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CHILD EXTRAFAMILIAL SEXUAL ABUSE: PREDICTING PARENT AND CHILD FUNCTIONING

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ABSTRACT

Objective: This study evaluated the emotional and behavioral adjustment of parents and children within 3 months and 1 year after the discovery of child extrafamilial sexual abuse.

Method: Ninety-two case parents (63 mothers, 29 fathers) and 56 children were compared to a nonclinical comparison group of 136 parents (74 mothers, 62 fathers) and 75 children. Parent adjustment was assessed using self-report measures while child functioning was assessed using a combination of child-, parent- and teacher-report measures.

Results: Mothers, fathers and sexually abused children experienced clinically significant effects both initially and at 12 months post-disclosure. Children's perceptions of self-blame and guilt for the abuse and the extent of traumatization predicted their self-reported symptomatology at 3 months and 1 year post-disclosure. Child age and gender also significantly contributed to the prediction of many of the child outcome measures. No abuse-related variable was related to any child self-report measure. Mothers' satisfaction in the parenting role, perceived support and intrusive symptoms predicted their initial emotional functioning. Avoidant symptoms, child's internalizing behavior and mothers' initial emotional functioning were significant predictors of longer-term emotional functioning.

Conclusions: Results emphasize the need to address children's abuse-related attributions and underscore the need to expand our focus beyond the child victims to the traumatized families. © 1998 Elsevier Science Ltd

Key Words—Sexual abuse, Children, Parents, Extrafamilial, Trauma.

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CHILD SEXUAL ABUSE (CSA) is a serious and, unfortunately, a common event (Cosentino & Collins, 1996). Canadian and American community surveys of adults suggest that extrafamilial sexual abuse (ESA) of children is the most prevalently reported form of sexual abuse. Approximately 20% of all abused respondents report intrafamilial sexual abuse (ISA), in contrast to 35% who report ESA (Russell, 1986; Wyatt & Peters, 1986). When noncontact abuse is included, the estimates of ESA are even higher, reaching 71% of the samples (Finkelhor & Hotaling, 1984). Researchers also agree that ESA is the most common form of sexual abuse among male victims (Finkelhor, 1979; Finkelhor, Hotaling, Lewis, & Smith, 1990; Vander Mey, 1988).

Considering the high prevalence of ESA and the paucity of studies that have investigated the specific effects of ESA on children or their parents, it is evident that further investigations in this area are warranted. The disclosure or discovery of ESA from another source (hereafter referred to as disclosure) has the potential to "traumatize" the entire family system (Figley, 1989; Haase, Kempe, & Grosz, 1990; McLeer & Rose, 1992; Regehr, 1990; Reyman, 1990). Children's perceptions of parental responses are likely to have a significant impact on their coping and adjustment post-disclosure (Conte & Schuerman, 1987; Mannarino, Cohen, & Gregor, 1989; McLeer & Rose, 1992; Wolfe & Gentile, 1992).

The current knowledge of children's adjustment following the disclosure of ESA is still very limited, and is based on two general kinds of studies. The first kind includes studies which focus exclusively on ESA and highlight the impact on children's emotional and behavioral functioning (Faller, 1988; Finkelhor, Williams, & Burns, 1988; Kelley, 1989; Ligezinska, Firestone, Manion, McIntyre, Ensom, & Wells, 1996; Waterman, Kelly, McCord, & Oliveri, 1993). The second includes investigations which compare functioning of ESA to ISA victims (Anderson, Bach, & Griffith, 1981; Cohen & Mannarino, 1988; Mannarino, Cohen, & Gregor, 1989; Mannarino, Cohen, Smith, & Moore-Motily, 1991; Mian, Marton, & LeBaron, 1996; Wagner, 1991). A summary of these studies findings can be found in Ligezinska and colleagues, 1996.

Gender differences have generally been understudied in the child sexual abuse literature. In studies that have looked at combined ISA and ESA samples, boys are typically underrepresented. Moreover, gender is confounded with type of abuse as boys are more likely to have experienced ESA. Studies on pure ESA that have investigated gender differences are few in number (see Burgess, Hartman, McCausland, & Powers, 1984; Kiser, Pugh, McColgan, Pruitt, & Edwards, 1991). With the exception of Ligezinska and colleagues (1996) to date, most methodologically sound studies on ESA have not included boys (i.e., studies by Mannarino and colleagues).

Several authors have identified the need to include family variables in assessing the psychological impact of child sexual abuse (Alexander & Lupfer, 1987; Conte & Schuerman, 1987; Esquilin, 1987; Friedrich, Beilke, & Urquiza, 1987; Pelletier & Handy, 1986; Wolfe & Gentile, 1992; Wyatt & Mickey, 1987). However, most of these studies have addressed parental functioning only within the context of assessing the traumatic impact of sexual abuse on the child and focused mainly on ISA or combined ISA with ESA (Finkelhor, 1984; Friedrich, 1991; Gomes-Schwartz, Horowitz, & Cardarelli, 1990; Rivera, 1988; Winton, 1990). The few studies directly assessing parental adjustment following disclosures of ESA support the premise that disclosure of child sexual abuse is a traumatic stressor for parents as well as children (Burgess, Hartman, Kelley, Grant, & Gray, 1990; Kelley, 1990; Kiser et al., 1988; Manion, McIntyre, Firestone, Ligezinska, Ensom, & Wells, 1996; Oates, O'Toole, Lynch, Stern, & Cooney, 1994; Wagner, 1991).

In summary, studies addressing the reactions of parents and children to ESA suggest that both parents and children are at risk for subsequent adjustment difficulties. Most have combined ISA and ESA, or have been retrospective with variable assessment procedures and nonstandardized measures. Many studies are limited by their small restrictive samples, lack control groups and theoretical background. None have done systematic analyses of families who refused to participate. The majority of studies do not typically distinguish between the time of abuse and its disclosure, do not control for the abuse-specific variables such as nature of the act(s), duration and frequency,

and use a single source to evaluate child functioning (Beitchman, Zucker, Hood, DaCosta, & Akman, 1991). Gender differences have been understudied with results on the differential effects of ESA being equivocal.

The goals of the present research were to evaluate parents' emotional and children's emotional and behavioral adjustment following the disclosure of ESA. Preliminary data on the initial reactions of children and their parents have been reported previously (Ligezinska et al., 1996; Manion et al., 1996). This paper evaluates the adjustment of child victims and their parents prospectively up to 1 year post-disclosure. A major strength of this research is its use of a theoretical framework. Moore Newberger and DeVos' (1988) "developmental lifespan model" of child sexual victimization was chosen as the framework for this investigation of child reactions to ESA and was modified as a model of secondary traumatization for parents. The model recognizes that the traumatic stressful experience begins with the onset of the abuse and continues through the disclosure phase. The potential sources of trauma identified by this model are objective aversive aspects of trauma and the subjective experience of trauma (based on Conte, 1985). This model has the advantage of integrating individual, cognitive, and familial variables in predicting the outcome of primary and secondary victims following sexual abuse. Oates and colleagues (1994) used this theoretical framework in their study of stability and change in outcomes for sexually abused children and their families. Accordingly, the extent to which the objective aspects of the abusive incident(s) and the subjective experience of the abuse predict parent and child adjustment 3 and 12 months post-disclosure were examined.

