ADJUSTMENT AMONG MOTHERS WHOSE CHILDREN HAVE BEEN SEXUALLY ABUSED: THE ROLE OF A HISTORY OF CHILD SEXUAL ABUSE, SOCIAL SUPPORT, AND COPING STRATEGIES

BY

DIANE HIEBERT-MURPHY

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Abstract

The issue of child sexual abuse increasingly is a concern for mental health practitioners and researchers. Mothers of children who have been sexually abused are frequently identified as important in intervention. Relatively little empirical research exists, however, to guide such intervention or to aid practitioners in understanding the experiences of these women. The purpose of the present study was to investigate various psychosocial factors which may be related to mothers' adjustment following disclosure. Specifically, the relationships between mothers' adjustment and a history of childhood sexual abuse, a history of adolescent sexual abuse, social support, and coping strategies were examined. One hundred and two women whose children disclosed sexual abuse completed a sexual abuse history questionnaire, the Provision of Social Relations Scale, the Coping Responses Inventory, the Brief Symptom Inventory, the Parenting Sense of Competence Scale, and a questionnaire requesting descriptive data. As predicted, results indicated that emotional distress was related to a history of childhood sexual abuse, a history of adolescent sexual abuse, a lack of support from friends and family, and greater use of avoidance coping strategies. Parenting self-esteem was related to a lack of support from friends and a greater reliance on avoidance coping. The findings suggest that greater attention be given to psychosocial variables which can assist practitioners in explaining the variability among the functioning of mothers and which might suggest potential interventions. Additional research is clearly needed to more fully understand the experiences of mothers.

INTRODUCTION

Interest in child sexual abuse has existed since at least the 1890s when Freud noted a connection between such experiences and the psychological difficulties of his patients (Freud, 1959). Subsequently, however, the occurrence of child sexual abuse was denied and attributed to sexual fantasy (Masson, 1984; Rush, 1980). More recently the feminist movement and the movement against child abuse have encouraged awareness of the sexual abuse of children (Finkelhor, 1979). Increasingly, child sexual abuse has become a concern for mental health practitioners and researchers.

Child Sexual Abuse: Definition, Prevalence, and Effects

From a legal perspective, there are many different behaviors which are considered sexual abuse. In Canadian criminal law, sexual offences against children include, for example, sexual assault, sexual interference, invitation to sexual touching, sexual exploitation, and exposure (Standing Committee on Justice and the Solicitor General, 1993). Among researchers, there is no consensus regarding an operational definition of child sexual abuse (Russell, 1983). Definitions vary along many dimensions including the age of the child, the age difference between the victim and the perpetrator, and the type of sexual acts considered to be abuse. For example, upper age limits for the definition of child have included age 12 (Finkelhor, 1979), age 13 (Russell, 1984), age 16 (Finkelhor, 1984), and age 18 (Peters, 1988). The age difference between the victim and the perpetrator also varies. While some researchers specify an age difference of five years (e.g. Peters, 1988) other researchers specify

various age differences depending on the age of the victim. Finkelhor (1979) and Fromuth (1986), for example, set the age discrepancy between the victim and the perpetrator at 5 years if the child is 12 years of age or younger, and at 10 years if the child is 13 to 16 years of age at the time of the abuse. Differences among studies also exist regarding the behavior that is considered sexual abuse. While some researchers include all types of sexual contact and noncontact in their definitions (e.g. Finkelhor, 1979), other researchers limit their definitions to sexual contact (i.e. physical touch) (e.g. Gold, 1986).

Many attempts have been made to study the prevalence of child sexual abuse (see Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986), with retrospective studies of experiences of child sexual abuse in adults being the most common (Dube & Hebert, 1988). These studies suggest that between 11% and 45% of women (Baker & Duncan, 1985; Finkelhor, 1979, 1984; Fromuth, 1986; Kercher & McShane, 1984; Russell, 1983; Wyatt, 1985) and 3% and 9% of men (Baker & Duncan, 1985; Finkelhor, 1979, 1984; Kercher & McShane, 1984) experience child sexual abuse. Canadian research suggests that between 18% and 24% of women (Bagley, 1988; Bagley & Ramsay, 1986; Bagley & Young, 1988) and 8% of men (Bagley, 1988) experience unwanted sexual acts in childhood. Despite discrepancies in the prevalence findings, posited by some researchers to be the result of definitional and methodological differences (see Wyatt & Peters, 1986a, 1986b), it appears that child sexual abuse is a frequently occurring psychosocial problem.

The effects of child sexual abuse have been extensively documented. Although

there are methodological limitations in the research on short-term effects (for reviews see Beitchman, Zucker, Hood, daCosta, & Akman, 1991, Browne & Finkelhor, 1986, and Kendall-Tackett, Williams, & Finkelhor, 1993), a review of the literature suggests that sexually abused children display more behavioral and psychological symptoms than nonabused children (Kendall-Tackett et al., 1993). For example, research suggests that children who experience sexual abuse are more likely to show sexualized behavior (e.g., Einbender & Friedrich, 1989; Friedrich, Beilke, & Urquiza, 1987; White, Halpin, Strom, & Santilli, 1988), internalizing behavior problems such as depression and anxiety (e.g., Conte & Schuerman, 1987, 1988; Einbender & Friedrich, 1989; Friedrich et al., 1987; Tong, Oates, & McDowell, 1987), and externalizing behavior problems such as aggression and antisocial behavior (Conte & Schuerman, 1987, 1988; Einbender & Friedrich, 1989; Friedrich et al., 1987; Tong et al., 1987).

A large body of research also documents the long-term effects of child sexual abuse (for a review see Beitchman, Zucker, Hood, daCosta, Akman, & Cassavia, 1992). Studies of adults in treatment provide evidence that sexually abused clients are more likely than nonabused clients to report anxiety (Briere & Runtz, 1988a; Hartman, Finn, & Leon, 1987), a negative self-image (Herman, 1981), difficulty in interpersonal relationships (Meiselman, 1978), sexual difficulties (Briere & Runtz, 1988a; Meiselman, 1978), substance abuse (Beck & van der Kolk, 1987; Briere & Runtz, 1988a; Herman, 1981), anger (Briere & Runtz, 1988a; Herman, 1981) and suicide symptoms and attempts (Briere & Runtz, 1986; Bryer, Nelson, Miller, & Krol, 1987; Carmen, Rieker, & Mills, 1984; Herman, 1981; Meiselman, 1978). In addition, studies

of nonclinical populations suggest that women who were sexually abused as children are more likely than women who have not experienced sexual abuse to report depression (Bagley & Ramsay, 1986; Briere & Runtz, 1988b; Gold, 1986; Peters, 1988; Sedney & Brooks, 1984; Stein, Golding, Siegel, Burnam, & Sorenson, 1988), anxiety (Bagley & Ramsay, 1986; Fromuth, 1986; Stein et al., 1988), poor social adjustment (Harter, Alexander, & Neimeyer, 1988), poor self-esteem (Alexander & Lupfer, 1987; Bagley & Ramsay, 1986; Courtois, 1979; Gold, 1986), alcohol and drug abuse (Peters, 1988), difficulties in sexual relationships (Fritz, Stoll, & Wagner, 1981; Gold, 1986), and suicidal ideation (Bagley & Ramsay, 1986). Studies demonstrating that a history of sexual abuse is frequently found in women who are psychiatric inpatients (Beck & van der Kolk, 1987; Sloan & Leichner, 1986), are prostitutes (James & Meyerding, 1977), have a history of eating disorders (Oppenheimer, Howells, Palmer, & Chaloner, 1985), have a diagnosis of borderline personality disorder (Barnard & Hirsch, 1985), or are being treated for multiple personality disorder (Coons, 1986) further suggest that childhood sexual abuse may be a risk factor for subsequent problems in psychological and social functioning.

Why Study Mothers?

The importance of mothers in child development and child adjustment has been widely discussed and researched. Object relations theorists, for example, focus on the primary role of human relationships in child development. The relationship with the primary caretaker (usually the mother) is considered the most important. This relationship is regarded as critical because it forms a template for all subsequent

relationships (Cashdan, 1988). Mahler, a prominent object relations theorist, charted the bonding between a mother and child and described the process by which a child moves from a position of symbiotic attachment to the mother to the achievement of a stable, autonomous identity (Mahler, Pine, & Bergman, 1975). She regarded the interactions between a mother and child as foundational to the lifelong process of separation-individuation. For object relations theorists, this process is central to long-term adjustment and psychological health.

Attachment theory has also stressed the importance of mothers in child development and adjustment. Attachment has been traditionally defined as a bond between an infant and caregiver (Rice, 1990). Attachment relationships are seen as central to guide the emotional and cognitive development of children and to influence their participation in other relationships throughout their lifetime (Bowlby, 1982). The responsiveness of the mother has been regarded as critical in the quality of the attachment relationship (Ainsworth, Blehar, Waters, & Wall, 1978). Recent life-span views of development have extended the definition of attachment beyond the mother-child relationship, and beyond infancy and young childhood. Attachments are seen as occurring at all ages and with individuals other than the mother (Rice, 1990). Nevertheless, the patterns of early attachment with a primary caregiver are seen as having considerable stability (Schneider, 1991). It should be noted that although the primary caregiver need not necessarily be the mother, compared to fathers, mothers spend considerably more time with their young children (Biller, 1993).

The importance of mothers in child adjustment has also been demonstrated in

the study of resilient children. Longitudinal studies provide evidence that maternal competence is a protective factor in the long-term adjustment of high risk children (Rutter, 1979; Werner & Smith, 1982, 1992). Resilience research consistently identifies the quality of the relationship between the child and primary caregivers as a major factor in children's resilience in stressful environments (e.g., Garmezy, 1991, Masten, Morison, Pellegrini, & Tellegen, 1990).

Given the central role that mothers play in child development and adjustment generally, it seems reasonable to explore the role of mothers in the adjustment of children to child sexual abuse. Sexual abuse research has identified social support as an important factor in coping with sexual abuse (Adams-Tucker, 1982; Conte & Schuerman, 1987; Wyatt & Mickey, 1988). When the victim is a child, the mother is frequently seen as a primary source of support (Everson, Hunter, Runyon, Edelsohn, & Coulter, 1989; Weeks, 1976). Furthermore, there is growing evidence to suggest that maternal support has an impact on the effect of the abuse on the child (Conte & Berliner, 1988; Everson et al., 1989; Esparza, 1993; Gomes-Schwartz, Horowitz, Cardarelli, Sauzier, Salt, & Calhoun, 1990). Further efforts to study the relationships between mothers and their children who have been sexually abused seems important in expanding our understanding of children's coping with sexual abuse.

In addition to the ways in which mothers directly impact on their children's experience of the abuse, mothers also play a key role in mediating between the family and external systems following a disclosure of sexual abuse (Hooper, 1992). This role is perhaps most evident in the relationship between the family and the child welfare

system. There is evidence that the reaction of the mother to the disclosed abuse is a critical factor in decisions about removing the child from the home (Pellegrin & Wagner, 1990).

Studying mothers seems important, therefore, from the perspective of understanding the impact of sexual abuse on children. Research on the supportiveness of mothers following disclosure and on factors which affect the ability of mothers to meet their children's needs is warranted.

A different rationale for studying mothers comes from a focus on the women themselves. A disclosure of sexual abuse can precipitate a crisis for not only the child, but for the child's family (Brant & Tisza, 1977; Simrel, Berg, & Thomas, 1979; Summit, 1983). Given the expectations of motherhood, mothers in particular may be vulnerable to increased stress following disclosure (De Jong, 1986; Hooper, 1992; Kelley, 1990; Newberger, Gremy, Waternaux, & Newberger, 1993). Validating and responding to the needs of these women is an important function for mental health professionals. Research which provides a better understanding of the experiences of mothers is a necessary foundation for such intervention. From this perspective, then, studies which attempt to describe mothers' experiences of their children's abuse and identify factors related to mothers' psychosocial distress following disclosure are necessary.

Consistent with this belief in the importance of understanding the experience of mothers of sexually abused children, the purpose of the present study was to identify factors important in the adjustment of mothers following a disclosure of sexual abuse.

A description of this study follows a review of the relevant literature.

Literature Review

The literature on child sexual abuse is beginning to reflect an increasing acknowledgement of the importance of mothers. In addition to clinical observations, a growing body of research is studying the experiences of mothers of victims. The following discussion examines the theoretical approaches to understanding mothers and reviews existing research on mothers of children who have been sexually abused.

Theoretical Approaches to Understanding Mothers

A review of the literature suggests three main theoretical approaches to understanding mothers of children who have been sexually abused: an individual psychopathology approach, a family systems approach, and a feminist approach.

Psychopathology of Mothers

Much of the early literature addressing mothers of victims dealt with intrafamilial abuse, with a particular focus on father-daughter incest. Early studies of the psychodynamics of incest focused on the psychopathology of individual family members, with special interest in the mother (e.g., Cormier, Kennedy, & Sangowicz, 1962; DeFrancis, 1969; Riemer, 1940).

Lustig, Dresser, Spellman, and Murray (1966), for example, noted that mothers often experience physical or psychological desertion in their own childhoods which results in "strong dependency residuals and needs to be mothered" (Lustig et al., 1966, p. 34). Apparently, unresolved needs lead women to place their daughters in maternal roles. Gordon (1955) suggested that mothers encourage incest as a way of dealing

with their own unmet needs. More recently, Zuelzer and Reposa (1983) suggested that mothers in incest families frequently have relationships with their own mothers which are undifferentiated and characterized by rejection and hostility. According to Zuelzer and Reposa (1983), as a result of this relationship with their own mothers, these woman are masochistic and are unable to deal with adult marital and parental responsibilities. Other descriptions of mothers as dependent (Kaufman, Peck, & Tagiuri, 1954; Rist, 1979; Spencer, 1978; Zuelzer & Reposa, 1983), infantile (Kaufman et al., 1954), passive (Cormier et al., 1962; Raphling, Carpenter, & Davis, 1967), rejecting (Gordon, 1955), and frigid (Justice & Justice, 1979) further suggest the presence of psychopathology in mothers of victims.

In this perspective, then, the focus is on personality weaknesses and individual psychopathology in an attempt to understand mothers of children who have been sexually abused. The implication is that because of these individual weaknesses, mothers somehow encourage or are collusive in the abuse of their children. As noted earlier, this perspective has tended to focus on incest and early writings had little to say about other types of sexual abuse.

There continues to be some interest in examining individual issues among mothers. For example, Howard (1993) proposes that mothers' responses to sexual abuse may be related to their level of identity development. As well, a number of recent studies have examined the personalities of mothers of sexually abused children (e.g., Friedrich, 1991; Scott & Stone, 1986). Although these studies look at individual factors, the tone is less mother-blaming than earlier studies. For example, Friedrich

(1991) suggests that research on the personalities of mothers might explain why some abuse can continue for long periods of time, might increase our understanding of factors affecting parental responses to abuse, and might improve our awareness of treatment needs for families of sexually abused children. Unlike earlier accounts, however, he emphasizes the importance of avoiding interpreting the data in a way which "links maternal pathology to a blanket conclusion of maternal duplicity" (Friedrich, 1991, p. 779).

The Role of Mothers in Family Dysfunction

Mothers get a great deal of attention from theorists who view the incest family as disturbed or pathological. In this approach, incest is seen as symptomatic of family dysfunction (Furniss, 1983; Hildebrand & Forbes, 1987; Lustig et al., 1966; Maisch, 1973). Although presumably many family members are involved in perpetuating the abuse (e.g., Brant & Tisza, 1977; Cohen, 1983), mothers frequently are regarded as pivotal in the establishment of the incest. Lustig et al. (1966), for example, described mothers as the "cornerstone in the pathological family system" (p. 39).

Mothers are seen as encouraging the incest in a number of ways. Some writers suggest that mothers promote a dysfunctional role allocation where daughters assume a spousal role because they are unwilling to fully assume this role (Bagley, 1969; Eist & Mandel, 1968; Guntheil & Avery, 1977; Henderson, 1972; Machotka, Pittman, & Flomenhaft, 1967; Sarles, 1975). Other writers blame mothers for not satisfying their husbands sexually (Henderson, 1972; Lustig et al., 1966; Weeks, 1976; Weiner, 1962), for failing in the nurturant role with their children (Cohen, 1983; Guntheil & Avery,

1977), and for engaging in activities outside the home (including employment) which interfere with their ability to meet their responsibilities at home (Spencer, 1978; Weeks, 1976).

More recently, interest in the role of the family has expanded to include both intrafamilial and extrafamilial sexual abuse (e.g., Pelletier & Handy, 1986), with less of an overt focus on the role of mothers. A number of researchers have investigated broader aspects of the family environment which presumably place children at risk for abuse (e.g., Alexander & Lupfer, 1987; Harter et al., 1988; Ray, Jackson, & Townsley, 1991). As well, some family systems theorists have modified their approaches to address issues raised by feminist theorists. For example, Masson and O'Byrne (1990) outline the limitations of family systems thinking, namely, the failure to recognize the social context and the impact of patriarchy. They argue, however, that family systems theory can be useful if these issues are addressed.

Despite these shifts, family approaches continue to be criticized. For example, according to Hooper (1992), although blatant mother-blaming messages as are found in the early family dysfunction literature are less frequent, subtle forms of blaming of mothers continues. She suggests that blame is implied by the proportion of responsibility given to mothers for the protection of their children as well in the messages given to mothers in treatment about their need to acknowledge ways in which they have contributed to the abuse (Hooper, 1992).

A Feminist Perspective

A feminist perspective is another theoretical approach which has attempted to

increase our understanding of sexual abuse (e.g., McIntyre, 1981; Russell, 1984; Wattenberg, 1985). This perspective links the sexual abuse of children to the underlying social structure (e.g., Butler, 1978; Rush, 1980). Sexual abuse is seen as a consequence of a patriarchal society in which there is an unequal power balance between men and women. Emphasizing that child sexual abuse is primarily perpetrated by males (Finkelhor & Russell, 1984), feminist theorists argue that it is essential to view power and sex role socialization as key factors in child sexual abuse (Finkelhor, 1984; Herman, 1981; Rush, 1980; Russell, 1975, 1984).

Feminist theorists are particularly critical of the role that mothers are given in sexual abuse. They reject the view that mothers are pathological or collusive, arguing that these labels blame sexual abuse on women (McIntyre, 1981). This strategy of "mother blaming" is not regarded as unique to sexual abuse; according to a feminist perspective, mothers are considered pathogenic and held responsible for a wide range of human ills (Bernard, 1975), ranging from learning problems to schizophrenia (Caplan & Hall-McCorquodale, 1985).

In understanding mothers, feminist theory emphasizes the importance of power. Patriarchal society is seen as perpetuating male dominance in many spheres of social functioning, including the family. As part of this dominance, women and children come to be viewed as property of men (McIntyre, 1981). Violence and abuse within the family are believed to be related to the extremely unequal power distribution between men and women (Cammaert, 1988). According to Herman and Hirschman (1977), within the incestuous family, the powerful husband does as he wishes and the

mother and children are submissive, helpless victims, acting as property owned by men to be used as sexual conveniences. The focus, then, is on the power exerted by the father as perpetrator, both in terms of economic power and in the level of physical or emotional threats to mother and child should they expose the family secret (Wattenberg, 1985).

Power is seen as equally important in understanding extrafamilial child sexual abuse. Within Russell's (1984) model of child sexual abuse, supremacy and the inherent power differential between men, and women and children, are seen as important factors in reducing the internal and external inhibitions against child sexual abuse in all perpetrators (i.e., not exclusively incest offenders).

Sex role socialization also provides insight into the behavior of mothers whose children have been sexually abused. McIntyre (1981) points out how women develop certain beliefs within a patriarchal society. Specifically, he suggests that women are taught that (a) they should define themselves by the needs, desires, and accomplishments of the men in their lives, (b) when they do not fulfil their role as the psychological, emotional, and sexual service stations for men they should accept blame, and (c) they should satisfy not only the needs of men, but also the needs of their children. McIntyre (1981) points out that these expectations create a double bind for mothers when the perpetrator is the father. Women find that functioning in their children's best interest threatens the physical, emotional, and financial basis of their existence.

Sex roles are also important in understanding the responsibility placed on

mothers for the protection of their children, whether or not the perpetrator is a family member. According to Hooper (1992), women are given a disproportionate share of responsibility for the welfare of their children. Although expected to fulfil these parental responsibilities, women are not given the necessary power or resources (Hooper, 1992; Myer, 1985). When abuse occurs, as much emphasis in often placed on the failure of the non-offending mother to protect the child as on the perpetrator (Elbow & Mayfield, 1991). As well, when extrafamilial abuse occurs, more fault for abuse is attributed to non-offending mothers than to non-offending fathers (Waterman & Foss-Goodman, 1984).

In summary, the feminist perspective argues that sexual abuse must be understood within a sociopolitical context. To understand mothers and their experiences, the context of their lives must be considered. This perspective challenges the concept of maternal collusion and suggests a new framework from which to view mothers' responses to sexual abuse. In providing this new perspective, the argument is made that more research attention needs to be given to understanding mothers' subjective experiences (Carter, 1993; Wattenberg, 1985).

Empirical Literature on Mothers of Children Who Have Been Sexually Abused

The early literature on sexual abuse contains conclusions about mothers which are strongly stated. On examination, however, it is clear that these "definitive" conclusions were based on scarce empirical evidence. Many writers based their conclusions on clinical experience or poorly controlled case studies (e.g., Cohen, 1983;

Cormier et al., 1962; Eist & Mandel, 1968; Guntheil & Avery, 1977; Lustig et al., 1966; Raphling et al., 1967; Weiner, 1962; Zuelzer & Reposa, 1983) or on reviews of previous articles (e.g., Bagley, 1969; Rist, 1979; Spencer, 1978; Weeks, 1976). A review of the empirical literature indicates that it is only recently that mothers have been studied in a systematic way. The existing research on mothers addresses four issues: personality functioning of mothers, abusive experiences of mothers, the ability of mothers to support their children, and the impact of disclosure on mothers.

Personality and Emotional Functioning

Several early studies examined incest families and described the characteristics of mothers. Lukianowicz (1972), for example, studied 26 cases of paternal incest and concluded that the mothers "appeared to be normal, hardworking and much suffering women with large families" (p. 305). Browning and Boatman (1977), in their review of 14 cases of incest, found that mothers were frequently physically absent and were functioning poorly due to chronic depression. In another study, 40 women who had incestuous relationships with their fathers during childhood were compared to 20 women whose fathers had been seductive but not overtly incestuous (Herman & Hirschman, 1981). The women who were victims of incest were more likely than the control women to describe their mothers as ill or disabled, as absent for some period of time, and as having more pregnancies and more children to care for (Herman & Hirschman, 1981). The designs of these studies place limitations on the conclusions that can be drawn. Only one study used a comparison group (i.e., Herman & Hirschman, 1981), and none of the studies used psychometrically-sound measurement

instruments or evaluated the reliability or validity of their data collection procedures.

