Factors Linked to Distress in Mothers of Children Disclosing Sexual Abuse

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Abstract: The aim of the present study is to investigate the variability in clinical level of psychological distress experienced by mothers of sexually abused children by exploring the role of (a) abuse-related variables (length, severity, and identity of perpetrator), (b) a history of childhood sexual abuse and partner violence experienced in the past year, and (c) mothers' coping and feelings of empowerment. Data were collected through self-report measures completed by 149 French-speaking mothers of girls aged 4 to 12 years disclosing sexual abuse. Results revealed that more than half of the mothers reported clinical levels of psychological distress and experienced child sexual abuse, and 1 of 4 mothers experienced physical partner violence. Logistic regression analysis revealed that mother's sexual abuse and partner violence as well as avoidance coping and empowerment contributed to scores reaching clinical levels of psychological distress. In addition, mothers of child victims of intrafamilial sexual abuse are more likely to report clinical levels of distress. Results underscore the importance of evaluating for trauma history and taking coping strategies and empowerment into account in treatment interventions.

Key Words: Mothers, psychological distress, sexual abuse.

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Data gathered to date suggest that sexually abused children are likely to present significant internalized and externalized behavior problems, posttraumatic stress disorder, and dissociation symptoms compared with nonabused children (Briere and Elliot, 2001; Collin-Vézina and Hébert, 2005; Hébert et al., 2006; Paolucci et al., 2001). A number of factors, namely maternal support, have been identified as crucial mediators related to outcomes in child victims of sexual abuse (SA) (Corcoran, 2004). Although mothers are often seen as playing a central role in facilitating the recovery of their sexually abused child, there has been little focus on their own needs and profiles. Although findings are likely to orient treatment recommendations, few studies have explored potential factors related to psychological distress in mothers of child victims of SA (Plummer, 2006). In an analysis of parents of child victims of extrafamilial abuse, Manion et al. (1998) found that mothers had higher risk than mothers of the comparison group to score in the clinically distressed range at 3 months after disclosure, and at 1 year after disclosure. Kelly (1990) observed that 52% of parents of children abused in daycare centers had psychological distress scores in the clinical range 2 years after the disclosure. Mothers' clinical level of psychological distress may interfere with their ability to optimally respond to their child's needs. However, not all mothers experience clinical levels of distress, highlighting the relevance of exploring factors associated with the diversity of profiles of mothers of sexually abused children.

Although some authors have argued that mothers' level of psychological distress is related to characteristics of the abuse, such as severity or identity of the perpetrator, empirical results have not been consistent in this regard. Newberger et al. (1993) found that severity of abuse was related to distress in mothers of sexually abused children. On the other hand, Manion et al. (1996, 1998) concluded that abuse-related variables (type or frequency of abuse, relationship with the perpetrator) did not contribute significantly to the prediction of maternal emotional functioning initially nor at 12-months after disclosure, suggesting that other variables may interplay in predicting distress in mothers of SA children.

The coping skills of mothers have been identified as potentially salient variables. Studies have indeed identified reliance on avoidant coping as associated with greater distress in populations dealing with a variety of stressors (Folkman and Moskowitz, 2004) and more specifically in mothers of sexually abused children (Hiebert-Murphy, 1998). Among other potential factors related to distress in mothers confronted with a major stressor is empowerment. In a recent review, Fitzsimons and Fuller (2002) suggest that negative life events can undermine self-concept and sense of control, leading to stress and adverse health outcomes. Literature on helplessness suggests that loss of power may play a causal role in the onset of depression and has long been identified as a key factor associated to heightened psychological distress

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(Seligman, 1972, 1975). Disclosure of SA by a child may be considered a major stressor that solicits family's resources in much the same way that chronic disease or mental health disorders of one child is likely to affect the whole family system. Learning about the sexual victimization of one's child is an unexpected and confusing event and acceptance of such an experience may involve deep emotional loss. Parents may experience sensations and emotions similar to those of parents whose children died including disbelief and denial (Elliott and Carnes, 2001). Disclosure of SA may be associated with feelings of failure in their parental role for some parents. Feelings of empowerment or self-efficacy have been studied in families whose children exhibit psychological distress, such as children with developmental disabilities (Nachshen and Minnes, 2005), presenting serious emotional disturbance (Singh et al., 1997) or children receiving mental health services (Taub et al., 2001). Results suggest that parents who report less self-efficacy and empowerment are more likely to experience greater internal stress when facing such challenges (Scheel and Rieckmann, 1998). In addition, parental self-efficacy might act as a mediator between parenting behaviors and children's behavior disorders (Jackson, 2000). Although self-efficacy might be an important variable associated with distress in parents of children disclosing SA, empirical studies have yet to investigate this factor. As parents' feelings of empowerment and sense of self-efficacy might be linked to parental distress and child's functioning (Taub et al., 2001), the consideration of this factor is likely to yield findings relevant for treatment in cases of child SA.