METHOD

Participants

Case Group. One hundred and fifty-one families in which a child had been sexually abused by someone outside of the family were contacted by the Child Protection Team of the Children's Hospital of Eastern Ontario (CHEO), Crown Attorneys' offices, and Children's Aid Societies in the Ottawa-Carleton Region. Of these, 66 families agreed to participate. Families were selected if the sexual abuse occurred no longer than 1 year prior to its disclosure. The present study defined ESA as one or more sexual experiences prior to the age 16 with someone unrelated by blood or marriage (official or common law) or with a distant relative who was not part of the nuclear family and did not reside with the victim. The sexual experience had to include some degree of body contact. No minimum age differential between victim and perpetrator was used.

In all, 92 case parents (63 mothers and 29 fathers) and 56 case children from 66 families participated and were seen initially an average of 12.8 weeks ($SD = 2.6$) after the disclosure of sexual abuse. Although both parents were encouraged to participate, parents who chose to participate without their partner were accepted. The average age of children from case families who had experienced ESA was 10.26 years ($SD = 3.1$) and ranged from 5.5 to 15.8 years. Child victims had to be living with at least one parent, step-parent or foster parent who functioned in a primary caretaker role for at least 6 months prior to the ESA incident(s). It was necessary for children to have an estimated IQ of at least 80 (based on the Peabody Picture Vocabulary Test-Revised, Form M; Dunn & Dunn, 1981). Participating parent(s) had a minimum of grade six education and fluency in English. Parent(s) with a child who had experienced both ISA and ESA were excluded.

Comparison families were selected based on the same inclusion and exclusion criteria as case families, with the exception that the child had never experienced any form of sexual abuse as reported by the parent(s) and/or the child. These families were recruited primarily through the medical records at CHEO. Families were matched on the sex and age of the child (within 6 months) and where possible, family constellation (single/two parent family). The comparison group con-

sisted of 75 families. In all, 136 comparison parents (74 mothers, 62 fathers) and 75 children participated in the study.

Assessment Procedures

The vast majority of families for both groups were seen in their own homes with a few families being seen at CHEO or at their referring agency. All of the interviewers conducting the assessments were women. During the assessment, one researcher worked with the child while another interviewed the parent(s). In families where both parents participated, they were seen together with self-report measures completed separately.

Intellectual screening was the first step of the child assessment process. To ensure that all children understood the measures, those younger than 12 years of age had the self-report measures read to them in a standardized format. Parental consent was obtained to permit the completion of the teacher-report questionnaire.

The Nature of the Abusive Experience Form (NAEF) was used to identify the parameters of the abuse experienced by the case children. This information was obtained through a review of the official records for all families referred to the project whether they chose to participate or not. Descriptive information was also obtained from the original referral source for all case families. The median income for each family was established by postal code obtained from Statistics Canada using data from the "FSA and Postal Code Data Bank System" for 1989. For case families, the assessments were conducted within 3- and 12-months of the disclosure of sexual abuse. Comparison families were seen at intervals matching the case assessment periods. Follow-up assessments were the same as initial assessments, except that the demographic questionnaire was not repeated and the Follow-up Structured Interview Specific to Sexual Abuse was used for the case families instead of the Initial Structured Interview.

Child Measures

Piers-Harris Children's Self-Concept Scale-Revised (Piers, 1984). The total score and the anxiety subscale score were used from this 80-item self-report measure of children's perceived self-concept.

Depression Self-Rating Scale for Children (Birleson, 1981). A Total Score reflecting the level of depressive symptomatology was used for this 18 item self-report scale.

Children's Self-Efficacy for Peer Interaction Scale (Wheeler & Ladd, 1982). This self-report scale assesses the ability of primary school aged children to perform successfully in a variety of social situations with peers. It consists of 22 statements which describe hypothetical social interactions, and the child is asked whether or not these interactions would be problematic for him/her.

Adolescent Social Self-Efficacy Scale (Connolly, 1988). This self-report scale measures adolescents' perceptions of social effectiveness in concrete social situations. It is an upward extension of the children's Self-Efficacy for Peer Interaction Scale (Wheeler & Ladd, 1982) and was administered to participants older than 12 years.

Fear Survey Schedule for Children-Revised (FSSC-R; Ollendick, 1983) and the *Sexual Abuse Fear Evaluation Scale* (SAFE; Wolfe & Wolfe, 1986). For administration purposes these two scales were presented in one format. The FSSC-R includes 80 short statements that ask about fears related to failure and criticism, the unknown, injury and small animals, danger and death, and health. The SAFE includes an additional 27 items which cluster along two dimensions: Sex-Associated Fears and Interpersonal Discomfort (Wolfe & Gentile, 1992). A Total Score of the FSSC-R and the two

sub-scale scores of the SAFE were used.

Measures Used with Case Children Only

Children's Impact of Traumatic Events Scale (CITES; Wolfe, Wolfe, Gentile, & LaRose, 1986). The CITES consists of 54 items assessing, in an interview-like format, perceptions and attributions related to sexually abusive experiences (Wolfe, Gentile, Michienzi, Sas, & Wolfe, 1991). Three sub-scales assessing the PTSD symptomatology were used: Intrusive Thoughts, Avoidance, and Sexual Anxiety (Wolfe & Gentile, 1992). As well, the Self-Blame and Guilt sub-scale was added to assess the children's abuse attributions.

Parent Measures

Brief Symptom Inventory (BSI, Derogatis & Spencer, 1982). The Brief Symptom Inventory is a 53-item shortened version of the SCL-90R (Derogatis, 1977) which evaluates psychological symptoms experienced within the previous week. It was used as the primary outcome measure to assess the level of psychological distress experienced by parents. It provides information on the nature and intensity of a person's emotional distress (global severity index), and the pattern of symptomatology along nine dimensions.

Parent Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978). This 17-item self-report instrument was used to assess parents' perceptions of their parenting abilities. It measures parental self-esteem along two dimensions: skill and knowledge in parenting (Efficacy), and the value and degree of comfort related to the Parenting Role (Satisfaction).

Family Adaptability and Cohesion Evaluation Scales—FACES III (Olson, Porter, & Lavee, 1985). This 40-item self-report measure was used to assess family functioning. There are two scales, one to assess perceived levels of family cohesion and adaptability (20 items) and another to assess desired levels of functioning (20 items). These characteristics are believed to be critical resources to cushion family members' perception of stress (Anderson, 1988).

Child Behavior Checklist—Parent Report Form (CBCL; Achenbach & Edelbrock, 1983). The 1983 version of this 138-item checklist was used for the assessment of parents' perceptions of child (4 to 18 years) emotional and behavioral problems. For purposes of this study, the Total Behavior T-score, and the T-scores on the Internalizing and Externalizing sub-scales were used.

Measures Used with Case Parents Only

Structured interview specific to sexual abuse. This interview was adapted from Bernbaum (1986) and was conducted in two parts. The first part established the context under which the sexual abuse was disclosed, knowledge of sexual abuse, the relationship of perpetrator to the family, and the details surrounding any involvement of the family with the court system. The second part assessed the events following the disclosure from a cognitive and affective perspective. Parents were asked about their perceptions of the aftermath of the sexual abuse on their family, their self-appraisal of how they dealt with the crises following disclosure, and the availability of emotional and community support for their own needs (cognitive appraisals). All scoring of the interviews was double-checked, 38% of which was coded by an independent rater. Inter-rater agreement for the open-ended items ranged from .88 to .92.

Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979). This 15-item self-report scale is designed to evaluate stress responses to a traumatic event. It classifies the effects of stress into two

major categories: Intrusion and Avoidance, and assesses the level of each over the past week.

Parent's Perception of Events (Wolfe & Wolfe, 1988). This 17-item self-report inventory is part of a larger Parent Impact Questionnaire which was devised by Wolfe & Wolfe (1988). It was used to assess parents' beliefs and attributions of blame for the sexual abuse along four dimensions: belief of the child, and attributions of responsibility to the perpetrator, to the child and to themselves.

Data from the Agencies

The Nature of Sexual Abuse Form (NAEF). This measure was adapted from Wolfe and colleagues' (1986) History of Victimization Form and used to collect information on the characteristics of the sexual abuse for the participating and refusing-to-participate case families. The form operationalizes the severity of abuse in terms of type, duration, frequency, number of perpetrators, degree of physical injury and the type of coercion. As well, agencies provided available information on the basic demographic characteristics for the case families who refused to participate in the study.

RESULTS

Recruited Case Participants Versus Refusers

Throughout recruitment, 151 case families meeting the definitional and inclusion criteria of the study were contacted. Of these, 85 (56.3%) declined to participate. Case participants and refusers were compared on major demographic characteristics (child's age and gender; parents' age and occupation; family income; single vs. two-parent status) and variables related to the nature of reported sexual abuse based on the NAEF collected from referring agencies. There were no differences on major demographic characteristics other than children from participating families being, on average, one year younger than refusers (9.4 vs. 10.5 years; $t(149) = 2.19, p < .05$) and having slightly less severe physical injury associated with their abuse (1.3 vs. 1.9; $t(149) = 2.44, p < .05$). Characteristics of the sexual abusive experience and perpetrator characteristics for participating families have been presented elsewhere (Manion et al., 1996).

Participants Versus Dropouts

More case than comparison families dropped out of the study at 1 year post-disclosure (11 mothers, 7 fathers, and 13 children dropped out of the case group vs. only 2 children out of the control group). On demographic information, dropout mothers had 2 fewer years of education, and were 3.7 years younger than mothers who remained in the study. There were no differences on any demographic variable for fathers or children who remained in the study at 12 months post-disclosure compared to those who dropped out. No differences were found on perpetrator variables, parent or child reports of child functioning, or parental self-reports of general emotional functioning. The only child variable that distinguished between participants and dropouts was child IQ scores (93.9 for dropouts vs. 104.1 for participant children).

Differences on Background Demographic Data

The matching procedure was successful in achieving equivalence between case and comparison participants on child's age and gender. The two groups differed significantly on certain demographic characteristics with case families being lower on parents' age, occupation, education, family income, and child IQ. There were twice as many single parent families in the case group (25 vs. 12; $\chi^2(2, n = 141) = 8.78, p < .05$). After examining the inter-correlations among these

Table 1. Means and Standard Deviations for Mother’s Questionnaires (Case and Comparison) by Phase of Assessment

Measures		Assessment					
		3 months post-disclosure			12 months post-disclosure		
		<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>
GSI ^a	case	57	62.49	9.46	46	58.52	11.95
	comparison	74	49.66	9.17	56	49.34	10.16
Efficacy ^b	case	55	35.00	6.56	45	33.47	5.96
	comparison	74	34.04	6.10	56	35.23	5.26
Satisfaction ^c	case	55	35.20	8.02	45	35.71	6.71
	comparison	74	41.54	5.80	56	41.79	5.98
Faces III ^d	case	54	7.76	4.43	45	7.87	4.54
	comparison	74	6.51	4.06	56	6.16	3.10
Intrusive Symptoms ^e	case	58	20.31	9.82	46	12.80	9.83
	comparison	--	-----	-----	--	-----	-----
Avoidant Symptoms ^e	case	58	17.50	8.71	46	13.87	10.61
	comparison	--	-----	-----	--	-----	-----
Internalizing behaviors ^f	case	56	65.61	10.56	47	63.17	8.75
	comparison	74	55.61	08.20	56	51.25	7.99
Externalizing behaviors ^g	case	56	62.41	9.67	47	61.45	7.99
	comparison	74	52.31	8.31	56	48.86	6.65

^a Global Severity Index - t-score.

^b Parent Sense of Competency - Efficacy raw score.

^c Parent Sense of Competency - Satisfaction raw score.

^d FacesIII = Family Adaptability and Cohesion Evaluation Scales III - Individual Distance from Centre.

^e Raw Sub-scale score on the Impact of Event Scale.

^f Child Behavior Checklist Parent Form - Internalizing t-score.

^g Child Behavior Checklist Parent Form - Externalizing t-score.

variables, mother’s age, parental occupation, and child IQ were used as covariates in further analyses.

Differences Between Case and Comparison Parent and Child Self-Reports

Mothers’ and Fathers’ Functioning. Means and standard deviations for mothers’ and fathers’ self-report measures are found in Tables 1 and 2, respectively. Separate repeated measures multivariate analyses of covariance (MANCOVA) were conducted assessing mothers’ and fathers’ emotional functioning at 3 and 12 months post-disclosure. The repeated measure was Time of assessment, the between subject factor was Group and the dependent Variables (DV) were FACES-III (individual Distance from Center), GSI (*t*-scores), Parent Satisfaction (raw scores), Parent Efficacy (raw scores). Adjustment was made for two covariates (parental occupation and mother’s age).

Table 2. Means and Standard Deviations for Father's Questionnaires (Case and Comparison) by Phase of Assessment

Measures		Assessment					
		3 months post-disclosure			12 months post-disclosure		
		<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>
GSI ^a	case	26	55.96	11.60	18	54.39	12.69
	comparison	62	49.61	09.60	47	50.57	10.03
Efficacy ^b	case	25	36.92	5.80	18	33.94	5.35
	comparison	62	33.50	5.45	47	33.13	4.87
Satisfaction ^c	case	25	39.24	6.83	18	39.28	6.61
	comparison	62	41.68	5.50	47	40.32	5.95
Faces III ^d	case	25	6.97	3.13	18	6.59	3.69
	comparison	62	5.39	3.29	46	5.75	2.94
Intrusive Symptoms ^e	case	26	11.27	8.33	18	6.39	7.36
	comparison	--	-----	-----	--	-----	-----
Avoidant Symptoms ^e	case	26	11.96	10.43	18	8.00	9.00
	comparison	--	-----	-----	--	-----	-----
Internalizing behaviors ^f	case	25	63.28	9.73	18	60.89	10.98
	comparison	62	52.71	8.36	47	51.53	08.69
Externalizing behaviors ^g	case	25	62.12	8.47	18	59.61	8.59
	comparison	62	50.95	8.00	47	49.87	8.65

^a Global Severity Index - t-score.

^b Parent Sense of Competency - Efficacy raw score.

^c Parent Sense of Competency - Satisfaction raw score.

^d FacesIII = Family Adaptability and Cohesion Evaluation Scales III - Individual Distance from Centre.

