

**Women's Responses to Their Child's
Disclosure of Sexual Abuse**

Tania Ware

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Department of Psychotherapy
Supervisors: Jonathan Fay and Jackie Feather

Abstract

The literature in this review considers women's responses to their child's disclosure of sexual abuse from three approaches: objective, subjective, and intersubjective. The literature review initially revealed two themes, the primary one being clinically observed descriptions of women's responses that suggested risk to the child. The second theme captured the subjective experience of how women were impacted by the disclosure. Both these approaches treated the mother and child as if they and their relationship existed in a vacuum. Therefore a third stream needed to be considered: those studies that attempted an intersubjective description of the social context in which disclosure and response occur.

The research then required development of a conceptual frame comprehensive enough to hold the varying interpretations that emerged from the literature. This frame needed to make conceptual links between objective, subjective and intersubjective descriptions. To do so, I employed four theoretical lenses by which their responses might be reconsidered: attachment theory, trauma theory, loss and grief theory, and caregiving theory.

The result of this critical interpretive synthesis is that when all three approaches (objective, subjective and intersubjective) are applied to the women's experience, a fuller assessment of their capacity to provide care and protection is gained. This assessment also provides a window into what will support women as mothers. I have proposed that attachment theory, trauma theory, grief and loss theory, and caregiving theory are present in the literature reviewed, and I suggest conceptual

links by providing interpretations of how I see them positioned to support women when combined with therapeutic knowledge and clinical understanding.

The critical interpretive synthesis revealed the complexity of what women and children experience and showed that by identifying and providing women in this context with the appropriate clinical care we provide enduring care and protection of children, families and society.

Table of contents

Abstract	2
Attestation of authorship	8
Acknowledgements	9
Chapter 1: Introduction	10
Prevalence of childhood sexual abuse worldwide.....	10
Sequelae of childhood sexual abuse	11
Historical framing of the maternal responses to disclosure.....	12
Rationale for the study	12
Purpose of the study	13
My positionality and purpose	14
Introduction to the research	15
The structure of the dissertation	16
Chapter 2: Methodology	18
Introduction	18
Epistemology of the present study	18
Theoretical framework	19
My positionality as researcher.....	19
Methodology: Critical interpretive synthesis of literature.....	20
Context of the present study	22
Methods	23

Literature search and sampling.....	23
Critical analysis	25
Interpretive synthesis.....	27
Chapter 3: Literature review	29
Introduction	29
Section one: Objective lens to the literature.....	29
Mothers' protection through support and belief.....	30
Risk factors identified for the care and protection of children.....	31
<i>Interpersonal variables</i>	31
<i>Substance or alcohol misuse or abuse</i>	32
<i>Local contextual data</i>	32
<i>Economic cost to families</i>	33
<i>Intergenerational transmission</i>	34
<i>Family structures</i>	35
Why the response has led the way.....	35
Section two: Subjective lens to the literature	36
<i>Shock, confusion and denial</i>	36
<i>Anger</i>	37
<i>Guilt, self-blame, isolation, sadness, depression</i>	38
<i>Immediate survival-oriented coping</i>	38
<i>Longer-term grief and loss</i>	39

<i>Gendered receptivity to other's experiences</i>	39
Section three: Intersubjective lens – family as social and cultural context.....	40
<i>Family</i>	40
<i>Social</i>	41
<i>Cultural</i>	42
Summary	43
Chapter 4: Critical interpretive synthesis	44
Introduction	44
Critical analysis	44
Interpretive synthesis.....	47
Attachment theory	47
<i>Attachment theory and emotional regulation</i>	48
<i>Attachment theory and risk assessment for the mother-child dyad</i>	49
Attachment theory and objective care and protection research.....	51
Psychological trauma	53
<i>Immediate and cumulative responses to trauma</i>	54
Trauma theory	56
Trauma theory and the subjective lens	57
Grief and loss theory and the subjective lens	58
Systemic theories of caregiving	60
Caregiving and the intersubjective lens.....	64

Summary	65
Chapter 5: Discussion and conclusion	66
Introduction	66
Attachment theory and women's objective responses.....	67
Trauma theory and women's responses	68
Grief and loss theory, and women's responses	68
Caregiving theory and women's responses	69
Clinical implications for treatment.....	70
<i>Assessment – Phase 1</i>	71
<i>Assessment – Phase 2</i>	71
Work with women.....	72
Conclusions and study strengths and limitations	74
References.....	76
Appendix A: Attachment theory	90
Classical.....	90
Child to adult.....	91

Attestation of authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of high learning.”

Signed: Tania Ware:



Date: 27 November 2015

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Chapter 1: Introduction

The topic of this dissertation is a critical interpretive synthesis (Dixon-Woods, Cavers, et al., 2006) of research on women's responses to their child's disclosure of sexual abuse. In this introductory chapter, I briefly summarise a few of the studies that report the prevalence of childhood sexual abuse around the world, and describe some of the sequelae or consequences of such abuse. I then introduce the literature on women's responses to their child's disclosure as a subset of the childhood sexual abuse literature, and briefly discuss the potential of a critical interpretive synthesis of this literature to contribute to working effectively with children who disclose sexual abuse, women whose children disclose sexual abuse, and families in which sexual abuse disclosures by children take place. I conclude by describing the structure of the dissertation.

Prevalence of childhood sexual abuse worldwide

There is no doubt that childhood sexual abuse is a severe problem with many longstanding, destructive consequences worldwide. In the largest meta-analysis ever undertaken, global figures were identified for the period 1980 to 2008 in a meta-analysis of "217 publications, ... including 331 independent samples, with a total of 9,911,748 participants" (Stoltenborgh, van IJzendoorn, Euser, & Bakermans-Kranenburg, 2011, p. 79). This study estimated the global figures for the sexual victimisation of children (under 18 years) to be 16.4%–19.7% for girls and 6.6%–8.8% for boys. Retrospective surveys by Finkelhor (1994) based on an American population of adults sexually harmed as children estimated somewhat higher prevalence rates of between 20%–25% of women and 5%–15% of men. Most recently, reviews of the data of sexual victimisation in the United States by Keyes (2012) offer even higher estimates of having been sexually harmed over their lifespan of 20%–40% for women

and 10%– 20% for men. The data consistently identifies women as being at greater risk of revictimisation throughout their life (Herman, 1992). Mechanic (2004) notes this violence against women “results in diminished quality of life or functional impairment across a variety of social, interpersonal, and occupational roles” (p. 1284).

Sequelae of childhood sexual abuse

Research highlights the complex range of psychological, physiological, and interpersonal problems children experience due to sexual abuse (Briere, 1992a; Briere & Elliott, 1994; Kendall-Tackett, Williams, & Finkelhor, 1993). Depending on the child's developmental stage, they may not be able to put words to their feelings or body sensations and will display through behavioural re-enactments. Children can experience altered states of consciousness, flashbacks, intrusive thoughts, sexualised behaviour, and addiction to pornography, and may fail to develop normative social and interpersonal skills (Levy & Orlans, 2014; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

These stress responses are the external expression of how “traumatic events are processed by the body's sensory systems through the brain's thalamus, which then activates the amygdala, a central component of the brain's fear detection and anxiety circuits. Cortisol levels become elevated through transmissions of fear signals ... changes in the heart rate, metabolic rate, blood pressure, and alertness” (De Bellis & Zisk, 2014, p. 187). This state of readiness for fight, flight or freeze, when consistently primed through ongoing reminders or actual traumatic events (sexual abuse or family dysfunction), diverts valuable resources designed for higher cognitive-emotional creative self-expression. Furthermore, when the threat emanates from within the family, as in the case of intrafamilial abuse, the child cannot remove themselves as

they are powerless and must adapt to survive the family environment (van der Kolk, 2005; van der Kolk et al., 2005).

It is worth noting the short- and long-term consequences of sexual abuse on the children who grow up to become the caregivers of tomorrow's families. Girls in particular carry a disproportionate share of this burden, as they are more likely to be abused and more likely to assume the primary caregiving role for their own children as adult women. As the literature on women's responses to their child's disclosure of sexual abuse makes clear (see chapter 3), women tend to come under severe criticism when they are unable to provide adequate care and protection of their child, which may in fact be related to their own history of childhood sexual abuse.

Historical framing of the maternal responses to disclosure

The recording of responses to their child's disclosure of sexual abuse has had a chequered history. Early literature sought to label mothers as "collusive" (Bagley, 1969). Feminist theorist Judith Herman (1992) challenged these historical patterns of labelling women, and Green (1996) highlighted this need for "blame and criticism" of women (p. 323). Descriptive interpretations by some researchers lacked empirical data (Tamraz, 1996) when describing women's mothering behaviour (Joyce, 1997) after a child disclosed sexual abuse.

Rationale for the study

Studies highlighted in the literature review focus on women, identifying a range of responses by them through the disclosure. Historically these responses have been analysed to gauge the women's capacity to be protective and provide appropriate care for the child. However, if the woman is unable to assuage care and protection concerns by statutory agencies, the family, or primarily women as the primary non-offending

caregiver, can find themselves mandated to participate in a care and protection plan. In some cases, statutory interventions include temporary or permanent placement of their child into care outside the family home.

The literature consistently reiterates that the wellbeing of the child is crucially dependent upon the capacity to provide care and protection. However, more recent literature has begun to reconsider women's responses, upon hearing their child describe how they have been sexually victimised, as a function of either grief or of their own secondary trauma.

Purpose of the study

The focus of early studies was consistently to highlight the disclosure process as a moment in time that offered a window on a woman's capacity to provide care and protection for her child. The 'objective' evaluative emphasis of early studies failed to recognise that disclosure itself is a major stressor on the psychological functioning of the mother. More recently, research has begun to highlight the traumatic impact of disclosure and to suggest that women may require care and support similar to the recommended interventions for their children (van Toledo & Seymour, 2013).

The purpose of this study is to summarise and make sense of the existing literature and to suggest avenues by which clinicians might extend their awareness and clinical practice with this client group. In this study I use the term woman, mother, and caregiver interchangeably. I readily acknowledge that men also parent, father, and provide care for their child and family. However, the division of caregiving within families still positions women as the primary caregiver, and the dominant discourse surrounding the care of children who have been sexually abused remains primarily oriented to women. This is also consistent with my clinical experience.

My positionality and purpose

I am a 60-year-old Maori woman and mother of two children, and have worked in the field of sexual abuse trauma and sexual abuse trauma therapy for many years. I trained in counselling initially, and more recently completed a three-year Master's degree in psychodynamic psychotherapy. The present work represents the completion of my degree requirements for the MHS in Psychotherapy. In the past I have worked with prepubescent boys and their families as well as young mothers who were at high risk of losing custody of their infants and young children as they struggled to care for them.

More recently I have specialised in working with families, predominantly women, whose children have disclosed in some manner that they have been harmed sexually by someone close to the family. These women and children come from varying socioeconomic and cultural circumstances. I work in partnership with a child psychotherapist at an agency that specialises in working with women and children. This partnership allows us to hold both the adult women and their children's needs and interests in mind, and maintain a dual focus, supporting the reorganisation and revitalisation of a relationship that has been disrupted and damaged or distorted.

I remember the daughter of the first woman I worked with describing her mother, saying "it's all about her", and this child was right. While physical safety was established for the child, psychological safety was not possible until the mother had been stabilised after being triggered by her daughter's disclosure. In my view, the psychological state is a matter of consequence to children, who have a myriad of reasons to be wary of and angry with their mothers. I have observed that when women develop their capacity to become consistently accessible, firstly by attending therapy every week and secondly by learning to listen, hear, and respond to their child's narrative, children feel safe enough to direct the therapeutic processing of their trauma.

Women also begin to feel safe enough to allow the therapeutic processing of their 'mothering self' and, if appropriate, the processing of their own traumatic response to their child.

Working with women in this context provided the impetus for me to want to develop a critical review of the literature surrounding children's disclosure of sexual abuse and women's responses to that disclosure.

Introduction to the research

My research sought to develop a critical interpretive synthesis of the literature describing women's responses to their child's disclosure of sexual abuse. The first step in this synthesis was a critical examination of the existing literature. The second step was the development of a conceptual frame within which to hold often conflicting and contradictory information.

