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# Maternal Perceptions and Responses to Child Sexual Abuse

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ABSTRACT

MATERNAL PERCEPTIONS AND RESPONSES TO CHILD SEXUAL ABUSE
by
Elizabeth U. Willingham

Child sexual abuse (CSA) is a complex phenomenon that requires various levels of intervention to address the safety, recovery, and prevention needs of children and families who have experienced victimization. Although there is a large body of literature that has identified and examined many aspects of CSA (Putnam, 2003), less is known about nonoffending caregivers of sexually abused children. The one consistent finding across studies that have investigated CSA, nonoffending caregivers, and traumatic stress in children is the importance the of child-caregiver relationship in facilitating recovery (Elliot & Carnes, 2001; Scheeringa & Zeanah, 2001). CSA is stressful for both the child and the caregiver, and it affects the child-caregiver relationship. Studies are needed to determine the underlying factors and processes that contribute to nonoffending caregivers' stress and coping responses, supportive and protective reactions, and intervention needs as they relate to supporting their children's recovery and healing the family unit. This exploratory study examined the phenomenological experiences of mothers whose children had been sexually abused. In-depth exploration and systematic analysis of mothers' perceptions about their children's victimization, their reaction, and their distress using constructivist grounded theory methods (Charmaz & Corbin, 2005) provided a better understanding of the mothers' collective experience and response. This

study used theoretical sampling (Miles & Huberman, 1994) for participant selection. The researcher interviewed 14 mothers of children who had been sexually abused and had received services at a child advocacy center. Two key informants were also interviewed to obtain a detailed conceptualization of the theoretical and practical aspects of the programs and services at the child advocacy. The findings from this naturalistic, phenomenological inquiry revealed that the mothers experienced crisis and traumatic distress following their children's disclosure. The findings also showed that even in the midst of traumatic distress and grief, the mothers did believe and protect their children. In addition, the results of this study highlight how maternal supportive responses are interdependent on numerous factors, especially their capacity to cope with past abuse, current distress, and their level of emotional and financial dependency on their child's perpetrator.

# MATERNAL PERCEPTIONS AND RESPONSES TO CHILD SEXUAL ABUSE

by
Elizabeth U. Willingham

A Dissertation

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in
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in
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in
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My Dissertation Committee

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## ABBREVIATIONS

| | |
|---|---|
| CAC | Child Advocacy Center |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| MDT | Multi-disciplinary Team |
| NOC | Nonoffending Caregiver |
| PTSD | Posttraumatic Stress Disorder |

# CHAPTER 1

# LITERATURE REVIEW

## Including Nonoffending Caregivers in Child Treatment for Child Sexual Abuse: The Rationale, Research, and Role of Child Advocacy Centers

### Introduction

Child sexual abuse (CSA) is a multifaceted concern that produces far-reaching effects for children and families who have experienced victimization. The breadth of the literature on CSA is remarkable, and it comprehensively addresses topics including epidemiology, risk factors, intergenerational transmission, traumagenic effects, clinical features and psychopathology, disclosure, treatment, associated outcomes, and prevention (reviewed in Putnam, 2003). In comparison, empirical literature devoted to nonoffending caregivers of sexually abuse children is in its infancy. Furthermore, methodological limitations of existing studies (e.g., small samples, heterogeneous samples, inconsistent definitions, lacking demographic data, absence of control or comparison groups) make it difficult to generalize findings or interpret inconsistent results (Elliot & Carnes, 2001). Nevertheless, the one consistent finding across studies on CSA, nonoffending caregivers, and child trauma is that primary caregivers are essential change agents in facilitating children's recovery (Scheeringa & Zeanah, 2001).

Studies on nonoffending caregivers show that their responses vary with regard to discovering and dealing with their children's victimization, and nonoffending caregivers' reactions to their children's disclosure of CSA and subsequent emotional and protective

responses are significant factors in child sexual abuse recovery (Elliot & Carnes, 2001). Moreover, recent findings in pediatric research underscore the negative impact of intrapersonal traumatic stress upon children's growth and development (Scheeringa & Zeanah, 2001) and emphasize the importance of the child-caregiver attachment relationship for children's adjustment to stressful experiences and global functioning. Children's stress and regulatory response systems are developed through attachment, and children depend on their primary caregivers for their basic needs and safety (Scheeringa & Zeanah, 2001). When both the child and caregiver experience a threat to their safety, such as in many cases of CSA, the child and the caregiver's functioning may be jeopardized. Impairment in functioning in response to CSA can affect the child-caregiver relationship and complicate recovery. Therefore, there is a need to understand the relational context of traumatic stress in order to treat CSA effectively. This paper reviews the existing literature on nonoffending mothers as well as identifies areas and presents guiding questions for future research.

## Relational Context of Posttraumatic Stress Disorder in Children

Scheeringa and Zeanah (2001) examined the clinical and empirical literature pertaining to the relational context of PTSD in young children. Findings across studies consistently document the association between negative parental or family factors and poor adjustment in children. Accordingly, the authors created a model of effects that attempt to explain the connection between relationships, trauma, and symptomology. They delineated the following four types of effects: (1) Minimal Effect (exposure to trauma does not result in symptom development), (2) Moderating Effect (mother-child relationship and mother's ability to respond to child's needs moderate impact of trauma),

(3) Vicarious Trauma Effect (mother's exposure to trauma and resulting symptom development in turn traumatizes the unexposed child), and (4) Compound Effect (combined moderating and vicarious effects result in traumatization for both mother and child whereby one's symptoms exacerbate the other's). The authors further proposed the concept of Relational PTSD as a characteristic feature of the Compound Effect.

Relational PTSD is a construct defined by response patterns that occur within the Compound Effect Model (Scheeringa & Zeanah, 2001). When both the caregiver and the child are traumatized by the same or separate events, the child's symptoms often appear to be "substantially intensified" by the child-caregiver relationship (p. 810). The authors identify three patterns of care giving that characterize the adults' responses: (1) Withdrawn/Unresponsive/Unavailable Pattern, (2) Overprotective/Constricting Pattern, and (3) Reenacting/Endangering/Frightening Pattern.

*Withdrawn/Unresponsive/Unavailable Pattern*

Children's recent traumatic events often trigger, or cause, negative thoughts and emotions to resurface in caregivers who have experienced past trauma and developed acute or chronic PTSD. The tendency for caregivers to withdraw or avoid re-experiencing the pain may interfere with their ability to respond appropriately and care adequately for their children. Moreover, caregivers may suffer from comorbid disorders (e.g., depression, anxiety, bereavement) that impair their functioning. The caregivers' distress, impaired functioning, and reduced parenting capacity likely increase symptoms of distress (e.g., anxiety, depression) in their children.

*Overprotective/Constricting Pattern*

Caregivers who adopt the overprotective or constrictive pattern respond to their

children's traumatization by implementing excessive parenting practices to prevent future trauma. Caregivers may or may not have experienced the same trauma as their children. Even caregivers who are not exposed to the same trauma as their children may become traumatized. Feeling guilty for not being there to protect their children, they may reconstruct the events of their children's trauma and then intrusively experience these images. Caregiver distress can negatively affect the parent–child relationship if the caregiver's functioning and parenting practices are impaired by these negative thoughts and emotions This particular pattern appears to be more persistent and resistant to intervention efforts.

*Reenacting/Endangering/Frightening Pattern*

Caregivers who engage in this response pattern become preoccupied with traumatic memories or triggers of the event. Their children may be traumatized by the caregivers' need to inquire about the event or to repeatedly discuss the details. Furthermore, these caregivers may have difficulty monitoring their own statements and actions in front of their children which may cause the children to suffer more distress.

Scheeringa and Zeanah (2001) offer the Relational PTSD as a construct to enhance the clinical understanding of a suggested reciprocal link between the caregiver-child relationship and the onset or progression of trauma symptoms. They recommend including caregivers in treatment for traumatized children and evaluating and addressing the caregivers' symptoms before treating the children. The rationale being that the caregiver-child relationship is a powerful instrument for change and that improving the caregivers' functioning will increase their capacity to appropriately respond to their children's needs, which should, in turn, assist the child's recovery. Additionally, they

discuss the need to qualitatively explore the mechanism of how caregiver functioning influences child adjustment.

While Scheeringa and Zeanah's (2001) model of parent and family variables as moderators and vicarious trauma agents for symptoms in young children is not specific to CSA cases, it is indeed applicable to children who have experienced CSA and to their nonoffending mothers. In fact, parental distress resulting from the child's sexual abuse disclosure strongly predicts treatment outcome for children irrespective of the type of treatment (Cohen & Mannarino, 1998). Deblinger and colleagues also found that nonoffending mothers' report of depression was significantly associated with child PTSD symptoms and parent-reported internalizing behavior problems (1999), and that maternal distress accounted for the variance for child externalizing behavior problems (1997) as measured by a structured parent interview, the Symptom Checklist-90- Revised (SCL-90-R, Derogatis, 1983), and the Child Behavior Checklist (CBCL, Achenback & Edelbrock, 1991). They additionally found that parenting practices that employed guilt and created anxiety for the child increased the child's PTSD symptoms (1999). Viewing the nonoffending mother-child relationship in terms of these effects and relational PTSD patterns may assist clinicians and researchers in identifying underlying factors and processes that influence maternal response and child adjustment. Furthermore, understanding the role and experiences of the nonoffending mother is critical for improving CSA outcomes.

## Nonoffending Mothers

### *The Collusive Mother: A Historical Conceptualization*

The nonoffending mother's role in CSA abuse cases has consistently been

recognized; however, nonoffending mothers have not necessarily been viewed from a positive perspective. Reviews of the literature on nonoffending caregivers—though rarely studied as their own entity—reveal that they have been historically conceptualized as weak, collusive, and psychologically disturbed (Bolen, 2003; Corcoran, 1998; Joyce, 1997; Tamraz, 1996). In fact, the mother has been blamed for the sexual abuse more so than the perpetrator in many cases. The idea of the "collusive mother"—the mother who is consciously or unconsciously aware of her child's abuse and does not protect because she is helpless, needy, dependent or because she is playing martyr—was broadly accepted in the 1980s (Joyce, 1997). This negative description of nonoffending mothers appears to have been based on clinical descriptions or opinion-based literature (studies where nonoffending mothers were included in interpretations of the results, but were not the primary source for data) and not on empirical data (Tamraz, 1996). Joyce (1997) suggested that the lack of research may have led to clinicians accepting the notion of the collusive mother as fact.

The accepted idea of the collusive mother prompted clinicians and researchers to apply theoretical frameworks within which to understand mothers' responses (Joyce, 1997). Psychodynamic tenets attempted to explain these mothers' behaviors in terms of having had unmet needs as children (Vander Mey & Neff, 1986). According to Joyce (1997), both psychodynamic and family systems principles to support the collusive mother concept in incest cases have been inconsistently applied to nonoffending mothers. For example, nonoffending mothers have been described as having a negative self-concept that resulted from undifferentiated relationships with their own hostile and rejecting mothers (psychodynamic) and, simultaneously, as passing incest on to their

children because their fear of intimacy resulted in relationship problems and sexually frustrated partners (family systems). Gelinas (1987) also used family systems theory to address collusion as an ingrained familial pattern in which the mother's lack of emotional energy is responsible for her avoidance of discovering the incest, and the father purposefully maintains the secret thereby creating a dynamic that further increases the distance between the mother and daughter. These particular theoretical models only focused on incest cases, which consequently limited the generalization to other types of sexual abuse.

