Dispelling Myths about Child Sexual Abuse among Indigenous People

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Abstract:
The myth that child sexual abuse is linked with being Alaska Native/American Indian (AN/AI) continues to perpetuate. Using data from the Alaska Longitudinal Child Abuse and Neglect Linkage project (ALCANLink) we demonstrate that after adjusting for multiple risk factors, this association disappears. We selected risk factors that had been previously documented in the literature as being linked to an increased risk of child sexual abuse. We then adjusted for these factors in a multivariable model. We compared the unadjusted and adjusted odds of child sexual abuse among AN/AI children relative to non-AN/AI children in Alaska. The unadjusted odds ratio attenuates by 60% ($OR_{unadjusted} = 3.2$, $OR_{adjusted} = 1.31$) and is insignificant ($p>0.05$) when adjusting for known associated risk factors. Therefore, the disproportionate burden of factors such as historical trauma, substance use, and poor mental health among the AN/AI population is driving the observed crude disparity.

Background:

Although there is no biological or cultural justification, the myth that child sexual abuse is linked with being Alaska Native/American Indian (AN/AI) continues to perpetuate. This misguided belief likely results from 1) institutional racism, 2) misunderstandings or lack of knowledge of underlying social determinants, and 3) misinterpretation of crude (or unadjusted) relative comparison measures. In 2018, AN/AI children in Alaska were 3.6 times as likely to be reported to the Office of Children's Services (OCS) for allegations of sexual abuse relative to non-AN/AI children. Likewise, AN/AI adults in Alaska are approximately 35% more likely to report experiencing sexual abuse as a child compared to non-AN/AI adults.[1] AN/AI children are also disproportionately seen at Alaskan Child Advocacy Centers (CACs) where the most common reason for the evaluation is sexual abuse.[2] While these crude figures clearly document disparate experiences that can be used to target interventions and resources, they should not be misinterpreted as causal. Failure to communicate disparities in context of social determinates can have the unintended consequence of continued stigmatization and impact the interactions of child sexual abuse victims and their families with the system intended to provide protection and justice.

Previous and emerging research in Alaska documents multiple modifiable risk factors that predict allegations of harm to OCS. Using Alaska data, Austin et al., found that maternal age, smoking during pregnancy, stressful life

events, marital status, residence, education, intimate partner violence (IPV), socioeconomic status (SES) and number of living children all influence the probability that a child experiences a report of harm to OCS before their ninth birthday.[3] This research was not specific to child sexual abuse reports, however the factors identified provide a contextual underpinning for the broad social determinants predicting maltreatment in Alaska. This analysis was designed to illustrate the impact that underlying factors have on the persistence of this observed disparity. To demonstrate this point, we built a multi-variable model to contrast the crude and adjusted associations.

Methods:

We used the Alaska Longitudinal Child Abuse and Neglect Linkage project (ALCANLink) data, which combines the Pregnancy Risk Assessment Monitoring System (PRAMS) survey data with administrative data in order to conduct a retrospective cohort study. PRAMS is a weighted sample from birth certificate records of mothers of newborns in Alaska who are surveyed about pre-pregnancy, prenatal, and post-birth factors. We linked 2007-2016 PRAMS data with 2007-2017 OCS data to measure longitudinal experiences of the children whose mothers responded to the survey. The ALCANLink data were used to adjust for pre-birth factors that independently predict contact with OCS for sexual abuse. We created a dichotomized AN/AI variable (Yes/No) for children born to mothers identifying as AN/AI on the birth certificate, and calculated the crude (un-adjusted), and adjusted association of AN/AI and child sexual abuse reports. Built upon covariates described in the Austin et al. paper, we initially tested the independent associations of each covariate, then constructed a multi-variable logistic regression model. For this analysis, we constructed models for both reported and screened-in allegations of sexual abuse to OCS. We built a forward stepwise logistic regression model, adding covariates into the model until the model was saturated with all covariates included allowing us to assess the individual impact of each covariate. Odds ratios were used to compare the effects that individual covariates had on the crude association between our dichotomized AN/AI variable and OCS contact for sexual abuse. We ordered the inclusion ranking of these covariates based on the largest individual effect on the observed crude relationship. Significance was set at α=0.05.