Initially what emerged from the data was two distinctly different approaches to women's responses to their child's disclosure. In the first approach, clinicians and researchers described what they observed about women's responses that correlated with objective risk to children. The second approach, by contrast, investigated women's subjective experience of how their child's disclosure impacted and continued to impact them. These two approaches might be summarised as representing objective and subjective polarities within the literature.

The first approach was driven by the recognition that both the mother's socio-contextual environment and her personal ability to provide support and care for her child were strongly correlated with child safety and prognosis for recovery. Children were at risk when their mothers were at risk, when either or both lived in unsafe conditions. Children were also at risk when their mothers were unable to empathise

with their child's experience of sexual abuse and therefore respond negatively or avoidantly to their disclosure. But it was the second, more subjective approach, that more clearly revealed the kinds of historical experiences that influenced women's ability to keep themselves or their children safe, or to sustain empathy. Women who themselves had a history of abuse and trauma were often unable to accurately assess safety or cope effectively with their child's trauma.

There was also a further difficulty or limitation found in both these approaches. Mother and child were being evaluated and understood as if they and their relationship existed in a vacuum. Therefore a third stream in the literature needed to be considered: those studies that attempted an intersubjective description of the social context in which disclosure and response occur. The literature described below will therefore be considered sequentially – as objective, subjective and intersubjective fields of inquiry.

The second part of the research follows with the development of a conceptual frame comprehensive enough to hold these varying interpretations. It consists of making conceptual links between objective, subjective, and intersubjective or contextually- oriented descriptions of women's responses to the disclosure of their child's sexual abuse, and four theoretical lenses by which their responses might be reconsidered: attachment theory, trauma theory, loss and grief theory, and caregiving theory. The overall objective of this research will be to use this investigation to facilitate the development of therapeutic knowledge and understanding that can be used to better support this client group.

The structure of the dissertation

Following on from this introductory chapter, this dissertation consists of four chapters. Chapter two describes the methodology and methods used to conduct this research

into the literature. Chapter three will discuss the literature reviewed for this research topic. Chapter four is the critical interpretive synthesis using the four theoretical lenses described above to consider the responses highlighted in the literature review. Chapter five will provide a discussion suggesting the clinical implications of the study for professionals engaged in the work with these women and their families.

Chapter 2: Methodology

Introduction

This chapter provides a description of the methodology and method applied to review, critique, and synthesise the literature of the research topic women's responses to their child's disclosure of sexual abuse. First, I discuss the guiding epistemology and theoretical framework chosen to conduct a critical review of the literature. Then I provide the methodological rationale for incorporating a critical interpretive synthesis of the literature reviewed, followed by a discussion of my methods, data selection and collection and interpretive strategies.

Epistemology of the present study

Epistemological questions ask "what counts as valid knowledge?" (Creswell, 2003, p. 21). Crotty (1998) suggests three fundamental epistemological positions: objectivism, subjectivism, and constructionism. Objectivism defines knowledge as independent of the observer, subjectivism defines knowledge as self-evident through the observer's personal experience, and constructionism defines knowledge that is constituted between object and subject (Crotty, 1998).

I have chosen the epistemology of constructionism to explore the existing literature that has been constructed from women's narrated subjective experiences, alongside the phenomena witnessed and observed by clinicians working with them, offering their more objective clinical view. The epistemology of constructionism follows a line of inquiry where knowledge and reality are considered to be socially constructed (Savin-Baden & Major, 2013).

Theoretical framework

The theoretical framework I have chosen to underpin this review of the literature is interpretivism. The primary phenomena are the lived experience of women's responses. The secondary data in the literature is a construction or interpretation of this lived experience within the research. Interpreting is a form of social construction. Constructionism recognises that any interpretation is influenced by the values of the researcher (Crotty, 1998). Ponterotto (2005) suggests these values cannot be eliminated but offer potential to be employed productively if made explicit. For example, I work for an organisation that specialises in providing clinical services for women and children, and crisis support to men, women and children as survivors of sexual abuse. My daily personal and clinical experience of this client group offers another perspective from which to consider the interpretations that are present in the literature. The use of the first person throughout this review is consistent with interpretivism, as it acknowledges that I bring a degree of subjectivity to the review.

My positionality as researcher

Originally I began the research with a critical literature review, but as I progressed I realised this review method asked too little, requiring only that I apply a systematic protocol that either screened in or out data via a precisely formulated research question. I wish to go beyond critique or cognitive awareness of limitations of the literature, instead conducting a review of the literature that describes "what works for whom" (Roth & Fonagy, 1996). This involves a paradox; on the one hand 'what works for whom' identifies the distinction between practice-based interventions, tailor-made therapeutic interventions for the client, whereas evidence-based therapy requires corresponding specific types of therapy with a specific presenting problem (Roth & Fonagy, 1996). The object of this research is to explore how conceptual links can be

developed, and so makes a contribution to meeting the challenge of working more effectively with a highly destructive personal and social phenomena.

The process of following in other footsteps, innovated by Dixon-Woods, Cavers, et al. (2006), led me through the process of addressing the review of a “complex body of literature” (p. 1) and resulted in refocusing the literature through a critical interpretive synthesis.

Methodology: Critical interpretive synthesis of literature

The research question was addressed through an integrative literature review described by Torraco (2005) as “a form of research that reviews, critiques, and synthesizes representative literature on a topic in an integrative way such that new frameworks and perspectives on the topic are generated” (p. 356). Dixon-Woods, Cavers, et al. (2006) emphasise that this approach “is sensitised” (p. 2) to issues highlighted in systematic literature reviews that have been historically embedded in a positivist research paradigm. The strength of interpretive approaches is that the inclusion of qualitative inquiry allows synthesis of diverse bodies of evidence.

Fundamental to this approach is the distinction between aggregative and interpretive reviews. Dixon-Woods, Bonas, et al. (2006) highlight and extend Noblit and Hare's (1988) approach to synthesising qualitative studies by proposing a further clarification between aggregative and interpretive synthesis. The word aggregative in this context is used to describe conventional systematic reviews, which primarily focus on pooling and summarising data through incorporating a population group that is well specified. In contrast to the summative purpose of aggregative reviews, Dixon-Woods, Bonas, et al. (2006) emphasise that critical interpretive synthesis is capable of:

generating concepts that have maximum explanatory value. This approach achieves synthesis through incorporating the concepts

identified in the primary studies into a more subsuming theoretical structure. The structure may include concepts which were not found in the original studies but which help to characterize the data as a whole (pp. 36-37).

In other words, aggregative and interpretive reviews diverge in the way they critique the literature. Aggregative synthesis predominantly confines its critique to methodological reviews of individual papers, whereas interpretive synthesis treats "the whole corpus of evidence ... as itself an object of scrutiny, for example by questioning the ways in which the literature constructs its problematics, the nature of the assumptions on the literature draw, or what [or who] has influenced proposed solutions" (Dixon-Woods, Cavers, et al., 2006, p. 2).

Another characteristic of a critical interpretive synthesis is its "acknowledgment of the authorial voice" (Dixon-Woods, Bonas, et al., 2006, p. 39). While an aggregative synthesis endeavours to secure claims of reproducibility for the protocols and findings, critical interpretive synthesise acknowledges the explicit dimension of subjectivity brought to bear on the generative aspect of interpretive work required to synthesise disparate bodies of evidence and theories competing to fix the 'problematic' women's responses. I have previously described the subjectivity I bring to this research. The investigative nature of any research inevitably incorporates some self-involvement, inasmuch as I chose the topic and my clinical daily practice with these women.

Despite the inherently subjective nature of interpretation using the authorial voice, Dixon-Woods, Cavers, et al. (2006) suggest that all interpretations be grounded in the data and strive for transparency, analytical honesty, and reflexivity:

Authors are charged with making conscientious and thorough searches, with making fair and appropriate selections of material, with seeking disconfirming evidence and other challenges to the

emergent theory, and with ensuring that the theory they generate is, while critically informed, plausible given the available evidence (p. 10).

Finally, as with any qualitative data analysis, it is commonly accepted that any researcher will interpret and code a transcript differently, and therefore some aspects of interpretive synthesis are neither reproducible nor auditable. Dixon-Woods, Cavers, et al. (2006) sharpen the distinction between methodological transparency and reproducibility, suggesting that “the dilemma between the ‘answerable’ question and the ‘meaningful’ question has received little attention, but it underpins key tensions between the two ends of the academic/pragmatic systematic review spectrum” (p. 11). Similarly, as with ‘what works for whom’ the paradox of the ‘answerable’ question is about specifics (the what), whereas the ‘meaningful’ questions seek to broaden understanding (the why).

As a sole researcher with limited resources, I cannot hope to provide a comprehensive meaning to such an extensive literature, but as mentioned in my introductory section, I have been able to synthesise and clarify the existing literature to some significant degree by applying a combination of objective, subjective and intersubjective epistemological lenses. My research not only meets academic requirements but furthers my own clinical journey with women, their children, and their families. This was achieved by articulating what I do innately from a cultural and gendered perspective, informed by my training and theoretical knowledge.

Context of the present study

For the past four decades, researchers have studied how mothers respond to the disclosure of the sexual abuse of their children. It would appear mothers' responses have not changed. A need identified to “operationalize” how mothers respond (Knott & Fabre, 2014) has described those responses as falling into three categories:

belief/protective/supportive, ambivalent, and non-belief/non-protective/non-supportive. It is the fluidity of these responses that appears to have confounded practitioners' attempts to conceptualise how to best intervene with the women to support children.

Torraco (2005) proposes that an integrative literature review of a mature topic is warranted when there is a discernible need for a reconceptualisation of a topic. Knott and Fabre (2014) highlight this need in their "systematic review and critical analysis of the literature" on maternal responses to the disclosure of child sexual abuse. An integrative review may also be required when there is a significant omission in the existing literature (Torraco, 2005). In my view, this significant omission exists insofar as we can only imagine what women as mothers might have contributed to the literature over the past four decades had they been consulted.

Methods

In considering an appropriate method for this review, I took Hart's (1988) view that methods naturally emerge from methodology, which aligns with Aveyard's (2014) contention that a literature review is a methodology in its own right. Therefore I applied critical interpretive synthesis methodology to guide how I approached, reviewed, and synthesised the literature.

Literature search and sampling

In consultation with the psychotherapy liaison librarian, I established that three databases would provide a multidisciplinary foundation without requiring resources beyond my capacity:

1. EBSCO Megafile Premiere: a multidisciplinary database providing comprehensive access to a research database with over 36,000 journals, e-

books, and secondary research databases, including SocINDEX, Psychology and Behavioral Sciences Collection, Newspaper Source, Medline, Humanities International Index Health Source: Nursing/Academic Edition, eBook Collection, CINHAL Plus with Full Text, Australia/New Zealand Reference Centre, and Academic Search Primer (EBSCO, 2015);

2. PEP digital archive, accessing 50 psychoanalytic journals (Psychoanalytic Electronic Publishing, 2013);
3. The Proquest Dissertation and Theses database, containing in excess of two million entries with new dissertations and theses added each year (ProQuest, 2014). The works in this database would remain relatively inaccessible if not for this service. This search provided material that potentially supported my clinical experience of the impact upon women within this particular context.

The preliminary literature search was initiated by searching the three electronic databases with these Keywords: Parent, Mother, Woman, Non-offending caregiver, Caregiver, Maternal. Respectively, each keyword was applied separately with these phrases: reaction OR response* to, OR experience* of, OR trauma*, OR disclos*, OR report*, AND "sexual* abuse* child*."

Search results were filtered to English language and a time frame of 1980 to 2014. My intention was to not screen out but to initially sweep the literature to get a sense of the breadth of the academic literature that contained both review articles and summative information. Successive searching was then informed by characteristics of the literature, for example, when women were directly quoted or researchers identified the subjective aspect of their research targeting women. A highly iterative process then ensued as I began reference chaining and screening reference lists for titles that might pertain to this project.

However, as such a broad sweep of the literature at first produced an unmanageable quantity of literature, I then began to sample the literature for the synthesis. Dixon-Woods, Cavers, et al. (2006) stress that “sampling is also warranted theoretically, in that the focus in interpretive synthesis is on development of concepts and theory rather than on exhaustive summary of all data” (p. 3). I began to realise that the concepts of attachment theory, trauma theory, grief and loss theory, and caregiving theory were subsumed in the overall literature. Throughout I was able to engage with the articles by using my own clinical experience, and to draw on my training to incorporate and clarify concepts.