Feminist models began to surface in the literature in the mid-1980s. These models posited that mothers' collusive responses to CSA were due to oppressive social factors that rendered them powerless, such as blame from the legal and child welfare systems as well as from mental health service providers (Herman, 1981), rather than to individual factors (Joyce, 1997). Wattenburg (1985) put forth the idea that a patriarchal society, insufficient documentation and poorly defined constructs were to blame for the myth that mothers are collusive. Joyce (1997) pointed out that despite the fact these frameworks operated from very different theoretical principles, early family systems and feminist models both portrayed mothers as helpless and unable to protect their children.

*Research on Nonoffending Mothers: Initial Findings and Limited Conclusions*

The majority of existing studies have focused on nonoffending mothers' psychological functioning and their reaction to their children's disclosure. A smaller number of studies have examined nonoffending mothers' marital role, parenting role, mother-child relationship, and exposure to domestic violence. Moreover, only a handful of studies have evaluated interventions for nonoffending mothers. Several reviews of the

literature (Bolen, 2003; Corcoran, 1998; DiLillo & Damashek, 2003; Elliot & Carnes; Joyce, 1997; Tamraz, 1996) highlight initial findings and implications.

*Mothers' Psychological Functioning*

Research studies investigating nonoffending mothers have not found strong associations between historical, anecdotal descriptions and empirical outcomes. According to Joyce (1997), mothers of sexually abused children do not necessarily have more psychological problems than mothers whose children have not been abused. Nonetheless, there are inconsistencies in the literature with regard to nonoffending mothers' functioning. Although Peterson, Basta, and Dykstra (1993) found that mothers of abused children scored higher on the Hypochondiasis, Low Energy Depression, Paranoia, Guilt/Resentment, Schizophrenia, and Psychosocial Inadequacy scales of the Clinical Analysis Questionnaire than mothers of nonabused children, data from a study conducted by Friedrich (1991) indicated nonoffending mothers fall with in the normal limits on the MMPI.

Wagner (1991) compared depression symptoms in mothers of children who experienced intrafamilial abuse, mothers of children who experienced extrafamilial abuse, and mothers of nonabused children. No significant differences in depression were found between groups; however, Lewin and Bergin (2001) found that 59% of mothers of sexually abuse children reported being depressed. These types of inconsistencies in outcomes may be due in part to the aforementioned methodological differences such as time of data collection, sample selection within CSA cases (e.g., extrafamilial abuse, intrafamilial abuse, incest), types of assessment protocols used, and other individual variables (e.g., maternal history of CSA) or environmental (e.g., social support) factors. It

is still unclear as to how mothers' psychological functioning prior to their children's disclosure is related to their reactions, distress, and functioning following the disclosure.

*Mothers' Reaction to Disclosure*

*Mothers' Distress.* Contrary to the original view of mothers colluding in CSA cases, it appears most mothers are unaware that their children are being sexually abused. Moreover, mothers seem to experience shock initially and are significantly distressed upon learning about their children's victimization. Many mothers view their children's disclosure as traumatic and experience numerous changes and losses as a result of the disclosure (Davies, 1995; Deblinger, Hathaway, Lippmann, & Steer,1993; McCallum, 2001). Massat and Lundy (1988) found that mothers experienced distress related to the "reporting costs" of their children's disclosure. The majority of these mothers experienced changes or losses in their family and social relationships, places of residence, employment, income, and custody of their children. Hooper (1992) also found that mothers of children of intrafamilial abuse experience intense grief and loss related to their perceived lack of trust in their spouse/partner, their ability to parent, and their sense of control when they discover their children have been abused.

Newberger, Gremy, Waternaux, and Newberger (1993) examined nonoffending mothers' symptomology over time using the Brief Symptom Inventory. They found that mothers' symptoms were significantly greater at the time of disclosure than at the one-year follow-up, indicating that mothers initially experience their children's disclosure as traumatic. Moreover, Manion and colleagues (1996) examined secondary trauma in 63 mothers of child sexual abuse victims in the first three months following an extrafamilial abuse disclosure. Mothers were significantly more distressed than mothers of nonabused

children and reported poorer family functioning, poorer marital functioning, and less parenting satisfaction. In addition, the researchers found that abuse-related factors (e.g., type of abuse, age of child) did not predict the mothers' level of emotional functioning; however, the mothers' perception of environmental support and parenting satisfaction were predictive of emotional functioning.

More recently, Lewin and Bergin (2001) found that mothers of child sexual abuse victims showed higher levels of depression, state anxiety, and trait anxiety as compared to mothers of nonabused children. Further, their findings indicated that that mothers of sexually abuse children in their sample engaged in fewer attachment behaviors (i.e., sensitivity, cooperation, acceptance, accessibility). All of these studies examined nonoffending mothers' distress. Although the findings were drawn from different types of samples (intrafamilial and extrafamilial) using various assessment methods at different points in time, it seems evident that nonoffending mothers do suffer distress and experience loss following their children's disclosure.

*Mothers' History of CSA.* It is often reported that many nonoffending caregivers have a personal history of CSA (Nakhle Tamraz, 1996), and studies suggest that nonoffending mothers who have a history of CSA are prone to elevated levels of stress following their children's disclosure (Banyard, 1997; Deblinger, Stauffer, & Landsberg, 1994). Green, Coupe, Fernandez, and Stevens (1995) conducted a case study analysis and reported that four mothers who were sexually abused as children were diagnosed with delayed-onset PTSD and comorbid depression and personality disorders after they learned about their children's abuse. Timmons-Mitchell, Chandler-Holtz, and Semple (1997) also found that mothers with a history of CSA showed more symptoms of PTSD

when their children disclosed than mothers without a history of CSA.

Hiebert-Murphy (1998) investigated 102 mothers of children who disclosed CSA and found a relationship between mothers' emotional distress and history of CSA. King et. al (2002) also reported that nonoffending mothers in their study reported increased stress, anxiety, and depression; and one half of the mothers disclosed a history of CSA. In contrast to these findings, Lewin and Bergin (2001) found no significant differences in depression, anxiety, or attachment for nonoffending mothers with a history of CSA as compared to those without a history. However, only 7.4% of their sample of 38 mothers reported sexual victimization in childhood.

*Mothers' Belief, Support, and Protection.* According to Elliot and Carnes (2001), the complexity of these constructs combined with methodological issues preclude extensive conclusions about nonoffending mothers' reactions; however, in a review of the literature, the authors did suggest initial trends. Overall, it appears that most nonoffending mothers do believe their children's disclosure. In addition, the majority of mothers are supportive and protective regardless of whether their children were victims of incest or nonincest, and caregiver support is associated with better adjustment for children. However, there are inconsistencies in these trends which indicate believing does not always lead to protection; mothers who do believe may respond inconsistently; and some mothers who do not believe or experience ambivalence do take protective measures to ensure their children's safety.

Several studies have examined maternal belief, support, and protection and attempted to identify factors that predict maternal response. Sirles and Franke (1989) found 78% of the nonoffending mothers (N=193) in their study believed their children

upon disclosure. More specifically, the researchers found that mothers were more likely to believe their children if: the child disclosed oral-genital abuse (90%) or digital-genital abuse (87%) than if the abuse was genital-genital (70%); the mother was not home during the molestation (89%) than if she was home (63%); the child was a preschooler (95%) or latency age (82%) than if the child was an adolescent (58%). Further the data showed mothers were less likely to believe their children if the perpetrator abused alcohol (70%) than if he did not (88%). De Young (1994) also reported that 65% of mothers of children who disclosed paternal incest believed their children. Five characteristics that predicted maternal belief, according to these studies, were (1) the mother was not currently sexually involved with the perpetrator, (2) the child was 12-years-old or younger, (3) the perpetrator did not abuse substances, (4) the child did not report physical abuse, and (5) the child did not experience intercourse when abused.

Salt, Myer, Colman, and Sauzier (1990) examined mothers' reactions to their children's disclosure and found the following about nonoffending mothers: 82% protected their children all or some of the time; 70% were not punitive toward child; 8% forced the perpetrator to leave the home (63% of perpetrators were not currently living in the home); 90% showed great concern for their children; 56% showed no or minimal concern for themselves; 88% showed no or minimal anger toward their children; 41% reported a history of CSA; and 34% reported a history of physical abuse or neglect. Finally, they found several other significant results: labile mothers were more likely to be self-concerned and angry at their children; and mothers whose children were offended by a boyfriend or stepfather were the least protective. These mothers also were the most angry and punitive toward their children.

Elbow and Mayfield (1991) reviewed 24 cases of father-daughter incest and found that the majority of the mothers in this sample (N=20) believed their daughters and took measures to protect them. They further concluded that the mothers' protection was associated with their ability to seek support from counseling and deal with the legal aspects of the disclosure. Heriot (1996) found that maternal belief is strongly associated with maternal protection. Fifty-two percent of nonoffending mothers in this study were protective; yet, there were mothers in this sample who believed and did not protect their children, as well as mothers who were ambivalent and did take measures to ensure their children's safety.

Pintello and Zuravin (2001) examined concordant belief and protection in a group of biological mothers whose children had experienced intrafamilial sexual abuse. They found that 41.8% of the mothers believed and protected; 30.8% neither believed nor protected; 27.3% were ambivalent with 13.3% believing but not protecting and 14% not believing but protecting. In addition, the researchers identified four factors that were predictive of mother's belief and protective responses. Mothers who have their first born child in adulthood, are not in a sexual relationship with the offender, had no knowledge about the abuse, and whose children are not exhibiting sexual behaviors were more likely to believe and protect their children.

*Parenting*

Parenting for nonoffending caregivers is often challenging. Studies have shown that parenting satisfaction and parenting efficacy are both affected by CSA. Manion et al. (1996) found that parents of children who had experienced extrafamilial abuse reported less parenting satisfaction than parents of children in a nonclinical group. They also

found that mothers' perceived parenting satisfaction predicted emotional functioning versus factors related to the abuse. Davies (1995) found that parents reported needing assistance in managing their children's behavior, particularly their children's sexualized behavior. Simarly, Hiebert-Murphy (2000) found that sexual problems and conduct problems predicted parenting efficacy; and conduct problems, social support, and coping styles predicted parenting satisfaction.

According to DeLilo and Damashek's review (2003), women incest survivors overall appear to have challenges with various aspects of parenting such as lower parenting confidence and poorer parenting skills (e.g., difficulties setting boundaries, permissive parenting, using severe physical punishment). Banyard, Williams, and Siegel (2003) found that complex trauma, or greater exposure to traumatic events, resulted in less parenting satisfaction, more child neglect and protective service reports, and the use of physical discipline. Due to the fact that many nonoffending caregivers appear to have a history of CSA, these findings are particularly relevant. Moreover, children's aggressive and sexualized behavior is a salient parenting issue as these types of behaviors seem to be resistant to treatment (Putnam, 2003).

Additionally, sexually abused children's perceptions about their caregivers and their caregivers' parenting practices are related to their adjustment and symptomology. Deblinger et al. (1999) found that children who perceived their mothers as rejecting rather than accepting had elevated levels of depression. Inappropriate or harsh parenting practices also increased their children's PTSD symptoms. According to Deblinger and Heflin (1996), parent support and parent training reduce parental stress and increase parental competency associated with the unique parenting concerns for sexually abused

children.

