THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON PARENTING: THE ROLES OF SOCIAL SUPPORT, COPING, AND RESOLUTION

By

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ABSTRACT

THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON PARENTING:
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The long-term effects of childhood sexual abuse have been widely documented. However, only more recently have the roles of potential moderating and mediating variables been examined. The current study sought to expand upon previous research by examining the potential buffering effects of social support on attenuating the negative effects of a history of sexual abuse on maternal confidence, warmth, control, and self-reported levels of depression. The mediational roles of coping and resolution of abuse-related issues were also tested to determine their relative impacts upon associations between sexual abuse, parenting outcomes, and depression. Results of regression analyses indicated direct effects of social support on psychological well-being and parenting confidence; however, no buffering effects were found. Severity of sexual abuse was directly related to greater maternal control. None of the coping variables or resolution mediated the effects of abuse. However, lack of resolution directly predicted depression. Severity of abuse predicted lack of resolution regarding abuse-related issues. Parental reappraisal coping predicted maternal confidence and maternal warmth and less maternal control. The implications of these findings are discussed.

ACKNOWLEDGMENTS

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Above all, I would like to thank the women who participated in this study. These women opened their lives and often their homes, many with the hope that their participation would be helpful to other survivors. I hope that this project has in some way fulfilled those hopes.

Finally, thanks and love to my mom and dad.

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CHAPTER I

INTRODUCTION

Overview and Purpose of Study

Over the past 25 years, a considerable amount of research has been devoted to the exploration of the etiology and effects of childhood sexual abuse on women. Researchers have clearly established that the experience of childhood sexual abuse (CSA) results in both short- as well as long-term negative effects. Two recent reviews (Beitchman, Zucker, Hood, DaCosta, Akman, & Cassavia, 1992; Kendall-Tackett, Meyer Williams, & Finkelhor, 1993) identified well over 50 studies published within the past 15 years that focused specifically on the effects of sexual abuse on children and adults. However, the majority of research focuses on the negative clinical effects of CSA on victim's psychological well-being (e.g., sexual dysfunction, mood disorders) and neglects other life areas that do not fall under the umbrella of this clinical deficit model.

This study attempted to avoid adhering solely to the deficit model by assessing not only the negative effects of sexual abuse, but also the psychological strengths that may mediate the association between abuse and outcome variables. In addition, various aspects of parenting, rather than psychopathology alone, were included as outcome variables in this study. With the exception of the work of Cole and her colleagues (1989; 1992), this association has gone relatively unexplored. Given that it has been estimated that nearly 1 in 4 girls will experience sexual assault at some point in their lives (Finkelhor, 1984), it is important to explore the impact of sexual abuse on what is

arguably one of the most critical relationships in the woman's life.

To further refine these empirical questions, this study sought to explore the effects of sexual abuse within the context of assessing the associations between stress, social support, and coping. Studies addressing the effects of CSA often lack a viable theoretical framework; they also typically assume a direct pathway between abuse and later outcomes. For example, studies tend not to explore the role of moderating or mediating variables that may buffer or exacerbate the effects of abuse. In this study, the stress-buffering hypothesis was tested to determine whether social support moderates the relationship between stress and depression with this particular population (See Figure 1). Other studies have found mixed results depending, in part, on the population to which it is applied (Vaux, 1985).

In a separate set of analyses, sexual abuse was substituted for stress and the buffering hypothesis was again tested to determine whether social support buffers the effects of sexual abuse (similar to the manner in which it does for daily stress (Figure 2a)) when predicting depression, or whether the effects are direct (Figure 2b). The buffering versus direct effects of social support were then tested with three different parenting outcomes: parenting confidence, maternal warmth, and maternal control (Figure 3).

Finally, five variables were hypothesized to mediate the relationship between sexual abuse and both psychological and parenting outcomes (Figure 4): reappraisal and avoidant coping styles (associated with parenting and abuse-related stress, respectively) and lack of resolution of abuse issues.

This approach was considered the initial step in developing a more precise model

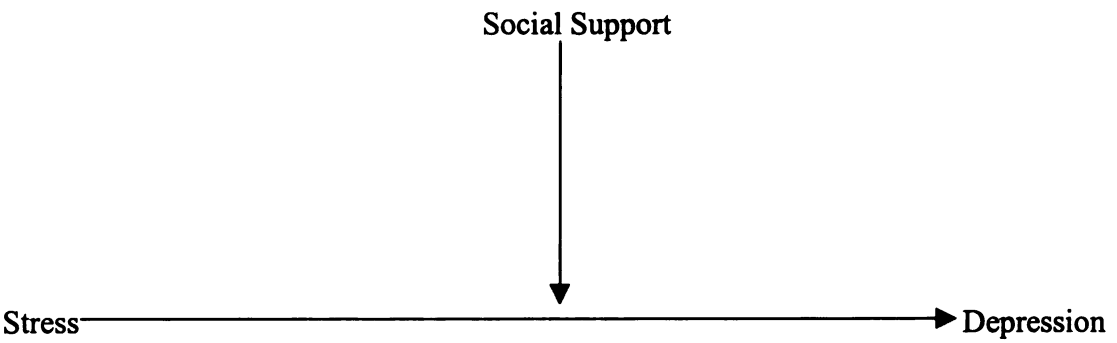

Figure1

Buffering Hypothesis for Stress/Social Support and Depression

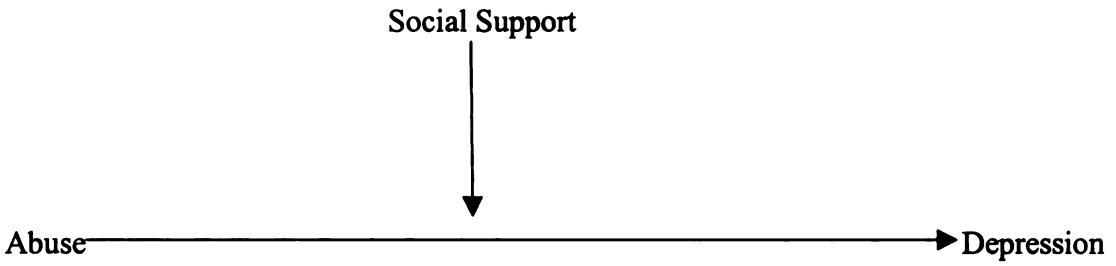

Figure 2a

Stress-Buffering Effects Model for Abuse/Social Support and Depression

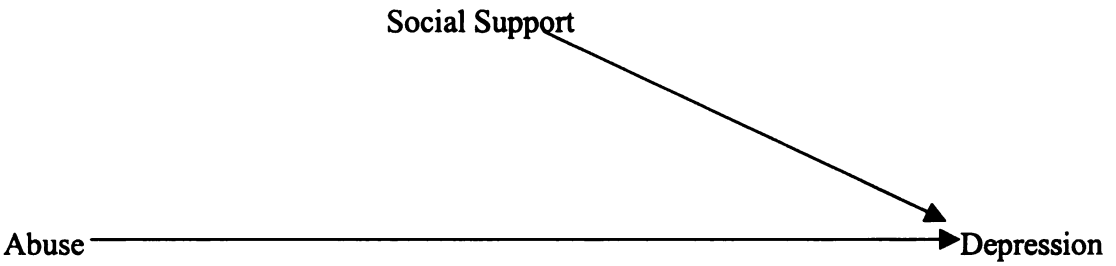

Figure 2b

Direct Effects Model for Abuse/Social Support and Depression

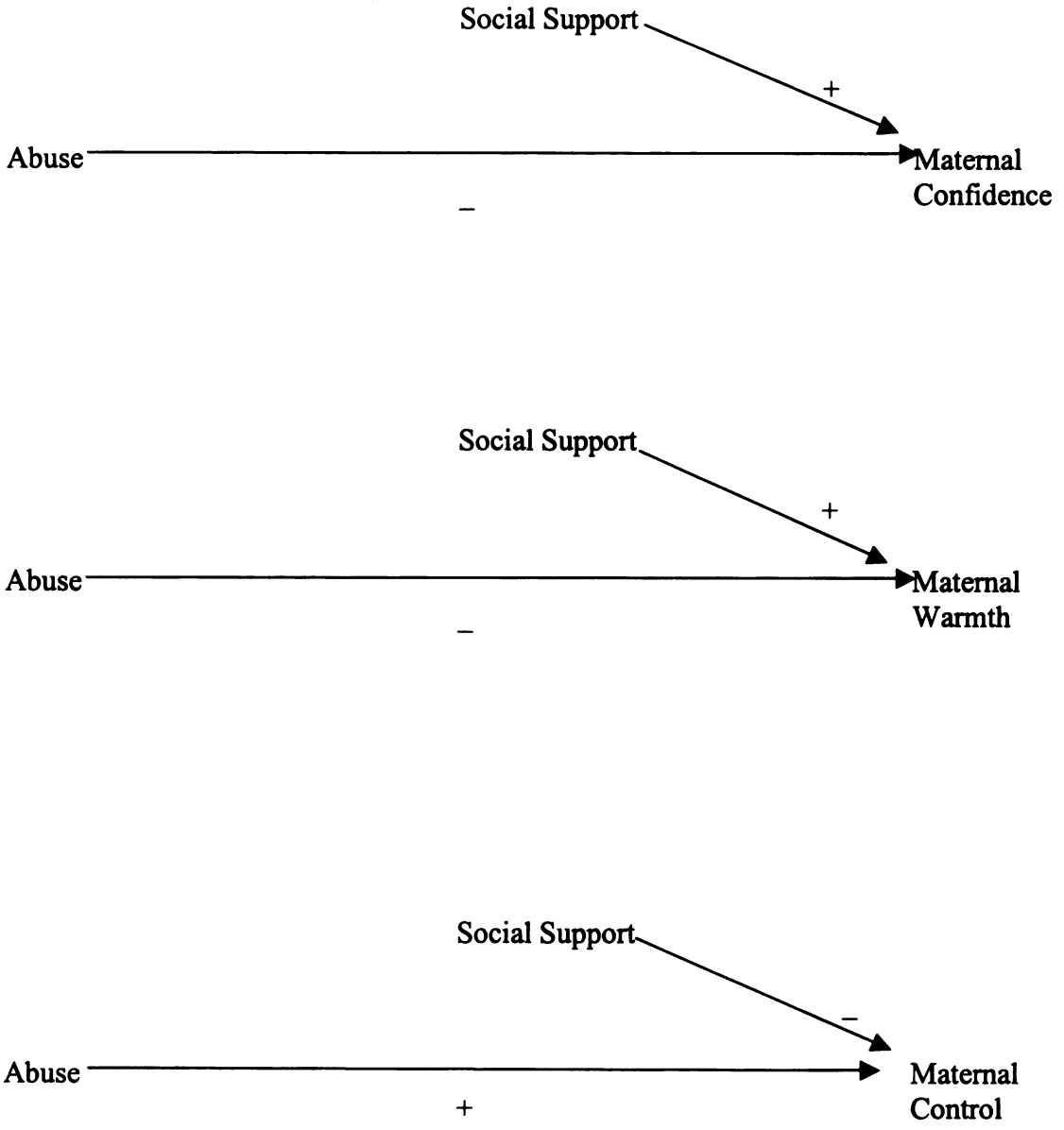

Figure 3

Direct Effects Model for Abuse/Social Support and Parenting Outcomes

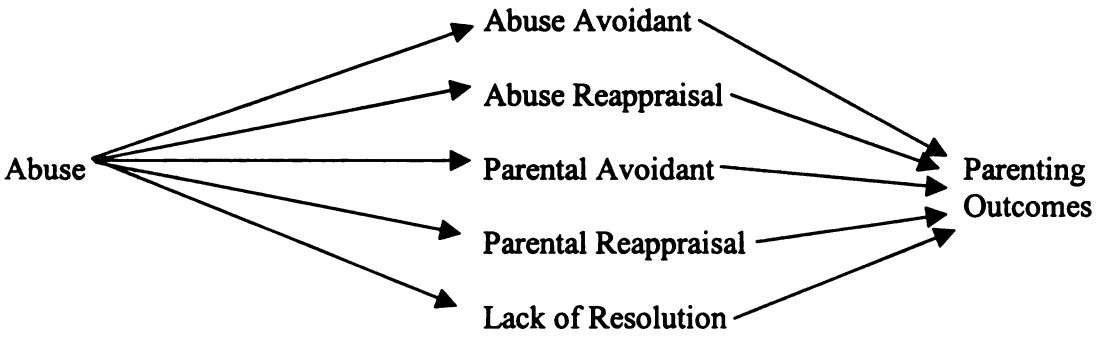

Figure 4

Proposed Mediational Effects of Coping and Lack of Resolution

for understanding the effects of childhood sexual abuse on parenting.

Child Sexual Abuse

Effects of CSA. Anna Freud (1981) stated that "where the chances of harming a child's normal developmental growth are concerned, sexual abuse ranks higher than abandonment, neglect, physical maltreatment or any other form of abuse" (p. 34). There is considerable research which assesses the nature and effects of childhood sexual abuse. The following review focuses on those studies which involved survivors of abuse perpetrated by either a member of her immediate family, a close relative, or a family acquaintance.

Among the short-term effects of CSA are the inability to trust others, especially those in authority (Gagliano, 1987; Hazzard, King, & Webb, 1986; Lindberg & Distad, 1985; Porter, Blick, & Sgroi, 1982; Sgroi, Blick, & Porter, 1982). Gagliano (1987) suggests that this is due to the fact that if the most important authority figure in the child victim's life is also his or her abuser, it becomes nearly impossible to either respect or trust others in positions of authority. Another primary effect is low self-esteem (Gagliano, 1987; Oates, Forrest, & Peacock, 1985; Porter et al., 1982). Researchers and therapists have also noted that intense shame and guilt (e.g., as a result of feeling responsible for abuse, disclosing the abuse and "causing" a disruption in the family; Damon, Todd, & Macfarlane, 1987; Hazzard et al., 1986; Lindberg & Distad, 1985), depression (Anderson et al., 1981; Hazzard et al., 1986), inappropriate sexual behavior (Friedrich, Urquiza, & Beilke, 1986; Tufts, 1984), and overwhelming anger (Anderson, Bach, & Griffith, 1981; Hazzard, King, & Webb, 1986; Tufts, 1984) are also negative

effects suffered by victims of CSA.

Several long-term outcomes, which are most often assessed in adult populations with histories of CSA, have been identified by both researchers and clinicians. Empirical and anecdotal evidence has tended to focus on the clinical symptoms associated with abuse. These most commonly include symptoms associated with Post-Traumatic Stress Disorder, such as intrusive daytime imagery, insomnia, depression, anger, guilt, mistrust, substance abuse, feelings of worthlessness, suicide attempts, isolation, and emotional numbing (Bagley & Ramsey, 1985; Briere, 1984; Courtois, 1979; Herman, 1981; Jehu, Gazan, & Klassen, 1985; Lindberg & Distad, 1985; Meiselman, 1978; Peters, 1984). Further examples of continued effects of childhood sexual abuse include anxiety and depression (Bagley & Ramsay, 1985; Briere, 1984; Luster & Small, 1997; Sedney & Brooks, 1984), impaired self-esteem (Bagley & Ramsay, 1985; Herman, 1981; Jehu et al., 1985), and sexual dysfunction (Herman, 1981; Jehu et al., 1985; Steele & Alexander, 1981). A history of child sexual abuse has also been associated with high frequencies of eating disorders (Palmer, Chaloner, & Oppenheimer, 1992; Waller & Ruddock, 1993). Compared to the effects of other types of child abuse, there is also some evidence that sexual abuse is more strongly associated with suicidal behavior in adolescent girls (Kosky, Silburn, & Zubrick, 1990; van der Kolk, Perry, & Herman, 1991; Shaunesey, Cohen, Plummer, & Berman, 1993).

One of the most detrimental effects adult survivors continually report is difficulty trusting others, especially those closest to them. Levay & Kagle (1977) reported that women who had been sexually abused were more successful with impersonal

relationships but experienced considerable intimacy dysfunction when relationships moved toward deeper levels. Courtois (1988), drawing from her clinical interactions with female survivors of childhood sexual abuse, noted that they tended to "experience relationships as threatening instead of gratifying" (p. 112), and they often felt "trapped" and "unable to move past a certain point (of intimate involvement)" in close relationships. In another clinical study, nearly 75% of the clients indicated a fear of intimate relationships with men (Jehu et al., 1985). As a result, these women tended to engage in a pattern of shorter, more superficial relationships. These results were consistent with earlier findings (Lukianowicz, 1972; Meiselman, 1978). Jehu and his colleagues suggest that avoiding deep, long-term relationships arises from fears of recreating the earlier abusive relationship as well as from the experience of betrayal and exploitation.

Effects of CSA on parenting. In general, the research indicates that, as a result of CSA, survivors' interpersonal relationships may be significantly affected because they experience difficulty trusting others, maintaining long-term relationships, and resolving conflict. It is therefore surprising that only a limited number of studies have explored the effects of CSA on the mother-child relationship.

Findings that do address this link suggest that mothers with histories of sexual abuse are more focused on their own needs rather than their children's needs (including relying on their children for emotional support) and engage in more belittling and less affirming interactions with their children than women without abusive histories (Burkett, 1991). In addition, sexually abused women tend to describe motherhood either in terms of its rewards or drawbacks, rather than relating experiences that were both positive and

negative (Burkett, 1991; Herzog, Gara, & Rosenberg, 1992). The results of two other studies revealed that women survivors' perceptions of their own parents and experiences of abuse predicted certain aspects of their own parenting. Survivors who held strongly negative perceptions of both parents were the most likely to report less nurturing and more controlling attitudes toward their children than non-victims. In addition, survivors reported less consistency, less organization, and fewer maturity demands from their children as well as lower levels of parenting confidence and control than non-victims (Cole & Woolger, 1989; Cole, Woolger, Power, & Smith, 1992).

There is also limited anecdotal evidence that a history of sexual abuse negatively impacts women's parenting. In particular, many clinicians have noted that women survivors experience considerable difficulty when their own children reach the age at which they themselves were first molested (Green, 1982). It is hypothesized that seeing and experiencing their children at this age triggers these women's own memories of abuse, thereby creating considerable stress, which in turn affects their parenting experience. In addition, clinicians have noted that women who are survivors often express fear that they will be poor mothers (Courtois, 1988; Herman, 1981); however, as Herman points out, these women often do a much better job of taking care of their children than they do taking care of themselves.