In a more recent study, Bennett (1990) compared mothers in families in which incest had occurred to a control group of mothers on personality measures compatible with the concepts of attachment theory. He found that mothers from the incest group experienced more disrupted early attachments than did mothers from the control group. He also reported that the personalities of mothers from the incest group showed greater indications of separation disorder and lower self-esteem. It was not clear, however, if the personality functioning of mothers from the incest group could be considered outside the normal range.

Several additional studies have evaluated the personalities of mothers using well-established personality inventories. Myer (1985), for example, assessed the personalities of mothers using the Millon Clinical Multiaxial Inventory. She found that mothers in families where father-daughter incest occurred varied considerably in personality. According to Myer, some mothers showed no personality disorders, while others were classified as Dependent, Borderline, or Narcissistic based on Millon's classification.

Peterson, Basta, and Dykstra (1993) used the Clinical Analysis Questionnaire to study three groups of mothers: mothers of children who had been molested by a family member, mothers of children who had been molested by a teacher, and a control group of mothers of children who had not been molested. These researchers reported few differences between the mothers in the two abuse groups. There were differences, however, between the mothers of children who had been molested and mothers from

the control group. While mothers of the abused children scored higher on the clinical scales, their scores fell in the nonpathological range. On the basis of these findings, Peterson et al. concluded that mothers of children who have been abused show more psychological distress, but should not be labelled as severely disturbed.

Muram, Rosenthal, and Beck (1994) compared mothers of children who had been sexually abused to mothers of children who had not been abused on the Eysenck Personality Questionnaire and the Leisure Interest Checklist. The results gave no evidence that mothers of children who had been sexually abused displayed psychopathology. The only differences observed were that mothers from the abuse group were less impulsive and somewhat more constricted that were mothers from the control group.

Additional studies have used the Minnesota Multiphasic Personality Inventory to study characteristics of mothers in families where incest occurred. Groff (1987) compared mothers of children who had been sexually abused by their fathers to 23 women who attended a clinic for treatment of chronic pain. Comparisons indicated higher scores for the pain clinic women on the Hypochondriasis, Depression, and Hysteria scales. There were no differences between the mothers of incest victims and the pain clinic referrals in the proportion of profiles classified as normal. Groff concluded that the personality characteristics of mothers from incest families are generally within normal limits as assessed by the MMPI.

Also using the MMPI, Scott and Stone (1986) compared mothers from families in which father-daughter incest occurred with a matched control group of mothers

from families where incest was not known to have occurred. They reported that although the mothers from incest families scored higher than the control group on a number of scales (F, Hypochondriasis, Depression, Hysteria, Psychopathic Deviate, Paranoia, Psychasthenia, Schizophrenia, and Social Introversion), the mean profile for the mothers from families in which incest had occurred was still within the normal range.

In a more recent study of MMPI profiles, Friedrich (1991) compared mothers of sexually abused children (including intrafamilial and extrafamilial abuse) with an outpatient group and a control group. Like Scott and Stone (1986), he found that the MMPI profiles of mothers were within normal limits. While there were a number of differences between the control group and the other two groups, mothers differed from the outpatient group on only one scale (Psychopathic Deviate).

Taken together, these studies do not support the contention that mothers show individual psychopathology. There is some evidence that mothers of children who have been sexually abused show greater signs of distress on various personality measures than do mothers of children who have not been sexually abused. However, standardized measures suggest that the personalities of mothers of children who are victims of sexual abuse generally fall within normal limits.

Abusive Experiences of Mothers

Sexual abuse. Much has been written in the treatment literature suggesting that childhood experiences of abuse are common in mothers of victims. Furthermore, it is suggested that these experiences impact negatively on a mother's ability to cope with

her child's abuse (e.g., Brant & Tisza, 1977; Hildebrand & Forbes, 1987; Koch & Jarvis, 1987; Sgroi & Dana, 1984). There is surprisingly little empirical research, however, supporting this assertion. Kent (cited in Goodwin, McCarthy, & DiVasto, 1981) reported a study in which 31% of mothers in incestuous families were themselves victims of childhood incest. Myer (1985) reported that 65% of mothers of incest victims experienced sexual abuse by a family member. Goodwin et al. (1981) studied 34 women from incest families and 500 women from the community. Among the women from families where incest had occurred, 20% of the mothers referred for psychiatric evaluation and 29% of mothers who completed the questionnaire as part of an intake for treatment reported a history of incest. Within the community sample, only 3% of women reported some form of incest prior to age 18.

These studies were limited to exploring intrafamilial abuse among mothers of incest victims. As a result, little can be said about the occurrence of other forms of sexual abuse among mothers of incest victims. In only one study was a more general definition of sexual abuse used. In this study, Melnechuk (1988) found that 53% of 32 mothers entering treatment following the sexual abuse of their children had experienced sexual abuse in their own childhoods. It should be noted that all of these studies were based on mothers of incest victims and thus the findings cannot be generalized to mothers of children who are abused by someone other than their father or a father figure.

In one study involving a more diverse sample of mothers (i.e., mothers of children who were victims of either intrafamilial or extrafamilial abuse), Friedrich

(1991) reported that 28% of the mothers experienced sexual abuse prior to age 14.

These studies suggest that sexual abuse is a common occurrence among mothers of sexually abused children. There are limitations in the research, however, which weaken the conclusions. The data is largely descriptive, with varying definitions of sexual abuse making comparisons across studies difficult. As well, the absence of control groups in most studies makes it unclear if the prevalence of child sexual abuse among mothers is greater than expected or simply reflects prevalence rates in the general population. Interpretation of the findings is also complicated by the suggestion that high rates of sexual abuse among mothers may reflect sample bias; memories of abuse may be triggered by the disclosure and/or a history of abuse may prompt a woman to seek help for her child (Hooper, 1992).

Partner abuse. Encouraged by both the feminist perspective which suggests that mothers are victims of power imbalance, and by clinical observations that men in incest families are often authoritarian, prone to use physical control, and alcoholic (e.g., Eist & Mandel, 1968; Kaufman et al., 1954; Spencer, 1978), several studies have documented the occurrence of spousal abuse in incest families. For example, in their sample of nine cases of father-daughter incest, Browning and Boatman (1977) found a high incidence of alcoholism and physical violence among the perpetrators. Tormes (1972) found that 13 out of 20 incestuous fathers were physically violent to their wives, and Julian and Mohr (1979) reported that wife abuse occurred in 25.5% of families where incest occurred. deYoung (1994b) found that 85% of 20 women whose husbands sexually abused their children were physically, emotionally, or sexually

abused by these men. Dietz and Craft (1980) reported that 78% of 200 child protection service workers believed that wife abuse occurred in the incestuous families with which they worked. In their study of 40 women who were abused by their fathers, Herman and Hirschman (1981) found that 55% of the women reported that their fathers used physical force and intimidation to dominate their families. Using a definition of abuse which included emotional, physical, and sexual abuse, Melnechuk (1988) reported that 83% of 32 mothers in treatment following their children's disclosures of paternal incest were themselves abused by the offender.

There has been only one study which has used a standardized measure to assess partner abuse in incest families. Truesdell, McNeil, and Deschner (1986) administered the Conflict Tactics Scale to a group of 30 women who attended a group for mothers of incest victims. These researchers found that 73% of the mothers reported psychological and physical abuse by their partners (the perpetrator of the sexual abuse). Among the abused women, 23% reported that they were beaten and 10% reported that they were threatened with a knife or gun.

These studies suggest that partner abuse is a common occurrence in families in which sexual abuse occurs. The studies, however, have obvious methodological limitations. The absence of control groups and the lack of standardized measures place restrictions on the conclusions that can be drawn. Furthermore, these studies have looked exclusively at partner abuse in incest families. It is not clear if these findings are generalizable to a sample of mothers whose children have been abused by someone other than the father.

Maternal Support

A frequent assumption is that mothers, although aware of the abuse, fail to act supportively towards their children. There are a number of studies which challenge this belief, providing evidence that the majority of mothers believe reported abuse. In a study of male children who were sexually abused by family members, relatives, or caretakers, Pierce and Pierce (1985) found that only 16% of the nonperpetrating parents refused to believe their children's disclosures of sexual abuse. Mannarino and Cohen (1986) documented that 56% of the mothers in their sample who had been informed of the abuse directly from their children made a formal complaint to authorities, a behavior they interpreted as representing belief in the children's statements.

Other studies have systematically tested the hypothesis that mothers are collusive and examined factors influencing mothers' reactions to the disclosures of sexual abuse. In one study, Faller (1988) studied 171 cases of sexual abuse in which the perpetrator was the biological father, step-father or live-in boyfriend, or noncustodial father. Following a clinical assessment, ratings were made on (a) the protectiveness of the mother's response to knowledge of the abuse, (b) the mother's relationship with the victim, and (c) the mother's dependency upon the perpetrator. Although the ratings were anchored to behavioral indicators, reliability of the ratings was not assessed. Faller found that protectiveness, relationship with the victim, and dependency varied according to the mothers' role relationships with the offenders. Mothers whose children were abused by biological fathers were rated as the most

unprotective, unsupportive, and dependent, followed by mothers whose children were abused by stepfathers or live-in partners. When the perpetrator was a noncustodial father, mothers on average were very protective, had good relationships with their children, and were somewhat independent of the perpetrators. Faller makes the important point that even among the two groups which were least protective, mothers did not tend to fall at the extreme ends of the scale, making it inappropriate use the label "collusive".

In a second study, Sirles and Franke (1989) studied 193 children who were abused by their fathers or father-figures, or by extended family members. The mother's reaction (i.e., believed or not believed) was rated following an intake interview. The results indicated that 78% of mothers believed their children's reports of the abuse. In addition, they found that the age of the victim, nature of the abuse, presence of the mother in the home during the abuse, relationship of the victim to the offender, prior physical abuse of the child, and alcohol abuse by the offender contributed to the mother's conclusion regarding the abuse.

In a third study, Everson et al. (1989) evaluated 88 children within two weeks following disclosure of intrafamilial sexual abuse (88% of the perpetrators were biological fathers, step-fathers, or boyfriends of the mother). A measure of clinical ratings of the parent's reaction and support following disclosure was developed and reliability established. Based on the ratings, 44% of mothers were classified as providing consistent support following disclosure, 32% of mothers were classified as ambivalent or providing inconsistent support, and 24% of mothers were classified as

unsupportive. Maternal support was not related to the characteristics of the child (e.g., age, gender), but was related to the offender's relationship to the mother and to the response of the offender to the disclosure (i.e., admission or denial of guilt). Furthermore, children in the low/no support group had higher levels of psychopathology than children in the high support or ambivalent support groups, emphasizing the importance of maternal support in a child's recovery.

In a recent qualitative study deYoung (1994a) studied the reactions of mothers within the first hour following disclosure or discovery of paternal incest. She found that mothers frequently experienced shock and anger. Only 40% of the mothers were described as nonprotective immediately following disclosure.

In another qualitative study, Johnson (1992) conducted indepth interviews with six women from families in which incest had occurred. She concluded that there is variability in how mothers respond to the disclosure of incest. Furthermore, she argues that to understand the actions a mother takes, the social context in which the disclosure occurs must be considered.

While the above studies focused on cases involving incest, one study has explored maternal support in a broader sample involving intrafamilial and extrafamilial sexual abuse. De Jong (1988) studied the responses of 103 mothers whose children were seen for evaluation of sexual assault. Based on responses to a questionnaire, 31% of the mothers were classified as nonsupportive (i.e., believed the abuse was a lie, a misunderstanding, or the child's fault) while 69% were supportive (i.e., believed that the child was telling the truth and that the perpetrator was responsible for the abuse).

No relationships were found between maternal response and the mother's history of sexual abuse, the perceived reaction of the child, the nature of the abuse, the child's age or sex, or the mother's relationship to the perpetrator.

These studies suggest that the stereotype of the collusive mother is not supported by data. While some mothers are nonsupportive, the majority of mothers believe their children's accounts of abuse and respond in a protective manner. Based on this data, it seems most appropriate to view mothers as a heterogeneous group who have varying responses to the sexual abuse of their children.

The Impact of the Disclosure on Mothers

It has been argued that sexual assault not only has an impact on the primary victim, but affects the individual's significant others as well (Remer & Elliott, 1988). Although not experiencing the assault directly, significant others are believed to experience secondary victimization as a result of their ongoing relationship with the primary victim (Remer & Elliott, 1988). Hooper (1992) suggests that a similar process of secondary victimization occurs in child sexual abuse. Furthermore, she suggests that given the expectations of motherhood, mothers' experiences of sexual abuse are unique from other individuals' experiences of secondary trauma (Hooper, 1992).

The impact of sexual abuse on mothers has been discussed by various authors based on their clinical observations or case studies. Not surprisingly, clinical literature suggests that mothers experience distress following disclosure (e.g., Regehr, 1990). Several reports have documented that some mothers experience significant difficulties following disclosure. De Jong (1986), for example, described three cases in which

disclosure of sexual abuse and the initial interventions subsequent to disclosure precipitated hospitalization for the mothers for physical and/or emotional difficulties. Based on a study of 201 families in which intrafamilial abuse occurred, Goodwin (1981) found that five mothers attempted suicide within five months after disclosure. Although not conclusive, these studies suggest that mothers' functioning can be negatively affected by the disclosure of sexual abuse.

Several recent qualitative studies have explored the impact of disclosure on mothers. Hooper (1992), for example, conducted a study of 15 mothers using an indepth interview methodology. She used the concept of loss to describe the experiences of mothers to the disclosure of sexual abuse and the aftermath. Carter (1993), in a qualitative study of 24 women whose children had been sexually abused, concluded that disclosure is a trauma for the mother impacting on psychological, social, and economic functioning.

There are also several recent quantitative studies which document the impact of sexual abuse on mothers. Kelley (1990), for example, compared parents of children who were abused in day-care settings with a sample of parents of nonabused children. She found that mothers of sexually abused children reported more distress than mothers of nonabused children. Mothers of children who experienced ritual abuse reported greater distress than mothers of children who were sexually abused without rituals.

Newberger et al. (1993) studied a group of 46 mothers over a 12 month period, beginning two to four months following disclosure. They found that 55% of mothers

were within the clinical range on measures of emotional distress at the time of the first interview. Although there was improvement over time, the mean score on emotional distress at 12 months continued to be elevated relative to the norms. Mothers' symptomatology was related to a variety of factors including the gender of the child, the severity of the abuse, the use of force, and the amount of treatment received by the mothers and their children.

Several studies have compared maternal distress experienced by mothers following disclosure of sexual abuse to various control groups. Wagner (1991), for example, looked at depression among 32 mothers who were seeking treatment for their children who had been victims of intrafamilial sexual abuse, 26 mothers seeking treatment for their children who had been victims of extrafamilial abuse, and 46 mothers seeking help for their nonabused children who had a variety of behavior problems. Wagner reported that between 50% and 69% of the mothers in each group experienced at least a moderate degree of depression. There were no differences, however, between the groups on depressive symptoms.

In a second study, McIntyre, Manion, Ensom, Wells, and Firestone (1993) looked at distress among four groups: sexually abused mothers of children who were sexually abused (extrafamilial abuse), nonabused mothers of children who were sexually abused (extrafamilial abuse), sexually abused mothers whose children were not abused, and nonabused mothers of children who were not abused. They found a main effect for a history of sexual abuse among mothers and a main effect for having a child who was sexually abused. Although no interaction effect was found, abused

mothers of a sexually abused child were the only group whose mean level of distress was in the clinical range during the first measurement period.

Several conclusions can be drawn from these studies. First, there is evidence that mothers experience distress following the disclosure of sexual abuse. Although it is not clear if this level of distress is different from the distress experienced by mothers whose children have other difficulties (Wagner, 1991), there is evidence suggesting that mothers of sexually abused children experience greater distress than mothers of children who are not abused (Kelley, 1990; McIntyre et al., 1993). Second, there is variability in mothers' distress. Not all mothers experience clinically significant levels of distress (Newberger et al., 1993). Third, much research is needed to determine the variables which differentiate women who experience high levels of distress from mothers who experience lower levels of distress. Existing research is limited to a consideration of demographic and abuse variables (Newberger et al., 1993), with minimal exploration of other psychosocial variables which may be of importance in understanding the impact on mothers.

Summary

It is clear that there is a paucity of research on mothers of children who have been sexually abused. Many studies focus on incest and thus are not generalizable to cases involving other perpetrators. Furthermore, many studies are descriptive and do not employ appropriate control groups and/or standardized measures. Obviously, much more research is needed to fully understand mothers of sexual abuse victims.

Of particular interest in this study is the research on the impact of the

disclosure on mothers. Existing studies suggest that while mothers are negatively impacted by the disclosure, there is variability in the levels of distress they experience. However, very little is known about factors which influence mothers' adjustment following disclosure.

The Present Study

The purpose of the present study was to investigate the variability in functioning among mothers of children who have been sexually abused. The research was based on the premise that it is important to explore the impact of disclosure on mothers in order to broaden our understanding of mothers' experiences. It must be emphasized that the purpose was not to perpetuate mother-blaming but to validate mothers' experiences by exploring factors which, based on their self-reports, related to their levels of distress. The specific psychosocial factors examined included a history of childhood sexual abuse, social support, and coping responses. In an attempt to place the results in context, additional descriptive data was collected. Two aspects of adjustment were examined: emotional distress and parenting self-esteem.

Impact of a History of Sexual Abuse on Mothers' Adjustment

It has been noted that mothers of sexually abused children frequently have a history of sexual abuse (e.g., Friedrich, 1991; Melnechuk, 1988; Myer, 1985) and further, that this history interferes with the ability of mothers to deal with the current abuse of their children (e.g., Brant & Tisza, 1977; Carter, 1993; Hildebrand & Forbes, 1987; Humphreys, 1992; Koch & Jarvis, 1987; Lamb, 1986; Sgroi & Dana, 1984; Timmons-Mitchell & Gardner, 1991). While a connection between mothers' sexual

abuse histories and their adjustment is often assumed, little empirical evidence addresses the issue.

Sexual Abuse History and Emotional Distress

Based on research on the long-term effects of sexual abuse, it seems likely that mothers who have experienced sexual abuse will experience greater emotional distress than mothers who have not experienced sexual abuse. Several studies have tested this hypothesis empirically, resulting in somewhat inconsistent findings.

Using the MMPI, Friedrich (1991) found that mothers with a history of sexual abuse had elevations on a number of scales compared to mothers who had no history of sexual abuse. Kelley (1990), in her study of parents who had children who were sexually abused in day-care centers, found that mothers who had histories of sexual abuse were more distressed than mothers without such histories. McIntyre et al. (1993), however, found that mothers with histories of sexual abuse did not differ from mothers without sexual abuse histories or from women with abuse histories without children who had been sexually abused. They based this conclusion on their comparison of the proportion of cases in each group which were assessed to be in the clinical range on a measure of symptomatology. In additional analyses, they found main effects for a maternal sexual abuse history and for having a child who had been sexually abused. Contrary to prediction, there was no interaction effect. These researchers suggested that an underreporting of sexual abuse and/or the fact that the study occurred during the crisis following disclosure may have resulted in the effects of a history of sexual abuse being masked.

Despite the widespread belief that maternal sexual abuse significantly impacts on a mother's experience, existing research is equivocal. The present study attempted to further examine this hypothesis in a diverse sample of mothers.

Sexual Abuse History and Parenting

Research on the etiology of child maltreatment suggests that the psychological resources of the parent may be an important factor in parental functioning (Belsky, 1984; Lahey, Conger, Atkeson, & Treiber, 1984). Given the research which documents that a history of childhood sexual abuse affects psychological functioning in adulthood, it is possible that a history of childhood abuse affects subsequent parenting. Consistent with this hypothesis, a history of abuse (including sexual abuse) is often seen as contributing to abusive parenting (Korbin, 1986).

There is some evidence indicating that a history of father-daughter incest influences subsequent parenting attitudes (Cole & Woolger, 1989), parenting behaviors (Cole, Woolger, Power, & Smith, 1992), and feelings about being a parent (Cole et al., 1992). Burkett (1991) has also found that experiencing intrafamilial sexual abuse impacts on how women subsequently parent their own children. Little attention, however, has been given to studying the relationship between a history of sexual abuse and parenting in mothers of children who have been sexually abused. Although it has been suggested that a history of abuse interferes with a mother's ability to support her child (e.g., Koch & Jarvis, 1987), research has not found a relationship between abuse history and maternal supportiveness following disclosure (De Jong, 1988). The relationship between a history of sexual abuse and other aspects of parenting (such as

parenting self-esteem) has not been examined and thus was explored in the present research.

Social Support

A large body of research documents the relationship between social support and both physical and mental health (see Kessler, Price, & Wortman, 1985; Leavy, 1983; Lieberman, 1982; Turner, Frankel, & Levin, 1983). Numerous studies have documented the importance of social support in adjusting to specific life crises such as widowhood (Vachon, Sheldon, Lancee, Lyall, Rogers, & Freeman, 1982), unemployment (Gore, 1978), parenthood (Cutrona, 1983), marital separation (Wilcox, 1981), sexual assault (Burgess & Holmstrom, 1979), and child sexual abuse (Conte & Schuerman, 1987; Wyatt & Mickey, 1988; Zimrin, 1986).

Social support has also been shown to be an important factor in parental functioning (Belsky, 1984; Gaudin & Pollane, 1983; Reis, Orme, Barbera-Stein, & Herz, 1987). For example, research has shown social support to be negatively related to maternal stress (Adamakos, Ryan, Ullman, Pascoe, Diaz, & Chessare, 1986; Carveth & Gottlieb, 1979) and child maltreatment (Salzinger, Kaplan, & Artemyeff, 1983), and positively related to the level of mothers' interaction with their children (Adamakos et al., 1986; Crnic, Greenberg, Robinson, & Ragozin, 1984).

The relationship between social support and mothers' adjustment following their children's disclosures of sexual abuse has not been systematically studied. Practice literature, however, generally advocates interventions which attempt to increase support for mothers (e.g., DeVoss & Newlon, 1986; Regehr, 1990). In the

present study, the relationships between social support and emotional functioning and parenting self-esteem were assessed.

Stress and Coping

The concept of stress has various meanings among researchers (Fleming, Baum, & Singer, 1984; Lazarus & Launier, 1978; Mason, 1975). While one view holds that stress is the individual's response to challenging events (e.g., Selye, 1976), another view regards stress as events external to the individual which make demands on that individual (e.g., Holmes & Rahe, 1967). Stress has also been treated as a transactional concept, describing the interactions between a person and the environment (Lazarus & Launier, 1978). The transactional view is regarded by some researchers as an important integrative framework in the area of stress (e.g., Cameron & Meichenbaum, 1982).