*Coping*

There are a limited number of empirical studies examining nonoffending caregivers' coping responses to stressors related to their children's disclosure. Davies (1995) investigated parental distress and coping in 30 parents following their children's disclosure of extrafamilial abuse. Based on data from semi-structured interviews and questionnaires, three types of parents were differentiated with regard to coping: (1) parents able to cope following initial distress, (2) parents able to cope, but with significant problems, and (3) parents unable to cope. Parents reported distress and difficulty coping with their: children's behavior, anger towards the perpetrator, loss of trust, feelings of isolation, and preoccupation with issues related to their sons' sexual orientation. One concerning finding was that parental stress did not remit over time even with agency intervention.

Hiebert-Murhpy (1998) found that a sample of 102 nonoffending mothers who had a history of CSA suffered emotional distress due to their own victimization, lack of social support from family and friends, and use of avoidant coping strategies. It was further noted that mothers' dependence on avoidance coping methods predicted maternal distress after controlling for the other factors. Heibert-Murphy (2001) also studied coping in mothers of sexually abused children who had experienced partner violence. The findings indicated that partner abuse was associated with avoidant coping styles related to their children's disclosure. There is clearly a need for more research focused on stress and coping responses for nonoffending mothers and caregivers. Understanding nonoffending mothers' stressors, coping abilities, and related factors and processes is

paramount to designing interventions that reduce their stress, enhance their coping, and assist them in resolving abuse-related issues.

*A Qualitative View of Nonoffending Mothers*

A few studies have utilized qualitative methods to obtain a deeper understanding of nonoffending mothers' reactions to their children's disclosure. Alaggia (2002) interviewed nonoffending mothers and defined their reactions in terms of three multi-dimensional categories: belief, affective response, and behavioral response. McCallum (2001) interviewed three mothers whose intimate partners abused their daughters. She found that their responses to the abuse were influenced by their feelings of blame, confusion, guilt, shame, alienation, and helplessness. These mothers experienced the dilemma of having to choose between helping their child or their partner, and they had to carry the responsibility of dealing with extended family, household issues, and "picking up the pieces" (p. 328). Finally, Allagia (2001) examined the role of cultural and religious beliefs in nonoffending mothers' responses to their children's disclosure of intrafamilial abuse. The results revealed that mothers experienced conflicts due to their cultural and religious beliefs which often emphasized patriarchal values and preserving the family. These mothers also experienced feeling torn between the loyalties to their children and their partners as well as fears about being estranged from their families and communities.

*Conclusions about Nonoffending Mothers*

Quantitative studies have established that nonoffending mothers of sexually abused children do experience distress and that their response is a significant factor in their children's adjustment. Qualitative studies have exposed various nuances concerning

nonoffending mothers' cognitive, emotional, and behavioral responses. Data suggests that the majority of nonoffending mothers believe their children and take protective actions; however, less is clear about ambivalent mothers and mothers whose belief, support, and actions are inconsistent. There is minimal research on nonoffending mothers' coping and parenting abilities; yet it appears that the stronger their abilities, the more positive the outcome for all parties affected. More research focused on nonoffending mothers is needed to confirm, disconfirm, or extend initial conclusions and theories. Reconceptualizing nonoffending mothers based on theories derived from empirical data is necessary because of their central role in child sexual abuse recovery and because they are "already stigmatized and an underserved population" (Joyce, 1997, p. 76).

Reconceptualizing Nonoffending Mothers: Beginning Steps to Understanding

It is clear that nonoffending caregivers play a central role in CSA cases. Often the nonoffending mother "is viewed simultaneously as the object of blame for failing to protect her children, to control the perpetrator, and to safeguard her family, and as a subject of hope for rescuing the victim and maintaining the home" (Tamraz, 1996, p. 76). It appears nonoffending mothers' varying reactions and responses to their children's disclosure and their inconsistent engagement with professionals and service providers are likely due to emotional distress caused by trying to balance their own needs with those of their children and families. The traumatic grief and numerous losses nonoffending mothers experience when they learn about their children's abuse seem to negatively influence their perceptions of self (as mother and wife), others (as trustworthy), and the world (as safe). Moreover, nonoffending mothers are frequently placed in positions that demand that they function in incompatible roles, which likely intensifies their distress.

Corcoran (1998) states that "nonoffending mothers are victims in their own right from biased societal expectations as well as societal conditions that incapacitate their abilities to protect their children" (p.367). Bolen (2003) suggests that there is an overwhelming number of CSA cases that are brought to the child welfare system's attention and a shortage of resources. Therefore, cases have to be triaged according to severity, which limits access to resources for other children and families in need. Moreover, because the judicial system has a need to protect the alleged offender's rights, many offenders are not removed from the home or area if they are not convicted of the crime. Consequently, legal statutes and child welfare policies place the responsibility for protecting the child on the nonoffending mother. Corcoran reiterates the need to increase awareness of cultural and social factors that hinder nonoffending mothers' efforts in providing safety and protection for their children. She also calls for a better understanding of nonoffending mothers so that support services and treatment can empower mothers rather than adding to their stress.

There are models and approaches for understanding sexual abuse dynamics and recovery outcomes. For example, Spaccarelli (1994) developed a transactional model of stress, appraisal, and coping in child sexual abuse cases which frames sexual abuse as a stressor involving a series of abuse, abuse-related, and disclosure-related events that could increase the risk for negative outcomes. This model also suggests that cognitive appraisals and coping methods are mediators to the events and environmental and developmental factors are moderators between sexual abuse stressors and victim responses.

Additionally, ecological models have been applied to sexual abuse outcomes.

Grauerholz (2000) used an ecological model that considers personal, interpersonal, and sociocultural factors and processes to account for sexual revictimization. These approaches, which are based on the CSA literature, seem promising in understanding child sexual abuse victims' responses and outcomes. Although they are not specific to nonoffending mothers or caregivers, it stands to reason that they could be readily applied to this population. Establishing models that provide a better understanding of how nonoffending caregivers experience, respond, and cope with CSA and its related effects will assist in designing appropriate NOC interventions and evaluating intervention efficacy.

## Intervention for Nonoffending Caregivers

There is a great deal of literature citing the need to include nonoffending caregivers in their children's treatment. This literature is based on the premise that providing concurrent services to the nonoffending caregiver will improve treatment outcomes for children (Deblinger & Heflin, 1996; Hiebert-Murphy, 1998). However, research on the efficacy of nonoffending caregiver treatment models is minimal. A small number of parallel group treatment models for sexually abuse children and their caregivers have been implemented and evaluated. The overall results of these studies indicate that support and education groups for nonoffending caregivers are beneficial to the recovery process for both the caregiver and the child (Lafir, 2000). However, similar to difficulties in researching other aspects of CSA and nonoffending caregivers, methodological challenges (e.g., difficulty obtaining control groups, attrition, funding and resources) often preclude large-scale intervention efficacy studies. Furthermore, limitations of available studies (e.g., sampling biases, inconsistent definitions, non-

standardized instruments) prevent generalization of conclusions. Moreover, only a few, if any, focus solely on nonoffending caregivers in terms of treatment needs, intervention, and outcome.

*Summary of Interventions and Outcomes*

Most of the outcome studies that have been tested and show promise are limited to trauma-focused cognitive behavior therapy (TF-CBT) for children and nonoffending mothers who have PTSD. Cohen and colleagues (1998, 2000, 2004) have developed, manualized, and studied trauma-focused cognitive behavioral treatment (TF-CBT) for sexually abused children diagnosed with PTSD and their nonoffending caregivers. Individual and group TF-CBT has been shown to be significantly more effective than nondirective interventions in reducing PTSD symptoms and abuse-related attributes as compared to nonspecific supportive therapy (NST) with this subset of sexually abused children and caregivers. However, due to the fact that child and caregiver treatment is concurrent, the most effective components of TF-CBT have yet to be determined. For example, when King et al. (2002) implemented this parallel CBT approach, they found that although child CBT was effective, family CBT (Deblinger & Heflin, 1996) was not found to be superior on some outcome measures. The authors suggest potential reasons for this unexpected finding may be either the narrow focus on the children's concerns (nonoffending mothers also reported feeling increased distress and more than half of the mothers in the study disclosed a history of CSA), or the smaller sample size.

Hyde, Bentovim, & Monck (1995) investigated 37 families who were randomly assigned to two groups: family/network treatment group or family/network treatment plus group work. Family/network treatment consisted of child, caregiver, and family meetings

with community professionals. The participants in the treatment plus group work group attended separate groups according to age and development. Number of weeks of group treatment varied by age and need. Both standardized and non-standardized (clinician ratings) measures were collected at the start of treatment and at 12 months. Results showed that clinical symptoms were significantly reduced for both children and caregivers; the caregiver-child relationship significantly improved; conflicted feelings toward the perpetrator were resolved; and children's self-concept improved; and the families were better able to recognize the child's needs.

Furthermore, they noted the benefits from participating in the group treatment. Nonoffending mothers reported reduced distress, increased ability to deal with abuse-related thoughts and feelings, and the ability to respond to their children in more appropriate ways. Findings also indicated that nonoffending mothers who were given support and coping skills were more responsive to their children. Finally, parents were better equipped to manage their children's behavior as a result of the parent training component of the group treatment. The major limitation of this study was that concurrent individual, family, and group treatment prohibited conclusions about whether the improvements were related to group, individual, or family participation and to what extent.

Winton (1990) studied the efficacy of a support and education group for nonoffending parents. The support component addressed therapeutic concerns, and the education component addressed parenting skills. A pre-post treatment design showed a significant reduction in scores on the Child Domain and the Adaptability scales of the Parenting Stress Index. In addition, a satisfaction questionnaire indicated that parents

acquired coping skills as a result of group participation. However, the researcher's hypothesis that parental distress would significantly decrease was not demonstrated. One explanation that was suggested for this nonsignificant finding is the short duration of the group (the mothers communicated wanting to continue past 13 weeks).

Jinich and Litrownik (1999) evaluated a video-tape intervention with 87 mothers referred to a child sexual abuse clinic for their children to be evaluated for suspected sexual abuse. Mothers were randomly assigned to either the treatment or the control group. The treatment group watched a 20 minute video ("Brave To Tell") while their children were being interviewed and evaluated. The video presented information about appropriate responses to children and common effects of CSA. Mothers were assessed on their knowledge, attitudes, and responses following the intervention and one week later. Data was also collected on the children's perceptions of support and level of functioning. Mothers in the treatment group were more supportive to their child immediately after viewing the video and could identify more supportive behaviors at follow-up. In addition, there was an association between the children's perceived support and mothers' reported responses.

Grosz, Kempe, and Kelly (2000) conducted a pilot study of 246 children (ages 2-14) who were victims of extrafamilial child sexual abuse and their parents (N=323). The purpose of the intervention study was to reduce emotional distress experienced by the children and families. Families engaged in several modes of treatment including crisis counseling, individual child sessions, individual parent sessions, child therapy groups, and parent support groups. Outcomes were assessed using self-report measures. The researchers found that the group was helpful for parents in expressing their concerns and

for addressing emotional distress including feelings of powerlessness and victimization by the justice system; decreasing their anger, sadness, guilt, and anxiety symptoms; increasing their confidence in parenting; improving their self-concept, and enhancing their marital relationships.

