthermore, all of the aforementioned consequences may lead to a greater extent of child self-blame.

Family context

Children from families that are socially isolated and below the poverty line are at greater risk of being maltreated in the first place, and may also be more vulnerable to poorer outcomes following abuse, since they may not have the environmental and personal resources that can buffer the effects of abuse (Briere & Jordan, 2009). For instance, low social support and poor family functioning have been connected with greater risk of the development of PTSD in children who have experienced maltreatment (Trickey, Siddaway, Meiser-Stedman, Serpell & Field, 2012). Parental mental health also seems to affect child psychological health following abuse, as a meta-analysis by Alisic et al. (2011) found that long term posttraumatic stress in children exposed to trauma was predicted by parental posttraumatic stress.

Relationship factors appear to have a strong influence on the presence of negative outcomes such as Axis I diagnoses and criminality following child maltreatment (Collishaw et al., 2007). Collishaw et al. showed that adults who had experienced child physical or sexual abuse were more likely to be resilient to later negative impacts if they had at least one parent who they thought of as very caring. They also found that good quality friendships in adolescence and adulthood, and stable adult romantic relationships were protective against psychological disorder and criminal behaviour in individuals who had been abused during childhood. The authors regarded these findings as evidence that resilience to the impact of child abuse develops from a continual process of learning how to form, maintain, and profit from caring interpersonal relationships, rather than the presence of one supportive person in the individual's life. These results suggest that enhancing relationships and relationship skills for victims of child abuse may be a worthwhile target for clinical interventions (Collishaw et al., 2007).

High family conflict is linked with poor outcomes for women who have been sexually abused in childhood (Fassler, Amodeo, Griffin, Clay & Ellis, 2005). New Zealand research found that females who were sexually abused prior to 13 years were more likely to show psychiatric morbidity and low self-esteem in adulthood if they had parents who had a relationship that was unaffectionate or violent (Romans et al., 1995). Romans et al. also found that the presence of a highly caring and not overly controlling mother was linked with better

psychological health outcomes, whereas the presence of a poor father-daughter relationship was linked with psychological difficulties in adulthood. Other research has identified that secure attachments appear to be protective against poor psychological outcome following CSA (Barker-Collo & Read, 2003).

Research on characteristics associated with the victim-offender cycle of sexual abuse also highlights the benefits of social contact (Lambie, Seymour, Lee, & Adams, 2002). Lambie et al. found that males who had been sexually victimized in childhood and then went on to sexually offend had a significantly lower frequency of social contact than victims who did not become offenders. Furthermore, the non-offending group obtained more emotional support, such as verbal and physical praise, from a greater range of sources compared to the offending group. The difference in level of emotional support was possibly due to differences in family environment, as people in the victim-offender group may have experienced a more detrimental family environment than the non-offending group.

For CPA, family factors such as whether or not the family consists of one or both parents, the socio-economic status of the family, parental education, and the age of the mother also contribute to outcome (Fergusson & Lynskey, 1997). When Fergusson and Lynskey controlled for social and contextual factors, previously significant associations between CPA and major depression, conduct disorder, nicotine and cannabis dependence, and property offending all lessened to non-significance. Several years later but on the same birth cohort, Fergusson et al. (2008) again found that after controlling for these confounds, several previously significant associations were no longer significant, which suggested that physical punishment was often embedded within a detrimental socio-economic and family context, which alone were probably risk factors for later mental health problems.

With regard to children exposed to DV, Hutch-Bocks and Hughes (2008) found direct relationships between parenting stress and parent-reported child problems, and child reported depression. Children exposed to DV may have better outcomes if they have a helpful grandparent, and church support may also help to attenuate the detrimental effects of exposure to DV (Lee, Kotch & Cox, 2004). Research with a sample of 148 African American children exposed to DV found that social support as perceived by the child mediated internalising and externalising difficulties, with higher perceived support being linked with decreased impacts

(Owen et al., 2008). Moreover, social support as perceived by the parent also mediated child internalising problems.

In summary, factors that appear to influence psychological outcome following child maltreatment include the frequency and severity of the abuse, attribution of blame, reactions to abuse disclosure, relationship to perpetrator, authority involvement, socio-economic status, the presence of a caring attachment figure, and social supports. Results from studies such as those described above can help to inform professionals as to particular risk factors that are linked with psychological difficulties following abuse.

Therapy

Although some children who experience abuse and neglect appear to be asymptomatic and resilient (McGloin & Widom, 2001), many others do experience detrimental impacts of maltreatment (Briere & Elliot, 2003). Fortunately, various psychosocial treatments have been shown to be efficacious when used with victims of child abuse (Cohen, Berliner, & Mannarino, 2000).

Interventions for maltreated children

Child-parent psychotherapy appears to be a useful form of therapy for maltreated children in general, as it can enhance parent-child attachment and the representations that the child has of themselves and their caregiver, and can help to reduce behavioural difficulties and post-traumatic stress symptoms (Shipman & Taussig, 2009). In addition, multidimensional treatment foster care has been shown to be effective in the reduction of behavioural problems of maltreated children who are placed in foster care (Shipman & Taussig, 2009).

Since children who have been abused may develop cognitive distortions in an effort to understand why the abuse happened to them, cognitive therapies are often used to treat CSA and CPA (Cohen, Mannarino, Berliner, & Deblinger, 2000). Cohen and colleagues suggest that children may try to find ways that they 'caused' the abuse in an attempt to retain a sense of control and prevent abuse re-occurrence. They may also become hypervigilant and develop the belief that the world is unsafe and that bad events will probably happen to them, so that they are prepared for future shock and pain. Cognitive distortions such as these, they argue, play a role in the development of sequelae such as depression, anxiety, and PTSD, and therefore various types of cognitive therapy are used to address cognitive errors and improve cognitive coping. Children

who have been traumatised often develop behavioural difficulties, and trauma-focussed cognitive behavioural therapy (CBT) that incorporates behavioural management techniques is an effective intervention for trauma and associated behavioural problems (Cohen, Berliner & Mannarino, 2010). Research with children from New Zealand who were victims of maltreatment showed that a manualised trauma-focussed CBT program effectively reduced PTSD symptomatology and enhanced child coping (Feather & Ronan, 2009). Furthermore, for cases where follow-up data were available, these beneficial effects had either been maintained or had improved further.

Interventions for sexually abused children

For CSA specifically, CBT appears to be a valuable form of therapy (Cohen, Berliner, et al., 2000). Indeed, reviews conclude that trauma-focused CBT interventions have the most support as an effective treatment of children traumatised by abuse (Putnam, 2003; Silverman et al., 2008). A meta-analysis by Harvey and Taylor (2010) found that CBT resulted in the biggest effect sizes with regard to the reduction of trauma symptoms following CSA, and these positive outcomes were enhanced with family involvement. Trauma-focussed CBT has been shown to be more effective for CSA than nondirective play therapy and child-centred therapies with regard to the reduction of externalizing and sexualized behaviours, as well as symptoms of anxiety, depression, and post-traumatic stress (Shipman & Taussig, 2009). The review by Cohen, Berliner, et al. (2000) reached a similar conclusion, that CBT can lessen PTSD and depressive symptoms in children who have been sexually abused, as well as sexualized, internalizing, and externalizing behaviours.

The disclosure of CSA tends to be highly distressing for parents, and in qualitative research by Humphreys (1995), all parents interviewed reported that support following their child's disclosure would have been helpful. Approximately 90% of primary carers in a New Zealand study said that counseling and support services were required immediately after disclosure of CSA (Davies et al., 2001). Moreover, four weeks after an evidential interview, close to 80% of the children and primary carers interviewed in this study had not accessed therapy, despite only about 8% saying that they did not want therapy.

Research shows that extending the delivery of CBT to other family members of children who have experienced CSA may be worthwhile. Deblinger, Lippmann, and Steer (1996) found that mothers who participated in CBT by themselves or with their child reported greater enhancement in their own parenting skills and larger reductions in child externalising

behaviours, compared to child only CBT or the community control intervention. Furthermore, the children of mothers who participated reported significantly larger reductions in their levels of depression than children placed in the other intervention groups. However, greater decreases in PTSD symptoms were found for children who participated in CBT by themselves or with a parent, compared to the parent-only CBT group or the community intervention. Therefore, this study suggests that CBT is an efficacious treatment for PTSD symptoms in children who have experienced sexual abuse, and parental involvement in CBT can help to improve child behaviour and levels of depression.

In contrast to this research, King et al. (2000) did not find any additional benefits for parental involvement in CBT, as opposed to child only CBT. This study investigated the efficacy of individual CBT and family CBT for the treatment of sexually abused children and young people with PTSD. Compared to wait-list controls, children who received CBT showed a significant reduction in PTSD symptoms, as well as reductions in fear and anxiety levels. In addition, parent ratings on the Child Behaviour Checklist (CBCL, Achenbach, 1991) also indicated improvements in PTSD symptoms, and clinician ratings illustrated increases of global functioning. Although therapists believed that family CBT strengthened the intervention, there were no significant differences found between the family CBT group and child CBT group for symptoms of PTSD, anxiety, depression, or global functioning. However, findings may have been limited by the small sample sizes of nine per CBT treatment group.

Cohen and Mannarino (1996) compared the effectiveness of CBT adapted for sexually abused preschool children (CBT-SAP) with nondirective supportive therapy (NST). Within-group comparisons depicted that children in the CBT-SAP intervention had highly significant improvements on measured outcomes following treatment, whereas there were no significant improvements in symptomatology for children in the NST condition. Post-intervention average scores for the CBT-SAP group decreased to non-clinical levels on all measures, whereas the average scores for the NST group were still in the clinical range for two out of four broad scales on the CBCL (Cohen & Mannarino, 1996). Furthermore, during the year following treatment, the CBT-SAP intervention had significantly better outcomes with regard to the maintenance of symptom improvements. However, parental ratings of satisfaction did not differ between the two programmes.

There is also some support for the use of individual psychotherapy and group psychotherapy in the treatment of sexually abused girls (Trowell et al., 2002). In one study, outcome measures displayed that both treatments were effective in terms of reduced psychological symptomatology and improved functioning, but individual psychotherapy was superior with regard to reductions in symptoms of PTSD (Trowell et al., 2002).

Interventions for physically abused children

Whilst research discussed here considers therapy for victims of CPA, a review of treatment of CPA perpetrators has been completed by Oliver and Washington (2009). In terms of child victims, one review illustrated that, compared to standard community care, CBT and family therapy led to greater reductions in child-to-parent violence, family conflict, parental distress, child externalizing behaviour, and repeat acts of CPA (Cohen et al., 2000). Abuse-focussed CBT also has empirical support for use with physically abused children, as it has been shown to help improve family cohesion and reduce externalizing behaviours and family conflict (Shipman & Taussig, 2009).

Further evidence for the effectiveness of CBT, as well as support for family therapy (FT), comes from a study which randomly assigned 55 cases of CPA to individual and parent CBT, FT, or routine community services (RCS). Results found that CBT and FT were superior to RCS with regard to reduction in child-to-parent violence, child externalising behaviour, and family conflict (Kolko, 1996). CBT and FT were also linked with greater improvements in family cohesion, parental distress, and risk for further abuse, compared to RCS (Kolko, 1996).

In addition, there is support for other therapies used in the treatment of CPA, such as Parent-Child Interaction Therapy (PCIT) and Resilient Peer Treatment (RPT) (Fantuzzo, Manz, Atkins, & Meyers, 2005; Hakman, Chaffin, Funderburk, & Silovsky, 2009; Thomas & Zimmer-Gembeck, 2011). A review by Shipman and Taussig (2009) indicated that PCIT can effectively reduce child behavioural difficulties and re-report rates of physical abuse, compared to standard community group therapy. Hakman et al. found that following PCIT, parental positive responses to appropriate child behaviour increased and negative responses decreased, and these changes were shown to be stable throughout therapy.

As mentioned above, RPT is another intervention which appears to be useful in the treatment of CPA (Fantuzzo et al., 2005). Through regular positive play with other children who function well socially, RPT attempts to enhance social competence among young children who

are socially withdrawn due to physical abuse or neglect. Compared to an attention control condition (AC) where the children were not paired with a play buddy, but with another classmate of average interactive abilities, children in the RPT intervention showed a significantly higher degree of interactive play and lower levels of alone play (Fantuzzo et al., 2005). In addition, two weeks after the intervention, teachers rated maltreated children in the RPT condition as showing a greater extent of interactive play and self-control, and a lower degree of disruptive behaviour, than children in the control condition. Thus, this research suggests that play between maltreated children and peers of high social-functioning can help to socially engage abused children and improve their levels of self-control. However, one limitation of this treatment was that it did not address other psychological symptoms that may develop as a result of physical abuse.

Interventions for neglected children

A review of treatments for children who have experienced neglect suggests that there is some emerging support for the effectiveness of RPT, multi-systemic therapy, and day treatment interventions (Macmillan et al., 2009). Macmillan et al. also reviewed research on preventative interventions, and concluded that the home visitation programme, Nurse-Family Partnership, had the most support in terms of preventing both neglect and physical abuse of children, and the Early Start programme also had some promising results. Furthermore, whilst there was evidence that PCIT could prevent the recurrence of physical abuse, similar results were not found for neglect. The parenting program, Incredible Years, has also been shown to enhance parenting practices and parental perception of child behaviour for parents involved with a child protection service due to neglect (Letarte, Normandeau & Allard, 2010).

Interventions for children exposed to domestic violence

Carlson (2000) concluded that interventions for DV should be focussed on the child's mother (assuming they were the victim) since they would probably be best able to support their child with any impacts. For instance, parent education, skills training for management of child behavioural difficulties, and guidance regarding how to discuss DV with their child may be beneficial. There is also evidence that child-parent psychotherapy is a promising treatment for children who have been exposed to DV (Macmillan et al., 2009).

However, a highly distressed parent who has been victimised may find it difficult to provide the support needed by their child (Carlson, 2000). With regard to interventions focussed on the

child, Carlson summarised that children should be made to feel safe during therapy, directly told that they were not to blame for the violence, and told that they would not be made to talk about anything they did not want to discuss. Trauma-focussed therapy, and techniques such as relaxation, reframing, and cognitive restructuring, can be helpful. Furthermore, child support, prevention, and education groups have also been implemented with some positive results.

Factors Related to Therapy Access

Although many children may be in need of therapy to ameliorate psychological symptoms following maltreatment, this may not translate into therapy attainment (Shipman & Taussig, 2009). For instance, one study found that less than half of the children who were victims of physical abuse in their sample received therapy, even when there was evidence of psychological problems of clinical significance (Swenson, Brown, & Sheidow, 2003). In addition, another study found that only one quarter of maltreated youths who demonstrated emotional or behavioural problems at a clinically significant level had received any mental health service (Burns et al., 2004). Various barriers to therapy uptake can prevent children from receiving needed psychological support following abuse (Tingus, Heger, Foy, & Leskin, 1996).

Abuse characteristics

Abuse characteristics such as type, frequency, and severity of abuse have been shown to be associated with entry into therapy (Kolko, Seleyo, & Brown, 1999; Tingus et al., 1996). In research that examined the receipt of services in families where CPA and CSA had occurred, it was revealed that a greater number of sexually abused children obtained individual therapy by the time of post-service assessment, compared to physically abused children (Kolko et al., 1999). Kolko and colleagues conjectured that caseworkers may perceive physical abuse to be adequately treated with family-based services, as opposed to sexual abuse which may be believed to require specialised support. As a result of this inferred viewpoint, physically abused children may not receive beneficial individual support, and the families of sexually abused children may not obtain more comprehensive family therapies. In addition, Tingus et al. found that frequency of sexual abuse was positively associated with therapy uptake. Their data also indicated that children who experienced a greater severity of sexual abuse had an enhanced likelihood of therapy entry.

Ethnicity

Ethnicity can also be related to whether an abused child receives therapy. For instance, a study by Burns et al. (2004) revealed that abused children who were African American had a decreased likelihood of receiving mental health system care compared to Caucasian children. Other research provided evidence that Hispanic and African American children were significantly less likely to enter therapy following sexual abuse compared to Caucasian children (Tingus et al., 1996). Kolko et al. (1999) have also found that physically and sexually abused children were more likely to receive support services if they were Caucasian.

Results from an earlier study are consistent with these studies, as African American children who had been sexually abused were significantly less likely to attend therapy than Caucasian children (Haskett, Nowlan, Hutcheson, & Whitworth, 1991). Haskett and colleagues surmised that this may be due to reasons such as long waiting lists at public centres, since African American families tended to live close to and therefore get referred to public centres, or the utilisation of informal support networks by African American families, such as community, family, and religious resources. The researchers also considered the possibility of a racial bias in terms of referral for mental health services, but concluded that their research did not show evidence for such a specific bias.

Location of the offending caregiver and abused child

With regard to children who experience physical abuse, if abusive caregivers live outside of the household at follow-up, children are significantly more likely to be in therapy (Ezzell, Swenson, & Faldowski, 1999; Swenson et al., 2003). Moreover, maltreated children who are placed outside their homes are significantly more likely to be given mental health services (Burns et al., 2004). Interestingly, this finding was still significant even when clinical need was taken into account. Research on 972 sexually abused children also demonstrated that children living outside the home were more likely to receive therapy than children who remained at home (Tingus et al., 1996). The authors suggested that this was possibly because the system intervention was more intense, children removed from their family home were seen as more in need of therapy, or because foster parents had more resources with which to access therapy.

Child factors

There is evidence that child factors can increase or decrease the likelihood of the receipt of mental health services. For instance, Tingus et al. (1996) found that sexually abused children younger than 7 years or older than 13 years were less likely to enter therapy than children within a 7 to 13 year old age bracket. Furthermore, Kolko et al. (1999) found that physically and sexually abused children were more likely to receive services at intake if they had lower levels of anxiety. The authors suggested that this may be because less anxious children are more likely to agree to partake in mental health services.

Parental factors

Some parental factors appear to have a bearing on whether support services are accessed. For example, in a study of CPA in which half of maltreating parents received treatment, parents who admitted to the abuse were more likely to obtain therapy than those who did not (Swenson et al., 2003). In addition, research has depicted that parents of physically and sexually abused children who were psychologically distressed or had their own background of abuse victimisation were more likely to receive support services at intake (Kolko et al., 1999). The researchers posited that psychologically distressed parents or parents who have their own history of abuse may be more motivated to engage in family support, and that these factors may increase the probability that parents will be referred by caseworkers for support.

This is congruent with findings of Burns et al. (2004); maltreated youth were more likely to be involved with mental health services if they had a parent with a severe mental illness. Similarly, Ezzell et al. (1999) showed that physically abused children were more likely to access mental health services if they had a female caregiver who reported many family stressors. Ezzell et al. suggested that this may be because caregivers who are highly stressed turn to mental health services for help, or alternatively caregivers who are not highly stressed may be able to handle parenting demands well, and therefore do not require additional support.

In addition, Burns et al. (2004) found that mothers who believed that their whole family would benefit from therapy were more likely to bring their maltreated child to counselling. However, whether mothers believed that their abused child required therapeutic support did not have an impact on whether or not they brought their child to the initial therapy appointment. The researchers propose that this may be because mothers of maltreated children who live in a

dysfunctional family may feel that they cannot adequately help their child to deal with the abuse, and may be more motivated to receive external support.

Involvement of authority

Another factor that seems to be related to whether or not maltreated children receive therapy is authority involvement. For example, research involving sexually abused children showed that when both the Department of Children's Services and law enforcement officials were involved, children were significantly more likely to obtain therapy than if only the Department of Children's Services were involved (Tingus et al., 1996). Not one child received therapy in cases where neither of these services had intervened.

Overall, research shows that many factors can have a bearing on whether children who have experienced maltreatment access therapy. These include abuse characteristics, child ethnicity, residence of the child and perpetrating caregiver, child age and anxiety level, parental distress and history of victimisation, and authority involvement.

Current Practice in New Zealand

If it is suspected that a child has experienced maltreatment, or if the child has disclosed abuse, New Zealand's child protection agency- Child Youth and Family (CYF), or the police are notified. Subsequent to this, a social worker investigates the case and completes a risk and needs assessment (CYF, 2010a). In cases where the child does disclose information which signals they may have been abused, they are referred to an Evidential Video Unit where an interview is carried out to investigate whether the child is safe, and to provide evidence if the case goes to court (Davies & Seymour, 1999). If the nature of the sexual abuse included physical contact a medical examination by a specialist doctor is encouraged. Once notification of abuse has been made, police begin a criminal investigation and decide whether to charge the alleged perpetrator (Davies & Seymour, 1999).

Therapy or counselling for children who have been subjected to maltreatment may be supported by funding from CYF, particularly in relation to CPA and neglect, and New Zealand's Accident Compensation Corporation (ACC), in the case of CSA. At the end of 2009, changes to ACC Sensitive Claims Counselling meant that counselling for sexual abuse victims would only be funded by ACC if they had been diagnosed with a mental injury and it could be proven that the abuse was directly caused the mental injury (ACC, 2009). However, these changes resulted

in protests, and following a subsequent review by an Independent Panel, people with a new sensitive claim or those waiting for an ACC assessment can now receive up to 16 hours of funded support (ACC, 2010). Furthermore, this counselling may now also include a limited involvement of caregivers in the therapy process. Research by Davies and Seymour (1999) demonstrated that in relation to CSA, referral to counselling was often distant from the time of initial disclosure, with the consequences that any therapy was delayed, and many families did not take up referrals. Research is lacking regarding the current situation regarding therapy access in relation to any of the forms of child maltreatment.

Conclusion

In conclusion, child abuse and neglect affects a substantial proportion of New Zealand children. Whilst some children appear resilient following victimisation, many children develop a range of behavioural and psychological problems. Fortunately, there is evidence that certain types of therapy can help to ameliorate negative impacts of child maltreatment. However, certain barriers can prevent children from receiving needed psychological support following abuse and neglect.

As noted above, the present research employed three linked studies. The first study aimed to examine the characteristics of children who presented to a multi-agency centre following the identification of maltreatment concerns. It was thought that the systematic examination of incidence of child abuse in the Auckland region would allow for comparisons with overseas research, and assist with child maltreatment prevention and treatment efforts in this country. The second study aimed to describe the psychological well-being of a subsample of these children and investigate what child, abuse, authority involvement, and family characteristics were associated with psychological well-being. Given that treatment resources are limited, this study provided an indication of the proportion of children experiencing difficulties following maltreatment, and identified what children may be particularly in need of psychological support. The aim of the final study was to explore parent and caregiver perceptions of support following presentation to the agency, as well as parent and caregiver experiences of the agency itself. These aims were thought to be important in that they allowed for the identification of barriers to accessing support following maltreatment, and provided information as to what was being done well at the multiagency centre, and what aspects could be improved.

Chapter Two: Study One

The aim of the current study was to describe characteristics of children and adolescents who presented to Puawaitahi, a multiagency centre for maltreated children, over a four month period. In particular, characteristics of the sample, features of the abuse experienced, authority involvement, and family factors are described. Knowledge of these characteristics is important in order to assist with the identification and prevention of child maltreatment, and to obtain an understanding of how to best support these children. It also allows for comparisons to be made with overseas studies, which may indicate whether findings from international research are applicable in a New Zealand context.

Method

Setting

Puawaitahi is a multi-agency service that investigates alleged maltreatment of children and young people in the Auckland region. Puawaitahi also works with victims of abuse and their families, to help with access to services that can provide treatment following abuse. It consists of several agencies: Te Puaruruhau, the Police Child Protection Team, the Central Auckland Video Unit (CAVU), and the Specialist Services Unit (SSU). Te Puaruruhau is the child and adolescent abuse assessment unit of Starship Children's Hospital, and is a health service that includes doctors, nurses, and social workers specialised in care and protection concerns. The Central Auckland Video Unit is where evidential videos are carried out in a conjoint operation between CYF and police interviewers. The SSU is a branch of CYF that carries out psychological and parenting assessments, and liaises with CYF social work sites around Auckland.

Sample

File information was collected on all children under 17 years of age who presented to Puawaitahi over a four month period (n = 307). Information was obtained from Te Puaruruhau, CAVU, and SSU, but was not collected from the Police Child Protection Team as they generally dealt with alleged perpetrators rather than victims of abuse. Some children presented to more than one Puawaitahi service within the four month period, so file information was combined from all sources to provide comprehensive data and avoid duplication.

Table 1
Child characteristics for the sample (n = 307)

		Frequency (%)
Gender	Female	192 (62.5%)
	Male	115 (37.5%)
Average age at presentation	Mean (SD)	8.9 years (5.07)
	Median	9 years
	Range	0 to 16 years
Age at presentation	0 to 3 years	60 (19.5%)
	4 to 7 years	65 (21.2%)
	8 to 10 years	42 (13.7%)
	11 to 13 years	56 (18.2%)
	14 to 16 years	84 (27.4%)
Ethnicity ^a	European/Pakeha	74 (24.1%)
	Māori	136 (44.3%)
	Pacific Islander	68 (22.1%)
	Asian	14 (4.6%)
	Other	15 (4.9%)

Note. ^a Multiple ethnicities were often listed in files; in these instances Māori was categorised first, followed by Pacific Islander, Asian, Other ethnicity, and European/Pakeha respectively.

Of the 307 children included in the overall file audit, over 60% were female (see Table 1). The average age of the sample at first presentation to Puawaitahi was close to 9 years old. With regard to ethnicity, there were a disproportionately high (to population) number of children who were identified as Māori or Pacific Islander in their file information.

Table 2
Child living situation for the sample (n = 307)

		Frequency (%)
Living Arrangements at Presentation	Biological Parent/s	201 (65.5%)
	Family/Whānau Caregiver	42 (13.7%)
	Non-kin Caregiver	64 (20.8%)
Residence: District Health Board	Waitemata	138 (45%)
	Auckland	106 (34.5%)
	Counties Manukau	58 (18.9%)
	Other	5 (1.6%)
Residence: District	Rodney	25 (8.1%)
	North Shore City	38 (12.4%)
	Waitakere City	75 (24.4%)
	Auckland City	102 (33.2%)
	Manukau City	52 (16.9%)
	Other	15 (4.9%)

At presentation, most children were living with their biological parents, resided within the Waitemata District Health Board (DHB) boundary, or Auckland DHB boundary, and lived in Waitakere City and Auckland City districts (refer to Table 2). In 2010, another multiagency centre opened in South Auckland, which may be why fewer referrals to Puawaitahi were received from this area.