Prior studies (Cyr et al., 1999; Deblinger et al., 1993; Faller, 1989; Leifer et al., 1993; Runyan et al., 1992) have reported higher prevalence of childhood SA in mothers of sexually abused children compared with mothers of nonabused children, arguing for an intergenerational transmission hypothesis (Collin-Vézina and Cyr, 2003). Disclosure of SA by their child may thus, at least for some mothers, stir up memories of their own experience of SA. Empirical data exploring whether a history of SA is linked to greater distress in mothers have not been unequivocal. Hiebert-Murphy (1998) found a link, whereas Deblinger et al. (1993) did not find a relationship between a history of SA and psychological distress in mothers of sexually abused children. The question of whether mothers with a history of child SA may benefit from an intervention specifically oriented to help them cope with their own victimization issues in addition to support intervention designed for nonoffending parents is of relevance to treatment implementation. Given that an important number of adults have not disclosed the abusive event in their childhood (London et al., 2005), the child's disclosure may serve as a precipitating event for mothers to unveil their past abuse for the very first time. Another significant issue that has been scantly addressed in this clientele is partner victimization. Bowen (2000) has argued that prevalence of partner violence is high in mothers of sexually abused children. In studies by Deblinger et al. (1993) and Sirles and Franke (1989), close to half (56.6% and 44.3%) of mothers reported experiencing partner violence. However, few studies have explored the co-occurrence of intimate partner violence and SA (Hiebert-Murphy, 2001; Paz et al., 2005).

The purpose of the present study was to further investigate the diversity of profiles of mothers of sexually abused children by exploring the role of (a) abuse-related variables (length, severity, and identity of perpetrator), (b) a history of child SA and partner violence experienced in the past year, and (c) mothers' coping and feelings of empowerment on clinical level of psychological distress. The results are likely to offer significant cues to orient treatment planning for this clientele.

METHODS

Participants

The sample consisted of 149 Canadian French-speaking mothers of girls aged 4 to 12 years who were referred for evaluation at the Child Protection Clinic of the Mère-Enfant Ste-Justine Hospital, a teaching tertiary care hospital in Montreal, Quebec, Canada, after disclosure of SA. Children are referred by Child Protection Services (CPS), their physician, by a community clinic, or by the Emergency Department. All cases are further reported to the CPS of the designated region.

All children reported an episode of SA that occurred in the past 6 months. A total of 71.2% of children experienced intrafamilial SA and for 28.9% of them the abuse lasted at least 6 months. In most cases, the sexual experience was very severe (sexual acts involving attempted or completed oral, vaginal, and/or anal penetration) (68.1%) or severe (unclothed touching) (29.1%). Close to half of the SA reported involved an immediate family member (50.7%), whereas 20.5% involved a member of the extended family. For 25.3% of the girls, the SA was perpetrated by a known but unrelated aggressor and 3.4% involved a stranger. Mothers were aged between 20 and 49 years ($M = 33.42$, $SD = 7.13$) and had a mean education level of 11.31 years ($SD = 2.94$). Mothers were living in single-parent families (50.3%), whereas 24.8% lived in stepfamilies and 24.2% in intact families. In total, 56.6% of mothers were employed, whereas 30.8% did not work, 5.6% were currently seeking a job, and 7.0% were involved in an educational program.