As I described previously, conventional reviews stress explicit exclusion and inclusion, clearly demarcating what will and will not inform the review, whereas critical interpretive synthesis supports the view that inclusion and exclusion criteria potentiate missing material that could ostensibly inform the aim of the review. Dixon-Woods, Cavers, et al. (2006) advocate a more intuitive and purposive sample strategy “prioritising ‘signal’ (likely relevance) over ‘noise’ (the inverse of methodological quality) ... to maximise the inclusion and contribution of a wide variety of papers at the level of *concepts* [their emphasis]” (p. 4). I was aiming to explore the conceptual level in support of clinical understanding.

Critical analysis

A critical interpretive synthesis innovatively critiques the whole body of the review, including its strengths and weaknesses. This attempt to provide a broader view of the literature allows multiple relationships and perspectives to interact so that new perspectives can emerge and be recognised for their potential contribution. It is not

possible with conventional reviews to address such a broad perspective. For the purposes of this study I was guided by Torraco (2005):

Critical analysis often required the author first to deconstruct a topic into its basic elements. These may include the history and origins of the topic, its main concepts, the key relationships through which the concepts interact, research methods, applications of the topic, and so on. Careful analysis often exposes knowledge that may be taken for granted or hidden by years of intervening research. It allows the author to reconstruct, conceptually, the topic for a clearer understanding of it and assess how well the topic is represented in the literature (pp. 361-362).

Categorising the literature in terms of objective, subjective, and intersubjective approaches provides the basic elements referred to in the quote above. As described in my introduction, this investigative approach offers multiple vantage points or epistemological viewpoints enabling me to frame the knowledge contained in the literature.

To facilitate identifying themes and patterns over such a diverse body of literature required setting up a grid to identify key concepts and themes. This process began to provide a way of organising a vast quantity of literature. However, my goal was not to produce an organised description of the extant literature but rather to explore conceptual frameworks and identify areas that could provide critique.

According to Torraco (2005):

The critique should identify aspects of a phenomenon that are missing, incomplete, or poorly represented in the literature, ... It also identifies knowledge that should be created or improved in light of recent developments on the topic ... Thus, by highlighting the strengths and identifying the deficiencies in the existing literature, critical analysis is a necessary step toward improving the knowledge base (p.362).

Methodological constraints were the predominant positivistic paradigm with which to address a diverse population, alongside the ecological criticism where women were

being identified as both risk and saviour to the child, while not recognising the potential to revictimise all concerned when the dominant focus remained on risk only to the child. In concert with Torraco's view, the finding of my critical analysis highlighted methodological and ecological criticisms of the literature and laid the groundwork for an interpretive synthesis.

Interpretive synthesis

Having identified two areas for criticism, I was able to employ my training and clinical experience to explore possible alternatives in the form of a "synthesizing argument" as described by Dixon-Woods, Cavers, et al. (2006):

This argument integrates evidence from across the studies in the review into a coherent theoretical framework ... Its function is to provide more insightful, formalised, and generalizable ways of understanding a phenomenon ... it may require the generation of what we call synthetic constructs, which are the result of a transformation of the underlying evidence into a new conceptual form. Synthetic constructs are grounded in the evidence, but result from a distinct interpretation of the whole of that evidence, and allow the possibility of several disparate aspects of a phenomenon being unified in a more useful and explanatory way (p. 5)

In the next chapter I provide for consideration three divergent approaches (objective, subjective, and intersubjective) views of the literature with the four theoretical lenses that I consider are subsumed in the literature: attachment theory, trauma theory, loss and grief theory, and caregiving theory. My rationale for the three approaches came from the search process, in which I identified that there was a large body of material focusing on children and the risk women represented for the child (objective). Then, emerging out of training institutions in the way of research articles such as this, a growing discourse emerged of how women were impacted (subjective) similarly to their child. What appeared to be underrepresented was the social (intersubjective) perspective, as though these lived experiences existed in a vacuum.

In chapter four I provide conceptual links with the above approaches. My thinking as to the four theoretical lenses (attachment, trauma, loss and grief, and caregiving theories) being subsumed in the literature, was that these lenses were being focused to assess risk for the child only and not applied to assess and formulate interventions and specific therapy for a broader presenting problem, which included the women, the child and their families. Similarly Torracco (2005) also proposes the interpretive synthesis “integrates existing ideas with new ideas to create a new formulation of a topic or issue” (p. 362).

How the care and protection of children is managed has been under continual review and a subject of the academic and social discussion for 40-plus years across western countries. My aim was not to provide more empirical data, but to investigate how women as mothers could be repositioned closer to the centre within those discussions and be more fully and effectively helped and supported through the trauma of their child's disclosure to provide the care and protection of their child that is in everyone's best interest.

Chapter 3: Literature review

Introduction

The review of the literature will be presented in three sections. Section one will review the literature that objectively interprets women's responses in terms of risk assessments of victimised children's ongoing needs for care and protection. Section two will review the literature that has begun to attend to the subjective aspect of the women's experience; such as secondary traumatisation and the disruption to the relationship between the mother and child. The final section will attempt to provide an intersubjective description of the family and social context in which the women's responses to the disclosure occur.

Section one: Objective lens to the literature

The care and protection debate examines the function of the mother's responses to her child and her capacity to be protective and or supportive as viewed primarily through state regulation and implementation of child protection services (Alaggia, 2002; Knott, 2008, 2012). Therefore the emphasis is on the woman in her mothering role being physically and emotionally available to provide immediate, ongoing safety for the child and ensure interventions assigned by social workers are adhered to (Alaggia, 2002). Coohy and O'Leary (2008) address the notion of "consistency" (p. 249) in providing enduring care and protection (Alaggia, 2002) for the child rather than vacillating due to her own psychological and contextual needs.

Bolen and Lamb (2004) reviewed interdisciplinary literature, describing vacillating, ambivalent responses by women post-disclosure, with one description of ambivalence in this context as "conflict in valences between child and perpetrator..." (p. 206). Historically, these responses were considered a negative response, witnessed

during disclosure and post-disclosure, with minimal consideration for how the disclosure was experienced by the woman and how the disclosure process could compound stressors in the orbit of the woman's life. Bolen and Lamb (2004) suggest ambivalence is a normative response to the initial disclosure, as previously suggested by other authors (Hooper, 1992b; Hooper & Humphreys, 1998) as occurring during a life-changing event.

Mothers' protection through support and belief

Elliott and Carnes (2001) identified that these constructs of protection, support, and belief (in the validity of the child's narrative) are not without methodological issues. Their literature review established that most nonoffending mothers believe their child at time of disclosure, and most mothers are protective and supportive; however, some women respond inconsistently over time, and believing does not always lead to continued protection and support. According to Tamraz (1996), the woman, as nonoffending caregiver, is "viewed simultaneously as the object of blame for not protecting her children, to control the perpetrator, and to safeguard her family, and as a subject of hope for rescuing the victim and maintaining the home" (p. 76).

Knott and Fabre (2014) proposed that the "existing theoretical conceptualization of maternal response...is inadequate" with the literature highlighting contradictory maternal responses being categorised into either positive or negative domains, and suggesting that these categories fail to articulate the complex interpersonal and contextual dynamics involved for these women and their children and families.

Risk factors identified for the care and protection of children

The risk factors discussed in the majority of the studies address women's responses that potentially place the child at risk. These have been identified as interpersonal factors, alcohol or substance misuse, socioeconomic factors, intergenerational transmission, and family structure.

Interpersonal variables

A significant interpersonal variable addresses what is socially called the "revolving door" partner or "Cinderella effect" (Burgess & Draiss, 1999), which describes a pattern of changing cohabiting male partners and identifies that children are at increased risk of physical harm, including homicide and sexual abuse, when a male partner is not the biological father. Men are consistently overrepresented as perpetrators of sexually abusing both girls and boys (Benoit, Coolbear, & Crawford, 2008; Green, 1996). The woman's relationship to the alleged perpetrator intersects with multiple variables, such as attachment styles between the adults, the length of time the adults have been cohabiting, the age or developmental levels of the adults, and their capacity to resource or respond from an adult perspective (Cassidy & Shaver, 2008).

The presence of domestic/spousal/interpersonal violence within the family group (Kim, Noll, Putnam, & Trickett, 2007) has been correlated with increased risk of children being sexually abused (Alaggia & Turton, 2005; Hendry, 1998). Research also highlights the correlation between domestic/spousal/interpersonal violence and child abuse (Benoit et al., 2008), noting the ongoing psychological impact upon a child witnessing these violent interpersonal interactions (Holden & Geffner, 2009; Shonkoff et al., 2004). Other studies indicate that the child's disclosure prompted some women to leave these relationships (Hiebert-Murphy, 2001), but data was not available or did not identify the capacity of these women to maintain a safe distance from these violent

relationships until a level of interpersonal safety was established between the adults involved.

Substance or alcohol misuse or abuse

Substance misuse or abuse by caregivers, regardless of gender, has been retrospectively associated with increased risk to the child of both physical and sexual abuse, and the risk further increases if the home is populated by two caregivers who misuse or abuse alcohol (Benoit et al., 2008). Significantly, the caregiver's capacity to be an effective adult/parent is diminished (Knott, 2008; Leifer, Kilbane, & Kalick, 2004) resulting in an unsafe environment. Some studies consistently iterate the co-occurrence of drug and alcohol misuse by women with a history of single and multiple incidents of trauma (Blakey & Hatcher, 2013).

Local contextual data

Contextual factors from a New Zealand perspective were described by Wynd (2013) in an analysis of data from Child, Youth and Family, who identified that between 2008 and 2012 that of the 12,000 substantiated cases of child abuse (emotional, physical, neglect, and sexual), only 6% were child sexual abuse (p. 7). Input from submissions "... noted the role of poverty and deprivation in child maltreatment" (p. 3). Wynd's (2013) literature review showed that poverty plays a significant role when mixed with the "dynamic matrix of individual stresses and capabilities" (Wynd, 2013, p. 3). Other studies consistent with this data, summarised by Simpson and Belsky (2008), also describe the impact of socioeconomic stress, which displays as "more insensitive, harsh, rejecting, inconsistent, and/or unpredictable parenting practices" (p. 143).

Adolescent mothers were highlighted by Wynd (2013) and Chaudhuri, Easterbrooks, and Davis (2009) as a group that is more vulnerable to the impact of

socioeconomic deprivation, often complicated by interrupted education and reliance upon extended family or social agencies to provide economic support.

Economic cost to families

Women unable to activate support to get help with the change in financial circumstances as a result of a child's disclosure can be left considering not disclosing or delaying disclosure, rather than the family (women and children) struggling to have basic needs met. This would subsequently compromise the child's safety and facilitate revictimisation (Alaggia & Turton, 2005; Breckenridge, 2006; Hooper, 1992b; Knott, 2008, 2012).

The nonoffending caregiver is left with domestic responsibilities (housing, food, getting children to school, attending appointments with ongoing care and protections services) and the financial burden is exacerbated if the family is a single income family. Also if the caregiver is employed, they find themselves negotiating with an employer for time off work to attend to the multiple competing demands often required post-disclosure with regulatory bodies and for the child.

The economic cost in America of child maltreatment, of which sexual abuse is one example, is estimated to be a social and economic burden of approximately \$220 million per day (Schofield, Lee, & Merrick, 2013). With the present capacity of statutory agencies directed at post-interventions, there is no conceivable way to infer anything other than a social "lifetime burden of new cases" (Schofield et al., 2013, p. S37). These data would readily correlate to other western countries including New Zealand.

Intergenerational transmission

There is considerable anecdotal and correlational data within the child sexual abuse literature suggesting the notion of intergenerational transmission (Alaggia, 1999; Breckenridge, 2006). This refers to ways of coping or responding to environmental impacts passing from one generation to the next. This notion, when applied to caregivers of children who have been sexually abused, describes parents who, as a child themselves, experienced abuse and or maltreatment (Carlson, 1994; Coohy & O'Leary, 2008; Herman, 1992).

The hypothesis is that many caregivers who appear to not intervene in response to covert signs of abuse or tentative disclosures lack skilful interventions and are therefore unable to provide safe environments for their children. These transmissions appear to be stress-related (Pintello, 2000), that is, trigger for the caregiver a cognitive or physiological response that might facilitate the adult into fuller awareness of an historical dilemma for themselves. However, while there remains inconclusive or dichotomous evidence from research into sexual abuse regarding parents of sexually abused children, it remains a clinical observation "that child abuse in one generation poses a risk to children in the next" (Alaggia, 1999; Herrenkohl, Klika, Brown, Herrenkohl, & Leeb, 2013, p. S19).