Abuse-related factors. A first step in developing a more refined understanding of the impact of CSA has been identifying and assessing the role of variables related to the nature of the abuse and the contextual situation within which it occurs. Although the findings are somewhat mixed, overall, researchers have found that the closer the relation

of the perpetrator to the child (Anderson et al., 1981; Friedrich, Urquiza, & Beilke, 1986; Wyall & Newcomb, 1990), the more deleterious the effects, particularly if the perpetrator is a father or step-father (Browne & Finkelhor, 1986). Longer duration (Bagley & Ramsay, 1985; Russell, 1986) and severity of the abuse (Bagley & Ramsay, 1985; Finkelhor, 1979; Mullen, Romans-Clarkson, Walton, & Herbison, 1988; Russell, 1986; Tufts study, 1984) have also been associated with more devastating consequences for the victim. For example, CSA involving force and violence is associated with more severe psychopathology (Mullen et al., 1988). However, the results of many of these studies are difficult to compare due to differences in how severity or the exact nature of the abuse itself were operationalized.

In addition, the responses a child encounters when she discloses the abuse may greatly affect her immediate, and possibly later, adjustment. Specifically, the more negative and ultimately unprotective response the child receives when the abuse is disclosed, the more negative the psychological outcome for the victim (Anderson et al., 1981; Davenport, Browne, & Palmer, 1994; Herman, 1981; Tufts study, 1984).

The Deficit Model: Why We Focus on the "Damaged" Woman

While it is expected that women's previous experiences of abuse will have created obstacles to their parenting, it is also considered important to determine how women survivors have succeeded in the face of their abusive experiences. In the past, research studies have either tended to utilize the clinical anecdotes of therapists who have worked with survivors or surveyed non-clinical populations using only measures which assess pathological outcomes. The tendency to assess pathology rather than health is a common

theme in psychology. Two examples, which are related to the current study, will help to put this phenomenon in context: the theory of intergenerational transmission of abuse and the theory of a cycle of victimization. Both these theories relate to abuse, and they also have been used more often to assess women's, rather than men's, roles (e.g., research involving the intergenerational transmission of abuse more often assesses maternal abuse).

The intergenerational transmission of abuse. Although more often associated with the occurrence of physical or emotional abuse rather than sexual abuse, the intergenerational transmission of abuse hypothesis contends that parents' own experiences of physical and/or emotional abuse and neglect may be associated with subsequent abuse of his or her own children (e.g., Herrenkohl, Herrenkohl, & Toedtler, 1983; MacEwen, 1994; Main & Goldwyn, 1984; Quinton, Rutter, & Liddle, 1984; Steele & Pollock, 1968). One possible explanation for this phenomenon is that rejected children become adults who are cautious of and unresponsive to intimate relationships and these adults are also more likely to become rejecting parents (Kempe & Kempe, 1978; Rohner & Rohner, 1980).

Despite evidence supporting this theory, several researchers have pointed out methodological limitations within this body of research (Altemeier, O'Connor, Vietze, Sandler, & Sherrod, 1982; Gelles & Cornell, 1985). For example, Ciccheti & Carlson (1989) compared multiple studies testing the intergenerational hypothesis and found that the rate of transmission varied from 18 to 70%, in part depending upon the methodology utilized. Ciccheti & Carlson estimated that the actual rate of transmission was closer to

30% ± 5%. Clearly, while a history of parental abuse may put some persons at increased risk of abusing their own children, the pathway is far from direct or simple.

With regard to sexual abuse, the intergenerational transmission hypothesis warrants even closer scrutiny. Zuravin and her colleagues (1996) recently explored whether parents who were physically, emotionally or sexually abused as children were more likely to abuse their own children. Findings suggested that mothers who experienced severe sexual abuse (i.e., intercourse vs. non-intercourse types of abuse) were more likely to have a maltreated child. However, the mother was rarely identified as the perpetrator; rather, the authors suggest that the mother's presumed lack of emotional availability secondary to having been abuse may have put the child at greater risk for abuse by other adults (e.g., sexual abuse by an adult male). While these findings are compelling, they do not provide information regarding the presence of variables that may moderate or mediate the association between abuse history and outcomes.

Is there a "cycle of victimization"? Another example of the deficit focus is the "cycle of victimization" theory, which supports the notion that certain women are repeatedly victimized. This belief has emerged from a concurrent belief in the existence of a "victim" personality, which has its origins in the Freudian and neoanalytic conceptualizations of the female "masochistic" and "hysterical" personalities. There is considerable argument over the viability of such conceptualizations; for example, feminist theorists contend that such diagnoses serve only to oppress and disempower women further because often the "symptoms" are actually the pathologizing of feminine characteristics (Chesler, 1972; Greenspan, 1983; Lerner, 1986).

In addition, there is controversy as to whether a true pattern of repeat victimization actually exists. Mandoki & Burkhart (1989) found that women who were victimized as children were no more likely to be victimized later in life than women who reported no childhood abuse. Furthermore, no predictive relationship was found between selected personality variables (e.g., assertiveness, self-esteem, dependency, and attributional style) and occurrence of victimization. However, the findings did indicate that, as the degree of child victimization increased, so did the number of adult consensual partners. Because the number of sexual partners also predicted victimization during adolescence, these findings suggest that an indirect relationship between early and later victimization may exist. The authors also point out that prior studies that show a correlation between childhood sexual assault and later victimization are actually reflecting the high base rate of victimization of women in general rather than a pattern of repeated abuse, per se.

Both the criticisms of and developments within these two theoretical domains highlight the need to focus on the positive, not only the pathological. Interestingly, the burgeoning self-help literature has addressed strengths as well as weaknesses in survivors of CSA (Bass & Davis, 1988; Poston & Lison, 1989). There is also some empirical evidence that survivors of CSA experience feelings of power, autonomy, and independence, and an increased sensitivity towards others as a result of their abuse (Brunngraber, 1986). However, these findings lack a theoretical context as well as an adequate explanation as to the potential mechanisms which may be driving the emergence of these positive outcomes.

CSA and the Stress/Social Support/Coping Model: A Theoretical Formulation of the Effects of CSA on Parenting

The intergenerational transmission of abuse theory has been criticized for being too simplistic. Mediating factors such as social support (Egeland & Jacobvitz, 1984; Herrenkohl et al., 1983; Hunter & Kilstrom, 1979), acknowledgement of and resolution not to repeat abuse (Egeland & Jacobvitz, 1984), and economic security (Straus, 1979) are just a few of the factors that predict the parenting behaviors of previously abused persons. These factors fit within a larger, ecological model of abuse developed by Belsky (1980), which extended and drew from prior models of abuse and development (Bronfenbrenner, 1977, 1979; Garbarino, 1977; Tinbergen, 1951). In addition, these ecological models resemble more general stress/social support/coping models. However, these more ecologically-based models have not been empirically tested as an explanation for the effects of childhood sexual abuse.

Stress: The First Portion of the Model

Definition and relevant research. The associations among stress, social support, and coping have experienced considerable attention over the past twenty or so years. Emerging from the work of Selye (1956) and others involving the effect of external stressors on animal and human physiology, the impact of stressors on psychological adjustment became a focus of much research during the 1960s. Selye identified the General Adaptation Syndrome (GAS), the physical effects and adaptation that occur when a living organism is exposed to an external stressor. Subsequently, social epidemiologists explored the psychosocial effects of exposure to stressors, and this area of research has

experienced substantial growth and expansion since the 1960s and 1970s.

Within the psychological and sociological realms, stress has been defined in a variety of ways; in general, a stressful event is defined as one that demands a degree of individual adaptation that is beyond the resources (tangible, emotional and/or physical) of the individual at that time (Dowrenwend & Dowrenwend, 1974).

The early work of Holmes & Rahe (e.g., 1967, 1979) explored the effects of recent major life events (e.g., loss of a loved one) on an individual's psychological well-being. This approach was widely used throughout the 1970s and 1980s and their measure, the Scale of Life Events (Holmes & Rahe, 1967), was utilized as an assessment tool in numerous studies. This scale involves the respondent marking off items on a stressful life events checklist, and an overall "stress" score is attained by tallying the number of events a person reports within a determined period of time. This manner of indicating stress is based on the notion that the number of events a person experiences is directly proportional to the extent of disequilibrium that is created, and, thus, the degree of adjustment that is required (Holmes & Rahe, 1967).

Although quite popular for a time, the technique of identifying discrete and often rare events has more recently given way to the measurement of daily "hassles," which Lazarus and his colleagues have defined as the "irritating, frustrating, distressing demands and troubled relationships that plague us day in and day out" (Lazarus & Delongis, 1983, p. 247). These "daily hassles" are more strongly related to psychological distress than the singular life events described by Holmes and Rahe (Kanner et al., 1981); therefore, measures of daily hassles, although criticized by some as being confounded with

measures of adaptational outcome (Dohrenwend & Shrout, 1985), continue to be a popular assessment strategy of choice in studies exploring the effects of personal stress. In addition, the hassles assessment approach has considerably more response variance compared to the life events approach (i.e., it's unlikely that most respondents will have experienced a recent major life event; however, many respondents will have experienced numerous, recent daily hassles).

However measured, the resultant effects of stress on individual physical and psychological conditions is well documented. Such findings have indicated that both stressful life events (e.g., job disruption, loss of a loved one, etc.) and chronic stress (e.g., "hassles" such as financial problems) can be associated with depression (Anderson, Noyes, & Hartford, 1977; Pearlin, Menaghan, Lieberman, & Mullan, 1981) and physical illnesses (Holmes & Masuda, 1974).

Taking the above description of the stress process, a woman's experience of childhood sexual abuse would seem to clearly fit the definition of "stressor." This is true not only during the course of the abuse, but also in regards to the long-term, chronic stress that is associated with issues such as mistrust in relationships, and feelings of anxiety, guilt, and anger.

Social Support

Definition of social support.

In general, social support is defined as "actual or perceived" social interactions that "provide instrumental and/or expressive functions" (Dean, 1986, p.9). More specifically, Thoits and others have identified two distinct and equally important aspects of social support: structural (e.g., number of persons in support

network, accessibility, frequency of contact, etc.) and functional (e.g., perceived amount of support and relative satisfaction with the amount and type of support received). In addition, most operationalized definitions of functional support include areas such as emotional support (e.g., empathic responses), instrumental or tangible support (e.g., financial assistance), and informational support or guidance/advice (e.g., provision of information regarding child development to a new mother) (House, 1981; Lin, Dean & Ensel, 1981; Russell & Cutrona, 1985; Wolf, 1981).

Social support and parenting. One aspect of the present study, the relationship between social support and parenting, is well-documented within the extant literature. In general, the research suggests that social support is associated with maternal confidence in parenting, greater maternal nurturance, and successful mother-child interactions (Barrett, 1978; Pascoe, Loda, Jeffries, & Earp, 1981; Tetzloff & Barrera, 1987). Greater social contacts have also predicted better parenting adjustment for single-mothers, while more tangible forms of support (e.g., household help) have been found to benefit mothers in two-parent homes (D'Ercole, 1988; Weinraub & Wolf, 1983).

Applied research in this area has sought to evaluate specific intervention programs that provide mothers with various forms of support. In general, these programs tend to provide informational (e.g., regarding diet, infant care) and emotional support and have also expanded the mother's social support network (Barrera, Rosenbaum, & Cunningham, 1986; Booth, Barnard, Mitchell, & Spieker, 1987; Dawson, vanDoorninck, & Robinson, 1989; Olds, Henderson, Chamberlin, & Tatelbaum, 1986). In general, the findings suggest that these interventions not only improve the mother's reported levels of social

support, but also improve the quality of the mother-infant relationship.

Direct vs. buffering effects of social support. The literature reflects an overall consensus that social support is associated with positive outcomes for individuals. However, the mechanism by which this association is realized has provoked debate. The focus of this argument has been whether social support has a direct beneficial effect on psychosocial adjustment, regardless of stress level, or whether this link only exists in the presence of high levels of stress, thereby "buffering" the individual from the effects of stress (Cohen & Wills, 1985).

Reviews of individual studies (see Cohen & Wills, 1985; Ensel & Lin, 1991; Levay, 1983; Vaux, 1985 for reviews of the literature) suggest that the direct vs. buffering effects of social support may vary across populations and may also be dependent upon the manner in which support is measured. For example, Vaux (1985) noted that women tend to experience greater social support than men and there is some indication that social support may play a more salient role in women's reactions to stressful situations. In their oft-cited review, Cohen & Wills (1985) argued that when specific, functional (i.e., the quality, rather than the amount, of social support) support scales are utilized to assess social support, buffering effects are more likely to be found; when the measure of social support involves assessment of one's social network, main effects are found.

Evidence for the direct effects hypothesis suggests that social support directly reduced reported intensity of depressive symptomatology in men and women (Miller & Ingham, 1976; Paykel et al., 1980; Surtees, 1980). In non-clinical samples of urban Americans, social support negatively correlated with psychological distress (Beigel et al.,

1980; Lin et al., 1979). In addition, Andrews et al. (1978) found that direct crisis support significantly differentiated between psychologically distressed and non-distressed individuals. The findings of the Lin et al. and Andrews et al. studies, both of which tested for the stress-buffering effect but found none, suggest that social support and stress independently affect outcomes.

Conversely, other researchers have argued that social support acts as a buffer between stress and outcome, and does not affect outcome independent of stress level. Both of the proposed mechanisms as well as the outcomes for this model have varied. Evidence in support of the buffering hypothesis has indicated that adequate levels of social support may attenuate the psychosomatic effects brought on by stressful events (de Araujo, Van Arsdel, Holmes, & Dudley, 1973; Nuckolis, Cassel, & Kaplan, 1972) such that, in conditions of high stress, those individuals reporting low levels of social support also report the highest degrees of psychosomatic distress. Additional evidence, has demonstrated the buffering effect with college undergraduates (Cutrona, 1986). Undergraduates who reported a greater frequency of received "helping behaviors" (e.g., advice, expressed worry or concern) reported lower levels of depressive affect following a stressful event than those students who indicated fewer indicators of social support. However, in a sample of new mothers (assessed during pregnancy, and at 2-,8-, and 52-week follow-ups), Cutrona (1984) reported no support for the buffering hypothesis. Specifically, the results of this study indicated that, at high levels of stress, social support did not alleviate reported levels of depression, but social support did positively impact outcomes at lower levels of stress. These findings suggest that, for this population, social

support imparts a positive effect only up to a certain point, which is in the opposite direction than is typically expected within the context of the buffering hypothesis.

Social support and CSA. There is relatively little research that determines the effects of specific aspects of social support (e.g., quality of support, type of support, etc.) on how a survivor copes with CSA. As mentioned earlier, there is considerable evidence that the reaction of those around her at the time of disclosure may have short-term and long-term impact. One study found that the amount of social support available, along with the existence of a close, positive relationship with an adult and the existence/absence of pathological family interactions were important predictors of children's level of distress immediately following disclosure of the abuse (Conte, 1987). Utilizing a somewhat different approach, another study found that the occurrence of sexual abuse negatively predicted the size of the survivors' current social support network, but did not significantly predict their level of perceived social support (Edwards & Alexander, 1992). This suggests that the experience of CSA may impact the extent of one's network, but may not interfere with one's perception of support.

Another body of related research addresses the impact of social support in helping an individual manage the outcome of sexual victimization (e.g., rape) rather than the effects of ongoing childhood sexual abuse per se. The majority of studies have found that social support, in a variety of forms ranging from groups to a sympathetic and validating ear, subsequently help women to deal with the crisis of rape (Golding, Siegle, Sorenson, & Burnam, 1989; Resick, 1993; Sharma, 1986). These findings suggest that social support is an important construct to consider within the context of adjustment to sexual

abuse and assault.

A relevant question for the current study is whether social support will directly predict outcome variables or whether it will buffer the effects of sexual abuse on outcomes. As noted above, findings in support of the buffering hypothesis have been mixed. In part to help explain these inconsistencies, Cohen and McKay (1984) proposed the "specificity hypothesis", which contends that specific types of support must be matched to the demands put forth by the particular stressor. Therefore, commonly used global measures of stress and support would create mixed findings and reflect a need for a more refined approach. With respect to the current study, the specific stressor, intensity level of sexual abuse, has not previously been assessed within the context of the buffering hypothesis. However, the nature of both this stressor as well as the target outcomes (parenting), helps provide a rationale for predicting a direct effects rather than a stress-buffering model.

First, much of the prior research supporting the buffering hypothesis assess the absence or presence of current, discrete stressors (i.e., daily hassles). Sexual abuse, in contrast, may be considered a potential source of chronic stress. Furthermore, all of the women in the current study experienced sexual abuse and outcomes are based on intensity of abuse rather than absence or presence of the experience. While it is beyond the scope of the current study, it is likely that the differences in stress (and associated outcomes) between a survivor of abuse and a person who did not experience this trauma is greater than the relative differences in stress between survivors. Therefore, while it is believed that intensity of abuse will be directly related to different levels of outcomes, it is not

believed that the presence of social support will significantly interact with different levels of abuse intensity. That is, the fact that a woman experienced abuse at all is an extreme stressor and while the buffering effects of social support may emerge in the presence of a non-abused control group, it is not expected here.

Secondly, the results of several studies testing the buffering hypothesis in predicting parenting outcomes have supported the direct but not buffering effects of social support (Cutrona, 1984; Tetzloff & Barrera, 1987). Given that the primary outcome variables in this study involve self-reported aspects of parenting, a direct effects model for social support is predicted.

The conceptualized role of social support in the present study. The present study will test whether social support buffers the effects of stress and CSA on survivors' reported levels of depression and parenting experiences. Since the existence of a buffering effect is to be tested, a measure of functional social support (vs. structural) was included. Specifically, social support was measured using the Social Provisions Scale, based on Weiss' (1974) theory of social provisions, which includes the presence of social support that provides any or all of the following: attachment, social integration, opportunity for nurturance, reassurance of worth, reliable alliance, and guidance.

Coping

Definition and relevant research. The role of individual coping strategies has emerged as a central factor in regards to how stress affects specific individuals. Lazarus (1966, 1984) and his colleagues identified the range of cognitive appraisal and coping strategies as reflections of the individual differences that emerged within the link between

stress and outcome.

Coping has been defined as the "person's constantly changing cognitive or behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the person's resources" (Lazarus & Folkman, 1984, p. 1984). Within Lazarus' stress and coping paradigm, the first process that an individual encounters upon facing a potentially "stressful" event is appraisal (Folkman et al., 1986). Initially, the individual determines what is at stake as a result of the stress (i.e., primary appraisal) and whether he/she will be able to avoid or overcome the stressful encounter (secondary appraisal).