Measures

The brief French version of the *Psychological Distress Scale of the Quebec Health Survey* (Préville et al., 1992) was used to capture the mothers' symptoms of mental health distress in the week before evaluation. The scale is a translation of the *Psychiatric Symptom Index* (Ilfeld, 1976, 1978). The *Psychiatric Symptom Index* was elaborated and validated using data from a community sample of over 2200 adults with diverse socioeconomic characteristics. This 29-item questionnaire generates a total score of psychological distress, which includes symptoms of anxiety, depression, irritability (negative feelings toward others, baffled, or annoyed easily), and cognitive problems (concentration, memory, and decision-making problems). Each item is rated on a 4-point Likert scale from 0 (*never*) to 3 (*very often*) with higher scores indicating increasing severity of distress. Ilfeld (1976) reported an α coefficient of 0.91 for the index. Items have been

shown to be consistent with established clinical criteria for diagnosing anxiety and depression and found to measure 7 of 9 criterion-based symptoms of Major Depressive Episode and 5 of 8 criterion-based symptoms of Generalized Anxiety Disorders as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (Okun et al., 1996). Concurrent validity was shown by correlating scores with criteria indicating emotional distress, such as use of psychoactive drugs and help seeking (Ilfeld, 1976). The total score is used in the present study and internal consistency has proved satisfactory (Cronbach α coefficient = 0.94). Normative values (corresponding to the 85th percentile) have been presented for noninstitutionalized Quebec population by gender and age (Boyer et al., 1993) and correspond to a score of 28.74 for women aged 15 years and more.

A brief 21-item version of the Ways of Coping Questionnaire (Folkman and Lazarus, 1998; French adaptation: Bouchard et al., 1995) was used to assess the dimensions of coping strategies mothers relied on after the child's disclosure of SA. Three subscales are used: seeking social support, problem solving, and avoidance coping. Each item is coded on a 4-point Likert scale with higher scores indicating increased use of these coping strategies. The French version of the scale was found to be reliable in the present study (Cronbach α coefficients ranging from 0.67 to 0.83). The family dimension (12 items) of the Family Empowerment Scale (Koren et al., 1992) designed to measure the empowerment of a parent or a caregiver of an emotionally disabled child was used. Items (e.g., "I feel I am a good parent," "I feel confident in my ability to help my child grow and develop," "I am able to get information to help me better understand my child") are evaluated on a 5-point scale (1 not true at all to 5 very true). Prior studies have reported adequate reliability and evidence for the validity of the scale (Corcoran and Fisher, 2000). In the present study, the scale provided adequate internal consistency (Cronbach α coefficient = 0.85).

History of Childhood SA and Experience of Partner Violence

Mothers answered a question pertaining to a history of childhood SA and completed a brief 12-item version of the Conflict Tactics Scale (Straus et al., 1996) regarding their experience of partner victimization in the past year. Items relating to both minor and severe form of physical violence were used and rated on a 5-point scale (0, it never happened; 1, once; 2, 2–5 times; 3, 6–10 times; 4, more than 10 times). Items were answered in reference to partner violence experienced in the past 12 months. If participants reported no current partner, they were asked to answer items in reference to their ex-partner. Internal consistencies of the scale proved satisfactory for all subscales (Cronbach α coefficient ranging from 0.80 to 0.88).

In the present study, 3 abuse-related variables were used and coded from medical records: (a) severity of abuse describing very severe SA (oral, vaginal, or anal penetration or attempted penetration), severe SA (unclothed touching, digital penetration), and less severe SA (touching while clothed, exhibitionism); (b) duration of abuse as single episode, more than 1 episode but lasting less than 3 months or chronic abuse (more than 3 episodes over a prolonged period of more than 6 months); (c) identity of the perpetrator: intrafamilial (from the immediate family or extended family) or extrafamilial (a known extrafamilial aggressor or a stranger).

Procedure

The objectives of the study were introduced to nonoffending mothers at their first hospital visit at the Clinic for a medical examination. An interdisciplinary team (pediatrician, nurse, social worker, and psychologist) is responsible for cases referred on an outpatient basis and for hospitalized patients. All SA allegations are further reported to the CPS of the designated region. However, final decisions of CPS are not returned to the Clinic. After a description of the study, if the mother agreed to participate, written informed consent for the study was obtained at the beginning of the interview. A trained graduate student assisted the parent in completing the different measures. Abuse variables were codified from medical records. The Human Research Review Committee of the University of Quebec in Montreal and the Ethics Committee of Ste-Justine Hospital approved the study.

RESULTS

Mean scores of mothers on the scale evaluating psychological distress correspond to 31.03 (SD = 17.17). A significant proportion of mothers (57.9%) achieved a score higher than the corresponding cutoff point of 85th percentile of noninstitutionalized women (28.74).

Prevalence of past history of childhood SA in mothers is 51%. Regarding prevalence estimates of partner violence in the past 12 months, 26.8% of mothers reported experiencing minor physical violence, whereas 12.1% reported severe physical violence by their partner in the past year.