The transactional view suggests that whether or not experiences are stressful depends on the balance between demands and resources available to meet those demands and hence prevent negative consequences (Lazarus & Launier, 1978). Stress is experienced when the perceived demands (either external or internal) are appraised to exceed the individual's capability to meet those demands. Within this framework, the relationship between life events and functioning is mediated by coping processes (Moos & Billings, 1982).

Coping is usually defined as the efforts made to master, tolerate, or reduce demands that exceed the person's resources (Pearlin & Schooler, 1978). Many coping strategies have been identified in the literature such as active problem-solving,

cognitive avoidance, and emotional discharge (for a review see Moos & Billing, 1982). In an attempt to bring clarity to research on coping, several efforts have been made to develop classification schemes for coping responses. For example, one way to classify coping responses is based on the focus of coping. A distinction has been made between problem-focused and emotion-focused coping (Lazarus & Launier, 1978; Pearlin & Schooler, 1978). Problem-focused coping includes attempts to modify or eliminate stress through one's behavior, while emotion-focused coping includes responses which manage the emotional consequences of stressors. A second way to classify coping responses is based on the method of coping. For example, coping responses can be divided into cognitive and behavioral responses (Billings & Moos, 1981, 1984). There has also been an attempt to combine these two approaches to classification. Moos (1990) has developed an inventory which divides coping responses into approach and avoidance (i.e., the focus of coping) and further divides each category into cognitive and behavioral coping (i.e., the method of coping).

There is much research indicating an association between coping strategies and adjustment in individuals exposed to stressful experiences (e.g., Billings & Moos, 1981; Holahan & Moos, 1986, 1987, 1991; Kessler et al., 1985; Pearlin & Schooler, 1978). While many different classification methods have been used, a consistent finding is that avoidance coping is associated with poorer adaptation (e.g., Holahan & Moos, 1985, 1986, 1987; Moos, 1988).

While the concept of coping has been useful in increasing the understanding of the adjustment of mothers dealing with various challenges such as seriously ill and

hospitalized children (Barbarin & Chesler, 1986; Wyckoff & Erickson, 1987), single parenthood (Mednick, 1987), handicapped children (Friedrich, 1979; Peterson, 1984), and divorce (Propst, Pardington, Ostrom, & Watkins, 1986), to date, no research has studied the coping responses of mothers of children who have been sexually abused. The research on coping clearly suggests that the ways in which mothers respond to the disclosure are likely important in their overall experience of the sexual abuse. In her challenge of the mother-blaming tone of much of the sexual abuse literature, Hooper (1989) has argued that mothers' responses are better understood as coping strategies than as collusion. According to this perspective, mothers' behaviors should be viewed as attempts to deal with the stressful situation and cope with their own needs and feelings as well as the many other demands of the situation. The concept of coping, therefore, removes blame from mothers and allows for an exploration of various psychosocial factors which might impact on mothers' responses.

The present study examined the relationship between coping responses and adjustment in a sample of mothers. There is considerable controversy about how effective coping or adjustment should be conceptualized and measured. Researchers studying the coping process have identified many variables thought to reflect good coping including keeping emotional distress within manageable limits, maintaining a positive attitude and a positive self-concept, and being able to carry out socially desired goals (Wortman, 1983). Based on a review of the conceptual difficulties in defining good coping, Wortman (1983) suggests that it may be unwise to formulate hypotheses about the relationship between various factors and effective coping in a

general sense. According to Wortman (1983), coping should be assessed along several dimensions such as the absence of psychiatric symptoms or extreme emotional distress, the presence of positive emotions, good physical health, and effective coping as defined by the individual (Wortman, 1983). In the present study, outcome/adjustment was assessed by looking at two dimensions: emotional functioning and symptoms, and self-reported parenting self-esteem (including dimensions of efficacy and satisfaction).

Of secondary interest was the relationship between coping strategies and social support. Given research which suggests a negative relationship between avoidance coping strategies and social support (Dunkel-Schetter, Folkman, & Lazarus, 1987; Fondacaro & Moos, 1987; Holahan & Moos, 1987; Holloway & Machida, 1991), this relationship was explored in the present study.

Exploratory Variables

In addition to the primary hypotheses, the present study also explored several variables which might be important in future research.

Partner Abuse

Abuse in marital/partner relationships occurs with alarming frequency. Prevalence research suggests that between 16% and 50% of women in the general population experience partner abuse (Finkelhor, Gelles, Hotaling, & Straus, 1983; Frieze, 1983; Russell, 1984; Straus, Gelles, & Steinmetz, 1980). Canadian research estimates that between one in eight (Guberman & Wolfe, 1985) and one in ten (MacLeod, 1987) women are battered each year. As well, the negative impact of this form of violence on women has been documented (e.g., Cascardi & O'Leary, 1992;

Houskamp & Foy, 1991; Walker, 1991). Theorists such as Walker (1979) suggest that spousal abuse impacts on a woman's self-esteem and emotional functioning. Research confirms that physical abuse by one's partner is associated with fear (Gianakos & Wagner, 1987), depression (Webster-Stratton & Hammond, 1988), psychological distress (Runtz, 1987), and dissociation (Coons, Bowman, Pellow, & Schneider, 1989). Given the incidence of domestic violence as well as its deleterious effects on women, it appears that any evaluation of women's adjustment must assess for domestic violence.

Studies which examine partner violence among mothers of children who have been sexually abused are limited to incest families. As reviewed earlier, these studies suggest that spousal violence occurs in between 25% to 85% of families in which incest occurs (deYoung, 1994b; Herman & Hirschman, 1981; Julian & Mohr, 1979; Melnechuk, 1988; Truesdell et al., 1986). The varying prevalence rates likely reflect different definitions of abuse as well as sampling differences. Research is lacking on the occurrence of domestic violence in families in which children experience other types of sexual abuse (e.g., non-incest sexual abuse).

The present study explored the prevalence of partner abuse in the sample. The relationship between a history of partner abuse and emotional distress was also examined.

Alcohol Use

A high incidence of alcohol abuse among fathers in incest families has been observed (Browning & Boatman, 1977; deYoung, 1994b). Alcohol abuse is not a

variable which has received much attention in the existing research on mothers of sexually abused children. The present study included several questions about the women's use of alcohol as well as their partners' use of alcohol. The purpose of these questions was to explore, on a descriptive level, the importance of alcohol abuse among mothers of sexually abused children.

Behavior Problems of the Sexually Abused Child

Research has shown a strong correlation between mothers' psychological distress following their children's disclosure of sexual abuse and their perceptions of their children's distress (Newberger et al., 1993). The relationship between these variables was explored in the present study, with particular attention given to examining the types of behavior problems that correlate with maternal distress.

Summary and Hypotheses

The purpose of the present study was to assess the relationship between various psychosocial factors and adjustment in mothers following their children's disclosures of sexual abuse. The independent variables were a history of child sexual abuse, social support, and coping strategies. The dimensions of adjustment that were examined included emotional distress and parenting self-esteem.

The primary hypotheses tested in the study were as follows:

1. Histories of childhood and adolescent sexual abuse will be positively associated with emotional distress and negatively associated with parenting self-esteem among mothers of children who have disclosed sexual abuse.
2. Social support will be negatively associated with emotional distress and

positively associated with parenting self-esteem among mothers of children who have disclosed sexual abuse.

3. Relative avoidance coping will be positively associated with emotional distress and negatively associated with parenting self-esteem among mothers of children who have disclosed sexual abuse.

In addition, the following secondary hypotheses were tested in the study:

1. A history of child sexual abuse with be positively associated with relative avoidance coping.
2. Social support will be negatively associated with relative avoidance coping.
3. Women whose children were abused by a family member will report greater emotional distress than women whose children were abused by a non-family member.
4. A history of child sexual abuse and relative avoidance coping will be negatively associated with mothers' self-reported belief in the disclosure. Social support will be positively associated with mothers' self-reported belief in the disclosure.
5. Abuse in the spouse/partner relationship will be positively associated with emotional distress.
6. Maternal reports of child behavior problems will be positively associated with emotional distress and negatively associated with parenting self-esteem.

METHOD

Participants

Participants were recruited from two sources: the Child Protection Centre and Children's Home of Winnipeg. The Child Protection Centre is a unit of the Children's Hospital of Winnipeg which focuses on the assessment of abuse in children. Participants were recruited through the Sexual Assault Clinic which provides medical assessments for children who have disclosed sexual abuse. Children are referred from all areas of Winnipeg as well as rural communities. Children's Home of Winnipeg is a social service agency offering a variety of services to children and families. Participants for the present study were recruited through its Families Affected by Sexual Assault Program. This program is a crisis intervention service for families affected by third party sexual abuse. In addition, a small number of participants (5%) were obtained from other sources (e.g., direct referral from child protection workers).

Inclusion criteria for the study were as follows: (a) the woman's child had made a disclosure of sexual abuse within the previous 12 months, (b) the woman was not identified as a perpetrator of the sexual abuse, (c) Child and Family Services (i.e., the child welfare authorities) and the police had been notified and an investigation of the allegations was in progress or had been completed, and (d) the woman was able to speak and read English.

A total of one hundred and seven women were interviewed for the present study. Although time since disclosure was a screening criterion (with only cases in which records indicated a disclosure within the previous 12 months being selected for

the study), during the interview, five women reported that a previous disclosure had been made. These women were excluded from the study leaving a final sample of 102 women.

Fifty-five participants (54%) were obtained through the Child Protection Centre, 42 participants (41%) were obtained through the Families Affected by Sexual Assault program, and 5 participants (5%) were from other related sources (e.g., direct referral from child protection workers who accompanied clients to the Sexual Assault Clinic). Seventy-seven percent of the women contacted through the Children's Hospital participated in the study and 63% of the women contacted through Children's Home agreed to participate.

Materials

Five major variables were examined in this study: a history of child sexual abuse, social support, coping strategies, emotional/psychological distress, and parenting self-esteem. As well, behavior problems of the children were assessed and demographic data and descriptive data were collected.

History of Child Sexual Abuse

The present study used a definition of sexual abuse similar to the definition used by Finkelhor (1979), although the upper age limit was 18 years of age. More specifically, sexual abuse was defined as (a) any forced or coerced sexual behavior imposed on a child or adolescent (up to age 18), (b) sexual contact between a child (up to and including age 12) and a person 5 or more years older whether or not obvious coercion was involved, and (c) sexual contact between an adolescent (aged 13

to 18 years) and an adult at least 10 years older whether or not obvious coercion was involved.

Child sexual abuse was assessed using a modified version of Finkelhor's (1979) sexual victimization survey (see Appendix A). Following an introduction to the scale, participants were asked to answer questions about any sexual experiences they had when they were 12 years old or younger with someone who was at least 5 years older, or with someone of any age if they did not agree to the activity. They were then asked similar questions about sexual experiences they had when they were adolescents (aged 13 to 18 years) with someone who was at least 10 years older, or with someone of any age if they did not agree to the activity. For the purposes of this study, the scale was scored based on the presence or absence of sexual abuse.

A version of this survey has been used in previous child abuse research (e.g. Fromuth, 1986; Gold, 1986; Runtz, 1987). Although Finkelhor does not report on the reliability of the scale, Runtz (1987) reported a Cronbach's alpha of .90 with a college student sample.

Social Support

The Provision of Social Relations Scale (PSR; Turner et al., 1983) was used to measure social support (see Appendix B). The PSR is a 15-item instrument which assesses support from family and friends. While initially based on the conceptualization of five components of social support (i.e., attachment, social integration, reassurance of worth, reliable alliance, and guidance), factor analysis revealed the PSR to have two dimensions, family support and friend support. The

PSR was developed in a series of studies involving university students, discharged psychiatric patients, and psychiatrically disabled community residents located in interviews with 11,000 households in Ontario. The PSR has good internal consistency, with alpha coefficients that range from .75 to .87 (Turner et al., 1983). The scale is positively correlated with the Kaplan Scale of Social Support, suggesting concurrent validity. It has also been shown to be negatively correlated with several measures of psychological distress, including anxiety and depression, and positively correlated with several measures of self-esteem. These findings provide support for construct validity.

Coping Responses

The Coping Responses Inventory - Part II (CRI; Moos, 1990) was used to assess the women's coping responses to the sexual abuse disclosure (see Appendix C). Participants rated their reliance on each of 48 coping items using a 4-point scale ranging from "no" to "yes, fairly often".

The CRI (Part II) is composed of eight subscales which measure different types of coping responses. These include logical analysis, positive reappraisal, seeking support and information, taking problem-solving action, cognitive avoidance, acceptance or resignation, seeking alternative rewards, and emotional discharge. The first four subscales measure approach coping while the last four subscales measure avoidance coping.

The CRI is a refinement of earlier 19-item (Billing & Moos, 1981) and 32 item (Billings & Moos, 1984) scales. Items were selected according to criteria based on content and face validity, item distribution, internal consistency, and subscale

independence. The final selection of items was based on several field trials (see Moos, 1990). Moos (1990) reports internal consistencies of .61 to .74 for the eight subscales. Moos (1990) defends these rather low internal consistencies by arguing that an upper limit may be placed on internal consistency coefficients by the fact that the use of one coping response may reduce stress and reduce the use of alternative responses. The eight subscales are moderately positively intercorrelated (average $\underline{r}$ = .29 for men and .25 for women; Moos, 1988). The correlations among the four approach strategies are somewhat higher (average $\underline{r}$ = .42 for women) than among the four avoidance strategies (average $\underline{r}$ = .24 for women; Moos, 1988). Test-retest reliabilities of .36 to .44 are reported for a 12 month interval (Moos, 1990).

A growing body of literature suggests that utilizing Moos' conceptualization of coping is useful. Using various versions of the scale, studies have indicated the ability of the measure to discriminate between adults with drinking problems and adults without drinking problems (Moos, Brennan, Fondacaro, & Moos, 1988), relapsed alcoholic patients and remitted alcoholic patients two years after treatment (Moos, Finney, & Chan, 1981), and depressed and nondepressed persons (Billings, Cronkite, & Moos, 1983; Billings & Moos, 1985; Foster & Gallagher, 1986; Rosenberg, Peterson, & Hayes, 1987). Furthermore, based on this classification, coping responses have been found to relate to mood and health-related functioning among various populations including individuals from the community (Billings & Moos, 1981; Cronkite & Moos, 1984), individuals with drinking problems (Cooper, Russell, & George, 1988; Cronkite & Moos, 1980; Moos et al., 1988), patients who are depressed

(Billings & Moos, 1984), spouses of alcoholic patients (Moos, Finney, & Gamble, 1982), patients who had treatment for cancer (Keyes, Bisno, Richardson, & Marston, 1987), men diagnosed as having AIDS (Namir, Wolcott, Fawzy, & Alumbaugh, 1987), and caregivers of elderly persons with dementia (Haley, Levine, Brown, & Bartolucci, 1987).

For the purposes of this study, the focus was on the distinction between approach and avoidance coping. The measure was scored for relative avoidance coping (total avoidance coping divided by total coping responses). This method of scoring has been used in previous research (e.g., Holahan & Moos, 1991). It has been argued that relative coping scores are preferable to raw scores because they control for the total number of coping efforts (Vitaliano, Maiuro, Russo, & Becker, 1987).

Emotional Distress

The Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983; Derogatis & Spencer, 1982) was used to assess emotional distress experienced by the participants since the disclosure (see Appendix D). The BSI is a 53-item short form of the SCL-90-R (Derogatis, 1977), a self-report inventory that has been used to assess psychological symptoms. The BSI is comprised of items selected to best reflect the nine primary symptom dimensions of the SCL-90-R in a brief measurement scale. These primary dimensions include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. In addition to the nine symptom dimensions, there are three global indices associated with the BSI: the general severity index, the positive symptom

distress index, and the positive symptom total.

Derogatis and Melisaratos (1983) report on the extensive psychometric evaluation of the BSI. Cronbach alpha reliability coefficients for the nine dimensions range from a low of .71 on psychoticism to a high of .85 on depression. Test-retest reliability over a two week interval range from .68 to .91 for the nine dimensions, with a test-retest reliability coefficient of .90 for the general severity index. Correlations between the same symptom dimensions as assessed by the BSI and the SCL-90-R range from .92 to .99. High convergence between BSI scales and similar dimensions of the Minnesota Multiphasic Personality Inventory provides evidence of convergent validity. In addition, factor analysis supports the construct validity of the BSI.

Parenting Self-Esteem

The Parenting Sense of Competence Scale (PSOC; Johnston & Mash, 1989) is a 16 item scale developed to assess parenting self-esteem (see Appendix E). Factor analysis suggests two dimensions for the measure: satisfaction (an affective dimension reflecting parenting frustration, anxiety, and motivation), and efficacy (an instrumental dimension reflecting competence, problem-solving, and capability in the parenting role) (Johnston & Mash, 1989). Internal reliability analyses indicate Cronbach's alpha coefficients of .75 to .79 for the total score, the satisfaction factor, and the efficacy factor (Johnston & Mash, 1989). There is also some evidence of the construct validity of the scale. Parents of hyperactive children obtained lower scores than parents of normal children (Mash & Johnston, 1983a), and abusive mothers reported lower PSOC scores than nonabusive mothers (Mash, Johnston, & Kovitz, 1983). As well, the

satisfaction and efficacy scores were found to predict mother behavior during play and task interactions with their hyperactive children (Mash & Johnston, 1983b), suggesting predictive validity of the measure.

Children's Behavior Problems

The Conners' Parent Rating Scales-48 (CPRS-48; Conners, 1990) was used to assess mothers' reports of problem behaviors in their children (see Appendix F). The CPRS-48 is a 48 item scale which assesses conduct problems, learning problems, psychosomatic behavior, impulsive-hyperactive behavior, and anxiety. Factor analysis supports the presence of these five subscales (Goyette, Conners, & Ulrich, 1978). Item-total correlations range from .13 to .65 (Goyette et al., 1978). Sandberg, Wieselberg, and Shaffer (1980) report an alpha internal-consistency reliability coefficient of .92 for the Hyperactivity Index. For the purposes of this study, mothers were asked to rate the behavior of their children since the disclosure.

In addition, a number of items were included to assess inappropriate sexual behavior. These items were adapted from the Child Behavior Checklist (Achenbach & Edelbrock, 1983) and have previously been used by researchers to form a separate scale of sexual behavior problems (e.g., Friedrich, Urquiza, & Beilke, 1986).

Demographic and Descriptive Data

Demographic information was collected in a questionnaire designed for the study (see Appendix G). Information such as the subject's age, marital status, level of education, employment, and number of children was collected.

Descriptive data on the sexual abuse of the woman's child was also included on

the questionnaire (see Appendix G). Information was collected on the relationship of the offender to the child, the duration of the abuse, the age of the child, the severity of the abuse, and the nature of the disclosure. Self-ratings of belief in the child's disclosure and the child's responsibility were also included. As well, questions assessing the use of alcohol by the women and her partner, and the severity of abuse in the woman's partner relationships were included (see Appendix G).

Procedure

Mothers of children referred to the Child Protection Centre were recruited in one of two ways. Women who accompanied their children to the Sexual Assault Clinic were given information about the research project (see Appendix H) and asked if they would be willing to participate. If they agreed, an appointment was made for a home visit in which the data was collected. Women who were not met at the Clinic were sent an initial letter of introduction by the agency (see Appendix I) and were then contacted by telephone. During the telephone conversation the research was explained. A home visit was scheduled with women who were interested in participating. A similar procedure was followed for all women referred to the Families Affected by Sexual Assault program (whether or not they chose to receive services). An initial letter was sent by the agency which was followed by telephone contact explaining the purpose of the study. Confidentiality and the independence between the research and the assessment or treatment they were receiving was emphasized. Once verbal consent was given, a home visit was scheduled. I made all contacts with the participants and conducted all home visits.

During the home visit the research was explained and any questions were answered. Confidentiality was discussed as was the woman's right to terminate her involvement at any time. All participants signed a consent form prior to the collection of data (see Appendix J).

The data collection consisted of the completion of the following questionnaires (counterbalanced to control for possible order effects): the PSR, the CRI, the BSI, the PSOC, and the CPRS. The questionnaire requesting demographic and descriptive data, and the questionnaire assessing history of child sexual abuse were given at the end of the interview to prevent these questionnaires from influencing responses to the other measures. I assisted subjects with the completion of the questionnaires by reading the items and explaining the directions.

At the end of the interview the questions were discussed with each participant. This debriefing allowed each woman to share any emotions elicited by the questionnaires and also provided each woman with the opportunity to talk about issues not directly assessed by the questionnaires. On average, the home visit took from 90 to 120 minutes.

RESULTS

Participants

As noted earlier, 55 subjects (54%) were obtained through the Child Protection Centre at Children's Hospital, 42 subjects (41%) were obtained through the Families Affected by Sexual Assault program at Children's Home, and 5 subjects (5%) were obtained from other sources. Seventy-seven percent of the women contacted through the Children's Hospital participated in the study and 63% of the women contacted through Children's Home agreed to participate. Referral source was not related to the dependent variables (i.e., there were no differences between subjects from the various referral sources on the General Severity Index of the BSI or the PSOC scale).

Participant Characteristics

The average age of the 102 women in the study was 33.67 years with women ranging in age from 22 to 46 years. The modal age was 30 years. Although the majority of the women were married (51%), a substantial number were separated or divorced (31%) or never married (17%). One percent of the sample was widowed. The women had an average of 3.03 children (including biological, adopted, foster, and stepchildren) with an average of 2.39 children living with them (a range of 1 to 5 children). Twenty-seven percent of the women were involved in full-time employment outside of the home at the time of the interview, 19% were employed part-time, and 55% were not employed outside the home. In terms of highest level of education obtained, 4% had less than 7 years of formal schooling, 14% had completed junior high school, 35% had some high school education, 20% were high school graduates,

12% had some postsecondary education, and 16% had a bachelor's degree or technical diploma.

Seventy-four percent of the sample identified themselves as Caucasian, 24% identified themselves as Aboriginal, and 2% were from other racial backgrounds. A series of t tests using Bonferroni's correction revealed a difference between Aboriginal and non-Aboriginal participants for relative avoidance coping and sexual behavior problems in children. Women who identified themselves as Aboriginal used more avoidance coping relative to total coping responses ($M = .44$) than did non-Aboriginal women ($M = .38$), $t(55.9) = -3.61$, $p < .001$. As well, non-Aboriginal women were more likely to report sexual behavior problems in their children ($M = 2.28$) than were Aboriginal women ($M = .68$), $t(92) = 3.49$, $p < .001$. No differences were found between Aboriginal and non-Aboriginal women on social support, emotional distress, parenting satisfaction, or subscales of the CPRS (i.e., conduct problem, learning problem, psychosomatic, impulsive-hyperactive, anxiety, and hyperactivity index). Chi-square analyses indicated no differences between racial groups for contact childhood sexual abuse, contact adolescent sexual abuse, emotional abuse in current or past partner relationships, physical abuse in current or past partner relationships, alcohol problems by current or former partners, history of receiving help, help received since the disclosure, or family socioeconomic status. However, compared to non-Aboriginal women, Aboriginal women were more likely to have never married, $\chi^2(3, N = 96) = 12.16$, $p < .01$, to have less formal education, $\chi^2(5, N = 96) = 27.10$, $p < .001$, to have no paid employment, $\chi^2(2, N = 96) = 10.80$, $p < .01$, and to report a history of

alcohol abuse, $\chi^2(1, N = 96) = 32.15, p < .000$.