^e Raw Sub-scale score on the Impact of Event Scale.

^f Child Behavior Checklist Parent Form - Internalizing t-score.

^g Child Behavior Checklist Parent Form - Externalizing t-score.

With the use of Pillais' criterion, the combined DVs for mothers' self-report measures were significantly related to the combined covariates ($F(8,182) = 3.30, p = .002$) and to the Group by Time interaction ($F(4,92) = 2.59, p = .042$). Effects of the Group by Time interaction on the DVs after adjustment for covariates were examined with follow-up univariate F -tests which revealed that mothers of abused children rated themselves as experiencing greater overall emotional distress (GSI, $F(1,95) = 5.47, p = .021$) than control mothers, both initially and at 12 months post-disclosure. For the case group, mothers' emotional distress decreased, whereas there was no change in the GSI scores of the comparison group. No differences were found for mothers on measures of family functioning (FACES-III) or on perceptions of their own parenting (Satisfaction and Efficacy).

With the use of Pillais' criterion, the combined DVs for fathers' self-report measures were significantly affected by Time of assessment ($F(4,55) = 3.43, p = .014$). There was no relationship between the combined DVs to the combined covariates. The multivariate test for the Group by

Time interaction and the main effect of Group failed to reach statistical significance. The follow-up univariate F -tests revealed that fathers' Efficacy scores provided a unique contribution to distinguishing between Time of assessment ($F(1,58) = 8.16, p = .006$). Specifically, fathers' Efficacy scores decreased over time. No other differences were found for fathers.

Odds ratio analyses revealed that both case mothers and fathers, in contrast to mothers and fathers in the comparison group, had a significantly greater chance of scoring in the clinically distressed range on the GSI at 3 months post-disclosure (mothers, 13.3 times, $p = .000$; fathers, 4.6 times, $p < .05$). At 1 year post-disclosure, only mothers had a significantly greater chance of scoring in the clinical range (mothers, 8.0 times, $p = .000$; fathers, 3.5 times, $p > .05$).

Differences between case mothers' and fathers' functioning. A repeated measures multivariate analysis of variance (MANOVA) was conducted assessing case parents' emotional functioning at 3 and 12 months post-disclosure. With the use of Pillais' criterion, the combined DVs for parents' self-report measures were significantly affected by Time of assessment ($F(4,53) = 3.39, p = .015$). The follow-up univariate F -tests revealed that parents' GSI ($F(1,56) = 5.43, p = .023$) and Efficacy scores ($F(1,56) = 4.45, p = .039$) each provided a unique contribution to distinguishing between Time of assessment. Specifically, Global Emotional Functioning improved and Efficacy decreased over time. No differences were found for parents on measures of family functioning (FACES-III), or on Parent Satisfaction. The multivariate test for the Group by Time interaction and the main effect of Group failed to reach statistical significance.

With respect to Post-Traumatic Stress Disorder (PTSD) symptomatology, a separate MANOVA was run with the Intrusive and Avoidant subscales of the Impact of Event Scale as the two DVs. With the use of Pillais' criterion, the combined DVs for parents' PTSD symptoms were significantly affected by Group membership ($F(2,55) = 6.59, p = .003$) and assessment Time ($F(2,55) = 13.23, p = .000$). The follow-up univariate F -tests revealed that both types of symptoms provided a unique contribution to distinguishing between Groups (Intrusion $F(1,56) = 11.85, p = .001$; Avoidance $F(1,56) = 9.24, p = .004$) and Time of assessment (Intrusion $F(1,56) = 26.68, p = .000$; Avoidance $F(1,56) = 9.53, p = .003$). Specifically, mothers had higher levels of Avoidant and Intrusive Symptoms than did fathers. Furthermore, parents combined had higher levels of Intrusive and Avoidant Symptoms at 3 months post-disclosure compared to 1 year.

Comparisons between sexually abused and nonabused children. Three separate repeated measures MANCOVAs were analyzed for child report measures, parent reports and teacher reports. Means and standard deviations for child IQ and self-report measures are found in Table 3. For the child self-report measures, the repeated measure was Time, the two between subject factors were Group (case, control) and Gender (male, female) and the three covariates were parental occupation, mothers' age, and child IQ. Significant intercorrelations were obtained among many of the child self-report measures. Consequently, the total scores on measures of Depression (raw scores), Social-Efficacy (Z-scores) and Fears (raw scores), were kept for the analysis. Z-transformations of the total scores on the children and adolescents' Social Self-Efficacy Scales were performed. This procedure allowed for a simultaneous entry of the transformed score in the analyses of the social self-perceptions for children in both age groups.

With the use of Pillais' criterion, the combined DVs were not significantly related to the combined covariates. They were, however, related to the main effect of Gender ($F(3,73) = 3.05, p = .034$), Group ($F(3,73) = 5.82, p = .001$) and assessment Time ($F(3, 76) = 24.78, p = .000$). Follow-up univariate F 's revealed that Depression were significant for Group ($F(1,75) = 16.69, p = .000$) and assessment Time ($F(1,78) = 15.38, p = .000$) with case children having significantly higher Depression scores than controls, with scores at 12 months post-disclosure being significantly lower than initial scores. Follow-up univariate F s for Fears was significant for Gender ($F(1,75) =$

Table 3. Means and Standard Deviations for Child Measures (Case and Comparison) by Phase of Assessment

Measures	Assessment							
	3 months post-disclosure				12 months post-disclosure			
	<u>n</u>	<u>M</u>	<u>SD</u>	<u>n</u>	<u>M</u>	<u>SD</u>		
Peabody Picture Vocabulary Test (IQ score)	case	male	22	103.73	13.08	--	_____	_____
		female	34	97.59	13.84	--	_____	_____
	comparison	male	30	111.83	13.69	--	_____	_____
		female	45	108.67	13.80	--	_____	_____
Children's Self Concept ^a	case	male	22	57.32	11.73	15	61.80	11.85
		female	29	50.14	14.68	23	58.30	12.38
	comparison	male	30	65.13	9.84	21	68.33	5.59
		female	45	65.56	9.68	36	70.19	7.70
Depression Self-Rating Scale	case	male	22	8.73	4.53	16	7.38	5.18
		female	29	12.21	6.55	23	9.61	4.53
	comparison	male	29	5.38	3.31	21	5.57	3.30
		female	45	6.62	3.47	36	5.39	3.26
Child Self-Efficacy Total Score	case	male	16	.34	.85	11	.34	.81
		female	18	-.46	1.14	12	-.33	1.36
	comparison	male	22	.26	1.11	17	.03	.97
		female	27	-.11	.78	22	.01	.88
Adolescent Self-Efficacy Total Score	case	male	5	-.34	.94	3	-.24	1.61
		female	11	-.42	1.36	9	-.24	1.33
	comparison	male	7	.23	.95	4	.09	.52
		female	18	.26	.71	15	.17	.79
Fear Survey Total Score	case	male	20	124.60	20.59	14	111.86	18.95
		female	29	162.24	28.14	21	140.90	29.25
	comparison	male	28	131.04	28.72	21	120.29	22.89
		female	45	140.89	26.16	36	122.14	27.05
Internalizing behavior ^b	case	male	17	58.24	9.13	13	54.15	11.66
		female	16	57.13	11.15	12	60.33	8.44
	comparison	male	17	54.76	10.38	15	52.93	10.26
		female	28	52.61	9.52	27	50.96	10.53
Externalizing behavior ^c	case	male	17	60.35	8.94	13	58.62	14.25
		female	16	58.75	8.57	12	62.17	9.26
	comparison	male	17	49.88	10.38	15	48.00	9.30
		female	28	48.32	7.44	27	50.52	8.70