Variables of Interest

Child variables: For details on how each variable was coded, see Appendix A. As presented in Table 1, child variables that were of interest included *age*, *gender*, and *ethnicity* of the child.

Child living situation: Information was collected on the living situation of the child, including *living arrangements at presentation* to Puawaitahi, *Residence: district health board*, and *Residence: district*.

Presentation information: Data was collected on *who the child was referred by*, *who the child was accompanied by* to Puawaitahi, *the first agency the child presented to* within Puawaitahi, and *the number of children that attended each agency*.

General maltreatment factors: Information was gathered on general abuse factors, and consisted of *number of types of abuse relating to current presentation*, *concerns that were part of presentation*, *delay in identification* following the first incident of abuse, *the residence of the alleged perpetrator*, and *the maltreatment concerns at time of presentation*.

Sexual abuse variables: Information was collected on whether the child *presented due to sexual abuse* concerns, whether *sexual abuse was found* to have happened, how the *sexual abuse was first identified*, and *who the sexual abuse was disclosed to*. Other sexual abuse factors regarded *age at first sexual abuse incident*, *type of sexual abuse*, *frequency of sexual abuse*, *number of alleged sexual abuse perpetrators*, *sexual abuse perpetrator relationship*, whether the *sexual abuse was intrafamilial or extrafamilial*, and *the age of the alleged sexual abuse perpetrator*.

Physical abuse variables: Physical abuse variables of interest involved whether the child *presented due to physical abuse concerns*, whether evidence of *physical abuse was found*, how

the *physical abuse was first identified, physical abuse perpetrator relationship* to the child, and whether the *physical abuse was intrafamilial or extrafamilial*. Information was also collected as to the *type of physical abuse, its severity, its frequency, and the number of alleged perpetrators*.

Neglect variables: Information was obtained on whether or not the child *presented due to neglect* concerns, whether *neglect was found* to have occurred, how the *neglect was first identified*, the *number of types of neglect*, the *duration of neglect*, and the *neglect perpetrator relationship* to the child.

Exposure to Domestic Violence: DV variables included whether the child *presented due to concerns of exposure to DV*, whether *exposure to DV was found*, how concerns of *exposure to DV were first identified*, *type of exposure to DV*, *severity of exposure to DV*, *frequency of exposure to DV*, and whether the *DV was life threatening*.

Authority involvement: Involvement of authorities was also explored, so information was collected as to current *police involvement*, whether there had been *previous police involvement* with the child or their family, current *CYF involvement*, whether there had been *previous CYF involvement* with the child or family, *total time spent in care*, and *number of CYF placements*.

Family characteristics: Family characteristics that were examined included the *number of home transitions* the child had experienced, whether there was *evidence of exposure to drug use/alcohol abuse within the family*, whether file information indicated there was a *family history of physical abuse* (past or current), and whether or not there was a *lack of parent/caregiver belief* about the abuse.

Procedure

Permission to access paper files was obtained from the Ministry of Health Regional X Health and Disabilities Ethics Committee, the Auckland District Health Board Research Review Committee, the Police Research and Evaluations Steering Committee, and the CYF Research Access Committee.

A spreadsheet was developed using PASW 18 software in order to record information obtained from the file audit. Information on variables of interest was gathered from paper files that related to the children who presented to Puawaitahi over the four month study period. To ensure the security of each file, all files were accessed within the agency the files belonged to.

Files were stripped of identifying information to protect the privacy of the children. Some children had contact with more than one service, and therefore every hard file (opened within the four month study period) relating to each child was reviewed. Following the removal of identifying information, information on variables of interest was recorded as written in the paper files. The data was then categorised for analysis.

Names of people under the age of 17 years who presented to Te Puaruruhau, SSU, and the CAVU over the four month study period were provided by Puawaitahi. The researcher then went through the files associated with each child, recording all relevant information on the PASW 18 spreadsheet. Data gathered during the file audit was coded and analysed using PASW 18 software.

Results

Inter-rater reliability was assessed using percentage agreement for variables that involved a coding judgement. Another rater coded 10% of cases for the following variables, with percent agreement shown in parentheses: *sexual abuse found* (96%), *type of sexual abuse* (96%), *physical abuse found* (93%), *type of physical abuse* (90%), and *severity of physical abuse* (87%).

Sample characteristics

In examining the characteristics of the sample (see Table 3), it can be seen that the majority were referred by a CYF social worker, and most were accompanied by their parents or a caregiver. The greatest number of children presented at Te Puaruruhau, followed by the CAVU, then the SSU. Approximately one fifth of children were referred due to concerns about two or more types of abuse.

Sexual abuse concerns featured in the majority of presentations to Puawaitahi, followed by physical abuse concerns, then neglect, and finally exposure to DV. Approximately one third of cases of abuse or neglect had been identified within one week of its occurrence, although almost a third of cases were identified more than one year after the maltreatment started. In most cases, the alleged perpetrator resided outside of the family home at the time the child presented to Puawaitahi. The most commonly co-occurring forms of maltreatment concerns were sexual abuse and physical abuse, followed by physical abuse and neglect, and then physical abuse, neglect, and DV.

Table 3
Presentation information for the sample (n = 307)

		Frequency (%)
Who child was referred by	Family or Self	7 (2.3%)
	CYF Social Worker	190 (61.9%)
	General Practitioner	26 (8.5%)
	District Health Board	21 (6.8%)
	Police	44 (14.3%)
	Community Health	11 (3.6%)
	Counsellor	8 (2.6%)
Who child was accompanied by	By Themselves	9 (2.9%)
	Parent/Caregiver no Social Worker	135 (44.0%)
	Parent/Caregiver with Social Worker	62 (20.2%)
	Family other than Parents	28 (9.1%)
	Friend	8 (2.6%)
	Social Worker	56 (18.2%)
	Other	9 (2.9%)
Number of children that attended agency ^a	Te Puaruru Hau (Health/Medical)	217 (70.7%)
	Central Auckland Video Unit	133 (43.3%)
	Specialist Services Unit	32 (10.4%)
Number of abuse types child was referred for	One	236 (76.8%)
	Two	48 (15.6%)
	Three	19 (6.2%)
	Four	4 (1.3%)
Presentation concerns	Sexual Abuse	173 (56.4%)
	Physical Abuse	131 (42.7%)
	Neglect	65 (21.2%)
	DV	36 (11.7%)
Delay in identification	One week or less	104 (33.9%)
	One week to a month	17 (5.5%)
	A month to one year	32 (10.4%)
	More than one year	95 (30.9%)
	Unknown	37 (12.1%)
	Not applicable	22 (7.2%)
Residence of alleged perpetrator	At family home with child	30 (9.8%)
	At family home without child	83 (27%)
	Living outside of family home	169 (55.0%)
	Not applicable	25 (8.1%)
Maltreatment Concerns	Sexual Abuse	139 (45.3%)
	Physical Abuse	72 (23.5%)
	Neglect	20 (6.5%)
	DV	5 (1.6%)
	Sexual Abuse and Physical Abuse	18 (5.9%)
	Sexual Abuse and Neglect	3 (1.0%)
	Sexual Abuse and DV	1 (0.3%)
	Physical Abuse and Neglect	15 (4.9%)
	Physical Abuse and DV	6 (2.0%)
	Neglect and DV	5 (1.6%)
	Sexual Abuse, Physical Abuse, Neglect	4 (1.3%)
	Sexual Abuse, Physical Abuse, DV	1 (0.3%)
	Sexual Abuse, Neglect, DV	3 (1.0%)
	Physical Abuse, Neglect, DV	11 (3.6%)
Sexual Abuse, Physical Abuse, Neglect, DV	4 (1.3%)	

Note. ^a Number of children that attended agency ≠ 100% as some children attended more than one agency

Table 4.
Abuse characteristics for children who presented due to sexual abuse concerns (n = 173)

		Frequency (%)
Sexual abuse found to have happened	No evidence	8 (4.6%)
	Unable to determine	12 (6.9%)
	Probable abuse	15 (8.7%)
	Clear evidence of abuse	138 (79.8%)
Sexual abuse first identified	Disclosure	148 (85.5%)
	Other person report	11 (6.4%)
	Physical symptom	14 (8.1%)
Who the sexual abuse was disclosed to	Family	94 (54.3%)
	Counsellor	13 (7.5%)
	Police	9 (5.2%)
	CYF	6 (3.5%)
	Other	29 (16.8%)
	Not disclosed	22 (12.7%)
Age at first sexual abuse incident	Mean (SD)	9.78 years (4.06)
	Median	10 years
	Range	2 to 16 years
	n	149
Type of sexual abuse	No indication/unclear	19 (11.0%)
	Non-contact sexual abuse	7 (4.0%)
	Contact- no intercourse	66 (38.2%)
	Intercourse attempted/completed	81 (46.8%)
Frequency of sexual abuse	No known events	19 (11.0%)
	One known event	95 (54.9%)
	Repeated events	40 (23.1%)
	Chronic abuse	19 (11.0%)
Number of alleged SA perpetrators	None	19 (11.0%)
	One	126 (72.8%)
	Two or more	28 (16.2%)
Sexual abuse perpetrator relationship	Father	13 (7.5%)
	Father and other/s	3 (1.7%)
	Step-father	12 (6.9%)
	Other family member	31 (17.9%)
	Person known to child	65 (37.6%)
	Stranger	30 (17.3%)
	Not applicable	19 (11.0%)
Intrafamilial /extrafamilial abuse	Intrafamilial	59 (34.1%)
	Extrafamilial	95 (54.9%)
	Not applicable	19 (11.0%)
Perpetrator age	Mean (SD)	27.6 (16.13)
	Median	20 years
	Range	7 to 65 years
	n	93
Grouped age of perpetrator	Less than thirteen years	10 (5.8%)
	Thirteen to twenty-one years	38 (22%)
	Older than twenty-one years	45 (26%)
	Unknown	61 (35.3%)
	Not applicable	19 (11.0%)

Sexual abuse characteristics

As seen in Table 4, there was clear evidence of sexual abuse for nearly four fifths of children who presented due to sexual abuse concerns. The majority of sexual abuse concerns were identified through child disclosure, and most of the time children disclosed to a family member. The average age of first sexual abuse incident was just under 10 years old. Close to half of children who presented due to sexual abuse concerns had experienced sexual abuse that involved attempted or completed vaginal, oral, or anal intercourse. File information showed that over a third of children who presented with sexual abuse concerns had experienced repeated events of sexual abuse or chronic sexual abuse. Whilst most of the children had been sexually abused by one perpetrator, many had been sexually abused by two or more perpetrators during their life. Over a third of children who presented with sexual abuse concerns had been sexually abused by a person known to them but not in their family. A further third had been sexually abused by a person in their family, whereas sexual abuse by a stranger was less common. Approximately 16% of the sample with sexual abuse concerns had been sexually abused by their father or their mother's husband/partner. The average age of the alleged perpetrator was found to be around twenty-eight years.

Physical abuse characteristics

As displayed in Table 5, for over one fifth of children who presented due to concerns of physical abuse, there was no evidence or it was unable to be determined whether physical abuse had occurred. Physical abuse concerns were mostly identified first through child disclosure, followed by physical symptoms of physical abuse, and then other person report. The vast majority of children had been physically abused by someone in their family, in most cases by their father. In terms of type of physical abuse experienced, almost a third of children had been choked, stabbed, burnt, had bones broken, or had sustained a brain injury. Over three quarters of children who presented due to physical abuse concerns were deemed to have experienced a severe or very severe assault. It was more common for children to experience repeated events or chronic abuse than one instance of physical abuse. File information indicated that a substantial proportion of children in this subsample had been allegedly physically abused by two or more people throughout their lives.

Table 5.

Abuse characteristics for children who presented due to physical abuse concerns (n = 131)

		Frequency (%)
Physical abuse found to have happened	No evidence	17 (13.0%)
	Unable to determine	11 (8.4%)
	Probable abuse	7 (5.3%)
	Clear evidence of abuse	96 (73.3%)
How concerns were first identified	Disclosure	63 (48.1%)
	Other person report	29 (22.1%)
	Physical symptom	39 (29.8%)
Physical abuse perpetrator relationship	Father	29 (22.1%)
	Mother	17 (13.0%)
	Mother and father	16 (12.2%)
	Father and other/s	3 (2.3%)
	Mother and other/s	11 (8.4%)
	Stepfather	5 (3.8%)
	Other family member	6 (4.6%)
	Caregiver	10 (7.6%)
	Person known to child (not family)	3 (2.3%)
	Stranger	1 (0.8%)
	Unknown from file information	2 (1.5%)
	Not applicable	28 (21.4%)
Intrafamilial/extrafamilial abuse	Intrafamilial	95 (72.5%)
	Extrafamilial	8 (6.1%)
	Not applicable	28 (21.4%)
Type of physical abuse	No indication/unclear	28 (21.4%)
	Pushed/hair pulled/kicked/hit	22 (16.8%)
	Hit with object/thrown against object	42 (32.1%)
	Choked/stabbed/bones broken/brain injury	39 (29.8%)
Severity of physical abuse	No evidence of assault	28 (21.4%)
	Minor assault	4 (3.1%)
	Severe assault	59 (45.0%)
	Very severe assault	40 (30.5%)
Frequency of physical abuse	No evidence of physical abuse	28 (21.4%)
	One known event	33 (25.2%)
	Repeated events	32 (24.4%)
	Chronic abuse	38 (29.0%)
Number of people who abused child	None	28 (21.4%)
	One	62 (47.3%)
	Two or more	41 (31.3%)

Neglect characteristics

Table 6 shows that probable or clear evidence of neglect was found for nearly all of the 65 children who presented to Puawaitahi due to concerns of neglect. Over three quarters of children had concerns of neglect that were identified through other person report, and concerns were

identified through physical symptoms of neglect in very few cases. It was rare for only one type of neglect to be experienced by these children, and more than half of this subsample had experienced neglect for over one year. In the vast majority of cases the alleged perpetrators were the mother and father, or mother of the child.

Table 6
Neglect characteristics for children who presented due to neglect concerns (n = 65)

		Frequency (%)
Neglect found	No evidence	0 (0.0%)
	Unable to determine	3 (4.6%)
	Probable neglect	9 (13.8%)
	Clear evidence of neglect	53 (81.5%)
How concerns were first identified	Disclosure	13 (20.0%)
	Other person report	49 (75.4%)
	Physical symptom	3 (4.6%)
Number of types of neglect	None	3 (4.6%)
	One type	16 (24.6%)
	Two or three types	25 (38.5%)
	Four or more types	21 (32.3%)
Duration of neglect	Less than a year	4 (6.2%)
	More than a year	34 (52.3%)
	Unknown	24 (36.9%)
	Not applicable	3 (4.6%)
Neglect perpetrator relationship	Mother	26 (40.0%)
	Mother and father	28 (43.1%)
	Mother and other/s	5 (7.7%)
	Caregiver	3 (4.6%)
	Not applicable	3 (4.6%)

Domestic violence characteristics

DV variables are presented in Table 7. There were concerns of exposure to DV for 36 children, and probable exposure or clear evidence of exposure was found for all of these children. Concerns of exposure to DV were identified through other person report for more than three quarters of these children.

Of this subsample, one third had a parent/caregiver who was choked, stabbed, burnt, had bones broken, sustained a brain injury, or was killed. More than three fifths of this subsample was exposed to a severe assault. The majority of children who presented with DV concerns had

been exposed to chronic DV, and approximately three fifths had been exposed to DV that was life threatening.

Table 7

Exposure to domestic violence characteristics for children who presented with these concerns (n = 36)

		Frequency (%)
Exposure to domestic violence found	No evidence	0 (0.0%)
	Unable to determine	0 (0.0%)
	Probable exposure	9 (25.0%)
	Clear evidence of exposure	27 (75.0%)
How concerns first identified	Disclosure	8 (22.2%)
	Other person report	28 (77.8%)
Type of exposure to domestic violence	No indication of exposure	0 (0.0%)
	Parent pushed/hair pulled/ kicked/hit	22 (61.1%)
	Hit with object/thrown against object	2 (5.6%)
	Choked/stabbed/burnt/bones broken /brain injury/death	12 (33.3%)
Severity-Revised Conflict Tactics Scales	No evidence of domestic assault	0 (0%)
	Minor assault (or no details)	14 (38.9%)
	Severe assault	22 (61.1%)
	No evidence of domestic violence	0 (0.0%)
Frequency of exposure to domestic violence	One known event	9 (25.0%)
	Repeated events	5 (13.9%)
	Chronic domestic violence	22 (61.1%)
Domestic violence life threatening	Yes	14 (38.9%)
	No/unknown	22 (61.1%)

Authority involvement and family characteristics

As can be seen in Table 8, Police were or became involved in over three quarters of cases, and CYF were or became involved in some way for almost all cases. In terms of previous involvement, file information indicated that a minority of children or their families had previously been involved with the Police, whereas CYF had previously been involved with the majority of children or their families. Approximately a third of children who presented to Puawaitahi had spent some time in care, and many had experienced two or more placements. Some children had not spent any time in care prior to presentation to Puawaitahi, but were placed in care following allegations/presentation to Puawaitahi.

More than two fifths of children had experienced one or more home transitions, which included informal family/whānau care. There was evidence of drug use or alcohol abuse within the child's family in approximately one third of cases. File information indicated that physical abuse had occurred in the child's family (either in the present or past) in nearly half of cases. A lack of parent or caregiver belief about the abuse was indicated in about one tenth of files.

Table 8
Authority involvement and family characteristics (n = 180)

		Frequency (%)
Police involved	Yes	237 (77.2%)
	No or unknown	70 (22.8%)
Police previously involved with family	Yes	43 (14%)
	No or unknown	264 (86%)
CYF ^a involved	Yes	288 (93.8%)
	No or unknown	19 (6.2%)
CYF previously involved with family	Yes	170 (55.4%)
	No or unknown	137 (44.6%)
Total time spent in care ^b	No time in care	213 (69.4%)
	Less than one month	25 (8.1%)
	One month to one year	33 (10.7%)
	More than one to five years	20 (6.5%)
	More than five years	16 (5.2%)
Number of CYF placements	None	200 (65.1%)
	One	63 (20.5%)
	Two or more	44 (14.3%)
Number of home transitions	None	174 (56.7%)
	One	73 (23.8%)
	Two or more	60 (19.5%)
Evidence of drug use within family	Yes	104 (33.9%)
	No/Unknown	203 (66.1%)
Family history of physical abuse	Yes	140 (45.6%)
	No/Unknown	167 (54.4%)
Parent/caregiver belief	Believed	158 (51.5%)
	Not Believed	30 (9.8%)
	Not Applicable	119 (38.7%)

Note. ^a CYF = Child, Youth and Family. ^b Figures for children who had spent no time in care were higher than those who had not been in any CYF placements, as for thirteen children placement into care coincided with time of presentation to Puawaitahi.

Discussion

In this study, a file audit was conducted on all children who presented over a four month period to Puawaitahi, an Auckland based multiagency child protection service. The main findings included that a substantial proportion of children seen at Puawaitahi presented due to multiple maltreatment concerns, and it was common for identification of maltreatment to be delayed. Most children who attended Puawaitahi did so due to sexual abuse concerns, whereas relatively few presented due to neglect or concerns of DV, and very few presented due to concerns of neglect or DV alone.

The most common forms of concurrent abuse were sexual abuse and physical abuse, followed by physical abuse and neglect. With regard to sexual abuse, the vast majority of children were abused by someone known to them, and most who disclosed told a family member. Most of the children who presented due to physical abuse concerns had been severely abused by a family member, and often this physical abuse was not a one-off event. It was unusual for children who attended Puawaitahi with neglect concerns to experience only one subtype of neglect. Close to two fifths of children who presented due to DV concerns had witnessed DV which was life threatening or resulted in death. Many of the children came from families who were already known to CYF, and there was evidence of exposure to alcohol abuse or substance abuse within the family for a third of cases.

Child characteristics

The majority of children who presented to Puawaitahi were female. This was probably because sexual abuse concerns were the most common reason for referral, and prevalence rates of CSA are higher for females than males (Gilbert et al., 2009). When ethnic group was classified using a prioritisation method in which children with multiple ethnicities listed were categorised by ethnicity in a certain order (Māori, Pacific Islander, Asian, Other, and European/Pakeha, respectively), the majority of children were classified into the Māori group, followed by European/Pakeha, then Pacific Islander, Other, and finally Asian. Many of the children in the sample had multiple ethnicities listed in their file information and it was unknown what ethnicity the child themselves would identify as. Marie et al. (2009) suggest that Māori children may be an over-represented group in terms of child maltreatment due to risk factors such as socio-economic disadvantage and family adversity. However, the way in which ethnicity is classified is also important to consider. For instance, a disadvantage of the method used in the

current study is that the number of children identified as European/Pakeha would be minimised. For children who had experienced sexual abuse, the median age of first sexual abuse incident was ten years old. This is close to other New Zealand research which found that the median age of first sexual abuse incident for females was nine years old (Fanslow et al., 2007).

Maltreatment characteristics

Approximately one fifth of the sample presented due to concerns of more than one type of maltreatment. The forms of maltreatment that most commonly co-occurred were sexual abuse and physical abuse, followed by physical abuse and neglect, although this was probably because more children presented due to sexual and physical abuse concerns as opposed to neglect and DV. Other research has found that children who experience one type of abuse often experience concurrent forms of abuse (Annerbäck, Sahlqvist, Svedin, Wingren & Gustafsson, 2012; Edwards, Holden, Felitti & Anda, 2003; Manly et al., 2001).

The majority of children presented due to sexual abuse concerns, followed by physical abuse concerns. Very few children presented solely due to concerns of neglect, which may be because of the high co-occurrence of neglect with other forms of abuse (Mennen, Kim, Sang & Trickett, 2010). Similarly, only a small number of children were seen at Puawaitahi due to DV concerns alone. It is likely that children are seen only in extreme cases of exposure to DV, as there are so many children who witness intimate partner violence in New Zealand that resources would be overwhelmed if all presented to services such as Puawaitahi.

In close to 90% of cases some form of sexual abuse was found, which indicates that referrals were made with good reason. As expected from extant literature (Shackel, 2009), the majority of children who disclosed sexual abuse told a family member. Very few cases of sexual abuse were identified through other person report or physical symptoms, whereas the majority of physical abuse cases were identified through these means. Concerns of child neglect and exposure to DV were primarily identified through other person report. This may be because children presenting due to concerns other than sexual abuse were on average younger and therefore less likely to have the verbal abilities to disclose maltreatment. In addition, physical symptoms of physical abuse (such as bruising) are more present and observable than physical symptoms of sexual abuse (such as sexually transmitted infections). Furthermore, if a child's day-to-day experience involves physical abuse, neglect, and DV, it is possible that these events become a "normal" part of life and are therefore not disclosed.

In just under a third of cases the maltreatment was identified or disclosed more than a year after it started. Other research has shown that a delay in disclosure of abuse is common; for instance London and colleagues (London, Bruck, Ceci & Shuman, 2005; London, Bruck, Wright & Ceci, 2008) found that two thirds of people who experienced childhood sexual abuse did not disclose until they were an adult. Whilst young children may have difficulty making a clear disclosure due to their lack of verbal ability, disclosures are often difficult for older children due to a multitude of reasons including fear of the perpetrator, fear of negative responses by family, fear of disbelief, shame, beliefs that the maltreatment was deserved, not knowing that the maltreatment was wrong or unusual, and a desire to protect the perpetrator or their family (Draucker et al., 2011; Hunt, 2011; Palmer, Brown, Rae-Grant & Loughlin, 1999). Young people may be reluctant to disclose experiences of abuse because they consider the consequences of disclosure as more threatening than the consequences of the abuse itself (Ungar et al., 2009).

Relatively few children who presented due to sexual abuse concerns had been abused by a stranger; it was more common that they were abused by a family member. This fits with extant literature which indicates that in most cases the perpetrator of sexual abuse is known to the child, either as an acquaintance or family member (Finkelhor, 1994; Flett et al., 2012). The vast majority of physical abuse was perpetrated by a family member; in most cases the biological father. This is also congruent with literature which indicates that fathers are over-represented as perpetrators of CPA (Lee, Bellamy & Guterman, 2009).

It was common for children to experience highly invasive sexual abuse that occurred on multiple occasions. Furthermore, physical abuse victimisation and exposure to DV was more often than not severe and repeated. Most children who were found to have experienced one form of neglect had experienced at least one other type of neglect (such as physical neglect and education neglect). Mennen et al. (2010) also found that various types of neglect frequently co-occurred, and that all forms of neglect were significantly associated with each other, apart from medical neglect.

Authority involvement

Compared to CYF involvement, child files indicated that Police had previously been involved with the child or their family in relatively few cases. However, it is possible that current or previous Police involvement occurred in more cases but may not have been indicated in the file information. File information indicated that more than half of the children who

presented to Puawaitahi had families that were previously known to CYF, and this number may be conservative since access to CYF computer records was not granted. Research has shown that investigations of child maltreatment concerns do not necessarily lead to improvements in risk factors for future maltreatment (Campbell, Cook, LaFleur & Keenan, 2010). Campbell et al. found that there were no significant improvements for social support, family functioning, financial difficulties, and maternal education following child maltreatment investigation, and maternal symptoms of depression actually worsened. Given that these modifiable risk factors did not change, Campbell et al. (2010) suggested that opportunities for preventing recurrent maltreatment were being missed.

About 30% of the sample had spent some time in care or had just been uplifted at time of presentation to Puawaitahi, and 14% of the sample had been in two or more CYF placements. It is thought that up to 65% of children who come into care have mental health and behavioural issues, so the CYF Gateway health and education assessments conducted upon entry into care are invaluable in identifying and accessing the support needed by these children (CYF, 2010b).