Finally, Seymour and Davies (2002) interviewed 124 parents of sexually abused children about their experiences related to the investigation, treatment, and prosecution phases of intervention. The findings indicated that parents encountered delays in service provision, poor coordination of services, poor use of therapy services, inadequate support, and a lack of support and information for children and parents who are called to testify in court proceedings.

The need for comprehensive, holistic, empirically sound intervention models for nonoffending caregivers is apparent. Professionals working in the field of child maltreatment have recognized this need for interventions that support nonoffending caregivers and that reduce the stress for children and families who have experienced abuse and trauma. The Child Advocacy Center Model was developed to address these complex issues and to promote positive outcomes in CSA cases.

## Child Advocacy Centers: Reducing Trauma and Facilitating Healing

The Child Advocacy Center Model was established in Huntsville, Alabama in 1985 to address the various needs of children and families who were simultaneously involved in the child welfare and criminal justices systems for CSA. Since the formation of the first CAC, hundreds of centers have been established in communities nationally. The purpose of the advocacy center is to provide comprehensive services that are developmentally and culturally appropriate from a multidisciplinary team approach in a

neutral, child-friendly environment. The goals of intervention are to reduce children and families' distress and to facilitate their movement through all phases of intervention without further trauma (National Children's Alliance, 2003).

Child advocacy centers are governed by the National Children's Alliance, which sets the standards of practice and competency requirements for all centers. Centers are required to collaborate with law enforcement, child protective services and with medical, mental health, and judiciary professionals. The overarching model of child advocacy centers is the same; however the set-up and services may differ based on the needs of the community the CAC is serving. In general services include forensic interviews, forensic evaluations, forensic medical exams or referrals, crisis counseling, clinical services for children and nonoffending caregivers, court advocacy, and community outreach and prevention.

Newman, Dannenfelser, and Pendleton (2005) surveyed 290 law enforcement and child protection investigators who utilized child advocacy centers for child sexual abuse cases. They found five reasons investigators gave for using child advocacy centers, four ways child advocacy centers facilitate collaboration, and three ways centers could be more helpful. Investigators used child advocacy centers because of the child-friendly environment; the support, referrals, counseling, and medical exam assistance; the CAC interviewers' expertise; the formal protocol, and the access to video and audio equipment. Investigators responded that child advocacy centers facilitate collaboration by coordination and communication, multidisciplinary team meetings, trainings, and staff support. Investigators suggestions for child advocacy centers were to increase staff availability (e.g., operation hours, number of interviewers), to increase equipment and

resources (e.g., space, number of locations, technological equipment), and to enhance collaboration and communication (e.g., increased face-to-face communication, scheduling interviews and exams, advanced training, prevention services).

Although there are a few research studies that have examined specific services and outcomes (e.g., forensic interviewing, child and family advocacy programs), there is a major void in the literature. Studies are lacking with regard to the overall efficacy of child advocacy centers and the perceptions and experiences of children and families referred for and receiving services.

## Conclusions and Guiding Questions

It is evident that CSA has sweeping effects for children and families. Abuse events, disclosure events, family response, investigation processes, and judicial procedures can be traumatic. Traumatic distress from CSA interferes with cognitive, affective, and physical functioning; growth and development, and overall health and well-being for the children and families. Children who have been sexually abused must rely on their nonoffending caregivers to protect them from the perpetrator and to provide support during the recovery process. Nonoffending caregivers' responses to children's disclosure are paramount to their children's perceived support, symptom development, receipt of services, overall adjustment, and often to custody placement.

The factors and processes related to CSA and nonoffending mothers' responses are complex to say the least. In the past two decades, researchers have intently focused on understanding CSA dynamics and identifying those factors and processes related to the many facets of abuse, response, and intervention. However, the broad range of CSA offenses, various abuse categories, numerous effects, and large spectrum of caregiver

responses often make defining and measuring constructs difficult. Moreover, the sensitive nature of CSA and the immediate intervention needs of children and families present methodological limitations such as establishing control groups for outcome measures.

Nevertheless, researchers and clinicians continue to conduct studies adding to our knowledge and understanding of CSA and nonoffending caregivers and to indicate future directions for research. Research on nonoffending caregivers is deficient. There is a clear gap in the literature regarding the underlying factors and process related to (1) nonoffending caregivers' reactions to disclosure, (2) nonoffending caregivers' stress and coping responses, (3) the relationship between nonoffending caregivers' functioning and their children's adjustment, (4) nonoffending caregivers' intervention needs, and (5) intervention efficacy.

Based upon the high prevalence rates of CSA, the established negative long-term effects, and the significant role that nonoffending caregivers play in the recovery process, studies on nonoffending caregivers are critically needed to answer many questions such as the following: How do nonoffending caregivers' perceptions of child sexual abuse disclosure influence their response? What are the stressors for nonoffending caregivers before, during, and following disclosure? How and in what ways do nonoffending caregivers cope with these stressors? How is maternal history related to nonoffending mothers' beliefs, emotions, and actions as it pertains to attachment, CSA disclosure, and response patterns? How do nonoffending caregivers perceive themselves and their roles as partners and parents? In what ways do culture and value/belief systems influence nonoffending caregivers' perceptions and responses? What do nonoffending caregivers need for recovery? What types of interventions are effective? What aspects of the

intervention process are/are not helpful? How can the intervention services be improved to meet nonoffending caregivers' needs? How do nonoffending caregivers view the CAC model of intervention?

In conclusion, understanding nonoffending caregivers' perceptions of stress, coping, and treatment needs; how their perceptions influence their responses to their children; and how their perceptions change at different stages of intervention will help practitioners design and evaluate interventions that will help them respond to their child's needs appropriately, thus, improving child and family recovery outcomes. Child advocacy centers strive to address the needs of children and families and improve outcomes through various types of intervention services. Although the CAC model is widely accepted for CSA intervention, more research is needed to determine how effective child advocacy centers are in accomplishing their goals.

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# CHAPTER 2

# RESEARCH MANUSCRIPT

## Maternal Perceptions and Responses to Child Sexual Abuse

### Introduction

Child sexual abuse (CSA) is a complex phenomenon that requires various levels of intervention to address the safety, recovery, and prevention needs of children and families who have experienced victimization. Although there is a large body of literature that has identified and examined many aspects of CSA (Putnam, 2003), there are fewer empirical studies that address nonoffending caregivers of sexually abused children. Yet, the factor that consistently appears to have the most influence on children's psychological adjustment to CSA is the nonoffending caregivers' reaction to the child's disclosure, and specifically, whether the nonoffending caregiver believes, protects, and supports the child (Tremblay, Hebert, & Piche, 1999). Furthermore, data show that CSA is stressful for both the child and the caregiver, and it affects the child-caregiver relationship (Elliot & Carnes, 2001; Scheeringa & Zeanah, 2001). Therefore, more studies are needed to determine the underlying factors and processes that contribute to nonoffending caregivers' stress responses as well as supportive and protective reactions as they relate to supporting their child's recovery and healing the family unit.

Like child victims, nonoffending caregivers experience significant distress when they learn about sexual abuse allegations involving their children (Deblinger, Hathaway, Lippmann, & Steer, 1993; Elliot & Carnes, 2001). Their responses also vary from

experiencing general psychological stress to clinical symptoms of depression, anxiety, and PTSD (Davies, 1995; Green, Coupe, Fernandez, & Stevens, 1995; Lewin & Bergin, 2001; Manion, McIntyre, Firestone, Ligezinska, Ensom, & Wells, 1996; Newberger, Gremy, Waternaux, & Newberger, 1993) which can affect their capacity to care for their children's needs.

Nonoffending caregivers' reactions to their children's abuse disclosure, often complicated by stress, range from believing, supportive, and protective to ambivalent, non-believing, non-supportive, and non-protective (Alaggia, 2002; Pintello & Zuravin, 2001). Research investigating nonoffending caregivers has focused primarily on nonoffending mothers and has attempted to isolate variables contributing to differential stress and protective responses by examining attachment, extrafamilial and intrafamilial abuse, the nonoffending mothers' past abuse history, and environmental factors (Davies, 1995; Hiebert-Murphy, 1998; Massat & Lundy, 1988; Pintello & Zuravin, 2001). However, inconsistencies in methods (e.g., defining and measuring constructs, sampling,) make it difficult to draw definitive conclusions from findings regarding mothers' responses (Elliot & Carnes, 2001).

According to Elliot and Carnes (2001), there are interesting trends in the literature regarding nonoffending mothers' responses. In contrast to original speculation that mothers of sexually abused children were nonbelieving and collusive, research suggests that the majority of mothers do believe, support, and protect their children (de Young, 1994; Pintello & Zuravin, 2001; Sirles & Franke, 1988; Tamaraz, 1996). In fact, many mothers who experience ambivalence or who may not fully believe their children's allegations still take protective measures to keep their children safe (Heriot, 1996). Some

studies have attempted to distinguish factors that predict maternal response (Deblinger, Hathaway, Lippmann, & Steer, 1993; de Young, 1994; Pintello & Zuravin, 2001) such as the mother's relationship with the perpetrator, maternal history of CSA, the child's age, and the victim's gender; however, findings are inconsistent. Other studies have begun to investigate how these variables and other environmental factors (e.g., social support) influence maternal response, coping, and parenting, as well as how maternal adjustment influences child adjustment (Cohen & Mannarino, 1996, 1997, 1998, 2000; Deblinger, Steer, & Lippmann, 1999; Deblinger, Taub, Maedel, Lippmann, & Stauffer, 1997; Hiebert-Murphy, 1998, 2000; Leifer, Kilband, & Kalick, 2004; Manion, McIntyre, Firestone, Ligenzinska, Ensom, & Wells, Massat & Lundy, 1988).

A few researchers have utilized qualitative methods in an effort to better understand nonoffending mothers' responses. Alaggia (2002) identified three primary categories of maternal responses (i.e., belief, affective response, behavioral response) which were multi-dimensional with respect to level and reaction. McCallum (2001) examined the experiences of three mothers whose husbands sexually abused their children. Results of this small, but revealing, sample indicated that these mothers experienced confusion, aloneness, shame, powerlessness, helplessness, and fear. They perceived blame for their children's abuse, and they had to assume the responsibility for holding the family together and handling the extended family following their children's disclosure. Authorities perceived the mothers' responses as resistant, which further contributed to the mothers' feelings of isolation and disengagement in the investigation and intervention processes. Alaggia (2001) also found cultural belief and value systems were misunderstood by service providers which created barriers that affected the level of

engagement for a sample of 10 nonoffending mothers. Finally, Davies (1995) found that parents of intrafamilial abuse experienced distress that negatively impacted the parent-child relationship. Parents reported that agency intervention services did not sufficiently meet the parents' needs in terms of anticipating what to expect (e.g., managing child, appropriate response to child).