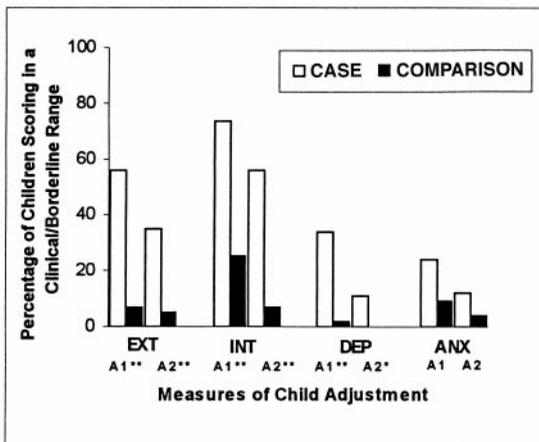
^a Piers-Harris Children's Self-Concept Scale - total raw score.

^b Child Behavior Checklist Teacher Form - Internalizing t-score.

^c Child Behavior Checklist Teacher Form - Externalizing t-score.

9.37, $p = .003$) and assessment Time ($F(1,78) = 53.90, p = .000$). Specifically, girls reported more Fears than boys and overall, Fears were significantly lower at 12 months post-disclosure.

The results on the parent reports revealed main effects for Group (F Pillais (2,83) = 19.22, $p = .000$) and assessment Time (F Pillais (2, 86) = 12.04, $p = .000$). There was no significant association between the combined DVs and the combined covariates or the main effect of Gender.



* Odd ratio cannot be calculated as no comparison child scored in a clinical range.
 ** p=.000.
 A1=First assessment; A2=Second assessment; EXT=Externalizing; INT=Internalizing;
 DEP=Depression; ANX=Anxiety.

Figure 1. Percentage of children scoring in a clinical/borderline range on self- and parent-report measures at 3 and 12 months postdisclosure.

Follow-up univariate *F*'s revealed that both Internalizing ($F(1,84) = 33.69, p = .000$) and Externalizing ($F(1,84) = 32.47, p = .000$) behaviors were higher in the case group than the control group. Furthermore both Internalizing ($F(1,87) = 24.13, p = .000$) and Externalizing ($F(1,87) = 15.26, p = .000$) behaviors significantly decreased by the second assessment.

For the teacher reports, a significant main effect for Group was found (F Pillais (2,39) = 5.79, $p = .006$). Follow-up univariate *F*'s indicated that only Externalizing behaviors significantly discriminated between Groups ($F(1,40) = 7.24, p = .010$) with case children receiving higher Externalizing scores than control children. There were no significant effects for Time or Gender.

Odds ratio analyses revealed that, at 3 months post-disclosure, sexually abused children, in contrast to the comparison group, had a significantly greater chance of scoring in a clinical/borderline range on self-reported symptoms of Depression, and parental reports of Internalizing and Externalizing behaviors. Similar findings were found at 1 year post-disclosure with the exception of child Depression scores (Figure 1). Differences over time were examined for the case group with the use of the McNemar test for two related dichotomous variables. Significant differences were found for Externalizing scores ($T = 7.4, p < .05$) and Depression scores ($T = 8.0, p < .01$). No differences were found over time for measures of Internalizing behaviors and Anxiety.

Regressions. Regression analyses were used to predict mother and child functioning. The number of fathers was insufficient to conduct such analyses. Missing data were handled through listwise deletion.

Predicting functioning of mothers of sexually abused children. Standard multiple regressions were conducted to determine the extent to which mothers' subjective experience of the trauma in the perceived environment domain (Total Support, Family Functioning), cognitive appraisal domain (Child Functioning, Parent Sense of Competency), emotional impact domain (Post Traumatic Stress), and objective abuse variables (type of sexual abuse, age of perpetrator, type of coercion, child's age and gender), predicted mothers' emotional functioning (GSI) 3 months and 1 year post-disclosure. The best predictors in each domain were entered into a final regression for each assessment time.

Variables that were significant 3 months post-disclosure have been presented in detail elsewhere (Manion et al., 1996). Abuse related variables were not related to maternal emotional functioning.

Significant variables in the three remaining domains were: maternal perception of Total Support, Satisfaction in the Parenting Role (Parent Sense of Competence Scale) and Intrusive Symptoms (Impact of Event Scale). A significant R for regression was obtained when the critical variables from each domain were entered together into a final regression ($F(3,51) = 20.07, p = .000$). The percentage of explained variability in the GSI scores was 54% (51% adjusted). All three independent variables (IV) contributed uniquely to the final solution: mothers' Intrusive Symptoms ($sr^2 = .09$), mothers' Satisfaction in the Parenting Role ($sr^2 = .20$) and mothers' perceived Total Support ($sr^2 = .12$).

The same procedure was followed for the measures obtained at 12-months post-disclosure with the exception of mothers' initial emotional functioning (GSI) being used as an additional predictor in the emotional impact domain. Objective abuse variables did not predict maternal emotional functioning. In the emotional impact domain, a significant R for regression was found for maternal emotional functioning ($F(3,38) = 19.46, p = .000$). The percentage of explained variability in the GSI scores was 60% (58% adjusted). Two IVs provided unique contributions to the prediction of maternal emotional functioning at 12-months post-disclosure (Avoidant symptomatology, $sr^2 = .11$ and GSI scores at 3 months post-disclosure, $sr^2 = .20$). In the cognitive appraisal domain, a significant R for regression was obtained for maternal emotional functioning ($F(4,40) = 11.24, p = .000$). The percentage of explained variability in the GSI scores was 53% (48% adjusted). Two variables made unique contributions to maternal emotional functioning (CBCL Internalizing t -score, $sr^2 = .15$ and Satisfaction in the parenting role, $sr^2 = .10$). In the perceived environment domain, a significant R for regression was obtained for maternal emotional functioning ($F(2,41) = 4.89, p = .012$). The percentage of variability explained in the GSI scores was 19% (15% adjusted). Total Support ($sr^2 = .19$) uniquely contributed to the prediction of maternal emotional functioning.

The best predictors of the three domains were entered into a final regression. A significant R for regression was found for maternal emotional functioning ($F(5,34) = 18.00, p = .000$). The percentage of explained variability in the GSI scores was 73% (69% adjusted). Three IVs contributed uniquely to the final solution: mothers' Avoidant symptoms ($sr^2 = .05$), mothers' perceptions of Internalizing problems in their child ($sr^2 = .05$) and mothers' initial level of emotional distress ($sr^2 = .13$).

Predicting Child Functioning

Standard multiple regressions were conducted to determine the extent to which Children's subjective experience of the trauma (Self-Blame/Guilt, PTSD) and objective abuse variables (type of sexual abuse, age of perpetrator, type of coercion, child's age and gender) predicted their functioning 3 and 12 months post-disclosure. The Self-Blame/Guilt variable is a sub-scale of the CITES and had a moderate positive skewness, which was normalized with a square root transformation. PTSD scores were computed as the sum of Intrusive Thoughts, Avoidance and Sexual Anxiety sub-scales scores of the CITES. The best objective and subjective predictors were then entered into a final hierarchical regression for each assessment time.