Limitations

There are several limitations in relation to this study. The information gathered was restricted to what was contained in the files, so it may not have been entirely comprehensive. Since the sample was comprised of all children who presented to Puawaitahi over a four month period and therefore a particular time of year, it was possible that characteristics of the sample were not generalisable to all children who are seen at Puawaitahi. The sample also related to the Auckland region, and therefore may not have been representative of all New Zealand children identified to have maltreatment concerns. If future studies were granted approval to access multiple sources of information, such as CYF computer records, this would be helpful in terms of providing more comprehensive information than paper files alone.

Chapter Three: Study Two

The previous study illustrated that children who presented to Puawaitahi commonly experienced severe and repeated maltreatment, and often experienced more than one type of abuse or neglect. Whilst child abuse and neglect are associated with detrimental impacts on mental health, not all children subjected to maltreatment are significantly affected (Finkelhor & Berliner, 1995; Nurcombe, 2000; Putnam, 2003). Limited treatment resources mean that it is important to understand factors that contribute to a greater impact of maltreatment, so that early intervention can be provided to children who are most vulnerable to psychological distress.

The first aim of this study was to establish the proportion of children experiencing internalising and externalising difficulties upon presentation to Puawaitahi. The second aim was to explore what child, abuse, authority involvement, and family factors were related to psychological and behavioural problems. The fulfilment of these aims provided an indication of the proportion of children who required support services following maltreatment, and helped to identify what children were particularly vulnerable to the negative consequences of abuse and neglect.

Method

Setting

This research was conducted at Puawaitahi, a multi-agency service that investigates alleged child maltreatment, and provides some treatment and/or links children and their families with services that can provide treatment following abuse. For a more detailed description of Puawaitahi see page 33.

Sample

The sample for the current study consisted of a subset of the 307 children described in Chapter Two. This subsample consisted of 180 children between the ages of four and sixteen years who presented to Puawaitahi over a four month period, and had a parent/caregiver complete the Strengths and Difficulties Questionnaire [SDQ] (Goodman, 1997), and/or completed a self-report SDQ. Demographic information was recorded from files: two thirds of

the subsample were female, the majority were aged between 14 and 16 years, and two fifths were of Māori ethnicity (see Table 9).

Variables of Interest

All variables of interest for the current study are listed on page 35, although *person who made the referral* to Puawaitahi, who the child was *accompanied by* at presentation, and the *entry agency* that the child first presented to, were not included in the current study.

Strengths and Difficulties Questionnaire

The measure of psychological well-being employed was the English (Australian) version of the SDQ (Goodman, 1997). The SDQ is a 25-item screening questionnaire for children and young people aged between 4 and 17 years (Goodman, 1997). It is used to assess a child's strengths and difficulties, and consists of emotional, conduct, hyperactivity-attention, peer, and pro-social subscales. There are three possible responses to each item: *not true*, *somewhat true*, and *certainly true*, and totals on each subscale can range from 0 to 10. Scores on these subscales are combined to obtain a total difficulties score, with the exception of the pro-social domain which is not included but can be used as a dependent variable itself. The SDQ has an optional impact supplement, which is used to investigate how long the difficulties have been present, how distressing they are for the child, what areas of the child's life are impacted by the difficulties, and whether the child's difficulties place a burden on their family. Scores from the impact supplement can also range from 0 to 10.

Each scale and subscale score can be classified into descriptive ranges of Normal, Borderline, and Abnormal, based on cut-off scores obtained from the SDQ website www.sdqscore.org (Youthinmind, 2010). Parent-report SDQ scores for the Borderline range were: 14 – 16 for total difficulties, 4 for emotional symptoms, 3 for behavioural problems, 6 for hyperactivity symptoms, 3 for peer problems, and 5 for pro-social behaviour. Parent-report SDQ cut-off scores for the Abnormal range were: 17 - 40 for total difficulties, 5 - 10 for emotional symptoms, 4 - 10 for behavioural problems, 7 - 10 for hyperactivity symptoms, 4 - 10 for peer problems, and 0 - 4 for pro-social behaviour. Self-report SDQ scores for the Borderline range were: 16 - 19 for total difficulties, 6 for emotional symptoms, 4 for behavioural problems, 6 for hyperactivity symptoms, 4 - 5 for peer problems, and 5 for pro-social behaviour. Self-report SDQ cut-off scores for the Abnormal range were: 20 - 40 for total difficulties, 7 - 10 for

emotional symptoms, 5 - 10 for behavioural problems, 7 - 10 for hyperactivity symptoms, 6 - 10 for peer problems, and 0 - 4 for pro-social behaviour.

The SDQ can be scored by hand, or entered into the website; online scoring combines self-report, parent/caregiver report, and impact supplement data to provide diagnostic predictions regarding risk of any (psychological) diagnosis, risk of an emotional disorder, risk of a behavioural disorder, and risk of a hyperactivity/concentration disorder. Predictions are of *Low Risk*, *Medium Risk*, and *High Risk* of having difficulties. According to the SDQ scoring website (Youthinmind, 2010), 25 to 60% of people classified as High Risk have a related clinician determined diagnosis, as do 10 to 15% of people deemed to be at Medium Risk. Only around 1 to 4% of individuals considered to be at Low Risk of a diagnosis would be given a relevant diagnosis by clinicians.

The SDQ has good psychometric properties. When used with a British sample of 5 to 15 year olds, a Cronbach's α of .73 was found (Goodman, 2001). Good acceptability and internal consistency for the SDQ has also been found in a US sample (Bourdon, Goodman, Rae, Simpson, & Koretz, 2005). In an Australian sample of 4 to 9 year olds the SDQ had sound internal reliability and external validity (Hawes & Dadds, 2004). The SDQ has been compared with an established measure, the Child Behaviour Checklist (CBCL, Achenbach, 1991). Mother-rated SDQ and CBCL questionnaires were found to have significantly and highly correlated total scores and subscale scores for 132 children aged between 5 and 7 years (Goodman & Scott, 1999). Furthermore, the children came from samples that were at low or high risk of psychological or behavioural issues, and the questionnaires performed well and to an equal degree when it came to discriminating between low and high risk groups. Thus, there is evidence that the SDQ has good concurrent and predictive validity.

The SDQ can be completed by parents and teachers of children and adolescents aged between 4 and 17 years, and by self-report for 11 to 17 year olds. Puawaitahi has adopted the Australian version of the SDQ as a New Zealand version and New Zealand norms have not yet been developed. At presentation to Puawaitahi, the child's parent or caregiver completed an SDQ, and the child also completed an SDQ if they were aged 11 or older.

Procedure

Permission to access paper files was obtained from the Regional X Health and Disabilities Ethics Committee, the Auckland District Health Board Research Review Committee, the Police Research and Evaluations Steering Committee, and the CYF Research Access Committee.

To record information obtained from the file audit, a spreadsheet was developed using PASW 18 software, as described in chapter two. Information was collected and recorded on the spreadsheet for child, abuse, and family factors, as well as authority involvement. Recorded information was then coded according to the classification system detailed in Appendix A. Percentage agreement for coding variables that required a judgement is reported on page 37.

In line with what had been recently implemented at Puawaitahi as standard practice, the child's parent/caregiver completed the SDQ upon initial presentation to any of the agencies within the service. To ensure people were not asked to fill in another SDQ if more than one agency was involved, a tracking form was completed. The young person was asked to fill out a self-report version of the SDQ if they were aged between 11 and 17 years. In cases where a young person presented without a caregiver or parent, but were aged 11 or older, only a self-report SDQ was filled out. No SDQ was filled out if the child was under four years old (the lower limit for the SDQ), if they were younger than 11 and were not accompanied by an adult who could fill out the measure, or if they were older than 11 but in such a highly distressed state that the administration of the SDQ would be inappropriate. Depending on the agency, completed questionnaires were then kept with the child's paper file or in a separate folder of SDQs. Answers to all items on the SDQ for each child were entered into the spreadsheet once other file information was collected.

Data analysis

Data gathered during the file audit was coded and analysed using PASW 18 software. In some cases, not all items on the SDQ outcome measure were answered. As missing data were scattered over cases, deletion of cases with missing responses would have resulted in a large loss of data. Goodman (2000) recommended prorating in cases where there are missing values but at least three scores for a subscale. Missing data was estimated by calculating the subscale average for each case. For instance, if a parent did not answer the item *many worries or often seems worried*, there would be a missing value on the emotional difficulties subscale. If they produced

an average score of 1.25 on remaining scale items, this value would be imputed as a best estimate. If a subscale had fewer than three values, it was marked as missing (Goodman, 2000).

The parent/caregiver and self-report total difficulties SDQ scores were used as dependent variables, as well as the emotional difficulties, behavioural difficulties, hyperactivity/concentration difficulties, peer problems, pro-social behaviour, and impact subscale scores. Risk of any diagnosis, risk of an emotional disorder, risk of a behavioural disorder, and risk of a hyperactivity/concentration disorder were also used as dependent variables.

Several tests were used to explore relationships between scores on the SDQ and demographic, abuse, authority involvement, and family factors. Pearson's correlations were used to explore relationships between continuous variables and SDQ scores, and Spearman's Rho was used for categorical variables. Multivariate Analysis of Variance (MANOVA) was employed to investigate group differences (e.g. whether parent or self-report SDQ scores differed based on severity of abuse). This method was used to protect against inflated Type 1 error due to multiple comparisons before examining results of univariate *t* tests or ANOVAs (with Bonferroni corrections for multiple comparisons). An alpha co-efficient of 0.05 was employed for all other tests. Non-parametric Chi-Square tests for independence were used to explore whether risk of diagnosis depended on categorical variables.

Results

Analyses were conducted in four stages. First, a sensitivity analysis was conducted to see whether children who had an SDQ differed from those who did not have an SDQ. Second, descriptive statistics were produced to describe the characteristics of this subsample. Third, SDQs were analysed with regard to the percentage of scores falling within *normal*, *borderline*, and *abnormal* ranges, mean scale and subscale scores, and risk of diagnosis. Finally, relationships between SDQ scores and variables of interest, as well as group differences in SDQ scores, were investigated with correlations, MANOVAs, and Chi-Square tests.

Sensitivity analysis

The SDQ sample only differed from those who did not have an SDQ completed in terms of age (see Table 9). The average age of children who had an SDQ was significantly higher than children who did not. This was expected given that the SDQ can only be completed for children aged four years and older, and Puawaitahi sees infants as well as older children and adolescents.

Table 9
Demographic information and sensitivity analysis

		SDQ Sample Frequency (%)	Non-SDQ Frequency (%)	<i>p</i> value	t or χ^2 value
Gender	Female	119 (66.1%)	73 (57.5%)	ns	$\chi^2(1) = 2.368$
	Male	61 (33.9%)	54 (42.5%)		
Average age at Presentation	Mean (SD)	11.2 years (3.62)	5.75 years (5.13)	<.001	t(305) = 10.916
	Median	12 years	4 years		
	Range	4 to 16 years	0 to 16 years		
Age at Presentation	0 to 3 years	0 to 3 years	60 (47.2%)		
	4 to 7 years	4 to 7 years	27 (21.3%)		
	8 to 10 years	8 to 10 years	9 (7.1%)		
	11 to 13 years	11 to 13 years	12 (9.4%)		
	14 to 16 years	14 to 16 years	19 (15.0%)		
Ethnicity ^a	European/Pakeha	51 (28.3%)	23 (18.1%)	ns	$\chi^2(4) = 7.065$
	Māori	72 (40.0%)	64 (50.4%)		
	Pacific Islander	37 (20.6%)	31 (24.4%)		
	Asian	9 (5.0%)	5 (3.9%)		
	Other	11 (6.1%)	4 (3.1%)		

Note. ^a Multiple ethnicities were often listed in files. For classification, in these instances Māori was categorised first, followed by Pacific Islander, Asian, Other ethnicity, and European/Pakeha respectively. ns = not significant.

Chi-square tests indicated that whether or not the SDQ was completed was not independent of district or DHB within which the child lived (see Table 10). More people than expected from Waitemata DHB had an SDQ completed, and less people than expected from Counties Manukau had an SDQ completed.

Table 10
Child living situation and sensitivity analysis

		SDQ Sample Frequency (%)	Non-SDQ Frequency (%)	<i>p</i> value	χ^2 value
Living Arrangements at Presentation	Biological Parent/s	121 (67.2%)	80 (63.0%)	ns	$\chi^2(2) = 4.06$
	Family Caregiver	28 (15.6%)	14 (11.0%)		
	Non-kin Caregiver	31 (17.2%)	33 (26.0%)		
Residence: District Health Board	Waitemata	106 (58.9%)	32 (25.2%)	<.001	$\chi^2(3) = 40.15$
	Auckland	52 (28.9%)	54 (42.5%)		
	Counties Manukau	22 (12.2%)	36 (28.3%)		
	Other	0 (0%)	5 (3.9%)		
Residence: District	Rodney	21 (11.7%)	4 (3.1%)	<.001	$\chi^2(5) = 36.28$
	North Shore City	30 (16.7%)	8 (6.3%)		
	Waitakere City	55 (30.6%)	20 (15.7%)		
	Auckland City	48 (26.7%)	54 (42.5%)		
	Manukau City	20 (11.1%)	32 (25.2%)		
	Other	6 (3.3%)	9 (7.1%)		

Note. ns = not significant.

Descriptive statistics

As shown in Table 11, the majority of children in the sample were referred to Puawaitahi by a CYF social worker, and most attended with a parent or caregiver. A high percentage of children attended Te Puaruruhau and the Central Auckland Video Unit, although relatively few were seen at the Specialist Services Unit. Children were mostly referred due to one type of maltreatment concern, and the majority were seen due to sexual abuse. For two fifths of children there had been a delay of a year or more between the first incident of abuse and the identification of the abuse. At the time of presentation to Puawaitahi, the alleged perpetrators primarily resided outside of the family home. Sexual abuse and physical abuse were most likely to co-occur.

Descriptive statistics for children who presented due to sexual abuse concerns are presented in Table 12. Sexual abuse concerns were primarily identified through child disclosure, and family members were the most likely to be told. The average age of children at the time of the first sexual abuse incident was around 10 years old. The majority of these children had experienced attempted or completed intercourse, and it was quite common for the sexual abuse to be a repeated rather than isolated event. Close to one fifth had been sexually abused by two or more perpetrators. Most children were abused by someone known to them but not in their family, although close to two fifths were abused by someone within their family. Most of the time, the alleged perpetrator was older than 21 years, with a mean age of just under thirty years.

There was clear evidence of abuse for almost all of the children who presented due to physical abuse concerns (see Table 13). Nearly one quarter had concerns that were identified through other person report or physical symptoms such as bruising, and fathers were the alleged perpetrators in most instances. All but five of the children who presented due to physical abuse were considered to have experienced either a severe or very severe assault. It was more common for physical abuse to be repeated rather than an isolated event, and in more than two fifths of cases there were two or more alleged perpetrators.

Table 11

Presentation information for the sample (n = 180)

		Frequency (%)
Who child was referred by	Family or Self	5 (2.8%)
	CYF Social Worker	116 (64.4%)
	General Practitioner	14 (7.8%)
	District Health Board	4 (2.2%)
	Police	26 (14.4%)
	Community Health	8 (4.4%)
	Counsellor	7 (3.9%)
Who child was accompanied by	By Themselves	6 (3.3%)
	Parent/Caregiver no Social Worker	65 (36.1%)
	Parent/Caregiver with Social Worker	49 (27.2%)
	Family other than Parents	21 (11.7%)
	Friend	6 (3.3%)
	Social Worker	27 (15%)
	Other	6 (3.3%)
Number of children that attended agency ^a	Te Puaruruhau (Health/Medical)	104 (57.8%)
	Central Auckland Video Unit	116 (64.4%)
	Specialist Services Unit	20 (11.1%)
Number of abuse types child was referred for	One	140 (77.8%)
	Two	29 (16.1%)
	Three	9 (5.0%)
	Four	2 (1.1%)
Presentation concerns	Sexual Abuse	127 (70.6%)
	Physical Abuse	70 (38.3%)
	Neglect	24 (13.3%)
	DV	12 (6.7%)
Delay in identification	One week or less	69 (33.3%)
	One week to a month	8 (4.4%)
	A month to one year	22 (12.2%)
	More than one year	72 (40.0%)
	Unknown	12 (6.7%)
	Not applicable	6 (3.3%)
Residence of alleged perpetrator	At family home with child	9 (5.0%)
	At family home without child	45 (25%)
	Living outside of family home	118 (65.6%)
	Not applicable	8 (4.4%)
Maltreatment Concerns	Sexual Abuse	101 (56.1%)
	Physical Abuse	35 (19.4%)
	Neglect	4 (2.2%)
	DV	0 (0.0%)
	Sexual Abuse and Physical Abuse	16 (8.9%)
	Sexual Abuse and Neglect	2 (1.1%)
	Sexual Abuse and DV	1 (0.6%)
	Physical Abuse and Neglect	6 (3.3%)
	Physical Abuse and DV	3 (1.7%)
	Neglect and DV	1 (0.6%)
	Sexual Abuse, Physical Abuse, Neglect	4 (2.2%)
	Sexual Abuse, Physical Abuse, DV	0 (0.0%)
	Sexual Abuse, Neglect, DV	1 (0.6%)
	Physical Abuse, Neglect, DV	4 (2.2%)
Sexual Abuse, Physical Abuse, Neglect, DV	2 (1.1%)	

Note. ^a Number of children that attended agency \neq 100% as some children attended more than one agency.

Table 12

Abuse characteristics for children who presented due to sexual abuse concerns (n = 127)

		Frequency (%)
Sexual abuse found to have happened	No evidence	6 (4.7%)
	Unable to determine	5 (3.9%)
	Probable abuse	9 (7.1%)
	Clear evidence of abuse	107 (84.3%)
Sexual abuse first identified	Disclosure	113 (89%)
	Other person report	8 (6.3%)
	Physical symptom	6 (4.7%)
Who the sexual abuse was disclosed to	Family	73 (57.5%)
	Counsellor	12 (9.4%)
	Police	5 (3.9%)
	CYF	4 (3.1%)
	Other	22 (17.3%)
	Not disclosed	11 (8.7%)
Age at first sexual abuse incident	Mean (SD)	9.86 (3.71)
	Median	10 years
	Range	3 to 16 years
	n	115
Type of sexual abuse	No indication/unclear	10 (7.9%)
	Non-contact sexual abuse	6 (4.7%)
	Contact- no intercourse	53 (41.7%)
	Intercourse attempted/completed	58 (45.7%)
Frequency of sexual abuse	No known events	10 (7.9%)
	One known event	64 (50.4%)
	Repeated events	36 (28.3%)
	Chronic abuse	17 (13.4%)
Number of alleged SA perpetrators	None	10 (7.9%)
	One	92 (72.4%)
	Two or more	25 (19.7%)
Sexual abuse perpetrator relationship	Father	11 (8.7%)
	Father and other/s	3 (2.4%)
	Step-father	10 (7.9%)
	Other family member	25 (19.7%)
	Person known to child	45 (35.4%)
	Stranger	23 (18.1%)
	Not applicable	10 (7.9%)
Intrafamilial /extrafamilial abuse	Intrafamilial	49 (38.6%)
	Extrafamilial	68 (53.5%)
	Not applicable	10 (7.9%)
Perpetrator age	Mean (SD)	28.9 (16.53)
	Median	23.5 years
	Range	7 to 65 years
	n	76
Grouped age of perpetrator	Less than thirteen years	8 (6.3%)
	Thirteen to twenty-one years	27 (21.3%)
	Older than twenty-one years	41 (32.3%)
	Unknown	41 (32.3%)
	Not applicable	10 (7.9%)

Table 13

Abuse characteristics for children who presented due to physical abuse concerns (n = 70)

		Frequency (%)
Physical abuse found to have happened	No evidence	2 (2.9%)
	Unable to determine	1 (1.4%)
	Probable abuse	1 (1.4%)
	Clear evidence of abuse	65 (94.2%)
How concerns were first identified	Disclosure	53 (75.7%)
	Other person report	8 (11.4%)
	Physical symptom	9 (12.9%)
Physical abuse perpetrator relationship	Father	19 (27.1%)
	Mother	9 (12.9%)
	Mother and father	9 (12.9%)
	Father and other/s	3 (4.3%)
	Mother and other/s	8 (11.4%)
	Stepfather	3 (4.3%)
	Other family member	5 (7.1%)
	Caregiver	7 (10.0%)
	Person known to child (not family)	2 (2.9%)
	Stranger	1 (1.4%)
	Unknown from file information	0 (0%)
Not applicable	4 (5.7%)	
Intrafamilial/ extrafamilial abuse	Intrafamilial	60 (85.7%)
	Extrafamilial	6 (8.6%)
	Not applicable	4 (5.7%)
Type of physical abuse	No indication/unclear	4 (5.7%)
	Pushed/hair pulled/kicked/hit	14 (20.0%)
	Hit with object/thrown against object	25 (35.7%)
	Choked/stabbed/bones broken/brain injury	27 (38.6%)
Severity of Physical Abuse	No evidence of assault	4 (5.7%)
	Minor assault	1 (1.4%)
	Severe assault	37 (52.9%)
	Very severe assault	28 (40.0%)
Frequency of physical abuse	No evidence of physical abuse	4 (5.7%)
	One known event	15 (21.4%)
	Repeated events	19 (27.1%)
	Chronic abuse	32 (45.7%)
No. of people who abused child	None	4 (5.7%)
	One	37 (52.9%)
	Two or more	29 (41.4%)

Details of the experiences of children who presented to Puawaitahi with concerns of neglect are presented in Table 14. There was clear evidence of neglect for all but one of these children, and compared to sexual abuse and physical abuse, concerns were more likely to be identified through other person report as opposed to child disclosure. Children who had been neglected seldom experienced only one form of neglect. Neglect tended to be of long duration and perpetrated by a parent.

Table 14
Neglect characteristics for children who presented due to neglect (n = 24)

		Frequency (%)
Neglect found	No evidence	0 (0.0%)
	Unable to determine	0 (0.0%)
	Probable neglect	1 (4.2%)
	Clear evidence of neglect	23 (95.8%)
How concerns were first identified	Disclosure	11 (45.8%)
	Other person report	12 (50.0%)
	Physical symptom	1 (4.2%)
Number of types of neglect	None	0 (0%)
	One type	2 (8.3%)
	Two or three types	11 (45.8%)
	Four or more types	11 (45.8%)
Duration of neglect	Less than a year	0 (0.0%)
	More than a year	18 (75.0%)
	Unknown	6 (25.0%)
	Not applicable	0 (0.0%)
Neglect perpetrator relationship	Mother	8 (33.3%)
	Mother and father	11 (45.8%)
	Mother and other/s	3 (12.5%)
	Caregiver	2 (8.3%)
	Not applicable	0 (0.0%)

Only 12 children in the sample had concerns of exposure to DV referred to in their file (see Table 15). There was clear evidence of exposure to DV for all but one of these children. Concerns were identified through other person report for half of these children, and for the other half concerns were recognised through child disclosure. The majority of this subsample had been exposed to a severe assault, which for most children included witnessing violence acts such as a parent being choked, stabbed, burnt, or killed. It was far more common for children to be

exposed to ongoing DV than a single episode of violence. In more than two thirds of cases, the violence these children were exposed to was considered life-threatening.

Table 15

Exposure to Domestic Violence characteristics for children who presented with these concerns (n =12)

		Frequency (%)
Exposure to domestic violence found	No evidence	0 (0.0%)
	Unable to determine	0 (0.0%)
	Probable exposure	1 (8.3%)
	Clear evidence of exposure	11 (91.7%)
How concerns first identified	Disclosure	6 (50.0%)
	Other person report	6 (50.0%)
Type of exposure to domestic violence	No indication of exposure	0 (0.0%)
	Parent pushed/hair pulled/ kicked/hit	3 (25.0%)
	Hit with object/thrown against object	2 (16.7%)
	Choked/stabbed/burnt/bones broken /brain injury/death	7 (58.3%)
Severity of physical abuse	No evidence of domestic assault	0 (0%)
	Minor assault (or no details)	3 (25.0%)
	Severe assault	9 (75.0%)
Frequency of exposure to domestic violence	No evidence of domestic violence	0 (0.0%)
	One known event	2 (16.7%)
	Repeated events	0 (0.0%)
	Chronic domestic violence	10 (83.3%)
Domestic violence life threatening	Yes	8 (66.7%)
	No/unknown	4 (33.3%)

Authority involvement and family factors are detailed in Table 16. Police and CYF became involved with most of the cases in this subsample, and close to three fifths of children had families who had been in contact with CYF previously. A substantial proportion of children had spent at least some time in care throughout their lives. Close to a third had been in at least one CYF placement, and an even greater proportion had experienced one or more home transitions (which included CYF placements and non-formal placements). File information indicated evidence of drug use within the family for over a third of the sample, and a family history of physical abuse was indicated for half of the sample. Files rarely indicated that parents or caregivers did not believe their child about the abuse.

Table 16
Authority involvement and family characteristics across all maltreatment types (n = 180)

		Frequency (%)
Police involved	Yes	147 (81.7%)
	No or unknown	33 (18.3%)
Police previously involved with family	Yes	28 (15.6%)
	No or unknown	152 (84.4%)
CYF involved	Yes	169 (93.9%)
	No or unknown	11 (6.1%)
CYF previously involved with family	Yes	107 (59.4%)
	No or unknown	73 (40.6%)
Total time spent in care ^a	No time in care	129 (71.7%)
	Less than one month	8 (4.4%)
	One month to one year	19 (10.6%)
	More than one to five years	15 (8.3%)
	More than five years	9 (5.0%)
Number of CYF placements	None	122(67.8%)
	One	29 (16.1%)
	Two or more	29 (16.1%)
Number of home transitions	None	99 (55.0%)
	One	40 (22.2%)
	Two or more	41 (22.8%)
Evidence of drug use within family	Yes	61 (33.9%)
	No/Unknown	119 (66.1%)
Family history of physical abuse	Yes	90 (50.0%)
	No/Unknown	90 (50.0%)
Parent/caregiver belief	Believed	109 (60.6%)
	Not Believed	24 (13.3%)
	Not Applicable	47 (26.1%)

Note. ^a Figures for children who had spent no time in care were higher than those who had not been in any CYF placements, because for seven children placement into care coincided with time of presentation to Puawaitahi

Scores on the SDQ

Percentage of scores in the normal, borderline, and abnormal range: As shown in Table 17, close to a third of SDQ parent report scores fell within the Abnormal Range for total difficulties, emotional difficulties, behavioural difficulties, and peer problems. More than one fifth scored in the Abnormal Range for parent report of hyperactivity/concentration problems, whereas less than 5% scored in the Abnormal Range for parent report of pro-social behaviour.