Several authors suggest that nonoffending mothers are marginalized and/or victimized by the child welfare, legal, and judicial systems and societal factors (Corcoran, 1998; Lovett, 2004). Nonoffending mothers, who are functioning in a state of crisis, are often blamed for their children's abuse when they show ambivalence or are inconsistent in making decisions following their children's disclosure (Corcoran). Balancing their own needs with the needs of their children and families can be a challenging and stressful task for nonoffending mothers (Alaggia, 2002). Furthermore, nonoffending mothers are not only responsible for protecting their children, but for maintaining the household and dealing with extended family (Bolen, 2003). Due to the lack of resources available to these mothers, they often feel stressed and alone (Bolen, 2003; Pithers, Busconi, & Houchens, 1998). These authors call for a new conceptualization for nonoffending mothers that will take into account cultural and societal stressors (Alaggia, 2001; 2002; Bolen, 2003; Corcoran, 1998; Joyce, 1997). These trends indicate that there are internal and familial factors that influence nonoffending mothers' responses, as well as systemic issues that contribute to the various types and levels nonoffending mothers' reactions. Studies on the underlying mechanisms associated with nonoffending mothers' stress responses and reactions toward their children are limited (Alaggia, 2001, 2002; Hiebert-Murphy, 1998). However, initial

findings and recommendations suggest that treating child sexual abuse from holistic, comprehensive, and empirically based approaches which include nonoffending caregivers will likely produce more beneficial results for children and families who have been victimized (Davies, 1995; King, Heyne, Tonge, Mullen, Myerson, Rollings, & Ollendick, 2002; Lovett, 2004; Manion et al., 1996). Therefore, it is imperative that these issues pertaining to the maternal response are further examined in order to close the gap in the literature, but more importantly, to effectively treat families who are dealing with the painful and complex experience of child sexual abuse.

In an effort to contribute to the resolution of this critical issue, this study focused on nonoffending mothers of child sexual abuse victims. The purpose of this study was to explore the phenomenological experiences of nonoffending mothers who had participated in intervention services at a child advocacy center (CAC) and to identify the underlying factors and processes related to their emotional reactions and responses to their children.

## Method

Constructivist grounded theory (Charmaz, 2005) methods of data collection and analysis were utilized in the present study to explore the phenomenological experiences of mothers whose children have been sexually molested and to identify the underlying structure and meaning of their response. Constructivist grounded theory is a systematic approach to qualitative inquiry that permits the integration of phenomenological experience and social and environmental conditions. This theoretical approach is based on grounded theory principles (Strauss & Corbin, 1990) but does not require strict adherence to objectivist assumptions, thus allowing the researcher to take into account empirical realities, collected interpretations, as well as the researcher's role within the

research process and influence on the outcome. Since the researcher enters the investigation with a subjective viewpoint, the observations, analysis, and results are interpretive representations of reality of the phenomenon under study; however, the interpretations are grounded in the data (Charmaz, 2005) to provide an accurate description of the shared, or unified, meaning of the mothers' experiences (Moustakas, 1994).

Constructivist grounded theory is a particularly fitting design given its wide use in researching social justice concerns. The combination of its phenomenological nature, inclusive stance, and systematic analysis allows researchers' biases to contribute to the exploration and findings in an empirical manner. Furthermore, constructivist grounded theory maintains principles and ethics that protect vulnerable populations by permitting investigators who are truly invested in the welfare of their participants to call on their own experience and expertise in order to research critical issues with sensitivity and understanding.

The researcher conducted and analyzed in-depth interviews of mothers whose children have been sexually molested as the principle source of data which allowed the researcher to observe and participate in the study simultaneously. Therefore, the researcher, acting as the primary instrument for collecting, analyzing, and interpreting the data, was able to attain a rich understanding of the context and the complex, latent, or underlying processes that occur (Schensul & LeCompte, 1999) associated with the maternal experience in child abuse cases. The following broad question guided the inquiry: (1) What are the mothers' perceptions about their children's victimization and about their personal responses to the allegations of abuse?

*Participants*

Theoretical sampling, based on specific criteria (Miles & Huberman, 1994), was used to select participants to purposefully limit the study for a better understanding of fundamental themes related to maternal responses and involvement in the child sexual abuse recovery process. The primary informants met the following criteria: (1) mothers of children who had experienced child sexual abuse, and (2) had received services at the CAC for 9 to 14 months These criteria were set to reflect the average amount of time families receive services at the CAC, as well as, to capture the mothers' reflections on their experiences over time.

In addition, two key informants (Director of Services and Nonoffending Caregiver Group Facilitator) were selected and interviewed based on: (1) their level of training and experience working with child victims and nonoffending caregivers, and (2) their extensive knowledge about CAC practices and services. The data from the key informants supplied a detailed conceptualization of the CAC model and practical aspects of the programs and services at the CAC. This data offered a rich description (Miles & Huberman, 1994) of the CAC context including the rationale for CAC intervention, collaboration with the multidisciplinary team (MDT), and types of services. This data also described the components of caregiver services, how the services meet the caregiver needs, and commonalities in caregiver response patterns. In other words, this data was used to provide an appreciation for the contextual factors and processes related to real-life child sexual abuse cases referred to a CAC and to elucidate the interplay between the CAC and maternal response.

Participants that met the aforementioned criteria were identified by CAC staff.

The Director of Services or the therapist presented potential participants with information about the study and were given the opportunity to participate. The researcher also posted the study description and researcher contact information in the CAC waiting room in order to give them the opportunity to participate. The researcher met with interested mothers to answer questions, review, and collect signed consent forms before conducting the interviews. Participation was voluntary, and a $25 gift card was given to the mothers at the time of the interview to compensate for their time and travel.

*CAC Context*

The CAC is a private, non-profit organization which provides a neutral, child-friendly environment where professionals and agencies utilize a multi-disciplinary team (MDT) approach to alleged child abuse cases. This CAC's mission is to reduce the trauma of children and their families by facilitating a comprehensive multidisciplinary team approach to intervention, investigation, prosecution, and treatment of alleged child sexual and severe physical abuse. The CAC offers free, on-going services to children and families including initial intervention and assessment of alleged child victims and nonoffending caregivers, joint child and family interviews, intervention and support services, individual therapy for child victims, group therapy for child victims and nonoffending caregivers, court assistance services and testimony, medical examination referrals, and community outreach and prevention services.

The center is housed with the county's Crimes Against Children law enforcement unit, the child protective service (CPS) unit, and a medical office that provides child forensic medical examinations. The close proximity of service providers and the team environment not only allows for continuous professional interaction, collaboration, and

service coordination related to incoming and on-going child abuse cases, but provides a central location for children and families to receive services. Children and families are referred for clinical services once a child's disclosure is investigated and substantiated. Cases are assigned to a therapist who provides weekly individual treatment for the child, weekly support and education sessions for caregivers, and family therapy as needed. Sessions for children and caregivers are approximately 45 minutes each. Child therapy groups and caregiver support and education groups are also offered when appropriate and available. Clinical services at the CAC are on-going and the number of sessions and modes of treatment are tailored to each child and family's needs. The clinical approach implemented at the CAC is holistic as it addresses both general child and family concerns and abuse-related issues.

The CAC is a full member of both the National Children's Alliance and Children's Advocacy Centers of Georgia Inc. and serves several counties in the Metro-Atlanta area. The CAC serves an average of 550 nonoffending caregivers and 555 children per year, and the clinical department manages approximately 60 on-going treatment cases per year. Additionally, the CAC is nationally recognized and approved to serve as mentor site for new, existing, and developing advocacy centers and provides extensive training for professionals in the field of child maltreatment.

*Procedure*

*Negotiating Entrée and Role of Researcher.* The researcher has a long-standing relationship with the staff and programs at the CAC and has served in several positions over the past seven years including intern, professional volunteer, child and family advocate, therapist, and forensic evaluator. The CAC agreed to support these research

efforts in order to increase the knowledge in the field of maltreatment and improve intervention services and training.

This study was informed by the investigator's administrative experience as the program director of another local CAC as well as her clinical and forensic experience working with families and children who have experienced sexual abuse at this particular CAC. The researcher designed and navigated the study, collected and analyzed the data, and interpreted the results. Therefore, researcher bias was expected given the primary investigators' varied and intense roles prior to and during this naturalistic inquiry (Lincoln & Guba, 1985). The researcher's biases about nonoffending mothers were as follows: (1) they experience extreme distress and crisis when their children disclose sexual abuse, (2) the majority of mothers are trying their best to survive in this situation and need guidance and support, (3) many of these mothers have other family or clinical issues that already exist or develop as a result of the disclosure, and (4) maternal functioning and child progress in treatment is interdependent. These biases were reviewed, explored, and analyzed during the course of the investigation.

*Research Team.* In addition to the primary investigator, several other individuals participated on the research team for this study. A doctoral level peer coder who had clinical experience at the CAC and qualitative research training and experience was employed to establish coding consensus and served as a peer debriefer. A master's level student who was completing her clinical internship at the CAC assisted in coordinating interviews and participated in the coding process. An undergraduate student who was completing a clinical practicum in human services and working as a part-time administrative assistant helped manage the data. All research team members participated

in research team meetings. Having team members with various experience and roles at the CAC provided perspectives at multiple levels at the research meetings which added to the credibility and overall trustworthiness of the study.

*Credibility.* The researcher used triangulation of multiple methods, informants, and data sources to enhance the credibility of the study. Prolonged engagement and persistent observation were achieved by extended contact with the participants and the CAC over seven months. The researcher's extensive experience in working with this population, long-standing relationship with the CAC, and counseling training contributed to her understanding of the phenomenon under examination and enabled her to build rapport and trust with the participants. The in-depth interview structure and recursive process involved in peer debriefing, member checking, and data analysis also allowed the researcher to achieve prolonged engagement and persistent observation which led to participants sharing more fully and openly with the researcher so that a more accurate narrative emerged (Lincoln & Guba, 1985). Informal member checking (reflecting back to the participant during the interview process to check for understanding) and formal member checking (consulting with individual participants following data analysis to share findings and check for accuracy) strategies gave participants the opportunity to clarify, elaborate, or give additional information regarding their experiences and the researcher's analysis and theoretical interpretation.

*Transferability, Dependability, and Confirmability.* The implementation of rigorous methodological strategies to establish credibility combined with documenting the intricate details of the content and process involved in data collection, analysis, and interpretation contributed to the dependability, confirmability, and overall trustworthiness

of the proposed study (Lincoln & Guba, 1985). Documentation was maintained in the researcher's reflexive journal and research notes creating an audit trail for the purposes of evaluation. Additionally, a detailed description of the context, participants, and methods has been included in this article so that readers may draw conclusions about the validity and significance of the project and determine whether the findings are relevant and applicable to their clinical context and practice.

*Data sources.* The primary data sources were individual interviews of the two key informants (i.e., CAC Director of Services, CAC Nonoffending Caregiver Group Leader), nine individual mother informants, and a focus group interview of five additional mother informants. Only eight of the nine individual mother interviews were used in the final analysis due to the researcher's realization that the first interview participant had not participated in services long enough to meet the time criterion for the study. The number of individual interviews needed for interpretive sufficiency was determined once there were enough observations to allow for multiple interpretations of the mothers' experiences (Christian, 2000; Denzin, 1989). The focus group interview was conducted to tap the collective experiences of mothers'of children who have been molested and to confirm, disconfirm, and elaborate on findings from individual interviews to inform the final emergent theory (Kamberelis & Dimitriadis, 2005).

A semi-structured interview format (Patton, 1990) was used for all interviews to address specific topics and simultaneously allow open-ended responses to capture unique differences and shared meanings between participants. The initial interview questions were developed from a comprehensive literature review and covered topics such as maternal response to CSA disclosure, maternal stress and coping, maternal relationship

with child, maternal history and family of origin, maternal relationship with the offender, and culture. The other interview questions assessed maternal perceptions about intervention needs and CAC services.

