ADOLESCENT MALE VICTIMS AND PERPETRATORS OF CHILD SEXUAL ABUSE: MATERNAL ATTRIBUTIONS

Michelle Jennifer Claire New

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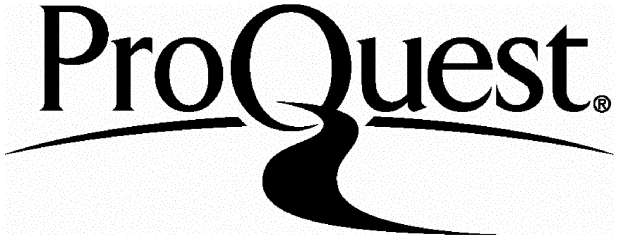
Institute of Child Health
University of London



ABSTRACT

This study forms part of a research programme investigating adolescent male victims and perpetrators of child sexual abuse. The focus is on maternal attributions for negative events. Maternal attributions have been identified as important markers of distressed relationships.

Previous research into physically abusive mothers raised a number of specific hypotheses regarding attributions of non-abusive or 'bystander' parents. This study represents the first attempt to assess systematically causal attributions in a unique clinical sample. The sample consisted of eighty mothers of 11 - 15 year old boys. The design included four groups of victims, victimised perpetrators and perpetrators of child sexual abuse, the three case groups, and an antisocial comparison group.

The Leeds Attributional Coding System (LACS) was used to code attributions made by these mothers extracted from verbatim transcripts of interviews. Attributions were coded along five causal dimensions (Stable, Global, Internal, Personal, Universal). The advantages of coding spoken attributions compared to traditional analogue methods are discussed.

Findings suggest high rates of previous child sexual abuse, adult physical abuse and current depression in the mothers. The implications of these findings for the study of attributions and for clinical intervention are discussed. There were few group differences on the causal dimensions. A discrepancy score for perceived control over negative outcomes revealed significant differences between the case groups and the antisocial comparison group.

It was concluded that maternal attributions may not be direct mediators of developmental pathways but are likely to reflect maternal coping styles. In this study, a 'defensive' coping style characterised by avoidance and active repression of difficult topics was proposed on the basis of a 'low mention' of abuse in the mothers' negative attributions. The implications for intervention and future research are discussed in light of this finding.

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In loving memory of my grandmother,

Klara New

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CHAPTER ONE

Introduction

I. INTRODUCTION

The spectre of child sexual abuse as a serious and pervasive developmental challenge has raised more dilemmas in the field of developmental psychopathology than any other in recent years. The fairly recent acknowledgement of sexual abuse as a serious problem has led to a proliferation of studies in the last twenty years and responding to all forms of child abuse has become a major focus for health and social service providers. However, there remain considerable ethical and societal barriers to conducting clinical research in this area.

Efforts to define the problem and describe its prevalence and incidence have been hampered by the very nature of sexual abuse. It often remains children's shameful secret until well into adulthood.

Research on adults abused in childhood has shown that the context of child sexual abuse is often one of multiple psychosocial disadvantage and that the effects are long-term and deleterious, thus leaving a research challenge which cannot be ignored.

Developmental psychopathology theory which emphasises the relationships between social, emotional and social-cognitive factors is a useful context in which to study the relationship between child sexual abuse and later adjustment. There is also a growing trend to incorporate social psychology theories into developmental models (Goodnow, 1988).

Cicchetti (1994) outlines the advances that have been made and also discusses the difficulties facing researchers who wish to investigate the effects of child maltreatment. He suggests that studies are beginning to progress from a limited focus, on group differences between abused and non-abused children to a broader assessment of

mechanisms that may mediate the effects of abuse upon current and later psychological adjustment.

One such mediating mechanism may lie in the support and responses of the child's main caregiver (usually the mother) to the discovery of abuse. Historically, studies on mothers of sexually abused children have focused on individual characteristics of non-abusive mothers in engendering a home environment in which abuse could occur. The potential role of mothers in the *recovery* of a child from sexual abuse has only recently begun to be addressed.

The recent focus on parental attributions in the developmental literature may begin to address research questions regarding the differential responses of young people to sexual abuse. Child sexual abuse varies along a number of dimensions of severity, type and frequency, but the contribution of these factors to children's adjustment following abuse remains unclear. What has emerged is that the effects of abuse are highly variable and likely to be influenced by a number of factors in the child's social and interpersonal world.

It is thought that boys and girls differ in their long-term adjustment to child sexual abuse. The underrepresentation of boys in the research on sexual abuse is surprising given the concern that today's male victim of abuse will become tomorrow's perpetrator.

A young person's relationship with their primary caregiver may become critically important following the discovery of sexual abuse. Being believed and supported may reduce the developmental risks facing the child following sexual abuse. Conversely, a poor relationship with the primary caregiver may exacerbate such risk leading to maladaptive responses, including sexual perpetration. One recent study suggests that

compared to girls, boys are highly influenced by negative events in their mother's lives, including mother's reactions to violence (Wolfe and McGee, 1994).

The limitations of cross-sectional designs to identify adaptational processes are well known in developmental psychopathology research and should be borne in mind as the reader proceeds.