Coping styles are often operationalized in terms of "emotion-focused" (e.g., managing stressful emotions) and "problem-focused" (e.g., actively working to change the stress inducing situation)(Dunkel-Schetter, Folkman, & Lazarus, 1987; Folkman & Lazarus, 1980; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986; Lazarus & Folkman, 1984). In general, emotion-focused coping involves strategies that do not directly affect or change the external stressful situation, but rather involve internal processes that allow the person more easily to fit the stressful situation within his or her cognitive and emotional understanding. Examples of this process may include, but are not limited to, cognitive reframing, minimization of the stress, behavioral interventions (e.g., relaxation, exercise, etc.), and escape through the use of drugs or alcohol.

Problem-focused coping, in contrast, directly seeks to affect a change in the stressful situation through strategies such as conflict resolution, information gathering, and advice seeking. In general, the latter strategies are most often utilized when an

individual perceives the situation to be changeable.

These two categories were empirically derived from a factor analysis of the eight scales of the Ways of Coping questionnaire, which was based on Lazarus' transactional model of stress (Aldwin, Folkman, Shaefer, Coyne, & Lazarus, 1980). These widely used scales include: Confrontive, Distancing, Self-Controlling, Seeking Social Support, Accepting Responsibility, Escape-Avoidance, Planful Problem-Solving, and Positive Reappraisal strategies for coping (Folkman et al., 1986). Others have measured coping in terms of changing the situation, managing emotional distress, and reinterpreting the meaning of the event (Pearlin & Schooler, 1978), as well as in terms of more specific behaviors, such as prayer, distraction, and seeking social support (Stone & Neal, 1984).

With regard to the effects of stress appraisal and coping on individual outcomes, Lazarus and others have found that certain coping strategies are associated with positive and negative outcomes. For example, individuals who used confrontive and distancing coping strategies reported less satisfactory outcomes (e.g., situation remained unresolved or worsened), whereas people who employed more problem- focused strategies or indicated that the situation provided them with personal growth, reported more satisfactory outcomes (e.g., situation resolved or improved) (Folkman et al., 1986). However, these findings are not conclusive; other researchers have shown that, in a relatively uncontrollable situation, problem-focused coping may lead to frustration and exhaustion (Cohen, Evans, Stokols, & Krantz, 1986). Furthermore, certain appraisal strategies have been associated with specific patterns of coping (Folkman et al., 1986). For example, individuals who appraised the initial situation as highly threatening to their

self-esteem were more likely to engage in self-controlling, confrontive, escape/avoidance, and self-responsibility coping strategies as compared to when they did not perceive their self-esteem to be threatened. Certain personality characteristics have also been related to both outcome and coping style in stressful situations (e.g., self-esteem, level of personal trust, discomfort with receiving help; Dunkel-Schetter, Folkman, & Lazarus, 1987).

While there is clearly a strong conceptual and empirical foundation for the stress and coping paradigm, research also suggests the need for further exploration of the situational determinants of coping effectiveness (Wethington & Kessler, 1991). For example, although there is some evidence that stressor characteristics are associated with the relative efficacy of specific coping strategies, more research of this type is necessary (Folkman et al., 1986). Therefore, it would be useful not only to explore the role of coping in situations of chronic stress (e.g., the prolonged effects of child sexual abuse in adulthood), but also to determine whether certain aspects of the event (e.g., severity of the abuse) are associated with certain coping strategies that are more successful than others.

Coping strategies and CSA. The extant literature indicates that survivors of CSA utilize a variety of coping strategies. For example, researchers have found that girls are more likely to seek help through disclosure than are boys (DeYoung, 1982; Finkelhor, Hotaling, Lewis, & Smith, 1990). One form of coping that is common in both young girls and women who are sexually victimized is dissociation and repression of the assault (Bagley & Ramsay, 1985; Courtois, 1979; Peters, 1984). Often, this type of coping is adaptive during childhood, and women will begin to recover memories of the abuse when they are older and have developed skills and resources that will better allow them to

process the trauma.

Investigating other long-term coping strategies, Crockett (1984) found that women who were physically and sexually abused as children and who adopted active coping strategies as adults (e.g., helping others, work, reaching out, etc.) reported more positive adjustment than women who engaged in more avoidant types of coping (e.g., emotional withdrawal). Similarly, avoidant coping strategies have consistently been shown to be associated with more negative outcomes such as anxiety, depression, likelihood for re-victimization, and global distress (Holohan & Moos, 19985; Proulx, Koverola, Fedorowicz, & Kral, 1995; Vollrath & Angst, 1993).

In studies of women's coping reactions to more general forms of sexual trauma (e.g., rape and other forms of sexual exploitation, not limited to CSA), short-term coping strategies tended to involve more self-destructive behaviors (e.g., alcohol use), whereas more proactive, long-term strategies tended to be more constructive (e.g., seeking information, learning how to avoid future exploitation) (Mims, 1982). This research suggests that women survivors of CSA may be able to access their inner strengths more readily (e.g., possibly within the context of their parenting) if they are able to employ coping strategies that are focused on accessing resources and taking positive action (both intrapsychic and external).

The present study examined the mediational effects of avoidant coping and reappraisal coping (as defined and measured by Folkman & Lazarus' Ways of Coping Checklist) on the associations between sexual abuse, parenting, and psychological well-being (i.e., depression). Spiccarelli's (1994) transactional model of abuse argues for

considering coping as a mediator of the effects of sexual abuse. For example, Spiccarelli argues that negative cognitive appraisals (e.g., self-blame) and maladaptive coping strategies (e.g., avoidance) related to molestation are directly related to increases in clinical symptomatology. Furthermore, Proulx, Koverola, Fedorowicz, & Kral (1995) highlighted the need for determining differences in coping specific to and depending upon the problem presented. That is, coping strategies utilized by an individual across a variety of problems are not necessarily constant.

In the present study, the role of coping as a mediator of the effects of childhood sexual abuse on parenting and psychological well-being were assessed. Specifically, the relative importance of coping with stress related to parenting and stress related to a stressful abuse-related experience were explored with respect to maternal confidence, warmth and control and maternal depression.

Resolution of abuse-related issues. Many researchers and theorists have explored the necessity of an individual's motivation to "search for meaning" when he/she is confronted by a stressful or undesirable situation (Frankl, 1963; Moos & Tsu, 1977). More recently, researchers have explored the applicability of this notion to the process of coping with sexual abuse (Bulman & Wortman, 1977; Silver, Boon, & Stones, 1983). In one study (Silver, Boon, & Stones, 1983), the majority of women surveyed reported that they continued to search for some sort of reason for their abuse even though, for many of the women, the abuse had ended over 20 years earlier. Furthermore, women who reported high levels of such searching also reported higher levels of current psychosocial stress, more abuse-related intrusive thoughts, lower self-esteem, and less resolution of the

experience, although these associations were correlational rather than predictive. The authors posit that women who were unable to identify any meaning for their abuse were caught in a kind of psychological limbo consisting of the interplay between their memories of the abuse and their active "searching" for meaning. Women who were able to identify some meaning for their abuse (e.g., labeling discord between their parents as a precipitating factor, empathizing with their perpetrator's misdirected need for love) reported more positive adjustment.

With regard to the current study, the extent to which women continue to deal with the unfinished business associated with their abuse may affect their experiences as parents. "Lack of resolution", which is defined within this study as the extent to which survivors of sexual abuse continue to be hindered in their daily lives by thoughts and emotional stress related to their abuse, is a concept unique to this study and hypothesized to mediate the association between sexual abuse and outcome variables. Himelen & McElrath (1996) found that women who had been sexually abused as children and reported not "having dealt with the abuse" generally reported lower levels of psychological adjustment than survivors who had developed some way of understanding the abuse. However, these findings were based on qualitative and anecdotal data. The present study seeks to operationalize the concept of abuse resolution and test the extent of its role as a mediator.

It is hypothesized that if a woman has achieved some measure of peace in regards to their experiences, she will be more likely to devote her energies and internal resources to the here and now rather than to the past. Drawing from the work of Silver et al.

(1983), among others, the current study explored the extent to which women report that negative thoughts or feelings related to the abuse intrude upon their daily lives and the extent to which they have resolved their relationships with both the perpetrator and the non-abusive parent(s). In her work with women survivors of sexual abuse, Herman (1982) noted that these women expressed feelings of intense anger and sadness towards their mothers, whom they believed to have betrayed and abandoned them through their inaction and silence during the abuse. From her interviews with women survivors of sexual abuse, Herman (1981) found that, for survivors,

> ...the legacy of their childhood was a feeling of having been profoundly betrayed by both parents. As a result, they came to expect abuse and disappointment in all intimate relationships: to be abandoned, as they felt their mothers had abandoned them, or to be exploited, as their fathers had exploited them. Given these possibilities, most women opted for exploitation. (pp. 99-100)

Maternal Depression: A Variable with Connections to CSA and Parenting

Extensive evidence has linked CSA with later depression (e.g., Bagley & Ramsay, 1985; Peters, 1984). In addition, research suggests that depression is a common outcome of general stress, and this linkage may, in turn, be partially moderated by the effects of social support and coping (Brown & Harris, 1978; Slater & Depue, 1981). Finally, maternal depression has been associated with certain problematic parenting and child outcomes (e.g., Hammen et al. 1987; Seligman et al., 1984). These points argue for assessing the survivor's current level of depression in order to determine the extent to which it plays a role in the current conceptualization separate from other variables.

In general, the preponderance of available research has focused on the effects of maternal depression on the behaviors and psychosocial adjustment of children ranging from infancy through latency years. The age (or range of age) during which the child is exposed to maternal depression may differentially determine the extent and nature of the effects on the child (Puckering, 1989). In addition, the time at which the depression occurs in the mother's life (e.g., before vs. after the birth of her child) also effects the severity of the problematic child behaviors (Murray, 1988).

Babies whose mothers are depressed tend to accommodate to their mothers' moods, appearing less responsive and more avoidant of their mothers, as well as less adaptive in other social situations, such as in the presence of a stranger (Field et al., 1988; Schaffer, 1984). Another study has demonstrated that infants of depressed mothers have more marked sleep disturbance (Zuckerman, Stevenson, & Bailey, 1987). However, this association is likely more complex, as there is some evidence that social support may attenuate mothers' experiences of post-partum depression (Cutrona, 1984).

Prolonged effects of maternal depression on the child have also been noted. In particular, children whose mothers were depressed when they were infants displayed some developmental delay several years later (Coghill, Caplan, Alexander, Robson, & Kumar, 1986). In addition, children whose mothers were depressed when they were younger may suffer continued sleep problems, greater behavioral problems (e.g., temper tantrums), and some reading and cognitive problem solving difficulties (Mills & Meadows, 1987; Richman & Stevenson, 1982; Zuckerman et al., 1987).

Several studies have also linked maternal depression with conduct disorder (Griest

et al., 1980; Webster-Stratton, 1988). However, the extent to which depressed mothers' perceptions and reports of their children as behaviorally difficult is confounded by their own depression (i.e., depressed mothers perceive their children more negatively) has become another research question (Brody & Forehand, 1986; Dumas et al., 1989; Webster-Stratton & Hammond, 1988).

The current study explored the association between sexual abuse and maternal depression. In addition, depression was entered in those analyses that included parenting variables significantly associated with depression. This was done to help disentangle the independent effects of abuse on parenting.

Summary and Rationale for the Present Study

In conclusion, the current study sought to broaden the existing research regarding the long-term effects of childhood sexual abuse. Specifically, the effects of CSA on women's parenting and level of depression were explored to provide information on both psychological well-being and an equally important, but less deficit-focused, area of women's lives. Given the associations between depression, sexual abuse, and parenting, the effects of CSA on depression were examined and depression was also controlled for (where relevant) in analyses examining whether various coping variables mediated the association between CSA and outcome variables.

In order to provide a first step in developing a more refined empirical model, the effects of CSA were also examined within the context of social support and coping. The role of social support in attenuating the negative psychological effects of stress has been well-established in the extant literature (Cohen & Wills, 1985). In particular, studies

assessing the stress-buffering effects (i.e., dependent on stress level) versus direct effects of social support on psychological well-being suggest that these effects may vary according to the population (Cohen & Wills, 1985; Cutrona, 1984; Ensel & Lin, 1991; Vaux, 1985). In the present study, the stress-buffering hypothesis was tested with a population of women who are survivors of sexual abuse. Stress was measured both in a conventional manner (i.e., stress defined in terms of "daily hassles") and when stress is defined as severity of sexual abuse.

With regard to coping styles, coping has been shown to mediate the association between traumatic events and psychological sequelae. In particular, avoidant coping strategies have consistently been associated with more negative outcomes such as anxiety, depression, likelihood for re-victimization, and global distress (Holohan & Moos, 19985; Proulx, Koverola, Fedorowicz, & Kral, 1995; Vollrath & Angst, 1993). Spiccarelli's (1994) transactional model of abuse argues for considering coping as a mediator of the effects of sexual abuse. The present study examined the mediational effects of avoidant coping and reappraisal coping (with both parenting and abuse-related stressors) on the association between sexual abuse and depression/parenting outcomes. In addition, lack of resolution, which was defined within this study as the extent to which survivors of sexual abuse continue to be hindered in their daily lives by thoughts and emotional stress related to their abuse, was hypothesized to mediate the association between sexual abuse and outcome variables. Specifically, the relative importance of coping with stress related to parenting and stress related to a history of childhood sexual abuse were be explored with respect to maternal confidence, warmth, and control. Cole and her colleagues have

assessed parenting confidence and control in prior studies. For example, maternal control (or "overprotectiveness") is considered to be a potentially relevant issue for survivors, for whom protecting their own children (particularly daughters) from similar violations may be paramount. Maternal control may also reflect the survivor's feelings of profound mistrust of others, which may make it difficulty to afford her own child the opportunity to engage in developmentally appropriate movements towards separation and greater responsibility.

Hypotheses

Hypothesis 1. Social support will buffer the effects of general daily stress on women's psychological well-being (level of depression). That is, at high levels of reported stress, women with high levels of social support will report lower levels of depression than women who have little or no social support.

Hypothesis 2. With stress defined in terms of a history of sexual abuse, social support will directly predict lower levels of depression and sexual abuse severity will be directly related to high levels of depression.

Hypothesis 3. Controlling for the effects of maternal depression where relevant, sexual abuse will be related to low maternal confidence, higher levels of maternal control and lower levels of maternal warmth. Social support will directly predict maternal confidence, warmth, and low levels of control.

Hypothesis 4. Coping with abuse and resolution of abuse issues will mediate the relationship between sexual abuse and depression such that avoidant coping and lack of resolution will be related to higher levels of depression and reappraisal coping will be

associated with less depression.

Hypothesis 5. Controlling for level of depression where relevant, coping with abuse and parenting stressors and resolution of abuse issues will mediate the relationship between sexual abuse and parenting variables. Specifically, avoidant coping and lack of resolution will be associated with less parenting confidence and warmth and more controlling mother-daughter relationships. Reappraisal will be associated with greater confidence and warmth and lower levels of controlling behaviors.

CHAPTER II

METHOD

Research Participants

Fifty women living in Michigan and California participated in this study. All women were survivors of sexual abuse and were also the parent of a daughter.

The majority (84%) of women were Caucasian. Age of participants ranged from 21 to 54 with a median of 41 and most had at least a high school education. Twenty-eight percent of the women interviewed had one child, 34% had 2 children, and 38% of the women had 3 or more children. All questions pertaining to mother-child relationships pertained to the woman's eldest daughter. The age of participants' eldest daughters ranged from 1 to 34, with a median daughter age of 15 years. (See Table 1)

Measures

Table 2 summarizes internal consistency values and the range of corrected item-total correlations for the questionnaire scales administered to subjects.

Demographics. A variety of demographic characteristics were assessed (e.g., age, race, education, relationship status, income) using a questionnaire developed for this study (Appendix A).

Child sexual abuse. Participants were asked specific information regarding the duration, frequency, type of abuse, and perceived distress related to each type of abuse (Appendix B). Abuse items were taken from Russell's (1986) Severity of Sexual Abuse Questionnaire, which identifies a variety of different sexual abuse events ranging in severity (e.g., "Forcible genital intercourse", "Nonforcible sexual kissing, intentional

Table 1

Demographics of Sample

	N	%
Age		
20-30	9	18
31-40	16	32
41-50	21	42
51-60	4	8
Race/Ethnicity		
Caucasian	42	84
African American	3	6
Asian/P.I.	1	2
Native American	1	2
Latina	2	4
Mexican American	1	2
Current Income		
<$10,000	6	12
10-20k	12	24
21-30k	8	16
31-40k	7	14
>40k	17	34
Education		
High School	9	18
2 years post H.S.	14	28
4 years post H.S.	13	26
Graduate/Professional	14	28
Relationship Status		
Single and dating	5	10
Single and not dating	10	20
Involved with:		
same sex partner	2	4
opposite sex partner	2	4
Living with:		
same sex partner	2	4
opposite sex partner	27	54
Missing Data	2	4
Number of Children		
1	14	28
2	17	34
3+	19	38
Age of eldest daughter		
<10 years old	19	38
11-20	18	36
21-30	9	18
>30	4	8

Table 2

Internal Consistency of Measures

Measure	Cronbach's alpha	(Range of Corrected Item-Total Correlations)
CSA Questionnaire	.88	.37 - .81
Daily Hassles Checklist	.92	.00 - 60
Social Provisions Scale	.90	.00 - .82
Ways of Coping		
Parenting-related stress		
Reappraisal Coping	.73	.06 - .66
Avoidant Coping	.49	.18 - .48
Abuse-related stress		
Reappraisal Coping	.78	.40 - .77
Avoidant Coping	.62	.28 - .45
Resolution Questionnaire	.79	.26 - .58
CES-D	.92	.34 - .77
Family Experiences Questionnaire		
Maternal Confidence	.92	.11 - .82
Maternal Control	.76	.15 - .64
Parental Relatedness Inventory		
Maternal Warmth	.81	.44 - .74

sexual touching of buttocks, thigh, leg, or clothed breasts or genitals"). This measure was adapted for the current study. First, the wording was changed to make it more understandable to the general public (e.g., fellatio, cunnilingus, anilingus was changed to "oral sex"). In addition, the "Yes/No" format was changed to a 4-point Likert type scale (1=1-2 times per year or less, 2=Several times per year, 3=Several times per month, 4=Several times per week) in order to provide a more exact assessment of the woman's experience. Finally, given the ambiguity of "forcible" vs. "non-forcible," this distinction was removed and a 4-point rating of distress was added to gain the women's subjective experience of distress for each abusive event (1=Not very distressing to 4=Very distressing). The final questionnaire contained 11 types of sexual abuse experienced with each perpetrator, frequency of the abuse, and the woman's rating of how distressing it was for her at the time. Additional questions included age at which the abuse started, woman's relationship to each perpetrator, whether the abuse was disclosed and, if so, the reaction to the disclosure. These variables were not included in the final abuse severity score; however, subsequent analyses were conducted to determine the extent to which each were related to outcome variables.