All interviews were conducted at the CAC and ranged in length from approximately 90 minutes to 3 hours each. The interviews were voice recorded digitally and transcribed verbatim. The individual interviews yielded at total of 465 pages of data. The focus group interview yielded 71 pages of data. Additionally, demographic information was collected from the mothers at the time of the interviews for the purposes of identifying personal, culture-specific, and abuse-related factors related to the target population. Secondary sources of data included member checking notes, peer reviewer comments, research memos, and a reflexive journal (Schensul & LeCompte, 1999).

*Coding and Analysis.* The coding process (Creswell, 1998) involved a series of open coding (to generate initial categories), axial coding (to examine pattern, conditions, and causal links), and selective coding (to produce the narrative). Constant comparison of the data permitted the data collection, analysis, and emerging theory to evolve as each informed the other in a recursive process (Lincoln & Guba, 1985). The researcher and peer debriefer coded the key informant interviews independently and then met to compare codes and come to consensus. After completing initial analysis for the key informant interviews, the researcher and peer debriefer began coding the individual interviews of the mothers.

Individual participant interviews were also coded individually and independently by the researcher and peer debriefer and then compared during the open coding phase of data analysis. As the individual mother participant interviews were being conducted, the

researcher and peer debriefer met face-to face once a week at a minimum to discuss emerging themes, process notes, and reflections in addition to regular phone consultation calls. These weekly research team meetings provided a forum to confer about the initial findings and provided information about how to adjust interview questions as needed. Themes and codes within individual interviews were established and used to recode across interviews during the axial coding phase (Creswell, 1998). The researcher analyzed both the content and process notes of the peer debriefer. Email and phone correspondence, as well as consultation sessions between the researcher, peer debriefer, research team members, and participants were used to validate codes and the emerging theories during the axial and selective coding phases to ensure all findings were explored thoroughly and systematically.

## Results

This exploratory study examined the phenomenological experiences of mothers whose children had been sexually abused. In-depth exploration and in-depth analysis of the mothers' perceptions about their children's victimization, their reaction, and their distress provided a powerful understanding of the mother's collective experience and response.

### *Maternal Response to Child's Victimization*

Mothers perceived their children's victimization as a traumatic, life changing experience which left them feeling overwhelmed, disconnected, and tainted: "I think it takes the connotations of a natural disaster, sort of like a flood, it comes in, washes over everything, dirties everything and it's very hard to relate to other people who haven't experienced it." Another mother compared it to war:

> It feels like someone just bombed you, and like messed your house up and there is no way possible you think at the time you can get through it and fix it because when one bomb drops and you see it clear, then another bomb drops.

As a whole, mothers described an initial state of crisis followed by enduring symptoms of distress. The overwhelming distress they experienced as a result of learning about their children's abuse and dealing with the aftermath of the disclosure reduced their level of functioning to survival mode. Their complex cognitive-emotional reaction was characterized by the following central themes: shock, confusion, guilt, anger, fear, shame, betrayal, distrust/isolation, grief/loss, and depression. Even in the midst of tremendous distress, all of the mothers believed, protected, and supported their children in response to the abuse disclosure. Descriptions and examples of the themes are given to elucidate the distress these mothers experienced and to account for the prevalence of each theme.

*Shock*

All of the mothers described the initial shock that they felt upon learning that their children had been sexually molested. The mothers were in disbelief that their children had been victimized, a situation that which these mothers never anticipated would happen in their families: "I never imagined not in my own house, not with my immediate family. I just—she and [perpetrator] had such a great relationship. I just think I went through that denial." Some mothers even described feelings of denial that accompanied the pain of the disclosure. There experiences ranged from surreal to paralyzing: "I mean it was unreal. It was like this is a movie I just say. You know after you see a movie, and you have that funny feeling afterwards…I can't explain it, but it was a thing like how could this happen?" Another mother described her shock:

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

*Confusion*

Seven individual participants and the focus group participants collectively described the confusion they felt regarding how to handle their children's disclosure and how to manage the legal system's response and procedures. These mothers expressed not knowing who to call for help, how to react to their children, or what to expect from the investigation and legal proceedings. One mother advised: "I knew that something happened; I didn't know what…I didn't know what to do or where to go, but I knew that I needed to ask her what happened alone." Another also mother described her confusion about what to do:

> I didn't even know who to call you know because in situations like this, you don't know—do you call the police?...I had no clue. Had it been a stranger, immediately I would have picked up the phone and called 911, but because it was someone in my house, do you call DFCS?

This mother shared her distress about not knowing how to react to her child:

> How can I reaction? I don't want to cry. I don't want to scream. I don't want to say nothing. My son needs me. I love to talk to my son. I said, how can I do it?... Okay, you have all my cooperation; help my son please. And at that moment, I

> teared a little bit, and I say 'Help my son; please help me. I don't know how I can do it. Help me'.

Some of the confusion that the mothers experienced was related to feeling uninformed about the child sexual abuse intervention process and the police response to the report. Feeling "left out of the loop," and in some cases blamed by the authorities, increased their anxiety and anger: This mother shared her experience:

> Then there's like lights in my driveway… and it was DFCS [Department of Family and Children's Services] and a police officer. I had no idea why; I had not received a phone call. They were real tough on me saying that if I put it in her head, I'm gonna be locked up….I'm very bitter about the police.

Another mother stated:

> I was mad, um confusion…when it first happened, I fell out of the loop. I was an outsider you know… and I'm not putting the detectives down or anything okay because they did a really good job at what they did, but I was not the offending person. Keep me in the loop!

*Anger*

Mothers in the study experienced a strong anger response, and they expressed their anger in various ways. Some mothers admitted taking it out on others: "Anger was my main thing….I tend to be particularly hard on people who love me." Another mother shared her anger toward her child for not confiding in her:

> And it's the fact that I asked [my child], and she told me that if she had not started bleeding, would not have told me. And you know, I had to sit there and fake it like I was okay with it because I told her to be honest with me, and I wouldn't get

> mad, and you know I just went through a period where I was like hateful of what she would have done you know. You would continue to put yourself through something like that and not speak to me when I am your biggest person to back you up. Nobody else has your back more than I do.

Five individual participants and four group participants expressed anger toward the perpetrator. Five mothers entertained thoughts of seeking revenge and wishing vengeance on the perpetrator: For example, this mother described her decision making process after catching the perpetrator with her child:

> I couldn't remember where my things were and between those kind of thoughts to kill, not to kill, what not to do, to leave the house, where your stuff, your real important stuff was, and he was knocking at the door, I was thinking how do I do it? Should I hit him with my hands…and then it was like that was not right. If I do, I will go to jail. Who is going to take care of my kids? But at the same time you are so mad at this person.

This mother expressed her need for vengeance:

> For me to get over this completely, I think to have him have to go through what he put them through. Um for him to be made a victim like he made them victims…I want him to feel helpless and violated and completely out of control…. I want him in jail with some big bald guy making him his bitch.

*Guilt*

All of the individual participants and the focus group participants collectively expressed feeling immense guilt about their children's victimization. They felt as if they were responsible for the abuse since they were not aware it was happening. Their notion

that they failed to protect their children, in their own home in several cases, caused them much distress as they engaged in retrospective questioning of their choices and their children's behavior. One mother stated what went through her mind: "How did it—what did I do? What didn't I do? You know I always watched her. I always did everything, you know. He was a wonderful big brother, what did I not see, you know what did I miss?" Another mother reflected: "I was cleaning my kitchen when he was molesting my daughter."

Several other mothers felt directly responsible and could not resolve the guilt: "I'm always going to carry the pain of what they had to go through, you know and that's my part in it…that leads back to the guilt." This mother shared:

> I felt like I put him in this situation…I was doing it [leaving him with child-care provider] just to get honestly to get a break for an hour…just to have some peace of mind for an hour, so I felt very guilty because I put them in that situation and it haunts me….I mean I literally handed my kids over to him all the time.

Another mother made a similar comment about her guilt:

> It killed me, it absolutely killed me. Not only did I bring this man into my life, but as soon as I step outside to do something for me, and in the long run it was for them too, but at the time I was doing it for me…There is still a large part of me that will always blame myself…I also am their mother, and I am the one that exposed them now, so it will always be a part of me that feels very guilty for that, and I will never forgive myself for that, so that's the cross I bear.

Recognizing their children's abuse-related behaviors in hindsight caused considerable self-blame among the mothers. One mother shared:

> No wonder my son he wouldn't want to go to bed at night. He would scream about going to bed, and I thought he was just being a brat, you know….I wondered why he constantly every time he [perpetrator] came around he always pooped on himself….I didn't click…. It was all my fault. I shouldn't have put him—gave him the opportunity for this to happen.

Another mother carries guilt because the abuse started the first time she left her children:

> That first trip I took, and I keep going back to that first trip, but that first trip has turned out to be—it was a lot of milestones in my life, and it turned out to be more milestones because now I'm finding out that was the beginning of it and that was the first time [my child] was away from me; that was my first trip from home ever.

She also felt like she failed as a parent because her child did not tell her about the abuse:

> I just feel like, I guess I didn't feel like I empowered her to feel like she could [say no]…. "How could it go on for two years, and baby you never tell me?" I felt at one point like I had a big impact on her life, but you know, I don't feel like it was as big of an impact…you know there is guilt associated with it.

*Fear*

All of the mothers experienced some type of fear. Several sources of fear surfaced. This mother commented on her fear of the perpetrator: "I had him on tape just like that threatening to kill us." Another mother also described her fear response to the perpetrator:

> I didn't know that he knew where I lived….I was running late…but when I got

> there, he [perpetrator] was there, too and [my child] was white as a sheet….I pulled up and both of them [children] got in the car with me….I have an automatic garage door opener, and I just shut it behind me, but I saw him pulling in….I go them in the house up the stairs, and I immediately called 911.

Mothers also expressed the fear of facing the situation alone: "I was afraid…Oh, please Lord, let me do this by myself" and the fear of having their children taken away:

> I had to meet with a DFACS lady and she gave me her card and she said, she was very nice…and she's saying, she's on my side, she is here to help and I'm thinking, you're the one who would take my daughter away from me. I'm not gonna talk to you. I'm not gonna tell you what I'm thinking, what I'm feeling, I'm not gonna give you any ammunition to use against me.

This mother revealed her fear of her children being revictimization:

> I just think my eyes are wide open…I have to know where my kids are all of the time. I don't like crowds; I'm like always holding their hands…if they go somewhere they have to have the glow in the dark necklaces or bracelets…or I will put on the matching outfits so if they get lost they can look for that particular outfit.

Additionally, mothers feared leaving their children: "I was scared to leave home," or that they would not be there for their children: "I just wanted her to know that I can be there for you, but I'm afraid that the one time I say, that this minute or hold on, you know, I'm afraid, so then If I try to be there whenever she needs me to." Finally, mothers feared treatment ending and the long-term effects of the abuse: "Really, I don't want to think about, but I am afraid when I finish [treatment at CAC]…I fear for my son's

choices because of his abuse."

*Shame*

Six of the individual participants and the focus group participants collectively described the enormous amount of shame and embarrassment they experienced. In addition to blaming themselves for their children's abuse, these mothers, five individual participants and four of the group participants perceived blame from others. They felt judged and stigmatized by family, friends, acquaintances, the legal system, and society. Some examples that were given by four different mothers are as follows: "Not only do you question yourself sometimes, how could you do this, this is your fault, I think society as a whole will look at you—how could you not know this is happening?"; "I have never felt shame like that ever in my entire life, I considered myself an excellent mother."; "I didn't tell anyone. The shame, the embarrassment, the judgment of other people, the not wanting my daughter to have to look at people"; "In the beginning, they [in-laws] blamed me….I just don't talk to them about it".