Furthermore, parents/caregivers rated more than one third of the sample to be in the Borderline Range for emotional and behavioural difficulties.

For self-report SDQ scores (see Table 17), more than one fifth of the sample scored in the Abnormal Range for total difficulties, and close to one quarter scored in the Abnormal Range for emotional difficulties, behavioural problems, and hyperactivity/concentration problems. Whilst relatively few scored in the Abnormal Range for peer problems, more than one quarter scored in the Borderline Range. Again, only a small percentage scored within the Abnormal Range for pro-social behaviour.

Table 17
Number of parent and self-report SDQ scores by SDQ clinical range

	Normal			Borderline			Abnormal		
	Cut-off	n	%	Cut-off	n	%	Cut-off	n	%
Parent SDQ (n = 153)									
Total difficulties	0 – 13	92	60.1	14 – 16	14	9.2	17 – 40	47	30.7
Emotional symptoms	0 – 3	89	58.2	4	19	12.4	5 – 10	45	29.4
Behavioural problems	0 – 2	86	56.2	3	19	12.4	4 – 10	48	31.4
Hyperactivity score	0 – 5	109	71.2	6	12	7.8	7 – 10	32	20.9
Peer problems	0 – 2	93	60.8	3	17	11.1	4 – 10	43	28.1
Pro-social behaviour	6 – 10	134	87.6	5	12	7.8	0 – 4	7	4.6
Self SDQ (n = 107)									
Total difficulties	0 – 15	53	49.5	16 – 19	31	29.0	20 – 40	23	21.5
Emotional symptoms	0 – 5	68	63.6	6	13	12.1	7 – 10	26	24.3
Behavioural problems	0 – 3	63	58.9	4	17	15.9	5 – 10	27	25.2
Hyperactivity score	0 – 5	64	59.8	6	15	14.0	7 – 10	28	26.2
Peer problems	0 – 3	72	67.3	4 – 5	28	26.2	6 – 10	7	6.5
Pro-social behaviour	6 – 10	92	86.0	5	11	10.3	0 – 4	4	3.7

Note. Ranges for normality are based on values obtained from the SDQ website.

Mean SDQ scores:

Average total SDQ score was found to be lower for parent/caregiver report than for self-report (see Table 18). On subscales, the highest means were for pro-social behaviour (higher scores indicate a greater level of pro-social behaviour) for both parent and self-report. Of the subscales that contributed to the total difficulties score, the highest means were for hyperactivity/concentration difficulties, followed by emotional symptoms.

There were 80 adolescents who had both a self and parent-completed SDQ, and paired samples *t* tests revealed that, on average, adolescents rated themselves as having significantly

greater total difficulties, emotional difficulties, behavioural difficulties, and hyperactivity/concentration problems than their parents or caregivers.

Table 18
Parent-report (n = 153) and self-report (n = 107) average SDQ scores

	Parent-Report Scores		Self-report Scores		<i>p</i>	t value
	Mean	SD	Mean	SD		
Total Difficulties	12.6	7.35	15.8	4.67	< .001	t(79) = -3.849
Emotional Difficulties	3.4	2.52	4.7	2.36	<.001	t(79) = -3.634
Behavioural Difficulties	2.6	2.32	3.3	1.88	.036	t(79) = -2.130
Hyperactivity Problems	4.2	2.54	5.1	1.99	.001	t(79) = -3.470
Peer Problems	2.4	1.98	2.8	1.82	ns	t(79) = -1.067
Pro-social Behaviour	8.1	1.92	7.6	1.91	ns	t(79) = 1.610
Life Impact ^a	1.7	2.43	2.1	2.23	ns	t(74) = -2.02

Note. ^a n = 146 for parent report, 104 for self report, and 75 for paired samples t test. Numbers for life impact differ as children/caregivers only completed impact supplements if they thought they/their child had difficulties in emotions, concentration, behaviour, or getting along with other people. ns = not significant.

Risk of diagnosis: Risk of diagnosis according to summary reports generated by the SDQ website was examined (see Table 19). Low risk was the most common label applied to all forms of diagnostic risk; although a fair proportion (16.7 to 23.9%) were at medium risk. A third of cases were at high risk of any diagnosis, although no one was at high risk of a hyperactivity/concentration disorder.

Table 19
Risk of diagnosis for children in the sample (n = 180)

		Frequency (%)
Risk of any diagnosis	Low	87 (48.3%)
	Medium	33 (18.3%)
	High	60 (33.3%)
Risk of an emotional disorder	Low	122 (67.8%)
	Medium	30 (16.7%)
	High	28 (15.6%)
Risk of a behavioural disorder	Low	113 (62.8%)
	Medium	32 (17.8%)
	High	35 (19.4%)
Risk of a hyperactivity/concentration disorder	Low	137 (76.1%)
	Medium	43 (23.9%)
	High	0 (0%)

Note. Children may have been at medium or high risk of diagnosis for more than one type of disorder, so figures for risk of emotional, behavioural, and hyperactivity/concentration disorders do not add up to figures for risk of any diagnosis.

Relationships and group differences

Because very few children presented to Puawaitahi due to concerns of neglect or DV without concurrent forms of abuse, neglect and DV variables were not included in the following statistical analyses. Furthermore, neglect and DV variables may have been unreliable as they may not have been noted in the file information if the child presented due to sexual or physical abuse concerns.

Correlational analyses: Correlational analyses between SDQ scale and subscale scores and demographic, abuse, child, and family factors were carried out. Spearman's rank correlation coefficient was used for ordinal variables, whereas Pearson correlation was used for continuous variables such as age. As appropriate, levels of variables such as *unknown* or *not applicable* were removed to allow for meaningful interpretation.

As shown in Table 20, parent report of peer problems increased as *age* of the child increased. A higher *number of abuse types relating to current presentation* was associated with greater self-report scores of emotional difficulties. A longer *delay between abuse event and identification* was associated with higher parent report of total difficulties, emotional difficulties, hyperactivity/concentration difficulties, and peer problems, and lower pro-social behaviour, although there were no significant correlations with self-report scores.

With regard to *type of sexual abuse*, sexual abuse that was more invasive was linked with greater parent report of total difficulties, emotional difficulties, behavioural problems, hyperactivity/concentration problems, and life impact, and greater self-report of behavioural problems. All of these correlations remained statistically significant when the *no indication of sexual abuse or unclear if abused* group was dropped from the analysis to ensure that the relationship was about the invasiveness of the abuse, rather than whether or not the child had experienced SA. Parent-report results were exactly the same for *frequency of sexual abuse* as they were for *type of sexual abuse*, although a greater *frequency of sexual abuse* was also positively correlated with greater self-report of life impact. Older *age of the alleged sexual abuse perpetrator* was associated with higher parent report scores of emotional difficulties and life impact. *Age at first sexual abuse incident*, and *number of alleged sexual abuse perpetrators*, were not included in the Table 20 as there were no significant correlations between these variables and SDQ scores ($p > .05$).

Table 20
Correlations between continuous and ordinal variables, and SDQ scores

	Age	No. of Types of Abuse	Delay in Identification	Type of SA	Frequency of SA	Age of SA Perpetrator	Severity of PA	Frequency of PA	Time in Care	No. of Placements	No. of Transitions
Parent-Report SDQ											
Total Difficulties	---	---	.228**	.361***	.326***	---	---	---	---	---	---
Emotional Difficulties	---	---	.190*	.281**	.336***	.238*	---	.302*	---	---	---
Behavioural Problems	---	---	---	.393***	.255**	---	---	---	---	---	.178*
Hyperactivity Problems	---	---	.183*	.285**	.208*	---	---	---	---	---	---
Peer Problems	.195*	---	.181*	---	---	---	---	---	---	---	---
Pro-social Behaviour	---	---	-.272**	---	---	---	---	---	---	-.232**	-.212**
Life Impact	---	---	---	.325**	.260**	.257*	---	---	---	---	.234**
Self-report SDQ											
Total Difficulties	---	---	---	---	---	---	---	---	---	---	.200*
Emotional Difficulties	---	.235*	---	---	---	---	---	---	---	---	---
Behavioural Problems	---	---	---	.308**	---	---	---	---	---	.218*	.207*
Hyperactivity Problems	---	---	---	---	---	---	---	---	---	---	---
Peer Problems	---	---	---	---	---	---	-.332*	---	---	---	---
Pro-social Behaviour	---	---	---	---	---	---	---	---	---	---	---
Life Impact	---	---	---	---	.239*	---	---	---	.204*	---	.202*

Note. * $p < .05$, ** $p < .01$, *** $p < .001$; --- represent correlations where $p > .05$.

In terms of physical abuse, a greater *severity of physical abuse* was correlated with lower self-report scores of peer problems, although a greater *frequency of physical abuse* was associated with higher parent report scores of emotional symptoms. There were no significant correlations between *number of alleged physical abuse perpetrators* and SDQ scores ($p > .05$).

Longer *total time spent in care* was linked with greater self-report scores of life impact. A greater *number of home transitions* was associated with higher parent report scores of behavioural problems and life impact, and higher self-report scores of total difficulties, behavioural problems and life impact, but lower parent report scores of pro-social behaviour.

Impact of grouping variables

A series of MANOVAS with post hoc analyses (when applicable) were used to examine group differences in parent and self-report SDQ scores. Separate MANOVAs were conducted for SDQ parent and self-report, so as to retain the maximum n possible. The parent and self-report dependent variables were: total difficulties, emotional difficulties, behavioural difficulties, hyperactivity/concentration difficulties, peer problems, pro-social behaviour, and life impact. Chi-Square tests for independence were employed to investigate whether there were any relationships between categorical variables and risk of diagnosis (Low, Medium, and High).

Gender: A one way MANOVA was conducted with child gender as a fixed factor and parent and self-report SDQ scores as dependent variables. There was a statistically significant difference between males and females for both parent-report and self-report SDQ scores (see Table 21). Univariate tests showed that males scored significantly higher than females for parent-report of hyperactivity/concentration problems and impact, whereas females scored significantly higher than males for pro-social behaviour. The difference between males and females for parent-report of behavioural symptoms approached significance ($p = .051$), with males having higher mean scores than females. In terms of self-report SDQ results, males scored significantly higher than females for behavioural difficulties and peer problems.

In line with parent reports, females scored significantly higher than males for pro-social behaviour. Chi-square analysis revealed a significant relationship between gender and risk of a behavioural disorder; more males than expected were at high risk of a behavioural disorder. No significant relationships were found between gender and risk of any diagnosis, risk of an emotional disorder, or risk of a concentration/hyperactivity disorder ($p > .05$).

Table 21
Significant MANOVA and Chi-square results for Gender

	Male		Female		Statistic	<i>p</i>
	M	SD	M	SD		
Parent report SDQ					$F(6, 139) = 2.91, \lambda = 0.888$	.010
Total difficulties	14.0	8.12	12.1	6.98	$F(1, 144) = 2.18$	ns
Emotional symptoms	3.22	2.69	3.51	2.48	$F(1, 144) = 0.41$	ns
Behavioural problems	3.20	2.57	2.40	2.18	$F(1, 144) = 3.88$	ns
Hyperactivity score	4.84	2.54	3.85	2.53	$F(1, 144) = 4.92$	.028
Peer problems	2.71	2.35	2.30	1.77	$F(1, 144) = 1.41$	ns
Pro-social behaviour	7.35	2.35	8.41	1.60	$F(1, 144) = 10.42$	.002
Impact	2.35	2.86	1.41	2.13	$F(1, 144) = 4.98$	.027
Self report SDQ					$F(6, 97) = 2.93, \lambda = 0.847$	.011
Total difficulties	17.0	4.73	15.4	4.62	$F(1, 102) = 2.71$	ns
Emotional symptoms	4.24	2.47	4.82	2.29	$F(1, 102) = 1.28$	ns
Behavioural problems	4.07	1.94	2.97	1.80	$F(1, 102) = 7.46$	.007
Hyperactivity score	5.34	2.13	4.98	1.96	$F(1, 102) = 0.68$	ns
Peer problems	3.38	1.88	2.59	1.78	$F(1, 102) = 4.03$	.047
Pro-social behaviour	6.79	2.21	8.02	1.68	$F(1, 102) = 9.26$	.003
Impact	1.79	2.04	2.21	2.36	$F(1, 102) = 0.71$	ns
Risk of Diagnosis	N	%	N	%		
Risk of behavioural disorder					$\chi^2(2) = 8.604$	.014
- Low	31	50.8	82	68.9		
- Medium	11	18.0	21	17.6		
- High	19	31.1	16	13.4		

Note. ns = not significant.

Age of child: When MANOVAs were run, no significant differences were found for parent or self-report SDQ scores based on age ($p > .05$).

Table 22
Significant Chi-square results for Age

	Age Group								Statistic	<i>p</i>
	4-7		8-10		11-13		14-16			
Risk of Diagnosis	N	%	N	%	N	%	N	%		
Risk of any diagnosis									$\chi^2(6) = 16.949$	.009
- Low	26	29.9	21	24.1	18	20.7	22	25.3		
- Medium	3	9.1	5	15.2	10	30.3	15	45.5		
- High	9	15.0	7	11.7	16	26.7	28	46.7		
Risk of emotional disorder									$\chi^2(6) = 16.471$	.011
- Low	29	23.8	27	22.1	31	25.4	35	28.7		
- Medium	7	23.3	4	13.3	3	10.0	16	53.3		
- High	2	7.1	2	7.1	10	35.7	14	50.0		

However, Chi-square analyses revealed significant relationships between age and risk of any diagnosis, as well as age and risk of an emotional disorder (see Table 22). Results illustrated that older children were more likely to be in the high risk of any diagnosis group, and the high risk of an emotional disorder group. Chi-square analyses showed no significant relationships between age and risk of a behavioural disorder, or risk of a concentration/hyperactivity disorder ($p > .05$).

Ethnicity: When MANOVAs were run, there were no significant differences in parent and self-report SDQ scores based on ethnicity ($p > .05$). No support was found to suggest that risk of diagnosis was dependent on ethnicity ($p > .05$).

Living arrangements: When a MANOVA was conducted, no significant differences were found for parent-report SDQ scores based on living arrangement. However, a statistically significant difference was found based on who the child was living with for self-report SDQ scores (see Table 23). Post hoc analyses indicated that self-report impact was higher for children living with a non-kin caregiver compared to children living with a biological parent ($p = .001$). No difference was found between children who lived with a whānau caregiver and children who lived with their biological parents ($p > .05$). Chi-square tests did not reveal any statistically significant results to indicate that risk of diagnosis depended on living arrangement of the child ($p > .05$).

Table 23
Significant MANOVA results for Living arrangement

	Living Arrangement						Statistic	<i>p</i>
	Home		Kin		Non-kin			
	M	SD	M	SD	M	SD		
Self-report SDQ							$F(12, 192) = 2.08, \lambda = 0.783$	.020
Total difficulties	15.7	4.92	15.8	4.69	16.7	3.67	$F(2, 101) = 0.27$	ns
Emotional symptoms	4.73	2.20	4.15	2.56	5.00	2.73	$F(2, 101) = 0.66$	ns
Behavioural problems	3.07	1.83	3.75	2.00	3.58	2.06	$F(2, 101) = 1.22$	ns
Hyperactivity score	5.21	2.10	5.10	1.80	4.47	1.81	$F(2, 101) = 0.85$	ns
Peer problems	2.64	1.82	2.80	1.36	3.60	2.29	$F(2, 101) = 1.72$	ns
Pro-social behaviour	7.81	2.00	7.30	1.66	7.55	1.87	$F(2, 101) = 0.56$	ns
Impact	1.63	2.02	2.35	2.39	3.88	2.43	$F(2, 101) = 6.87$	.002

Note. Home refers to children living with their biological parents, kin a family/whānau caregiver, and non-kin a caregiver who is not a family member. ns = not significant.

Number of types of abuse relating to current presentation: No significant results were found when MANOVAs were conducted to see whether SDQ scores differed based on number

of types of abuse relating to current presentation ($p > .05$). Nor were any significant results found when chi-square tests were run to see whether risk of diagnosis was dependent on number of types of abuse ($p > .05$).

Delay between abuse event and identification: A MANOVA revealed statistically significant differences in parent-report SDQ scores based on the delay between the first event of abuse and its identification (see Table 24). Delay between the first abusive event and identification was found to have a statistically significant effect on parent-report total SDQ scores, emotional difficulties, behavioural problems, peer problems, and pro-social behaviour. Post hoc analyses with Bonferroni corrections showed that parent-report total difficulties scores were higher for children for whom there had been a delay of *more than one year*, compared to those for whom the delay was *one week or less* ($p = .012$). Parent report of emotional difficulties was significantly higher for children for whom the delay was from *more than one month to a year*, or *more than a year*, compared to those children for whom the abuse was identified in *one week or less* ($p = .001$ and $p = .044$, respectively). Parent report of behavioural problems was significantly higher for children who had abuse identified after *more than a year* compared to those who had abuse identified in *one week or less* ($p = .048$). Parent report of pro-social behaviour was higher for children for whom the abuse had been identified in *one week or less*, as opposed to those for whom the abuse went unidentified for *more than one year* ($p = .002$).

Table 24
Significant MANOVA results for Delay in identification

	Delay								Statistic	<i>p</i>
	1 week or less		1 week – 1 month		1 month - 1 year		More than one year			
	M	SD	M	SD	M	SD	M	SD		
Parent report SDQ									$F(18, 343) = 2.246,$ $\lambda = 0.730$	.003
Total difficulties	10.2	6.03	14.2	8.57	15.0	7.63	14.7	7.92	$F(3, 126) = 4.03$	.009
Emotional symptoms	2.49	1.89	4.17	2.86	5.04	2.63	3.76	2.64	$F(3, 126) = 6.08$	.001
Behavioural problems	2.00	1.90	3.71	2.12	2.95	2.37	3.22	2.60	$F(3, 126) = 2.88$	.038
Hyperactivity score	3.78	2.50	4.33	3.50	3.93	2.76	4.85	2.47	$F(3, 126) = 1.65$	ns
Peer problems	1.93	1.72	2.00	2.28	3.13	1.82	2.86	2.22	$F(3, 126) = 2.72$	.048
Pro-social behaviour	8.74	1.24	7.83	2.32	7.95	1.70	7.40	2.29	$F(3, 126) = 4.47$	.005
Impact	1.21	1.87	1.17	2.40	2.49	2.45	2.23	2.86	$F(3, 126) = 2.17$	ns

Note: Levels of *unknown* and *not applicable* were dropped for this analysis. ns = not significant.

There were no statistically significant differences found for self-report SDQ scores based on the delay between the first abusive event and discovery/identification ($p > .05$). Chi-square tests did not illustrate and significant results as to whether risk of diagnosis depended on delay in identification ($p > .05$).

Residence of alleged perpetrator: When MANOVAs were run, there were no significant differences in parent-report SDQ scores based on residence of the alleged perpetrator ($p > .05$). A statistically significant difference in adolescent self-report of SDQ scores was found based on alleged perpetrator residence, $F(18, 269) = 1.69$, $p = .040$; Wilk's $\lambda = 0.738$. However, univariate tests showed no significant differences in the dependent variables based on alleged perpetrator residence; the only dependent variable that approached significance was self-report of hyperactivity problems ($p = .065$). Chi-square tests did not illustrate any significant results to indicate risk of diagnosis was dependent on *residence of alleged perpetrator* ($p > .05$).

Presented due to sexual abuse: Differences in parent-report SDQ scores based on referral due to sexual abuse only approached significance ($p = .053$). However, for self-report scores, there were significant differences for children referred due to concerns of sexual abuse, compared to those referred for other reasons (see Table 25). Children who were referred due to sexual abuse concerns had significantly higher self-report scores of pro-social behaviour compared to those who were not. No other differences were significant ($p > .05$).

Table 25
Significant MANOVA and Chi-square results for Presented due to sexual abuse

	Presented due to sexual abuse				Statistic	<i>p</i> value
	Yes		No			
	M	SD	M	SD		
Self report SDQ					$F(6, 97) = 2.36$, $\lambda = 0.873$	.036
Total difficulties	16.0	4.65	15.0	4.85	$F(1, 102) = 0.77$	ns
Emotional symptoms	4.85	2.24	3.94	2.63	$F(1, 102) = 2.64$	ns
Behavioural problems	3.24	1.95	3.40	1.71	$F(1, 102) = 0.11$	ns
Hyperactivity score	5.23	2.02	4.52	1.88	$F(1, 102) = 2.21$	ns
Peer problems	2.71	1.88	3.18	1.65	$F(1, 102) = 1.16$	ns
Pro-social behaviour	7.93	1.73	6.74	2.27	$F(1, 102) = 7.10$	.009
Impact	2.17	2.27	1.83	2.34	$F(1, 102) = 0.38$	ns
Risk of Diagnosis	N	%	N	%		
Risk of emotional disorder					$\chi^2(2) = 6.362$	.042
- Low	79	62.2	43	81.1		
- Medium	24	18.9	6	11.3		
- High	24	18.9	4	7.5		

Note. ns = not significant.

A chi-square analysis revealed a significant relationship between referral due to sexual abuse and risk of an emotional disorder. Results illustrated that, for the group of children who did not present due to sexual abuse concerns, fewer than expected were at high risk of an emotional disorder, whereas for those who did present due to sexual abuse concerns, a greater number than expected were at high risk of an emotional disorder. No significant relationships were found based on whether or not the child was referred due to sexual abuse and risk of diagnosis ($p > .05$).

Sexual abuse found: When MANOVAs were run, no significant differences were identified based on whether sexual abuse was found to have happened or not, for both parent and self-report SDQ scores ($p > .05$). A chi-square test for independence revealed significant relationships between whether sexual abuse was found or not and risk of any diagnosis, as well as risk of an emotional disorder (see Table 26). The expected count assumption was violated, and Fisher's Exact Tests showed a p value of .018 and .019 for risk of any diagnosis and risk of an emotional disorder, respectively. Results showed that in the no evidence of sexual abuse group, fewer children than expected were at medium or high risk of any diagnosis/risk of an emotional disorder, and more than expected were at low risk of any diagnosis/risk of an emotional disorder. The standardised residuals indicated that in the definite sexual abuse group, a greater number of children than expected were at medium or high risk of an emotional disorder. There were no significant relationships based on whether or not sexual abuse was found for risk of a behavioural disorder, or risk of a hyperactivity/concentration disorder ($p > .05$).

Table 26
Significant Chi-square results for Sexual abuse found

	No evidence		Sexual Abuse Found				Statistic	p
	N	%	Unable to determine	Probable abuse	Definite abuse			
Risk of Diagnosis								
Risk of any diagnosis							$\chi^2 (6) = 15.003$	.020
- Low	37	62.7	4	80.0	6	66.7	40	37.4
- Medium	7	11.9	0	0.00	0	0.00	26	24.3
- High	15	25.4	1	20.0	3	33.3	41	38.3
Risk of emotional disorder							$\chi^2 (6) = 14.080$	.029
- Low	49	83.1	4	80.0	7	77.8	62	57.9
- Medium	6	10.2	0	0.00	2	22.2	22	20.6
- High	4	6.8	1	20.0	0	0.00	23	21.5

Sexual abuse first identified: When MANOVAs were run, there were no significant differences in parent and self-report SDQ scores based on how the sexual abuse was identified ($p > .05$). Chi-square analyses found no significant results to suggest that risk of diagnosis was dependent on how the sexual abuse was identified ($p > .05$).

Who the sexual abuse was disclosed to: Cases in which sexual abuse was *not disclosed* were dropped from this analysis to allow for meaningful interpretation. MANOVAs showed no significant differences in parent or self-report SDQ scores based on who the sexual abuse was disclosed to ($p > .05$). Nor were any significant relationships found between who the sexual abuse was disclosed to and risk of diagnosis ($p > .05$).

Age at first sexual abuse: This variable included a *0 to 3 years* category, as although no children younger than 4 years had an SDQ completed, file information indicated that some children 4 years and older who presented to Puawaitahi were first sexually abused before they were 4 years old. When a MANOVA was run, statistically significant differences in parent-report SDQ scores were found based on the age at first sexual abuse incident (see Table 27). This was due to significant differences in mean impact scores based on age at first sexual abuse incident. Post hoc analyses with Bonferroni corrections showed that parent-report SDQ impact scores were higher for children who had experienced the first event of sexual abuse between the ages of *0 to 3 years* compared to *4 to 7 years* ($p = .014$), *8 to 10 years* ($p = .001$), *11 to 13 years* ($p = .006$), and *14 to 16 years* ($p = .029$).

Table 27
Significant MANOVA and Chi-square results for Age at first sexual abuse

	Age Group										Statistic	<i>p</i>
	0-3		4-7		8-10		11-13		14-16			
	M	SD	M	SD	M	SD	M	SD	M	SD		
Parent-report SDQ											$F(24, 294) =$	.045
											1.576, $\lambda = 0.656$.	
Total difficulties	19.8	7.86	12.7	7.88	13.7	7.2	13.8	6.23	11.5	5.76	$F(4, 89) = 1.71$	ns
Emotional symptoms	5.33	2.88	3.72	2.81	4.05	2.67	3.91	2.50	3.15	1.78	$F(4, 89) = 0.91$	ns
Behavioural problems	3.83	3.13	2.84	2.84	2.33	1.65	2.76	2.04	2.17	1.86	$F(4, 89) = 0.78$	ns
Hyperactivity score	7.00	1.67	4.31	2.80	4.81	2.70	4.29	2.60	3.50	1.96	$F(4, 89) = 2.32$	ns
Peer problems	3.67	2.07	1.85	1.37	2.50	1.86	2.83	1.88	2.67	1.81	$F(4, 89) = 1.78$	ns
Pro-social behaviour	8.17	1.83	8.28	2.11	8.19	1.50	8.13	1.78	8.17	1.69	$F(4, 89) = 0.02$	ns
Impact	5.29	3.15	1.81	2.67	0.99	1.90	1.52	2.27	1.94	1.95	$F(4, 89) = 4.14$	.004

Note. ns = not significant. Some children who presented to Puawaitahi were first sexually abused before they were 4 years old, resulting in the *0 to 3 years* category.