A total abuse score was calculated for subsequent analyses by multiplying the frequency of each item for each perpetrator by its rated level of distress. In addition, types of abuse were weighted according to level of severity. The weighting values for each example of sexual abuse was as follows: sexual kissing (1), the perpetrator fondled the child over her clothes or the perpetrator forced the child fondle him over his clothes (2), the perpetrator fondled the child under her clothes or the perpetrator forced the child

fondle him under his clothes (3), penetration (not intercourse) or oral sex demanded or perpetrated by abuser (4), vaginal intercourse (5), and anal intercourse (6). For example, if a woman had two perpetrators who both fondled her genitals, one on one occasion (frequency rating of 1) and the other perpetrator several times per week (frequency rating of 4), the score for that item would be 3*1*distress rating + 3*4*distress rating. Total item scores were added and the calculated mean was the final abuse score for that subject. The internal consistency score for this sample was .88 (Cronbach's alpha).

Stress. The Daily Hassles Checklist (Kanner et al., 1981) assessed the woman's current experiences of chronic, routine irritations in her day-to-day life (e.g., job stress, having enough money for necessities)(Appendix C). This 117-item questionnaire measures stress with a 3-point Likert-type scale. Participants are first asked to check each item that they have experienced in the past month; they are then instructed to rate the level of stress for each checked item.

Two scores can be tabulated: frequency (a count of all the items checked) and intensity (the mean severity reported for all the items checked). This is a widely-used questionnaire that has established test-retest reliabilities of r =.48 (for adjacent month-to-month ratings of intensity taken over a 9-month period) and r=.79 (for adjacent month-to-month ratings of frequency taken over a 9-month period) (DeLongis et al., 1982). The internal consistency score for the current sample, based on intensity of stress reported by women, was .92 (Cronbach's alpha).

Social support. The 24-item Social Provisions questionnaire (Russell & Cutrona, 1985), based on Weiss' theory of social provisions, assesses the extent to which persons

are receiving functional social support (Appendix D). A 4-point Likert type scale determines the extent to which the item is descriptive of the participant's current relationships (e.g., "There are people I can depend on to help me if I really need it"). For the present study, all 24 items were totaled and the mean score was used in subsequent analyses.

Scores on the SPS have been shown to account for significance variance on a scale of loneliness (Cutrona, 1982), and have been negatively correlated with measures of negative affect across a variety of populations (Cutrona, 1984; Cutrona, Russell, & Rose, 1986; Russell, Altmaier, & Van Velzen, 1985). The internal consistency score for the entire social support measure with the current sample was .90 (Cronbach's alpha).

Coping. The Ways of Coping Checklist (Folkman & Lazarus, 1980) is a 67-item measure that assesses the extent to which the individual uses specific strategies in order to cope with stressful events (Appendix E). The entire measure contains 8 scales, 2 of which were used in the present study: escape/avoidance (6 items; e.g., "I refused to believe it had happened) and positive reappraisal (6 items; e.g., "I came out of the experience better than when I went in"). These particular scales were chosen for theoretical relevance and relatively strong internal consistency scores within the current population. Participants were first asked to describe a recent problem they encountered and then to rate on a 4-point Likert type scale the extent to which they engaged in each of the coping strategies. Prior research has found reliability alphas for each scale that range from .61 to .79 (Dunkel-Schetter, Folkman, & Lazarus, 1987).

For the current study, participants completed this questionnaire twice; first, in

regard to a parenting problem, and again in regard to a problem related to their abuse. For this sample, internal consistency reliabilities for the positive reappraisal and avoidance coping scales with regard to a parenting problem identified by participants were .73 and .49, respectively (Cronbach's alphas). Alpha coefficients for reappraisal and avoidance scales with regard to an abuse related problem were .78 and .62, respectively.

Lack of resolution of abuse. The Resolution Questionnaire is a 12-item measure developed for this study to assess the extent to which women believe they have resolved their relationships with their perpetrators as well as their non-abusive parents (Appendix F). Items assess the extent to which the participant has reconciled with each parent (e.g., "To what extent have you forgiven your abuser?") as well as the extent to which she continues to feel bound by her memories and feelings associated with the abuse (e.g., "To what extent do you feel that much of your energy is tied up in working through your feelings related to the abuse?").

Items are rated on a 4-point Likert type scale. The internal consistency score for this population was .79 (Cronbach's alpha). High scores on this measure correspond to lack of resolution regarding abuse issues.

Maternal depression. The Center for Epidemiological Studies Depression Scale (CES-D) is a 20-item measure that draws from several widely utilized measures of depression including the Beck Depression Scale (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the Minnesota Multiphasic Personality Inventory (Dohlstrom & Welsh, 1960), the Zung Depression Scale (Zung, 1965), the Raskin Self-Reported Depression Scale (Raskin, Chulterbrandt, Reating, & McKeon, 1970), and the Gardner Symptom

Checklist (Gardner, 1968)(Appendix G). This scale assesses the major characteristics associated with depressive symptomatology including feelings of guilt and worthlessness, depressive mood, sleep disturbance, feelings of helplessness and hopelessness, eating disturbance, and psychomotor retardation that the woman has experienced over the past week (e.g., "I felt tearful," "I felt I was just as good as other people").

The CES-D, initially developed to assess depression within a community sample, has high internal consistency (Radloff, 1977) and test-retest reliability. It's also significantly associated with other standardized depression scales (Weissman & Locke, 1975; Weissman et al., 1977). The internal consistency score for the current sample was .92 (Cronbach's alpha).

Measures of parenting. To eliminate the potentially confounding effects of gender and birth-order, women were asked questions about how they parented their eldest daughter. Three areas of parenting were assessed: Parenting Confidence, Maternal Control, and Maternal Warmth. For those cases in which daughters no longer lived at home (approximately 10 cases), women were asked to respond retrospectively.

Maternal confidence and control. The Family Experiences Questionnaire (Frank, Hole, Jacobson, Justkowski, & Huyck, 1986) is a 56-item questionnaire that assesses various aspects of the spousal and parenting relationships (Appendix H). This questionnaire uses a 4-point Likert type scale and has demonstrated both reliability and validity within a number of populations (Frank et al., 1991; Floyd & Zmich, 1992).

Two subscales of this questionnaire were used in this study. The maternal confidence scale contains 15 items that assess the respondent's ability as a parent (e.g., "I

know that I am doing a good job as a parent"). The maternal control scale contains 11 items, which assess respondent's need to protect her child from external influences as well as control her child's behavior (e.g., "I am overly protective of my children").

Alphas for these scales range from .80 to .94 (Cole, Woolger, Power & Smith, 1992; Frank, Hole, Jacobson, & Huyck, 1986). Internal consistencies for the parental confidence and parental control scales in the present sample were .92 and .76, respectively (Cronbach's alphas).

Maternal warmth. An adapted form of the Parental Relationship Inventory's relatedness scale (Stutman & Lich, 1984) was used to assess the extent to which participants experience their relationship with their child as warm and enjoyable (Appendix I). The maternal warmth scale contains 10 items which are rated on a 4-point, Likert type scale. These items were originally designed for completion by the child; however, given the lack of an adequate measure of parental warmth, this scale was chosen as an appropriate, face valid tool and adapted such that the items now apply to maternal perceptions of relatedness (e.g., "It is fun to be with my daughter," "I feel very warmly towards my daughter"). Internal consistency reliability for the present sample was .81 (Cronbach's alpha).

Procedures

Recruitment took place in two sites, central Michigan and northern California. Participants were made aware of this study through advertisements in local newspapers and parenting magazines and flyers posted in public areas such as community centers, laundromats, stores, and libraries. Facilitators of sexual abuse survivor support groups

and private therapists specializing in work with survivors were also contacted and flyers were provided to place in their waiting rooms.

Study flyers and advertisements contained a brief description of the "Women's Research Project", initial criteria for participation and a phone number to call for more information. Criteria included on the flyer was as follows: 1) being a woman who is a survivor of childhood sexual abuse and 2) having a daughter (see Appendix J). When a woman called the project number on the flyer, the principal investigator provided any additional information requested by the woman and also conducted a brief follow-up screening to determine final eligibility for the study. Specifically, women were asked whether they had clear memories of the abuse and their relation to the abuser. Only women who had clear memories of the abuse and whose abusers were male were allowed to participate in the study. Women who were survivors but did not meet participation criteria were offered information about resources in their community for survivors of sexual abuse.

Approximately 80% of participants heard about the Women's Research Project through advertisements or flyers. The remainder of participants were made aware of the study through survivor support resources and by word-of-mouth from other women who had been interviewed. Approximately 60 women and one man called the number provided on the flyer or ad. The man who called indicated that he had been sexually abused by his mother and was referred to local resources for survivors after the criteria of this study were explained. For the remaining women, reasons for not qualifying for participation included: not having a daughter, not having a clear memory of who the

perpetrator was, indicating that the primary perpetrator was female, and having a daughter who was sexually abused (although the caller had not been). A few women also called seeking more information regarding the study for friends or family members.

Interviews were conducted in a one-on-one format with either the principal investigator or a trained research assistant. All of the interviews conducted in California (N=15) were completed by the principal investigator.

At the Michigan site, three undergraduate research assistants enrolled in an independent study with the principal investigator for approximately one year. All assistants attended weekly 2-hour meetings to discuss theoretical and practical issues related to the study. Each student participated in at least 4 months (approximately 50 hours) of training directly related to conducting project interviews. Training proceeded along the following schedule: 1) reading, discussion of articles related to the area of sexual abuse and its effects on women with the goal of raising consciousness, 2) training in the area of interview skills, including the acquisition of active/empathic listening skills, role plays utilizing these skills in general situations and then in situations involving sexual abuse, 3) completion of mock interviews with other assistants, which were taped and reviewed by the principal investigator and 4) training in the administration of the questionnaires.

In addition, interviewers discussed and role-played what to do if a woman were to become upset during the interview. For example, if a woman became obviously distressed while discussing her experience of abuse, the interviewer was instructed to acknowledge this empathically and offer her the opportunity to take a break or even stop

for the day. In addition, women were informed at the onset of the interview that, if they became too uncomfortable, they had the right to stop at any point during the process. One woman asked to complete the interview in two sessions and, following the first meeting, indicated that she would rather not complete the second session because she anticipated that the material covered, which dealt primarily with details about the sexual abuse, would be too difficult to discuss.

Although many women reported that portions of the interview had been emotionally difficult for them to complete, all women reported that they felt the process had been respectful and supportive. In addition, many women indicated that they felt empowered by talking about their experiences and knowing that they were contributing to a larger fund of knowledge about sexual abuse.

Following the telephone screening procedure, if a woman met criteria for participation and was interested in completing an interview, she was informed that the interview would last approximately 2 hours and could be conducted over 1 or 2 meetings. She was also provided with a brief overview of the types of questions she would be asked and the rationale for the study. Participants were provided with the choice of whether to complete the interview in their homes, in a public place, or in the project office. Approximately 80% of participants opted to complete the interview in their homes.

At the beginning of the interview, participants were asked to review and sign an informed consent (Appendix K). In order to establish and maintain rapport, as well as to decrease the risk of missing data, the majority of questionnaires were read to women by the interviewers. Participants were provided with index cards for each questionnaire that

indicated response choices based on Likert-type scales (e.g., 1=strongly agree, 2=agree, 3=disagree, 4=strongly disagree). Questionnaires assessing depression and participants' perceptions of their relationships with their daughters were given directly to the women and they were asked to complete them independently. With the exception of the demographic questions and the questions specifically regarding the sexual abuse, which were administered first and last, respectively, questionnaire order was counterbalanced to avoid bias created by ordering effects.

Following the interview, participants were encouraged to contact the project office if they had concerns or questions following the interview. Approximately 10-15% of the women who participated did contact the principal investigator following the interview, mostly to seek information regarding referrals for survivor resources.

CHAPTER III

RESULTS

Descriptive Analyses

Tables 3-5 summarize various aspects of the abuse reported by subjects. Slightly over half of the women reported more than one perpetrator. All women were able to identify a primary perpetrator, the person whom they indicated to be the perpetrator of the majority of the abuse. The most common forms of sexual abuse from the primary perpetrator included sexual kissing, being forced to fondle the perpetrator's unclothed genitals and clothed/unclothed breast fondling by the perpetrator. Women reported that their primary perpetrator was most frequently their biological father (54%). Step-fathers, grandfathers, uncles and brothers (at least 5 years older than the participant) were also reported to be primary perpetrators.

The average Abuse severity score was 21.21 (SD=23.06; range=1.45 to 141.09), suggesting a wide range in abuse experiences as assessed by a combination of sexual abuse frequency, number of perpetrators, and retrospective report of distress. Lack of Resolution scores ranged from 1.17 to 3.58 with a mean score of 2.38 (SD=.61). This suggests that generally women in this study perceived themselves to be generally satisfied with the nature and level of social support available to them; however, the range in scores also indicates that some women perceived themselves to have little support, while others were extremely satisfied by their current level of support. Overall Stress scores ranged from .11 to 1.35 with a mean score of .66 (SD= .28). The mean Depression score for the sample was 2.18 (SD=.41) with a range of 1.50 to 3.05. These findings suggest that

Table 3

Number of Perpetrators Reported by Women

# of Perpetrators	N	% of sample
1	23	46%
2	13	26%
3	6	12%
4	5	10%
5	3	6%

Table 4

Number of Women Reporting Abuse Types (Primary Perpetrator)

Abuse Type	N	%
1. Sexual Kissing	36	72%
2. Breast contact (clothed)	31	62%
3. Breast contact (unclothed)	30	60%
4. Genitals fondled by perpetrator (clothed)	31	62%
5. Perpetrator forced you to fondle his genitals (clothed)	20	40%
6. Perpetrator forced you to fondle his genitals (unclothed)	41	82%
7. Genitals fondled by perpetrator (unclothed)	23	46%
8. Perpetrator performed oral sex	28	36%
9. Perpetrator forced you to perform oral sex	17	34%
10. Vaginal Intercourse	22	44%
11. Anal Intercourse	4	8%

Table 5

Relationship of Woman to Primary Perpetrator

Perpetrator	N	% of sample
Biological Father	27	54%
Step-father	5	10%
Maternal Grandfather	3	6%
Paternal Grandfather	1	2%
Maternal Uncle	3	5%
Paternal Uncle	2	4%
Brother (at least 5 years older)	5	10%
Other	4	8%

while this population reported a range in their self-reported severity levels of depressive symptomatology, the range of responses regarding severity of daily stress was somewhat more restricted. Regarding coping strategies, mean scores for Parental/Abuse Avoidant and Parental/Abuse Reappraisal Coping ranged from .89 to 1.26, with scale scores ranging from 0 to 3.00. Finally, regarding parenting outcome variables, the mean score for Maternal Warmth was 3.39 (SD=.58) and scale scores ranged from 1.80 to 4.0. This suggests that, generally, women in this study reported that they perceived their relationships with their daughters to be nurturing, respectful and supportive. The mean score for Maternal Control was 2.17 (SD=.46) and the range in scale scores was 1.45 to 3.36, which suggests slightly more variability in responses regarding issues of protectiveness and control in comparison to those associated with warmth. Similarly, the mean score for Maternal Confidence was 2.76 (SD=.62) and scale scores ranged from 1.47 to 3.87, suggesting variability in the level of self-reported confidence in parenting abilities endorsed by women in this study.

Intercorrelations of Study Variables

Table 6 contains intercorrelations between all variables in this study. Notably, level of Abuse is significantly correlated with a Lack of Resolution regarding the abuse ($r=.37$, $p \leq .05$) and level of Maternal Control ($r=.28$, $p \leq .05$). In addition, although level of Abuse is not significantly correlated with Stress, Depression, Maternal Warmth or Maternal Confidence, Lack of Resolution is significantly related to all of these variables. Specifically, Lack of Resolution is positively correlated with Stress ($r=.45$, $p \leq .01$), Depression ($r=.41$, $p \leq .01$) and negatively correlated with levels of Maternal Warmth

Table 6

Intercorrelations of Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.
1. Abuse	1.00										
2. Stress	.24										
3. Depression	.16	.49c									
4. Support	.04	-.37b	-.56c								
5. Lack of Res.	.37a	.45b	.41b	-.27t							
6. A. Avoid	.08	.11	.11	-.10	.30a						
7. A. Reapp.	-.04	-.25t	-.22	.29	-.04	.10					
8. P. Avoid	.18	.05	.21	-.17	.26	.27t	.16				
9. P. Reapp.	.12	-.22	-.15	.26t	-.06	-.04	.47c	.02			
10. Confidence	.03	-.29c	-.27a	.43	-.30a	-.14	.17	-.25	.47c		
11. Warmth	-.17	-.21	-.09	.17	-.31a	-.06	.17	-.11	.29a	.63c	
12. Control	.28a	.01	-.05	-.01	.15	-.14	-.23	.12	-.25	-.32a	-.36c

Note. A.=Abuse; P.=Parent; Reapp.=Reappraisal; Res.=Resolution
a= $p \leq .05$, b= $p \leq .01$, c= $p \leq .001$

(r=-.31, $p \leq .05$) and Maternal Confidence (r=-.30, $p \leq .05$).

In addition, Stress was positively correlated with level of Depression (r=.49, $p \leq .001$) and negatively correlated with Social Support (r=-.37, $p \leq .01$) and Maternal Confidence (r=-.29, $p \leq .05$). Depression was negatively correlated with level of Social Support (r=-.56, $p \leq .001$) and Maternal Confidence (r=-.27, $p \leq .05$).

With regard to coping style, Parental Reappraisal Coping was positively correlated with Maternal Confidence (r=.47, $p \leq .001$) and Maternal Warmth (r=.29, $p \leq .05$). Parental Reappraisal Coping was also positively correlated with Abuse Reappraisal Coping (r=.47, $p \leq .001$). Parental Avoidant Coping was slightly correlated with Abuse Avoidant Coping (r=.27, $p \leq .07$).

Effects of Abuse-Related and Demographic Variables

A series of analyses were conducted to determine the presence of any significant effects of abuse and demographic variables that were not included in the hypotheses but were considered potentially relevant.