A logistic regression analysis was conducted to assess whether factors are associated with clinical level of distress (Table 1). Maternal mean age and level of education were used as covariates in the analysis. In addition, abuse-related variables (intrafamilial perpetrator, length of the abuse, and severity of the abuse), maternal history of SA and of partner violence, and personal factors (coping strategies and sense of empowerment) were considered as potential predictors of clinical level of distress.

The results indicated the final logistic regression model is significant ($\chi^2_{(11)} = 36.30$, $p < 0.001$). Data reveal that for the abuse-related variables, only perpetrator's identity is independently associated with a distress score reaching clinical level. Thus, when the abuse disclosed by the child involves an intrafamilial perpetrator, the odds of mothers reaching a clinical level of psychological distress is increased (OR = 2.74). In addition, when mothers report physical partner violence, the odds of mothers reaching a clinical level of psychological distress is increased by 3-fold (OR = 3.22). Maternal history of SA is also associated with participants scoring in the clinical range for psychological distress (OR = 2.97). Finally, inspection of the results also reveals that avoidance coping and empowerment contribute independently to the prediction of clinical distress. Mothers relying

TABLE 1. Results of Logistic Regression Analysis Predicting Clinical Level Distress Scores

Predictors	*B*	*SE*	*W*	*p*	Odds Ratio
Sociodemographic variables					
Mother's age	0.02	0.04	0.16	ns	1.02
Mother's education level	0.10	0.10	0.95	ns	1.01
Variables related to child's SA					
Intrafamilial perpetrator	1.01	0.52	3.82	0.05	2.74
Length of abuse	−0.20	0.30	0.44	ns	0.82
Severity of abuse	−0.03	0.43	0.01	ns	0.96
Mother's experience of abuse/PV					
History of SA	1.09	0.47	5.33	0.02	2.97
Partner violence (PV)	1.17	0.58	4.13	0.04	3.22
Personal factors					
Social support coping	0.03	0.08	0.16	ns	1.03
Problem-solving coping	−0.04	0.06	0.53	ns	0.96
Avoidance coping	0.18	0.07	7.19	0.007	1.20
Sense of empowerment	−0.13	0.05	7.04	0.008	0.88

$\chi^2_{(11)} = 36.30$; $p < 0.001$.

more frequently on avoidance coping and obtaining low scores of sense of empowerment are more likely to report clinical levels of psychological distress.

DISCUSSION

The aim of this study was to assess the needs of mothers of SA children and explore potential factors associated with clinical level of psychological distress. Results indicate that more than half (57.9%) of mothers of sexually abused children scored within the clinical range of psychological distress. Findings suggest that after disclosure of SA by their child, a significant proportion of mothers are in need of support and counseling to help them cope with the aftermaths of disclosure. These results are in line with prior research that identifies a large proportion of clinical distress in parents of sexually abused children (Cyr et al., 1999; Kelly, 1990; Manion et al., 1996). Given the cross-sectional nature of the study, it is not possible to conclude that the psychological distress preceded or followed the disclosure. Nevertheless, the results suggest that half of the mothers may show significant psychological distress and may be in need of intervention. Clearly, parental emotional health is of importance to child victims' recovery, as parents in distress may be unable to provide optimal support. Neither chronicity nor severity of the abuse was associated with the distress level reported by mothers, whereas identity of the perpetrator was linked to distress. Thus, mothers of child victims of intrafamilial SA were found to be more likely to display clinical levels of distress compared with mothers of children reporting extrafamilial SA. Intrafamilial SA may be more likely to be associated with a sense of betrayal and major concomitant life events such as financial loss and residential change (Lovett, 1995). In addition, separation or divorce and losses in family and social networks may follow and place additional burden on coping resources (Massat and Lundy, 1998).