Results:

Children born to AN/AI mothers are 3.2 times as likely to be reported to OCS for sexual abuse compared to children born to non-AN/AI mothers. The unadjusted odds ratio (OR) for children born to AN/AI mothers and OCS contact for sexual abuse is attenuated by 60% ($OR_{unadjusted}$ = 3.2, $OR_{adjusted}$ = 1.31, **Figure 1**) when adjusting for known associated risk and protective factors (see Table 1 for unadjusted associations). In the final model, AN/AI becomes an insignificant independent predictor of child sexual abuse. Substance use during pregnancy had the single biggest attenuating effect on the observed crude association. Although the main outcome of our study is reported allegations of sexual abuse, using screened-in sexual abuse reports as an outcome followed the same trends.

Discussion:

When we adjust for known associated risk factors of child sexual abuse, we see that the observed crude association (disparity) towards AN/AI people is created by social determinants, not because someone identifies

Figure 1: Adjusted and Unadjusted Maternal AN/AI Status and Sexual Abuse Allegation Odds Ratio

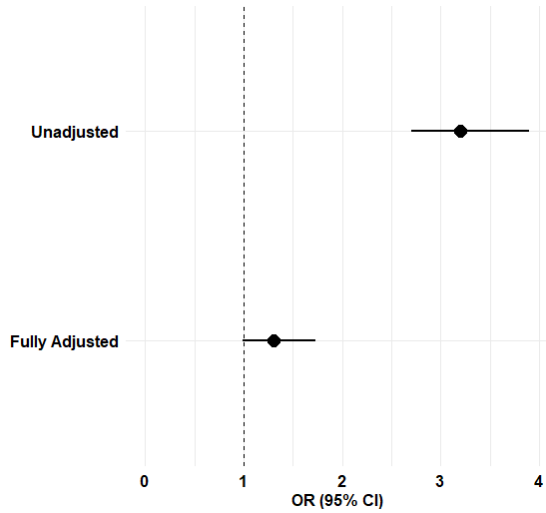

Figure 1. Changes in AN/AI and sexual abuse allegation odds ratio between unadjusted and fully adjusted (maternal substance use during pregnancy, socioeconomic status, marital status, maternal education, number of living children, and timing of prenatal care) models.

as AN/AI. These findings reaffirm that childhood alleged sexual abuse is predicted by and associated with multiple social/behavioral factors, such as socioeconomic status and substance use. While we are able to attenuate the crude effect, it is important to recognize that many of the covariates adjusted for are likely broad indicators of other underlying factors such as acute and intergenerational trauma, violence, or other social determinants of health. The strong independent association with maternal substance use during pregnancy is a good example, as the causal etiology between these behaviors and child sexual abuse reports is likely through trauma or other factors that are not otherwise captured in our data. Healthcare workers and researchers need to look past typical classifications (e.g. culture, community) and work to understand the underlying socioeconomic and other factors that drive disparities. It is important to note however, that the observed association is also likely impacted by systemic institutional racism that we were unable to quantify in this analysis. Efforts should be taken to evaluate systems for these systemic issues that can result in differential treatment and identification.

The disproportionate burden of many social determinants among the AN/AI population, including intergenerational trauma and violence, is likely driving the observed crude disparity. Targeted interventions based on stratified research should focus on understanding and addressing these underlying factors. For more research assessing the underlying risk and protective factors for maltreatment visit the ALCANLink webpage at http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/ALCANLink/publications.aspx. Researchers and providers as well as those professionals who respond to child victims and their families need to be mindful of the relationship between underlying socioeconomic and perceived disparities to avoid further stigmatizing the Indigenous population. Efforts must be made to build upon and promote cultural strengths as a way of addressing these underlying factors. Researchers are advised to review material on childtrends.org on how to incorporate racial and ethnic equity perspectives https://www.childtrends.org/publications/a-guide-to-incorporating-a-racial-and-ethnic-equity-perspective-throughout-the-research-process

Conclusion:

Clinicians, practitioners, public health professionals, child protection workers, law enforcement officers, prosecutors, and advocates need to be aware that there is no biological or cultural link between AN/AI people and child sexual abuse. Moving forward, providers can use the prenatal and early childhood periods as key times to assess

and address the aforementioned socioeconomic indicators, and identify crucial services that will help promote the best possible environment for child rearing and development. Providers can also increase their understanding and utilization of evidence based approaches, such as Nurse-Family Partnership programs and Strengthening Families™, that can help families reduce stress, address risk factors, and promote healthy development. Finally, addressing social determinants in a culturally appropriate way will help address disparities and reduce the stigma faced by the AN/AI people.