Both the concept of revictimisation (Classen, Palesh, & Aggarwal, 2005) and that of intergenerational transmission describe how children and families develop responses to the impact of being harmed and assaulted, but the term revictimisation more clearly identifies contextual vulnerabilities that influence client's interactions with the environment rather than suggesting a genetic code or contagion that is passed from generation to generation.

Family structures

Understanding the structure of families as a social variable means a family can comprise any group of adults and children/adolescents cohabiting. As indicated above, the risk to children increases when an adult that cohabits with the primary caregiver is nonbiological. Step-families (reconstituting) families are correlated with increased intrafamilial abuse, with perpetrators being both biological and step-parents or siblings. Single parent and step-families do not differ significantly in regard to extrafamilial abuse and victimisation of children. Children and youth in traditional families still experience victimisation; however it is suggested they are confronted by fewer external factors (Turner, Finkelhor, & Ormond, 2007). Notably missing in the majority of the literature was a lack of data concerning siblings and how they were impacted. Nevertheless, it is clear that while parents remain the primary attachment relationship for children, children benefit from all their secure relationships with other adults and children. Kinship or larger family systems may include the neighbourhood (Shonkoff et al., 2004).

Why the response has led the way

Across studies there is consistency in reporting that the mother's response is fundamental to the child's immediate and ongoing recovery and continued developmental wellbeing, with positive maternal responses resulting in reduced symptomology and revictimisation (Alaggia & Turton, 2005; Briere, 1992a; Briere & Elliott, 1994; Elliott & Carnes, 2001; Godbout, Briere, Sabourin, & Lussier, 2014; Hooper, 1992b; Hooper & Humphreys, 1998; Scheeringa & Zeanah, 2001; Spaccarelli, 1994). For this reason, studies with a child-centred focus have tended to see mothers as conduits for the care and protection of the child (Featherstone, White, & Morris, 2014). On the one hand, women are positioned as agents for their children's

recovery, but on the other, they themselves receive little support to expand their awareness or develop their capacity to meet their own or their child's functional interpersonal needs.

Section two: Subjective lens to the literature

Women's responses captured as themes by the literature identify shock, confusion, denial, anger, guilt, blame, isolation, sadness, depression, grief, immediate survival-oriented coping, and longer-term loss. These subjective narrative themes identify the internal psychological and traumatic responses these women experienced at the same time as processing their child's disclosure. This section will briefly present what is consistently represented in the literature. While each response has its own narrative, together they highlight a universality of responses that the literature has translated from the loss and grief literature to women's response in this context.

Shock, confusion and denial

A woman describes her initial reaction: "When it first happened, you feel like, God, I'm the only one, you know, and I have got to keep it to myself. I don't want anybody to know...It was really hard, because I didn't want to open up and let anybody know what was going on. So I don't really talk to anybody about it...I just kind of kept it inside" (Carlson, 1994, p. 142).

Another woman said that, "I felt like that deer running across the road. Yeah, I was like the deer; you know you're like what, what's next? Just sort of in shock and not sure which – do I keep going or, you know trying to process I am about to get hit...you're like wait-no-wait. You know it's a shock, you know like you just want to stop. Do you run, or what, because you don't know what's happening next. You don't

want to know what's happening next. You just want to wait" (Willingham, 2007, p. 50).

A final description: "I think it takes the connotation of a natural disaster, sort like a flood, it comes in, washes over everything, dirties everything and it's very hard to relate to other people who haven't experienced it" (Willingham, 2007, p. 48).

Anger

Research data by Finkelhor (1984) of 541 randomly selected parents found 9% had children who had experienced sexual abuse. The predominant reaction of these parents' to their child's disclosure was anger followed by fright and guilt. However, the 91% of the parents who had children with no sexual abuse history reported that they would experience more embarrassment, suggesting a difference between a subjective experience and an objective estimation.

One woman's response to her son's sexual assault by a neighbour's child was, "...we had a lot of pride in our community and we cared a lot about kids, now we for the most part could care less about what happens to the community... I used to teach tennis and I didn't even pick up a racket this year cause I was afraid I might hit somebody with it, and that would be bad. So I figure, no, I better not work with some kids" (Sanders, 2012, p. 103).

However anger appears to have multiple functions and can be displaced by distorted thinking, as described in a group process by this woman:

Yeah. I was real angry, real angry at my daughter, really angry at my well, soon-to-be ex-husband, real angry at myself. ... Because he could find the sexual gratification supposedly from her, rather than from his own wife. And that made me angry. And I kind of – sometimes I looked at her, and it's just like, you know, what did she have that I didn't have? Or what could she do that I couldn't do? And it was just – I don't know. I would just – I would get really

angry sometimes looking at her. It's just like how dare you step into my place (Carlson, 1994, p. 115).

It took a group process with other nonoffending mothers to challenge this distorted thinking to support this woman to identify that it wasn't her four-year-old daughter's fault and begin to apportion responsibility to the adult who harmed her child.

Guilt, self-blame, isolation, sadness, depression

In describing her post-disclosure depression, one woman stated, "I didn't know how to deal with it. ... There was guilt to think that something was happening to my child that I was not aware of, and that I wasn't protecting her adequately. ... But I couldn't really deal with that, because I was – you know, I was overwhelmed by everything" (Carlson, 1994, p. 138).

Another woman describes her descent into isolation: "I became a person I didn't know... There were times I wouldn't want my children to know I was crying...I'd go in my closet and stick my head in the pillow and cry...Or scream because there was nowhere to really let it out" (Lindros, 2010, p. 72).

Immediate survival-oriented coping

Some women choose not to end their marriage even after their child discloses sexual abuse from their partner. One mother describes the decision she made to ensure she could support her child: "My family are my kids and my husband, my parents are both dead. I have no connection with anybody in the older generation, they are all dead. There is no family ... I had to deal with things like bail money, in between my daughter being hysterical and not wanting to go to school. I was trying to do them both at the same time, but I was ill and he was the sole support of my family, and I needed him to keep that job, ... so I needed to protect that we could eat and function and I didn't get thrown out of my house" (Willingham, 2007, p. 69).

Longer-term grief and loss

This woman's description, "I just wish you could say 'it's gone.' Like taking the trash out, 'it's gone.' But it's never gone. It gets easier, but it's never gone." (Krigbaum-Rich, 1991, p. 143) describing the impact five years' post-disclosure.

However, my clinical experience would suggest responses when considered in the context of a disclosure often fail to highlight that a disclosure is not a single event for the child or the mother, something that can be specifically identified as beginning and ending at a set point. Like the child's disclosure, women's responses unfold, and often this is a recursive process as with each retelling by their child women rediscover their responses anew.

Gendered receptivity to other's experiences

According to Baum (2014), the literature on gendered receptivity "shows that females in the family, whether daughters, wives, or mothers, are consistently more likely than the male ... to experience the Posttraumatic Stress Disorder ... symptoms of a traumatized family member without having experienced the traumatic event itself" (p.225). This subjective experience of secondary traumatisation was experienced whether the primary victim experienced a single (sexual assault) or a cumulative event (holocaust), whether the event was recent or decades had passed, whether the secondary victim was a child or adult, or whether they were living together or apart. This suggests that the capacity of women to empathise with another, especially a close other, facilitates the process of secondary traumatisation (Baum, 2014; Figley, 2012).

Not surprisingly and similarly to their child, women can experience both short- and long-term impacts upon hearing their child's disclosure. Although the literature regarding the degree and presence of clinical psychological adjustment is

contradictory, whether there is any historical agency (regardless of typology) or is a direct impact of the sexual abuse disclosure, the psychological trauma/impact has been noted to persist after the disclosure from a one- to five-year time frame (Gomez-Schwartz et al., 1990; Manion et al., 1998; Tubbet, Swanston, Oates, & O'Toole, 1997).

Section three: Intersubjective lens – family as social and cultural context

The intersubjective lens “refers to the reciprocal influence of ...two or more people [or systems] in a relationship” (Natterson & Friedman, 1995, p. 1) implicitly or explicitly shaping the other via their interactions. The intergenerational process of mothering to child, child to woman, woman to mothering invites an ecological approach when nested in the whole social system, the child (microsystems), women as mothers (mesosystems), the family (exosystems), and society (macrosystems) (Bronfenbrenner, 1979).

Family

When considering family structures as an intersubjective experience, adult development, especially that of women, has been described by Gilligan (1982) as the ongoing struggle between connection and disconnection. In being present to others (such as partners) women may become absent to their own needs. It would seem in some instances that this also impacts their capacity to identify with their child's needs. As previously discussed, the risk to children if the woman's partner is not a biological parent significantly increases, particularly in cases of incest and intrafamilial abuse. Massat and Lundy (1998) note the stigmatisation of the nonoffending caregiver, resulting in reduced family and relational support. Women still experience the loss of an intimate relationship despite the fact that this close other has victimised their child. Social isolation is strongly correlated with these intrafamilial disclosures (Finkelhor,

1984). Often women feel responsible for their partner's sexual violations, and are reluctant to disclose these in the community.

I was not able to locate literature that captured recursive family processes familiar to clinicians in intrafamilial abuse cases. However, my own clinical experience suggests that families under stress often choose from a limited repertoire. For example, one pathway is when a family chooses not to disclose to members of the wider family. Here they may begin to isolate themselves or find creative ways to continue the illusion that the family has not changed. For example, a family might choose to attend extended family functions with one child in the morning and other family members in the afternoon, thereby giving the appearance of unity and preserving family rituals. Women also begin to isolate children for fear of others finding out by reducing extracurricular activities.

An alternative pathway is when women choose to disclose intrafamilial abuse to the whole family. Here families often become divided over the veracity of the child's disclosure, resulting in the stigmatisation of the child and mother (Sirles & Franke, 1989). Biological family members of the offending adult will often display similar responses as the mother did when her child first disclosed.

Social

This review advocates the definition of family as a social unit or "conceptual tool" (Featherstone et al., 2014, p. 131), to describe groups that share accommodation or people co-habiting in close relationship. Family support or protection of children has tended to focus on women to the exclusion of the other adult or the family as a whole system (Featherstone et al., 2014). Therefore responses to women as mothers within

vulnerable families struggling with multiple life stressors that intervene to support only the child, that is, only one part of the system, lack ecological validity.

Cultural

When cultural issues are raised in the literature describing women's responses, the primary considerations are about colour, ethnicity, or religious practices that influence women's responses, and highlight culture as areas for further investigation or consideration (Knott & Fabre, 2014; Ortiz, 2013). This theorising predominantly originates out of western cultures (Solomon, 2002). Useful observations can be found about gender. Social work, for example, is performed predominantly by female clinical workers (Featherstone, 2006), highlighting the cultural pattern of women policing women's mothering practices.

Culture can be understood as the "transmitter, buffer, and healer" (Danieli, 2007, p. 78) of how shared life experiences are transmitted (Tronick, 2007), constructing and mediating experiences that include trauma. Culturally influenced issues and traumas include colonisation of peoples within most western cultures, gendered practices such as patriarchal (Herman, 1992) and matriarchal social structures (Featherstone, 2006), and specific to this study, unrealistic social views of women's capacity to care for children despite both extrafamilial and intrafamilial sexual abuse of children by persons in roles of trust after, but not always, an extensive grooming process (Herrera, 2007).

Alaggia (1999) suggests that we can learn from the social and clinical work with battered women not to focus narrowly on "personality disorders, ego deficits and dysfunctional relationships patterns" (p.109), but rather to develop approaches that

support women by comprehending their context – the full spectrum of individual, social, cultural, and political influences as contributing factors in women's responses.

As iterated in section one, there is consistency across studies in reporting that the mother's response is fundamental to the child's immediate and ongoing recovery and wellbeing (Alaggia & Turton, 2005; Briere, 1992a; Briere & Elliott, 1994; Elliott & Carnes, 2001; Hooper, 1992a; Hooper & Humphreys, 1998; Knott & Fabre, 2014; Scheeringa & Zeanah, 2001; Spaccarelli, 1994). Therefore, this reorientation of what women require as mothers to support their recovery might potentially expand a child-centred focus to include the woman and her family context, with resulting reduced intergenerational revictimisation through dyadic relational and caregiving patterns by women.