Our data confirms that the prevalence of SA among mothers of sexually abused children is high as half (51%) reported a history of SA in childhood. This percentage is considerably higher than figures reported by studies of community or national samples. In the Ontario Health Supplement study (MacMillan et al., 1997), a history of SA during childhood was reported by 13% of women. In a recent survey involving a representative sample of 804 adults of the province of Quebec, 21.4% of adult women reported SA (Hébert et al., under preparation). However, our results are consistent with those of other researchers done with mothers of sexually abused children (Cyr et al., 1999; Deblinger et al., 1993; Faller, 1989; Leifer et al., 1993; Runyan et al., 1992), who have found that rate of SA during childhood is at least double that found in community samples. The prevalence of physical partner violence experienced in the past 12 months by mothers of sexually abused children is also quite high, as 1 of 4 women report either minor or severe physical violence. In a study of a nationally representative sample of close to 17,000 Canadian men and women, rates of partner violence SA for adult women (not necessarily mothers) with a current or past partner were much lower, 8.5% (Daigneault et al., submitted for publication). From a clinical perspective, these findings underscore the need of assessing for maternal history of SA and partner violence in mothers seeking services after their child's disclosure of SA. The results also suggest that significant proportions of sexually abused children are likely to have witnessed abusive partner relationships. Witnessing partner violence may act as an additional trauma that may solicit children's coping resources.

Results suggest that mothers who report partner victimization are more likely to display clinical level of distress. In addition, mothers who themselves were victims of SA seem more vulnerable to distress reaching clinical level. As Hiebert-Murphy (1998) proposed, mothers may experience trauma when they learn about their child's abuse because either they reexperience their own abuse or the observed distress may in fact reflect long-term effects of SA. Thus, differences among mothers with and without a history of SA may not be directly related to the disclosure (Hiebert-Murphy, 1998), and the cross-sectional nature of the study precludes causal inference. The data still reveals that close to 40% of mothers with a history of SA do not reach clinical level of distress. As Breckenridge (2006) has convincingly argued, mothers with a history of child SA are not a homogeneous group and clearly further research is needed to explore the diversity of profiles. As not all mothers with past SA exhibit significant distress, future studies may aim to provide a better documentation of circumstances surrounding the SA experienced (severity, identity of the perpetrator, whether or not it was disclosed, the support received, potential intervention after disclosure). In addition, one should not overemphasize the role of prior SA as a multidimensional model considering both prior trauma history and personal factors is best suited to document the diversity of reactions and profiles of mothers of sexually abused children. In addition, exploring factors linked to resilience in mothers with a

trauma history may help design interventions build upon strengths (Breckenridge, 2006).

In selecting interventions for SA children, trauma-focused cognitive-behavioral therapy (TF-CBT) clearly stands out as one of the best evidence-based treatment models. In a recent randomized controlled trial, Cohen et al. (2004) found that TF-CBT is associated with improvement in terms of symptoms of posttraumatic stress, behavior problems, and depression for children. In addition, parents report lower levels of depression, greater support of the children, and more effective parenting practices. When mothers of SA children have themselves been traumatized, albeit given their own childhood SA or when they are victims of partner violence, involvement of parents provides them with trauma-focused components that may help them deal with trauma and overcome distress symptoms. However, TF-CBT remains a child-focused intervention and some mothers may need referral to a specific intervention designed to help them cope with unresolved issues related to their own trauma. Indeed with parents presenting with severe trauma histories, dealing with these issues may not always be feasible or optimized in a child-centered treatment approach (Cohen et al., 2006). A number of group interventions have been implemented for adult survivors of SA and recent empirical evidence suggests that group intervention might be an efficient treatment modality to help reduce the consequences of SA and enhance the well-being of adult women survivors of SA (Kessler et al., 2003). In one recent evaluation, a feminist-based model was found to be associated with significant gains for women, notably in terms of reduced psychological distress and depressive feelings, and diminished feelings of self-blame and sense of powerlessness (Hébert and Bergeron, in press). Group work is often a preferred intervention modality for adult women presenting with distress related to childhood SA (Bagley and Young, 1998; Callahan et al., 2004; Westbury and Tutty, 1999). The relevance of a group intervention format for survivors of SA is linked to unique therapeutic benefits associated with a group setting. The group format offering women the opportunity to share their past victimization experience among other survivors within the boundaries of a secure setting may act as a crucial element in fostering the resolution of issues related to secrecy and shame associated with SA (Herman and Schatzow, 1984; Ritchers et al., 1997). Sense of isolation and stigmatization can thus be reduced (Courtois, 1988) and the group may serve to create a supportive social network. Participants may enhance a sense of empowerment and self-esteem by recognizing that their personal testimony is valued and beneficial to other participants (Ritcher et al., 1997).