Socioeconomic status (SES) was determined by occupation using the Standard Occupational Classification (1980) and the 1981 Census Unit Groups (Statistics Canada, 1981). Using Pineo-Porter-McRoberts' socioeconomic classification of occupations (Pineo, 1984), families were ranked from 1 to 16 (with 16 being the highest SES grouping) based on the occupation(s) of the parents. When both parents were employed, the highest ranking occupation was used. Families without income from employment were classified as 0. Using this classification system, family SES of 33% of the women in the sample were classified as 0 (i.e., at the lowest end of the SES scale). Thirty-four percent were ranked in the semi-skilled and unskilled groups (i.e., categories 1 to 5), 20% were in the skilled groups (i.e., categories 6 to 8), and 13% were in the supervisory, management, and professional groups (categories 9 to 16). Family SES was not related to either emotional distress or parenting self-esteem.

Descriptive Data

Characteristics of the Children's Sexual Abuse

The mean age of the children who were sexually abused was 8.5 years with the children ranging in age from 2 to 17 years. Seventy-seven percent of the child victims were girls and 23% of the child victims were boys. The average time since disclosure was 17 weeks.

Table 1 shows the relationship of the perpetrator to the mother. Ninety percent of the perpetrators were male, 9% of the perpetrators were female, and in 1% of the cases both male and female perpetrators were involved. Sixteen percent of the

Table 1

Perpetrators of the Sexual Abuse of the Children

Perpetrator	n	%
Friend/Acquaintance of the Child	13	13
Child of Mother's Friend/Acquaintance	12	12
Mother's Exhusband/Partner	12	12
Mother's Brother, Stepbrother, or Brother-in-Law	9	9
Mother's Friend/Acquaintance	9	9
Other Male Relative	8	8
Babysitter/Caretaker of the Child	8	8
Mother's Son/Stepson	7	7
Mother's Husband/Partner	5	5
Boyfriend of Mother's Friend/Relative	5	5
Neighbor	5	5
Stranger	5	5
Mother's Ex-boyfriend	2	2
Female Relative	2	2

Note. N = 102.

perpetrators were children, 32% of the perpetrators were adolescents, 50% of the perpetrators were adults, and in 3% of the cases the perpetrators included both adults and adolescents. To the mother's knowledge, in 2% of the cases the abuse involved exposure, in 11% of the cases the abuse involved fondling over clothing, in 52% of the cases the abuse involved fondling under clothing, and in 35% of the cases the abuse involved genital-genital contact and/or oral-genital contact. The abuse varied in length from one incident to seven years, with the modal length of abuse being one incident (43%). Time since the last occurrence of the abuse ranged from less than one month to 10 years.

Emotional distress (i.e., General Severity Index of the BSI) and parenting self-esteem were not related to time since disclosure, time since the occurrence of the sexual abuse, length of time the abuse occurred, gender of the offender, gender of the child, age of the offender, or severity of the sexual abuse. While the age of the child was not related to the mothers' emotional distress, it was related to the mothers' reported parenting self-esteem ($r = -.20$, $p < .05$). Analysis of the subscales showed that while age of the child was not related to parenting satisfaction, it was related to parenting efficacy ($r = -.29$, $p < .005$).

History of Abuse in Partner Relationships

Abuse in Current Relationship

Thirty-three percent of the sample indicated that questions regarding abuse in a current relationship were not applicable (i.e., they were not currently involved in a partner relationship). Of the remaining women ($n = 68$), 37 (54%) indicated that they

had experienced some type of abuse in their current husband/partner relationship. Table 2 displays the frequency of endorsement of the individual items.

Of the women who at the time of the interview were involved in a marital/partner relationship (n = 68), 33 (49%) had experienced some type of emotional abuse (endorsement of item 1, 2, 3, 4, 5, 6, or 7), and 20 women (29%) had experienced physical abuse (endorsement of item 8, 9, 10, or 11). It is important to note that four women in the sample were in relationships in which they had experienced extreme physical abuse (i.e., punching) with two women requiring medical attention for their injuries.

Abuse in Past Relationships

The women participating in the study were asked similar questions about their experiences in previous marital/partner relationships. Twenty-one women indicated that questions regarding previous relationships were not applicable (i.e., they had not been involved in a relationship with anyone other than their current partner) and one women refused to answer these questions, resulting in a subsample of 80 women. Of these 80 women, 73 (91%) indicated that they had experienced some type of abuse in a previous husband/partner relationship. Table 3 reports the frequency of endorsement of the individual items.

Of the women who had previous marital/partner relationships (n = 80), 71 (89%) experienced some type of emotional abuse (endorsement of item 1, 2, 3, 4, 5, 6, or 7), and 66 (83%) experienced physical abuse (endorsement of item 8, 9, 10, or 11) in that relationship. It is important to note that a large number of women in the

Table 2

Abuse in Current Partner Relationship: Frequency of Item Endorsement

Items		n	%
1)	act like he is jealous and suspicious of your friends	20	29
2)	withhold money you need to run the home	7	10
3)	say you are ugly or stupid	6	9
4)	insult you in front of other people	10	15
5)	demand sex whether you want it or not	9	13
6)	verbally threaten to hurt you	6	9
7)	threaten you with a weapon	2	3
8)	push or shove you	17	25
9)	slap you	7	10
10)	punch you with fists	4	6
11)	beat you so badly you must seek medical help	2	3

Note. N = 68.

Table 3

Abuse in Previous Partner Relationships: Frequency of Item Endorsement

Items		n	%
1)	act like he is jealous and suspicious of your friends	58	73
2)	withhold money you need to run the home	46	58
3)	say you are ugly or stupid	43	54
4)	insult you in front of other people	51	64
5)	demand sex whether you want it or not	45	56
6)	verbally threaten to hurt you	53	66
7)	threaten you with a weapon	31	39
8)	push or shove you	63	79
9)	slap you	55	69
10)	punch you with fists	38	48
11)	beat you so badly you must seek medical help	25	31

Note. N = 80.

sample had been in relationships in which they experienced severe physical abuse; 38 women had been punched by a partner with 25 women requiring medical attention for their injuries.

Use of Alcohol

Women's Use of Alcohol

Table 4 reports the frequency of current alcohol use among the women in the sample. As shown in the table, the majority of women acknowledged the use of alcohol (75%), although no women reported daily use and only 4% reported using alcohol several times per week.

When asked about their history of alcohol use, twenty-two women (22%) acknowledged a time in their life when they had a drinking problem. Of the women who reported drinking problems, eight (36%) indicated that they drank every day, seven (32%) indicated that they drank several times per week, five (23%) indicated that they drank once a week, and one (5%) indicated that she drank less than once per month (there was missing data for one subject).

Husband/Partners' Use of Alcohol

Table 5 reports the frequency of alcohol use among the husbands/partners of the women in the study. According to the women, 22 of their husbands/partners (34%) had a drinking problem at some time during their relationship. Of these men, 10 (45%) drank every day, 8 (36%) drank several times a week, 2 (9%) drank once a week, and 2 (9%) drank once a month.

Of the 81 women who had previous husbands/partners, 75 (93%) reported that

Table 4

Current Alcohol Use Among Women in the Sample

Frequency of Alcohol Use	n	%
Never	26	25
Less than Once a Month	36	35
Once a Month	22	22
Once a Week	14	14
Several Times a Week	4	4
Every Day	0	0

Note. N = 102.

Table 5

Current Alcohol Use Among Husband/Partners of Women in the Sample

Frequency of Alcohol Use	n	%
Never	12	18
Less than Once a Month	15	22
Once a Month	17	25
Once a Week	12	18
Several Times a Week	10	15
Every Day	2	3

Note. N = 68.

these men used alcohol. Table 6 displays the frequency of drinking among the previous partners of these 81 women. Forty-eight (67%) of the women who had previous partners indicated that at least one of their former partners had a drinking problem.

History of Child Sexual Abuse

Childhood Sexual Abuse

For the purposes of the study, childhood sexual abuse was defined as nonconsensual sexual experiences and/or sexual experiences with someone at least five years older (consensual or nonconsensual) prior to age 13. Table 7 reports the responses to individual abuse items.

Sixty women (59%) reported some unwanted or exploitive sexual experiences during childhood. Seven women in the sample (7%) reported experiencing noncontact sexual abuse (i.e., a sexual invitation or request or exposure), 30 women (29%) reported sexual touching (excluding intercourse or oral-genital contact), and 23 women (23%) reported genital-genital contact or oral-genital contact.

Contact child sexual abuse. Fifty-three women (52%) reported experiences of sexual abuse involving physical contact. Average age at the start of the abuse was 7.15 years with a modal age of 9 years. Offenders ranged in age from 8 to 65 years. Five women (10%) identified their offender as a child (i.e., between 8 and 12 years of age), 14 women (27%) reported that the offender was an adolescent (between ages 13 and 17), and 33 women (63%) reported being offended by an adult (18 years of age or older). In one case (2%) the offender was a female while in 52 cases (98%) the

Table 6

Alcohol Use Among Previous Husbands/Partners of Women in the Sample

Frequency of Alcohol Use	n	%
Never	6	7
Less than Once a Month	6	7
Once a Month	8	10
Once a Week	9	11
Several Times a Week	27	33
Every Day	25	31

Note. N = 81.

Table 7

Sexual Abuse During Childhood: Frequency of Item Endorsement

Items		n	%
1)	sexual invitation	27	27
2)	kissing & hugging	18	18
3)	exposure by another person	32	32
4)	exposure by subject	30	30
5)	fondling by another person	44	44
6)	subject fondling another person	18	18
7)	another person touching subject's sex organs	37	37
8)	subject touching another person's sex organs	20	20
9)	attempted intercourse	19	19
10)	intercourse	12	12
11)	other sexual activity:		
	digital penetration	3	3
	oral sex	9	9

offender was male.

Table 8 displays the relationship of the offender to the woman. In most cases the offender was known to the woman, with the majority of offenders being relatives (62%). In only 3 cases (6%) was the offender a stranger.

For most women, the abuse occurred once or twice (n = 24, 45%) or for a number of years (n = 20, 38%). For a smaller number of women the abuse occurred over a number of days (n = 2, 4%), a number of weeks (n = 2, 4%), or a number of months (n = 5, 9%). The women were threatened in 35% of the cases, forced in 59% of the cases, physically hurt in 29% of the cases, and convinced to participate in 49% of the cases.

The majority of the women found the sexual abuse experiences to be negative (81%) or mostly negative (15%) with only 2 women (4%) rating the experience(s) as neutral.

The study also found that a substantial number of women in the sample were victims of sexual abuse by more than one perpetrator during childhood. In addition to the sexual abuse experience the women rated as most significant, 23 women (23%) reported additional sexual abuse during childhood. More specifically, twelve women (12%) reported sexual abuse by one additional perpetrator, 5 women (5%) reported sexual abuse by two additional perpetrators, and 6 women (6%) reported sexual abuse by at least three additional perpetrators.

Adolescent Sexual Abuse

Adolescent sexual abuse was defined as nonconsensual sexual experiences

Table 8

Perpetrators of the Childhood Sexual Abuse of the Participants

Perpetrator	n	%
Brother, Stepbrother, or Adopted Brother	11	21
Father or Stepfather	9	17
Cousin	7	13
Uncle	6	11
Neighbor	4	8
Friend of Parents	4	8
Acquaintance	4	8
Stranger	3	6
Physician	2	4
Other Relative	1	2
Friend	1	2
Priest	1	2

Note. N = 53.

and/or sexual experiences with someone at least 10 years older (consensual or nonconsensual) occurring between ages 13 and 18 years (i.e., prior to age 18).

Table 9 reports the frequency of endorsement of individual abuse items. A total of 56 women (55%) reported some unwanted or exploitive sexual experiences during adolescence. Three of the women in the sample (3%) reported experiencing noncontact sexual abuse (i.e., a sexual invitation or request or exposure), 18 women (18%) reported sexual touching (excluding intercourse or oral-genital contact), and 35 women (34%) reported genital-genital contact or oral-genital contact.

Contact adolescent sexual abuse. The data indicate that 53 women (52%) experienced contact sexual abuse during adolescence. Average age at the start of the abuse was 14.87 years with a modal age of 16 years. Offenders ranged in age from 16 to 67 years. Ten of the women (19%) identified their offender as an adolescent (between ages 13 and 17) and 42 women (79%) reported being offended by an adult (18 years of age or older). In all cases the offender was male although in one case a female offender was also involved.

Table 10 shows the relationship of the offender to the woman. In most cases the offender was someone known to the woman (81%), with friends being the most likely perpetrators (n = 14, 26%). In 10 cases (19%) the perpetrator was a stranger.

For most women, the abuse occurred once or twice (n = 33, 62%) although for a considerable number of women (n = 12, 23%) the abuse lasted for a number of years. For other women the abuse occurred over a number of days (n = 3, 6%), a number of weeks (n = 2, 4%), or a number of months (n = 3, 6%). The women were

Table 9

Sexual Abuse During Adolescence: Frequency of Item Endorsement

Items		n	%
1)	sexual invitation	20	20
2)	kissing & hugging	23	23
3)	exposure by another person	31	30
4)	exposure by subject	27	26
5)	fondling by another person	44	43
6)	subject fondling another person	19	19
7)	another person touching subject's sex organs	38	37
8)	subject touching another person's sex organs	18	18
9)	attempted intercourse	27	26
10)	intercourse	29	28
11)	other sexual activity:		
	oral sex	3	3
	forced to prostitute	1	1

Table 10

Perpetrators of the Adolescent Sexual Abuse of the Participants

Perpetrator	n	%
Friend	14	26
Stranger	10	19
Brother, Stepbrother, or Adopted Brother	5	9
Acquaintance	5	9
Employer	4	8
Friend of Parents	3	6
Brother-in-Law	3	6
Father or Foster Father	2	4
Uncle	2	4
Boyfriend of a Relative	2	4
Cousin	1	2
Husband	1	2
Church Choir Director	1	2

Note. N = 53.

threatened in 31% of the cases, forced in 71% of the cases, physically hurt in 39% of the cases, and convinced to participate in 37% of the cases.

The majority of the women found the experience to be negative (74%) or mostly negative (17%) with only five women (9%) rating the experience(s) as neutral.

The data indicate that a substantial number of women in the sample were victims of multiple sexual abuse during adolescence (i.e., abuse by more than one perpetrator). In addition to the sexual abuse experience the women rated as most significant, 21 women (21%) reported experiencing sexual abuse by another perpetrator during adolescence. Twelve women (12%) reported abuse by one additional perpetrator, five women (5%) reported abuse by two other perpetrators, and four women (4%) reported abuse by three additional perpetrators.

Responses to the Abuse Experiences

In summary, 75 women in the sample (74%) reported at least one experience of contact sexual abuse during childhood or adolescence. Of these women, 22 (22%) experienced contact sexual abuse during childhood only, 22 (22%) experienced contact sexual abuse during adolescence only, and 31 (30%) experienced contact sexual abuse during both childhood and adolescence.

Of the women who reported that they had been victims of contact sexual abuse, 77% indicated that they felt they had been sexually abused while 22% indicated that they did not regard themselves as having been sexually abused (1% of the women were unsure). The majority of the women (59%) did not tell anyone about the sexual abuse experiences at the time. Of the women who made disclosures of the sexual

abuse when it occurred, 24% told their mother, 11% told their father, 9% told a sibling, 4% told a friend, 4% told a teacher, and 9% told another adult. Eighty-five percent of the sample indicated that they told someone about the sexual abuse during adulthood. Sixty-nine percent told a husband or boyfriend, 61% told a friend, 41% told a sibling, 35% told their mother, 16% told their father, and 24% told another adult. A majority of the women (60%) had not talked about their sexual abuse experiences with a mental health professional.

History of Help-Seeking Behavior

Seventy-two of the women in the sample (72%) reported that they had at some point in the past received help from a professional person. While the modal length of time the help continued was less than one month (28%), the length of time each women received help ranged from less then one month to 10 years. Thirty-seven percent of the women received help from a social worker, 33% received help from a counsellor, 17% received help from a psychologist, 11% received help from a medical doctor, 4% received help from a minister, and 2% received help from a psychiatrist.

Since their children's disclosures of sexual abuse, each woman in the sample had some contact with a professional through either the child welfare system or legal system. However, only 66 women (65%) reported that they received help from a professional person during this process. Forty-nine percent received help from a social worker, 18% received help from a counsellor, 12% received help from a psychologist, 7% received help from a medical doctor, 3% received help from a minister, 3% received help from a psychiatrist, 2% received help from the police, and 1% received

help from a public health nurse.

Pearson product-moment correlational analyses indicated that there was no relationship between the length of time the women had received help in the past and emotional distress or parenting self-esteem. The length of time help had been received since the disclosure was also not related to emotional distress or parenting self-esteem. However, the mean General Severity Index scores (square root) of the BSI were higher for women who had received help in the past ($\underline{M}$ = 1.05) than for women who had never received help in the past ($\underline{M}$ = .87), $\underline{t}(98) = -2.48$, $\underline{p} < .05$. There were no differences between women who had received help in the past and women who had not received help on parenting self-esteem. There were also no differences between women who had received help since the disclosure and women who had not received help on self-reported emotional distress or parenting self-esteem.

Data Screening

Missing Values

Prior to the analysis of the data, all variables were checked for accuracy of data entry and missing values. The data set contained minimal amounts of missing data. Missing values on descriptive variables were left missing and were deleted from analyses. As recommended by Derogatis and Spencer (1982), missing values on the BSI were left missing, with the total number of items adjusted accordingly for the calculation of the General Severity Index. Only one case had missing values on items comprising the BSI subscales; the one missing item was replaced with the item mode. One case had two missing values on the CPRS-48. These missing values were also

replaced with the item modes. Two subjects did not complete the sexual behavior problems questions; these cases were deleted from analyses involving this scale.

Normality of the Variables

The main variables in the study (i.e., General Severity Index of the BSI, the BSI subscales, total support, support from friends, support from family, parenting self-esteem, relative avoidance coping, and subscales of the CPRS-48) were examined for the fit between their distributions and the assumptions of multivariate analysis. To reduce skewness of the General Severity Index and all subscales of the BSI, square root transformations were applied. Logarithmic transformations were applied to the subscales of the PSR (support from friends and support from family subscales). Square root transformations were applied to the Conduct Problem, Learning Problem, Psychosomatic, and Hyperactivity subscales of the CPRS-48, and the sexual behavior problem scale.

Outliers

The data were examined for both univariate and multivariate outliers. While two variables were found to have one univariate outlier ($z > 3.00$), no multivariate outliers were identified using Mahalanobis distance with $p < .001$. Consequently, all cases were retained for the analyses.

Linearity, Homoscedasticity, Multicollinearity, and Singularity

Assumptions of linearity and homoscedasticity were considered by examining bivariate scatterplots. Squared multiple correlations were examined to check for multicollinearity and singularity. No variables were found which violated the

assumptions for multivariate analysis.

Internal Consistency

The internal consistency of each scale was considered by examining Cronbach's alpha. Scale means, standard deviations, and internal consistency reliability coefficients are reported in Table 11.

The Brief Symptom Inventory

The General Severity Index (GSI) was used to measure overall distress. The mean GSI score for the sample was 1.12 (SD = .70). This score falls between published norms for a non-patient normal adult sample (M = .30, SD = .31) and a psychiatric outpatient sample (M = 1.32, SD = .72; Derogatis & Spencer, 1982). The Cronbach's coefficient alpha for the GSI was .96. The alpha coefficients for the subscales, which ranged from a low of .65 (Psychoticism subscale) to .85 (Depression subscale), compare favourably with the published data on the subscales which report alpha coefficients ranging from .71 to .85 (Derogatis & Spencer, 1982).

Coping Responses Inventory

For the purposes of this study, the Coping Responses Inventory (Moos, 1990) was scored according to the focus of coping (i.e., problem-focused vs. emotion-focused), resulting in approach and avoidance subscales. The approach coping subscale had a Cronbach's alpha coefficient of .81 and the avoidance subscale had a Cronbach's alpha coefficient of .76. These findings are similar to the findings of Holahan and Moos (1990) who report alpha coefficients of .83 for approach coping and .60 for avoidance coping. As discussed earlier, the analyses were conducted using

Table 11

Statistics of Measures

Variables	Mean	SD	Alpha
Brief Symptom Inventory			
General Severity Index	1.12	0.70	.96
Somatization	0.78	0.80	.83
Obsessive-Compulsive	1.39	1.01	.87
Interpersonal Sensitivity	1.06	0.93	.78
Depression	1.11	0.90	.85
Anxiety	1.37	0.90	.83
Hostility	1.26	0.83	.71
Phobic Anxiety	0.68	0.84	.77
Paranoid Ideation	1.33	0.87	.65
Psychoticism	0.84	0.85	.77
Coping Responses Inventory			
Approach Coping	43.08	11.40	.81
Avoidance Coping	28.85	10.33	.76

Table 11 (continued)

Statistics of Measures

Variables	Mean	SD	Alpha
Provision of Social Relations			
Lack of Support (Total)	31.92	10.04	.82
Lack of Family Support	15.38	7.63	.92
Lack of Friend Support	16.54	5.13	.71
Parenting Sense of Competence Scale			
Total Score	62.57	9.96	.73
Conners' Parent Rating Scale			
Conduct Problem	8.90	5.53	.80
Learning Problem	4.13	3.38	.78
Psychosomatic	2.15	2.36	.65
Impulsive-Hyperactive	6.47	3.30	.68
Anxiety	4.48	2.92	.56
Hyperactivity Index	12.36	6.61	.81
Sexual Behavior Problems			
Total Score	1.87	2.36	.56

relative avoidance scores.

Provision of Social Relations

Internal consistency analysis was conducted on the total score of the PSR as well as on the two dimensions of support (family support and friend support). Cronbach's alpha coefficients were .82 for total support, .92 for family support, and .71 for friend support. Turner et al. (1983) report similar alpha coefficients for the scales (i.e., alphas ranging from .75 to .87).

Parenting Sense of Competence Scale

The mean total score on the PSOC scale (M = 62.57, SD = 9.96) is similar to the means presented by Johnston & Mash (1989) for a normative sample of mothers of children aged 4 to 9 years of age (they report means ranging from 62.48 to 64.19). A Cronbach's alpha coefficient of .73 was calculated for the total parenting self-esteem scale. This finding compares favorably to the normative study which found an alpha of .79 for the total score (Johnston & Mash, 1989).