Summary

In this chapter, I have provided a sample of what the literature is highlighting when considering women's responses to their child's disclosure through an objective, subjective, and intersubjective view. In the next chapter I will provide the critical interpretive synthesis of this literature with the four theories: attachment, trauma, loss and grief, and caregiving.

Chapter 4: Critical interpretive synthesis

Introduction

This chapter offers a brief critical analysis of the literature reviewed and addresses a number of perceived limitations. This critical analysis is then expanded by providing four theoretical lenses by which women's responses can be more rigorously conceptualised: attachment theory, trauma theory, grief and loss theory, and caregiving theory.

Critical analysis

The critical analysis provided here identifies limitations in the literature, such as positivistic approaches to practice, theory and research, preservation of the family unit prioritised over wellbeing of women and children, lack of conceptual clarity, and inconsistent ecological validity.

Originating in the sociopolitical context of the 1950s, the literature on maternal responses shared the positivistic approaches to practice, theory, and research characteristic of the times. Women's responses were evaluated as healthy or sick, and measured in terms of whether they enhanced child safety and/or protected the family unit. In fact, a strong focus on the care and protection of children only emerged as recently as the 1990s (Gelles, 1993; Vesneski, 2009).

Knott and Fabre (2014) explicitly address the need to operationalise and reconceptualise the maternal response, in particular, that "understanding the complexity of an oscillating maternal response dynamic is critical to advance practice" (Knott & Fabre, 2014, p. 1). Originally driven by the need to organise and deliver care and protection services (Knott, 2008), providers viewed any maternal response of ambivalence in highly negative terms. The scope of services historically provided to

women in this context lacked conceptual knowledge concerning normative psychological process for any person confronted by a traumatic disclosure that profoundly disrupts their life, while requiring at the same time a new level of responsibility to keep their child safe. The concept of ambivalence has a significant clinical lineage in social work, psychology, and psychoanalytic thinking. It could play a key role in understanding the relationship between mother and child, therapist and client, and state and society in situations of stress (Holloway & Featherstone, 1997). As Bolen and Lamb (2004) have identified “tapping into theoretical interdisciplinary literature” (p. 202) would extend research to support this client group.

The use of retrospective data from women with a history of unresolved/interpersonal trauma, who potentially have distortions in their autobiographical memory (Schoe, 1994), or even secure-enough women in a period of interpersonal crisis such as the post-disclosure period, raises questions about the reliability of data obtained under traumatic conditions. Briere (1992b) has previously highlighted the need for “greater attention to design sensitivity, greater control over extraneous variables, and careful inferences about causality” (p. 202) regarding methodological issues in the study of sexual abuse. Several authors in the literature also identify limitations due to small, clinical, and convenience samples being utilised, making generalisation less than optimal (Alaggia, 2002; Alaggia & Turton, 2005; Bolen & Lamb, 2007; Deblinger, Hathaway, Lippmann, & Steer, 1993; Faller, 1988; Kim, Trickett, & Putnam, 2010; Lipton, 1997; Pintello & Zuravin, 2001; Plummer, 2006). Similarly Pintello (2000) reviewed the literature of “17 empirical studies that examine maternal belief and protective action” (p. 33), identifying that no similar studies prior to 1985 existed and highlighting methodological inconsistency across these studies.

Ecological validity also needs further consideration. I described in the introduction how women and children were often discussed in the literature as if they existed in a vacuum and suggested that this approach might lack ecological validity. A majority of the studies reviewed suggested that the immediate and ongoing recovery of the child was dependent upon the care and support of the mother and that the women's sociocontextual environment was correlated with risk for the child. These concerns have a history "in [classical] attachment theory, [where] there is a pre-supposition of power to provide children with primary protection, provision, and guidance, [and] women lack considerable power in negotiating their own protection, provision, and guidance" (Solomon, 2002, p. 141).

While classical attachment theory provided the groundwork to understand the impact upon the child of contextual factors influenced through the caregiver, I believe modern attachment theory now provides an ecological view of how the world of the infant-mother is not divisible. Care and protection afforded to children on their own is neither ethical nor effective. Recent data from neuroscience can be incorporated into modern attachment theory, yielding a theory of emotional regulation of mind and body (Schore, 1994; Schore & Schore, 2007). A mother's need for care and protection via therapeutic and social intervention in order to enhance her capacity to regulate both herself and her child's emotional experience through the disclosure process is vital.

How do we come to know and support women in their roles as mothers when faced with a crisis? It has been identified that most therapies have efficacy when targeted appropriately (Roth & Fonagy, 1996). When working with families, the success of interventions is observable in the short-term through the child's reduced symptomology (Crittenden, Dallos, & Landini, 2014), whereas one long-term measure of success would be the child in adulthood becoming a successful partner and parent.

Interpretive synthesis

The construction of multiple views to inform theory, science, and practice identifies that methodological pluralism is essential as “cumulative problems can only be viewed by cross-disciplinary consideration and their treatment is only conceivable by comprehensive measures” (Göppner, 2012, p. 547). Anastas (2014) likewise highlights the “rapprochement ... between practice and science” (p.571).

A cross-disciplinary approach informed my thinking when reading the literature on women's responses. It seemed to me that attachment theory, trauma theory, loss and grief theory, and caregiving theory were implicitly if not explicitly present in most of the research articles I reviewed. The integration of these four theoretical lenses has the potential to overcome reductionist approaches historically associated with divisive responses to working in a post-disclosure context by providing a more complex and nuanced understanding of the context of these women's lived experience. This interpretive synthesis attempts to provide such an integration.

Attachment theory

Classical attachment theory and how it was operationalised (see Appendix A) provides indicators of risk to children. However as Fonagy and Target (2002) note:

Linking attachment to mere relationship representations underrates its importance for psychic development. Early relationships are far more important than we originally thought. However, their role is not to set templates or internal working models that would govern subsequent relationships. Attachment relationships are formative because they facilitate the development of the brain's major self-regulatory mechanisms, which in turn allows the individual to perform effectively in society (p. 328).

Attachment theory and emotional regulation

Over the past two decades attachment theory has incorporated interdisciplinary data from neurobiology, expanding attachment theory's emphasis on observational data, narrative, and reflective capacities to include "bodily-based processes, interactive regulation, early experience-dependent brain maturation, stress and nonconscious relational transaction" (Schoore & Schoore, 2007, p. 9; van der Kolk, 2005). This extends attachment theory to a theory of self-regulation that emerges from the mother-infant coregulation, initially as an interactive process, then becoming an internalised process of self-regulation for the developing child-adolescent-adult. This was also reflected by Fonagy, Gergeley, Jurist, and Target's (2002) publication *Affect Regulation, Mentalization, and the Development of the Self*. Mentalisation refers to the capacity to implicitly and explicitly reflect upon cognitions and affect about oneself and others while regulating these in order to assess and interpret them into meaningful fluid communications.

The development of the rules of communicating within the dyadic relationship are "structured processes serving to obtain or limit access to information" (Main, Kaplan, & Cassidy, 1985, p. 77), describing internal implicit representational patterns of relational engagement. For example, a mother unable to attune to her child will intrusively continue to interact through play or eye contact and the infant will actively snub her, averting his or her gaze in order to manage the engagement or awareness of the impact of the mother's behaviour. If this relational pattern dominates their interactions it can leave the infant in a state of heightened arousal, overwhelmed in its attempts to regulate its cognitive/emotional/somatic state, and secondly, hindering his or her ability to develop the capacity to mentalise (Fonagy & Target, 2006).

Mentalising refers to the capacity to think about one's thinking, which for an

infant describes initially becoming aware of his or her own feelings through an interaction with a caregiver noticing her behaviour had overwhelmed the child and adapting her responses to support the child. This allows the child to become aware of his or her response rather than be overwhelmed by the adult's response (Fonagy & Target, 2006; Holmes, 1993). When considering the rules of communication it is worth repeating that the mother's responses in this context are in response to the disclosure (communication) process by the child, and the assessment by professionals of the woman's responses and reaction are also a communication.

A recent study investigating the intergenerational transmission of attachment style from mothers with unresolved childhood trauma or neglect has highlighted that it is not that they lack the capacity to mentalise in general, but more specifically exhibit "the *absence of mentalization regarding [their] trauma* that underlies the risk of infant attachment disorganisation" (Berthelot et al., 2015, p. 209). This deficit in the caregiver predicts attachment disorganisation for infants, and highlights the need to support parents develop their reflective functioning through mentalising about their child's mental states (think about how the child might be experiencing themselves). This allows them to consider their own reaction to their child's distress, rather than simply projecting and assigning trauma-related ideation to the child. Unless brought to awareness through the capacity to mentalise in a secure enough relationship, "attachment experiences are thus imprinted in an internal working model that encodes strategies of affect regulation that act at implicit nonconscious levels" (Schore & Schore, 2007, p. 12).

Attachment theory and risk assessment for the mother-child dyad

The foregoing has important implications for risk assessment of children and for the women who are their primary caregivers, as well as for the development of strategies

that could support clinical engagement with this client group. We need to understand what might be transpiring for a child once they disclose. In some cases they have disclosed outside the family, and this might indicate they are able to seek other relationships to support their approach to mother and family in a crisis. For other children it might suggest that disclosure has forced a breakdown in the status quo with their caregiver. For children who are able to disclose to a parent, this highlights their attempt to activate the protective function of their attachment system. This may indicate prior experience of receiving support or protection within the dyadic or family system. Attachment theory has consistently identified that what a child needs from the attachment system is a secure base within which to find coregulation of any arousal caused by disruption to any aspect of their environment.

The primary nonoffending caregiver usually remains central to their child's environment. Assessment of the caregiver's capacity to regulate both herself and the child is often demonstrated in the clinical setting. While an adult has considerable experience at defensively engaging other adults, a child will display or enact the dyadic attachment pattern much more obviously and directly. Through understanding and using attachment theory, clinicians have a lens through which to identify the woman's strategies and interpersonal relations or deficits developed around the regulation of her emotional responses. This lens provides valuable information on how to engage the woman, and how to scaffold and support the woman's capacity to regulate her emotional, behavioural, and cognitive arousal. The primary task for clinicians working with families or mother-child dyads is to become a partner in the coregulation of the dyad, supporting the woman, her child, or both parties.

Attachment theory has conceptualised how therapists need to understand not only the woman's attachment style but their own attachment style, providing a

compass to support the development of a working alliance with women rather than activate their (therapist) own implicit defences associated with early attachment relationships. A therapist who is unaware of their attachment style will tend to reinforce the client's early defences associated with approaching or avoiding another as a secure base. For example, a woman identified as struggling to leave her husband or latest partner even in the face of evidence this person sexually harmed or violated her child might have a preoccupied attachment style. For many of these women, their greatest fear as a child was being abandoned through separation or loss. Their defence against this loss has become to achieve closeness at any cost to their personal selves.

If the therapist working with this client has an underlying avoidant attachment style, they might struggle with the closeness this woman requires as she potentially transitions out of her codependant relationship with her partner. Therapists who recognise the need to meet the client where they are would begin the therapeutic task of expanding the client's emotional repertoire and regulation (Wallin, 2007), whereas misattunement by the therapist potentially reinforces the client's early survival strategies, producing ongoing interpersonal trauma for the dyad and perpetuating intergenerational patterns of insecure attachment for the woman and child.

Attachment theory and objective care and protection research

Chapter three captures the clinical data describing research on how mothers' responses are viewed as supportive and protective or non-supportive and non-protective. This research identifies whether the women are physically and emotionally available as well as any risk factors that impede the women's capacity to perform functional mothering. These risk factors address interpersonal variables, domestic violence, interpersonal violence, substance and alcohol misuse, intergenerational transmission, family structure, and economic status, and are correlated to the unavailability of

consistent and appropriate care of the child when the primary caregiver is under the influence of these contextually environmental stimuli.

It was notable that these women were not considered at risk from these stimuli, nor that their lifestyles reflected learnt intergenerational patterns that may have impeded developmentally appropriate task orientations (Erickson, 1968). The focus of the data was on what the women could perform, rather than identifying a lack of capacity or skill or both. Nevertheless, state regulation and child protection services require mothers to provide consistent enduring care (Alaggia, 2002; Coohy & O'Leary, 2008; Knott, 2008, 2012). When viewed through the classical attachment research (see Appendix A), both attachment theory and child protection agencies are in accordance as to the immediacy of what is imperative for the child (Ainsworth, 1978; Bowlby, 1982).