Parenting outcome variables were regressed onto subject's income, current age, age at which the abuse began, and age of daughter. None of these variables contributed significantly to the variance in parenting outcome scores (R^2= .16, F=2.11, p=.10). Results of analysis of variance indicated that subject education level and race are not significantly associated with parenting outcomes (F (3,40)= .23, 1.43, and .34 for Maternal Warmth, Control and Confidence, respectively for education level; F (5,44)=1.00, .36, and 1.54 for Maternal Warmth, Control and Confidence, respectively for race). Similarly, the relationship of the perpetrator to the woman was not significantly

associated with any parenting outcomes (F (6,39)= 1.49, .35, and .38 for Maternal Warmth, Control and Confidence, respectively). Neither disclosure of abuse during childhood (F (1,47)=1.62, .00, and 1.53 for Maternal Warmth, Control, and Confidence, respectively) nor reaction to disclosure (F (3,11)=.40, .29, and .72 for Maternal Warmth, Control and Confidence, respectively) were related to parenting outcomes.

Testing the Research Hypotheses

Given the number of analyses required to test for the buffering and mediational effects of social support and coping, respectively, and the overall N, only findings that are significant at $p \leq .05$ were interpreted.

Hypothesis 1: Testing the Stress-Buffering Hypothesis with a CSA Population

The first empirical question posed by this study was whether the stress-buffering hypothesis would hold up with this population. Regression analysis was conducted. Predicting Depression, the Main Effects for Stress and Social Support were entered in the first block using the Enter command. The interaction between Stress and Social Support were entered in the second block. Women's reported level of Stress and current Social Support significantly contributed to their self-reported levels of Depression (R^2=.40, F=15.81, $p \leq .001$). High levels of stress positively predicted Depression. Social Support was negatively associated with Depression. In addition, the interaction between Stress and Social Support was significant at the $p \leq .05$ level; therefore, although notable, this finding will not be interpreted. See Table 7(a) for a summary of these results.

Hypothesis 2: Sexual Abuse as Stressor

It was next hypothesized that Abuse would function as a chronic stressor in

women's lives, the effects of which would be buffered by Social Support in a manner similar to the initial hypothesis. In a regression analysis, the Main Effects of Abuse and Social Support were entered together in the first block predicting Depression. The interaction between Social Support and Abuse was entered in the second block. Table 7 (b) summarizes these results. Social Support negatively predicted Depression. The Main Effect for Abuse was not significant. The interaction between Social Support and Abuse was not significant and did not significantly add to the variance in Depression scores (R^2 change=.02, F=8.53).

Hypothesis 3: The Effects of Abuse on Parenting Outcomes

A series of linear regression analyses were conducted to determine the relative effects of Abuse and Social Support on parenting outcome variables. Analyses focused on three specific parenting variables including self-reported levels of parenting confidence (Maternal Confidence), levels of interpersonal warmth (Maternal Warmth) and controlling parenting behaviors (Maternal Control) within the mother-daughter relationship. Table 8 provides an overview of these results.

Similar to previous analyses, Abuse and Social Support were entered in the first block to predict Parenting Confidence. Depression, which is correlated with Maternal Confidence (Pearson r=-.27, p=.06), was entered first to control for its effects. Depression, Abuse and Social Support accounted for 19% of the variance in Maternal Confidence (F=3.54, $p \leq .05$). The Main effect of Social Support emerged as the strongest positive predictor of Maternal Confidence (Beta=.41, T=2.51, $p \leq .05$). The interaction between Abuse and Social Support, which was entered in the second step, was

Table 7

Social Support as a Buffer of Stress and Abuse Predicting Depression

(a)	R^2	R^2Ch.	F	Beta	T
Stress	.40		15.81[c]	.32	2.68[b]
Social Support				-.44	3.61[c]
Stress X Social Support	.44	.04	12.27[c]	.22	1.87
(b)					
Abuse	.34		12.01[c]	.19	1.58
Social Support				-.56	-4.70[c]
Abuse X Social Support	.36	.02	8.53[c]	.16	1.17

Note. a= $p \leq .05$, b= $p \leq .01$, c= $p < .001$

Table 8

Social Support as a Buffer of Abuse Predicting Parenting Outcomes

			Maternal Confidence		
	R^2	R^2Ch.	F	Beta	T
Abuse	.19		3.54[a]	.02	1.06
Social Support				.41	2.51[a]
Abuse X Social Support	.22	.03	3.15[a]	.21	1.34
			Maternal Warmth		
Abuse	.06		1.46	-.18	-1.24
Social Support				.18	1.22
Abuse X Social Support	.11	.05	1.82	.26	1.57
			Maternal Control		
Abuse	.08		2.05	.28	2.02[a]
Social Support				-.02	- .02
Abuse X Social Support	.08	.00	1.37	.05	.30

Note. a= $p \leq .05$

not a significant predictor of confidence.

The second parenting outcome variable which was examined was the degree of interpersonal warmth within the mother-daughter relationship as reported by mothers. Since Depression was not correlated with Maternal Warmth, it was not added into the equation. Abuse and Social Support were entered in the first block of the regression analysis, predicting level of Maternal Warmth. Neither variable significantly contributed to the variance in Maternal Warmth (R^2=.06, F=1.46, p=.24), nor was the interaction between Abuse and Social Support, which was entered in the second block, (R^2 change=.05, F=1.82, p=.16) significant.

The final parenting variable which was examined was the level of self-reported Maternal Control which is exhibited within the mother-daughter relationship. When entered together in the first block, Social Support and Abuse did not significantly contribute to the variance in Maternal Control (R^2=.08, F=2.05, p=.14). However, the T-score for Abuse was significant in predicting Maternal Control (Beta=.28, T=2.02, $p \leq .05$). The interaction between Abuse and Social Support, entered in the second block of the regression analysis, was not a significant predictor of Maternal Control (R^2 change=.00, F=1.37, p=.26).

<u>The Mediational Roles of Coping and Lack of Resolution</u>

The role of coping in mediating the effects of sexual abuse was examined next. According to Baron and Kenny (1986), three regression equations are used to test for mediation: 1) regressing the mediator on the independent variable, 2) regressing the dependent variable on the independent variable, and 3) regressing the dependent variable

on both the independent variable and the mediator. To prove that a variable is functioning as a mediator, the following three conditions must be met: 1) The independent variable must affect the mediator, 2) the independent variable must affect the dependent variable, and 3) the mediator must affect the dependent variable in the last equation. In addition, the effect of the independent variable in the last equation must be larger than the effect in the second equation.

Following Baron & Kenny's (1986) guidelines for testing mediational hypotheses, a series of regression analyses were conducted. First, proposed mediators (coping variables and Lack of Resolution) were regressed onto the independent variable (Abuse). Outcome variables were then regressed onto the independent variable (Abuse). In the final analyses, the outcome variables were regressed onto both the IV and mediators. If results are significant in the first two analyses and the effects of the independent variable decrease in from the second to the final analysis, a mediational effect was considered to be proven.

Hypothesis 4: Mediators Related to Maternal Depression

In the first set of analyses predicting the women's self-reported levels of Depression, two types of coping were included: Abuse Avoidant Coping and Abuse Reappraisal Coping. Another regression analysis tested Lack of Resolution mediated the association between Abuse and Depression. Figure 5 summarizes the results of the regression analyses.

Results of these analyses indicated that none of the proposed variables (Abuse Avoidance Coping, Abuse Reappraisal Coping, Lack of Resolution) mediated the

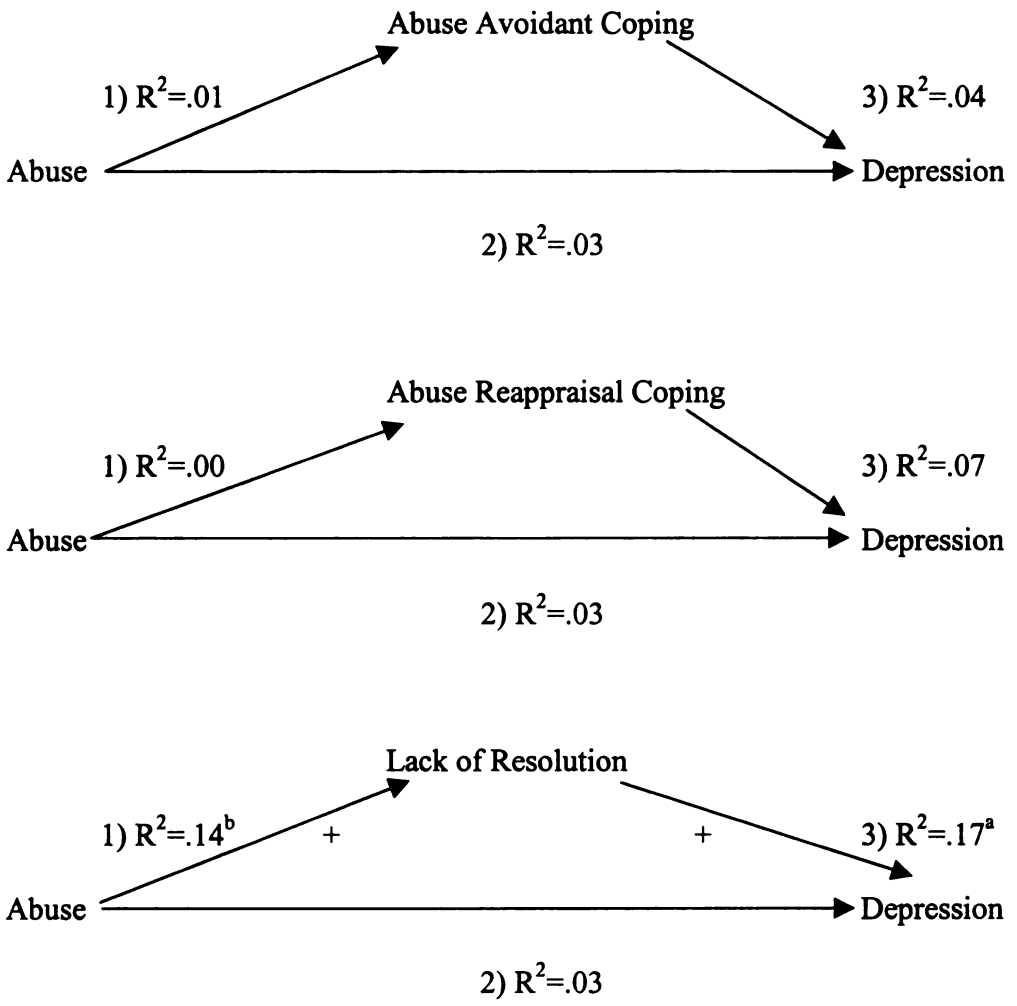

Figure 5

Coping and Lack of Resolution as Mediators of the Effects of Abuse on Level of Depression

Note. Pathway 1= Mediator regressed onto IV
2= DV regressed onto IV
3= DV regressed onto IV and mediator
a= $p \leq .05$; b= $p \leq .01$

association between sexual abuse and depression. Abuse did not predict Abuse Avoidant Coping and neither Abuse nor Abuse Avoidance Coping predicted Depression. Similarly, Abuse did not predict Abuse Reappraisal Coping and neither Abuse nor Abuse Reappraisal Coping predicted Depression. In the final set of analyses, Abuse did account for a significant amount of variance in Lack of Resolution scores (R^2=.14, F=7.27, $p \leq$ .01). In addition, Lack of Resolution positively predicted depression (Beta=.40, T=2.74, $p \leq .01$).

Hypothesis 5: Mediators Related to Parenting Outcomes

The second set of analyses focused on the mediational effects of coping variables and Lack of Resolution on the association between Abuse and parenting outcomes. Coping related to both parenting and abuse-related issues were included to determine whether one type of coping was more relevant to parenting outcomes than the others.

Figure 6 summarizes the results for Parenting Confidence. Neither Abuse Avoidant Coping nor Abuse Reappraisal Coping related to abuse stressors mediated the association between Abuse and Parenting Confidence. Similarly, Parental Avoidant Coping and Parental Reappraisal Coping did not mediate the relationship between Abuse and Parenting Confidence. However Parental Reappraisal Coping directly predicted Parenting Confidence (R^2=.23, F=6.84, $p \leq .01$, Beta=.48, T=3.69, $p \leq .001$). Abuse predicted Lack of Resolution (R^2=.14, $p \leq .01$, Beta=.37, T=2.70, $p \leq .01$). In addition, Lack of Resolution was associated with Maternal Confidence (R^2=.12, F=3.00, p=.06, Beta=-.37, T=-2.43, $p \leq .05$), but at the $p \geq .05$ level. Since there was no direct

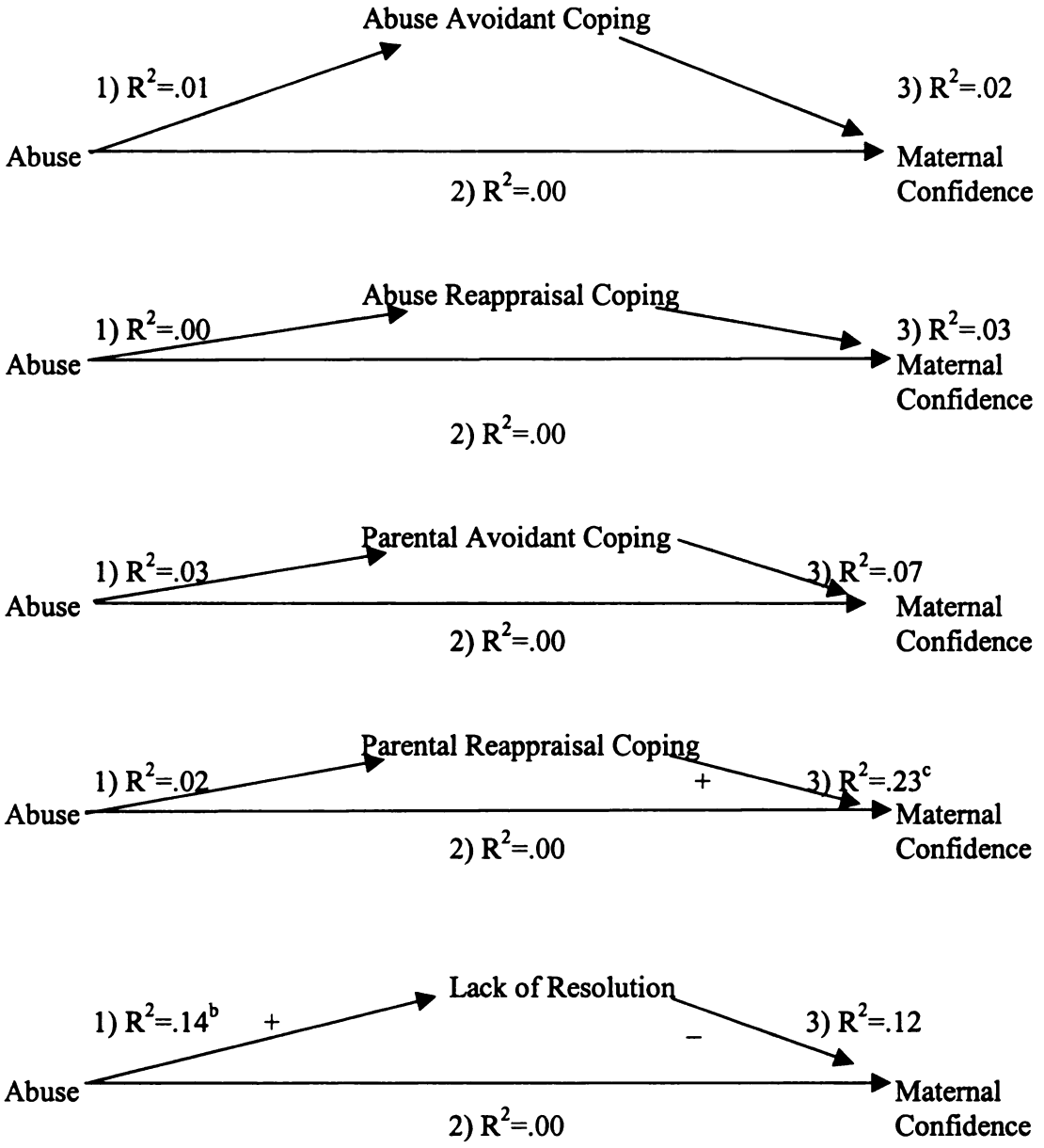

Figure 6

Coping and Lack of Resolution as Mediators of the Effects of Abuse on Maternal Confidence

Note. Pathway 1= Mediator regressed onto IV
2= DV regressed onto IV
3= DV regressed onto IV and mediator
a= $p \leq .05$; b= $p \leq .01$; c= $p \leq .001$

relationship between Abuse and Parenting Confidence, no mediational effect emerged.

Similarly, no mediational effects for any of the coping variables or Lack of Resolution were found predicting either Maternal Warmth or Maternal Control from Abuse. See Figures 7 and 8 for a summary of the regression analyses for Warmth and Control, respectively. However, Parental Reappraisal Coping directly predicted Maternal Warmth ($\underline{R}^2$=.13, F=3.47, $\underline{p} \leq .05$, Beta .32, T=2.32, $\underline{p} \leq .05$). In addition, Abuse directly predicted Maternal Control ($\underline{R}^2$=.08, F=4.23, $\underline{p} \leq .05$, Beta=.28, T=2.06, $\underline{p} \leq .05$) and Lack of Resolution ($\underline{R2}$=.14, F=7.27, $\underline{p} \leq .01$, Beta=.37, T=2.70, $\underline{p} \leq .01$). Finally, Parental Reappraisal Coping negatively predicted Maternal Control ($\underline{R}^2$=.16, F=4.58, $\underline{p} \leq .05$, Beta=-.29, T=-.215, $\underline{p} \leq .05$).