Another mother stopped attending church because she felt judged:

> I used to go to church, but when this happened church dropped the ball…just the way they seemed to view me after this happened….and uh I don't like it they look down on me….I guess because I couldn't protect my kids you know.

A different mother felt judged and blamed by law enforcement:

> If it's the husband or the father of the child, they look at you like you have to pass the test? You gotta make sure you didn't do it to and it makes you feel even worse, because you know your child's been hurt, here the police are going, "well,

you could have stopped this you know.

*Betrayal*

The majority of the children (twelve out of 13 families) in the study were molested by an individual the mother knew and trusted , thus, betrayal emerged as a common theme . The following are examples of how three different mothers felt betrayed: "You trusted that you had somebody there to help take care of the kids while you were sick"; "This can't be happening because I had so much faith in this guy, and I didn't want to feel like some, that he would do something like that. Like I felt betrayed"; "He had taken the place of their fathers…we had all put our trust and faith in him, and to do this was horrible……it was just how could you do this? It hurt that he could do that."

*Distrust/Isolation*

All of the mothers described how the experience affected their trust in others. Six individual participants and at least two group participants shared how distrust inhibited their ability to establish and maintain relationships. This lack of trust and security lead to social withdrawal and isolation. One mother described it as, "Paranoia. You just don't know who you can trust anymore and who you trust, I trust very few people with my children anymore." Another mother stated, "Well your boundaries are destroyed. Not just your child's, yours. I mean there are none. It's a free for all once it happens." A different mother commented on her social withdrawal: "I'm cutting away from everybody cause you know I'm trying to protect me and I'm trying to protect my kids…This [coming to CAC] is my weekly outing." These two mothers also described their distrust:

> It's definitely altered my view of people…I will never trust another human being completely for the rest of my life, and I wasn't like that. I am a very loving, giving, open, generous woman, or was, and I'll never do that again. I'll never open myself up like that to anybody to be hurt like that ever again.
>
> It made me not believe in the whole relationship thing, and it makes it hard for people to get close to you….not trusting…it kind of did make me reclusive…My whole outlook on the way that the world is different. I don't trust a whole lot of...anyone.

Mothers also explained how the abuse has affected their intimate relationships: This mother said, "It almost to a point where I don't feel like I can have a relationship until they leave, until they move out…I absolutely can't trust anybody as far as males are concerned." A different mother expressed: "How many times has anybody ever contemplated, you know I don't think I will ever have sex again, or how it effects your personal intimacy, or the fact that you can't get close to somebody else."

*Grief and Loss*

Six of the individual participants and the focus group participants collectively suffered significant grief and loss. Most obvious was the grief they experienced from the betrayal and loss of the relationship with the perpetrator and the disruption the abuse caused to the family. In many cases, the families were emotionally torn apart and physically divided because the abuse was perpetrated by a relative or close friend. One mother spoke about her husband: "He was my entire support system… and then we had an order that we are not even allowed to speak until court date." Another mother's marriage was broken: "I think I am protecting [child] and he's protecting [perpetrator] so

we have been kind of separated instead of coming together and you know resolving this within our own family, so it's basically torn us apart….We're getting a divorce." A different mother compared grief and loss to the death of a loved one: "It was like somebody died in the family." This other mother conveyed her extreme pain:

> I wanted to die, the pain was so great, I couldn't decide, I felt like I had to chose between the two people I love most in the entire world and I couldn't, the shock that one had hurt the other was just unbelievable to me, and I just wanted to die.

Another mother shared the grief and loss over her best friend:

> I guess, you know, not to make a rationale for it, but… if it had been a total stranger, if I would have felt different or it would have been easier, but because this lady was in the emergency room when my baby was born, she helped me move my stuff; she was the emergency contact over their father…because I could depend on her

Relationships among immediate and extended family were also conflicted or estranged in five cases: For instance: "I know that with my sister our relationship is nothing like it used to be….I mean when she [mother's sister] blames my kids for what her son did, I'm like no, no, no, goodbye click." Another aspect of grief for the mothers was over the loss of "what was" and "what would be" for their children and families as they recognized that the world as they knew it before the abuse would never be the same. This mother expressed:

> I wish I could have them in bunk beds together, because I had them so close….[child was sexually acting out with brother] we can't have them do anything together; I can't leave them alone together, I just can't have a normal

> life….They can't have sleepovers…his friends are coming over this weekend and they are going to want to sleep together, and I'm going to be like, you've got to sleep with your mom…we always have to find an excuse.

*Depression and Other Symptoms of Distress*

At least 10 of the participants reported some symptoms of depression . They described profound sadness and crying spells: "Well, at first when this first happened, I cried at the drop of my hat," as well as sleep and eating disturbances: "Adding depression—I stayed every weekend when I don't want to work…I just stay in my bedroom for a whole day and sleep and crying and sleeping and crying, sleeping, crying and eating." Another mother stated, "In the middle of my depression….I lost weight, and I know me that years before I was looking young…but at that moment, a few months ago, I could see my face, and I say oh my goodness, now I am old."

Mothers also described symptoms such as irritability, withdrawal, inability to concentrate, and loss of interest and energy in doing their regular activities as manifiestations of the emotional distress they experienced. One mother shared, "They've had to up my dosage of antidepressants because my temper's got really, really bad." Another mother commented, "I got some depression because in that moment for maybe two months, I didn't want to work and go outside of my home….I don't want to finish nothing." Likewise, this mother remarked:

> I spent all my time in my room, except when I got groceries…or when I did things for my daughter, otherwise I just withdrew into my bedroom most of the time. I only go dressed when I had to and I would pretend I was okay for a few hours when she got home from school… And then she'd go to bed and I'd go

back into my room and just, I spent a couple months staring at a ceiling.

Mothers also experienced other symptoms of distress including nightmares: "Nightmares, I had nightmares"; intrusive thoughts about their children's abuse: "You know I try to keep the pictures out of my mind, about you know what was actually going through my baby's head"; and physical problems: "I've really had more migraines. I've been having migraines for years now, but I've been to the emergency room twice since this incident" and "I was very stressed out…to the point where…my left eye would flicker. It was doing it constantly."

### *Factors Influencing Maternal Belief, Protection, and Support Responses to Child Victimization*

#### *Concern for Children's Safety*

All of the mothers showed great concern for their children's safety and well-being. Three major themes demonstrating their concern emerged: belief, support, and protection. All of the mothers in this study believed their children had been abused. It is important to note that the mother's initial disbelief was related to the shock that their children were victimized and was independent of their belief in their children's disclosure.

*Belief.* Belief was defined as the mother believing that her child had been sexually abused. Mothers who believed their children did not necessarily know all the details of their children's victimization, but believed something had happened. Several mothers shared: "Initially it was disbelief. I mean I believed the girls. I believed my girls when they came to me. I knew they were telling the truth, it was just disbelief that he could actually do that"; "I knew that something happened; I didn't know what"; "For me there

is not a fence with her disclosing and then everything that has taken place since then. I am very clear"; "This is stuff, that there is no way he can make up. There is no way…he says it so innocently"; and:

> What could you do to a 22 month old—what could be gotten out of that…he was in diapers…what can he do? What can he get out of this…I was going back and forth; I'm not saying I didn't believe him, I just kept going back and forth—just what would you get out of it?

*Protection.* Protection was defined as the mother's actions to ensure her child's safety from the perpetrator. All of the mothers in the study protected their children from the perpetrator. The following quotes illustrate the mothers' protective stance:

> When she told me it was one of those instantaneous things. Seeing her telling me that that was something that you don't make up…as a mother of my child…I can see that, her face, you don't make that up… I was like, okay, you need to leave, um and he [perpetrator] said "let me explain" and I said no, you need to leave. And so that was like basically the end of it and I didn't even think twice about it.

Another mother explained:

> I didn't want it to affect the kids any more than it had already affected them, so I left. I didn't have any other choice at that point. There was no way that I was going to subject my kids to that any longer.

This mother described having to make a critical decision in a matter of minutes:

> It was a matter of seconds or maybe one or two minutes that I had to decide to leave the house for C without my little one, but at the same time I didn't want to leave my little one because he was little and he needs mommy, too, and I knew

> that I was leaving the house for sure. I was not coming back, and I didn't know what to do until I was looking at [my child] through the mirror …and she was like this, like kind of shaking. I had to leave the house.

*Support.* Support was defined as the mother's commitment to her child's safety and well-being. Support was evidenced by the mother's actions to protect, as well as her emotional commitment to her child and the child's treatment and recovery. All of the mothers supported their children in some way. These mothers sought resources to help their children deal with their abuse and attempted to meet their children's needs: "I tried to get all the help I could get from school, from anywhere, and from church". They also believed and communicated to their children that the abuse was not the children's fault: "It was not my son's fault, it was him [perpetrator]". Another mother shared: "It was not the kids fault, and they know that, too."

In cases where the abuse was intrafamilial, supporting meant that the mother had to make choices between the child and the perpetrator: "[Stand by your child] at whatever costs, unfortunately, you—some things we can't—we want people to be at different places, but I have to protect my daughter. I have no choice." Supportive mothers also recognized their children's need for emotional safety in addition to physical safety: This mother wanted to protect her daughter from an unsupportive grandmother: "I don't want her to talk to [grandmother], but it's because I know mom would kind of be dismissive about it. She would be dismissive about it, and that may not be what she needs." These mothers listened to their children and acknowledged their children's need to express thoughts and feelings about the abuse, even ambivalent feelings about the perpetrator: One mother shared: "There are days that she glorifies her father and then there are days

when she says really bad things about him….I just allow her to say it, and I remind her of what he's done." Another mother expressed her willingness to listen to her child:

> I'm telling [child] that at any time you have to be away from me and you feel like you need to talk to me, you can call me, if you need to talk to somebody… I just wanted her to know that I can be there for you.

Support was also evidenced by mothers restraining their own thoughts and feelings in order to help the child. This mother described how she handled her child's disclosure: "You could see my heart hit the floor, and I thanked her for telling me you know, and I didn't tell her I was welling inside. I let her know that I was very appreciative that she did talk to mama." Another mother shared how she supports her children:

> They do take a lot of their cues from me….I try to be very positive about things, and Mondays are hard for them, but it's like okay, we're going to do this. It's gonna be fine, and we're going to get through it and then…I get them home, make sure their taken care of, and then I go to Starbucks for a couple of hours and just scream.

This mother commented on her commitment to her child's therapy: "I can't imagine that if I left and drop my son here, and how can he be feeling if I am just his taxi. Just, 'okay go do your therapy, I am here in the car. When you finish come here'."

Finally, supportive mothers communicated to their children that they would always be there to meet their needs: "I have tried very hard to let them know throughout this whole thing that everything is okay, I'm always going to be here, I'm not worried about it, whatever they need, I'm there, and I've got there back on it."