The relationship between children's subjective experiences of abuse and their functioning was explored separately for self-report versus parent-report data (due to an insufficient number, teacher reports were not considered for these analyses). The results at 3 and 12 months post-disclosure for which significant R statistics were found are presented in Table 4. The two predictor variables were only related to some of the children's self-report measures and not to the parent reports. At the initial assessment, Self Blame/Guilt uniquely contributed to the prediction of Depression, Social Efficacy and Anxiety, PTSD uniquely contributed to the prediction of Interpersonal Discomfort and both Self/Blame/Guilt and PTSD provided unique contributions to the prediction of Total Fears and Sexual Fears. At 12 months post-disclosure, Self Blame/Guilt uniquely contributed to the predic-

Table 4. Significant Multiple Regressions of Self-Blame/Guilt and PTSD Variables on Children’s Self-Report Measures at 3 and 12 Months Postdisclosure

	Predictors						R ^{2a}	R
	PTSD			Self-Blame/Guilt				
	B	β	sr ²	B	β	sr ²		
Three Months								
Depression	.24	.20	.04	4.38*	.32	.10	.16 (.12)	.39*
Social Efficacy	.01	.05	.00	-.93*	-.38	.14	.14 (.10)	.38*
Total Fears	2.36*	.36	.13	15.65*	.22	.05	.19 (.15)	.44*
Sexual Fears	.41*	.38	.14	3.26*	.28	.08	.24 (.20)	.49**
Interpersonal Discomfort	.39*	.36	.13	2.73	.23	.05	.20 (.16)	.45*
Anxiety	-.10	-.14	.02	-2.55*	-.32	.10	.13 (.09)	.37*
Twelve Months								
Total Fears	2.14*	.40	.14	22.95	.26	.06	.32 (.26)	.56*
Sexual Fears	.31*	.39	.13	3.28	.25	.05	.29 (.24)	.54*
Self Concept	-.08	-.04	.00	-18.18*	-.50	.20	.26 (.21)	.51*
Anxiety	-.12	-.18	.03	-3.49	-.36	.11	.22 (.17)	.47*

Note. Adjusted α = .005.

^a Adjusted R².

*p<.05. **p<.007.

tion of Self-Concept and PTSD provided a unique contribution to the prediction of Total Fears and Sexual Fears.

The relationship between objective aspects of the abuse and child functioning was also assessed. Abuse related variables did not predict child functioning at 3 or 12 months post-disclosure. However, child’s age and gender provided significant contributions to predicting child self-report measures. A significant *R* for regression was found for Total Fears ($F(5,43) = 6.35, p = .000$), Sexual Fears ($F(5,43) = 8.28, p = .000$), Interpersonal Discomfort ($F(5,43) = 3.49, p = .01$) and Anxiety ($F(5, 45) = 2.52, p = .043$). The percentage of explained variability for the significant regressions were as follows: Total Fears, 43% (36% adjusted); Sexual Fears, 49% (43% adjusted); Interpersonal Discomfort, 29% (21% adjusted); and Anxiety, 22% (13% adjusted). Child gender

made a unique contribution to the prediction of Total Fears ($sr^2 = .39$), Interpersonal Discomfort ($sr^2 = .23$), and Anxiety ($sr^2 = .10$). Both child gender and age made unique contributions to the prediction of Sexual Fears ($sr^2 = .41$, $sr^2 = .08$, respectively). At 12 months post-disclosure, a significant R for regression was found for Total Fears ($F(5,29) = 3.33$, $p = .017$), Sexual Fears ($F(5,29) = 4.06$, $p = .006$), Interpersonal Discomfort ($F(5,29) = 3.09$, $p = .024$), Internalizing ($F(5,40) = 2.53$, $p = .044$), and Externalizing ($F(5,40) = 4.33$, $p = .003$). The percentage of explained variability for the significant regressions were as follows: Total Fears, 37% (26% adjusted); Sexual Fears, 41% (31% adjusted); Interpersonal Discomfort, 35% (24% adjusted); Externalizing, 35% (27% adjusted); and Internalizing, 24% (15% adjusted). Child Gender uniquely contributed to the prediction of Total Fears ($sr^2 = .33$) and Interpersonal Discomfort ($sr^2 = .27$). Both child gender and age made unique contributions to the prediction of Sexual Fears ($sr^2 = .26$, $sr^2 = .23$, respectively). On parent reports of child functioning, child age and type of coercion each made unique contributions to the prediction of Externalizing behaviors ($sr^2 = .17$, $sr^2 = .08$, respectively). Both the age of the child and perpetrator made unique contributions to the prediction of Internalizing behaviors ($sr^2 = .10$, $sr^2 = .09$, respectively). In all cases, with the exception of Externalizing behavior at the initial assessment, being female was associated with poorer adjustment. Being younger was also associated with poorer adjustment on measures of Total Fears, Sexual Fears, Externalizing, and Internalizing behavior, whereas being older was associated with poorer adjustment on measures of Anxiety and Interpersonal Discomfort. Greater coercion and an older perpetrator (adult vs. adolescent) were associated with poorer adjustment on measures of Externalizing behavior and Internalizing behavior, respectively.

Hierarchical regressions were used to determine if the best of the subjective measures as determined in the initial standard regressions would improve prediction of child functioning beyond that provided by the significant objective variables. At 3 months post-disclosure, the addition of subjective variables reliably improved R^2 for Total Fears ($Finc(2,41) = 14.77$, $p = .000$), Interpersonal Discomfort ($Finc(2,41) = 7.07$, $p < .01$) and Anxiety ($Finc(2,48) = 6.27$, $p < .01$). Sexual Fears was the exception to this finding. The percentage of obtained variability for the significant regressions were as follows: Total Fears, 42% (39% adjusted); Interpersonal Discomfort, 26% (22% adjusted); Anxiety, 21% (17% adjusted). Both gender and PTSD symptoms uniquely contributed to the prediction of Total Fears ($sr^2 = .28$ and $sr^2 = .08$, respectively) and Interpersonal Discomfort ($sr^2 = .11$ and $sr^2 = .09$, respectively). Self-Blame/Guilt was the only variable that uniquely contributed to the prediction of Anxiety ($sr^2 = .09$). At the second assessment, the addition of subjective variables after objective variables were entered reliably improved R^2 for Total Fears ($Finc(2,30) = 12.53$, $p = .000$) and Sexual Fears ($Finc(3,29) = 7.24$, $p = .001$). Interpersonal Discomfort did not follow this pattern. The percentage of explained variability for Total Fears and Sexual Fears was 46% (42% adjusted) and 43% (37% adjusted), respectively. Both gender and PTSD symptoms uniquely contributed to the prediction of Total Fears ($sr^2 = .17$ and $sr^2 = .24$, respectively) and Sexual Fears ($sr^2 = .16$ and $sr^2 = .09$, respectively).

Mother's measures of emotional, social and cognitive variables as predictors of child functioning.