There were no statistically significant differences found for self-report SDQ scores based on age at first sexual abuse incident ($p > .05$). Chi-square tests revealed no statistically significant relationships between age at first incident of sexual abuse and risk of diagnosis ($p > .05$).

Type of sexual abuse: No significant differences in parent and self-report SDQ scores were found based on *type of sexual abuse* when MANOVAs were conducted ($p > .05$). Chi-square analysis indicated a significant relationship between type of sexual abuse and risk of any diagnosis, and risk of a hyperactivity/concentration disorder (refer to Table 28). As the expected cell count assumption was violated, a Fisher's Exact Test was run, and results were in agreement for both risk of any diagnosis ($p = .010$) and risk of a hyperactivity/concentration disorder ($p = .026$). For risk of any diagnosis, the largest standardised residuals indicated that fewer children than expected in the *contact sexual abuse involving attempted or completed vaginal, oral, or anal intercourse* group were at low risk of any diagnosis, and a greater number of these children than expected were at a high risk of any diagnosis. For risk of a hyperactivity/concentration disorder, the largest standardised residuals indicated that in the *no indication of sexual abuse* group, a greater number of children than expected were at low risk of any diagnosis, and fewer of these children than expected were at a medium risk of a hyperactivity/concentration disorder. No significant relationships were found based on type of sexual abuse for risk of an emotional disorder, or risk of a behavioural disorder ($p > .05$).

Table 28
Significant Chi-square results for Type of sexual abuse

Risk of Diagnosis	No Indication		Non-contact		Contact no intercourse		Contact involving intercourse		Statistic	<i>p</i>
	N	%	N	%	N	%	N	%		
Risk of any diagnosis									$\chi^2 (6) = 16.102$	.011
- Low	9	16.1	3	5.4	27	48.2	17	30.4		
- Medium	0	0.0	2	7.7	10	38.5	14	53.8		
- High	1	2.2	1	2.2	16	35.6	27	60		
Risk of hyperactivity disorder									$\chi^2 (3) = 9.076$	.028
- Low	10	10.6	6	6.4	41	43.6	37	39.4		
- Medium	0	0.0	0	0.0	12	36.4	21	63.6		
- High	0	0.0	0	0.0	0	0.0	0	0.0		

Frequency of sexual abuse: When MANOVAs were run, no statistically significant differences were obtained for SDQ scores based on frequency of sexual abuse ($p > .05$). Chi-

square analysis illustrated a relationship between frequency of sexual abuse and risk of any diagnosis (see Table 29). The largest standardised residuals indicated that in the *no indication of sexual abuse group*, more children than expected were at low risk of any diagnosis, and fewer than expected were at medium or high risk of any diagnosis. A greater number of children than expected in the *chronic abuse group* were at high risk of any diagnosis. No significant relationships were found between frequency of sexual abuse and risk of an emotional, behavioural, or concentration disorder ($p > .05$).

Table 29
Significant Chi-square results for Frequency of sexual abuse

	No Indication		One known event		Repeated events		Chronic abuse		Statistic	<i>p</i>
	N	%	N	%	N	%	N	%		
Risk of any diagnosis									$\chi^2 (6) = 14.879$	.019
- Low	9	90.0	27	42.4	16	44.4	4	23.5		
- Medium	0	0.0	17	26.6	6	16.7	3	17.6		
- High	1	10.0	20	31.3	14	38.9	10	58.8		

Number of alleged sexual abuse perpetrators: MANOVA results showed no significant differences in parent or self-report SDQ scores based on the number of alleged sexual abuse perpetrators ($p > .05$). Chi-square analysis illustrated a relationship between the number of alleged sexual abuse perpetrators and risk of any diagnosis ($\chi^2 (4) = 9.960$, $p = .041$). However, as too many cells had expected counts < 5 , Fisher's Exact Test was run and results were not significant ($p > .05$). No significant relationship was found between the alleged number of perpetrators and risk of an emotional, behavioural, or hyperactivity/concentration disorder ($p > .05$).

Sexual abuse perpetrator relationship: No significant differences in SDQ scores, or significant relationships with risk of diagnosis, were found based on the relationship between the victim and alleged sexual abuse perpetrator ($p > .05$).

Sexual abuse intrafamilial or extrafamilial: When MANOVAs were conducted, there were no statistically significant differences in parent or self-report SDQ scores based on whether the abuse was intrafamilial or extrafamilial ($p > .05$). Chi-square analysis illustrated a relationship between whether the abuse was intrafamilial or extrafamilial and risk of any

diagnosis ($\chi^2_{(4)} = 10.696, p = .030$). As the expected counts assumption was violated, Fisher's Exact Test was run and was found to be in agreement ($p = .043$). However, the largest standardised residuals were for the *not applicable* group (i.e. no evidence of sexual abuse found), and when this level was dropped no results were significant. Therefore, the significant relationship was probably related to whether or not the child/young person had experienced sexual abuse, rather than whether the sexual abuse was intrafamilial or extrafamilial. No significant relationships were found between whether the abuse was intrafamilial or extrafamilial, and risk of an emotional, behavioural, or concentration disorder ($p > .05$).

Age of alleged sexual abuse perpetrator: There were no significant group differences found for parent and self-report SDQ scores when MANOVAs were run. Nor were any significant relationships found with risk of diagnosis when chi-square tests were used ($p > .05$).

Physical abuse variables: When physical abuse variables were analysed using MANOVAs and Chi-square tests, no significant results were apparent for any of the variables of interest. These included *presented due to physical abuse, physical abuse found, physical abuse first identified, alleged physical abuse perpetrator relationship, physical abuse intrafamilial or extrafamilial, type of physical abuse, severity of physical abuse, frequency of physical abuse, and number of alleged physical abuse perpetrators.*

Police involvement and previous Police involvement: When MANOVA's were conducted, no significant results were found to suggest that SDQ scale scores and subscale scores differed based on whether or not the *Police were currently involved*, or whether or not there was *previous Police involvement* with the child or their family ($p > .05$). Additionally, no significant relationships were found when chi-square tests were used ($p > .05$).

CYF involvement: MANOVAs did not show any significant differences in parent or self-report SDQ scores based on whether or not CYF were currently involved with the child or their family ($p > .05$). Chi-square tests showed no support against the null hypothesis that risk of diagnosis and current CYF involvement were independent ($p > .05$).

Previous CYF involvement: There was a statistically significant difference in parent report of SDQ scores based on whether CYF was previously involved with the child or their family (refer to Table 30). Univariate tests indicated that compared to children whose families had not

previously been involved with CYF, children whose families had previously been involved with CYF had higher scores of behavioural difficulties and lower scores of pro-social behaviour. There were also statistically significant differences in adolescent self-report of SDQ scores based on whether CYF were previously involved with the adolescent/their family. Self-reported peer problems were higher for adolescents who had families previously involved with CYF compared to those who did not, and self-reported pro-social behaviour was lower for adolescents who had families previously involved with CYF compared to those who did not.

Table 30
Significant MANOVA and Chi-square results for Previous CYF involvement

	Yes		No/unknown		Statistic	p
	M	SD	M	SD		
Parent report SDQ					$F(6, 139) = 2.811, \lambda = 0.892$	
Total difficulties	13.4	7.90	11.8	6.62	$F(1, 144) = 1.73$	ns
Emotional symptoms	3.3	2.56	3.6	2.55	$F(1, 144) = 0.41$	ns
Behavioural problems	3.1	2.55	2.0	1.84	$F(1, 144) = 8.12$	.005
Hyperactivity score	4.5	2.67	3.8	2.36	$F(1, 144) = 2.92$	ns
Peer problems	2.5	2.13	2.4	1.79	$F(1, 144) = 0.06$	ns
Pro-social behaviour	7.7	2.12	8.6	1.51	$F(1, 144) = 8.91$	.003
Impact	1.8	2.51	1.6	2.33	$F(1, 144) = 0.32$	ns
Self report SDQ					$F(6, 97) = 3.350, \lambda = 0.828$	.005
Total difficulties	16.3	4.61	15.2	4.77	$F(1, 102) = 1.37$	ns
Emotional symptoms	4.4	2.21	5.0	2.51	$F(1, 102) = 1.22$	ns
Behavioural problems	3.6	1.90	2.9	1.85	$F(1, 102) = 3.01$	ns
Hyperactivity score	5.1	2.18	5.0	1.77	$F(1, 102) = 0.13$	ns
Peer problems	3.2	2.04	2.3	1.40	$F(1, 102) = 5.14$	.025
Pro-social behaviour	7.1	1.91	8.4	1.64	$F(1, 102) = 13.61$	<.001
Impact	1.9	2.00	2.4	2.61	$F(1, 102) = 1.01$	ns
Risk of Diagnosis	n	%	n	%		
Risk of emotional disorder					$\chi^2(2) = 10.513$	.005
- Low	70	65.4	52	71.2		
- Medium	25	23.4	5	6.8		
- High	12	11.2	16	21.9		
Risk of behavioural disorder					$\chi^2(2) = 7.506$	.023
- Low	59	55.1	54	74.0		
- Medium	21	19.6	11	15.1		
- High	27	25.2	8	11.0		

Note. ns = not significant.

Chi-square analyses indicated significant relationships between previous CYF involvement and risk of an emotional disorder, and risk of a behavioural disorder. With regard to risk of an emotional disorder, the largest standardised residual showed that, within the group who had

families that were not previously involved with CYF, fewer than expected were at medium risk of an emotional disorder. Within the group who had families that had been previously involved with CYF, a higher number than expected were at medium risk of an emotional disorder. In terms of risk of behavioural disorder, the largest standardised residuals indicated that, within the group who had families that were not previously involved with CYF, fewer than expected were at a high risk of a behavioural disorder, and more than expected were at a low risk of a behavioural disorder. However, within the group who had families that were previously involved with CYF, a greater number than expected were at high risk of a behavioural disorder. No significant relationships were found for risk of any diagnosis, or risk of a hyperactivity/concentration disorder, based on whether or not CYF had previously been involved ($p > .05$).

Total time spent in care: A MANOVA showed a statistically significant difference in parent-report of SDQ scores based on time in care (refer to Table 31). Statistically significant differences were found based on time in care for parent report of behavioural difficulties, peer problems, pro-social behaviour, and impact. Post hoc analyses with Bonferroni corrections did not indicate any significant differences for parent report of behavioural difficulties based on time in care. Post hoc tests did indicate that parent report of peer problems for children who had spent *no time in care* was significantly lower than children who had spent *less than a month in care*. Peer problem subscale scores were also significantly higher for children who had spent *less than a month in care* compared to those who had spent *one month to a year inclusive* in care. Parent report of pro-social behaviour was significantly higher for children who had spent *one month to a year* in care, compared to those who had spent *more than one to five years* in care, or *more than five years in care*. Finally, parent report of impact was significantly higher for children who had been in care *more than five years*, compared to children who had *never been in care*, or children who had been in care for *one month to a year inclusive*. Statistically significant differences were also evident in adolescent self-report SDQ scores based on time in care, due to group differences in emotional difficulties scores. Post hoc analyses with Bonferroni corrections indicated that people who had been in care for *less than a month* had higher self-report scores of emotional difficulties than people who had been in care *for more than a year to five years inclusive*.

Table 31
Significant MANOVA and Chi-square results for Time in care

	No time		< 1 month		1 month – 1 year		1 year – 5 years		> 5 years		Statistic	p
	M	SD	M	SD	M	SD	M	SD	M	SD		
Parent-report SDQ											$F(24, 476) =$	.018
											1.73, $\lambda = 0.747$	
Total difficulties	12.5	7.16	22.2	3.82	9.8	6.31	13.3	8.62	15.9	9.99	$F(4, 141) = 2.12$	ns
Emotional symptoms	3.5	2.50	5.7	2.52	2.9	2.63	2.8	2.62	3.0	3.16	$F(4, 141) = 0.92$	ns
Behavioural problems	2.5	2.16	5.0	1.00	1.8	2.24	3.3	3.16	4.7	3.09	$F(4, 141) = 3.00$	.021
Hyperactivity score	4.2	2.60	5.8	1.44	3.2	2.83	4.2	2.04	4.9	2.41	$F(4, 141) = 0.88$	ns
Peer problems	2.3	1.86	5.7	0.58	1.9	1.20	3.0	2.67	3.3	3.15	$F(4, 141) = 2.98$	.021
Pro-social behaviour	8.2	1.78	8.0	0.00	9.0	1.35	6.6	2.76	6.1	2.61	$F(4, 141) = 4.39$	.002
Impact	1.6	2.28	3.7	1.53	0.9	1.66	1.9	2.81	4.4	3.92	$F(4, 141) = 3.16$	.016
Self-report SDQ											$F(24, 329) =$	.028
											1.66, $\lambda = 0.671$	
Total difficulties	15.6	4.59	17.8	3.76	14.7	5.46	17.8	4.23	15.5	10.61	$F(4, 99) = 0.84$	ns
Emotional symptoms	4.6	2.24	6.9	1.68	4.4	3.06	3.1	1.55	5.5	3.54	$F(4, 99) = 2.65$	.037
Behavioural problems	3.1	1.83	3.4	1.80	3.0	1.94	4.6	2.07	4.5	3.54	$F(4, 99) = 1.42$	ns
Hyperactivity score	5.2	2.04	4.0	1.83	4.3	1.77	6.4	1.51	3.5	0.71	$F(4, 99) = 2.19$	ns
Peer problems	2.6	1.69	3.6	1.90	3.0	1.63	3.6	2.97	2.0	2.83	$F(4, 99) = 0.97$	ns
Pro-social behaviour	7.8	1.81	7.5	2.04	7.8	1.48	6.4	3.02	6.5	0.71	$F(4, 99) = 1.31$	ns
Impact	1.8	2.18	4.3	2.81	2.4	2.05	2.5	2.27	2.0	2.83	$F(4, 99) = 2.12$	ns
Risk of Diagnosis	N	%	N	%	N	%	N	%	N	%		
Risk of emotional disorder											$\chi^2(8) = 23.376$	.003
- Low	92	71.3	1	12.5	12	63.2	12	80.0	5	55.6		
- Medium	18	14.0	2	25.0	4	21.2	2	13.3	4	44.4		
- High	19	14.7	5	62.5	3	15.8	1	6.7	0	0.0		

Note. ns = not significant.

Chi-square analyses indicated a significant relationship between time in care and risk of an emotional disorder. Since the expected counts assumption was violated, a Fisher's Exact Test was run, and results were in agreement ($p = .006$). The largest standardised residuals indicated that in the group who had been in care for *less than a month*, fewer than expected were at a low risk of an emotional disorder, and a greater number than expected were at a high risk of an emotional disorder. Additionally, of those who had spent *more than five years* in care, a greater number than expected were at a medium risk of an emotional disorder. No significant relationships were found between time in care and risk of any diagnosis, risk of a behavioural disorder, or risk of a concentration disorder ($p > .05$).

Number of CYF placements: MANOVAs did not reveal any statistically significant differences in parent or self-report SDQ scored based on number of CYF placements ($p > .05$).

Similarly, Chi-square tests did not show any significant results to suggest that risk of diagnosis depended on number of CYF placements ($p > .05$).

Number of home transitions: Despite number of home transitions being significantly correlated with several SDQ scale and subscales scores, when this variable was categorised MANOVAs did not reveal any statistically significant differences in parent or self-report SDQ scores ($p > .05$). Nor did chi-square tests show any significant results to suggest that risk of diagnosis depended on number of home transitions ($p > .05$).

Evidence of exposure to drug use/alcohol abuse within family: No significant differences were found in SDQ scores with regard to whether there was evidence of exposure to drug use/alcohol abuse within the family ($p > .05$). No significant results were found when chi-square tests were run to suggest that risk of diagnosis depended on whether or not the child was exposed to drug use or alcohol abuse within their family ($p > .05$).

Family history of physical abuse: No statistically significant differences were found for parent report SDQ scores based on whether or not there was a history of physical abuse within the family of origin ($p > .05$). However, a one way MANOVA showed a statistically significant difference in adolescent self-report of SDQ scores, based on whether there was a family history of physical abuse (refer to Table 32). When file information indicated that there was a history of physical abuse within the family, adolescents reported higher peer problems scores and lower pro-social behaviour scores. No significant results were found using chi-square tests ($p > .05$).

Table 32
Significant MANOVA results for Family history of physical abuse

	Yes		No/Unknown		Statistic	<i>p</i>
	M	SD	M	SD		
Self-report SDQ					$F(6, 97) = 2.771 \lambda = 0.854$	.016
Total difficulties	15.9	4.30	15.8	5.12	$F(1, 102) = 0.00$	ns
Emotional symptoms	4.4	2.30	5.0	2.37	$F(1, 102) = 1.77$	ns
Behavioural problems	3.5	1.92	3.1	1.86	$F(1, 102) = 1.26$	ns
Hyperactivity score	4.8	1.90	5.4	2.08	$F(1, 102) = 2.50$	ns
Peer problems	3.2	2.06	2.4	1.44	$F(1, 102) = 6.02$	.016
Pro-social behaviour	7.2	1.85	8.1	1.88	$F(1, 102) = 5.97$	.016
Impact	2.0	2.07	2.2	2.50	$F(1, 102) = 0.08$	ns

Note. ns = not significant

Parent/caregiver belief: The level *not applicable* was dropped for these analyses. MANOVA results indicated statistically significant differences for parent report of SDQ scores, in relation to whether or not the parent/caregiver believed the child (see Table 33). Parent report of SDQ total difficulties, behavioural problems, and hyperactivity symptoms were higher for children for whom there was an indication that they were not believed, as opposed to children who were believed/no indication that they were not believed. Furthermore, parents/caregivers rated children who were not believed as displaying less pro-social behaviour than those who were believed. There were no statistically significant differences found for self report SDQ scores, based on whether or not the adolescent was believed by their parent ($p > .05$).

Table 33
Significant MANOVA results for Parent/caregiver belief

	Yes/Unknown		No		Statistic	<i>p</i>
	M	SD	M	SD		
Parent report SDQ					$F(6, 113) = 2.787 \lambda = 0.871$	.014
Total difficulties	12.5	7.10	16.8	7.41	$F(1, 118) = 5.71$	.018
Emotional symptoms	3.5	2.41	4.4	2.85	$F(1, 118) = 1.86$	ns
Behavioural problems	2.5	2.12	3.8	2.67	$F(1, 118) = 5.71$	.018
Hyperactivity score	4.1	2.67	5.6	2.19	$F(1, 118) = 5.23$	.024
Peer problems	2.4	1.97	3.0	1.83	$F(1, 118) = 1.55$	ns
Pro-social behaviour	8.3	1.75	7.1	2.04	$F(1, 118) = 8.20$	.005
Impact	1.8	2.52	1.6	1.38	$F(1, 118) = 0.06$	ns
Risk of Diagnosis	n	%	n	%		
Risk of behavioural disorder					$\chi^2(2) = 7.181$	.028
- Low	72	66.1	9	37.5		
- Medium	18	16.5	6	25.0		
- High	19	17.4	9	37.5		

Note: ns = not significant.

Chi-square analyses revealed that risk of a behavioural disorder did depend on *parent/caregiver belief*. The largest standardised residuals indicated that for the group of children who were not believed by a parent/caregiver, there were a greater number of cases than expected at high risk of a behavioural disorder, and fewer cases than expected were at low risk of a behavioural disorder. The opposite pattern of results was found for children who did seem to be believed. No significant relationships were found between *parent/caregiver belief* and risk of any diagnosis, risk of an emotional disorder, or risk of a hyperactivity/concentration disorder ($p > .05$).

Discussion

The current study involved a file audit which explored the psychological well-being of 180 children who presented to Puawaitahi over a four month period, and investigated what characteristics were associated with internalising and externalising difficulties for these children. Key findings were that a large proportion of children who presented to Puawaitahi were experiencing emotional, behavioural, hyperactivity/concentration, and peer problems.

Children who were particularly vulnerable to such difficulties were male, older, resided with a non-kin caregiver, and had maltreatment that was not identified within the first week that it occurred. A greater degree of invasiveness and a higher frequency of sexual abuse were linked with higher levels of internalising and externalising symptoms. Children from families who had been involved with CYF previously had more behavioural issues and lower levels of pro-social behaviour, and the period just following transition into care appeared to be particularly emotionally distressing for young people. Finally, greater difficulties were found for children from families in which there was a past or present indication of physical abuse, and for children who were not believed by a parent/caregiver following disclosure.

Scores on the SDQ

Of all children who presented to Puawaitahi during a four month period, 153 had a parent/caregiver report SDQ completed, and 107 had completed a self-report SDQ. For adolescents who had both a parent-report and self-report SDQ ($n = 80$), results showed that adolescents rated themselves as having greater difficulties than parents/caregivers. It is possible that this is because parents and caregivers only have behavioural data to base their reports on, whereas adolescents may give more accurate accounts given that they are privy to their own internal experiences. For instance, Karver (2006) found that parent and child reports of psychological difficulties were in closer agreement when reporting on behaviours that were more salient and observable. Alternatively, involvement with child protection agencies may be anxiety-provoking for some parents and caregivers, and therefore they may minimise reports of child difficulties.

According to the SDQ website (Goodman, 2000), approximately 10% of a community sample would have parent and self-report symptom scores within the Borderline Range, and about a further 10% would have parent and self-report symptom scores within the Abnormal Range. The present sample had well over 10% in the Abnormal Range for all parent report

scores except pro-social behaviour. Furthermore, the percentage of cases that fell within the Borderline Range greatly exceeded 10% for emotional symptoms and conduct problems. In terms of self-report, more than 20% of cases fell in the Abnormal Range for total difficulties, emotional difficulties, behavioural problems, and hyperactivity/concentration problems. Additionally, the percentage of cases in the Borderline Range for total difficulties and peer problems greatly exceeded 10%. Therefore, a far greater proportion of this sample experienced internalising and externalising difficulties in the Abnormal or Borderline Range, than would be expected in a general community sample.

Compared to normative parent-report scores from a sample of Australian children and adolescents (Mellor, 2005), SDQ scores in the current study were substantially higher for total difficulties, emotional difficulties, behavioural problems, hyperactivity/concentration problems, and peer problems. This indicates a greater level of distress in the current sample compared to the Australian normative sample. Compared to scores found in the current study, average parent and self-report scores of pro-social behaviour were slightly higher in the normative sample, indicating less pro-social behaviour in this sample. The present sample of maltreated adolescents also reported greater difficulties than a New Zealand sample of secondary school students (Black, Pulford, Christie, & Wheeler, 2010), although pro-social scores were similar.

Based on SDQ scores, many of the children who presented to Puawaitahi were considered to be at a medium or high risk of any diagnosis, an emotional disorder, or a behavioural disorder, and close to one quarter were found to be at medium risk of a hyperactivity/concentration disorder. However, just under half of the SDQ subsample was not found to be at risk for any diagnosis.

In conclusion, a high percentage of the present sample experienced emotional, behavioural, hyperactivity/concentration, and social difficulties. These findings are in line with the multitude of studies which show a wide range of sequelae linked with childhood maltreatment (Ackerman et al., 1998; Briere & Elliot, 2003; Hussey et al., 2006; Fergusson et al., 2008; Mullen et al., 1996). However, a large proportion of the sample was also found to be at low risk of these disorders, which supports research which has shown that some children are resilient despite experiences of maltreatment (Finkelhor & Berliner, 1995; Haskett, Nears, Ward & McPherson, 2006; McGloin & Widom, 2001; Williams & Nelson-Gardell, 2012).

Significant Relationships and Group Differences

Child variables: Results revealed that children who were male, older at time of presentation to Puawaitahi, and living with a non-kin caregiver were particularly likely to experience difficulties. Male children tended to experience greater externalising difficulties than female children, which concurs with previous research which showed that males were more likely to have externalising disorders than females following abuse (Ackerman et al., 1998). However, other research by Maikovich-Fong and Jaffee (2010) did not find any differences in caregiver report of behavioural or emotional symptoms based on gender, for children who had been sexually abused. Male adolescents also self-reported greater peer problems than females. It is probable that externalising difficulties function as a mediator between child maltreatment and peer difficulties, as children who are more aggressive and impulsive may have greater problems in forming and maintaining friendships. Indeed, research has shown that aggressive and pro-social behaviours were mediators between CPA and positive or negative social status (Salzinger, Feldman, Ng-Mak, Mojica & Stockhammer, 2001).

Older age at time of presentation to Puawaitahi was associated with risk of any diagnosis and risk of an emotional disorder. Other research has also found that older children who experienced sexual abuse had higher externalising and internalising scores on the CBCL than younger children (Maikovich-Fong & Jaffee, 2010). Furthermore, in a sample of children and adolescents who had experienced sexual abuse, it was found that adolescents reported greater depressive symptoms, lower self-worth, lower social support, and greater negative reactions from others, compared to children (Feiring, Taska & Lewis, 1999). It could be posited that older children may have experienced a greater duration of maltreatment, thereby contributing to the association between age and SDQ outcome scores. Furthermore, sexual and physical abuse at an older age may involve greater force from the perpetrator. Emotional difficulties may also be higher for adolescents as compared to children they may blame themselves more, or people around them may attribute greater responsibility to them for the abuse (Feiring et al., 1999). Furthermore, Steel et al. (2004) revealed that people who had experienced sexual abuse were more likely to feel responsible for its occurrence the older they were at the time of abuse.