Child Behavior Problem Scales

Mean scores on the subscales of the CPRS-48 are higher than those reported by Goyette et al. (1978) for the normative sample. Cronbach's alpha coefficients for the subscales ranged from .56 to .81. The alpha coefficient for the sexual behavior items was .56.

Tests of Hypotheses

Primary Hypotheses

Overview

The primary hypotheses were tested with canonical correlation analyses followed by multiple regression analyses. The goal of canonical correlation is to analyze the relationships between two sets of variables (Tabachnick & Fidell, 1989). Linear combinations of variables (called canonical variates) are created which represent mathematically viable dimensions of the variables. Since there are several variables on each side of the equation, there may be several ways to recombine the variables on both sides to relate them to each other. Thus, canonical correlation explores the number and type of relationships between two sets of variables and allows for an assessment of both the correlation between variates as well as the unique contribution of each variable to the relationship. Using the guidelines suggested by Tabachnick and Fidell (1989), variables with correlations of .30 and above on the variate were interpreted as part of the variate while variables with loadings below .30 were not. Following the appearance of a significant canonical correlation, post-hoc multiple regressions were performed with independent variables regressed on the adjustment variables.

Hypothesis One

The first hypothesis predicted that histories of childhood and adolescent sexual abuse would be associated with greater emotional distress and lower parenting self-esteem. This hypothesis was tested with a canonical correlation analysis with a set of

abuse variables (contact childhood sexual abuse and contact adolescent sexual abuse) versus a set of adjustment variables (GSI and parenting self-esteem). The overall canonical correlation analysis was significant, $F(4,196) = 2.83$, $p < .05$, resulting in one significant canonical correlation. Data on the first pair of canonical variates appear in Table 12.

The canonical correlation analysis indicates general support for hypothesis one. The analysis suggests that women with histories of childhood and adolescent sexual abuse experience greater emotional distress and lower parenting self-esteem. The percentage of variance accounted for was 10%. The canonical redundancy analysis shows that the proportion of variance of the abuse variables explained by the first canonical variate of the adjustment variables was .058 and the proportion of variance of the adjustment variables explained by the first canonical variate of the abuse variables was .058. The squared multiple correlations indicate that the first canonical variate of the abuse variables had some predictive power for psychological symptomatology (.101) but little predictive power for parenting satisfaction and efficacy (.015). The opposite signs between the correlation between parenting self-esteem and the first canonical variate, and its standardized canonical coefficient, suggest that it was a suppressor variable, enhancing the correlation between emotional distress and abuse.

Table 13 show the results of the post-hoc multiple regression analysis performed between emotional distress (square root of the GSI scores) as the dependent variable and childhood sexual abuse and adolescent sexual abuse as independent

Table 12

Canonical Correlation of Abuse Variables with Adjustment Variables

	Canonical Variate	
	Correlation	Coefficient
Independent Variables		
Childhood Sexual Abuse	.75	.66
Adolescent Sexual Abuse	.76	.67
Percent of Variance	.57	
Redundancy	.06	
Dependent Variables		
Emotional Distress (Square root of GSI)	1.00	1.03
Parenting Self-Esteem	-.38	.07
Percent of Variance	.57	
Redundancy	.06	
Canonical Correlation	.32	

Note. N = 102.

Table 13

Multiple Regression of Sexual Abuse Variables on Emotional Distress (SQGSI)

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Childhood Sexual Abuse	.143	.213*	.045
Adolescent Sexual Abuse	.140	.208*	.043
Intercept	.856		

R-square = .101

Adjusted R-square = .083

Note. N = 102. SQGSI = Square root of GSI scores.

*p < .05.

variables. R for regression (R = .32) was significantly different from zero, F(2,99) = 5.55, p < .01. Tests of the regression components indicate that both childhood contact sexual abuse and adolescent contact sexual abuse contributed to the prediction of emotional distress (p < .05). The 95% confidence limits for childhood sexual abuse were .015 to .272 and for adolescent sexual abuse were .011 to .269. Childhood sexual abuse accounted for 4.5% of the variability of emotional distress and adolescent sexual abuse accounted for 4.3% of the variability. The two independent variables in combination contributed another .4% in shared variability. Altogether, 10% (8.3% adjusted) of the variability in emotional distress was accounted for by knowing whether or not the women had histories of childhood and adolescent sexual abuse.

The differences in self-reported emotional distress between women who had histories of childhood or adolescent sexual abuse and those women who did not was also examined using a t test. The results indicated a difference between the groups (t(100) = 3.30, p < .01). Women who experienced sexual abuse in childhood or adolescence reported greater emotional distress (M = 1.07) than did women who did not report a history of sexual abuse (M = .83).

The impact of receiving treatment for childhood and adolescent sexual abuse on emotional distress was examined using a one-way analysis of variance. The women were categorized either as having no sexual abuse experiences, as having been sexually abused but having talked about these experiences in counselling/treatment, or as having sexual abuse experiences but not having addressed these issues in counselling or treatment. The dependent variable was the square root of the GSI scores. The

analysis of variance was significant, $F(2,97) = 5.73$, $p < .01$. Post-hoc comparisons of the means using Scheffe's multiple-comparison procedure indicated that women who had not received help in dealing with their sexual abuse experiences ($M = 1.03$) and women who had received help in dealing with their sexual abuse experience ($M = 1.11$) reported more emotional distress than did women who had no history of sexual abuse ($M = .83$). There were no differences between women who received treatment for their abuse experiences and women who did not receive treatment.

The multiple regression analysis with parenting self-esteem as the dependent variable and childhood and adolescent sexual abuse as independent variables was not significant ($F(2,99) = .98$, $p = .38$).

Hypothesis Two

The second hypothesis predicted that a lack of social support would be associated with greater emotional distress and lower parenting self-esteem. This hypothesis was tested with a canonical correlation analysis with a set of support variables (log of lack of support from friends and log of lack of support from family) versus a set of adjustment variables (square root of the GSI and parenting self-esteem). With two canonical correlations included $F(4,196) = 7.00$, $p < .001$, and with the first canonical correlation removed $F(1,99) = 4.29$, $p < .05$. The first canonical correlation was .45 (accounting for 20% of the variance). Although the second canonical variate pair was marginally significant ($p < .05$), the canonical correlation was only .20 (accounting for 4% of the variance). Thus the second pair of canonical variates was not interpreted.

Data on the first pair of canonical variates appear in Table 14. The first canonical variate pair indicates general support for hypothesis two. Lack of support from friends and family was associated with greater emotional distress and lower parenting self-esteem. The percentage of variance accounted for was 20%. The canonical redundancy analysis shows the proportion of variance of the support variables explained by the first canonical variate of the adjustment variables was .144 and the proportion of the variance of the adjustment variables explained by the first canonical variate of the support variables was .119. The squared multiple correlations indicate that the first canonical variate of the support variables had some predictive power for both emotional distress (.136) and parenting self-esteem (.153).

Table 15 shows the results of the post-hoc multiple regression analysis performed between emotional distress (square root of the GSI scores) as the dependent variable and lack of support from friends and family (logarithmic transformations) as independent variables. $\underline{R}$ for regression ($\underline{R} = .39$) was significantly different from zero, $\underline{F}(2,99) = 8.71$, $\underline{p} < .001$. Tests of the regression components indicate that lack of support from friends ($\underline{p} < .01$) and lack of support from family ($\underline{p} < .05$) contributed to the prediction of emotional distress. The 95% confidence limits for log of lack of support from friends were .220 to 1.222 and log of lack of support from family were .024 to .599. Log of lack of support from friends accounted for 7.0% of the variability of emotional distress and log of lack of support from family accounted for 4.0% of the variability. The two independent variables in combination contributed another 2.2% in shared variability. Altogether, 15% (13.2% adjusted) of the

Table 14

Canonical Correlation of Support Variables with Adjustment Variables

	Canonical Variate	
	Correlation	Coefficient
Independent Variables		
Log of Lack of Support from Friends	.97	.91
Log of Lack of Support from Family	.49	.25
Percent of Variance	.59	
Redundancy	.12	
Dependent Variables		
Emotional Distress (Square root of the GSI)	.82	.55
Parenting Self-Esteem	-.87	-.63
Percent of Variance	.72	
Redundancy	.14	
Canonical Correlation	.45	

Note. N = 102.

Table 15

Multiple Regression of Support Variables on Emotional Distress (SQGSI)

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Log of Lack of Support from Friends	.721	.275**	.070
Log of Lack of Support from Family	.312	.208*	.040
Intercept	-.214		
R-square = .150			
Adjusted R-square = .132			

Note. N = 102. SQGSI = Square root of GSI scores.

*p < .05. **p < .01.

variability in emotional distress was accounted for by knowing the support women received from friends and family.

The results of the post-hoc multiple regression analysis performed between parenting self-esteem as the dependent variable and the log of lack of support from friends and family as independent variables are shown in Table 16. R for regression (R = .40) was significantly different from zero, F(2,99) = 9.63, p < .001. Tests of the regression components indicate that only lack of support from friends contributed to the prediction of parenting self-esteem (p < .001). The 95% confidence limits for log of lack of support from friends were -45.954 to -16.602. Log of lack of support from friends accounted for 15.2% of the variability in parenting self-esteem. The two independent variables in combination contributed only another 1.1% in shared variability. Altogether, 16.3% (14.6% adjusted) of the variability in parenting self-esteem was accounted for by knowing the support women perceived as receiving from friends and family.

Hypothesis Three

The third hypothesis predicted that greater relative avoidance coping would be associated with greater emotional distress and lower parenting self-esteem. This hypothesis was tested with a canonical correlation analysis with relative avoidance coping versus a set of adjustment variables (square root of the GSI and parenting self-esteem). The canonical correlation was significant, F(2,99) = 11.84, p < .001. The canonical correlation was .44, accounting for 19.3% of the variance.

Data on the canonical variates appear in Table 17. The first canonical variate

Table 16

Multiple Regression of Support Variables on Parenting Self-Esteem

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Log of Lack of Support from Friends	-31.278	-.405*	.152
Log of Lack of Support from Family	.204	.005	.000
Intercept	99.846		
R-square = .163			
Adjusted R-square = .146			

Note. N =102.

*p < .001.

Table 17

Canonical Correlation of Relative Avoidance Coping with Adjustment Variables

	Canonical Variate	
	Correlation	Coefficient
Independent Variable		
Relative Avoidance Coping	1.00	1.00
Percent of Variance	1.00	
Redundancy	.19	
Dependent Variables		
Emotional Distress (square root of the GSI)	.79	.49
Parenting Self-Esteem	-.90	-.68
Percent of Variance	.71	
Redundancy	.14	
Canonical Correlations	.44	

Note. N = 102.

pair indicates support for hypothesis three; greater relative use of avoidance coping was associated with greater emotional distress and lower parenting self-esteem. The proportion of variance of the coping variables explained by the canonical variate of the adjustment variables was .138 and the proportion of variance of the adjustment variables explained by the canonical variate of relative avoidance coping was .193. The squared multiple correlations indicate that relative avoidance coping had predictive power for emotional distress (.120) and for parenting self-esteem (.156).

Table 18 shows the results of the post-hoc regression analysis performed between emotional distress (square root of the GSI scores) as the dependent variable and relative avoidance coping as the independent variable. $\underline{R}$ for regression ($\underline{R}$ = .35) was significantly different from zero, $\underline{F}(1,100) = 13.63$, $\underline{p} < .001$. Tests of the regression components indicate that relative avoidance coping contributed to the prediction of emotional distress ($\underline{p} < .001$). The 95% confidence limits for relative avoidance coping were .676 to 2.258. Relative avoidance coping accounted for 12.0% (11.1% adjusted) of the variability in emotional distress.

Results of the post-hoc regression analysis performed between parenting self-esteem as the dependent variable and relative avoidance coping as the independent variable are shown in Table 19. $\underline{R}$ for regression ($\underline{R}$ = .39) was significantly different from zero, $\underline{F}(1,100) = 18.45$, $\underline{p} < .001$. Tests of the regression components indicates that relative avoidance coping contributed to the prediction of parenting self-esteem ($\underline{p} < .001$). The 95% confidence limits for relative avoidance coping were -72.222 to -26.490. Relative avoidance coping accounted for 15.6% (14.7% adjusted) of the

Table 18

Regression of Relative Avoidance Coping on Emotional Distress (SQGSI)

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Relative Avoidance Coping	1.467	.346*	.120
Intercept	.424		
R-square = .120			
Adjusted R-square = .111			

Note. N = 102. SQGSI = Square root of GSI scores.

*p < .001.

Table 19

Regression of Relative Avoidance Coping on Parenting Self-Esteem

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Relative Avoidance Coping	-49.356	-.395*	.156
Intercept	82.063		

R-square = .156

Adjusted R-square = .147

Note. N =102.

*p < .001.

variability in parenting self-esteem.

Secondary Hypotheses

Hypothesis One

The first secondary hypothesis posited a relationship between a history of sexual abuse and the use of avoidance and approach coping responses. Specifically, it was predicted that a history of child sexual abuse would be positively associated with relative avoidance coping. Correlational analysis did not support this hypothesis. The Pearson product-moment correlations between childhood sexual abuse and relative avoidance coping ($r = .10$, $p = .31$) and between adolescent sexual abuse and relative avoidance coping ($r = .00$, $p = 1.00$) were not significant.

Hypothesis Two

The second hypothesis predicted that lack of social support would be positively associated with relative avoidance coping. Correlational analysis supports this hypothesis. The Pearson product-moment correlation between lack of support and relative avoidance coping was .26 ($p < .01$).

Hypothesis Three

The third secondary hypothesis predicted that women whose children were abused by a family member would report greater emotional distress than women whose children were abused by an individual outside the family. To test this hypothesis a t test was performed on the General Severity Index of the BSI. The independent variable was the relationship of the perpetrator to the family, with the two groups being women whose children were abused by someone inside the family and women

whose children were abused by someone outside the family. Although the means were in the expected direction, the analysis was not significant ($t(100) = -1.05$, $p = .30$).

Hypothesis Four

The fourth hypothesis predicted that a history of sexual abuse, a lack of social support, and greater relative avoidance coping would be associated with lower self-reported belief in the disclosure. The responses of the women to the question asking them to rate the extent to which they believed their child's disclosure revealed that the majority of women ($n = 88$, 86%) believed their child completely. Given the extreme skewness to the distribution, the variable was dichotomized. Pearson product-moment correlations between self-reported belief and childhood sexual abuse ($r = .02$, $p = .88$), adolescent sexual abuse ($r = .19$, $p = .06$), lack of social support ($r = -.03$, $p = .73$), and relative avoidance coping ($r = .02$, $p = .81$) were not significant.

Hypothesis Five

The fifth hypothesis predicted a positive association between abuse in the partner relationship and emotional distress. This hypothesis was tested with a canonical correlation analysis with a set of partner physical abuse variables (physical abuse in current partner relationship and physical abuse in past partner relationships) versus a set of emotional distress variables (square root transformations of the subscales of the BSI). The overall canonical correlation analysis was significant, resulting in one significant canonical correlation, $F(18,180) = 2.27$, $p < .005$. Data on the first pair of canonical variates appear in Table 20.

The canonical correlation analysis indicates partial support for the hypothesis.

Table 20

Canonical Correlation of Partner Abuse Variables with Emotional Distress

	Canonical Variate	
	Correlation	Coefficient
Independent Variables		
Abuse in the Current Partner Relationship	.97	1.05
Abuse in Past Partner Relationships	-.09	.25
Percent of Variance	.48	
Redundancy	.13	
Dependent Variables[a]		
Somatization	-.36	-.83
Obsessive-Compulsive	.18	.23
Interpersonal Sensitivity	.38	.30
Depression	-.03	-.68
Anxiety	.04	-.10
Hostility	.29	.35
Phobic Anxiety	.33	.52
Paranoid Ideation	.52	.46
Psychoticism	.11	.07
Percent of Variance	.09	
Redundancy	.02	
Canonical Correlation	.53	

Note. N = 101.

[a]These subscales were subject to a square root transformation prior to the analysis.

The results suggest a relationship between women who report physical abuse in their current relationship and greater interpersonal sensitivity, phobic anxiety, and paranoid ideation as well as fewer somatic symptoms. The percentage of variance accounted for was 28%. The canonical redundancy analysis shows that the proportions of variance of one set explained by the opposite set were .132 and .024. The squared multiple correlations indicate that the first canonical variate of the abuse variables had minimal predictive power for the square roots of somatic symptoms (.037), interpersonal sensitivity (.039), phobic anxiety (.030), and paranoid ideation (.075).

Post-hoc multiple regression analyses were performed between emotional distress (square roots of the BSI subscale scores) as the dependent variable and physical abuse in the current partner relationship and physical abuse in a previous partner relationship as independent variables. One regression analysis was significant; $\underline{R}$ for regression ($\underline{R} = .27$) on paranoid ideation (square root) was significantly different from zero, $\underline{F}(2,98) = 4.00$, $\underline{p} < .05$.

Table 21 shows the results of this regression analysis. Tests of the regression components indicate that physical abuse in the current partner relationship contributed to the prediction of paranoid ideation ($\underline{p} < .01$). The 95% confidence limits for physical abuse in the current partner relationship were .090 to .516. Physical abuse in the current relationship accounted for 7.5% of the variability in paranoid ideation. Physical abuse in past partner relationships accounted for virtually no variability (.01%). Overall, 7.6% (5.7% adjusted) of the variability in paranoid ideation was accounted for by knowing whether or not the women experienced physical abuse in

Table 21

Multiple Regression of Partner Abuse Variables on the Paranoid Ideation Subscale of the BSI[a]

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Abuse in Current Partner Relationship	.303	.290*	.075
Abuse in Previous Partner Relationships	.087	.099	.009
Intercept	.962		
R-square = .076			
Adjusted R-square = .057			

Note. N = 102.

[a]The analysis was conducted using a square root transformation of the subscale.

*p < .01.

their current and past partner relationships.

Hypothesis Six

The final secondary hypothesis predicted that greater behavior problems in the children would be associated with greater emotional distress and lower parenting self-esteem. The relationship between these variables was explored in a canonical correlation analysis with the child behavior problem scales entered as one set and the adjustment variables entered in the other set. The overall canonical correlation analysis was significant, resulting in one significant canonical correlation, $F(14,182) = 4.50$, $p < .001$. Data on the first pair of canonical variates appear in Table 22.

The canonical correlation analysis indicates a positive relationship between women who report behavior problems in their children and emotional distress and a negative relationship between child behavior problems and parenting self-esteem. The percentage of variance accounted for was 43%. The canonical redundancy analysis shows that the proportion of variance of the adjustment variables explained by the first canonical variate of the behavior problem variables was .203 and the proportion of variance of the child behavior problem variables explained by the first canonical variate of the adjustment variables was .302. The squared multiple correlations indicate that the first canonical variate of the child behavior problem variables had some predictive power for both emotional distress (.385) and parenting self-esteem (.219). The opposite signs between the correlation between the hyperactivity index and the first canonical variate, and its standardized canonical coefficient, suggest that it was a suppressor variable, enhancing the correlation between child behavior problems

Table 22

Canonical Correlation of Child Behavior Problem Scales with Adjustment Variables

	Canonical Variate	
	Correlation	Coefficient
Problem Behavior Scales		
Conduct Problem (Sqrt)	.86	.55
Learning Problem (Sqrt)	.71	.43
Psychosomatic (Sqrt)	.55	.03
Impulsive-Hyperactivity	.67	.28
Anxiety	.60	.29
10-item Hyperactivity Index (Sqrt)	.82	-.29
Sex Items (Sqrt)	.49	.18
Percent of Variance	.47	
Redundancy	.20	
Dependent Variables		
Emotional Distress (Sqrt of the GSI)	.94	.78
Parenting Self-Esteem	-.71	-.37
Percent of Variance	.70	
Redundancy	.30	
Canonical Correlation	.66	

Note. N = 100. Sqrt means a square root transformation was applied to the variable.

and adjustment.

Table 23 show the results of the post-hoc multiple regression analysis performed between emotional distress (square root of the GSI scores) as the dependent variable and the child behavior problems scales as independent variables. R for regression ($R = .62$) was significantly different from zero, $F(7,92) = 8.34$, $p < .001$. Tests of the regression components indicate that conduct problems (square root), learning problems (square root), and anxiety contributed to the prediction of emotional distress ($p < .05$). The 95% confidence limits for conduct problems were .003 to .179, for learning problems were .001 to .172, and for anxiety were .0002 to .043. Conduct problems accounted for 2.8% of the variability in emotional distress, learning problems accounted for 2.7% of the variability, and anxiety accounted for 2.7% of the variability. Altogether, 38.8% (34.2% adjusted) of the variability in emotional distress was predicted by knowing the behavior problems of the children as reported by their mothers.

Table 24 shows the results of the post-hoc multiple regression analysis performed between parenting self-esteem as the dependent variable and the child behavior problems scales as independent variables. R for regression ($R = .48$) was significantly different from zero, $F(7,92) = 3.96$, $p < .001$. Tests of the regression components indicated that only conduct problems contributed significantly to the prediction of parenting self-esteem ($p < .05$). The 95% confidence limits for conduct problems were -.788 to -6.667. Conduct problems accounted for 5.3% of the variability in parenting self-esteem. Altogether, 23.1% (17.3% adjusted) of the

Table 23

Multiple Regression of Child Behavior Problem Scales on Emotional Distress (Sqrt of the GSI)

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Conduct Problem (Sqrt)	.09	.28*	.03
Learning Problem (Sqrt)	.09	.26*	.03
Psychosomatic (Sqrt)	.02	.05	.00
Impulsive-Hyperactivity	.02	.20	.01
Anxiety	.02	.19*	.03
10-item Hyperactivity Index (Sqrt)	-.05	-.16	.00
Sex Items (Sqrt)	.04	.11	.01
Intercept	.48		
R-square =	.388		
Adjusted R-square =	.342		

Note. N = 100. Sqrt means a square root transformation was applied to the variable.

*p < .05.

Table 24

Multiple Regression of Child Behavior Problem Scales on Parenting Self-Esteem

	Unstandardized Regression Coefficients	Standardized Regression Coefficients	Squared Semipartial Correlations
Conduct Problem (Sqrt)	-3.73	-.38*	.05
Learning Problem (Sqrt)	-2.27	-.23	.02
Psychosomatic (Sqrt)	.72	.06	.00
Impulsive-Hyperactivity	-.25	-.08	.00
Anxiety	-.39	-.11	.01
10-item Hyperactivity Index (Sqrt)	1.82	.18	.00
Sex Items (Sqrt)	-.77	-.07	.00
Intercept	74.30		
R-square =	.231		
Adjusted R-square =	.173		

Note. N = 100. Sqrt means a square root transformation was applied to the variable prior to analysis.