Four main factors emerged in the data that appeared to influence whether mothers responded in a believing, supportive, and protective manner to their children's sexual abuse. These factors were the mothers' history of abuse, ability to cope with their own distress, relationship with the perpetrator, and amount of support and validation they perceived. Eight of the mothers in the study reported that they had experienced some form of emotional, physical, or sexual abuse in their past. Six mothers had experienced child sexual abuse. It was evident that their abuse experiences influenced how they felt about their own children's victimization, as well as how they responded to their children's disclosure. Many of the mothers gave accounts in which they were not believed, their abuse was never reported, or they never received help. Consequently, several of the mothers continued to have contact with the perpetrators that molested them. The mothers' own abuse experiences enabled them to relate to their children's victimization, and therefore factored into how they responded when their children disclosed.

These mothers who reported histories of abuse made conscious decisions to believe, support, and protect their children in order to prevent them from experiencing the same pain they experienced as children. This mother stated, "I swore when I was growing up—I swore there was no way my kids were gonna go through what I went through…If they came to me and told me Mom, hey, I would believe them." Another mother made a similar declaration:

> I'm strong in that way, but I kept—I mean I'll do anything to—because I was molested as a child, and my parents denied it, so I am the opposite. I was going to do anything to make sure he got his help…Even though my parents never

> believed me, I am not going to do that to my child. I am going to believe everything he says. I am going to be the other extreme.

Many of the choices the mothers made as parents prior to their children's disclosure reflected their concern for their children's safety and well-being which increased the shock, disbelief, and guilt they felt upon learning that their children had been abused. For example this mother advised:

> I don't know if it is because of what I went through because I was trying so hard to be the protective mother. We never had babysitters; we never—the reason I went to the Y is because of the whole background check and everything…I checked on them periodically here and there, I mean, I thought I did my due diligence.

Furthermore, many of the mothers were reminded of their own abuse, forcing them to cope with thoughts and feelings from the past in addition to dealing with the current trauma of their child's victimization. One participant commented about the effects of her own mother's response, "I wish she would have believed me when I was in a place like this maybe I wouldn't have grown up as screwed up as I was." Another mother said:

> It reminds me when I was little that somebody did to me, and nobody did anything for me…not my mom, not my grandmother, nobody. I even had to stay and live in there with the same person living there for years, for years, so one thing that I knew for sure that if it ever happened to one of my kids, that I will leave wherever it took place….They actually found him [step-grandfather] touching me and everything, and it was a huge argument in the house.

During the interviews, several mothers stated that they wanted to break the

intergenerational cycle of abuse. For example this mother shared: “I want my kids to grow up having a normal childhood you know into adulthood and not to carry on the chain because this has been a factor you know grandfather, uncle. I want to stop the cycle.”

Mothers’ inability to cope with their distress influenced their capacity to support and care for their children. These mothers gave examples to illustrate this finding: “I can turn around and concentrate on my children. Before I was blaming myself; I was not giving the kids the support they need you know. But when it finally sunk in that it was not my fault, now it’s the kids I’m concentrating on; helping them recover.” Another mother shared: “The kids didn’t know, but they did all the mess in the living room and their room, and when I heard a lot of noises, just wake up and I would say “What are you doing? Please, mommy wants to sleep and then keep crying”

All mothers in the study believed and protected their children. However, the mothers’ relationship with the perpetrator, and more specifically, the mothers’ level of dependency on the relationship influenced the level of support they were capable of showing. Mothers who were more emotionally or financially dependent upon the perpetrator were less equipped to sever their relationship with the perpetrator in complete support their child. For example this mother shared her perspective about a peer:

> I could really see her struggling with it [leaving the perpetrator]; I don’t think she had, I know she didn’t have the financial backing; I don’t know if she really had the family behind her to help with that either, so I think she was really struggling with that.

Another mother admitted that she was at a financial “advantage”:

> I know that is a big issue with a lot of other mothers. They don't have that income, and it's scary…so that was one thing I knew I had to fall back on. I knew I could do it myself…I know with my whole heart, if I hadn't had it [income] there, I never could have gotten out in the first place.

A different mother did not have a hard time cutting ties with the perpetrator because she was not involved with him anymore; however, she contemplated the difficulty she would have if her daughter were to make allegations against her current partner:

> She gets pissed off at him now and how much more difficult would it be for me to side with her when I love this person?... I mean what if it really did happen? And I think that this happens a lot is that these people abuse these kids and it's because you know mom is gonna side with the husband or the guy because they love—I mean I loved her father, but it was very simple for me to point some fingers and start saying you know and that kind of thing. But I I think that it's very common you know. I don't know—that would just be a guess in my mind that it would be very hard to choose between the two.

Another mother made the choice not to end her marriage with the perpetrator. Her comments show how her relationship with her husband affected her decision:

> My family are my kids and my husband, my parents are both gone, I have no connection with anybody in the older generation, they are all dead. There is no family…I had to deal with things like bail money, in between my daughter being hysterical and not wanting to go to school. I was trying to do them both at the same time, but I was ill and he was the sole support of my family, and I needed him to keep that job, he is also the only person, that we had insurance through,

> medical insurance for my daughter, though she has not seen him since, I've used that medical insurance for her 20 times since the event took place, and so I needed to protect that we could eat and function and I didn't get thrown out of my house

Finally, mothers voiced needing their own support in order to, in turn, give support to their children. This mother's statement reflects the importance of maternal support:

> Don't be afraid to ask for the help that you need or the support you need because you are going to have to give it back to you kids, and that's the important thing. If you are gonna see your kids—if your kids are going to get through this, you've gotta get through this, so that's the important thing.

## Discussion

The findings from this naturalistic, phenomenological inquiry on mothers whose children have been sexually abuse are revealing and significant to research and practice in the CSA field. The finding that the mothers experienced crisis and traumatic distress following their children's disclosure is consistent with existing literature that shows mothers suffer from symptoms of distress in response to their children's victimization (Davies, 1995; Green, Coupe, Fernandez, & Stevens, 1995; Lewin & Bergin, 2001; Manion, McIntyre, Firestone, Ligezinska, Ensom, & Wells, 1996; Newberger, Gremy, Waternaux, & Newberger, 1993). In addition, the results from this study confirm findings from other studies that report that the majority of mothers do believe their children and protect their children (de Young, 1994; Pintello & Zuravin, 2001; Sirles & Franke, 1988; Tamaraz, 1996). The results of the present study also highlight how maternal supportive responses are interdependent on numerous factors, especially their capacity to cope with past abuse, current distress, and their level of emotional and financial dependency on

their child's perpetrator.

It is remarkable that this sample of mothers in this study showed tremendous concern for their children's safety and well-being, and they made significant efforts to meet their children's needs and the needs of their families in the midst of traumatic distress and grief. Though holding their lives together was challenging and exhausting, these mothers did not give up. They had a strong will to heal their children and themselves which underscores their remarkable resiliency. Their stories embodied the significance of being a mother and illustrated the instinctual survival mechanisms mothers possess. Their stories and experiences greatly contrasted with older conceptualizations of the collusive, unsupportive, weak mother. Instead, these findings reveal the complexity and dynamic nature of trauma and grief and its effects on the maternal response. These mothers' voices articulate the maternal capacity to survive and care for their children as best they can in the wake of the devastating and traumatic effects of CSA, both past and present.

The conclusions from this study contradict reports that mothers typically believe their children but do not seek resources and professional assistance in CSA cases (Runyan, Hunter, Everson, & Devos, 1992). The mothers in this study all believed, protected, and supported their children and were all receiving professional services at a CAC. The results from this study may not be congruent with other findings that mothers do not protect and support their children or that mothers do not seek help. This may be due to the fact that belief, protection, and support are not consistently defined in existing studies (Elliot & Carnes, 2001). The definitions in this study take into account the complexity of these constructs and identify specific cognitive, emotional, and behavioral

aspects of the maternal response. It could also be possible that the CAC model and programs adequately met the needs of this sample of mothers which would explain not only their retention in treatment for nine to fourteen months, but also their willingness to participate in the study. This suggests that given appropriate support and resources, mothers will take advantage of services that will assist them and their children in recovery.

This idea is supported by one mother who participated in the focus group who did not feel supported by the CAC. She decided to terminate treatment because the services were not meeting her needs but expressed that had she received the support and validation like she got from participating in the focus group from the CAC services, her decision may have been different. This mother's experience in combination with the other mothers' stories reveal the important implications of understanding and meeting non-offending mothers' needs to help families heal from CSA.

*Implications*

It is helpful to view mothers' responses to their children's sexual abuse within the context of trauma (Scheeringa & Zeanah, 2001). Conceptualizing mothers within this framework creates important implications for understanding their experiences and helping them to heal. It is important for helping professionals to recognize that these mothers are launched into acute crisis upon learning that their children have been abused. It is also important for professionals to appreciate the fact that the mothers' world as they once knew it has been shattered, and fundamental aspects of safety and relationship, such as trust, have been violated. The guilt and shame the mothers experience create additional feelings of isolation and withdrawal. These are key considerations for helping

professionals who expect or require mothers to openly share personal information. Recognizing that anger, disbelief, and withdrawal are often protective responses rather than uncooperative responses may increase professionals' empathy and patience when working with mothers whose children have been abused.

Confusion about how to respond to their children and how the investigation and legal process works compounds the already overwhelming emotions of grief. The cycle of grief and traumatic distress oftentimes leads to symptoms of depression. Assessing mothers' level of distress, depressive symptoms, and coping skills and offering appropriate support and resources are critical. Moreover, educating mothers about what to say to and do for their children and guiding mothers through the intervention process may help reduce their fear and anxiety.

Providing these mothers with a safe place, a listening ear, and a nonjudgmental approach is essential to establishing rapport and building trust. Based on the mothers' experiences from this study, it appears validating and normalizing their experiences is also crucial to helping them overcome shame and guilt, socially reconnect, and feel more secure in the world. This is especially important to increase parenting efficacy since their children's victimization frequently causes them to question their own judgment and role as a mother. Those mothers who have personally experienced abuse may need additional support as their children's abuse may elicit memories and symptoms related to their own victimization. Acknowledging mothers' efforts to seek help and approaching each mother with sensitivity and empathy will not only enhance the professional-mother relationship, but should lead to better outcomes for the children and families as the mothers feel increased safety and empowerment as women and mothers.

*Limitations and Future Directions*

The results of this study are limited to mothers who have received services and followed through with treatment for an average period of 9 to 14 months. This sample of mothers may be characteristically different than those who have received treatment for a shorter or longer period of time. Another similar limitation is voluntary participation. Voluntary participants' experiences, as a group, may differ from the experiences of mothers who chose not to be involved in the study.

Due to the fact that this study is exploratory and the findings are tentative, more research needs to be conducted to confirm or elaborate upon mothers' experiences on a larger scale. Although, it appears that perceived support and validation are critical components to addressing traumatic distress, increasing functioning, and improving maternal retention in treatment, future studies should investigate mothers who drop out of treatment in order to get a better understanding of their response and needs. Furthermore, larger studies need to be conducted on program evaluation and efficacy for CACs. These studies should examine the types of caregiver services and most effective modes of delivery, as well as the multi-disciplinary team response to mothers involved in the child sexual abuse intervention process.

Providing services for mothers whose children have been sexually abuse is an important aspect of child treatment at CACs. It is very important to work with the entire family on abuse-related issues since the effects of the abuse impact all family members. Thomlenson (2003) advised that retaining families in the intervention process is a significant problem and called for more research to address this issue. Evaluating how CAC services do or do not meet the needs of these mothers and families and designing

appropriate, effective interventions is an important next step in the fight to heal and prevent child sexual abuse.

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