Adolescents living with a non-kin caregiver rated impact of difficulties as greater than those living with their biological parents. One explanation for this may be that children living with a non-kin caregiver could have experienced a greater severity of maltreatment which led to them

being uplifted. However, since there were no significant differences in SDQ scores between adolescents living with their biological parents and those living with a whānau caregiver, impact of difficulties may not be as great for children who are placed with extended family rather than a non-kin caregiver. Rubin et al. (2008) found that children who lived with family members were more likely to have stable placements and less likely to have behavioural problems than children in foster care. Other research also found that compared to children in foster care, children placed with family members were more likely to remain in the placement, less likely to have a new notification of abuse or neglect, and less likely to be in contact with the juvenile justice system (Winokur, Crawford, Longobardi & Valentine, 2008). It could be hypothesised that there may be less upheaval to a child's life when staying within their extended family. For instance, they may be more likely to be placed with their siblings, stay in the same area and at the same school, and remain in consistent contact with their biological parents (Berrick, Barth & Needell, 1994). Therefore, this would support current CYF practice in which, if at all possible, children remain with extended family or people known to the family when taken into care (CYF, 2010b).

Maltreatment characteristics: A key finding in relation to maltreatment characteristics was that better outcomes were found when maltreatment was identified soon after it first occurred. Moreover, CSA appeared to be particularly linked with emotional difficulties, and the impact of such difficulties was greatest for children who had been sexually abused prior to 4 years of age. Children who experienced a greater frequency and invasiveness of CSA tended to have higher scores on a number of subscales. In contrast to other research, whether or not the CSA was intra or extra-familial did not appear to have any bearing on SDQ scores. No significant differences were found based on physical abuse variables, although this may be because the subsample of children who presented due to physical abuse was relatively small, and the distribution of cases across groups was very uneven.

Results indicated that parent report of total difficulties, emotional difficulties, behavioural problems, and peer problems were lowest for children who had maltreatment identified within a week of its occurrence. There are several potential mechanisms through which these results could be explained. Early identification of abuse would allow the abuse to be stopped quickly, and research has shown that if disclosure stops sexual abuse this is a protective factor against psychopathology (Bulik et al., 2001). Thus, a longer delay between first maltreatment and identification may lead to a greater frequency of abuse, thereby resulting in poorer outcomes. It

is also possible that children who take longer to disclose experience greater anxiety about the abuse and the consequences of its identification. Finally, it could be conjectured that living for a long time with these concerns and possible feelings of guilt and shame may take a further emotional toll on a young person, and until the maltreatment was identified the victims would be less likely to receive any social or psychological support they may need.

Sexual abuse victimisation appeared to be linked with emotional difficulties. This aligns with extant literature which demonstrates that CSA is linked with internalising difficulties such as anxiety and depression (Fergusson et al., 2008; Goodwin et al., 2005; Manly et al., 2001; Maniglio 2009; Nurcombe, 2000; Putnam, 2003). In a review of reviews Markovich-Fong and Jaffee (2010) also concluded that there were higher internalising scores on the CBCL for children who had sexual abuse substantiated compared to those who did not. Parent-report of impact was highest for children who experienced the first event of sexual abuse between the ages of 0 to 3 years, compared to any other age group. Other research showed that earlier age at onset of sexual abuse was associated with higher trauma scores (Zink, Klesges, Stevens & Decker, 2009), and Manly et al. (2001) found that very early maltreatment posed a high risk to later adaptation. Manly et al. suggested that this period may have a large impact on later adaptation due to the deleterious effects of maltreatment on attachment, as well as the barrier that maltreatment poses in terms of resolution of child developmental tasks.

A greater invasiveness and frequency of sexual abuse was associated with higher reports of total difficulties, emotional difficulties, behavioural problems, attention problems, and life impact. These findings support Maniglio's (2009) conclusion that CSA should be regarded as a nonspecific risk factor for a multitude of psychopathologies. Many studies have revealed connections between more invasive experiences of CSA and poorer outcomes, including higher levels of internalising behaviours (Coohey, 2010), trauma symptoms (Zink et al., 2009), alcohol abuse and psychosis (Cutajar et al., 2010), major depressive disorder, generalised anxiety disorder, bulimia nervosa, and drug dependence (Bulik et al., 2001). Furthermore, Briere and Elliot (1992) found that a greater frequency of CSA was significantly associated with several subscale scores on the Trauma Symptom Checklist-40, and Steel et al. (2004) illustrated that a longer duration of sexual abuse was directly linked with general psychological distress in adulthood. It is possible that a greater frequency and invasiveness of CSA leads to a greater degree of traumatisation, which in turn may result in multiple presenting problems such as those

listed above. Diverse presenting problems may develop following CSA because complex trauma can result in dysregulation in consciousness, emotion, behaviour, self-perception, and functioning in relationships (Ford, Courtois, Steele, van der Hart & Nijenhuis, 2005).

No significant differences or relationships were found based on whether or not the sexual abuse was intrafamilial or extrafamilial. The research is mixed as to whether intrafamilial versus extrafamilial sexual abuse influences psychological outcome. For instance, a review by Barker-Collo and Read (2003) indicated that intrafamilial CSA was related to poorer outcomes than extrafamilial CSA, although Coohy (2010) found that sexual abuse by a non-relative was linked with a greater likelihood of internalising difficulties than sexual abuse by a relative. Briere and Elliot (2003) did not find any differences in psychological symptoms based on whether sexual abuse was intrafamilial or extrafamilial. It is possible that no differences were found in the current study because both intrafamilial and extrafamilial sexual abuse are traumatic but in different ways. For instance, if the abuse is intrafamilial the child may feel a greater sense of betrayal, they may be more likely to receive disbelieving responses, they may experience more disruption to their life such as fragmentation of their family, and the abuse may be more chronic (Beitchman et al., 1992), whereas extrafamilial sexual abuse may involve greater use of force, threats and violence.

Authority involvement: Previous CYF involvement, time in care, and number of CYF placements all affected SDQ scores. Parent-report of behavioural symptoms was higher and parent-report of pro-social behaviour was lower when CYF had previously been involved with the child or their family. Furthermore, adolescents scored themselves as having more peer problems and engaging in less pro-social behaviour when CYF had previously been involved with their family of origin. Other research has shown that child behaviour problems increased as time since child protective services investigation lengthened (Campbell et al., 2010), and Manly et al. (1994) found that as the number of reports to child protection services increased, peer report of pro-social behaviour decreased. It could be posited that previous CYF involvement reflects a greater degree of enduring family dysfunction, which would thereby result in greater behavioural difficulties and lower pro-social behaviour for children, which in turn would negatively impact peer interactions.

A greater number of children than expected were at high risk of an emotional disorder when they had been in care for less than a month. Children who had been in care for less than a month

were also reported to have greater parent-reported peer problems than those who had spent more than a year in care, and greater self-reported emotional difficulties than children who had been in care for more than a year to five years. These results were not unexpected given that the period just following transition into a placement with family members or foster carers is known to be a particularly difficult time for children and adolescents (CYF, 2010b). Placement into care is often a sudden and immense change which can also involve ambiguity about reasons for the placement and whether contact with parents will be maintained. Qualitative research identified that many children reported experiencing fear, anxiety, sadness, and anger when notified that they were being placed into care (Mitchell & Kuczynski, 2010). It is understandable that children would experience emotional difficulties upon transition into care, given that they have to contend with a new living environment, new relationships, and grief and loneliness due to disconnection from family.

Correlations showed that a higher number of CYF placements was associated with lower parent-reported pro-social behaviour, and higher self-reported behavioural problems. Barber, Delfabbro, and Cooper (2001) found that children with psychological or behavioural difficulties were the most likely to experience a placement breakdown, and the least likely to show enhanced adjustment when in care. Other research has shown that unstable placement histories result in deleterious psychological and behavioural impacts, especially for children who have experienced multiple placement breakdowns (Newton, Litrownik & Landsverk, 2000). Newton et al. concluded that behavioural difficulties both caused and were a consequence of placement breakdowns. Thus, there appears to be a negative spiral in which children who have been maltreated develop challenging behaviours which are then exacerbated by the upheaval of transitioning into care. When caregivers are unable to cope with the behaviour of the distressed child the placement breaks down, resulting in another transition for the child. Consequently, symptoms may worsen and increase vulnerability to future placement breakdowns, thereby preventing the obtainment of a stable environment for the children who need it most.

Family characteristics: SDQ scores were found to differ based on whether or not there was past or present physical abuse within the child's family, and whether or not the child was believed following disclosure. Adolescents scored themselves as having greater peer problems and engaging in less pro-social behaviour when there was evidence that there had been past or present physical abuse within their family. It is likely that a large proportion of these children

were victims of the physical abuse that occurred within their family. Research by Kim and Cicchetti (2010) illustrated that children who were physically maltreated had more difficulties with emotion regulation than non-maltreated children, which may have resulted in aggressive interactions with peers and consequent social rejection. The findings of the current study are also supported by research with a large sample of Finnish and Danish adolescents, in which the experience of parental violence was linked with a reduction in self reported SDQ pro-social behaviour (Peltonen, Ellonen, Larsen & Helweg-Larsen, 2010).

Results showed that children who were not believed following disclosure had greater parent report scores of externalising difficulties and lower pro-social behaviour compared to those who were believed. It could be argued that children who show greater externalising symptoms and lower pro-social behaviour are less likely to be believed about the abuse by their parents/caregivers, rather than lack of belief causing the higher externalising symptoms and lower pro-social behaviour. However, Bulik et al. (2001) also found that negative responses to sexual abuse disclosure, including lack of parental belief, were associated with negative outcomes in adulthood such as generalised anxiety, panic disorder, and substance abuse. Furthermore, other research has shown that children who feel supported by their parents following the experience of sexual abuse show lower externalising behaviours and more positive evaluations of self-worth (Tremblay, Hébert & Piché, 1999).

Limitations

Limitations outlined for study one are also applicable to this study (see page 48), and additional limitations particular to the current study are discussed here. A large proportion of the overall sample did not have an SDQ completed for various reasons. These included that the child was under the age of 4 years, the child was accompanied by an adult who was not their caregiver or parent, or the young person was in such a distressed state that they were not able to complete the self-report questionnaire. It is possible that there may have been differences (in addition to age) between those children who had at least one completed SDQ and those children who did not. As the SDQ can only be completed for children aged 4 and over, the study does not illustrate the psychological and behavioural impact of maltreatment on very young children.

Furthermore, the SDQ is a rather general measure of strengths and difficulties and does not include symptoms of traumatic stress which can commonly result from maltreatment. Due to practical considerations of time required to complete questionnaires, it had been intended that a

two tiered approach would be employed, in which trauma measures would be completed for children identified to have difficulties on the SDQ: specifically the Child Report of Post-traumatic Symptoms and the Parent Report of Post-traumatic Symptoms (Greenwald & Rubin, 1999). However, not enough of these measures were obtained to enable statistical analysis, so only the SDQ was utilised.

The study aimed to explore links between sexual abuse, physical abuse, DV, and neglect. As most children were referred due to sexual abuse concerns, and fewer were referred due to physical abuse, neglect, or DV, there was less statistical power to identify significant relationships and differences for children not referred due to sexual abuse. Emotional maltreatment was not explored as a particular subtype of abuse in this study. This was because emotional abuse tends to be inherent in other forms of abuse, and information on emotional abuse may not have been reliably recorded when children presented due to concerns such as sexual or physical abuse.

Multiple analyses were run in this study, and therefore results should be interpreted with caution given that this increases the risk of Type 1 error. Since this study was observational rather than experimental for obvious reasons, causal links between factors of interest and psychological and behavioural difficulties cannot be drawn. This is because the direction of the relationships cannot be determined, and there may be a third variable that is acting as a mediator or moderator of the relationships.

Chapter Four: Study Three

The previous study illustrated that a large proportion of children who presented to Puawaitahi experienced problems in domains of behaviour, emotion, hyperactivity and attention, and peer interaction. Characteristics that may leave children particularly vulnerable to such difficulties were identified, including male gender, older age at presentation, earlier age at onset of sexual abuse, greater invasiveness of sexual abuse, previous CYF involvement, a high number of home transitions, recent placement into care, and a lack of parental belief about the abuse. Whilst it was likely that many of these children may have benefited from psychological support following presentation to Puawaitahi, it was not known whether any of these children or their parents had been able to subsequently access support services. Therefore, the primary aim of the present study was to examine what support services were needed in the opinion of caregivers and what support services were actually accessed by Puawaitahi clients and their family/whānau, and to explore potential barriers to therapy uptake.

Puawaitahi, New Zealand's first multiagency centre for the investigation of child abuse, arose from research highlighting poor inter-agency communication, a lack of case management co-ordination, unacceptable time delays, and poor information provision and access to support (Davies & Seymour, 1999; Davies et al., 2001). Given that Puawaitahi was created with aspirations of improving these features of child abuse investigation, a second aim of this study was to explore service user perspectives of Puawaitahi, and whether or not these issues appeared to be addressed by the new structure. This aim was of particular interest to Puawaitahi staff.

Recruitment occurred over a four month period. Initially it was hoped that a greater number of parent and caregivers would be recruited for this study from every agency within Puawaitahi. However, obtaining appropriate permissions for the study took longer than expected, and by the time the data collection period started necessary approvals had only been obtained for Te Puaruruhau, the health agency within Puawaitahi. Therefore, only Te Puaruruhau staff could recruit participants, resulting in 25 people consenting to being contacted for a telephone interview. Consequently, findings primarily relate to Te Puaruruhau, although in some cases participants had also been seen by other agencies in Puawaitahi and talked about these experiences. There was not enough statistical power to perform statistical analyses on the data, so only the qualitative approach of thematic analysis (Braun & Clarke, 2006) was adopted.

Method

Setting

This research was conducted at Puawaitahi, a multi-agency service that investigates alleged child maltreatment, provides children with some physical health treatment and psychological support following abuse, and links children and their families with services that can provide further treatment following abuse. Refer to page 33 for a more comprehensive description of Puawaitahi.

Participants

A total of 22 parents and caregivers were contacted for telephone interviews three months after initial presentation to Puawaitahi. Te Puaruruhau staff provided parents and caregivers with participant information sheets (see Appendix B), and were asked if they would like to be involved in the study. As agreed with service leaders from Puawaitahi and the Regional X Health and Disabilities Ethics Committee, inclusion criteria for recruitment included that the person provided written informed consent (see Appendix C), and that the person was a parent or caregiver of a child who presented to Puawaitahi within the given four month period. Exclusion criteria were that the parent/caregiver was thought to be the perpetrator of maltreatment, or the parent/caregiver could not converse well in either English or Māori. There were three people who agreed to take part but were not interviewed because they were unable to be contacted or they met the exclusion criteria.

The majority of parent and caregiver participants were female and were biological parents of the child presenting to Puawaitahi (see Table 34). Sixteen were parents or caregivers of children who were referred to Puawaitahi because of concerns regarding CSA, three because of concerns related to CPA, two because of both CSA and CPA concerns, and one because of both CPA and neglect concerns.

Table 34

Demographic information for the parent and caregiver telephone interview participants

		Frequency (%)
Gender	Female	15 (68.2)
	Male	7 (31.8)
Relationship to Child who Presented	Biological Parent	16 (72.7%)
	Caregiver (family/whānau or non-kin)	6 (27.3%)

Interview schedule

For the telephone interviews, a semi-structured interview was used to guide questioning (see Appendix D). Semi-structured interviews are useful when specific questions need to be asked, but flexibility of conversation is also important (Fylan, 2005). The interview schedule for parent/caregiver participants was developed in collaboration with Puawaitahi staff. Questions of interest related to what support was needed following presentation to Puawaitahi, for example *What support do you think you needed?*, as well as what support was actually accessed, for instance *Since visiting Puawaitahi have you or your child accessed any other types of support?* They were also questioned more generally about experiences of Puawaitahi services, for instance, *What were the helpful things about coming to Puawaitahi*, and *Can you suggest any improvements that Puawaitahi could make?*.

Procedure

Permission to conduct telephone interviews with consenting non-offending parents and caregivers was obtained from the Regional X Health and Disabilities Ethics Committee, the Auckland District Health Board Research Review Committee, the Police Research and Evaluations Steering Committee, and the CYF Research Access Committee.

Upon initial presentation to Puawaitahi, non-offending parents and caregivers were invited to be involved in the telephone interview component of the study. Te Puarurhau staff members provided potential participants with information sheets and consent forms, and obtained written consent for those who agreed to be contacted.

Contact was made approximately three months after the parent/caregiver initially attended Puawaitahi. As agreed with the ethics committee, the five Māori participants were interviewed by a Māori interviewer, and a choice of English or Te Reo Māori was offered. The interviews were recorded on a Dictaphone after verbal consent had been given by the participant, and some answers were written on paper copies of the telephone interview. A number was assigned to each participant and used on paper and audio files rather than names. Interview durations ranged from about 10 to 50 minutes.

Data analysis

Thematic analysis, as described by Braun and Clarke (2006), was used to identify semantic themes in the data. Once the interviews were completed they were transcribed verbatim into

Microsoft Word. The recommended six stages of thematic analysis were followed: familiarisation with the data through repeated and active reading, generating initial codes from the data, sorting codes into possible themes, reviewing and refining themes, defining and labelling themes, and writing the report.

Transcripts were read numerous times and coded in order to identify potential themes relating to support received following presentation to Puawaitahi, and experiences of Puawaitahi services. The interview schedule (see Appendix D) provided a flexible guideline which ensured that certain topics were discussed, and at the same time open-ended questions offered participants the opportunity to raise issues that they wanted to discuss in relation to the topic areas. Themes were coded according to topics of what support services were needed, what support services were actually accessed following presentation to Puawaitahi, what was helpful about attending Puawaitahi, and what improvements Puawaitahi could make. Themes were then refined and labelled, and broken down into sub-themes. Themes and subthemes were discussed with the primary supervisor and modified and refined accordingly to minimise individual bias. Quotes that exemplified the themes were selected following the removal of any information that could identify participants. As the number of participants was relatively small, exact numbers of participants that made comments in relation to a theme or sub-theme were not included. Instead, words such as *few*, *some*, *many*, and *most* were used as a general indication of the number of participants who spoke about a theme or sub-theme. For instance, if only two or three participants spoke about a theme or subtheme the term ‘few’ was used, if more than three participants but less than the majority discussed a theme the word ‘some’ was utilised, if the majority of participants referred to a theme the term ‘many’ was used, and if the theme was evident in almost all of the interviews the term ‘most’ was employed.

Results

Experience of support outside Puawaitahi

When experience of support outside of Puawaitahi was explored, five themes developed. These were: *therapy is helpful*, *school and other agencies were supportive*, *whānau/family and friends were supportive*, *more support is needed*, and *there are barriers to accessing support*.

Therapy is helpful: Only six participants and four children of participants had accessed some form of counselling between the time of presentation to Puawaitahi and the telephone

interview. Nearly all of these participants who had accessed counselling or therapy, or whose children had accessed counselling or therapy, described it as helpful.

The first time I went to see him the whole session that we had was just about how our daughter was coping and how we were coping with her and how we were able to help her and things like that. I must admit he's just said to me, he actually has been able to give us a little bit of a heads up with some things. (Mother, CSA)

School, church, and other agencies/professionals were supportive: Several participants said that their child's school or church had been supportive. A few also felt supported by professionals and other supportive agencies they had been in contact with.

We've had support in other areas rather, well, like we're dealing with the Police, we've got a really lovely policewoman who I know that my daughter is comfortable talking to her and so she has done quite a bit of talking to her. But the counselling thing no, none of us have been... Her choice is I don't want to go and talk to a stranger. She was more comfortable talking to the policewoman who she had a really good rapport with and who still is working on the case. (Mother, CSA)

Whānau/family and friends were supportive: A few participants mentioned that their whānau and friends were supportive during this time. Furthermore, many talked about providing support to their child themselves, although a couple said this was difficult when they had been advised that they could not discuss details prior to the evidential interview.

Only at the moment, just the family as well, they have been supporting me, my own immediate family. Not at church. I go to church but we just want to keep it to ourselves. Only my own family, I don't want to spread it out, even her as well she doesn't want to tell the whole world. (Mother, CSA)

More support is needed: Many parents and caregivers said that they did not feel the support they received was adequate. Only a couple of participants conveyed that they were coping well within a support network of friends and family and did not believe that they needed additional support.

Two subthemes were identified: Most parents and caregivers expressed a desire to access counselling for themselves or their children. Many of these participants had been unable to do so, or in some cases they/their child had accessed counselling, but they required it sooner, or the sessions available were inadequate in number. Participants talked about needing counselling themselves because of their own responses to abuse disclosure, which echoed sentiments of parents in other studies of CSA (Humphreys, 1995; Davies et al., 2001).

The issue has been the total lack of counselling support we've been able to get for her. I gathered that the whole thing is completely underfunded these days. (Father, CSA)

I think seeing a counsellor or something like that, they know how to take you just that little bit further so they can actually help you to get that out and not leave it inside. Because I said to her the more that that's actually still in your head that it's your fault, the more that's going to fester. (Mother, CSA)

Yeah, it has been, yeah because within the first couple of months I was quite depressed and there was no real counselling for me. And my daughter was quite depressed as well and there was no counselling for her... I think it is probably more crucial to have the counselling within the first couple of weeks rather than months down the track. (Mother, CSA)

A second subtheme was that more support from agencies outside of Puawaitahi was needed. Some participants stated that they had expected more support from agencies. Several indicated that they would have liked to attend some form of support group or have their child attend an activity group. Some participants did not believe that the crisis support received was enough, and a few participants mentioned that they had expected CYF to be more involved.

We heard once, and then I had to beg for help the day it happened. Like is my daughter going to get support? Oh well, 24 hours later we got it, but heard from them at the Police station once and that was it kind of thing. So I think more support for victims.... When it's happening. And just a follow up, how you going and things like that. You're sort of just left. (Mother, CSA)

There are barriers to accessing support: Many participants spoke of barriers to accessing support for themselves or their child. Subthemes were that their child did not want counselling, there were time delays, there was a lack of follow up/communication, and there were practical barriers.

Many parents and caregivers reported that their child refused to go to counselling. Participant statements indicated that some children felt embarrassed about talking to strangers about what happened, whereas other children simply thought that they did not need support external to their family.

For her it's the whole embarrassment factor of it, and this is even when it comes to wanting to go to a counsellor. Even though she knows they are trained and blah, blah, blah, her saying to me I don't want to go and talk to a stranger about it. (Mother, CSA)

She has actually explained why she doesn't want to do it. She just said it happened and nothing's going to get done about it and talking about it is not going to change it. So we are stuck in the situation at the moment where we are trying to explain to her that it might help her. Because at the moment she's not sleeping very well, she's not eating properly and her whole attitude at the moment is, it's almost like she doesn't care about herself anymore. (Mother, CSA)

A second subtheme related to time delays. Several participants stated that they were either waiting for a referral for counselling to be made, or a referral had been made but they had not received a response at that time. Comments also indicated that in some cases it took a while before ACC made contact, and when some participants tried alternative avenues they were placed on a waitlist.

ACC did eventually try and get hold of her. By that time she was so petrified of the whole business she didn't follow it back. But we're trying to convince her to at least have an assessment with them so that if she doesn't accept any counselling now she has access to, she has the ability to do it later. (Father, CSA)

Another subtheme that some participants spoke of was a lack of follow-up and communication. In some instances, parents/caregivers were initially told that they would be able to access certain types of support, but no follow-up or further communication eventuated.

But yeah they sort of said they would get it for us ... maybe they tried and they couldn't get it, I don't know. We never heard from them again. (Mother, CSA)

Practical concerns such as lack of time, transport, money, and childcare also posed barriers to support. Other barriers mentioned were difficulty accessing support because of caregiver changes, and because of the travel distance required to reach counsellors. These barriers may be exacerbated following the identification of abuse, especially if one parent is removed from the household.

Well personally I haven't looked for any counselling because simply I just don't have the time and also I simply don't have the you know the car to help me get there... Yeah and also if any time I go to the counselling I definitely will have to take my children, maybe one or two you know if it is during the school time otherwise it will end up you know four children going to the counselling... Yeah it's not going to work. We really you know not practical. So at the moment forget about it. (Mother, CPA)

Experience of Puawaitahi services

Puawaitahi is a child friendly environment: Many participants said that they liked the child-oriented environment of Puawaitahi. The toys and activities at Puawaitahi helped to put the children at ease and allowed them to feel comfortable. Participants described liking that they could see what their children were doing in the play room, so that they could be in a separate room where they could talk about things that would be inappropriate for their children to hear. As childcare presented a problem for some parents/caregivers, the fact that they could bring their other children to the appointment and have them in the play room was appreciated. A few participants mentioned that having their child complete an evidential video interview at Puawaitahi was more favourable than completing one at a Police station, as Police stations may be more intimidating.

I think it was a very good set-up how they had the visual area where the children could play and not be listening to things that may not have been appropriate. (Mother, CSA)

Staff interaction with the children/young people and their parents/caregivers was appreciated: Responses often reflected that participants found the staff at Puawaitahi to be lovely, respectful, understanding, and professional. Subthemes were that children and young people were made to feel welcome and comfortable, young people were given choice, staff had a positive manner towards parents/caregivers, good information was provided to parents/caregivers and links were made with other services, and staff clarified what happened and brought it out into the open.

Children and young people were made to feel welcome and comfortable: Most participants said that when talking to their child, staff used age-appropriate terminology, explained everything clearly, and made sure they were understood. Participants described staff interacting with their children in a manner that was genuine, supportive, non-judgemental, and humorous when appropriate.

Oh they were great. The people there were really, really good. They handled the child really well and explained everything to him. He was quite relaxed and happy with everything and the way they explained everything to us was great as well. I couldn't fault them.... They just seemed to have genuine concern. It didn't seem like they were going through the motions or anything like that. (Caregiver, CSA & CPA)

Young people were given choice: Several participants reported that they were impressed that Puawaitahi staff did not force any decisions upon their child. Participants said that they liked that their child was not forced to have a medical exam, was given the option of a female doctor, and was not pressured to attend follow-up counselling.