Separate regressions were run with predictor variables from the emotional impact domain and the perceived environment domain. At 3 months post-disclosure, only variables from the perceived environment domain could reliably predict any child measure. A significant R for regression was obtained for child Anxiety ($F(2,42) = 3.32$, $p < .05$), Self Efficacy ($F(2,42) = 3.37$, $p < .05$) and Total Self-concept ($F(2,42) = 3.95$, $p < .05$). The percentage of explained variability was 14% (10% adjusted) for Anxiety and Self-Efficacy and 16% (12% adjusted) for Total Self-concept. Total Support uniquely contributed ($sr^2 = .09$) to predicting Self-Concept. At 12 months post-disclosure, there was a significant R for regression for both Depression ($F(3,31) = 3.13$, $p < .05$) and Total Fears ($F(2,27) = 3.44$, $p < .05$). The percent of explained variability in Depression scores was 23%

(16% adjusted) by variables in the emotional impact domain. Post Traumatic Stress Symptoms, specifically symptoms of Intrusion significantly contributed to the prediction of Depression ($sr^2 = .20$). Twenty percent (14% adjusted) of variability in Total Fear scores could be explained by variables in the perceived environment domain. Precisely, FACES III (individual distance from center) significantly enhanced the prediction of Total Fears ($sr^2 = .13$).

With respect to maternal self-report measures as predictors of mothers' reports of child functioning (CBCL), variables in the emotional impact and cognitive appraisal domains could reliably predict Internalizing and Externalizing t -scores. At 3 months post-disclosure, variables in the emotional impact domain could reliably predict Internalizing t -scores ($F(3,52) = 4.21, p = .01$). The percent of explained variability was 20% (15% adjusted) with mothers' GSI scores uniquely contributing to the prediction of Internalizing t -scores ($sr^2 = .15$). At the second assessment, there was a significant R for regression for both Internalizing ($F(3,43) = 11.59, p < .000$) and Externalizing ($F(3,42) = 4.08, p < .01$) t -scores. The percent of explained variability was 45% (41% adjusted) and 23% (17% adjusted), respectively. Once again, mothers' GSI scores significantly enhanced the prediction of both Internalizing ($sr^2 = .13$) and Externalizing ($sr^2 = .08$) behaviors.

DISCUSSION

This study demonstrated that child victims of ESA show adjustment problems in both emotional and behavioral domains. The pattern of adjustment difficulties, however, differs depending on who rates the behavior. The only group difference for child self-report measures was for Depression. Case children had higher Depression scores than control children and these scores were higher initially than at 12 months post-disclosure for both case and control children. For parent and teacher reports, case children scored higher and were significantly more likely to function in the clinical/borderline range on both Internalizing and Externalizing behaviors. Parent reports further revealed that both types of behaviors decrease at 12 months post-disclosure for both case and control children whereas teacher reports did not change significantly over time.

Social functioning was not impaired in ESA children at either assessment time which is contrary to what has been reported in other studies (Burgess, Hartman, & McCormack, 1987; Kelley, 1989; Mannarino et al., 1991). This discrepancy may be attributable to the differences between parental reports and child self-evaluations of social competency. This underscores the need to include self-report measures with other methods of assessment.

The only gender difference found was for Total Fears with girls having more reported fears than boys. However, this was only a gender effect and not a group by gender interaction, which suggests that sexually abused boys and girls do not respond differentially. Once again, Fears were higher initially and decreased at 12-months post-disclosure for both boys and girls.

It appears that mothers do experience secondary traumatization initially and that this effect diminishes over time. However, even at 12 months post-disclosure, 38% of case mothers had global emotional functioning scores that fell within the clinical range. The levels of emotional distress observed in these mothers may be due to their role as the primary support for their abused child (Burge, 1983; Figley, 1983). This is consistent with Figley's (1989) model of traumatized families, the clinical literature on initial parent reaction to ESA (Gomes-Schwartz et al., 1990; Newberger, Gremy & Waternaux, 1991), and Kelley's (1990) premise that the sexual victimization of one's child can be an acute and chronic stressor for parents.

Despite the lack of a mean group difference, case fathers are 4.6 times more likely to score in the clinical range initially on measures of Global Emotional Functioning in contrast to comparison fathers. This risk decreases slightly at 12 months post-disclosure (3.5 times). In fact, the only difference between case mothers and fathers was in the number of Intrusive and Avoidant

symptoms, where mothers had higher levels of symptoms than fathers both initially and at 12 months post-disclosure. Symptoms at 3 months were higher than those at 12 months for both parents.

The lack of more pronounced differences between case and comparison fathers in the present study can be interpreted in a number of ways. Contrary to previous research (Kelley, 1990), fathers may not be as affected by this experience as are mothers. Alternatively, the psychometrics of the scales used here may be more variable for fathers, thus moderating the findings. More likely, a selection bias was present as fewer than half of the eligible fathers chose to participate. Conceivably, fathers more affected by this experience were less likely to participate.

In the present study, Satisfaction in the Parenting role, Perceived Environmental Support, and Intrusive Symptoms were significant predictors of initial maternal functioning following the disclosure of ESA. At 12 months post-disclosure, Avoidant symptoms, child's Internalizing behavior and mother's initial emotional functioning were significant predictors of emotional functioning. Abuse-related variables did not contribute to the prediction of mothers' emotional functioning initially or at 12 months post-disclosure. This finding is consistent with recent trauma theory which ascribes more importance to the meaning given to the traumatic event by the victim (Janoff-Bulman, 1992).

Regression analyses for child outcome measures at 3 months post-disclosure revealed that subjective variables improved the prediction of Total Fears, Interpersonal Discomfort, and Anxiety beyond that provided by the significant demographic variables. This was also the case at 12 months post-disclosure for Total Fears and Sexual Fears. Subjective variables did not improve the prediction of Sexual Fears at the initial assessment or Interpersonal Discomfort at the follow-up assessment beyond what the objective demographic variables could reliably predict. Both age and gender were significant predictors for many of the child outcome measures and warrant further exploration. Younger females seem at higher risk for poorer outcomes for some variables (e.g., Total Fears, Sexual Fears), whereas older females are at higher risk for others (e.g., Anxiety, Interpersonal Discomfort). Children's attributions of guilt and blame for sexual abuse are important factors in evaluating their initial and longer term functioning. Initially, children who felt guilt and blamed themselves for the abuse also reported more symptoms of depression, anxiety, general fears, sexual fears, and impaired social efficacy. At follow-up, these children reported more symptoms of anxiety and poor self-concept. Children who reported intrusive thinking patterns, avoidance behaviors, and sexual anxieties also experienced high levels of general and abuse specific fears both initially and at 12 months post-disclosure.

Consistent with a majority of recent studies, the objective aspects of the abuse were not predictive of children's adjustment following sexual abuse (Cohen & Mannarino, 1988; Einbender & Friedrich, 1989; Koverola, Pound, Heger, & Lytle, 1993; Merry & Andrews, 1994; Sauzier, 1989). This suggests that the child's subjective experience of abuse represents the most relevant element for both immediate and longer term adjustment to such trauma.

The interplay between parent and child functioning was minimal with the exception of mothers' self-reported distress (GSI) and their reports of distress in their children (CBCL). It is unlikely that child distress was only a projection of mothers' own adjustment difficulties as both child self-report and teacher-reports demonstrated that children were having adjustment difficulties.