In Knott and Fabre's (2014) systematic review and critical analysis of the literature, they suggest the "existing theoretical conceptualization of maternal response ... is inadequate" (p. 1), highlighting how women's responses have been polarised in the literature. As an example of this polarisation, Bolen and Lamb's (2004) review of the literature highlighted how women's ambivalent responses were viewed in the child sexual abuse literature as negative responses, and they suggest tapping into interdisciplinary theory to extend this research area. Modern attachment theory could position ambivalent responses as a dysregulation of the psychobiological system, addressing the cognitive and psychological dissonance that can occur when communication (child's disclosure) about the attachment system (to a close other) has activated early implicit attachment responses to relational disruption.

As described earlier, women are positioned as agents for their children's recovery, but receive little support to expand their awareness or develop their own or their child's functional interpersonal needs. Notwithstanding these concerns, the convergence of interdisciplinary research (Schoore & Schoore, 2007) that now informs modern attachment theory extends the concepts of safety and security (Bowlby, 1988), the cornerstones of attachment theory. Modern attachment theory as a theory of psychobiological regulation describes the development of self- and other-regulation, an implicit right brain function that can be facilitated into explicit awareness via a supportive therapeutic relationship. It is only when a woman can self-regulate that she can support her child to regulate. The development of self-regulation from an attachment perspective allows both the woman and child to resume and extend their interpersonal functioning with more flexibility, and to participate as social and cultured agents.

Psychological trauma

This section briefly summarises the work of trauma theorists Judith Herman, Charles Figley, and others. Herman (1992) identified three waves or phases of theory that have culminated in the identification of a psychology of trauma. First, in their seminal work in the late 18th century, Jean-Martin Charcot, Pierre Janet, and Sigmund Freud identified the process of how external events experienced as traumatic are not consciously assimilated and cannot be given every day meaning, but are still incorporated into the psychological functioning of persons, often remaining out of awareness.

The second wave, the study of war veterans from World War 1 through to the Vietnam War, identified the impact of exposure to military engagements causing "shell shock or combat neurosis" (Herman, 1992, p. 9). The third wave was in the

1970s, when the impact on victims of sexual and domestic violence was acknowledged (Herman, 1992). Herman (1992) contends that the change in political climate around the Vietnam War and the feminist movement's support for survivors of childhood sexual abuse progressed the diagnosis of Post-Traumatic Stress Disorder (PTSD) into the DSM-111 in 1980. PTSD is the ongoing re-experiencing of the initial stress reaction. According to Herman (1992) this clinical picture did not capture the full range of symptomology of adult survivors of childhood sexual abuse; for example, dissociation, ongoing interpersonal problems, and somatisation were not included. Subsequently, the diagnosis of complex-PTSD was created to support the clinical data being presented (Figley, 2012; Herman, 1992). The resurgence of a psychology of trauma was therefore facilitated by both sociopolitical and cultural influences (Figley, 2012; Herman, 1992).

Immediate and cumulative responses to trauma

The fight or flight stress reactions that can occur following exposure to trauma were first described by Cannon (1914) as a sequence of events that precede cognitive processing, identifying a response where neither the body nor mind are able to consciously control aspects of the response. This dysregulation of the mind-body response can potentiate immediate and enduring cognitive and emotional difficulties. Underpinning and reinforcing these responses are the physiological changes, neurochemical and neuroanatomical, that take place due to the stress hormones released at onset of the perceived traumatic event. Fiorillo and Follette (2012) in their review of "related research that addressed the conceptual, operational, and methodological issues relevant to cumulative trauma", list the following terms: "accumulated trauma or exposure to violence, retraumatization, revictimization, co-occurrence, lifetime trauma, life span revictimization, cumulative exposure or effects,

polytraumatization and polyvictimization” (p. 187). They identified that most of the research has focused on women within the context of interpersonal trauma, with exposure to trauma often beginning in childhood and facilitating repeated aspects of abuse in adulthood. Evidence suggests a significant number of women experience trauma; however the severity and duration is complex to determine, with variable responses by each individual (Figley, 2012), and evidence of a trauma having occurred being dependent upon it being reported or captured in studies.

The prevalence of interpersonal abuse for women having experienced childhood sexual abuse has consistently identified revictimisation. However children who have experienced both sexual and physical violence are at even greater risk of psychological retraumatisation. Baum (2014), as discussed previously, suggests “gendered receptivity to Secondary Traumatic Syndrome” (p.225), and found sufficient data to allow for the consideration that mothers of sexually abused girls are at greater risk of empathic receptivity of their child's distress and displaying similar distress as their child.

Exposure to another's communication of traumatic experience for clinicians has also gained considerable momentum in the research literature, and has been described as secondary traumatic stress, vicarious trauma, and compassion fatigue. Figley (1995) states: “Professionals who listen to clients stories of fear, pain and suffering may feel similar fear, pain, and suffering because they care” (p. 1), and coined the terms *secondary traumatic stress* and *secondary traumatic stress disorder*, defining them as “natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by another” (p. 7).

Similarly, another phenomena, *vicarious trauma*, a term coined by McCann and Pearlman (1990), describes inner transformations in the cognitive schema of professionals working with survivors of traumatic events that distorts their belief systems, own interpersonal relationships, and sense of safety in the world. As Figley (1995) continued this line of research, he changed the term secondary trauma to *compassion fatigue*, iterating that this description was less stigmatising of the normative occupational consequences of working with trauma victims. He defined compassion fatigue as “a state of exhaustion and dysfunction – biological, psychologically, and socially – as a result of prolonged exposure to compassion stress and all that is evoked” (1995, p. 253). Once the renaming of secondary trauma to compassion fatigue was facilitated it provided a space for professionals and clinicians to communicate their experiences and confirm an array of psychological impacts of working with trauma survivors.

If trained clinicians experience diminished psychological and physical capacity, it is conceivable that women as mothers of children in this context would also experience similar psychological and physiological effects. It is worth noting that mothers don't go home at the end of the day, but are involved 24 hours, seven days a week in the impact of another abusing their child.

Trauma theory

The use of trauma theory when assessing women and their responses through both theoretical and empirical research highlights both complex and interrelated factors, such as, trauma symptoms that might indicate developmental and interpersonal trauma. How any event was experienced, the nature of the event, and as indicated above, the sociocultural/political influence on how events are permitted expression, and therefore how supportive interventions are, identify an “ecological view of

responses to trauma” (Lebowitz, Harvey, & Herman, 1993, p. 378). When clinicians include a trauma focus it makes the often incomprehensible verbal and “disproportionate behaviour reactions to current circumstances” (Gold, 2008, p. 271) comprehensible, including the vast array of phenomena women can display when triggered by an event, in this context, the victimisation of their child.

Trauma theory and the subjective lens

The review of the literature describing and presenting the women's subjective experience highlights, on the one hand, a universality of experience across the literature, while, at the same time, each woman describes her experience as a personal one. More to the point, the disclosure moment is pivotal in setting off a cascade of responses that can recouple implicit and explicit awareness. Research into empathic receptivity (Baum, 2014), but more precisely psychological trauma (Herman, 1992), offers accumulating research that shows that women who experienced either physical or sexual victimisation as children are more likely to be impacted by revictimisation, which potentiates diminished quality of life and functional capacity in a vast array of personal and social activities (Briere & Jordan, 2004; Cloitre et al., 2009; Fiorillo & Follette, 2012), mothering being the primary one focussed on in this research.

The majority of studies in this research identify a child focus, with the women as conduit for delivery of child-focused work, whereas I suggest we hold both, and also include the trauma to the dyad as an entity in its own right. It is within the dyad that the transmission of what will be thought and given expression takes place. This is correlated to how clinicians are impacted by hearing their clients retelling their subjective experiences, highlighting both physiological and psychological changes that take place within the therapist because of the relationship they establish with the client, a close other. This again highlights how experiences can and do impact self and

other in ways that reshape functional and emotional capacity to remain engaged with the task of relational engagement.

Grief and loss theory and the subjective lens

The subjective reactions of the mothers were also considered and framed within the literature as a grief and loss response, with researchers most often citing the Kubler-Ross (1969) categories associated with death and dying. These reactions are described in this research literature as shock, denial and confusion, anger, guilt and blame, bargaining, depression, and, finally, hope and acceptance (Carlson, 1994; Jackson, 2007; Krigbaum-Rich, 1991; Massat & Lundy, 1998; McCourt, Peel, & O'Carroll, 1998; Triarhos-Suchlicki, 2007; Willingham, 2007). But what is grief and how has it come to define responses to loss? Within the last century *grief work*, a concept proposed by Freud (1917) to define the mourning process of a survivor breaking their emotional bond and preoccupation with the deceased and relinquishing emotional ties, was considered necessary so that the survivor could move on and build new relationships. While this pioneering work shaped early clinical engagement, later theorists proposed a more stage- or phase- oriented conceptualisation of grief work (Bowlby, 1980; Kubler-Ross, 1969), thereby beginning to foreground the subjective experience of loss.

The most recognised model is that of Kubler-Ross (1969) in her text *On Death and Dying*, written initially in response to a void in the literature and drawing on her clinical work with people who were terminally ill. Where children were concerned, it highlighted how parents could stay in relationship with the child rather than define the child or their loss through the disease. However her model of the five stages of grief (1) shock and denial; (2) anger, resentment and guilt; (3) bargaining; (4) depression; and (5) acceptance has come to encapsulate both bereavement and loss, and the

response to other forms of change. While this model might suggest conceptual clarity to a complex process it has been criticised for promising "... 'recovery and closure' ... [often failing to] address the multiplicity of physical, psychological, social and spiritual needs" (Hall, 2011, p. 8). Though this critique has some merit, Kubler-Ross (1969) was revolutionary, and her reformulating of loss and grief brought it back into both public and professional awareness. This model might better apply to extrafamilial abuse, where the threat emanated from outside the family system. Families that are impacted by intrafamilial abuse often face a more complex process of working through the impact upon their child, the woman and the family unit.

Bowlby's publication, *Attachment and Loss* (1980), resulted from observations of mother-infant/child separations. He identified three phases that an infant negotiates if the caregiver does not return or respond in a timely manner: protest (activation of the behavioural attachment system), despair (after several attempts to call the caregiver has failed), and detachment (the caregiver is not responding) as responses to loss of the caregiver (see Appendix A: Attachment styles for the long-term impact of each of these responses).

Bowlby (1980) translated these into adult grief responses through four phases of (1) numbing; (2) yearning and searching; (3) disorganisation and despair; and (4) reorganisation. Bowlby (1980) brought to grief responses the link between how early attachment has the potential to shape all future engagements, affecting how a person negotiates both implicitly and explicitly the loss of a close other.

Our clients present a continuum of life experiences and skills at attachment, detachment, and reorganisation under duress. These are their life skills; they are well versed in using them in their own environment and attempt to translate them into the

therapeutic setting. Women, through their silent and verbal protest, give us a window into how they protested as children (Bowlby, 1980) to separations, the cornerstone of loss, be it a person, an object, or a desire.

Perhaps ambiguity in the context of this research indicates how clinicians positioned women's subjective descriptions within the model associated with death and dying (Kubler-Ross, 1969), professionally constructed narratives using traditional theories to highlight women's protest and despair. Alternatively, ambiguity might reside within theories as social protest when women don't or can't relinquish their attachment to the offending adult immediately. Care and protection of children is a social act, whereas grief and loss is essentially a private matter. The social and cultural context of how grief occurs will profoundly affect the way meaning is attributed to loss and how it is integrated or even reorganised (Neimeyer, 2000).

Mentalisation (Fonagy & Target, 2006) and affect regulation theory (Schoore & Schoore, 2007), previously described above, comes under the rubric of *meaning making*. As a result when grief is deprived of recognition, described as "disenfranchised grief" by Green (1996, p. 322), there is no recognition of loss. Consequently, reorganisation and integration become a truncated process. The intersubjective interaction between mother and child and the social interaction between woman and therapist of meaning making does not facilitate a fuller recognition and re-evaluation of assumptions of self, other, and world views (Gilbert, 1996), potentiating further revictimisation for the mother and child.