*p < .05.

variability in parenting self-esteem was predicted by knowing the behavior problems of the children as reported by their mothers.

DISCUSSION

Overall, the present study found support for many of the major hypotheses. Specifically, a history of child sexual abuse, social support, and coping strategies were found to be important in predicting women's self-reported emotional distress. As well, social support and coping strategies were found to be related to parenting self-esteem. Contrary to expectation, a history of child sexual abuse was not related to parenting self-esteem. Each of these results will be discussed and the research and clinical implications explored. In addition, the implications of the exploratory analyses will also be considered.

Sexual Abuse and Psychosocial Adjustment Among Mothers

Prevalence of Child Sexual Abuse Among Mothers

That child sexual abuse is a frequently occurring experience has been well documented by the prevalence literature (see Bagley & King, 1990). Seventy-four percent of women in the present sample reported at least one experience of contact sexual abuse during childhood or adolescence. This strikingly high prevalence rate may in part be related to the methodology of the study. The present study used face-to-face interviews in which subjects were asked about their histories of sexual abuse. Compared to questionnaire methods, the use of this type of interviewing has been shown to result in higher rates of self-reported abuse (Russell, 1984).

The design of the present study does not allow the conclusion that the occurrence of sexual abuse in this sample is different from a control group of women matched on important variables (such as SES). However, compared to prevalence

research which suggests that between 15% and 38% of women experience child sexual abuse (see Bagley & King, 1990), the findings of this study suggest that experiences of sexual abuse were more common in this sample than in the general population. This is consistent with research which suggests that incest among mothers of abused children is higher than among women without children who were sexually abused (Goodwin et al., 1981).

This finding must be interpreted with caution. There may be some temptation to argue that the high prevalence rate supports the intergenerational theory of sexual abuse. This theory suggests that women who have been sexually abused are more likely to have children who will be sexually abused. Although the way in which a mother's history of abuse is linked to her child's subsequent abuse is not clearly specified, there is a tendency to assume a causal connection (Hooper, 1992). A causal relationship implies that there is something about mothers which results in the sexual abuse of their children. The mother-blaming tone of such a theory is apparent.

The high prevalence of sexual abuse among mothers is open to alternate interpretations. For example, it is possible that the relationship between the abuse of mothers and children is correlational, with the causal factor being a third variable (such as limited economic resources) which puts both women and children at risk for sexual abuse. Clearly, much research is needed to clarify the issue of causality.

The issue of causality aside, the high incidence of sexual abuse among mothers raises important questions about the dynamics in families in which a child is sexually abused. As described earlier, much has been written about family functioning in

incestuous families. The extent to which issues such as poor boundaries (Koch & Jarvis, 1987), lack of trust between the mother and the child who is victimized (Timmons-Mitchell & Gardner, 1991), role-reversal in the mother-child relationship (Herman, 1981), enmeshment (Alexander, 1985), lack of protection (Furniss, 1991), and loss and desertion experiences of parents (Bennett, 1990; Friedrich, 1990) may be related to a maternal history of sexual victimization should be explored. The challenge is to examine these issues in a way which does not perpetuate mother-blaming, but at the same time enhances our understanding of the interplay of various contextual variables in child sexual abuse.

Child Sexual Abuse History and Emotional Distress Among Mothers

Clinicians have speculated that a history of child sexual abuse makes it difficult for a woman to deal with the current abuse of her child. This study found support for the hypothesis that women who report histories of sexual abuse have greater emotional distress following disclosure than do mothers who do not have this history. This finding is consistent with a study of mothers of children who had been sexually abused in which mothers with histories of sexual abuse had MMPI profiles suggesting more difficulties than did mothers without a history of sexual abuse (Friedrich, 1991). In a sample of women whose children had been abused in day-care centres, Kelley (1990) also found that mothers who had a history of sexual abuse were more distressed than were mothers who had not experienced child sexual abuse.

There are several competing explanations for the relationship between a history of child sexual abuse and greater distress following disclosure. One theory is that

mothers with a history of sexual abuse experience trauma when they learn about their child's abuse because of the potential to reexperience their own abuse (McIntyre et al., 1993). It has been suggested that mothers' memories of abuse may be triggered by their children's abuse (Courtois & Sprei, 1988).

It is also possible that the greater distress shown by mothers with histories of sexual abuse is a reflection of the long-term effects of child sexual abuse. The research literature clearly documents that experiences of sexual abuse in childhood are related to adjustment difficulties in adulthood. The observed differences may have existed prior to the disclosure of sexual abuse and may not be directly related to the disclosure.

To test these theories, further research is needed which includes a control group of women with histories of sexual abuse but without a child who has been sexually abused. McIntyre et al. (1993) conducted such a study and found no differences in clinically significant symptoms among women who had histories of abuse, women who had histories of abuse and had a child who disclosed sexual abuse, and women without histories of sexual abuse who had a child who disclosed sexual abuse. These researchers note that the absence of an interaction between abuse history and having a child who was sexually abused may have been due to an underreporting of sexual abuse or may have been related to the fact that differences were hidden because the study was conducted within three months of disclosure, a time when many mothers reported focusing on their child's needs rather than their feelings about their own experiences. Additional research is clearly needed to address this issue.

From a clinical perspective, the present finding suggests the importance of assessing for a maternal history of child sexual abuse when working with mothers of children who have disclosed sexual abuse. It is important to not only assess for the presence of such experiences, but to explore women's perceptions of the impact of these experiences on their current functioning. Practitioners must be sensitive to the fact that these women may not have had prior opportunity to share their experiences and/or may not have received any help in dealing with these abusive acts. In the present sample, a majority of the women (60%) had never talked about their experiences with a mental health professional. Obtaining this history, therefore, must be done in a way which validates the experiences of mothers and does not imply that because of their histories they have somehow caused the abuse of their children.

In this study sexual abuse occurring in childhood and sexual abuse occurring in adolescence were both predictors of emotional distress. This finding suggests that it is important that attention be given to abusive experiences which occur in adolescence as well as in childhood.

In the present study no differences in levels of distress were found between women who had a history of abuse and who had talked about their experiences in counselling or treatment and women who had not talked about their abuse experiences in treatment. This finding may be accounted for by the fact that a thorough assessment of the nature and extent of treatment was not done. Further research examining the role of treatment in mediating the relationship between abuse experiences and distress among mothers is clearly needed.

It should be noted that the focus of this study was on the relationship between the presence of a history of sexual abuse and emotional distress. Future research might build on the current findings and go beyond assessing for the presence of the experience to look at the context in which the abuse occurred. It would be interesting to explore how certain factors surrounding the abuse (such as whether or not the woman disclosed the abuse, whether or not her disclosure was believed, and whether or not she received support from her family) relate to a mother's distress following her child's disclosure.

It should also be emphasized that while a history of sexual abuse appears to be related to emotional distress among mothers, in the present study it accounted for a relatively small proportion of variance. In part, this may be the result of having used a dichotomous distinction between abuse and nonabuse rather than a continuous measure of severity of abuse. The present results, however, clearly suggest that sexual abuse history is not the only variable or even necessarily the most important variable in understanding the distress experienced by mothers. In spite of its clinical appeal, the importance of this variable should not be overemphasized. Other psychosocial variables which impact on mothers need to be explored. This underscores the need for a multidimensional model for understanding mothers of children who have been sexually abused.

Child Sexual Abuse History and Parenting Among Mothers

Parenting has been shown to be influenced by the psychological resources of the parent (Belsky, 1984; Lahey et al., 1984). Given that a history of child sexual

abuse is associated with increased emotional distress, it seems likely that parenting would also be impacted by a history of sexual abuse. Research with women with histories of incest suggests that these childhood experiences impact on attitudes and feelings about parenting (Cole & Woolger, 1989; Cole et al., 1992). Contrary to prediction, in this study a history of child sexual abuse was not related to lower parenting self-esteem.

There are a number of possible explanations for the absence of a relationship between maternal sexual abuse history and parenting self-esteem. First, to date research has focused on the impact of father-daughter incest on parenting. For women in the present sample, father-daughter incest accounted for only 17% of the sexual abuse they experienced during childhood and 4% of the sexual abuse they experienced during adolescence. It is possible that the impact of other types of sexual abuse (particularly abuse which occurs outside of the context of the family) does not have the same effects on the individual's subsequent feelings about parenting.

Second, the measure used in this study focused on parenting self-esteem. Attitudes about parenting and specific parenting behaviors were not assessed. It is possible that a history of abuse impacts on various aspects of parenting (such as behaviors) while not impacting on other aspects (such as sense of competence as a parent).

Third, it is likely that the relationship between a history of abuse and effects on parenting is complex. Perhaps there are intervening variables (such as a supportive reaction by caring adults) not accounted for in this study which mediate this

relationship.

Clearly, more research is needed. Subsequent studies might use broader evaluations of parenting (including for example, parental self-esteem, attitudes towards parenting, and parenting behavior), varied methods of assessment (e.g., self-report and observation), and appropriate control groups to more fully address questions about the relationship between a history of sexual abuse and subsequent parenting among mothers of children who have been sexually abused.

Social Support and Adjustment Among Mothers

Social support has received a great deal of attention in the literature due to the research which indicates that it mediates the effects of stress on well-being (see Kessler et al., 1985; Turner et al., 1983). From a clinical perspective, social support is important given the evidence which suggests that interventions aimed at improving social support among stressed individuals facilitate adjustment (Gottlieb, 1983). Although the literature on intervening with mothers of sexually abused children advocates interventions which increase support (DeVoss & Newlon, 1986; Regehr, 1990), the present study appears to be the first piece of empirical research to document the relationship between social support and adjustment among mothers of sexually abused children.

Social Support and Emotional Distress Among Mothers

In the present study, as predicted, social support was related to emotional distress among mothers following their children's disclosures of sexual abuse. Both support from friends and support from family were related to lower self-reported

emotional distress. This finding is consistent with the growing body of research which indicates a relationship between support and emotional distress (e.g., Kessler et al., 1985).

The cross-sectional design of the study does not permit the conclusion that lack of social support causes emotional distress. Women who have a strong support network may be better equipped to deal with the stress that results from a disclosure of sexual abuse. Alternately, women who are less distressed may be better able to maintain or develop satisfying relationships and hence perceive their networks as more supportive. Exploring the causal relationship between support and emotional distress among mothers of sexually abused children is definitely a useful direction for future research.

This study demonstrated a main effect for social support. That is, social support was found to have beneficial effects on mothers' well-being following disclosure regardless of individual differences in stress level experienced by these mothers. As Quittner, Glueckauf, and Jackson (1990) point out, this is only one mechanism by which social support may modify the outcome of a stressful experience. Alternatively, social support may serve a "buffering" effect in which social support interacts with stress level to impact on adjustment. A third alternative is a mediator model which suggests that social support is an intervening variable between the stressor and the outcome. Future research might compare these three models in order to more fully understand the role of social support in the relationship between the stress caused by the disclosure and mothers' adjustment. To compare these models,

studies would have to measure (a) the levels of stress experienced by mothers, (b) mothers' social support , and (c) mothers' adjustment. Competing models could then be compared statistically (see Quittner et al., 1990).

There are obviously many unanswered questions regarding the role of social support in dealing with the sexual abuse of a child. The current study suggests that further exploration of the role of support in the process of recovery following disclosure is warranted. As noted above, one area for future research would be exploring the causal relationship between social support and emotional distress. Studies which examine the ways in which mothers access support, the types of support mothers perceive as most helpful, and the types of support that mothers use at various points in the process of recovery would also enhance our understanding of the importance of social support for mothers.

The observed relationship between social support and emotional distress is consistent with the practice literature which acknowledges the importance of providing support to parents of abused children (DeVoss & Newlon, 1986; Regehr, 1990). This finding suggests that efforts to strengthen the basis of support for mothers of children who have been sexually abused may be beneficial. For example, participating in a support group might result in a decrease in mothers' distress. Further work might examine ways in which mothers access resources within their network following disclosure and how this process might be facilitated by professionals. Interventions which help women mobilize support within their current networks (in addition to or instead of focusing on building new supportive links) might prove to be helpful.

Additional studies which evaluate the effectiveness of interventions in fostering support for women would greatly enrich clinical practice.

Social Support and Parenting Among Mothers

In addition to exploring the relationship between social support and emotional distress, the present study also looked at another dimension of adjustment, namely, the relationship between support and parenting self-esteem. As expected, greater perceived social support from friends was associated with increased parenting self-esteem. This finding is consistent with research which suggests that social support is related to parenting variables such as maternal stress (Adamakos et al., 1986; Koeske & Koeske, 1990), parent-child relationships (Cochran & Brassard, 1979; Pascoe & Earp, 1984; Powell, 1980), and child abuse (Gaudin & Pollane, 1983; Salzinger et al., 1983).

There are several possible reasons for the relationship between perceived support from friends and parenting self-esteem. First, mothers may rely on friends to provide needed emotional support during the crisis period following the disclosure and the subsequent period of adjustment. This emotional support may impact directly on the woman's sense of satisfaction and efficacy with parenting by providing feedback that she is a good parent and is capable of responding to her child. This type of social feedback may challenge any self-blame or guilt that the woman may feel because of the trauma that her child has experienced. Friends may also strengthen the mother's sense of competence as a parent by listening to parenting difficulties she is experiencing, by helping her problem solve, and by making suggestions about how to deal with her child.

Second, although not assessed directly by the measure in this study, perceived support may reflect mothers' satisfaction with the amount of assistance received. Friends may be able to anticipate some of the demands of parenting and be available to provide tangible help in meeting these demands, thereby relieving some of the mother's stress. This might be particularly helpful following disclosure when, in addition to dealing with ongoing responsibilities, the woman is faced with a new set of stressors. Having access to needed tangible help may allow a mother to continue to feel competent in her role as a parent.

Third, it also is possible that parenting is impacted indirectly through the relationship between social support and emotional distress. As has been discussed, women who have support from friends are less emotionally distressed. Women who are experiencing less distress may be better able to respond to the demands of parenting and hence experience a heightened sense of satisfaction and efficacy in the parenting role.

Contrary to expectation, support from family was not related to parenting self-esteem. This is inconsistent with research which suggests that support from a partner/spouse and extended family is related to parenting satisfaction and behavior (Belsky, 1984; Crnic et al., 1984). There are several possible explanations for the lack of support for the hypothesized relationship between support from family and parenting self-esteem.

First, it is possible that the results are related to the instrument used to study social support in this study. The PSR (Turner et al., 1983) includes six items

requiring judgments about the support provided by one's "family". Many women in the study struggled with these items reporting confusion about who constituted their "family". They reported additional difficulty evaluating the support received because there were dramatic differences in the responses of various family members to the disclosure of abuse. Some women experienced support from some family members while feeling abandoned by others. These women reported difficulty selecting a response that adequately reflected their experience. These factors may have impacted on the reliability of the measurement. The measure used in the present study also focused on the provision of emotional support, with no direct assessment of other aspects of support such as providing material aid. It is possible that important aspects of family support were not assessed by the measure, resulting in the absence of a relationship between the variables.

Second, measurement issues aside, it is possible that the conflict that existed in some families over the disclosure had a powerful impact on the mothers' parenting self-esteem. Perhaps the presence of even a few family members who were critical of the woman was sufficient to negate the positive effects of the support provided by other family members.

The correlational nature of the data does not permit the conclusion that a lack of social support reduces parenting self-esteem. The present findings do suggest, however, that additional research exploring the role of support in parenting might improve our understanding of the experience of mothering following a sexual abuse disclosure. Future research might address whether social support plays a mediating or

moderating effect on parenting (see Quittner et al., 1990). As well, further research might explore the effect of social support on other aspects of parenting such as maternal stress, parent-child interaction, and parenting attitudes. It would be helpful if future studies included a broader assessment of support. This assessment might include social network variables (such as number of contacts and source of the connection) as well as measures of perceived support. It would also be useful to evaluate the availability of a variety of supportive behaviors including instrumental support, advice, positive feedback, and emotional support.

Coping Strategies and Adjustment Among Mothers

Although it has been suggested that the concept of coping might be useful in understanding mothers (Hooper, 1989), to date little research has studied coping strategies among mothers. Coping with roles conflicts experienced by women in paternally incestuous families has been recently addressed (deYoung, 1994b), but it appears that no additional studies have looked at coping efforts among a more diverse sample of mothers. The results of the present study suggest that coping is a useful concept in understanding mothers' adaptation following their children's disclosures of sexual abuse.

Coping Strategies and Emotional Distress Among Mothers

In the present study, increased reliance on avoidance coping relative to total coping responses predicted an increase in emotional distress. That is, women who relied more on active behavioral and/or cognitive strategies to deal with the situation experienced less emotional distress than did women who used relatively more

avoidance strategies. This finding is consistent with the literature that suggests an association between coping strategies and adjustment (Billings & Moos, 1981; Holahan & Moos, 1986, 1987, 1991; Pearlin & Schooler, 1978) and, in particular, with research that indicates an association between avoidance coping and poorer adaptation (Holahan & Moos, 1985, 1986, 1987; Moos, 1988).

The correlational nature of the study does not permit a conclusion about causality. It is not clear if experiencing higher level of emotional distress results in greater reliance on avoidance strategies in an attempt to respond to this distress or if the use of avoidance strategies results in more emotional distress.

If coping is determined by perceived emotional distress, the results of this study suggest the importance of emotional functioning in the process of coping in stressful situations. It is possible that experiencing symptoms is a signal to individuals that they need to engage in coping behaviors which are directed at managing their emotional distress, and as a result, rely to a greater extent on avoidance strategies. Emotional distress may also influence coping through its influence on the appraisal of the situation. As symptomatology increases, individuals may alter their perceptions of their ability to control the stressful situation. Ongoing or intensifying emotional distress may result in an appraisal of the situation as unchangeable. Rather than continuing to strive to alter the situation, mothers may shift their energies to coping strategies which attempt to provide some relief for their emotional responses. There is evidence to suggest that individuals use more avoidance strategies in situations that they appraise as having to be accepted (Folkman, Lazarus, Dunkel-Schetter, DeLongis,

& Gruen, 1986).

An alternative interpretation is that coping affects the level of emotional distress a mother experiences following her child's disclosure. This explanation is supported by data from prospective studies which suggest a causal relationship between avoidance coping and emotional distress (Folkman & Lazarus, 1988a; Holahan & Moos, 1986, 1991). According to Folkman and Lazarus (1988b), coping can mediate emotion by altering the subjective meaning of an encounter. For women experiencing this stressful event, avoidance coping is likely to strengthen the perception of the sexual abuse as an insurmountable event which is too overwhelming to be tackled directly. This belief is likely to reinforce an appraisal of the situation as unchangeable. Powerlessness in the situation is likely to result in increased distress. As well, women who engage in avoidance coping are likely to have minimal impact on the situation which in turn is likely to lead to increased feelings of helplessness and distress.

If coping affects emotional distress, there are some interesting implications for practitioners. Unlike other variables (such as a history of abuse) which are related to outcome, coping strategies can be changed. Coping strategies may be an appropriate target for intervention. For example, it may be useful to assess the type of responses a woman makes to the disclosure of her child's sexual abuse and work with the woman to develop strategies which promote positive adaptation. According to this study, it appears that encouraging the use of approach strategies (on behavioral and/or cognitive levels) and decreasing reliance on avoidance strategies would be helpful. To promote

approach coping, women might be given information about available resources and/or be encouraged to seek support from their social networks. As well, mothers might be educated about such pertinent issues as the functioning of the legal system and the child welfare system, and the effects of sexual abuse on children. Professionals might also encourage approach coping by supporting women in their problem-solving efforts. Helping mothers develop and utilize approach coping is consistent with an empowerment strategy in intervention, which is essential in effective work with mothers (deYoung, 1994b).

It is important to note that coping strategies and emotional distress may not be related in a simple linear manner. It is perhaps most likely that bidirectional relationships exist between coping and emotional distress. This is consistent with a transactional theory of coping which emphasizes that coping is a process in which variables both influence and are influenced by each other in a dynamic way (Lazarus & Folkman, 1984). Questions of causality are obviously important to both understanding the complex nature of the relationship between the variables and in designing interventions. Hence, more careful study of coping among mothers of children who have been sexually abused is warranted.

It is clear that the present findings raise many questions for further research. On a general level, the results suggest that further exploration of the coping responses of women following their children's disclosures may lead to a better understanding of the distress experienced by mothers. It appears that coping strategies are important in predicting the emotional distress of mothers. As discussed above, the correlational

nature of the current study does not allow causal explanations for the relationship. Longitudinal research which assesses coping strategies at one time and emotional distress at a future measurement date is needed to clarify the nature of the relationship between coping and emotional distress in this population. In addition to addressing the causal relationship between coping and emotional distress, future research might examine factors which are associated with the use of more effective coping strategies by mothers. The role of cognitive appraisal in mothers' coping is also an area to be explored. Research which examines how coping changes during the process of adaptation among mothers would also further our understanding of coping. Finally, research which evaluates the effectiveness of interventions which attempt to increase health-promoting coping among mothers is important for clinicians.

It is also interesting that differences emerged in the relative use of avoidance coping by Aboriginal and non-Aboriginal participants. It is unclear if this finding represents a cultural difference in coping or if the particular measure of coping used in the present study is culturally biased. That is, it is possible that the items on the CRI used to measure coping do not adequately assess the range of coping behaviors used by Aboriginal women. Further research looking at cultural issues in coping among mothers is needed.

Coping Strategies and Parenting Among Mothers

Research indicates that mothers in stressful situations who use active coping strategies are more likely to experience feelings of control in parenting situations (e.g., Holloway & Machida, 1991). The present study appears to be the first study to

examine the relationship between coping strategies and parenting self-esteem among mothers of children who have been sexually abused. As predicted, the results of this study suggest that the coping strategies a woman uses are related to how she feels as a parent following her child's disclosure of sexual abuse. More specifically, this study found that women who used relatively fewer avoidance strategies (i.e., are more active in their coping) were more likely to experience greater parenting self-esteem.

This finding has several important implications. First, how a mother feels in her role as a parent is one important indicator of her adjustment. Thus, the relationship between coping strategies and parenting self-esteem suggests that how a mother copes with her child's disclosure of sexual abuse may be important in understanding resilience among mothers whose children have been sexually abused.

Second, the ability of a mother to provide support to her child is considered important in the child's recovery from the trauma of sexual abuse (Everson et al., 1989; Faller, 1988; Sirles & Franke, 1989). Although parenting behavior was not directly assessed, the ability of the PSOC scale to predict parental behavior (see Mash & Johnston, 1983b) suggests that coping strategies may be important in understanding the behavior of a mother following disclosure.