Taken together, these results suggest that children who have been abused by someone outside of the immediate family do display enduring measurable effects in both emotional and behavioral functioning. Although improvements in functioning are noted 1 year post-disclosure, children continue to show clinically relevant levels of adjustment difficulties. The "trauma" experienced by these children is shared by their parents, with mothers being more likely to experience secondary effects. In fact, mothers appear to show the most significant and lasting effects.

Although the present study attempted to improve upon existing research (i.e., theoretical framework, control group, large heterogeneous sample, inclusion of fathers, multi-dimensional

assessment), there were still limitations with respect to design, sampling, and measurement that could be improved upon (e.g., the use of a nonabuse trauma control group in future research will help clarify abuse-specific sequelae; more creativity is required in ensuring greater participation from fathers). This study's analysis of parent and child reactions to the court process was limited by a lack of access to court-related data and by a predetermined assessment schedule that did not allow us to study acute changes associated with the stress of court involvement. The constructs assessed here are likely relevant to the court experience, both as a part of the larger process and as a potentially traumatic anticipation, an event in and of itself. Unsolicited parent comments about the negative experience associated with court underscore the need for such investigation.

The findings of this study will likely hold few surprises for clinicians with extensive experience with child and parent victims of ESA. The findings may, however, be useful in addressing the serious problem of ESA at three levels:

- (1) Clinical interactions with families. The strong link between mothers' and child victims' functioning reinforces practice wisdom that the route to child recovery is often found via parent and family support. Clinicians need to expand their treatment focus beyond the child victims to the traumatized families and to normalize the potential for all close family members to be vulnerable to adjustment difficulties (Figley, 1989). Given the importance of the subjective experience for both mother and child, those working with families where such an experience has occurred should be particularly sensitive with respect to their approach towards the family at disclosure, throughout the investigation and possible court process, and beyond. For example, behaviors that directly or indirectly increase the child's sense of perceived blame are likely to contribute to greater adjustment problems. This may be particularly relevant at initial disclosure when the child is most vulnerable, as well as, later during the court process when the atmosphere is more adversarial and confrontational.
- (2) Guidance to educators. Educational programs and materials provided to the public in general and concerned parents in particular must be accurate and enabling. Education should contain the encouraging news that many children who have experienced ESA do not appear to be harmed by it; that children's interpretations of their sexual abuse better predicts their adjustment than the objective aspects of the sexual abuse which mythology once held; and that informed parents can greatly assist their children after discovering their abuse. Given that many of the children and parents in this study did not experience clinically significant levels of emotional distress, there may be significant factors related to individual and family resiliency that need to be identified in future research. These comments are made with some caution however as the present study did not evaluate the long-term (beyond 1 year) sequelae of ESA. The fact that many children and parents are functioning well 1 year post-disclosure does not preclude the possibility of re-experiencing the trauma at some later date.
- (3) Policy and program design and administration. Decisions about the allocation and benefit of precious resources can be made with greater confidence. Useful information needs to be provided promptly to anxious and struggling parents in order to reduce potential trauma for their whole family. Providing and tailoring this kind of initial assistance/screening for parents seeking help is much less expensive. It will often be equally efficacious as automatically providing assessment/therapy for every case and certainly more helpful than assigning highly anxious parents and children to waiting lists. Families who lack sufficient internal resources and resiliency to be able to respond to the provision of tailored information will require the direct therapeutic assistance which cannot be provided to, and this study demonstrates is not required by, all families who must deal with the ESA of a child.

This research reminds us not to assume that children who have experienced ESA are necessarily traumatized by it. Rather, it should be assumed that the experience represents a potential for trauma which will be increased by a failure to recognize the impact of ESA on parents and provide them

with support. Clinically, it is important to emphasize family strengths when dealing with such trauma.

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RÉSUMÉ

Objectif: Cette étude a évalué l'adaptation émotionnelle et du comportement chez des parents et des enfants, trois mois suivant une expérience d'abus sexuels extra-familiaux, puis un an plus tard.

Méthode: On a comparé 92 parents (63 mères et 29 pères) et 56 enfants à un groupe de comparaison non clinique composé de 136 parents (74 mères et 62 pères) et 75 enfants. L'adaptation des parents a été évaluée à partir d'une auto-évaluation de la situation tandis que l'adaptation des enfants a été mesurée en se fiant à des rapports obtenus des enfants, des parents et des enseignants.

Résultats: Les mères, les pères et les enfants abusés sexuellement ont connu des effets cliniques importants, dès l'expérience et dans les 12 mois qui ont suivi. Le blâme que les enfants s'attribuaient et les sentiments de culpabilité, ainsi que la gravité du traumatisme vécu servaient à prédire les symptômes qu'ils disaient vivre, tant au 3 mois qu'au douzième mois. L'âge et le sexe de l'enfant étaient aussi des facteurs importants. Pour ce qui est des variables non reliées aux mauvais traitements, on a remarqué aucun lien. La satisfaction que les mères éprouvaient dans leur rôle maternel, les appuis qu'elles considéraient avoir obtenus et les symptômes graves étaient reliés à leur fonctionnement émotionnel. Les symptômes de contournement, l'intériorisation des enfants par rapport à leur comportement et le fonctionnement initial de la mère se sont avérés des facteurs importants pour prédire les troubles d'adaptation à longue échéance.

Conclusions: Les résultats soulignent l'importance de se pencher sur la façon dont les enfants attribuent les mauvais traitements sexuels et d'élargir nos préoccupations au delà de l'enfant, pour considérer les traumatismes de la famille entière.

RESUMEN

Objetivo: Este estudio evaluó el ajuste emocional y conductual de los padres y los hijos desde los tres meses hasta un año después de descubrir el abuso sexual extrafamiliar en la niñez.

Método: Noventa y dos casos de padres (63 madres, 29 padres) y 56 niños fueron comparados con un grupo no clínico de 136 padres (74 madres, 62 padres) y 75 niños. El ajuste parental fue evaluado utilizando medidas de auto-reporte mientras que el funcionamiento infantil fue evaluado utilizando una combinación de medidas reportadas por el niño, los padres y el maestro.

Resultados: Las madres, los padres y los niños sexualmente abusados experimentaron efectos clínicamente significativos tanto inicialmente como a los 12 meses post-descubrimiento. Las percepciones infantiles de auto-sanción y culpa por el abuso y la intensidad del trauma predijo su sintomatología autoreportada a los 3 meses y al año después del descubrimiento. La edad y el sexo del niño también contribuyeron significativamente a la predicción de muchos de los resultados de las medidas en el niño. Ninguna variable relacionada con el abuso se relacionó con cualquiera de las medidas de auto-reporte. La satisfacción de la madre en el rol parental, el apoyo percibido y los síntomas invasivos predecían su funcionamiento emocional inicial. Los síntomas de evitación, la conducta infantil de internalización y el funcionamiento emocional de las madres eran predictores significativos de funcionamiento emocional a largo plazo.

Conclusiones: Los resultados destacan la necesidad de responder a las atribuciones relacionadas con el abuso a los niños y acentúan la necesidad de ampliar nuestro enfoque más allá del niño víctima hasta sus familias traumatizadas.