Systemic theories of caregiving

This theoretical lens includes the recent research into the caregiving systems by Solomon and George (1996), George and Solomon (2008), Bell (2010), and Heard and

Lake, (2009), and includes the infant developmental psychology of Daniel Stern (1985), and the research into intimate caregiving within intimate relationship by Reizer, Dahan, and Shaver (2013). The latter explore how attachment and caregiving potentially shape "Living a Meaningful Life" (p. 1039), and reiterate the lack of research into this complementary behavioural system. The acceptance of the notion that caregiving is a life's work in conjunction with attachment imperatives means that evidence is beginning to accumulate about the relational dynamics of intimate and social bonds.

George and Solomon (2008) highlight that what has not been thoroughly investigated is the interaction between the infant behavioural system and the primary caregiver's behavioural system, as well as that of spouses, that is, caregiver to caregiver (partnered) in their relationship with a specific child. Research by Ed Tronick (as cited in Fonagy, 2015, p. 361) highlights the mother's capacity to enhance the passing from one generation to the next both social and cultural intelligence: "Her 'cultured way' is transferred to her child, affecting what the child experiences and how the child experiences him- or herself in the world" (p. 361).

Attachment theory describes proximal and felt security behaviour and motivation, while the caregiving system theory describes the response of the adult, as well as the child's capacity to elicit caregiver responses for a range of distress and nurturance needs. These interactions have been described as bidirectional (Bell, 2010), and when attuned (Stern, 1985) both child and mother achieve homeostasis through coregulations and adaption of the behavioural system while regulating the needs of the other. For example, a child might not appraise a situation as dangerous; however the caregiver does assess danger and removes the child. In this instance the caregiving system overrode the attachment system of the child. Similarly, when there is an

imbalance described as “dominant/submissive patterns” of regulation (Heard & Lake, 2009) such that a parent over- or underestimates danger to the child, and if this particular style of parenting dominates the dyadic relationship, developmental adaptive learning is not achieved and the infant learns to modulate its responses to maintain the caregiver's proximity.

George and Solomon (2008) suggest that attachment research emphasises that the linear pathway of the “maternal caregiving is the transmission of the mother's attachment to the next generation” (p. 837). They suggest that the assimilation model, where “new experiences and information are integrated into existing schemes; attachment theorists suggest that the mother integrates her experiences with the child into her mental representations of attachment” (p. 837). George and Solomon (2008) contend that while this has empirical support, it predominantly applies to a mother “judged secure or autonomous on the AAI [Adult Attachment Interview]” (p. 837).

However two areas offer contradictory results. They are mothers with “earned security [who] ... with respect to their own childhood trauma have been shown to be disorganized parents” (George & Solomon, 2008, p. 837). The Berthelot et al. (2015) study, briefly described above, also highlights that mothers who are unable to mentalise about their own childhood trauma can display insensitivity in some aspects of their relationship to their infant. George and Solomon (2008) describe how avoidant and ambivalent mothers employ defensive strategies that allow competing behavioural system integration around caregiving provisions, and maintain their homeostasis around caregiving provisions and attachment styles. For example, mothers of ambivalent-resistant children will escalate the attachment system over the child-exploratory systems, whereas mothers of avoidant children will elevate exploratory, external resources (education, sports) and down-regulate the attachment needs of the

child. Generally these mothers are capable of sufficient care of the child, whereas mothers described as disorganised are unable to activate care and protection strategies to support the child, and are described as helpless or abdicating of care (George & Solomon, 1996, 2008; Solomon & George, 2011).

Clinically, these findings of George and Solomon (2008) provide valuable insight into the attachment-caregiving strategies that some parents implement to manage the activation of their own attachment style when their child's disclosure potentially triggers their own attachment behavioral system. The parents described as unresolved certainly require a more thorough and systematic assessment to ascertain their strengths and deficits. As with all attachment styles or categories it is not black and white. The assessment process has the potential to support some reorganisation of the attachment-caregiving system, that is, in the therapeutic setting women are supported to bring fuller awareness to their own past in the care seeking or caregiving domains of their experiential self (Crittenden, 2006; Iyengar, Kim, Martinez, Fonagy, & Strathearn, 2014).

Parents who present themselves for therapy want to help their child and engage with the caregiving behavioral system on this basis. Initially engaging with them about what the child needs can be fulfilling for them, as developmental steps in caregiving are translated into the home. The task of building a therapeutic relationship with the women involves providing them with an experience of seeking and sustaining support for themselves, first as mothers, then as women. This provides the therapeutic leverage needed for more systemic work addressing embedded family patterns of caregiving and care seeking.

Caregiving and the intersubjective lens

Chapter three attempts an intersubjective lens to the literature. This section takes a more systemic and ecological view and brings awareness to the social and cultural structuring of women as mothers, and how external influences shape what is and is not permissible. For example, that only the child receives support potentially signals to the woman and society that this is how you must be and do for children, your distress and functional capacity must be attended to elsewhere, and it must not impact on the child. Massat and Lundy (1998) address how stigmatisation isolates women at a time when they have their world view shattered or have potentially lost a close other. They need support to manage the disruption to their perception of reality, and lack of support potentially reinforces old coping strategies.

Caregiving theory, although underresearched (George & Solomon, 2008) compared to attachment theory, is now identifying that caregiving is a lifetime's work, both in the immediacy of the mother-child relationship, but also that the giving and receiving of care translates into all social and intimate relationships (Reizer et al., 2013), and could be considered the *sine qua non* that allows relationships once formed to flourish. Described above, research by Tronick (2007) now highlights the intergenerational passage of both cultured and social ways of interacting in the world by the mother to the child. Similarly Danieli (2007) suggests that incorporated into cultural transmission is how any trauma can and cannot be mediated, and relevant to this research, it suggests that women as mothers are excluded from social and cultural recognition, therefore negating their capacity to create a narrative around their experience (Fonagy et al., 2002). Furthermore, gendered influences observed in the research identify that both patriarchal social structures (Herman, 1992) and

matriarchal social structures (Featherstone, 2006) continue to shape unrealistic social views of women as mothers when another has caused harm to their child.

Finally, Crittenden (1993) addresses the need to hold in mind that parents who cause harm or appear to have incomprehensible parenting behaviour operate from early developmental process, often distorted though originally self-protective when they were children and through which meaning was made, that continues to shape the women's behaviour in their own parenting engagement out of their conscious awareness. These repeated patterns are described in the literature as "intergenerational transmission of dysregulated maternal caregiving" (Solomon & George, 2006, p. 265).

Summary

In this chapter I have provided a critical analysis of the literature reviewed in chapter three and then suggested four theoretical lenses which are present in the literature, attachment, trauma, loss and grief, and caregiving theory. In chapter five, I will open a discussion with which to consider clinical implications.

Chapter 5: Discussion and conclusion

Introduction

In the earlier chapters I briefly outlined the historical framing of the maternal response, with a brief history, prevalence, and sequelae of childhood sexual abuse. This was followed by the methodology and method employed to explore the literature reviewed.

The literature review was explored through three divergent approaches. These objective, subjective and intersubjective approaches provided multiple vantage points with which to consider women's responses, potentially highlighting the complexity of what a response might be communicating. The objective view provided what had been observed by clinicians, the subjective view provided what had been narrated by the women, and the intersubjective view highlighted how the women's responses engaged with their environment.

I then provided a brief synopsis of four theoretical lenses (attachment, trauma, grief and loss, and caregiving theory) suggesting conceptual links that will provide in the following discussion a broad theoretical overview while also suggesting their practical clinical implications. It was notable even in the earliest literature on women's responses how consistently the mother's capacity to provide support and protection was correlated to their child's recovery. Yet women's own need for support and recovery was nearly invisible in the early literature. Berthelot et al. (2015) suggest that mothers who are unable to mentalise about traumatic experiences may be more susceptible "to momentary failures in responding congruently or modulating aggression or fear in the context of mother-infant interactions where trauma-related affects or memories are triggered" (p. 209). Therefore identifying and developing

treatment models to support this population is an essential part of research and therapeutic enquiry.

Attachment theory and women's objective responses

In this section I explore the relationship between attachment theory and key features of women's responses.

The objective view of women is clearly an index feature of risk to the child and I would also suggest for the woman. From my experience, regardless of her attachment style, the disclosure process disrupts most women's capacity to remain consistently available, often rendering them unable to operate from their functioning adult self. The contextual features identified in the literature are concrete evidence that some women are struggling in their daily family relationships.

As described earlier, the historical focus of attachment theory was on attachment styles or categories, these patterns providing valuable information about how most dyads that present for assessment have been operating within their interpersonal domains. It also provides insight into how the women will approach or avoid the therapeutic tasks required to support their child.

More recently, attachment theory has highlighted affective regulation (Schoore, 2011; Schoore & Schoore, 2007) as the primary developmental task of dyadic attachment relationships. This extension of the theory clearly has far-reaching considerations for clinicians choosing to work with this client group, as there is potential to become a partner in a dyadic relationship with women. It therefore places the onus on clinicians to understand how these women and children will approach their therapeutic tasks, and to provide the necessary secure base for this behaviour, while therapeutically supporting the women to come into relational engagement with their children, and

keeping their children safe by coming into relationship with themselves as mothers and women.

Trauma theory and women's responses

In this section I use trauma theory to consider women's responses, and suggest that if they are viewed as a trauma response, it makes clinical sense that these women have little control over many of their reactions. The literature on trauma theory clearly indicates that most people are impacted when confronted by an event that disrupts their sense of how the world is ordered. If they have historical trauma, whether explicit or implicit, this process has already prewired their responses through the fight, flight, or freeze responses that affect cognitive and physiological responses.

Women with a history of childhood sexual abuse have already learnt to defensively avoid anxiety-provoking situations, so if they do not act in response to a disclosure, there is no intention to deceive, but rather they have such a pervasive pattern of managing their anxiety, they may be unable to directly attend to their child's disclosure. As described in chapter four, these women require support to mentalise, and like their child they also need to narrate their trauma within a safe relationship. What trauma theory has to offer any therapeutic intervention is the notion of working within the window of tolerance where "various intensities of emotional [affective] and physiological arousal can be processed without disrupting the functioning system" (Siegel, 1999, p. 253).

Grief and loss theory, and women's responses

In this brief section in chapter four, I discussed how the literature had attempted to articulate the women's responses to their child's disclosure as shock, confusion, denial, anger, guilt, blame, isolation, sadness, depression, and grief. Maybe in their

attempt to find a rationale for these women's expressions of intersecting cognitive, physiological, psychological, and interpersonal experiences, the researchers aligned these expressions with existing models such as Kubler-Ross's (1926–2004). Nonetheless, some researchers were able to identify the subjectivity of women's responses and perhaps empathise with the universal experience of loss, while simultaneously holding the complexity of what it means when mothers are "physically present ... [but] psychologically absent" (Boss, 2010) for the child and themselves.

Attachment literature (Bowlby, 1973, 1982), as previously described, the impact of separation (loss) where an infant-child learns to protest, signalling distress then despair and finally detachment, and demonstrates that these contingent and learnt behavioural responses continue into adulthood and can often be denied expression when emanating from an adult in their regressed form.

Caregiving theory and women's responses

In this section I consider how understanding caregiver theory can inform working with women's responses. While this theory is in some respects considered an adjunct to attachment theory, its strength lies in its direct application to the therapeutic setting. The caregiving system describes the mother's capacity to guide but also adapt to the child's engagement with developmental tasks, emphasising a willingness to respond and adapt to the child's requirements (from emotional regulation to engaging with the external world). Mother and child develop the capacity to be in relationship, identifying self and other's needs and differences (George, 1996).

On a daily basis, the mother-child interaction will provoke and provide some interaction for evaluation within the therapeutic setting. It is more consciously accessible than an attachment behaviour and provides an arena to develop a

therapeutic relationships with clients and support women to mentalise and begin to develop or redevelop healthy dyadic patterns of relating, that is, listening-hearing-allowing self-expression for the child. Conceptualising the caregiving system provides for the mothers an understanding of how the child perceives the mother and her responses to the child's disclosure, and facilitates her learning to communicate so that individual differences are recognised and respected within the context of a caring, supportive, ongoing dyadic relationship.