As has been discussed, the correlational nature of the study limits the conclusions that can be drawn. While coping strategies might influence parenting self-esteem, it is also possible that a mother's sense of parenting self-esteem may influence the strategies she chooses to cope. Prospective research which examines the relationship between coping strategies and parenting attitudes and behavior is needed

to determine causality.

Clearly, more research is needed. In addition to research which explores the causal relationships between these variables, studies which examine the relationship between coping strategies and parental behavior of mothers would be particularly helpful. Given the importance of maternal support following disclosure (Everson et al., 1989), the relationship between coping strategies and the ability to provide consistent support to the child would be particularly interesting.

Coping Strategies and Social Support Among Mothers

As predicted, relative avoidance coping was negatively related to social support in the present study. This finding is consistent with existing research which suggests that individuals who have social supports are less likely to use avoidance coping (Fondacaro & Moos, 1987; Holahan & Moos, 1987; Holloway & Machida, 1991) and are more likely to use active-cognitive or active-behavioral strategies (Dunkel-Schetter et al., 1987).

The nature of the causal relationship between coping strategies and social support is not clear. It is possible that coping behaviors elicit certain types of support and, alternatively, that the presence of support encourages the use of specific coping strategies. According to Dunkel-Schetter et al. (1987), it is likely that the causal processes are dynamic. That is, it is possible that coping affects the availability of social support which in turn influences coping. This bidirectional approach to causality is consistent with Lazarus and Folkman's (1984) person-environment transaction theory of stress and coping.

The relationship between coping and social support in this sample raises some interesting issues. It is possible that mothers who engage in considerable avoidance coping do not seek support because the very act of reaching out to members of the network may challenge their avoidance. That is, seeking support in dealing with the disclosure may be inconsistent with certain avoidance strategies such as trying to forget about the problem and denial. On the other hand, the absence of support may make it difficult for mothers to engage in problem-solving or other active strategies. Ironically, if women perceive little support from members of their social networks, they may be discouraged from taking action to elicit support from these members.

Without a clear understanding of the causal nature of the relationship, the implications for practice are not clear. It is possible that interventions designed to strengthen social support might also have the effect of decreasing reliance on avoidance strategies. Conversely, attempts to strengthen a mother's approach strategies may result in improved social support. It is obvious that prospective research is needed to clarify the causality issue and to give direction to practice. At this point, it appears that evaluations of interventions directed at either coping or social support among mothers should consider the impact on both variables.

Exploratory Variables

Partner Abuse

The present study indicated that 54% of the women who were in a partner relationship had experienced some type of abuse in that relationship. For 29% of the women, this abuse had involved some type of physical abuse (i.e., pushed, slapped,

punched, and/or beaten). This finding is generally consistent with research on the general population which reports prevalence rates of partner abuse varying from 16% to 50% (Finkelhor et al., 1983; Frieze, 1983; Russell, 1984; Straus et al., 1980). Estimates of the incidence of women being battered each year in Canada include one in ten (MacLeod, 1987) and one in eight (Guberman & Wolfe, 1985). Although no literature has documented partner violence among a diverse sample of mothers of children who have been sexually abused, the present findings are consistent with the incest literature which documents the frequent occurrence of spousal violence in incest families (e.g., Browning & Boatman, 1977; Julian & Mohr, 1979; Melnechuk, 1988; Truesdell et al., 1986).

Given that women who are abused by a partner experience psychological distress related to this experience (Cascardi & O'Leary, 1992; Houskamp & Foy, 1991; Mitchell & Hodson, 1983), it seems obvious that violence in the lives of mothers must be considered if their emotional reactions to their children's disclosures of sexual abuse are to be understood. The present study suggests that physical abuse in the current partner relationship is related to the emotional distress a mother experiences following her child's disclosure. Specifically, this study found a relationship between experiencing abuse in a current relationship and suspiciousness and distrust.

The relationship between current partner abuse and certain symptoms of emotional distress supports the argument by feminist theorists that social context is important in understanding child sexual abuse. Attempts to understand a mother's behavior following the disclosure without examining the presence of partner violence

is to ignore a potentially important contextual variable. Interventions designed to help mothers must be sensitive to family violence issues that go beyond the disclosed sexual abuse. To ignore violence in the family is likely to result in interventions which are of limited success.

It should also be noted that domestic violence not only affects mothers but is a significant risk factor for children. Witnessing abusive marital relationships has been linked to short-term and long-term psychosocial problems in children (Hurley & Jaffe, 1990; Jaffe, Wolf, & Wilson, 1990). The relationship between witnessing marital violence and outcome is complex, with children responding in different ways. While some children appear to be resilient, other children become increasingly aggressive, and still others come to see themselves as powerless and worthless, thereby increasing their likelihood of subsequent victimization (Berman, 1993). For children who have been sexually abused, witnessing marital violence is an additional stressor which is likely to further tax their coping resources. Interventions which address the partner violence are essential from the perspective of fostering safe environments in which children who have been sexually abused can be supported in their efforts to cope.

Alcohol Use

It has been suggested that alcohol abuse is prevalent in incest families (Browning & Boatman, 1977). Many women in the present study were affected by alcohol abuse at some point in their lives. A large number of women (22%) reported that they had histories of alcohol abuse. The majority of women in the sample (75%) acknowledged using alcohol although only a small percentage (4%) reported frequent

use (several times per week) or regular use (once a week). A limitation of the study was that no questions were asked about whether the women considered their current alcohol use to be a problem.

Many women who were involved in relationships (34%) reported that their current partner had a drinking problem at some time during their relationship. Sixty-seven percent of the women who had previously been involved in partner relationships reported that at least one of their partners had a drinking problem.

Overall, the descriptive questions indicated that for many women in the sample, alcohol abuse had at some point in their adult lives been an issue. Given the impact of alcohol misuse on women (see Oppenheimer, 1991) together with the research which documents the negative impact of living with a partner with an alcohol problem (Weinberg & Vogler, 1990), it seems important to further explore the impact of substance abuse in this population. Additional research which uses standardized measures to assess alcohol use and which assesses the use of other substances would be useful in defining the importance of substance abuse in the lives of mothers of children who have been sexually abused. Then, the relationship between substance abuse and adjustment following disclosure could be examined. Existing research also suggests a relationship between substance abuse and a history of childhood abuse (Miller, Downs, Gondoli, & Keil, 1987; Swett, Cohen, Surrey, Compaine, & Chavez, 1991), spousal violence (Barnett & Fagan, 1993; Kantor & Straus, 1989; Leonard & Blane, 1992), and coping strategies (Finn, 1985). Exploring the relationships among these variables is another direction for future research with mothers of sexually abused

children.

Children's Behavior Problems

Of interest in this study was the relationship between a mother's self-reported adjustment and her evaluation of the behavior problems of the child who was sexually abused. An initial exploration of this relationship was undertaken, with the results indicating a relationship between conduct problems, learning problems, and anxiety in children and emotional distress in mothers. As well, the level of conduct problems in children was related to parenting self-esteem. This is consistent with previous research which found that among mothers of sexually abused children, mothers' psychological distress strongly correlated with their reports of their children's distress (Newberger et al., 1993).

There are a number of plausible interpretations of these findings. It is possible that the way in which a child behaves following disclosure may affect how a mother is impacted by the experience. The measure of the child's behavior problems may be a measure of the mother's level of stress. If a mother perceives her child as having numerous behavior problems following disclosure, she may tend to have a more negative appraisal of the situation, which in turn impacts on her level of distress. It is also possible that dealing with a child who has a variety of difficulties may result in increasing demands on the mother which, at a time when she is attempting to cope with her own reactions to the disclosure, may result in increased distress.

An alternative interpretation is that mothers who are more distressed have a greater likelihood of perceiving difficulties in their children. Perhaps mothers who are

struggling to cope with the disclosure are more likely to interpret their children's behavior as problematic. The ability of mothers to accurately report on their children's psychological states has been questioned (Achenbach, McConaughy, & Howell, 1987; Griest, Forehand, Wells, & McMahon, 1980). There is evidence that mothers with depressed mood have more negative perceptions of their children than do other adults (e.g., Johnston, 1991). There has been a particular interest in the relationship between maternal depression and mothers' reports of greater depression in their children (see Richters & Pellegrini, 1989), although it is unclear if this relationship is the result of distortion or actual higher levels of depression in the children (Richters, 1992).

It also is possible that a child whose mother is distressed experiences greater difficulty coping with the abuse and, as a result, manifests more behavior problems. This interpretation is consistent with research which speaks to the importance of maternal behavior in a child's ability to cope with sexual abuse (e.g., Conte & Berliner, 1988; Esparza, 1993; Everson et al., 1989).

Finally, it may be that the distress experienced by both the mother and child is related to a third factor. For example, the distress experienced by both the mother and the child might be caused by the sexual abuse, with no etiological relationship between maternal distress and child behavior problems. Alternatively, the relationship between the variables might be due to a particular response bias of the mother. That is, the findings may be the result of a tendency to respond positively to questions which assess distress.

The observed negative relationship between conduct problems and parenting self-esteem is not surprising. Parenting a child who exhibits conduct problems is likely to challenge a mother's resources thereby diminishing her sense of competence and satisfaction in that role. It is also possible that a mother who is dissatisfied with her parenting is more likely to perceive her child as having conduct problems.

Clarification of the complex nature of the relationship between maternal adjustment (including maternal distress and parenting self-esteem) and child behavior problems could be the subject of future investigations. Prospective studies which examine maternal distress and child behavior problems at various points during the post-disclosure period would permit an examination of the causal relationship between the variables. A problem in assessing this relationship is the difficulty in controlling for the possibility of pre-existing psychological problems in the mother and/or the child. Although it is not possible to experimentally control for these factors, future research might attempt to systematically document prior distress in the histories of the mother (by looking at history of previous treatment for example). Repeated measures of these variables following disclosure (as has been done by Newberger et al., 1993) allows for an examination of the process of recovery in both mothers and children and a consideration of the relationship between maternal and child distress at different times. Future studies might also use a variety of measures of the child's behavior such as direct observation, the child's self-report, and reports by significant others (such as a teacher or day-care provider) which would address the issue of possible distortion in maternal reports.

Demographic and Abuse Variables

The present study examined the relationship between a number of demographic and abuse variables and mothers' emotional distress and parenting self-esteem. Only one relationship was found; the child's age was negatively related to parenting self-esteem.

The absence of a relationship between SES and adjustment was somewhat surprising given research which suggests that SES increases vulnerability to undesirable life events (McLeod & Kessler, 1990) and is associated with greater psychological distress (Mirowsky & Ross, 1986). In one study of mothers of sexually abused children, SES was related to psychological distress in the initial period following disclosure but was not significant at subsequent interviews (Newberger et al., 1993).

There are a number of possible explanations for the absence of a relationship between SES and distress in this study. First, the parents' occupational status was the variable used to assess SES. It may be that relying solely on this variable resulted in an inaccurate assessment of SES. Assessing SES based on family income may have increased the validity of the SES measure. Second, the sample was fairly homogeneous in terms of social class, with two-thirds of the women falling in the lowest levels (i.e., no income from employment or working in semi-skilled or unskilled jobs). Homogeneity of the sample may be the reason that SES was not found to be related to distress.

Abuse variables also were not found to be related to distress or parenting self-

esteem. This is inconsistent with other research which has found that, shortly after disclosure, severity and the use of force were related to maternal distress (Newberger et al., 1993). It is possible that the relationship between abuse variables and adjustment was absent in the present study because the length of time since disclosure varied. Perhaps, this relationship exists shortly after disclosure but as the length of time from disclosure increases, other factors become more influential in predicting mother's adjustment. Additional research which controls for time since disclosure might address this issue.

The age of the child was found to be related to parenting self-esteem. It appears that the older the child, the lower the mother's sense of competence as a parent. The current sample included children from age 2 to 17 years. It is possible that when sexual abuse is disclosed by an older child or adolescent, additional stress is placed on a situation that is already perceived as a parenting challenge. The present study suggests that more attention needs to be given to developmental issues in understanding how mothers experience their parenting role following disclosure.

Limitations of the Study

There are numerous limitations to the present study. As has been discussed at various points, the correlational nature of the design places restrictions on the conclusions that can be drawn. While the results generally support the hypotheses, causality should not be inferred. Although the data indicate relationships between a history of child sexual abuse, social support, and coping strategies and various adjustment variables, it is not possible to conclude that the relationships are causal.

Additional research which employs prospective designs is needed.

The absence of a control group also impacts on how the results should be interpreted. This study focuses on variability within a sample of mothers of children who have disclosed sexual abuse. The results should not be taken as evidence that this group is necessarily more distressed than a matched sample of control mothers whose children have not disclosed sexual abuse or that the sexual abuse disclosure is the cause of the observed distress. That is, this type of design does not demonstrate a causal relationship between the sexual abuse disclosure and the distress. Additional research which includes a control sample of women matched on important variables (e.g., age, marital status, SES, abuse history) is needed.

The measures used in the present study were self-report and relied on retrospective judgments (e.g., how the women had coped since the disclosure). It is possible that this methodology decreased the validity of the measures and resulted in a lack of support for some of the hypotheses. Future research might periodically assess variables of interest in the post-disclosure period thereby reducing the time frame for measurement and the threats to reliability that result. Attention might also be given to using a multi-method approach to measurement; studies which use a variety of methods (e.g., self-report, observation, other-report, behavioral measures) to measure the constructs of interest would permit stronger conclusions.

It also should be noted that the sample used in the present study was an opportunity sample, not a random sample. Generalizability of the results, therefore, must be carefully assessed. The present sample tended to be of lower SES, included a

large number of single parents, and included Caucasian and Aboriginal women. The results may not generalize to a sample with women of different SES, marital status, and/or cultural backgrounds. As well, the procedure for recruitment meant that women in the study needed to have some ability to provide support for their children following the disclosure. Women whose children were apprehended by child protection authorities because of their inability to provide support and protection to their children following disclosure were not included in the sample. As a result, intrafamilial sexual abuse (especially when the perpetrator was a male partner living in the household) may be underrepresented in the sample. Clearly, the present results should not be generalized to women who are completely rejecting of their children following disclosure.

Conclusion

Overall, the present study suggests that mothers of children who have experienced sexual abuse are a heterogeneous group. There is variability in how mothers react to their children's disclosures. The results of the study further indicate that there are a number of factors that are important in understanding the variability in how mothers are impacted. Specifically, this study indicates that a history of child sexual abuse, the availability of social support, and the coping strategies employed are important in predicting the adjustment of mothers.

The limitations of existing research have been repeatedly addressed throughout this discussion. These limitations speak to the fact that mothers of sexually abused children have only recently become the focus of research efforts. Obviously, there are

many unresolved issues which require additional study. It seems clear that understanding mothers' reactions to sexual abuse requires a multifactorial model. This study confirms that adjustment is a complicated process. Simple explanations/theories are likely to be inadequate in capturing the complexity of mothers' experiences. Further research, then, is needed to identify additional variables of importance. Exploratory analyses in this study suggest that particular attention should be given to important contextual variables including the presence of partner abuse and alcohol abuse. Future research might explore other variables such as a history of physical and emotional abuse, the presence of other life stressors, and the availability of a variety of social resources. As well, longitudinal research which allows for the determination of causal relationships and studies which permit the testing of causal models would be helpful in furthering our understanding of the interrelationships between risk factors, resources, and adjustment among mothers.

The study of mothers of sexually abused children would also be furthered by additional development of theory to guide research. Further exploration of theoretical models might generate new research ideas and provide an organizing framework for work in this area. The feminist critique of the area has prompted a much needed consideration of many issues, including the importance of social context. The specific hypotheses generated by this perspective warrant more careful elaboration and examination. As well, attempts might be made to integrate existing theoretical frameworks with a feminist perspective. For example, the present study suggests that a stress-coping model such as has been proposed by Moos (1988) may be a useful

theoretical tool in understanding mothers' experience following a disclosure of sexual abuse. Conceptualized within this framework, the present study can be seen as exploring risk factors (a history of sexual abuse) as well as stress-resistance factors (coping strategies and social support). The stress-coping theoretical model addresses many of the issues raised by a feminist critique. Consistent with a feminist perspective, the theory allows for the inclusion of important contextual variables and permits a consideration of factors which promote resilience (i.e., strengths).

What is clear from both the review of the literature and the exploratory nature of the present study is that our knowledge of the experiences of mothers of children who have been sexually abused is quite limited. It appears that it would serve both researchers and practitioners well to approach work in this area with humility. In the course of the study of child sexual abuse, mothers have been both ignored and blamed. It is time to pay greater attention to what these women have to teach us about the complexity of the issues they face.

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Appendix A

History of Abuse

It is now generally realized that most people have sexual experiences as children and while they are still growing up. Some of these are with friends and playmates, and some with relatives and family members. Some are very upsetting and painful, and some are not. Some influence people's later lives and sexual experiences, and some are practically forgotten. Although these are often important events, very little is actually known about them.

We would like you to try to remember the sexual experiences you had while growing up. By "sexual" we mean a broad range of things, anything from playing "doctor" to sexual intercourse - in fact anything that might have seemed "sexual" to you.

A. PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT ANY SEXUAL EXPERIENCES YOU HAD UP TO AND INCLUDING AGE 12 WITH SOMEONE AT LEAST 5 YEARS OLDER THAN YOURSELF OR WITH SOMEONE OF ANY AGE IF YOU DID NOT AGREE TO THE EXPERIENCE.

1. Did you experience any of the following? (check all that apply)

____ a) an invitation or request to do something sexual
____ b) kissing and hugging in a sexual way
____ c) another person showing his/her sex organs to you
____ d) you showing your sex organs to another person
____ e) another person fondling you in a sexual way
____ f) you fondling another person in a sexual way
____ g) another person touching your sex organs
____ h) you touching another person's sex organs
____ i) attempted intercourse
____ j) intercourse
____ k) other (please specify) _____

If any of the above experiences occurred with more than one person, then answer the following questions for the experience that seems most significant to you.

1. How old were you the first time this happened? _____

2. How old was the other person the first time this happened? _____

3. Was the other person (check one): male _____ female _____

4. Was the other person (check one):

____ a stranger
____ person you knew, but not a friend
____ a friend of yours
____ a friend of your parents
____ your father or mother
____ your grandfather or grandmother
____ an uncle or aunt
____ a brother or sister
____ a cousin
____ a neighbor
____ your babysitter
____ your teacher
____ other (specify):
_____

5. How long would you estimate that this sexual behavior continued? (check one)

____ happened once or twice
____ a number of days
____ a number of weeks
____ a number of months
____ a number of years

6. Did the other person (check yes or no for each statement):

YES	NO	
___	___	threaten you
___	___	force you
___	___	hurt you physically
___	___	convince you to participate

7. In retrospect, would you say this experience was (check one):

____ positive
____ mostly positive
____ neutral
____ mostly negative
____ negative

8. In addition to the experience you have just answered questions about, as a child did you have sexual experiences with someone else who was at least 5 years older than you or with someone of any age if you did not agree to the activity?

yes _____ no _____

If yes, was the other person(s): (check all that apply)

____ a stranger
____ person you knew, but not a friend
____ a friend of yours
____ a friend of your parents
____ your father or mother
____ your grandfather or grandmother
____ an uncle or aunt
____ a brother or sister
____ a cousin
____ a neighbor
____ your babysitter
____ your teacher
____ other (specify):
_____

B. NOW I WOULD LIKE YOU TO ANSWER THE SAME QUESTIONS FOR ANY SEXUAL EXPERIENCES YOU HAD AS AN ADOLESCENT. PLEASE ANSWER THE FOLLOWING QUESTIONS FOR EXPERIENCES THAT OCCURRED BETWEEN AGES 13 AND 18 WITH SOMEONE AT LEAST 10 YEARS OLDER THAN YOURSELF, OR WITH SOMEONE OF ANY AGE IF YOU DID NOT AGREE TO THE EXPERIENCE.

1. Did you experience any of the following? (check all that apply)

____ a) an invitation or request to do something sexual
____ b) kissing and hugging in a sexual way
____ c) another person showing his/her sex organs to you
____ d) you showing your sex organs to another person
____ e) another person fondling you in a sexual way
____ f) you fondling another person in a sexual way
____ g) another person touching your sex organs
____ h) you touching another person's sex organs
____ i) attempted intercourse
____ j) intercourse
____ k) other (please specify) _____

If any of the above experiences occurred with more than one person, then answer the following questions for the experience that seems most significant to you.

1. How old were you the first time this happened? _____

2. How old was the other person the first time this happened? _____

3. Was the other person (check one): male _____ female _____

4. Was the other person (check one):

____ a stranger
____ person you knew, but not a friend
____ a friend of yours
____ a friend of your parents
____ your father or mother
____ your grandfather or grandmother
____ an uncle or aunt
____ a brother or sister
____ a cousin
____ a neighbor
____ your babysitter
____ your teacher
____ other (specify):
_____

5. How long would you estimate that this sexual behavior continued? (check one)

____ happened once or twice
____ a number of days
____ a number of weeks
____ a number of months
____ a number of years

6. Did the other person (check yes or no for each statement):

YES	NO	
___	___	threaten you
___	___	force you
___	___	hurt you physically
___	___	convince you to participate

7. In retrospect, would you say this experience was (check one):

____ positive
____ mostly positive
____ neutral
____ mostly negative
____ negative

8. In addition to the experience you have just answered questions about, as an adolescent did you have sexual experiences with someone else who was at least 10 years older than you or with someone of any age if you did not agree to the activity?

yes _____ no _____

If yes, was the other person(s): (check all that apply)

____ a stranger
____ person you knew, but not a friend
____ a friend of yours
____ a friend of your parents
____ your father or mother
____ your grandfather or grandmother
____ an uncle or aunt
____ a brother or sister
____ a cousin
____ a neighbor
____ your babysitter
____ your teacher
____ other (specify):
_____

C. HERE ARE SOME FINAL QUESTIONS ABOUT YOUR SEXUAL EXPERIENCES AS A CHILD OR ADOLESCENT.

1. Do you feel you were sexually abused as a child or adolescent?

yes _____ no _____

2. If you indicated above that you had sexual experiences as a child or adolescent, did you tell anyone about the experience <u>at the time</u>?

yes _____ no _____

If yes, who did you tell? (check all that apply)

___ a) mother
___ b) father
___ c) brother/sister
___ d) friend
___ e) teacher
___ f) other adult (specify)_____
_____

3. If you indicated above that you had sexual experiences as a child or adolescent, <u>while an adult</u> have you told anyone about these experiences?

yes _____ no _____

If yes, who have you told? (check all that apply)

___ a) mother
___ b) father
___ c) husband/boyfriend
___ d) friend
___ e) teacher
___ f) other adult (specify)_____
_____

4. Have you ever talked about these experiences in counselling or treatment?

yes _____ no _____

Appendix B

The Provision of Social Relations Scale

We would like to know something about your relationships with other people. Please read each statement below and decide how well the statement describes you. For each statement, show your answer by indicating to the left of the item the number that best describes how you feel. The numbers represent the following answers.