I was really, really impressed with how she wasn't forced to do anything. But at the same time this comes down to an actual medical examination, which she chose, she didn't want to have, but they explained completely all the pros and cons of having a medical examination or not having one, and gave her time to weigh that up in her own mind, as to whether she was going to choose to have one. There was no pressure. There was no, well if you don't have this then we've got nothing to go on sort of thing. They were really good about that. I was really impressed. I can only sing praises. (Mother, CSA)

Staff had a positive manner towards parents/caregivers: Most parent and caregiver responses illustrated that they felt that Puawaitahi staff interacted with them in a positive manner. Participants described staff as friendly, lovely, professional, understanding and supportive. Participants appreciated that staff explained everything clearly, told them what to expect, and were open and honest. Parents/caregivers said staff made them feel comfortable, were able to answer any questions they had, and were not judgemental or accusatory.

Oh it was fantastic. They made you feel really comfortable and they explained everything that was going to happen and you know, including being honest about like how not all cases... Quite often the cases will go to court and people will be found not guilty. They gave us basically all the facts and didn't try and colour it up at all. They were honest about everything. (Mother, CSA)

Good information was provided to parents/caregivers and links were made with other services: Several participants commented that going to Puawaitahi was helpful as they were given lots of information and linked in with other services. Some mentioned that they were too stressed at the time to absorb much information, but written information was useful as they could read over it when they were ready. People described that Puawaitahi staff were able to clarify unclear information that they had received from other sources. A few participants were given psycho-education about behaviours they might expect their child to exhibit, and strategies to help with symptoms such as sleep difficulties and nightmares. Parents/caregivers were linked to other services through Puawaitahi, such as counselling and medical services. Participants reported that even if they/their child did not access support from other sources straight away, they liked knowing what support options were available, should they wish to pursue them in the future.

You go there and you get all the information that you need. Right from the first, because we went there twice I think. From the first time they explained what was going to happen, the next time we came and they got the police interviewer down from upstairs to explain to us how that would all happen. (Mother, CSA)

Staff clarified what happened and brought it out into the open: Many participants mentioned that Puawaitahi staff clarified what had happened and brought it out into the open. In instances where abuse was not found to have occurred, the reassurance that nothing had

happened was a relief for parents. When abuse was found to have occurred, talking about what happened offered parents/caregivers a greater understanding of what their child had endured. Some participants believed that their children were helped by having the opportunity to talk about what happened to them, and that talking about the abuse gave participants the chance to reassure their children that they believed/supported them. This is important as parental support may be a better predictor of outcome than abuse factors (Elliott & Carnes, 2001).

I mean ah ever since we gone in there and done those interviews and that she's changed a lot now. She was pretty closed off before... I couldn't get anything out of her... And when I did it was just a big um lot of swear words and stuff like that like disrespecting but now she's sort of closed off all that now... Yeah I think the hardest thing for her like I said before was having it built up inside her and not knowing who to talk to about it... And now that it's out she sort of talks about it sort of freely now to me... Yeah her behaviour has changed a hell of a lot since then. (Father, CSA & CPA)

Puawaitahi was reassuring: Some participants indicated that Puawaitahi involvement was reassuring. This theme consisted of two subthemes: medical tests and screening conducted at Puawaitahi provided relief, and the knowledge that Puawaitahi existed was reassuring.

Medical tests and screening provided relief: Whether or not a child has been physically harmed as a result of sexual abuse is often a primary concern of parents (Leventhal, Murphy & Anses, 2010). Indeed, a few participants stated that they found the medical examinations and psychological screening of their children reassuring. Participants stated that it was a relief when they were told that their children were physically and psychologically well. When a medical problem was found Puawaitahi addressed it or referred participants to services that could. Participants also appreciated that staff kept in touch about test results and gave them the option of coming back for follow-up appointments.

Look it was great. My daughter was in some trepidation about the whole business and really wanted to know what it was all about. I had made a couple of phone calls and I understood that it was probably going to be about check up with her to make sure she hadn't picked up any disease, which she had. (Father, CSA)

Several participants stated that they were pleased to know that Puawaitahi existed, so that people can get the support they need during difficult times.

Well it was just reassuring knowing that the service exists, because I think most people aren't aware of that kind of thing and if something had happened significant I felt that there would have been the appropriate resources were there, had it been required and had it come to that. Yeah I felt that it was good to know that that existed. (Mother, CSA)

Improvements could be made: Participants outlined several potential improvements that could be made to Puawaitahi services. A subtheme was that communication could have happened differently. A few parents/caregivers felt uncomfortable with the communication between themselves, Puawaitahi, and their child. For instance, some were uncomfortable that their teenage-age child was spoken to directly about results, so perhaps Puawaitahi staff could say this would happen in advance and provide reasons for this. One participant was not happy that they were not notified that CYF was taking their child from school to Puawaitahi. A few participants stated that their children found the questioning repetitive and intrusive.

I was a bit nervous about it but, you know, when I came they talked to her directly, you know, they talk to her and all that stuff I am not use to that, I'm use to like umm they I felt like they should have asked me that it was alright to contact her first rather than me rather than her regarding the tests, you know. (Mother, CSA)

And that's what she kept getting sick of, having to repeat herself about the whole incident. (Mother, CSA)

A second subtheme identified was that some information was unclear. Whilst the majority of participants reported that they received helpful information from Puawaitahi, a few others indicated otherwise. Some parents/caregivers stated that their child did not understand what had been told to them about procedures and tests results. They also indicated that some parts of the medical could be made more explicit, such as a discussion around genital photographs and what was involved in an internal examination. This underscores the importance of staff being very explicit in their communication, as well as the importance of checking whether people understand what has been discussed and providing opportunities for questions to be asked. Other

feedback involved being told that certain things were going to happen with Police cases, only to have them not eventuate, and not being kept updated with Police cases.

They told her later on they gave her a result. They said she was clear... I didn't really know what that means whether that was some transmittable diseases or whether she is intact or not. (Grandmother, CSA)

I thought maybe even the police could have come around and said, sort of where they were, if they had arrested them and things like that. Because she was petrified to go out there in case they were still there... But like I say, I'd like to know what happened to those guys. Have they got them? Are they out? (Mother, CSA)

Another concern was that the time between and duration of appointments was too long. Some parent and caregiver answers highlighted that their children found the length of appointments, and gaps between appointments difficult. Waiting for the evidential video interview was considered particularly difficult since some parents/caregivers thought they were not allowed to talk to their children about the event or have their children attend counselling prior to the interview.

Yes, but once they went to the video unit, they referral them urgently. Because they couldn't go on the counselling before... Maybe can be improved the time. From the time we complained to the time the video unit, was a few months... Maybe that could be improved, because they have nightmares and flashback and all that. (Mother, CSA)

Furthermore, a few participants felt that Puawaitahi was not quite right for their situation, and were unsure or confused as to why they needed to go there. Other responses indicated that participants would have preferred to deal with the situation within their family, and felt exposed when several agencies became involved.

I was very satisfied with the staff and how they handled it. But the whole, I don't think the whole service really met the need of what we were there for, of our situation I should say... (Mother, CSA)

We would have dealt with it ourselves... I wanted a chance to fix our problem ok we have had a complaint against one of us and I wanted to be able to fix it cause we are not a

family aye with a history of this kind of thing. We deal with things ourselves and we do fix things aye because there is all of us involved... Yeah and as for the process I just regretted going down that road because of that so many people became involved ... We were exposed we our [family] was exposed to all those people. (Grandmother, CSA)

Finally, some suggestions were offered by participants with regard to how the experience at Puawaitahi could be made easier/more comfortable for parents/caregivers. As questions at the video unit could feel quite intense, it was suggested that parents/caregivers could be made to feel more comfortable if offered water or a hot beverage, and perhaps taken into a room away from the waiting area to answer questions. Responses also indicated that identifying Puawaitahi as the appropriate service, locating the building, and finding a parking place could be quite difficult.

If they want to interview people, I think it would be better to make them a little bit more comfortable before they start interviewing them. Don't just sit them down and just straight start interviewing them. At least give them a coffee or a water and take them into a separate room and start talking to them, not just sit them down and just start interviewing them straight there in the foyer. I found that to be a bit intrusive. (Mother, CSA)

Discussion

The present study involved telephone interviews with 22 non-offending parent and caregivers who had presented to Puawaitahi with their child/children during a particular four month period. The aims of this study were to explore parent/caregiver perceptions of support following presentation to Puawaitahi, and parent/caregiver views of Puawaitahi itself.

Nearly all participants indicated that the support they received was helpful, although much of this appeared to be non-formal support through family, friends, schools, and churches. However, many indicated that there were deficiencies in support received outside of Puawaitahi. As this research showed, parents and caregivers tend to be the people who support their child in the wake of maltreatment, although parents often need their own support at this time (Elliott & Carnes, 2001). The disclosure of CSA tends to be experienced as a painful and disruptive crisis by families, with parental impacts such as loss of sleep and nightmares, mood lability, disbelief, and intense anger and guilt (Humphreys, 1995). Parent and caregiver support is particularly

important given that parent/caregiver psychological well-being appears to be associated with the child maltreatment outcomes (Elliott & Carnes, 2001; Lipton, 1997; Williams & Nelson-Gardell, 2012).

Despite the perceived helpfulness of therapy, many participants in this study had been unable to access support for themselves or their children. This study also illustrated that support avenues may be further limited, as parents may be selective in whom they seek support from due to the sensitive nature of abuse. Time delays in access to therapy were identified by Davies and Seymour (1999), and the current research illustrated that this continued to be a problem. Parents and caregivers may feel bereft of support as a result of time delays, and their stress may be heightened by not knowing how best to support their child. Thus, it would seem important that referrals are made and responses received in a timely fashion. The present study identified further barriers to accessing support, including the child being reluctant to attend counselling, and practical considerations such as a lack of transport, childcare, and time.

With regard to experiences of Puawaitahi, interviewees in this research said that they were made to feel welcome and supported by Puawaitahi staff and did not feel as though they were being judged or accused. Participants also liked that their children were put at ease by Puawaitahi staff. This is very important as investigative processes are often highly stressful for children (Westcott & Davies, 1996). Davies and Seymour (1999) showed that more than two thirds of primary carers of children who had been sexually abused reported that they had not received enough information with regard to investigative processes and roles of different staff. However, most interviewees in the current study described receiving adequate information from Puawaitahi about what to expect and where to seek further support.

Whilst the majority of feedback regarding Puawaitahi was positive, some constructive feedback was provided by participants. Investigations following child maltreatment often involve several parties such as Police, social workers, and doctors (Cross, Jones, Walsh, Simone & Kolko, 2007). Uncoordinated investigations may lead to children having to tell their story repeatedly to various interviewers (Cross et al., 2007), and insensitive investigative procedures including multiple interviews may result in further harm to maltreated children (Kolbo & Strong, 1997). Some participants in the current study indicated that their children experienced questioning at Puawaitahi as intrusive, and found having to repeat what happened difficult. This raises the question as to whether it would be possible to further enhance collaboration amongst

professionals at Puawaitahi so that children do not feel as though they have to answer the same difficult questions repeatedly. It was apparent that delays between the identification of abuse and appointments at Puawaitahi were a source of stress for parents. It is understandable that children and families would want to move forward from abuse, which may be difficult to do when stressful investigative processes are prolonged.

Limitations

Time constraints meant that delays in obtaining permissions for this study resulted in fewer than expected parents and caregivers in the sample group. Given there were only 22 telephone interviews conducted, results can only be considered exploratory as it is possible that participant views were not entirely representative of the population of non-offending parents and caregivers who present to Puawaitahi. Furthermore, since participants were not randomly selected but opted to be involved, views of those who agreed to participate may differ from those who chose not to participate. Moreover, it is possible that only certain non-offending parents and caregivers were invited to participate in the study, for instance a highly distressed parent might not have been approached. A bias may also have been introduced by excluding parents and caregivers who were alleged offenders, as it is possible that non-offending caregivers would be more complimentary of Puawaitahi than parents and caregivers considered to be possible perpetrators of abuse.

Chapter Five: Conclusions and Recommendations

Implications of Study One

The aim of the first study was to describe characteristics of children who presented to Puawaitahi. Key findings illustrated that a large percentage of children presented to Puawaitahi due to more than one type of maltreatment, and delays in maltreatment identification were common. Children primarily presented due to sexual abuse concerns, whereas very few attended solely due to neglect and exposure to DV concerns. In most cases, children referred to Puawaitahi following disclosure of sexual abuse told a family member about the abuse. Most children seen due to sexual abuse concerns were abused by someone known to them. In almost all cases of CPA, the alleged perpetrator was a family member, and the abuse tended to be severe and repeated. Children who presented due to neglect frequently experienced multiple forms of neglect, and concerns of exposure to DV were mostly identified through other person report.

Since many children find disclosure of maltreatment extremely difficult and do not tell for more than a year after the first event, it is important that people are aware of the indicators of abuse and maltreatment, and foster environments which make it easier for children to disclose. Studies have shown that direct inquiry about sexual abuse victimisation substantially increases reports (Lanktree, Briere & Zaidi, 1991). Therefore, when children present to clinical settings such as mental health services, it is imperative that questions around exposure to abuse are asked at assessment, as it is unlikely that a child will disclose spontaneously. Not asking about experiences of abuse routinely may place children at risk of further abuse, and may result in missed opportunities for helping children to deal with the sequelae of abuse (Lanktree et al., 1991).

The relatively small number of children who presented to Puawaitahi due to witnessing DV was not reflective of the high rates of violence found within New Zealand families (CYF, 2012). In New Zealand, Police notify CYF whenever a child is present at a DV case, which has significantly contributed to the large increases in notifications every year (CYF, 2010b). As child welfare agencies are designed to follow up reports of maltreatment and are therefore unlikely to respond to cases of DV exposure that are of low to moderate severity (Cross, Mathews, Tonmyr, Scott & Ouimet, 2012), the extent of DV in New Zealand may mean that the well-being of children in these environments is not followed up due to limited resources. Indeed,

due to demand far exceeding capacity, CYF applies thresholds so that they only become involved with the most serious cases (CYF, 2010b). Therefore, there may be a large gap in support provision for children who are exposed to DV, and this should be investigated further.

With regard to children who presented due to sexual abuse concerns, most children who disclosed told a family member about the abuse. Since reactions to disclosure can mediate the psychological effects of CSA (Barker-Collo & Read, 2003), it is important that family members and professionals are supported to respond effectively to child disclosures of maltreatment. Research by Draucker et al. (2011) highlighted the importance of telling children that the sexual abuse they experienced was wrong and not their fault. In the majority of cases the alleged perpetrator of CSA was known to the victim. Despite this, parents and caregivers tend to focus their sexual abuse education efforts on warning children against going into cars with strangers, and relatively few discuss potential sexual abuse by a known adult, peer, or family member (Deblinger, Thakkar-Kolar, Berry & Schroeder, 2010). This implies that CSA prevention needs to expand beyond messages of “stranger danger,” so that children feel able to talk to a trusted adult about experiences of sexual abuse with less fear of being disbelieved, regardless of perpetrator relationship.

In almost all cases of CPA, the alleged perpetrator was a family member, and the abuse tended to be severe and repeated. Furthermore, many of the children who presented to Puawaitahi came from families that were already known to CYF. These findings imply that abuse occurring within families often involves repeated rather than discrete events, and suggests that continued monitoring and support of high-risk families is imperative to prevent further incidents of abuse.

Children who presented due to neglect were found to frequently experience multiple forms of neglect. Other research has also illustrated that various forms of neglect frequently co-occur, and has shown that neglect often occurs alongside other types of maltreatment (Mennen et al., 2010). In the present study, concerns of exposure to DV were identified through other person report as opposed to child disclosure in the majority of cases, which suggests that children exposed to DV are not likely to report these experiences spontaneously. These findings imply that it is important that children who come to the attention of agencies due to neglect and DV are screened for different forms of neglect and other types of maltreatment.

Implications of Study Two

The primary aim of the second study was to describe the psychological wellbeing of a New Zealand sample of children who had experienced maltreatment, and to examine what demographic, abuse, authority involvement, and family characteristics related to SDQ scores. SDQ results showed that a large proportion of children who presented to Puawaitahi were experiencing behavioural and emotional difficulties, as well as problems in peer interactions. Key findings were that male gender was associated with behavioural problems, and older age at time of presentation was linked with greater emotional and peer problems. Better psychological outcomes for children were found when abuse was identified sooner. Sexual abuse that was invasive or repeated was linked with greater difficulties for several of the subscales. Poorer psychological outcomes were found for children who underwent a greater number of CYF placements or home transitions, and the period just after children transitioned into care seemed particularly emotionally upsetting for children. Finally, results indicated that a lack of parental belief was linked with greater behavioural and total difficulties.

These findings illustrate that a substantial proportion of children who are victims of maltreatment experience internalising, externalising, and peer difficulties. Therefore, all children who are found to have experienced maltreatment should be screened for psychological difficulties, and the choice of follow-up support should be provided as indicated. Results suggest that interventions which target behavioural problems may be particularly important for male children. That earlier identification of abuse was related to better outcomes highlights the importance that professionals who work with children are trained in terms of identifying signs of abuse and neglect, and what to do when maltreatment is suspected. Furthermore, clinicians should be aware that children who have been sexually abused may especially be in need of support if the abuse was highly invasive or repeated.

Children who had recently transitioned into care experienced greater emotional difficulties, and there was a positive association between psychological and behavioural difficulties and number of home transitions. In order to support children transitioning into foster care, ambiguity should be reduced through the provision of clear information (Mitchell & Kuczynski, 2010). This could include information about reasons for and the purpose of the placement, information about where and with whom they will be living, information about opportunities for continued contact with family members, and the opportunity to ask questions and discuss any worries

(Mitchell & Kuczynski, 2010). Psychological support may be particularly important for children and their caregivers during the period of transition into care. This may help to attenuate child emotional and behavioural issues, and enhance caregiver skills for responding to child difficulties. Hopefully, this would aid in the prevention of placement breakdowns, which would in turn help to provide children with much needed stability.

Results showed that a lack of parent or caregiver belief was associated with behavioural and overall difficulties, possibly because children with greater externalising difficulties were less likely to be believed. It is not uncommon for non-offending parents to question whether or not to believe their child in cases of sexual abuse, particularly if the alleged perpetrator is a family member, if there has been a delay in disclosure, or if the child is considered to “tell stories” (Leventhal et al., 2010). Therefore, parents and caregivers of children who disclose abuse should be encouraged to talk with their child about what happened in a non-blaming, believing, and supportive manner, and clinicians should explain to parents why children may delay abuse disclosure (Leventhal et al., 2010). To prevent future episodes of abuse, parents who are uncertain as to whether or not sexual abuse occurred should be advised to care for their child as though it was a certainty, and prevent contact with the alleged perpetrator and help their child access support services if needed (Leventhal et al., 2010).

Implications of Study Three

The primary aim of the final study was to explore non-offending parent and caregiver perceptions of what support was needed and what support was actually received, following presentation to Puawaitahi. An additional aim was to investigate participant satisfaction with Puawaitahi services. Almost all participants found support they received helpful, although support often came in the form of family, friends, schools, and churches, rather than therapy or counselling. Whilst the support received was appreciated, many said that this support was not adequate, and attempts to access counselling or therapy had been too difficult or had involved delays. Some participants talked about receiving conflicting messages from various sources, and said that they did not receive as much support as they had expected. Reported barriers to accessing support involved the child not wanting to attend counselling, and practical barriers including transport difficulties, problems with arranging childcare, and lack of time.

In terms of experiences at Puawaitahi, many interviewees talked about the multiagency centre and its staff in positive terms, and most described receiving sufficient information. However, it was apparent that delays between the identification of abuse and appointments at Puawaitahi continued to be stressful for parents and caregivers, as well as not knowing what was happening with regard to prosecution of alleged perpetrators of CSA.

This study highlighted that referrals for therapy or counselling should be made as early as possible. Parents are often at a loss as to how to talk with their child during investigative processes, and would benefit from guidance around this. Support groups may be beneficial for parents of children who have experienced sexual abuse. It was apparent that the investigative process itself could be confusing for parents at an already stressful time. Ideally, parents and caregivers would have one contact support person to walk them through all aspects of the investigative process, which may also help to reduce the provision of conflicting information. Whilst some barriers to therapy access may be difficult to modify, such as child reluctance to attend, access to therapy may be enhanced if support services were able to help with practical barriers, such as transport and provision of activities for siblings during appointments.

Some participants reported dissatisfaction with delays between the identification of abuse and appointments at Puawaitahi, particularly for the evidential video unit. Therefore, the multiagency service may wish to examine current processes to consider whether any steps can be taken so that children are seen sooner. Parents of sexually abused children are often concerned about when the perpetrator will be arrested. Given that parents cannot control how long investigations take or the outcome of investigations, Leventhal et al. (2010) recommend helping parents to focus on what they can control, such as keeping their child safe and helping them to access therapy.

Future Research

There are several potential modifications to this research that future studies could employ. If future studies were granted approval to access multiple sources of information, such as CYF computer records, this would be helpful in terms of providing more comprehensive information than paper files alone. Future studies could utilise outcome measures which include trauma symptoms to investigate relationships between variables of interest and symptoms of traumatic

stress. Furthermore, research with larger samples of children would help to further clarify what physical abuse, neglect, and exposure to DV factors impact on psychological well-being.

Given the small sample size of the qualitative study, future research involving a larger sample size of parents and caregivers would be desirable. This would allow access to therapy to be investigated statistically, and would also provide a better representation of parent and caregiver views. Parents and caregivers suspected of abuse may have different perspectives about Puawaitahi, so future research could consider including them in the sample group. A more comprehensive evaluation of Puawaitahi would be useful, and could include a control group to see whether goals such as enhanced interagency communication have been achieved as a result of forming Puawaitahi.

Concluding Remarks

In conclusion, there were several benefits of conducting the three studies described here. Firstly, examining the characteristics of children presenting to child protection services was useful in that the delays in disclosure and co-occurrence of maltreatment types identified illustrated that children need to be asked directly about maltreatment. Furthermore, the initial study highlighted a potential lack of service provision to children who are psychologically affected by exposure to DV. The second study highlighted what characteristics may leave children particularly vulnerable to psychological difficulties in the wake of maltreatment, and consequently what children may be most in need of the limited treatment resources available. The final study recognised that child and parent needs for support following abuse are not being met, and identified that parents and caregivers face particular barriers when trying to access support for themselves or their child. It also illustrated what measures could be taken to improve practice both within and outside of Puawaitahi. More generally, the current research allows comparisons with international research to be made, so as to take advantage of advances in service delivery seen elsewhere.

Appendix A: Categorisation of File Information

Child Variables

Age. Age was used as a continuous variable and was also separated into age bands for statistical analysis. The English (Australian) version of the SDQ could not be completed on children under 4 years of age, and young people over the age of 16 were excluded from the study. Therefore, categorised ages started at 4 years old and ended at 16 years old. Age bands were: *4 to 7 years old, 8 to 10 years old, 11 to 13 years old and 14 to 16 years old.*

Gender. Children were categorised as *male* or *female* based on what gender they were listed as in the file information.

Ethnicity. During data collection all ethnicities listed for each child person were recorded. They were then categorised into *New Zealand European, Māori, Pacific Islander, Asian,* and *Other* groupings. A Middle Eastern/Latin American/African category was not included due to a small number of cases. Multiple ethnic groups were reduced for data analysis using a prioritisation method (Ministry of Health, 2010). Individuals were categorised into a single ethnic group; ethnicity was prioritised in the following order: *Māori, Pacific Islander, Asian, other* groups except *New Zealand European*, and *New Zealand European*. There are strengths and limitations to the prioritisation method, as it allows ethnic groups to be compared and all Māori responses to be counted in the analysis, but undercounts the other ethnic groups as they do not have first priority (Cormack & Robson, 2010).

Child Living Situation

Living arrangements. The living arrangement of the child at the time of presentation to Puawaitahi was classified into *living with biological parent/s, living with family/whanau caregiver/s,* and *living with non-kin caregiver.*

Residence: District Health Board. Residence was also categorised by district health board (DHB). Categories were comprised of *Waitemata DHB, Auckland DHB, Counties Manukau DHB,* and *Other DHB.* The *other DHB* category was used when the frequency was five or less for a particular DHB.

Residence: District. The child's/young person's current residence was categorised based on what district they lived in. Districts consisted of *Rodney, North Shore City, Waitakere City, Auckland City, Manukau City, and other*. The Other category was used when there were five or less people in a district.

Presentation Information

Who child was referred by. This variable related to the person who made the referral to the first service in Puawaitahi that saw the child. Categories that comprised this variable were *family, CYF social worker, general practitioner, DHB, Police, community health, and counsellor*. The *family* category included self-referrals, the *DHB* category referred to any referral from a service within a DHB, including hospitals and registrars, and the *Police* category also covered referrals from youth justice, a child protection team, or referrals from another video unit. *Community health* related to referrals from health services in the community such as sexual health clinics and public health nurses, and the *counsellor* category regarded any form of counsellor/therapist, including school counsellors.

Who child was accompanied by. This variable related to who presented with the child to their first appointment at Puawaitahi. Categories consisted of *by themselves, parent/s or caregiver with social worker, parent/s or caregiver without social worker, family other than parents, friend, social worker, or other*. If multiple people accompanied the child, a prioritisation method was used for categorisation in which *parent/s, family other than parents, friend, social worker, and other*, took precedence in that order. *Other* referred to any support person that did not fit into the previous categories, such as a counsellor, nurse, or Police person.

First agency child presented to. This variable meant the agency within Puawaitahi that the child went to first; *Te Puaruruhau (health), Central Auckland Video Unit, or Specialist Services Unit*.

Number of children that attended each agency. This variable related to the number of children that attended each agency (*Te Puaruruhau (health), Central Auckland Video Unit, or Specialist Services Unit*) over the four month study period.

General Maltreatment Characteristics

Number of abuse types child referred for. All types of abuse that the child presented for currently. This included sexual abuse, physical abuse, witnessing DV, and neglect. Therefore, categories were *one, two, three, or four* types of abuse.

Concerns that were part of presentation. Type of maltreatment concern/s that led to presentation at Puawaitahi. Categories included *sexual abuse, physical abuse, neglect, and DV*. In some cases children presented due to more than one type of maltreatment concern, and were counted under each relevant category.

Delay in identification. This variable related to the time that passed between the first event of abuse and discovery/disclosure of the abuse (if evidence of abuse was found). Levels of this variable were *one week or less, more than one week to one month, more than one month to one year, more than one year, unknown, and not applicable* (if child was not found to have experienced abuse).