Our data suggest that coping, namely reliance on avoidance strategies, is an important factor predicting clinical level of distress of mothers of sexually abused children. Our results thus corroborate prior studies in suggesting that avoidant coping contributes to the prediction of emotional distress (Hiebert-Murphy, 1998). Approach coping allows for cognitive and emotional apprehension of an event; they facilitate the gathering of the information required for appropriate action, or for noticing and taking advantage of changes that might make a situation more controllable. Avoidant coping strategies minimize the emotional impact of an event; they may reduce stress and may protect the individual from becoming emotionally overwhelmed and dysfunctional. Avoidant strategies are frequently reported as means of coping by sexually abused women (Dufour et al., 2000; Leitenberg et al., 2004). However, the use of avoidant strategies may interfere with the gathering of information that could lead to productive action. Although avoidance may be perceived as a valuable form of coping by survivors in the short run, significant relations between avoidance and increased psychological symptoms are reported in studies of individuals confronted with various stressful situations (Wright et al., 2005). In the present study, avoidant coping was the only type of coping associated with clinical level of psychological distress. Avoidant coping strategies specifically used to deal with SA or everyday stressors have also been directly related to increased difficulties in SA populations (Chaffin et al., 1997; Johnson and Kenkel, 1991; Tremblay et al., 1999). However, approach coping (seeking social support and problem solving) did not act as a protective factor, reducing psychological distress for mothers of SA children in the present study. This result is disconcerting but not unexpected. Indeed, the hypothesized protective action of approach coping has often not been sustained by empirical results in SA populations, including mothers sexually abused in childhood (Chaffin et al., 1997; Daigneault et al., 2006; Wright et al., 2005). Prior studies have found that social support networks of mothers of SA children may be quite small (Cyr et al., 1999). In this context, reliance on approach coping, such as seeking social support, may not be a feasible or efficient strategy.

Sense of empowerment has been found to be related to distress in mothers of sexually abused children. Women's perceived sense of control and self-efficacy as a parent facing the needs of her sexually abused child or her perceptions of her own abilities to take care of her child are important factors related to her own sense of psychological well-being. Although more studies are needed to better explore the dimensions of empowerment in mothers of SA children, treatment issues could address their sense of control and self-efficacy in managing their child's reaction to the abuse to increase their sense of empowerment and in return diminish their psychological distress. Interventions in which parents gain support through identification with other parents may increase self-efficacy and sense of empowerment (Schell and Rieckmann, 1998). Such group interventions for parents of sexually abused children may include information to educate parents about SA and skills to facilitate adequate responses to children. The group format may provide opportunities for parental empowerment and building and/or strengthening social support networks (Banyard et al., 2001). Intervention with parents is a central element to enhance maternal support and to foster parenting skills to help reduce symptoms in their child.

CONCLUSIONS

In summary, the present data confirm the high rates of psychological distress in mothers of children disclosing SA.

Our results should be interpreted with the limitations inherent to the cross-sectional nature of the study with measures that were administered only once. A longitudinal design would allow for a better interpretation of the role of factors associated with psychological distress. In addition, the present study did not document the potential impact of multiple events after disclosure (multiple police and CPS interviews, testifying in court proceedings, separation and divorce, change of residence, etc.) that may interplay (Dyb et al., 2003). The interpretation of the present data is also limited by the fact that no comparison group of mothers was included and that a general measure of psychological distress was used. Further analysis may consider exploring a wider range of outcomes including posttraumatic stress disorder symptoms and evaluating other potential mediators of distress (for instance rumination, Plummer, 2006). Future studies are needed to explore the distress of fathers of SA children. The Quebec Incidence Study found that only 16% of cases involved father–daughter incest (Tourigny et al., 2002). Thus, for an important number of SA children, fathers may play a supportive role in the child's recovery process.

Implications of the current findings relate to the treatment of children disclosing SA and their families because the data provides a valuable step toward a more systematic comprehension of factors associated with psychological distress manifested by mothers. Our data supports the need for a comprehensive individualized assessment that considers both the antecedent of sexual victimization and the evaluation of partner violence. Our study further outlines the role of coping and empowerment as factors linked to distress for mothers of sexually abused children. These results provide additional support for interventions addressing the needs of the nonoffending parent. Banyard et al. (2001) have reviewed the elements of a trauma-group intervention for nonoffending caregivers: providing information, building behavioral skills to promote coping with both child's behaviors and with caregivers' own reactions, and facilitating social support and advocacy. In addition, models of intervention designed specifically for adult survivors of childhood SA have been proposed and found to be effective in enhancing psychological functioning (Kessler et al., 2003; Talbot et al., 2005).

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