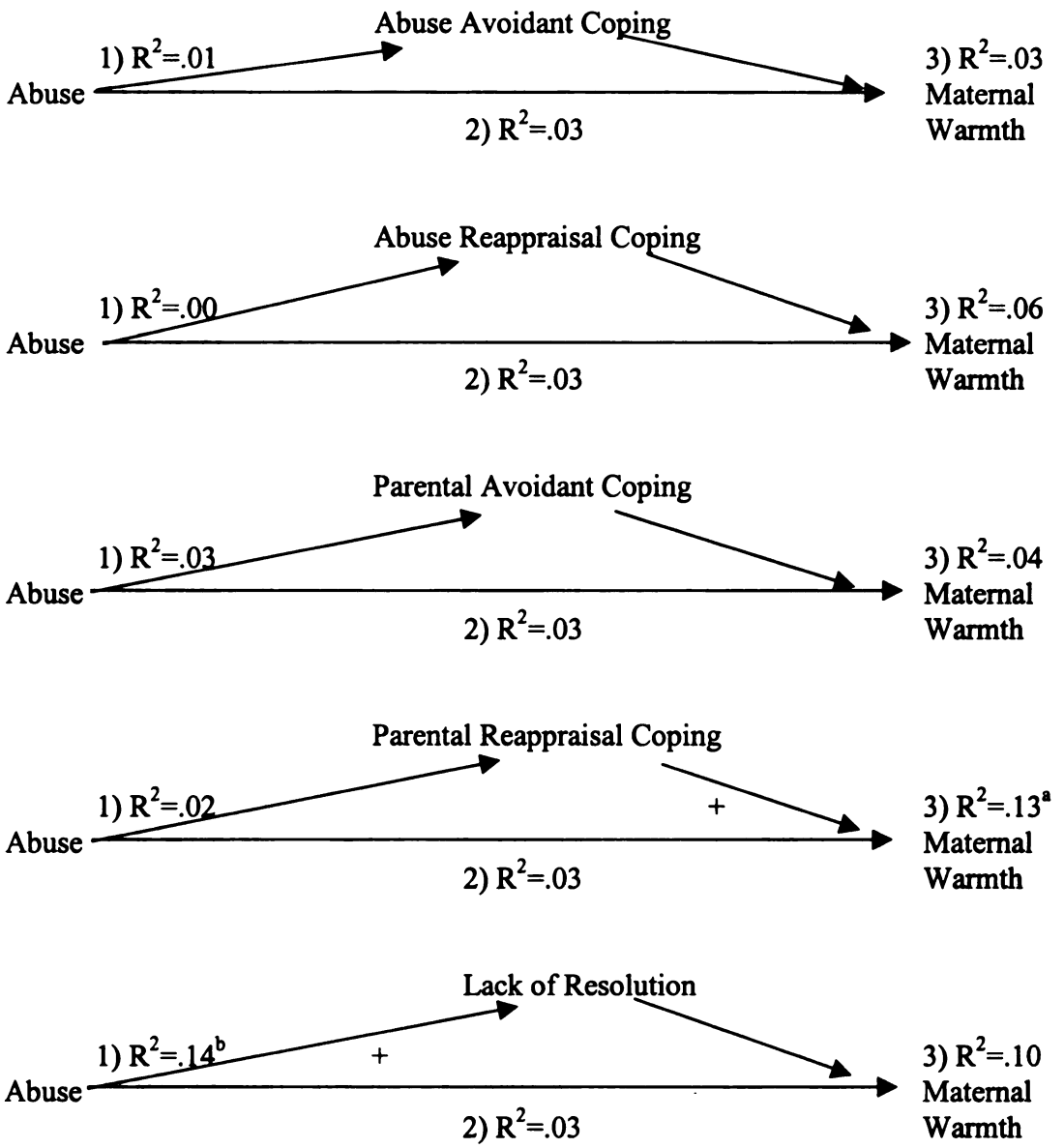

FIGURE 7

Coping and Lack of Resolution as Mediators of the Effects of Abuse on Maternal Warmth

Note. Pathway 1= Mediator regressed onto IV
2= DV regressed onto IV
3= DV regressed onto IV and mediator
a= $p \leq .05$; b= $p \leq .01$

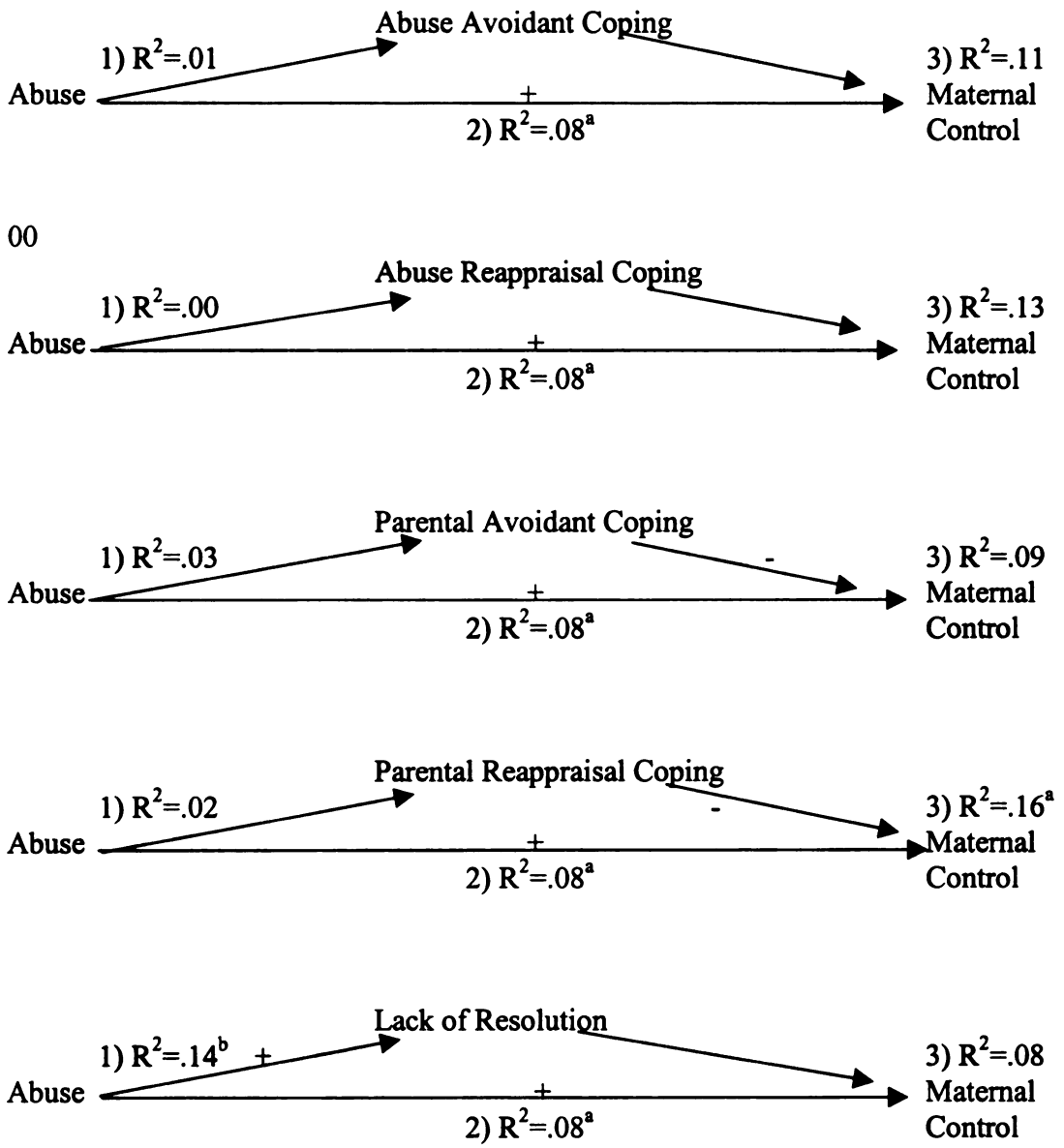

Figure 8

Coping and Lack of Resolution as Mediators of the Effects of Abuse on Maternal Control

Note. Pathway 1= Mediator regressed onto IV
2= DV regressed onto IV
3= DV regressed onto IV and mediator
a= $p \leq .05$; b= $p \leq .01$

CHAPTER IV

DISCUSSION

The primary goal of this study was to explore the impact of social support and coping on the associations between sexual abuse and various outcome variables. In addition, this study sought to depart from a purely deficit-focused approach by including psychological well-being as well as parenting outcomes in analyses. Until recently, the effects of childhood sexual abuse have been studied largely outside the framework of theoretical models that include potential moderating and mediating variables. This study used two bodies of related work as a theoretical basis: (1) the stress-buffering effects of social support and (2) Spiccarelli's (1994) recently proposed model, which conceptualizes abuse as a stressor that is mediated by coping style and cognitive appraisal, which, in turn, predicts psychological symptomatology. Support and individual factors are also predicted to affect coping in Spiccarelli's model. In addition, Spiccarelli's model assumes that the effects are being assessed near the time of abuse.

The current study departed from both the typical stress-buffering studies and Spiccarelli's work in two major ways. First, in comparison to Spiccarelli's work, the data in this study were retrospective. A second and more compelling difference is that the outcome variables in this study included psychological well-being as well as parenting. The majority of prior research has tended to focus on variables associated with clinical pathology (e.g., sexual dysfunction, post traumatic stress symptomatology) rather than focusing on non-clinical life events.

Results of this study indicated that social support did not act as a stress buffer. However, social support was negatively associated with depression. This is consistent with prior research demonstrating the ameliorative effects of social support on psychological well-being (Andrews, Tennant, Hewson, & Vaillant, 1978; Bell, LeRoy, & Stephenson, 1982; Lin, Simeone, Ensel, & Kuo, 19791 Miller & Ingham, 1976; Paykel et al., 1980; Surtees, 1980; Valentine, Holahand, & Moos, 1994).

In addition, although significant at only the $p \geq .05$ level, and therefore not interpreted according to the criteria of the current study, it is notable that social support interacted with stress level. Interestingly, post-hoc analysis revealed that social support interacted most strongly at lower levels of stress to predict less depression. This finding is in the opposite direction of what most have come to expect when testing the stress-buffering hypothesis. That is, the moderating effects of social support are commonly found at high levels of stress rather than low levels. However, at least one researcher (Cutrona, 1984) has found that social support signifcantly attenuates the effects of stress at lower levels but has no impact as level of stress rises. In Cutrona's study, the outcome variables were also related to parenting, which may suggest that social support may be relevant and impactful up to a point when looking at parenting outcomes; however, beyond a certain level of stress, social support loses its potency when it comes to affecting aspects of parenting.

This finding departs from Cohen & Wills' (1985) position that when measures of functional support are used (as in the present study), buffering effects are more likely to emerge. The lack of stress-buffering effects in the current study may reflect the

differences in the populations studied. Vaux (1985) highlighted the importance of considering the variance across subgroups when testing for direct versus stress-buffering effects of social support. The population of this study was comprised of survivors of sexual abuse, reflecting a very specific experience. The arguably unique character of this experience may be associated with differences in the way social support fits into this association from other groups in which the buffering hypothesis is supported. Future research that compares the role of social support in the lives of sexual abuse survivors with similar, non-abused population would help to clarify this issue.

It was next hypothesized that when sexual abuse was substituted for a global measure of stress, social support would not buffer the effects of abuse; rather, sexual abuse and social support would have direct effects on the outcome variables, depression and parenting. This hypothesis was consistent with Cohen & McKay's (1984) call for more specific measures of stress to help illuminate the effects of social support. Specifically, it was hypothesized that social support would be associated with lower levels of depression, greater maternal confidence and warmth, and less maternal control. Similarly, it was predicted that severity of sexual abuse would be positively related to depression and maternal control, and negatively related to maternal confidence and warmth.

Results indicated that social support did not buffer or moderate the effects of sexual abuse on level of depression or parenting outcomes. However, as noted in the first set of analyses, social support was directly associated with lower levels of depression. In the current study, the measure of functional social support that was used is characterized

by the woman's perceptions that she belongs to a group with similar concerns, beliefs, and interests and that she is part of a network from whom she is able to access emotional and practical support. Given that depression is clinically hallmarked by feelings of hopelessness and worthlessness, the presence of this type of support is likely functioning to diminish feelings associated with isolation and disconnection. Addressing the issue of disconnection may be of particular importance for survivors of sexual abuse. As Herman (1992, p.51) notes, "Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community." The heightened level of "otherness" and isolation that is experienced by the survivor of sexual abuse may make social support, which engenders a sense of belonging, particularly relevant.

Social support was also significantly related to higher levels of self-reported maternal confidence. Supporting prior research (Barrett, 1978; Pascoe, Loda, Jeffries, & Earp, 1981; Tetzloff & Barrera, 1987), social support likely protects against the feelings of isolation and resultant self-doubt as well as providing relevant, practical support. Notably, the measure of support used in this study did not specifically address the presence of parenting support per se, but rather the woman's perception that she had access to a network with similar concerns and interests and that she felt valued and supported by this network. It can be hypothesized that, for a survivor and mother, this support would include parent-specific aspects.

Interestingly, social support was not directly related to either maternal warmth or maternal control. There is some evidence that social support is associated with decreased

likelihood of child maltreatment (Egeland, Brietenbacher, & Rosenberg, 1980); therefore, one might have expected that mothers in this study who perceived themselves as having less social support may also report more problematic relationships with their daughters (e.g., excessive control, lack of warmth). However, prior research in this area has often focused on adolescent mothers with young children. In the current study, the ages of mothers and daughters varied. It is possible that the role of social support varies according to the developmental stage (and associated needs) of mothers and daughters. In addition, the type of support provided likely contributes to the identified associations with particular outcomes.

Regarding the lack of findings associating support with maternal control, it is also important to consider that control, per se, may not always be associated with "abusive" behavior or negative parent-child dynamics. In the current study, maternal control was operationalized in terms of the mother's attempts to protect her child (particularly from negative events) through attempts to impact her daughter's behavior and environment. While excessive levels of control may be associated with negative child outcomes, particularly at specific developmental stages, maternal control may also reflect a level of protectiveness that is both understandable and potentially helpful for the child.

Directly related to this point is the finding that severity of childhood sexual abuse was associated with higher levels of self-reported maternal control. This finding may reflect an association between level of violation accompanying more severe abuse and women's subsequent need to more carefully evaluate and guard against potentially unsafe interpersonal or social situations, particularly to the extent these situations affect her

child. As Herman (1992) points out, the survivor's basic assumptions regarding the safety of the world are dismantled following the trauma. In this case, women who experienced more severe abuse may understandably be less able to believe in a safe or just world.

This finding also provides another, less deficit-focused, way in which to understand the sexual abuse survivor's role as protector of her own children. Within the context of the intergenerational transmission of abuse hypothesis, it has been well documented that a history of abuse is a risk factor for abusing one's own children (Altemeier et al., 1984; Kaufman & Zigler, 1987; Kempe, 1973). This body of research has focused primarily on the transmission of physical abuse. Similarly, a history of maternal sexual abuse has been suggested to be a potential risk factor that may increase her child's vulnerability to sexual abuse (Koch & Jarvis, 1987). However, it is important to note the qualitative differences between these two proposed pathways. While the transmission of emotional an physical abuse is often direct, the pathway that sexual abuse travels is notably more complex. For example, it has been suggested that a woman may be unable to adequately attend to her child's safety due to her own preoccupation and/or unconscious denial of her own abuse. Subsequently, she may have difficulty acknowledging that her own child is being abused, often by a significant male in the woman's life.

While it is beyond the scope of this study to determine whether this increased vulnerability exists, the results do suggest that some women who are survivors of abuse may actually be more attentive and protective of their own children, rather than victims of their own experiences who are presumably blind to the needs and vulnerabilities of their

own children. Notably, this "overprotectiveness" is often cast within a pathological light and assumed to result in negative adjustment for the child (Koch & Jarvis, 1987). As noted previously, it is likely that high levels of maternal control may prove to be a hindrance inasmuch as it impedes age appropriate movements towards more autonomous behavior, which by necessity requires the parent to allow her child to take certain risks as she moves toward adulthood. However, an attempt to protect one's child from negative experiences, particularly for the parent with first-hand knowledge regarding the detrimental effects of such experiences, is not necessarily indicative of a pathological process. Furthermore, it is also common for the original perpetrator (e.g., the mother's father) to have ongoing contact with the mother and, therefore, pose a very real risk to her child. Therefore, her attempts in limiting her daughter's exposure to potentially risky situations can be seen as a proactive attempt to protect her daughter from serious harm rather than simply an unconscious process. Future research that provides longitudinal data regarding child outcomes and child-reports of maternal control would provide a more refined understanding of the potentially deleterious and positive long-term effects of this variable.

The lack of findings regarding the effect of sexual abuse on depression, maternal confidence, and maternal warmth are somewhat more surprising. However, it is likely that the structure of this study contributed to this phenomenon. That is, the outcomes were predicted from severity of abuse, not its presence or absence. As noted by Green (1993), relative severity of abuse is often neglected in sexual abuse research. While some research has found an association between severity of abuse (often defined by type of

sexual act) and severity of outcomes (Bagley & Ramsay, 1985; Tufts, 1984), the majority of studies that have found associations between sexual abuse and psychological well-being compare symptomatology between abused groups and non-abused controls (e.g., Briere & Runtz, 1985; Gorcey, Santiago, & McCall-Perez, 1986; Sedney & Brooks, 1984). This methodological approach is even more pronounced when associations between sexual abuse and parenting outcomes are studied (Burkett, 1991; Cole & Woolger, 1989; Cole et al., 1992). The findings of this study suggest that the presence or absence of abuse, rather than level per se, is the more powerful predictor of certain outcomes.

In addition to examining the role of social support, this study explored the mediating effects of various coping strategies on the association between sexual abuse and depression and parenting outcomes. No mediational effects were found for any of the 5 proposed variables (parental avoidant coping, abuse avoidant coping, parental reappraisal coping, abuse reappraisal coping, and lack of resolution). However, several direct relationships between variables emerged.

First, severity of sexual abuse directly predicted the extent to which women remain unresolved regarding their abuse. Interestingly, although childhood sexual abuse did not directly predict level of depression, severity of abuse was related to the extent to which the woman felt consumed by issues related to the abuse in her day-to-day life. In addition, the greater the woman's lack of resolution around the abuse, the higher the level of self-reported depression. These findings may partially account for the inconsistent findings regarding the impact of abuse-related variables on outcomes (e.g., Leitenberg et

al., 1992). That is, it is the extent to which the abuse remains an active part of the woman's life, a "daily hassle" of enormous proportions, that is related to psychological well-being, rather than solely the specifics surrounding the abuse itself. The importance of an individual's perception of the abuse has been shown to impact the outcomes experienced. For example, Himelein & McElrath (1996) found that "refusal to dwell on child sexual abuse" was associated with better adjustment. One subject from that study, who was categorized as well-adjusted, reported the following regarding her experience of sexual abuse: "(Don't) let it control you. I think that's what I did for the first 10 years after it happened. It was just everything. Once I was able to put it aside..it made a huge difference" (p. 755). The present study supports and further refines the phenomenon underlying this comment providing an operationalized measure of resolution and exploring its impact on a variety of outcomes.