Residence of the alleged perpetrator. Where the alleged perpetrator lived at time of presentation to Puawaitahi was categorised into *at family home with child/young person, at family home without child/young person, living outside of family home, and not applicable*. *Not applicable* referred to those instances in which no abuse was found to have occurred or the alleged perpetrator was deceased.

Maltreatment concerns at time of presentation. This variable regards the maltreatment concerns at current presentation to Puawaitahi, and explores the number of children who presented due to single or concurrent forms of maltreatment. There were fifteen levels for this variable due to the different permutations of maltreatment types.

Sexual Abuse Variables

Presented due to sexual abuse concerns. This related to whether or not concerns of sexual abuse were the reason or part of the reason for presentation to Puawaitahi: *yes or no*.

Sexual abuse found to have happened. This variable referred to whether or not there was evidence that sexual abuse had occurred in relation to the current presentation. Categories used were *no evidence of sexual abuse, unable to determine, probable abuse, and definite abuse*. The

no evidence of sexual abuse category was used when there was no physical evidence, self-disclosure, or other person report indicating that sexual abuse had occurred. *Unable to determine* was used if there was a possibility that the child may have been sexually abused, but no clear indication that they had. This included cases in which there was an issue with the child's genital health which may not have been due to sexual abuse, times in which the child was showing sexualised behaviour at a young age but there was no other indication of sexual abuse, and instances in which an accusation was made between separated parents and a conclusion could not be reached as to whether sexual abuse occurred. *Probable abuse* was used if there were strong concerns that a child may have been abused but there was no clear disclosure. For instance, a child had come into contact with a known sex offender and was displaying sexualised behaviour, made a disclosure which was not totally clear or later retracted, or had an unexplained sexually transmitted infection. *Clear evidence of abuse* was used if the child made a clear disclosure that they had experienced sexual abuse.

Sexual abuse first identified. How concerns of sexual abuse were first identified: *child disclosure, other person report, or physical symptom*.

Who the sexual abuse was disclosed to. Who the sexual abuse was disclosed to was categorised into *family, counsellor, Police, CYF, other, and not disclosed*.

Age at first sexual abuse. The age at which sexual abuse first occurred was recorded in years, although for some children this information was not available. For analysis, this variable was also broken into levels of *0 to 3 years, 4 to 7 years, 8 to 10 years, 11 to 13 years, and 14 to 16 years*.

Type of sexual abuse. To enhance comparability to other studies, details of the sexual abuse were classified based on categories used in other New Zealand research on sexual abuse (Fergusson, Horwood & Lynskey, 1996). Categories were slightly adapted, as they were originally used for young adults reporting on CSA at age eighteen. The categories used for this study were *no indication of sexual abuse, noncontact sexual abuse only, contact sexual abuse not involving attempted or completed intercourse, and contact sexual abuse involving attempted or completed vaginal, oral, or anal intercourse*. If the abuse could be categorised under more than one group, it was categorised in the priority of abuse involving attempted or completed

intercourse, contact sexual abuse, and non-contact sexual abuse respectively. *Non-contact sexual abuse* involved indecent exposure, exposure to public masturbation, indecent sexual approaches made to the child/young person, or witnessing the sexual abuse of another child. *Contact sexual abuse not involving attempted or completed intercourse* included acts such as sexual fondling, genital contact, and removal of the child's clothing. If the file stated that sexual assault/violation had occurred but gave no further details, this would be classified as *contact sexual abuse not involving attempted or completed intercourse*.

Frequency of sexual abuse. The frequency of the sexual abuse was categorised as *no known events*, *one known event*, *repeated events*, and *chronic abuse*. If there was more than one event, the category *repeated events* would be used. If there were more than five instances of sexual abuse, and these events occurred over a period of at least one year, these cases were classified as *chronic abuse*.

Number of alleged sexual abuse perpetrators. This variable referred to the number of alleged perpetrators who had sexually abused the child. If the file information indicated that the child had been sexually abused by a different perpetrator at another point in time, this was also counted towards the number of alleged sexual abuse perpetrators.

Sexual abuse perpetrator relationship. This referred to the relationship between the alleged perpetrator/s and the child. Resulting categories were *father*, *father and others*, *step-father* (including mother's boyfriend), *other family member*, *person known to child but outside family*, *stranger*, and *not applicable*. *Not applicable* was used for cases in which no abuse was found or sexual abuse was unable to be determined.

Sexual abuse intrafamilial or extrafamilial. Whether the alleged perpetrator of sexual abuse was a family member or not was categorised. *Intrafamilial* was used if any alleged perpetrator was related to the child by blood or marriage, or was in a de-facto relationship with the victim's mother. *Extrafamilial* was used for alleged perpetrators who were not related by blood or marriage. *Not applicable* was used for cases in which no abuse was found or sexual abuse was unable to be determined. Abuse was categorised as *intrafamilial* in instances where sexual abuse occurred both within and outside the family.

Age of the alleged sexual abuse perpetrator. The age of the sexual abuse alleged perpetrator was recorded in years, and was also grouped into categories of *less than 13 years old*, *13 to 21 years old*, *older than 21 years old* and *unknown* for analysis. *Not applicable* was used for cases in which no abuse was found or sexual abuse was unable to be determined.

Physical Abuse Variables

Presented due to physical abuse concerns. This related to whether or not concerns of physical abuse were the reason or part of the reason for presentation to Puawaitahi: *yes* or *no*.

Physical abuse found to have happened. This variable referred to whether or not there was evidence that physical abuse had occurred (for the current presentation). Categories used were *no evidence of physical abuse*, *unable to determine*, *probable abuse*, and *definite abuse*. The *no evidence of physical abuse* category was used when there was no physical evidence, self-disclosure, or other person report indicating that physical abuse had occurred. *Unable to determine* was used if there was a possibility that the child may have been physically abused, but no clear indication that they had, such as an injury that could have been accidental or non-accidental. *Probable abuse* was used if there were strong concerns that a child may have been physically abused, but no definite indication, such as when an explanation for an injury was not consistent with features of the injury. *Clear evidence of abuse* was used if the child made a clear disclosure that they had experienced physical abuse, if another person reported physical abuse that was supported by physical evidence, or if the medical team (Te Puaruruhau) concluded that the physical injuries were inflicted.

Physical abuse first identified. How concerns of physical abuse were first identified: *child disclosure*, *other person report*, or *physical symptom*. If a child was examined because their sibling had an unexplained injury, this was counted under *physical symptom*.

Physical abuse perpetrator relationship. This referred to the relationship between the alleged perpetrator/s and the child. Resulting categories were *father*, *father and others*, *mother*, *mother and others*, *mother and father*, *step-father* (including mother's boyfriend), *other family member*, *caregiver*, *person known to child but outside family*, *stranger*, and *unknown from file information*.

Physical abuse intrafamilial or extrafamilial. Whether the alleged physical abuse perpetrator was a family member or not was categorised. *Intrafamilial* was used if any alleged perpetrator was related to the child by blood or marriage, or was in a de-facto relationship with the victim's mother. *Extrafamilial* was used for alleged perpetrators who were not related by blood or marriage.

Type of physical abuse. Details of the physical abuse were categorised into *no indication of physical abuse*, *was pushed/had hair pulled/was kicked/was hit with a hand/fist, hit with an object or thrown against something*, and *choked/stabbed/burnt/had bones broken/sustained brain injury*. It was assumed that each level was more severe than the last, so if child/young person had been injured in several ways the most severe category was employed.

Severity of physical abuse. As there are so many acts that can come under physical abuse, details of the physical abuse were categorised into *no evidence of assault*, *minor assault*, *severe assault*, and *very severe assault* using the Parent-Child Conflict Tactics Scales (Straus, Hamby, Finkelhor, Moore & Runyan, 1998). A *minor assault* consisted of the following acts: being spanked on the bottom with an open hand or hard object, being slapped on the hand/arm/leg, being pinched, or being shaken (if the child was older than two years old). A *severe assault* involved the following acts: being slapped on the head/face/ears, being hit on a part of the body that was not the bottom with a hard object, being thrown or knocked down, or being hit with a fist or kicked hard. A *very severe assault* was deemed to include: being shaken if younger than two years old, being beaten up (hit over and over again as hard as possible), being grabbed around the neck and choked, being burned or scolded intentionally, or being threatened with a gun or knife/threatened with death using another object. If the child/young person had been hurt in multiple ways the act considered to be the most severe would be categorised. If the mechanism of the injury was not clear in the file information, but the child had sustained a broken bone or brain injury, this was classified as *very severe assault*. If only a general term such as "physical abuse" was used in the file, this was classified as *severe assault*.

Frequency of physical abuse. The frequency of the physical abuse was categorised as *no known events*, *one known event*, *repeated events*, and *chronic abuse*. If there was more than one event, the category *repeated events* would be used. If there were more than five instances of

physical abuse, and these events occurred over a period of at least one year, these cases were classified as *chronic abuse*.

Number of alleged physical abuse perpetrators. This variable referred to the number of alleged perpetrators who had physically abused the child. If the file information indicated that the child had been physically abused by a different perpetrator at another time, this was also counted towards the number of alleged physical abuse perpetrators.

Neglect Variables

Presented due to neglect concerns. This related to whether or not concerns of neglect were the reason or part of the reason for presentation to Puawaitahi: *yes* or *no*.

Neglect found. This variable referred to whether or not there was evidence that neglect had occurred (for the current presentation). Categories used were *no evidence of neglect*, *unable to determine*, *probable neglect*, and *definite neglect*. The *no evidence of neglect* category was used when there was no physical evidence, self-disclosure, or other person report indicating that neglect had occurred. *Unable to determine* was used if there was a possibility that the child may have been neglected, but no clear indication that they had, such as an allegation that was not supported by other evidence. *Probable neglect* was used if there were strong concerns that a child may have been neglected, but no definite indication, such as school concerns of neglect. *Clear evidence of neglect* was used if the child made a clear disclosure that they had been neglected, if another person reported neglect that was supported by corroborating evidence, or if the medical team (Te Puaruruhau) concluded that there was physical evidence of neglect.

Neglect first identified. How concerns of neglect were first identified: *child disclosure*, *other person report*, or *physical symptom*. If physical evidence of neglect was found during examination for another type of abuse, this was counted as *physical symptom*.

Number of types of neglect. Initially, an attempt was made at categorising the type of neglect that the child had experienced. However, as so many children had experienced more than one type of neglect there were too many potential combinations, so the number of types of neglect the child had experienced was opted for. The different types of neglect were considered to be lack of parental supervision, poor living conditions (including inadequate, inconsistent, or

unhygienic housing), education non-attendance, inadequate clothing/nutrition, health care neglect, parental drug use, dealing, or manufacture, parentified child (child is made to do excessive chores/cooking dinner/looking after younger children when they are young themselves), and inadequate nurturance/affection. The levels of this variable were *none*, *one type of neglect*, *two or three types of neglect*, and *four or more types of neglect*.

Duration of neglect. The duration of the neglect was categorised as *less than a year or unknown*, or *more than a year*.

Neglect perpetrator relationship. This referred to the relationship between the alleged perpetrator/s of neglect and the child. Resulting categories were *mother*, *mother and father*, *mother and other/s*, and *caregiver/s*.

Domestic Violence Characteristics

Presented due to concerns of exposure to DV. This related to whether or not concerns of exposure to DV were the reason or part of the reason for presentation to Puawaitahi: *yes* or *no*.

Exposure to DV found. This variable referred to whether or not there was evidence that the child had been exposed to DV in relation to the current presentation. Categories used were *no evidence of exposure*, *unable to determine*, *probable exposure*, and *definite exposure*. The *no evidence of exposure* category was used when there was no physical evidence on the victim, child self-disclosure, or other person report (including the victim) indicating that exposure to DV had occurred. *Unable to determine* was used if there was a possibility that the child may have been exposed to DV, but no clear indication that they had, such as other person report of concerns of DV with no other indications. *Probable exposure* was used if there were strong concerns that a child may have been exposed to DV, but no definite indication, such as when there are reports of DV but no indication as to whether the child was present. *Clear evidence of exposure* was used if the child made a clear disclosure that they had been exposed to DV, or if another person reported DV that was supported by physical evidence.

Exposure to DV first identified. How concerns of exposure to DV were first identified: *child disclosure*, or *other person report*.

Type of exposure to DV. Details of the DV were categorised into *no indication of exposure to DV*, *parent/caregiver was pushed/had hair pulled/was kicked/was hit with a hand/fist*, *parent/caregiver was hit with an object or thrown against something*, and *parent/caregiver was choked/stabbed/burnt/had bones broken/suffered brain injury*. It was assumed that each level was more severe than the last, so if child had been exposed to several forms of DV, the last category was used.

Severity of exposure to DV. As so many acts can come under DV, details of violence were categorised into *no evidence of DV*, *minor assault*, and *severe assault* using the Conflict Tactics Scales (Straus, Hamby, Boney-McCoy & Sugarman, 1996). A *minor assault* included: throwing an item at their partner that could hurt, twisting their partner's arm or hair, pushing or shoving their partner, grabbing their partner, and slapping their partner. A *severe assault* involved the following acts: using a knife or gun on their partner, punching or hitting their partner with something that could hurt, choking their partner, slamming their partner against a wall, beating up their partner, burning or scalding their partner intentionally, or kicking their partner. If multiple acts of violence had been committed, the act considered to be the most severe would be categorised. If no detail is provided about the DV, this was marked as *minor assault*.

Frequency of exposure to DV. The frequency of exposure to DV was categorised as *no known events*, *one known event*, *repeated events*, and *chronic exposure to DV*. If there was more than one event, the category *repeated events* would be used. If there were more than five instances of exposure to DV, and these events occurred over a period of at least one year, these cases were classified as *chronic exposure to DV*.

Whether DV was life threatening. Whether or not the DV was life threatening or resulted in death: *yes*, or *no/unknown*.

Authority Involvement

Police involvement. Whether or not the case was referred to the Police/Police were involved: *yes*, or *no/unknown*.

Previous Police involvement. Whether or not the Police had previously been involved with the child/child's family: *yes*, or *no/unknown*.

CYF involvement. Whether or not the case was referred to CYF/CYF were involved: *yes*, or *no/unknown*.

Previous CYF involvement. Whether or not CYF had been previously involved with the child/child's family: *yes*, or *no/unknown*.

Total time spent in care. Time that the child had spent in care under CYF was categorised into *no time in care*, *less than one month*, *one month to a year inclusive*, *more than one year to five years inclusive*, and *more than five years*.

Number of CYF placements. Number of placements into care (as required by CYF) that the child had experienced was categorised into *none*, *one placement*, and *two or more placements*. This included placements following presentation to Puawaitahi.

Family Characteristics

Number of home transitions. Number of home transitions away from family of origin that the child had experienced was categorised into *none*, *one home transition*, and *two or more home transitions*. This included both placements into care and informal family/whānau care.

Evidence of exposure to drug use/alcohol abuse within family. Whether or not files indicated that there was a history of drug use/alcohol abuse within the child's family; *yes* or *no/unknown*.

Family history of physical abuse. Whether or not there was a history of physical abuse within the child's family; *yes* or *no/unknown*. This included cases in which the child currently presented due to physical abuse.

Parent/caregiver belief. This variable regarded whether there was any indication that a parent/caregiver did not believe them about the abuse. This variable had levels of: *yes* (child was believed/no indication that child was not believed), *no* (indication that child was not believed), and *not applicable*. If a close relative did not believe the child, such as a grandparents, then this was categorised as *no* (indication that child was not believed). *Not Applicable* was used in instances where the investigation did not raise any concerns of abuse, when the child was not in contact with their parents, or when the parents were perpetrators.

Appendix B: Participant Information Sheet



Human Sciences Building
Level 6, 10 Symonds Street
Auckland, New Zealand
Telephone: 64 9 373 7599 ext 88557
Facsimile: 64 9 373 7450
The University of Auckland
Private Bag 92019
Auckland, New Zealand

Participant Information Sheet

- Title of research project:*** Identifying factors that influence psychological health and therapy uptake in children/young people who have experienced child abuse.
- Researchers:*** Ms. Sarah Wolstenholme (Doctor of Clinical Psychology Student),
Professor Fred Seymour (Professor in Clinical Psychology)
- Contact Details:*** Department of Psychology,
University of Auckland
Private Bag 92019, Auckland.
Ph: (09) 373 7599 ext. 88414
Email: swol010@aucklanduni.ac.nz

You are invited to take part in research investigating what factors influence service uptake in children/young people who have experienced abuse. This project is being carried out by Ms Sarah Wolstenholme under the supervision of Professor Fred Seymour, in partial fulfilment of a Doctorate in Clinical Psychology. Thank you for taking the time to read this information sheet.

What is the research about?

This research aims to identify what factors may influence whether a child/family receives support services. We would like to learn from you ways that we could enhance access to supportive services for children who have experienced abuse.

What do I need to do to be in this research project?

If you choose to be involved in this research, you will be contacted in around three months for a brief 10-15 minute interview over the phone. If you are still happy to participate at this time you will be asked questions about what support services your child/family has received since visiting Puawaitahi, and your satisfaction with services provided by Puawaitahi. We will not ask to speak to your child, and will not ask any questions about the abuse itself. Rather, information

gained from the interview will be linked with your child's file data kept at Puawaitahi, so we do not have to question you about the abuse itself.

Please feel welcome to discuss this project with whanau/family or friends before deciding whether you would like to participate.

If I agree to be contacted for a brief telephone interview, who will I speak to?

In most cases the interviewer will be Ms. Sarah Wolstenholme. However, a Maori woman is also available to do telephone interviews, as well as one other telephone interviewer.

What happens to the information?

Sarah, and the other interviewer if it is not Sarah, will be the only people to know what you say during your telephone interview. The people you have seen, like the people at Puawaitahi, will not know what you have said as an individual. However, if you tell us about any abuse that has not been reported to Child, Youth and Family Services or the police, we will tell someone from Child, Youth and Family Services. If we had to go to court, which is very unlikely, we may have to give some information to the court. Apart from these two exceptions, we promise that no one else will know what you said.

The taped interviews will be typed word for word. The tapes and the typed interviews will be kept in a locked filing cabinet at the university and identified by a number. Your name will not be on the tape or the typed interview. The only other people who may see the information are Professor Fred Seymour and possibly a transcriber who would have signed a confidentiality agreement, but they would only see the information and your number. No one outside of the research team will see your information.

Any results will be reported in a way that does not identify you or your child. All information will be stored until 10 years after your child reaches age 16, and will then be securely destroyed.

Will I be informed of the results when the research project is finished?

If you wish to know the results of the research project once it has been completed, we would be happy to send you a letter summarising our findings in non-technical language.

Participation in this study is voluntary. Whether you decide to participate or not will not affect any of the services offered to you/your child by Puawaitahi or your relationship with the researchers. You do not have to take part and can withdraw from this research project at any time. No explanation is needed.

Confidentiality and Privacy

Strict confidentiality of your information will be observed. No material that could personally identify you or your child will be used in any reports on this study.

Right to ask Questions

If you have any queries, please discuss them with the researchers (Sarah Wolstenholme or Professor Fred Seymour). You may telephone Fred on (09) 373 7599 ext 88414, or email Sarah at swol010@aucklanduni.ac.nz. Remember that you have the right to withdraw at any time. You may also withdraw any data traceable to you/your child up until the 20th of July 2011.

Research Funding

Funding for this research has been provided by University of Auckland Research Committee.

We appreciate the time you have taken to read this Information Sheet.

Health Advocate contact information,

If you have any questions or concerns about your rights as a participant in a research study you can contact an independent health and disability advocate. This is a free service provided under the Health and Disability Commissioner Act.

Telephone: (NZ wide) 0800 555 050

Free Fax (NZ wide):

0800 2787 7678 (0800 2 SUPPORT)

Email (NZ wide): advocacy@hdc.org.nz

Maori Health Support contact information,

For Maori health support, or to discuss any concerns or issues regarding this study, please contact Mata Forbes RGON, Maori Health Advisor, Maori Health Services, 5th Level, GM Suite, Auckland City Hospital. Tel 307 4949 extn. 23939 or Mobile 021 348 432

This study has received ethical approval from the Northern X Regional Ethics Committee. Ethics reference number NTX/10/07/067.

Appendix C: Consent Form



Human Sciences Building
Level 6, 10 Symonds Street
Auckland, New Zealand
Telephone: 64 9 373 7599 ext 88557
Facsimile: 64 9 373 7450
The University of Auckland
Private Bag 92019
Auckland, New Zealand

Consent Form

This consent form will be held for a period of six years.

Title of research project: Identifying factors that influence psychological health and therapy uptake in children/young people who have experienced child abuse.

Researchers: Ms. Sarah Wolstenholme (Doctor of Clinical Psychology Student),
Professor Fred Seymour (Professor in Clinical Psychology)

Name of child: _____

Name of caregiver: _____

Participant number: _____

I have read and I understand the information sheet dated 16 November 2010. I have had an opportunity to ask questions and have them answered.

I have been given the opportunity to discuss the project with whanau/family or friends before deciding whether to participate.

I am aware that the exception to confidentiality will be if the interviewer has significant concerns about the safety of myself or others.

I understand that I can withdraw myself from the research at any time, without giving any reason.

I understand that my telephone interview will be audiotaped

.

I have been told what will happen to the information that I give, who will see it, and where it will be held. I understand that confidentiality can be guaranteed with the following exceptions:

- If new or so far unreported abuse is disclosed during an interview, this information (and this information only) will be given to Child, Youth and Family Services.
- In the unlikely event that this information is subpoenaed to court, information from the interviewer may have to be disclosed to the court.

I agree to being contacted in around three months for a brief 10-15 minute telephone interview:

Yes No

I agree that the information given in the telephone interview can be linked with my child’s file information kept by Puawaitahi:

Yes No

I wish to receive a copy of the results:

Yes No

Name:
(Please print clearly) _____

Signed: _____

Contact Phone Number: _____

Date: _____

Appendix D: Telephone Interview Schedule

Hello, this is _____, I'm from Auckland University and am doing research with Puawaitahi. You may remember three months ago you attended Puawaitahi and gave permission to be contacted for a follow up. We are conducting research into what people think about the services here, and any other support services you may have had contact with. The interview takes about 10-15 minutes. Are you still happy about talking with us?

Yes No

(If yes continue, if no say Thanks for your time anyway).

Is now O.K.?

Yes No me to call back: _____

(If yes continue, if no book another time to call back).

Just to let you know, nobody will be able to identify you from the information that you give me. Also, if there is any question that you do not want to answer you can just say pass.

So that I can be sure that I remember what is said, I wish to record the telephone interview. Is this alright with you? The only people with access to this recording will be me and my supervisor Professor Fred Seymour. Is it O.K. that I record this interview?

Yes No

(If yes continue, if no answer any questions they may have and if they do not wish to be recorded say That's no problem, I can just write down what you say if you are happy to continue?)

1. Who did you see when you went to Puawaitahi?

(Prompt: Doctors downstairs, people in the video unit, a psychologist)

2. How was that?: How satisfied were you with the services you received from Puawaitahi?

3. In terms of the (enter service here), would you say you were:

(Repeat for each service received. If they have used these words in question 2 then use this question to confirm)

- 1) Very satisfied
- 2) Satisfied
- 3) Neither satisfied nor dissatisfied
- 4) Dissatisfied

5) Very dissatisfied

4. What were the helpful things about coming to Puawaitahi?

5. Can you suggest any improvements that Puawaitahi could make?

6. Can you recall whether your child or anyone else in your family was referred for counselling or therapy by Puawaitahi?

7. a) Has your child ever received individual counselling or therapy support?

(If yes continue to 7b, if no go to question 8)

7. b) Was this before or after coming to Puawaitahi?

(If after Puawaitahi go to question 7c, if no go to 7d)

7. c) How soon after visiting Puawaitahi did your child receive counselling?

7. d) How many times has your child been to counselling? Over how long?

7. e) Was this counselling funded through ACC?

Yes

No

Don't Know

(If no ask question 7f, if yes skip to 7g)

7. f) How was the counselling funded?

7. g) Is your child in counselling at the moment?

Yes

No

7. h) In terms of the counselling your child has received, would you say you were:

(If they have used these words in question g then use this question to confirm)

- 1) Very satisfied
- 2) Satisfied
- 3) Neither satisfied nor dissatisfied
- 4) Dissatisfied
- 5) Very dissatisfied

8. a) It can often be a stressful time for the families and caregivers/parents of children who are seen at Puawaitahi, so we were also wanting to know about any support that caregivers/parents receive. Since visiting Puawaitahi, have you as a parent/caregiver, or your family, received any counselling or therapy services?

(Family members other than child of interest)

Yes

No

(If yes go to question 8b, if no go to question 9)

b) How soon after visiting Puawaitahi did you/your family receive counselling?

c) How many sessions have you been to?

d) Are you/your family receiving counselling or other support services at the moment?

Yes

No

g) Are you satisfied with the counselling that you/members of your family received?

Yes

No

h) In terms of the counselling that you/members of your family received, would you say you were:

(If they have used these words in question g then use this question to confirm)

- 1) Very satisfied
- 2) Satisfied
- 3) Neither satisfied nor dissatisfied
- 4) Dissatisfied
- 5) Very dissatisfied

9. Since visiting Puawaitahi, have you or your child accessed any other type of services for support?

(Prompt: Cultural services/naturopathy/church support)

10. Do you think you, your family, or your child, needed extra support over the last three months?

(If yes go to question 11, if no got to question 12)

11. What support do you think you needed?

12. *(Ask this question if they do not mention therapy in question 7 or 8. Depending on what type of therapy they HAVE NOT accessed, insert your child/you/your family)*

Do you believe counselling for your child/you/your family would have been helpful?

Yes No Don't Know

13. Has any professional, such as a psychologist, given you a name for any problems your child might have? *(i.e. a diagnosis)*

(If yes clarify whether the diagnosis was given after visiting Puawaitahi)

That's all of the questions I have to ask you, is there anything else you would like to add that we have not talked about today?

Thanks very much for the time you have given to contribute to this research

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