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2. Cathy Baldwin-Johnson, personal communication, November, 2019
3. Austin A.E., Parrish J.W., & Shanahan M.E. (2018). Using time-to-event analysis to identify preconception and prenatal predictors of child protective services contact. Child Abuse & Neglect, 82(2018), 83–91.

Table 1. Pre-birth predictor characteristics and unadjusted associations with OCS contact for sexual abuse in Alaska (2007-2016)

Pre-birth Predictors	N	% Weighted Mean (95% CI)[a]	OR (95% CI)[b]
Alaska Native/American Indian			
Yes	4395	10.7 (9.8, 11.6)	3.2 (2.7, 3.9)
No	7221	3.6 (3.1, 4.1)	ref
Financial Stress[c]			
One or more stressors	3301	9.5 (8.3, 10.7)	2.7 (2.2, 3.2)
None	8629	3.8 (3.3, 4.2)	ref
Maternal Intimate Partner Violence[d]			
Abuse	706	16.0 (12.5, 19.4)	3.8 (2.9, 5.0)
None	11288	4.7 (4.3, 5.2)	ref
Maternal Education			
12 or more years	10137	4.3 (3.9, 4.8)	0.32 (0.26, 0.39)
<12 years	1621	12.5 (10.6, 14.5)	ref
Marital Status			
Married	7160	3.0 (2.5, 3.5)	0.29 (0.24, 0.35)
Not married	5053	9.6 (8.6, 10.6)	ref
Partner Stress[e]			
One or more stressors	3542	8.8 (7.7, 9.9)	2.4 (2.0, 2.9)
None	8415	3.9 (3.4, 4.3)	ref
Support Stress[f]			
One or more stressors	4630	7.7 (6.7, 8.6)	2.0 (1.7, 2.5)
None	7354	3.9 (3.5, 4.4)	ref
Substance use during pregnancy[g]			
Use of one or more substances	2528	12.4 (10.8, 14.0)	1.9 (1.5, 2.5)
None	2077	6.9 (5.6, 8.1)	ref
Medicaid patient			
Medicaid	4825	9.8 (8.8, 10.8)	3.9 (3.2, 4.7)
Not Medicaid	7236	2.7 (2.3, 3.2)	ref
Maternal tobacco chew			
User	830	7.7 (6.0, 9.4)	1.5 (1.2, 2.0)
No	11063	5.2 (4.7, 5.7)	ref
Mental Health[h]			
Depression diagnosis or symptoms	5673	6.7 (5.9, 7.4)	1.7 (1.4, 2.0)
None	6110	4.1 (3.6, 4.7)	ref
Prenatal Care[i]			
Early care	8903	5.2 (4.7, 5.7)	0.79 (0.63, 0.98)
Late care	2357	6.5 (5.4, 7.7)	ref

[a] Survey weighted percent of pre-birth predictor in OCS sexual abuse allegations
[b] Bivariate OR of logistic regression between pre-birth predictor and OCS allegation of sexual assault
[c] Financial Stress defined as having one or more: mother and/or partner lost job, couldn't pay bill, homeless
[d] Maternal IPV defined as experiencing one or more: physical abuse from partner, calling 911 because you felt unsafe
[e] Partner Stress defined as having one or more: divorce, argue with partner, partner in jail, partner didn't want pregnancy
[f] Support Stress defined as having one or more: someone close to you is doing drugs, death in family, family member ill
[g] Substance use: smoking marijuana during pregnancy and/or cigarettes during last 3 months of pregnancy
[h] Mental Health defined as having one or more: post-partum depression and/or lack of interest, feeling slow/hopeless
[i] Prenatal Care: early if seen during first trimester