Similarly, lack of resolution was associated with less maternal confidence. Again, the pathway between abuse and parenting outcomes may be best understood by first understanding the woman's current level of preoccupation with abuse-related issues. It is likely that the woman who feels overwhelmed and preoccupied with abuse-related thoughts and feelings would also feel unsure about her ability to succeed in the parental role. Notably, given the lack of a direct association between severity of abuse and maternal confidence or ability to express maternal warmth, these fears may or may not be related to fact. As pointed out by Herman (1981) and Courtois (1988), survivors of sexual abuse tend to express significant concern about their ability to parent, some to the extent that they ended up setting unrealistic expectations for themselves.

Although beyond the scope of this study, it is also important to explore the different pathways that resolution of abuse issues may take for individual women. For example, it is likely that achieving resolution is not a linear process, but rather influenced by developmental and situational factors in the woman's life. If a woman is actively dealing with abuse-related issues, it is highly likely that she is "preoccupied" with these issues. However, this may actually reflect a stage of therapeutic healing that must occur before further progress can be made. However, for other women, lack of resolution may reflect the woman's entanglement in abuse issues that is static rather than progressive. Future research could provide additional information regarding whether qualitatively different types of resolution exist (and whether these types are differentially associated with outcomes).

Parental reappraisal coping was associated with more maternal confidence and less maternal control. Reappraisal coping, or a positive cognitive restructuring of an event, has been associated with greater resilience from stressful experiences (Charlton & Thompson, 1996; Mrazek et al., 1987). Therefore, being able to reframe a stressful parent-child interaction proved to be a source of self-worth for mothers. This ability to reframe the situation into a positive may also have predicted less controlling behaviors due to the fact mothers who are able to focus on the positive aspects of the situation may experience less anxiety or fear regarding their child's behavior, which in turn may be related to less of a general need to impose control in order to manage that anxiety.

Avoidant coping was unrelated to either psychological or parenting outcomes. This is in contrast to research that has shown that denial and avoidance-based coping has

been found to mediate the association between sexual abuse and poor psychological outcomes (Janoff-Bulman, 1985; Koss & Burkhart, 1989; Leitenberg et al., 1992; Proulx, Koverola, Fedorowicz, & Kral, 1995).

The lack of findings regarding the mediational and even direct effects of coping and resolution variables may have been associated with some of the limitations of this study. Most notably, the small sample size of this study greatly impacted statistical power. This fact, in addition to utilizing Baron & Kenny's relatively stringent criteria for testing for mediation, likely contributed to the lack of significant findings. For example, although CSA predicted Lack of Resolution and Lack of Resolution predicted Depression, Lack of Resolution was not determined to mediated the association between CSA and Depression because CSA did not predict Depression. However, according to Cohen's (1992) guidelines for conducting statistical power analysis, even anticipating a medium effect size (ES=.15) at a .05 level of significance with 2 independent variables would require at least 67 subjects to achieve a power of .80. The effect size of the association predicting Depression from CSA was notably small (R^2=.03; ES=.02), which would have required over 400 subjects to attain a statistical power value of .80. Therefore, it is highly likely that, with a larger sample size, a more robust association between CSA and Depression, and, subsequently, stronger evidence for the mediational role of Lack of Resoltuion, would have emerged.

In addition to the issue of lack of adequate statistical power, the inclusion of a non-abused control group would also have potentially allowed for the detection of more significant differences than could be obtained by only assessing differences in severity.

Additionally, the Ways of Coping measure may not have been the best choice for assessing coping with abuse-related issues. The manner in which this measure is structured required the woman to describe a specific problem (i.e. related to the abuse) and then answer questions regarding how she coped with the situation. In contrast to describing stressful parenting situations, many women had difficulty identifying specific abuse-related situations in their current lives. Most women discussed issues such as flashbacks or more general difficulties they felt were resultant of their abuse. Forcing the woman to describe a particular event may have unnecessarily limited her responses to the subsequent coping questions. That is, a more general question such as "How have you generally coped with the abuse in your adulthood" may have tapped a wider and more representative range of responses. More recent studies that have shown more robust effects of coping with sexual abuse survivors have utilized this approach (Leitenberg et al., 1992) and have also used a revised version of the WOC that asked respondents to indicate how often different strategies were used within a specific time period (e.g., the past few weeks) without asking the individual to describe a specific stressful situation (Proulx et al., 1995).

Several methodological and statistical choices were made in the process of conducting this study that presented specific costs and benefits. For example, although it was believed that limiting the sample to women with daughters would decrease potential confounds in the outcomes, the age of daughters ranged from infancy to adulthood. Therefore, the types of parenting outcome measures that could be utilized were somewhat limited. For example, it would have been useful to assess the quality of emotional

boundaries within mother-daughter relationships given that boundary violations are a central component of sexual abuse trauma. However, the level of maternal involvement in her child's life (e.g., making choices regarding clothing, friends) varies greatly depending upon the child's developmental stage. Therefore, this aspect of the relationship could not have been validly assessed. Another important decision involved the computation of a sexual abuse severity score. In this study, the overall CSA severity score included information regarding the type and frequency of sexual abuse experienced, the number of perpetrators, and the level of perceived distress at the time of the abuse. Clearly, by including a number of abuse-related factors in one score, there is an increased risk that certain discrete findings may have been overshadowed. However, it was felt that it was necessary to include more information than merely, for example, how severe the woman perceived her abuse to be. Similarly, certain abuse-related variable were not included due to the specific nature of this sample. For example, there is some anecdotal evidence that when children reach the age at which their mothers' were sexually abused, certain mothers can experience extreme distress related to their memories of the abuse. While this is a compelling empirical question, in reality, this sample only contained 2 mothers whose daughters were currently at the age at which the women were abused. Therefore, including this variable would have been meaningless.

Finally, this study used retrospective and cross-sectional, self-report data. As with any retrospective study, the recollection of specific events, particularly involving trauma, is fraught with potential errors in reporting. However, given that the most striking results involve the importance of a woman's current preoccupation with the

abuse, the accuracy of specifics related to the actual abuse may be less relevant than one would expect. The cross-sectional nature of this study provides a glimpse of the mother-child relationship that would be considerably more informed by a longitudinal approach that assesses parenting outcomes, support and coping over time to determine the extent to which each varies across time and developmental stage. Mims (1982) suggested that survivors' coping styles may transform as the time from the actual abuse increases. Finally, the fact that all the data in this study was self-report posed a problem, particularly when it came to testing for mediation. Trying to establish a series of causal relationships can yield potentially questionable results when self-report data alone is relied upon for measurement. Given coping's established role as a mediator in the extant literature, it's role in the present study was similarly tested. However, it may have provided fewer potential confounds to the study if less sensitive analyses (e.g., direct effects and/or moderators) were considered.

In conclusion, this study demonstrated the importance of considering the effects of abuse and related variables on both psychological well-being and parenting outcomes. In particular, the extent to which women are preoccupied with issues around their prior abuse may affect both their level of depression as well as their level of confidence regarding their ability to parent. However, results of this study also indicated that abuse did not directly affect a woman's ability to experience and express warmth in her relationship with her daughter. Severity of abuse did predict the women's level of control in their relationships with their daughters. This highlights the importance of reaching beyond a deficit-focused theory when assessing the effects of sexual abuse.

Consistent with prior research, social support was found to help attenuate the effects of general stress and was related to less depression and greater parenting confidence. However, general social support did not affect the impact of abuse nor did it buffer the effects of abuse on outcome variables. Clinical implications of this research include assessing the woman's current level of resolution regarding her abuse, which may be as important as the abuse itself for predicting level of depression and certain parenting outcomes, and providing the appropriate support and interventions. For example, support groups that provides specific assistance around parenting and abuse issues may be of particular help. Because abuse itself was related to the mother's self-reported level of maternal control, this aspect of the relationship should be addressed. Control might be reframed for the mother as a way she is seeking to protect her daughter from a similar fate.

Future research would do well to gain the daughter's perspectives on her relationship with her mother to determine how these findings are associated with child outcomes. In addition, a longitudinal approach that included abused and non-abused groups and followed mothers pre- and post-partum and then across childhood would capture a much more refined picture of how women simultaneously cope with parenting and a history of abuse. This type of approach would also contribute to the current pool of knowledge and help to develop an actual model for sexual abuse, social support and coping as they relate to parenting outcomes over time. By limiting the age of the child in such a way, this would also allow for a wider variety of parenting outcomes to be assessed. For example, parental encouragement of autonomy, which could be interpreted

differently depending upon the age of the child and has been identified as a relevant variable for sexual abuse survivors (Cole & Woolger, 1989), could be included in such an assessment.

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APPENDICES

APPENDIX A

APPENDIX A

DEMOGRAPHIC QUESTIONNAIRE
(Completed by Interviewer)

1. What is your date of birth? _____

2. What is your race? (please circle appropriate letter)
   a) Caucasian
   b) African-American/Black
   c) Asian American/Pacific Islander
   d) North American Indian/Native American
   e) Latino/Hispanic
   f) Chicano/Mexican American
   g) Other: _____

3. What is your highest level of education? (please circle the appropriate letter)
   a) less than high school
   b) high school
   c) 2 year post-high school
   d) 4 year post-high school
   e) graduate or professional degree

4. What is your current occupation?

5. What is your current estimated family income? _____

6. Who did you live with while you were growing up?

   a) biological mother and biological father
   b) biological mother and step-father
   c) biological father and step-mother
   d) biological mother alone
   e) biological father alone
   f) other (explain): _____

7. What was your mother's highest level of education?

   a) less than high school
   b) high school
   c) 2 year post-high school
   d) 4 year post-high school
   e) graduate or professional degree

8. What is/was her occupation?

9. What was your father's highest level of education?
   a) less than high school
   b) high school
   c) 2 year post-high school
   d) 4 year post-high school
   e) graduate or professional degree

10. What is/was his occupation?

11. Can you estimate your family's yearly income and/or SES level (e.g., working class, middle class, poverty level) while you were growing up? _____

12. What is your current relationship status? (check one)

    Single and dating _____

    Single and not dating _____

    Living with opposite-sex partner _____

    Living with same-sex partner _____

    Involved with opposite-sex partner, living apart _____

    Involved with same-sex partner, living apart _____

13. Are you currently married? Yes _____ No _____

    If yes, how many years? _____

    Were you married previously? Yes _____ No _____

    If yes, how long ago were you divorced? _____

    How long were you married? _____

14. Do you currently have a parenting partner? Yes _____

    No _____

    If yes, what is this person's relationship to you?

15. How many children do you have? _____

16. What are their ages and sex?

17. Are all of your children currently living in the home?
    Yes _____
    No _____ , please describe situation (use other side if needed):

APPENDIX B

APPENDIX B

CSA QUESTIONNAIRE

INTERVIEWER: READ THE BELOW DESCRIPTION TO THE WOMAN BEFORE YOU START ASKING THE QUESTIONS. EXPLAIN THAT YOU UNDERSTAND THESE QUESTIONS ARE VERY PERSONAL AND REMIND THE WOMAN THAT ALL OF HER ANSWERS WILL BE HELD IN STRICTEST CONFIDENCE. PROVIDE THE WOMAN WITH CARDS AND ASK HER TO INDICATE WHICH RATING BEST FITS HER EXPERIENCE.

Description: The following questions refer to the type of abuse you may have experienced. First look at CSA Card and please indicate the extent to which you experienced each of the following types of abuse. I also want to understand how personally distressing each experience was for you specifically, so after you have decided on a rating, look at the rating card and let me know how distressing that type of abuse was for you. Please take your time and if you have any questions, please ask.

1. Who abused you (e.g., determine whether it was biological father, step-father, uncle, etc.) **NOTE: IF THE WOMAN HAD MORE THAN ONE ABUSER MAKE SURE YOU INDICATE EACH ONE AND WHAT THEIR RELATIONSHIP IS/WAS TO HER

2. At what age did your abuse begin? **NOTE: IF THE WOMAN HAD MORE THAN ONE ABUSER, FIND OUT WHEN THE ABUSE BEGAN AND ENDED <u>FOR EACH PERPETRATOR</u> (e.g., father-age 7; brother-age 12; uncle-age 8)

3. At what age did your abuse end? **SEE NOTE IN PREVIOUS QUESTION

4. Did (fill in identity of abuser here, e.g., "your father") abuse any other members of your family?

1=NO
2=YES

If yes, who else was abused?

5. Were you abused (either physically, sexually, or emotionally) by anyone else as a child?

1=NO
2=YES
If yes, who else abused you and what happened?

6. Did you ever tell anyone about the abuse?

1=NO
2=YES

If yes, what happened (who did you tell, what was their reaction, what happened after you told, did the abuse stop?)

READ THE FOLLOWING DIRECTIONS TO THE WOMAN*

DIRECTIONS: Now I am going to ask you about different types of sexual abuse you may or may not have experienced. First I will ask you whether and how often you experienced each of these types of abuse. You can use this card (hand woman card with "number of times" scale) to let me know how often, if at all, this happened. Then, using this card (hand woman "how distressing" scale) to let me know, as best as you can remember, how distressing these instances were <u>at the time</u>.

1. Sexual kissing, intentional touching of buttocks, thigh, leg, or clothed breasts or genitals

1a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

1b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

2. Breast contact (over clothes)

2a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

2b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

3. Breast contact (unclothed)

3a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

3b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

4. Genital contact by abuser (over your clothes)

4a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

4b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

5. Abuser forced you to touch his clothed, genital area (over clothes)

5a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

5b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

6. Abuser forced you to touch his unclothed, genital area

6a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

6b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

7. Abuser touched or penetrated your unclothed, genital area

7a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

7b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

8. Oral sex (performed by abuser)

8a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

8b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

9. Oral sex (abuser forced you to perform on him)

9a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

9b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

10. Vaginal intercourse

10a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

10b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

11. Anal intercourse

11a. Approximately how frequently did the abuse occur?

1	2	3	4	8
1-2x a year or less	Several times a year	Several times a month	Several times a week	N/A

11b. In your own opinion, how distressing were these experiences of abuse?

1	2	3	4
Not very Distressing	Somewhat Distressing	Quite Distressing	Very Distressing

APPENDIX C

APPENDIX C

Hassles Scale

Directions: Hassles are irritants that can range from minor annoyances to fairly major pressures, problems, or difficulties. They can occur few or many times.

Listed on the following pages are a number of ways in which a person can feel hassled. Read through the list, and every time you find a hassle that has happened to you in the past month, underline that item. For example, the first item on the list is "Misplacing or losing things." If this has been an annoyance or problemfor you in the past month, then underline that statement. For now, ignore the items to the right of the statement. Just read through the list and underline ALL the items that have hassled you. If an item has not hassled you in the past month, don't underline it.

	Somewhat Severe	Moderately Severe	Extremely Severe
1. Misplacing or losing things.....	1	2	3
2. Troublesome neighbors.....	1	2	3
3. Social obligations.....	1	2	3
4. Inconsiderate smokers.....	1	2	3
5. Troubling thoughts about your future.....	1	2	3
6. Thoughts about death.....	1	2	3
7. Health of a family member.....	1	2	3
8. Not enough money for clothing.....	1	2	3
9. Not enough money for housing.....	1	2	3
10. Concerns about owing money.....	1	2	3
11. Concerns about getting credit.....	1	2	3
12. Concerns about money for emergencies.....	1	2	3
13. Someone owes you money.....	1	2	3
14. Financial responsibility for someone..... who doesn't live with you.	1	2	3

	Somewhat Severe	Moderately Severe	Extremely Severe
15. Cutting down on electricity, water, etc.	1	2	3
16. Smoking too much	1	2	3
17. Use of alcohol	1	2	3
18. Personal use of drugs	1	2	3
19. Too many responsibilities	1	2	3
20. Decisions about having children	1	2	3
21. Non-family members living in your house	1	2	3
22. Care for pet	1	2	3
23. Planning meals	1	2	3
24. Concerned about the meaning of life	1	2	3
25. Trouble relaxing	1	2	3
26. Trouble making decisions	1	2	3
27. Problems getting along with fellow workers	1	2	3
28. Customers or clients give you a hard time.	1	2	3
29. Home maintenance (inside)	1	2	3
30. Concerns about job security	1	2	3
31. Concerns about retirement	1	2	3
32. Laid-off or out of work	1	2	3
33. Don't like current work duties	1	2	3
34. Don't like fellow workers	1	2	3
35. Not enough money for basic necessities	1	2	3
36. Not enough money for food	1	2	3
37. Too many interruptions	1	2	3
38. Unexpected company	1	2	3
39. Too much time on hands	1	2	3
40. Having to wait	1	2	3
41. Concerns about accidents	1	2	3
42. Being lonely	1	2	3
43. Not enough money for health care	1	2	3

	Somewhat Severe	Moderately Severe	Extremely Severe
44. Fear of confrontation.....	1	2	3
45. Financial security.....	1	2	3
46. Silly practical mistakes.....	1	2	3
47. Inability to express yourself.....	1	2	3
48. Physical illness.....	1	2	3
49. Side effects of medication.....	1	2	3
50. Concerns about medical treatment.....	1	2	3
51. Physical appearance.....	1	2	3
52. Fear of rejection.....	1	2	3
53. Difficulties with getting pregnant.....	1	2	3
54. Sexual problems that result from physical problems.....	1	2	3
55. Sexual problems other than those resulting from physical problems.....	1	2	3
56. Concerns about health in general.....	1	2	3
57. Not seeing enough people.....	1	2	3
58. Friends or relatives too far away.....	1	2	3
59. Preparing meals.....	1	2	3
60. Wasting time.....	1	2	3
61. Auto maintenance.....	1	2	3
62. Filling out forms.....	1	2	3
63. Neighborhood deterioration.....	1	2	3
64. Financing children's education.....	1	2	3
65. Problems with employees.....	1	2	3
66. Problems on job due to being a woman or man.....	1	2	3
67. Declining physical abilities.....	1	2	3
68. Being exploited.....	1	2	3
69. Concerns about bodily functions.....	1	2	3
70. Rising prices of common goods.....	1	2	3

	Somewhat Severe	Moderately Severe	Extremely Severe
71. Not getting enough rest	1	2	3
72. Not getting enough sleep	1	2	3
73. Problems with aging parents	1	2	3
74. Problems with your children	1	2	3
75. Problems with persons younger than yourself	1	2	3
76. Problems with your lover	1	2	3
77. Difficulties seeing or hearing	1	2	3
78. Overloaded with family responsibilities	1	2	3
79. Too many things to do	1	2	3
80. Unchallenging work	1	2	3
81. Concerns about meeting high standards	1	2	3
82. Financial dealings with friends or acquaintances	1	2	3
83. Job dissatisfactions	1	2	3
84. Worries about decisions to change jobs	1	2	3
85. Trouble with reading, writing or spelling abilities	1	2	3
86. Too many meetings	1	2	3
87. Problems with divorce or separation	1	2	3
88. Trouble with arithmetic skills	1	2	3
89. Gossip	1	2	3
90. Legal problems	1	2	3
91. Concerns about weight	1	2	3
92. Not enough time to do the things you need to do	1	2	3
93. Television	1	2	3
94. Not enough personal energy	1	2	3
95. Concerns about inner conflicts	1	2	3
96. Feel conflicted over what to do	1	2	3
97. Regrets over past decisions	1	2	3

	Somewhat Severe	Moderately Severe	Extremely Severe
98. Menstrual (period) Problems.....	1	2	3
99. The weather.....	1	2	3
100. Nightmares.....	1	2	3
101. Concerns about getting ahead.....	1	2	3
102. Hassles from boss or supervisor.....	1	2	3
103. Difficulties with friends.....	1	2	3
104. Not enough time for family.....	1	2	3
105. Transportation problems.....	1	2	3
106. Not enough money for transportation.....	1	2	3
107. Not enough money for entertainment and recreation.....	1	2	3
108. Shopping.....	1	2	3
109. Prejudice and discrimination from others..	1	2	3
110. Property, investments or taxes.....	1	2	3
111. Not enough time for entertainment and recreation.....	1	2	3
112. Yard work or outside home maintenance.....	1	2	3
113. Concerns about news events.....	1	2	3
114. Noise.....	1	2	3
115. Crime.....	1	2	3
116. Traffic.....	1	2	3
117. Pollution.....	1	2	3

HAVE WE MISSED ANY OF YOUR HASSLES? IF SO, WRITE THEM IN BELOW:

118._____	1	2	3

ONE MORE THING: HAS THERE BEEN A CHANGE IN YOUR LIFE THAT AFFECTED HOW YOU ANSWERED THIS SCALE? IF SO, TELL US

WHAT IT WAS:

_____

NOW GO BACK TO PAGE ONE, AND FOR ALL THE ITEMS THAT YOU'VE UNDERLINED, THINK ABOUT HOW SEVERE the hassle has been in the past month, and give your answer by circling a 1, 2, or 3. Only circle the items you have already underlined. Leave the others blank.