Clinical implications for treatment

In the discussion below I describe how we (I work with a child psychotherapist) engage clinically with this client group and how attachment, trauma, loss and grief, and caregiving theories guide engagement with this population with an awareness of the need to process the loss and grief that arises once women comes into engagement with their therapeutic process. Both attachment and trauma theory utilise the window of tolerance (Siegel, 1999) to engage clients.

Clients can learn to stay present and modulate their tendencies to approach or avoid anxiety-provoking situations by identifying and managing emotional dysregulation and other dysfunctional behaviours as these are triggered by their implicit attachment models. Clients who become more available to themselves are able to narrate and integrate a fuller version of how life impacts on them, and the more present they become to themselves the more present they become to their child. Holding both an adult and child focus allows both the child and woman to be therapeutically supported and the therapists to develop both the individual and dyadic interventions required. This dual focus that we developed (child psychotherapist and myself) is what drove me to find and employ the critical interpretive synthesis as an

alternative method to the systematic literature review paradigm as I wanted a 'both and' not a 'this or that' perspective.

Assessment – Phase 1

The assessment process involves two sessions. The first session attends to the woman's subjective experiences of discovering that her child has been victimised, which allows her to highlight what she perceives as relevant and identifies clinically her self-narrative coherence. By placing the woman first in this process it supports the development of the therapeutic relationship and provides a model of support and containment.

The second session is a child-focused developmental assessment, with the focus not on the victimising incident but on how the woman holds the child in her mind, her descriptive subjective experience of the child from birth to present day. However, this time the intervention is to support her coherence and curiosity, and potentially facilitate and identify the early child and dyadic attachment relationship.

Assessment – Phase 2

After the initial adult assessment process, the dyad is invited to attend three assessment sessions, and the mother is instructed to tell the child she is going to meet someone who helps with worries. Sessions begin with the dyad together and the conversation is light but informative, so that the child is informed that the mother has communicated to us about the victimisation, and open but not intrusive communication is conveyed. If the child is comfortable with attending therapy with a child-focused therapist then the dyad separate for ongoing individual assessment.

The dyad is brought back together for the last ten minutes at every session so that any communication from the child to the mother is appropriately supported to

maintain both parties, but primarily to attend to the child's window of tolerance. After the dyad has attended three assessment sessions, the mother is invited back so the child therapist can convey the child's worries and his or her willingness to engage. Throughout this process both the child-focused therapist and I reassess how assessment or interventions worked or not and how best to support the individual and dyadic therapeutic process. In consultation with the mother we discuss how best to support both the woman and child, and that we will work in blocks of six sessions followed by a review session.

The review session allows a consultative process to develop with the woman, including addressing how the mother can translate interventions into the home as well as monitor the child's interaction with the environment after attending therapy. The mother's capacity to observe and bring back to therapy her observations is encouraged as it deepens her understanding of her child and supports her capacity to mentalise what might be transpiring for the child.

The therapeutic task with these women and children is to foster safe attachment, and as they both develop tolerance for the therapeutic work involved trauma processing is considered and constantly monitored. This is achieved through understanding how both attachment trauma and trauma through sexual victimisation are often comorbid in this population.

Work with women

Conducting the critical interpretive synthesis has strengthened my conviction that individualised treatment requires attending to the whole person, while continually monitoring a woman's capacity to engage reparatively (Holmes, 2010) with the attachment and trauma needs of the child, which takes place in conjunction with

developing a working relationship with a therapist. Tronick (2007) offers us insight into early dyadic miscommunication as repair-rupture sequences. He describes these as “messiness” (p. 11) in relational activation communication. These miscommunications violate expectancy, but when they are repaired, the dyad generates the experience of coherence and deepens; in this context the dyad can be facilitated to experience the re-emergence of dyadic coherence.

For the woman this can be achieved by developing a collaborative process of attending to her multiple aspects. Her mothering self is supported to manage the often disruptive behaviour that children display post disclosure, or that can emerge once children begin to achieve a sense of safety. Other areas of family life can be expressed and the women supported to manage their interactions in a safe manner, allowing them to rebuild mastery outside of the therapeutic setting. As Fonagy and Elizabeth (2014) suggest, the development of trust in a therapeutic relationship potentially restores social engagement, thereby allowing, in this instance, women to acquire new insights about themselves from the external environment.

As discussed above, the caregiving internal models (George, 1996) of self are more consciously available for re-examination and provide an arena to scaffold on attachment-related discussions and concerns as the women begin to develop trust in the working relationship. Attachment conversations naturally occur through the exploration of the women's own narrative, and again working with the window of tolerance supports ongoing discussion. This recursive process both expands and deepens the women's capacity to tolerate and work through their subjective experiences as previously described in the literature review.

I have on numerous occasions said that children bring their mothers to therapy, because they need their mothers to process their own traumas so that they become more available to them. What a trauma is differs for each person, but consistently the women have to confront the disclosure process of who, how, and what happened to their child, question where she was, and reconcile that life has changed in a significant way forever.

Some families are able to sustain long-term therapy; other families can only tolerate blocks of therapy. Families, once engaged and informed of the trauma process, learn to manage their need to attend therapy. My experience is that a few families will struggle and often will not re-present until child developmental phases force re-engagement, and it is essential that basic keep safe psychoeducation for the child and family are addressed. Depending on our assessment of risk to the child, we encourage some families with follow-up calls at approximately three to six months inviting them to return in order to reinforce previous therapy tasks. The therapeutic rationale is to encourage families to seek and experience asking for support, and to develop the concept of a community of care. For families that persist, the reward is the re-emergence of strengthened relationships and bidirectional communication.

Conclusions and study strengths and limitations

I have provided a critical interpretive synthesis of the literature, reviewing women's responses to their child's disclosure of sexual abuse. This study was based on constructionism and interpretivism focused through a critical interpretive synthesis. As discussed earlier, this approach was chosen because it provided the vehicle with which to consider many bodies of literature and to enable the integration of attachment, trauma, grief and loss, and caregiving theories, which I suggest are already present in the literature.

I readily acknowledge my own subjectivity and bias. I work with this population daily. I never intended this review to be objectively reproducible as I clearly identify with the social construction and interpretive view of how knowledge and ways of being in the world are construed. Rather, it has been my intention to make a clinical contribution and a social statement. I suggest that we have done women a disservice by keeping their need to process the traumatic experience of their children's disclosure of sexual abuse invisible. Historical trauma and present day trauma are linked. Today's primary trauma is tomorrow's secondary trauma. Today's victim is tomorrow's candidate for revictimisation. We do ourselves and the generations to come a disservice when we fail to recognise the needs of entire families and family systems. We need to consider the impact of gender and culture on public attitudes towards women, family and society. Without a fuller understanding of women as mothers, we objectify them for children and society's needs rather than support them in their subjectivity. I suggest what children want and need from their mothers is a woman who is more fluid and autonomous in her roles.

I recognise that I could not fully address the complexity of this subject and the intergenerational lived experiences that women and children present. Further research is needed into this population to redefine how social policy will provide for children by supporting their social system, most particularly the women who are their primary caregivers.

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Appendix A: Attachment theory

Classical

Attachment theory evolved from Bowlby's (1982) "theoretical model of instinctive behaviour [systems], of which caregiving is a component, [and] provides a solid theoretical foundation for understanding how the relationship a child has with his parents can affect his well-being and the unfolding of his developing sense of self" (Heard & Lake, 2009, p. 3).

These behavioural cues and internal motivational patterns to elicit care by the infant describes "a set of models of self and others, based on repeated [nuanced] patterns of interactive experience" Holmes (1993, p. 78). This interactive process is achieved through ongoing and repetitive micro-engagements where the infant's initial physical needs are met, then, as the infant develops a sense of eliciting and achieving responses to its proximal patterns, other behavioural systems activate. For example, the exploratory system can emerge. This system describes the child's capacity to explore and expand his environment and develop security in the awareness that he can return to his secure base, the primary attachment figure (Ainsworth, 1978; Cassidy & Shaver, 2008).

Another intricate behavioural system also begins to emerge in parallel with the exploratory system, the fear system. The fear system identifies the child's dawning awareness of separation from his caregiver as he begins exploration, and again the interactive process of both infant and caregiver's developing capacity to read the signals of proximity requirement, coregulating the engagement with new stimuli for the child, while simultaneously allowing the caregiver to adjust to both the expanding

and changing needs of the infant-child (Cassidy & Shaver, 2008). Each dyad will achieve their own pattern of relational engagement.

Attachment theory has expanded since its initial focus on child attachment patterns established by Mary Ainsworth through her studies in Uganda and later in both a laboratory and home setting, which she called the Strange Situation. In this research infants' and mothers' behaviours were assessed on reunion after a contrived separation (Wolff & Ijzendoorn, 1997), and the child's ability to be soothed upon reunion was correlated with the mother's sensitivity to re-engagement.

Child to adult

For simplicity, the research and burgeoning study of attachment has evolved into two approaches over the past fifty-plus years. One approach to research by social psychologists implements Ainsworth's results from the Strange Situation, highlighting the continuity of attachment styles that develop out of a two-dimensional continuum of attachment anxiety and attachment avoidance.

Anxiety describes the child's distress, crying with no capacity to play in the mother's absence and upon the mother's return being unable to be soothed. Avoidance describes children who are self-reliant and seek no obvious reunion upon the mother's return, but still monitor the return. These behaviours were initially translated into adult attachment styles of secure, avoidant, and anxious, with a fourth style, fearful, subsequently added, creating a four-box grid representing a high-to-low continuum of anxiety and a high-to-low continuum of avoidance. Adult data in this process primarily comes through self-reports, that is, conscious recollection of self in attachment and social relationships.

The second research approach by developmental psychologists implemented Ainsworth's results into attachment categories. They are autonomous-secure, dismissing, and preoccupied, plus unresolved disorganised. This line of research moved into representation, that is, adults' cognitive schema revealed through narratives of recalled early relationship with caregivers. This interview process identifies through language and speech patterns the coherence of the adult's narrative between recollected feelings and thinking regarding these early relationships. The implementation of this interview is designed to elicit their understanding through free association, for example, adults are asked to reflect on their early attachment and their now adult functioning, or asked to give five adjectives to describe their relationship with their parents (Hess, 1999).

The interview results highlight that secure-autonomous adults (secure attachment as children) have a realistic representation of their own parents and have often integrated past and present. They display insight into their own narrative and can remain open with the interviewer as these thoughts, images, and affects arise. Dismissing adults (insecure-avoidant attachment as children) present as unaffected and detached with idealised memories of childhood. They can describe events and objects succinctly, but not the attachment and relational aspects of their experience. Preoccupied adults (insecure-ambivalent attachment as children) demonstrate a preoccupation with the value and meaning of early attachment relationships.

Several years later, two more categories were added, necessitated by interviews that did not fit the original coding process of adults with high levels of incoherence around memories associated with either loss and/or abuse. These categories were named unresolved/disorganised and unorganised/cannot classify (Hesse & Main, 1999). The category of unresolved adults (disorganised attachment as

children) identifies adults whose incoherence emanates from episodic memory around early relational losses experienced as a trauma that lacks integration into semantic knowledge of the self. Research evidence regarding the unorganised/cannot classify adult suggests elevated levels of dissociative states resulting from early child-parent experiences that forced a paradoxical situation of both needing to approach the caregiver for security, while also wanting to flee their often unpredictable and frightening/frightened mother (Hesse & Main, 2000; Main & Solomon, 1990).

While the secure, dismissive, and preoccupied adults as children developed ways to manage their parents' inconsistencies, the two unresolved adult attachment styles identified from the AAI (Hesse & Main, 2000) highlight that as children they often failed to develop either behavioural or attentional/cognitive strategies to mediate these early interactions. The implications from this research is that these early attachment-trauma, implicitly encoded ways of interpersonal relating mediate all relationships when their attachment system is activated, for example, by the sexual abuse of their child by a close other. It is worth noting at this point that we are discussing for the purposes of this review the attachment style the child will develop with the primary caregiver-mother, and that children are capable of developing multiple attachment styles that differ with other people who are to some degree a consistent presence in their environment, such as a father, aunty or grandparent.

In summary, these approaches to attachment interpretations, whether categories or dimensional, as Mikulincer and Shaver (2007) note, "both derive from Bowlby and Ainsworth's writing, and both deal with secure and insecure categories of emotion regulation and behaviour in close relationships" (p. 107), and describe classical attachment theory; more precisely, they describe the operationalisation of classical attachment theory.