1 = Very much like me
2 = Much like me
3 = Somewhat like me
4 = Not very much like me
5 = Not at all like me

____ 1. When I'm with my friends, I feel completely able to relax and be myself.

____ 2. I share the same approach to life that many of my friends do.

____ 3. People who know me trust me and respect me.

____ 4. No matter what happens. I know that my family will always be there for me should I need them.

____ 5. When I want to go out to do things I know that many of my friends would enjoy doing these things with me.

____ 6. I have at least one friend I could tell anything to.

____ 7. Sometimes I'm not sure if I can completely rely on my family.

____ 8. People who know me think I am good at what I do.

____ 9. I feel very close to some of my friends.

____10. People in my family have confidence in me.

____11. My family lets me know they think I am a worthwhile person.

____12. People in my family provide me with help in finding solutions to my problems.

____13. My friends would take the time to talk over my problems, should I ever want to.

____14. I know my family will always stand by me.

____15. Even when I am with my friends I feel alone.

Appendix C

Coping Responses Inventory

Please think about your child's disclosure of sexual abuse; indicate which of the following you have done in connection with this situation.

DID YOU:	NO	YES, once or twice	YES, some-times	YES, fairly often
1. think of different ways to deal with the problem?	1	2	3	4
2. tell yourself things to make yourself feel better?	1	2	3	4
3. talk with your spouse or other relative about the problem? . . .	1	2	3	4
4. make a plan of action and follow it?	1	2	3	4
5. try to forget the whole thing?. .	1	2	3	4
6. feel that time would make a difference--the only thing to do was wait?.	1	2	3	4
7. try to help others deal with a similar problem?.	1	2	3	4
8. take it out on other people when you felt angry or depressed?. . .	1	2	3	4
9. try to step back from the situation and be more objective?.	1	2	3	4
10. remind yourself how much worse things could be?.	1	2	3	4
11. talk with a friend about the problem?.	1	2	3	4

DID YOU:	NO	YES, once or twice	YES, sometimes	YES, fairly often
12. know what had to be done and try hard to make things work? . .	1	2	3	4
13. try not to think about the problem?.	1	2	3	4
14. realize that you had no control over the problem?	1	2	3	4
15. get involved in new activities? .	1	2	3	4
16. take a chance and do something risky?.	1	2	3	4
17. go over in your mind what you would say or do?.	1	2	3	4
18. try to see the good side of the situation?.	1	2	3	4
19. talk with a professional person (e.g., doctor, lawyer, clergy)? .	1	2	3	4
20. decide what you wanted and try hard to get it?	1	2	3	4
21. daydream or imagine a better time or place than the one you were in?.	1	2	3	4
22. think that the outcome would be decided by fate?.	1	2	3	4
23. try to make new friends?.	1	2	3	4
24. keep away from people in general?.	1	2	3	4

DID YOU:	NO	YES, once or twice	YES, some-times	YES, fairly often
25. try to anticipate how things would turn out?	1	2	3	4
26. think about how you were better off than other people with similar problems?	1	2	3	4
27. seek help from persons or groups with the same type of problem?.	1	2	3	4
28. try at least two different ways to solve the problem?	1	2	3	4
29. try to put off thinking about the situation, even though you knew you would have to at some point?	1	2	3	4
30. accept it; nothing could be done?	1	2	3	4
31. read more often as a source of enjoyment?.	1	2	3	4
32. yell or shout to let off steam? .	1	2	3	4
33. try to find some personal meaning in the situation?	1	2	3	4
34. try to tell yourself that things would get better?	1	2	3	4
35. try to find out more about the situation?.	1	2	3	4
36. try to learn to do more things on your own?.	1	2	3	4

DID YOU:	NO	YES, once or twice	YES, some-times	YES, fairly often
37. wish the problem would go away or somehow be over with?.	1	2	3	4
38. expect the worst possible outcome?.	1	2	3	4
39. spend more time in recreational activities?	1	2	3	4
40. cry to let your feelings out? . .	1	2	3	4
41. try to anticipate the new demands that would be placed on you?. . .	1	2	3	4
42. think about how this event could change your life in a positive way?.	1	2	3	4
43. pray for guidance and/or strength?	1	2	3	4
44. take things a day at a time, one step at a time?	1	2	3	4
45. try to deny how serious the problem really was?	1	2	3	4
46. lose hope that things would ever be the same?.	1	2	3	4
47. turn to work or other activities to help you manage things?. . . .	1	2	3	4
48. do something that you didn't think would work, but at least you were doing something?	1	2	3	4

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Appendix D

Brief Symptom Inventory

Below are a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please circle one of the numbers to the right which best describes how much that problem has bothered or distressed you since your child's disclosure of sexual abuse. Please use the following scale and do not skip any items.

NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
0	1	2	3	4

HOW MUCH WERE YOU BOTHERED BY:

1. Nervousness or shakiness inside.	0 1 2 3 4
2. Faintness or dizziness.	0 1 2 3 4
3. The idea that someone else can control your thoughts.	0 1 2 3 4
4. Feeling others are to blame for most of your troubles.	0 1 2 3 4
5. Trouble remembering things.	0 1 2 3 4
6. Feeling easily annoyed or irritated.	0 1 2 3 4
7. Pains in heart or chest.	0 1 2 3 4
8. Feeling afraid in open spaces or on the streets.	0 1 2 3 4
9. Thoughts of ending your life.	0 1 2 3 4
10. Feeling that most people cannot be trusted.	0 1 2 3 4
11. Poor appetite.	0 1 2 3 4
12. Suddenly scared for no reason.	0 1 2 3 4

NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
0	1	2	3	4

13. Temper outbursts that you could not control.	0 1 2 3 4
14. Feelings lonely even when you are with people.	0 1 2 3 4
15. Feeling blocked in getting things done.	0 1 2 3 4
16. Feeling lonely.	0 1 2 3 4
17. Feeling blue.	0 1 2 3 4
18. Feeling no interest in things.	0 1 2 3 4
19. Feeling fearful.	0 1 2 3 4
20. Your feelings being easily hurt.	0 1 2 3 4
21. Feeling that people are unfriendly or dislike you.	0 1 2 3 4
22. Feeling inferior to others.	0 1 2 3 4
23. Nausea or upset stomach.	0 1 2 3 4
24. Feeling that you are watched or talked about by others.	0 1 2 3 4
25. Trouble falling asleep.	0 1 2 3 4
26. Having to check and double-check what you do.	0 1 2 3 4
27. Difficulty making decisions.	0 1 2 3 4
28. Feeling afraid to travel on buses, subways, or trains.	0 1 2 3 4
29. Trouble getting your breath.	0 1 2 3 4

NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
0	1	2	3	4

30. Hot or cold spells.	0 1 2 3 4
31. Having to avoid certain things, places, or activities because they frighten you.	0 1 2 3 4
32. Your mind going blank.	0 1 2 3 4
33. Numbness or tingling in parts of your body.	0 1 2 3 4
34. The idea that you should be punished for your sins.	0 1 2 3 4
35. Feeling hopeless about the future.	0 1 2 3 4
36. Trouble concentrating.	0 1 2 3 4
37. Feeling weak in parts of your body.	0 1 2 3 4
38. Feeling tense or keyed up.	0 1 2 3 4
39. Thoughts of death or dying.	0 1 2 3 4
40. Having urges to beat, injure, or harm someone.	0 1 2 3 4
41. Having urges to break or smash things.	0 1 2 3 4
42. Feeling very self-conscious with others.	0 1 2 3 4
43. Feeling uneasy in crowds.	0 1 2 3 4
44. Never feeling close to another person.	0 1 2 3 4
45. Spells of terror or panic.	0 1 2 3 4
46. Getting into frequent arguments.	0 1 2 3 4
47. Feeling nervous when you are alone.	0 1 2 3 4

NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
0	1	2	3	4

48. Others not giving you proper credit for your achievements.	0 1 2 3 4
49. Feeling so restless you couldn't sit still.	0 1 2 3 4
50. Feelings of worthlessness.	0 1 2 3 4
51. Feeling that people will take advantage of you if you let them.	0 1 2 3 4
52. Feelings of guilt.	0 1 2 3 4
53. The idea that something is wrong with your mind.	0 1 2 3 4

Note: Published forms of this instrument were purchased and used in the study.

Appendix E

Parenting Sense of Competence Scale

Listed below are a number of statements. Please respond to each item, indicating your agreement or disagreement with each statement in the following manner:

If you strongly agree, circle the letter SA
If you agree, circle the letter A
If you mildly agree, circle the letters MA
If you mildly disagree, circle the letters MD
If you disagree, circle the letter D
If you strongly disagree, circle the letters SD

1.	The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.	SA	A	MA	MD	D	SD
2.	Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age.	SA	A	MA	MD	D	SD
3.	I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot.	SA	A	MA	MD	D	SD
4.	I do not know what it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.	SA	A	MA	MD	D	SD
5.	My mother was better prepared to be a good mother than I am.	SA	A	MA	MD	D	SD
6.	I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent.	SA	A	MA	MD	D	SD
7.	Being a parent is manageable, and any problems are easily solved.	SA	A	MA	MD	D	SD

If you strongly agree, circle the letter SA
If you agree, circle the letter A
If you mildly agree, circle the letters MA
If you mildly disagree, circle the letters MD
If you disagree, circle the letter D
If you strongly disagree, circle the letters SD

8.	A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.	SA	A	MA	MD	D	SD
9.	Sometimes I feel like I'm not getting anything done.	SA	A	MA	MD	D	SD
10.	I meet my own personal expectations for expertise in caring for my child.	SA	A	MA	MD	D	SD
11.	If anyone can find the answer to what is troubling my child, I am the one.	SA	A	MA	MD	D	SD
12.	My talents and interests are in other areas, not in being a parent.	SA	A	MA	MD	D	SD
13.	Considering how long I've been a mother, I feel thoroughly familiar with this role.	SA	A	MA	MD	D	SD
14.	If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent.	SA	A	MA	MD	D	SD
15.	I honestly believe I have all the skills necessary to be a good mother to my child.	SA	A	MA	MD	D	SD
16.	Being a parent makes me tense and anxious.	SA	A	MA	MD	D	SD

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Appendix F

Conners' Parent Rating Scales-48

Read each item below carefully, and decide how much you think your child has been bothered by this problem since the disclosure of sexual abuse.

Not at All	Just a Little	Pretty Much	Very Much	
0	1	2	3	1. Picks at things (nails, fingers, hair, clothing)
0	1	2	3	2. Sassy to grown-ups
0	1	2	3	3. Problems with making or keeping friends
0	1	2	3	4. Excitable, impulsive
0	1	2	3	5. Wants to run things
0	1	2	3	6. Sucks or chews (thumb, clothing, blankets)
0	1	2	3	7. Cries easily or often
0	1	2	3	8. Carries a chip on his/her shoulder
0	1	2	3	9. Daydreams
0	1	2	3	10. Difficulty in learning
0	1	2	3	11. Restless in the "squirmy" sense
0	1	2	3	12. Fearful (of new situations, new people or places, going to school)
0	1	2	3	13. Restless, always up and on the go
0	1	2	3	14. Destructive
0	1	2	3	15. Tells lies or stories that aren't true
0	1	2	3	16. Shy

Not at All	Just a Little	Pretty Much	Very Much	
0	1	2	3	17. Gets into more trouble than others same age
0	1	2	3	18. Speaks differently from others same age (baby talk, stuttering, hard to understand)
0	1	2	3	19. Denies mistakes or blames others
0	1	2	3	20. Quarrelsome
0	1	2	3	21. Pouts or sulks
0	1	2	3	22. Steals
0	1	2	3	23. Disobedient or obeys but resentfully
0	1	2	3	24. Worries more than others (about being alone, illness or death)
0	1	2	3	25. Fails to finish things
0	1	2	3	26. Feelings easily hurt
0	1	2	3	27. Bullies others
0	1	2	3	28. Unable to stop a repetitive activity
0	1	2	3	29. Cruel
0	1	2	3	30. Childish or immature (wants help s/he shouldn't need, clings, needs constant reassurance)
0	1	2	3	31. Distractibility or attention span a problem
0	1	2	3	32. Headaches
0	1	2	3	33. Mood changes quickly and drastically
0	1	2	3	34. Doesn't like or doesn't follow rules or restrictions

Not at All	Just a Little	Pretty Much	Very Much	
0	1	2	3	35. Fights constantly
0	1	2	3	36. Doesn't get along well with brothers or sisters
0	1	2	3	37. Easily frustrated in efforts
0	1	2	3	38. Disturbs other children
0	1	2	3	39. Basically an unhappy child
0	1	2	3	40. Problems with eating (poor appetite, up between bites)
0	1	2	3	41. Stomach aches
0	1	2	3	42. Problems with sleep (can't fall asleep, up too early, up in the night)
0	1	2	3	43. Other aches and pains
0	1	2	3	44. Vomiting or nausea
0	1	2	3	45. Feels cheated in family circle
0	1	2	3	46. Boasts or brags
0	1	2	3	47. Lets self be pushed around
0	1	2	3	48. Bowel problems (frequently loose, irregular habits, constipation)

Additional Items:

0	1	2	3	49. Behaves like opposite sex
0	1	2	3	50. Plays with own sex parts in public
0	1	2	3	51. Plays with own sex parts too much
0	1	2	3	52. Sexual problems (describe) _____

Not at All	Just a Little	Pretty Much	Very Much	
0	1	2	3	53. Thinks about sex too much
0	1	2	3	54. Wishes to be of opposite sex

Note: Published forms of the Conners' Scale were purchased and used in the study.

Appendix G

Demographic Information

GENERAL INFORMATION:

1. Your age? _____ Racial/ethnic background? _____

2. Marital Status: (check one)

single _____
married or living as married _____
separated or divorced _____
other (specify) _____

3. What is the highest level of education you obtained? (check one)

less than 7 years of formal schooling _____
junior high school _____
some high school ____
high school graduate _____
some university or technical college _____
bachelor's degree or technical diploma ____
graduate degree _____

4. Are you currently (check one):

not employed outside the home _____
employed part-time _____
employed full-time _____

5. If employed, what kind of work do you do? (Please be specific, for example: teacher, salesclerk, lawyer, secretary)

_____

6. How many biological children do you have?

Number of girls _____
Number of boys _____

7. What are your children's ages?

Girls _____
Boys _____

8. a) Do you have any foster children?

Number of girls____
Number of boys ____

b) Do you have any step-children?

Number of girls____
Number of boys ____

9. How many children live with you? _____

If you have children who are not currently living with you, where do they live (for example, in foster care, on their own, with their father, etc.)?

_____

10. How old is the child who was sexually abused? _____

11. Is the child (check one): a girl _____ a boy _____

12. When did you first find out about the sexual abuse?

_____

13. How did you find out?_____

_____

14. Has your child talked to you directly about the abuse? yes ____
no ____

15. a) Who does your child say abused him/her? (Do not give the person's name, just their relationship to you, for example, your husband, son, brother, a neighbor, a stranger, etc.)

_____

b) What is the relationship between this person and your child? (e.g., your child's father, babysitter, uncle, neighbor, etc.)

_____

16. To your knowledge, what did the abuse involve? (check all that apply)

_____ a) an invitation or request to do something sexual
_____ b) kissing and hugging in a sexual way
_____ c) another person showing his/her sex organs to your child
_____ d) your child showing his/her sex organs to another person
_____ e) another person fondling your child in a sexual way
_____ f) your child fondling another person in a sexual way
_____ g) another person touching your child's sex organs
_____ h) your child touching another person's sex organs
_____ i) attempted intercourse
_____ j) intercourse
_____ k) other (please specify)_____

17. Approximately how long did the abuse go on? _____
When did the abuse last occur? _____

18. On the following scale, please rate how difficult it has been for you to accept that your child was sexually abused.

1	2	3	4	5	6	7
Very difficult			Somewhat difficult			Not at all difficult

19. To what extent do you believe what your child is saying?

1	2	3	4	5	6	7
I don't believe my child at all			I believe my child somewhat			I believe my child completely

20. How responsible do you think your child is for what has happened?

1	2	3	4	5	6	7
Not at all responsible			Somewhat responsible			Very Much responsible

21. How responsible is the other person (i.e., the person who is accused of acting in a sexual way with your child) for what has happened?

1	2	3	4	5	6	7
Not at all responsible			Somewhat responsible			Very Much responsible

22. How has the other person reacted to what your child says has happened?

1	2	3	4	5	6	7
Denies that anything happened						Fully admits that what your child says is true

23. How much responsibility has the other person taken for what has happened?

1	2	3	4	5	6	7
Has taken no responsibility			Has accepted some responsibility			Has accepted full responsibility

24. How much do you think you have been affected by what your child has said about being sexually abused?

1	2	3	4	5	6	7
Not at all			Somewhat			Very Much

25. How much do you think your child has been affected by this experience?

1	2	3	4	5	6	7
Not at all			Somewhat			Very Much

26. How well do you think you are coping with the disclosure of sexual abuse?

1	2	3	4	5	6	7
Not Coping Well At All			Coping Somewhat			Coping Very Well

27. a) Prior to finding out about your child's abuse, were you receiving help from any professional person (e.g., a counsellor, social worker, minister, doctor)?

yes ____ no ____

If yes, from whom? (check all that apply)

___counsellor ___social worker ___minister
___medical doctor ___psychologist ___psychiatrist
___other (specify) _____

For how long had you been getting help? _____

b) In the past, have you ever received help from a professional person (e.g., a counsellor, social worker, minister, doctor)?

yes ____ no ____

If yes, from whom? (check all that apply)

___counsellor ___social worker ___minister
___medical doctor ___psychologist ___psychiatrist
___other (specify) _____

For how long did you get help? _____

28. Have you received any professional help since finding out about the abuse?

yes ____ no ____

If yes, from whom? (check all that apply)

___counsellor ___social worker ___minister
___medical doctor ___psychologist ___psychiatrist
___other (specify) _____

How long have you been getting help? _____

29. a) How often do you use alcohol? (check one)

____never
____less than once a month
____once a month
____once a week
____several times a week
____every day

b) Has there ever been a time in your life when you had a drinking problem?

yes ____ no ____

If yes, how often did you drink?

____less than once a month
____once a month
____once a week
____several times a week
____every day

DIRECTIONS:

Here are some questions about your marital/partner relationships. (If you are not presently involved in a marital or partner relationship, please begin with question 7.)

1. What is the highest level of education your husband/partner obtained? (check one)

less than 7 years of formal schooling _____
junior high school _____
some high school ____
high school graduate _____
some university or technical college _____
bachelor's degree or technical diploma ____
graduate degree _____

2. Is your husband/partner currently (check one):

unemployed _____
employed part-time _____
employed full-time _____

3. If employed, what kind of work does he do? (Please be specific, for example: teacher, salesclerk, lawyer, construction worker)

_____

4. How satisfied are you with your marital/partner relationship?

1	2	3	4	5	6	7
Not at all Satisfied			Somewhat Satisfied			Very Satisfied

5. Does you husband/partner ever (check yes or no for each statement):

YES	NO	
___	___	act like he is jealous and suspicious of your friends
___	___	withhold money you need to run the home
___	___	say you are ugly or stupid
___	___	insult you in front of other people
___	___	demand sex whether you want it or not
___	___	verbally threaten to hurt you
___	___	threaten you with a weapon
___	___	push or shove you
___	___	slap you
___	___	punch you with his fists
___	___	beat you so badly you must seek medical help

6. a) How often does your husband/partner use alcohol? (check one)

____never
____less than once a month
____once a month
____once a week
____several times a week
____every day

b) Has there ever been a time during your relationship when your husband/partner had a drinking problem?

yes ____ no ____

If yes, how often did you drink?

____less than once a month
____once a month
____once a week
____several times a week
____every day

7. In any of your previous marital or partner relationships (i.e., not including your present relationship), did your husband/partner ever (check yes or no for each statement):

YES	NO	
___	___	act like he was jealous and suspicious of your friends
___	___	withhold money you needed to run the home
___	___	say you were ugly or stupid
___	___	insult you in front of other people
___	___	demand sex whether you wanted it or not
___	___	verbally threaten to hurt you
___	___	threaten you with a weapon
___	___	push or shove you
___	___	slap you
___	___	punch you with his fists
___	___	beat you so badly you had to seek medical help

8. a) Did any of your previous husbands/partners use alcohol?

yes ____ no ____

b) If yes, how often did he drink? (check one) (If you have more than one previous husband/partner who used alcohol, answer for the husband/partner who used alcohol the most.)

____less than once a month
____once a month
____once a week
____several times a week
____every day

c) Did any of your previous husbands/partners have a drinking problem?

yes ____ no ____

Appendix H

Introduction to the Project

I would like to ask you to participate in this study of experiences and feelings of mothers whose children have been sexually abused. I am interested in understanding more about how mothers think and feel after their child has told them about being sexually abused. In order to learn more about this, I am asking mothers who have children who have been sexually abused to meet with me to answer some questions. The information you give is COMPLETELY CONFIDENTIAL. Only the researcher will have access to the information. Your answers will not be shared with anyone and in no way will your participation in the research affect the services you receive from the Child Protection Centre/Children's Home. I am only interested in how mothers as a group feel, not how any one person answers the questions.

I am a graduate student at the University of Manitoba and am conducting this research as part of my doctoral studies. Rayleen De Luca, Ph.D., C.Psych., Assistant Professor is the research supervisor. I greatly appreciate your cooperation.

Sincerely,

Appendix I

Letter of Introduction by the Agency

Dear

I am writing this letter to clients and former clients of (the Child Protection Centre or Families Affected by Sexual Assault) in order to introduce Ms. Diane Hiebert-Murphy. Ms. Hiebert is currently completing research requirements for her doctoral dissertation which has to do with how mothers cope with the sexual assault of their children. Ms. Hiebert is a trained social worker as well as a doctoral student in Psychology at the University of Manitoba and will complete some of her work through this agency.

In the near future Ms. Hiebert will likely contact you by phone and request to meet with you at your home. If you prefer not to be contacted by Ms. Hiebert, please leave a message with our Administrative Assistant (name of contact person and telephone number), within the next three days.

Your decision regarding this will not in any way affect your ability to receive service from (the Child Protection Centre or Families Affected by Sexual Assault). Furthermore, any response you may give to Ms. Hiebert will be held in strictest confidence.

Please feel free to contact me if you have any comments or questions regarding this and thank you for your possible assistance in this matter.

Sincerely,

(Name of the Director of the Program)

Appendix J

Consent Form

I, _____, agree to participate in this research project studying experiences and feelings of mothers whose children have been sexually abused. I understand that my participation is voluntary and that the information I give is completely confidential. I understand that I do not have to answer any question(s) that I do not want to, and can stop my participation at any time.

_____ _____

Date Signature