APPENDIX D

APPENDIX D

SOCIAL PROVISIONS SCALE

INTERVIEWER: PROVIDE PARTICIPANT WITH CARD #2 AND READ THE FOLLOWING ITEMS TO HER, ASKING HER TO RATE EACH ONE. WRITE THE APPROPRIATE NUMBER IN THE SPACE AS SHE PROVIDES IT.

Description: This next questionnaire asks about the types of supports you have in your life. After I read an item, please look at the rating card and decide how true each is of you. There are no right or wrong answers and if you have any questions, please ask.

1=Strongly Disagree
2=Disagree
3=Agree
4=Strongly Agree

Rating

_____ 1. There are people I can depend on to help me if I really need it.

_____ 2. I feel that I do not have any close personal relationships with other people.

_____ 3. There is no one I can turn to for guidance in times of stress.

_____ 4. There are people who depend on me for help.

_____ 5. There are people who enjoy the same social activities I do.

_____ 6. Other people do not view me as competent.

_____ 7. I feel personally responsible for the well-being of another person.

_____ 8. I feel part of a group of people who share my attitudes and beliefs.

_____ 9. I do not think other people respect my skills and abilities.

_____ 10. If something went wrong, no one would come to my assistance.

_____ 11. I have close relationships that provide me with a sense of emotional security and well-being.

_____ 12. There is someone I could talk to about important decisions in my life.

_____ 13. I have relationships where my competence and skill are recognized.

_____ 14. There is no one who shares my interests and concerns.

_____ 15. There is no one who really relies on me for their well-being.

_____ 16. There is a trustworthy person I could turn to for advice if I were having problems.

_____ 17. I feel a strong emotional bond with at least one other person.

_____ 18. There is no one I can depend on for aid if I really need it.

_____ 19. There is no one I feel comfortable talking about problems with.

_____ 20. There are people who admire my talents and abilities.

_____ 21. I lack a feeling of intimacy with another person.

_____ 22. There is no one who likes to do the things I do.

_____ 23. There are people I can count on in an emergency.

_____ 24. No one needs me to care for them anymore.

APPENDIX E

APPENDIX E

WAYS OF COPING-PARENTING

Description: The next two questionnaires ask about different ways you may deal with difficult situations. The first one involves parenting. First, I am going to ask you to describe a stressful event related to your parenting and they I will ask you a series of questions about how you coped with this. Do you have any questions?

INTERVIEWER:

1.ASK THE WOMAN TO DESCRIBE A STRESSFUL SITUATION INVOLVING HER EXPERIENCE OF PARENTING. WRITE THE SITUATION BELOW:

2. AFTER SHE FINISHES DESCRIBING THE SITUATION, PROVIDE HER WITH CARD #2 AND ASK HER TO RATE HOW MUCH SHE USED EACH OF THE TECHNIQUES DESCRIBED ON THE WAYS OF COPING QUESTIONNAIRE-FORM 1. READ EACH ITEM TO THE WOMAN AND THEN CIRCLE THE APPROPRIATE NUMBER ON THE QUESTIONNAIRE

3. ASK THE WOMAN IF THERE ARE ANY OTHER WAYS SHE COPES THAT YOU HAVE NOT MENTIONED. IF SO, WRITE THEM BELOW:

WAYS OF COPING-FORM 1

INTERVIEWER:
FOR EACH OF THE FOLLOWING ITEMS, ASK THE PARTICIPANT TO RATE HOW MUCH SHE USED EACH OF THE TECHNIQUES DESCRIBED TO DEAL WITH THE STRESSFUL SITUATION RELATED TO PARENTING. PROVIDE HER WITH CARD #2, READ EACH ITEM TO THE WOMAN AND THEN WRITE THE APPROPRIATE NUMBER IN THE SPACE LOCATED NEXT TO EACH ITEM.

8=Doesn't apply
1=Used somewhat
2=Used quite a lot
3=Used a great deal

Rating

Avoidant Scale

_____ 7. Hoped a miracle would happen.

_____ 12. Slept more than usual.

_____ 25. Tried to make myself feel better by eating, drinking,smoking, using drugs or medication, and so forth.

_____ 31. Avoided being with people in general.

_____ 41. Refused to believe it had happened.

_____ 46. Wished that the situation would go away or somehow be over with.

Positive Reappraisal Scale

_____ 11. Looked for the silver lining, so to speak; tried to look on the bright side of things.

_____ 15. I was inspired to do something creative.

_____ 18. Changed or grew as a person in a good way.

_____ 23. I came out of the experience better than when I went in.

_____ 28. Found new faith.

_____ 29. Rediscovered what is important in life.

WAYS OF COPING-ABUSE

Description: The second difficult situation that I am going to ask you to describe involves any problems or stressful situations that you believe to be related to your past abuse (for example, a painful memory that interferes with something you are trying to do). Like before, I am going to ask you to describe a stressful event related to your abuse and then I will ask you a series of questions about how you coped with this. Do you have any quesitons?

INTERVIEWER:

1.ASK THE WOMAN TO DESCRIBE A STRESSFUL SITUATION INVOLVING HER PAST ABUSE. WRITE THE SITUATION BELOW:

2. AFTER SHE FINISHES DESCRIBING THE SITUATION, PROVIDE HER WITH CARD #2 AND ASK HER TO RATE HOW MUCH SHE USED EACH OF THE TECHNIQUES DESCRIBED ON THE WAYS OF COPING QUESTIONNAIRE-FORM 2. READ EACH ITEM TO THE WOMAN AND THEN CIRCLE THE APPROPRIATE NUMBER ON THE QUESTIONNAIRE

3. ASK THE WOMAN IF THERE ARE ANY OTHER WAYS SHE COPES THAT YOU HAVE NOT MENTIONED. IF SO, WRITE THEM BELOW:

WAYS OF COPING-FORM 2

INTERVIEWER:
FOR EACH OF THE FOLLOWING ITEMS, ASK THE PARTICIPANT TO RATE HOW MUCH SHE USED EACH OF THE TECHNIQUES DESCRIBED TO DEAL WITH THE STRESSFUL SITUATION RELATED TO HER ABUSE. PROVIDE HER WITH CARD #2, READ EACH ITEM TO THE WOMAN AND THEN WRITE THE APPROPRIATE NUMBER IN THE SPACE LOCATED NEXT TO EACH ITEM.

8=Doesn't apply
1=Used somewhat
2=Used quite a lot
3=Used a great deal

Rating

Avoidant Scale

_____ 7. Hoped a miracle would happen.

_____ 12. Slept more than usual.

_____ 25. Tried to make myself feel better by eating, drinking,smoking, using drugs or medication, and so forth.

_____ 31. Avoided being with people in general.

_____ 41. Refused to believe it had happened.

_____ 46. Wished that the situation would go away or somehow be over with.

Positive Reappraisal Scale

_____ 11. Looked for the silver lining, so to speak; tried to look on the bright side of things.

_____ 15. I was inspired to do something creative.

_____ 18. Changed or grew as a person in a good way.

_____ 23. I came out of the experience better than when I went in.

_____ 28. Found new faith.

_____ 29. Rediscovered what is important in life.

APPENDIX F

APPENDIX F

RESOLUTION QUESTIONNAIRE

INTERVIEWER: READ THE FOLLOWING DESCRIPTION TO THE WOMAN. PROVIDE HER WITH CARDS #3A AND #3B AND EXPLAIN THAT THE RATING SCALE IS WORDED A BIT DIFFERENTLY AND YOU WILL LET HER KNOW WHICH SCALE TO USE FOR WHICH QUESTIONS.

Description: Now we are going to ask you to think about how your past abuse currently affects you. Please rate the following questions in regards to how much each applies to you. We'll start by using this scale (PROVIDE WITH CARD 3A). Take your time and decide the rating that fits best and let me know what that is.

KEY 1=not at all
2=some of the time
3=moderate amount of time
4=most of the time

PROVIDE WOMAN WITH CARD #3A

Rating

_____ 1. How often do you find yourself thinking about your abuser?

_____ 2. How often do you find yourself trying <u>not</u> to think about your abuser? (e.g., how often do you find yourself trying to distract yourself from memories or thoughts related to your abuser?)

_____ 3. How often do you find yourself thinking about your non-abusive parent(s)?

_____ 4. How often do you find yourself trying <u>not</u> to think about your non-abusive parent(s)? (e.g., how often do you find yourself trying to distract yourself from memories or thoughts related to your parent(s) who failed to protect you from the abuse?)

Please answer the following questions in the same manner. The scale is worded slightly differently.

PROVIDE WOMAN WITH CARD #3B

KEY 1=not at all
2=somewhat
3=quite a bit
4=completely

_____ 5. To what extent do you feel you are "at peace" with your feelings towards your non-abusive parent(s)?

_____ 6. To what extent to you feel that much of your energy is tied up in working through your feelings related to the abuse?

_____ 7. To what extent do you feel your days are spent replaying the abuse over and over in your mind?

_____ 8. To what extent do you feel free of the distress and emotional constraints that the abuse has caused you?

_____ 9. To what extent do you feel that your thinking about the abuse gets in the way of your day to day life?

_____ 10. To what extent have you forgiven your abuser?

_____ 11. To what extent have you forgiven your non-abusive parent(s) for not protecting you from the abuse?

_____ 12. To what extent do you feel you are "at peace" with your feelings toward your abuser?

APPENDIX G

APPENDIX G

CES-D

Directions: Please read each of the items below and indicate how often you have felt this way during the last week. Use the key below to determine your rating and then place the appropriate number in the space next to each statement.

KEY: 1=Rarely or none of the time
2=Some or a little of the time (1-2 days a week)
3=Occasionally or a moderate amount of the time (3-4 days a week)
4=Most or all of the time (5-7 days a week)

Rating

_____ 1. I was bothered by things that ususally don't bother me.

_____ 2. I felt that everything I did was an effort.

_____ 3. I felt I was just as good as other people.

_____ 4. I had trouble keeping my mind on what I was doing.

_____ 5. I felt sad.

_____ 6. I felt tearful.

_____ 7. I felt lonely.

_____ 8. I had crying spells.

_____ 9. I talked less than usual.

_____ 10. My sleep was restless.

_____ 11. I enjoyed life.

_____ 12. I felt that I could not shake off the blues even with the help of my family/friends.

_____ 13. I thought my life had been a failure.

_____ 14. I was happy.

_____ 15. I could not get "going".

KEY: 1=Rarely or none of the time
2=Some or a little of the time (1-2 days a week)
3=Occasionally or a moderate amount of the time (3-4 days a week)
4=Most or all of the time (5-7 days a week)

_____ 16. I felt hopeful about the future.

_____ 17. People were unfriendly.

_____ 18. I did not feel like eating; my appetite was poor.

_____ 19. I felt depressed.

_____ 20. I felt that people disliked me.

APPENDIX H

APPENDIX H

PARENTING QUESTIONNAIRE

INTERVIEWER: PROVIDE PARTICIPANT WITH CARD #2 AND READ THE FOLLOWING ITEMS TO HER, ASKING HER TO RATE EACH ONE. WRITE THE APPROPRIATE NUMBER IN THE SPACE AS SHE PROVIDES IT.

Description: This next questionnaire asks about some of your experiences as a parent. Just like you did on the questionnaire I just read, after I read an item, please look at the rating card and decide how true each is of you. There are no right or wrong answers and if you have any questions, please ask.

1=Strongly disagree
2=Disagree
3=Agree
4=Strongly Agree

Maternal Confidence Scale (*=recoded items)

	Rating
2. I know I am doing a good job as a parent.	_____
3. Being a parent turned out not to be as difficult as I thought it would be.	_____
*5. Being a parent makes me feel drained and depleted.	_____
9. I have the knowledge I need to be a good parent.	_____
*13. I should have read more books on parenting because I often feel like I don't know what I am doing.	_____
16. If I could do it over again I would raise my children the same way I am raising them now.	_____
*18. I often worry that I am letting my children down.	_____
*20. Whenever I start feeling comfortable as a parent something goes wrong and the doubts start all over again.	_____
*22. I worry that I am not doing the right thing as a parent.	_____

*25. No matter how hard I try, I never seem to be a good enough parent. _____

*27. I often worry that I don't know enough to be a good parent. _____

*32. I often feel guilty about neglecting my children. _____

36. Juggling all the responsibilities of being a parent is one of my talents. _____

38. Parenting means a lot of responsibilities and problems, but I always feel that I can cope with the difficulties that come along. _____

43. When there is a crisis with the children, I know that I will do what needs to be done. _____

Maternal Control Scale (*=recoded items)

*46. I try to give my children direction but mostly I let them grow by themselves. _____

47. I am overly protective of my children; it is better to be safe than sorry. _____

48. I am a very strict parent. _____

49. I see to it that my children are only exposed to things that I want them exposed to. _____

*50. I have learned to accept that I cannot shelter my children from everything I do not like. _____

*51. I try not box my children in with too many rules. _____

52. I have to be on guard with my children all the time to keep them from getting into trouble. _____

53. I work hard at shaping my children's lives rather than just letting them grow up as they would. _____

54. When my children show their will, I make sure they know who is boss. _____

55. When I tell my children to do something, they will do it, no "ifs", "ands", or "buts". _____

*56. I have learned to accept that sometimes my children will not do what I want no matter how hard I try. _____

APPENDIX I

APPENDIX I

RELATIONSHIP WITH CHILD

Directions: Please read each of the following questions and decide to which extent each is true in regard to your relationship with your daughter. Using the key provided, rate each item and place the appropriate number in the space located next to the statement.

KEY

1=Strongly Disagree
2=Disagree
3=Agree
4=Strongly Agree

Maternal Warmth Scale (*=recoded items)

1. It is fun to be with my daughter. _____

2. When my child is trying to reach a goal, she can depend on me for support. _____

3*. In her relationship with me, my daughter often feels like an "orphan". _____

4*. When she is feeling bad, it is difficult for me to show the interest in her feelings that is needed. _____

5*. My daughter and I feel like strangers to one another. _____

6. I feel happy when I am with my daughter. _____

7. When my child is feeling badly, she can count on me to remind her of her worth. _____

8*. I feel tense around my daughter. _____

9*. My daughter and I don't seem to have very much in common with each other. _____

10. I feel very warmly towards my daughter. _____

APPENDIX J

APPENDIX J

The MSU Women's Research Project
CONSENT FOR PARTICIPATION IN RESEARCH

I consent to participate in the study involving the family experiences of women who are survivors of childhood sexual abuse. This study is being conducted by Linda Burke of Michigan State University. The purpose of this study is to understand the effects of sexual abuse on women's later experiences within their own families.

I understand that I will be interviewed to obtain my thoughts, opinions and feelings regarding my history of abuse, my relationships with my children, family and friends, and my general well-being.

I understand that my participation in this study is completely voluntary and that my refusal to participate will involve no penalty. If I decide to participate, I may refuse to answer certain questions or may quit at any time without penalty. A summary of the results from this study will be available to me upon request when the study is completed.

Participation involves approximately 3 hours, during which time the interviewer will ask me a series of questions involving my past abuse, my current coping styles, personal support systems, parenting experiences and general well-being. The study has been explained to me and I understand the purpose and procedures.

I understand that any information I provide will be kept completely confidential. All of my responses will be identified by code number only. Only the principle investigators will have access to this information, which will be kept in a locked file in the primary investigator's office. Furthermore, any audiotaped material will be identified by code number only. Audio tapes will be kept in a secured area until they are transcribed, after which point they will be erased.

In order to ensure accuracy, we are asking all participants whether they would mind having the interview portion tape-recorded. These tapes will only be heard by the principle investigators and will be erased once your responses have been transcribed. You do not have to agree to be tape recorded in order to participate in this study and, if you do agree to recording, you may ask to stop the tape at any time during the interview without penalty.

_____ I agree to being audiotaped

_____ I prefer not to be audiotaped

Any questions or concerns I have about the study can be addressed to Linda Burke, M.A., Department of Psychology, Michigan State University, (517) 882-2605.

_____ _____
Signature of Participant Date

_____
Signature of Witness/Interviewer

APPENDIX K

APPENDIX K

RECRUITMENT FLYER

SURVIVORS OF SEXUAL ABUSE

The Women's Research Project is looking for women who:

- *Are survivors of sexual abuse*
- *Have a daughter*

To participate in a university-based research project involving women's experiences of abuse and current family relationships

Call **415-322-2049** for more information

PARTICIPATION IS COMPLETELY CONFIDENTIAL

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