This study focuses on mothers of adolescent male victims and perpetrators of child sexual abuse in a unique clinical study. The central aim was to examine maternal causal attributions for negative events in their own and their son's lives. Maternal attributions have been identified as potential markers of distressed parent-child relationships and may be important mediators of both affective and behavioural parental responses (Dix, 1991; Bugental, 1992). The study of mothers and their attributions in this sample of adolescent boys represents an original contribution to the field of child sexual abuse. The design consists of four groups of mothers of boys aged 11 to 15 years. These four groups are mothers of boys who have been i) sexually abused, ii) sexually abused another child, iii) have been sexually abused and subsequently abused another child, and iv) an antisocial comparison group.

This study applies a well-established social psychological model, attribution theory, to the clinical field of child maltreatment. Attribution theory provides a rich framework incorporating causal concepts into the understanding of social cognitions.

Early applications of attribution theory focussed on the study of attributions about academic success and failure (Weiner, 1979) . Following the reformulation of the learned helplessness model of depression (Abramson, Seligman, and Teasdale, 1978), attribution theory was brought into the domain of clinical psychology. Attribution theory has now been applied to a broad range of study including for example, distressed interpersonal relationships, adaptation following traumatic life events, and

adjustment to mental illness in the family (Fincham, Beach and Baucom, 1987; Brewin, MacCarthy, Duda and Vaughn, 1991; Joseph, Brewin, Yule and Williams, 1991).

The way children and their parents interpret their interpersonal world has recently received much attention in the socialisation literature (e.g.Dodge and Coie, 1987; Bugental, Blue, Cortez, Fleck, Kopeikin, Lewis and Lyon, 1993). It is proposed that the study of parental cognitions may add to our understanding of the factors that influence children's response to adversity.

Previous studies into parental attributions have identified maladaptive patterns of attributions which distinguish physically abusive from non-abusive mothers (e.g., Bugental, Mantyla and Lewis, 1989). This thesis reviews studies of parental attributions which lead to a number of hypotheses about the nature of maternal attributions in the current study. The original contribution lies in the application and extension of social-cognitive models of development (Dix, 1991; Bugental, 1992) to the study of maternal attributions in clinical samples.

Major difficulties with previous work in attribution research have arisen due to methodological limitations inherent in experimental techniques to assess implicit cognitions. A heavy reliance on vignettes, questionnaires and analogue descriptions have led to a somewhat artificial state of affairs. Recently coding systems have been developed to investigate attributions as they occur in natural discourse which is particularly useful in sensitive clinical contexts.

To date, the lack of a methodological framework to analyse spoken material has restricted the study of causal attributions in sensitive areas such as child maltreatment. This study aims to address this gap in the literature by investigating the causal attributions made by mothers.

The Leeds Attributional Coding System (Stratton, Munton, Hanks, Heard, and Davidson, 1988) was used to test specific hypotheses relating to the causal attributions mothers make about negative outcomes in their own and their sons' lives.

This study was carried out as part of a programme at Great Ormond Street Hospital for Children NHS Trust, London, investigating the effects of child sexual abuse on boys. A particular focus was the possible consequence of such abuse in terms of the development of sexually abusive behaviour.

Structure of dissertation

The dissertation begins with a literature review (Chapter Two) on child sexual abuse introducing the separate literature on male victims and adolescent male perpetrators of child sexual abuse. The role of mothers is identified in a separate section within this chapter. Chapter Three reviews studies relating to the intergenerational transmission of abuse and finally a link is made between child sexual abuse in boys and antisocial behaviour in order to understand the importance of recruiting an antisocial comparison group.

Chapter Four reviews the social psychology literature relating to causal attributions with a brief introduction to attribution theory followed by a review of parental attributions as they relate to child behaviour, parental affect and perceived control in caregiving situations. The brief literature available regarding attributions and sexual abuse is reviewed and finally a section on the measurement of causal attributions leads to a consideration of the use of a non-intrusive coding system to analyse spoken attributions.

Chapter Five attempts to integrate these theoretically distinct fields of psychology and describes the aims of this largely exploratory study. This chapter also presents the research hypotheses guiding the design of the study. The methodology section (Chapter Six) describes the unique research sample and explains the selection and use of methods and procedures of the study.

Chapter Seven presents the results of the study with the relevant research hypotheses. The main focus of the present study was the analysis of maternal attributions, this analysis is described in the results section after examining the data from the semi-structured interviews with the eighty mothers in the study. The controversial relationship between causal attributions and depression is also discussed in the final section of the results.

The thesis concludes with a summary of the findings (Chapter Eight), along with a discussion of the relevance and limitations of the current study and recommendations for future research in this field.

CHAPTER TWO

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II: Literature Review: Child Sexual Abuse I

2.1 Male victims of child sexual abuse

2.1.1 Introduction

In the wealth of clinical literature devoted to the study of child sexual abuse, victims and perpetrators are traditionally considered separately arising out of an historical focus on father-daughter incest. Although it is now acknowledged that many perpetrators of sexual abuse have themselves been victims of some form of maltreatment (e.g. Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau and Murphy, 1987; Becker, 1988; Longo, 1982), the literature and the clinical field it serves remains a divided one.

As this study is concerned with the mothers of adolescent male victims and perpetrators of child sexual abuse, the following chapter will attempt to be selective in orienting the reader to the major issues in the consideration of boys as victims and as young perpetrators. This will be followed by sections considering the mothers of male victims and perpetrators of child sexual abuse.

The next chapter (Chapter Three) considers the intergenerational transmission of abuse, as well as a discussion of the relevance of including an antisocial comparison group in this study. Methodological issues relating to the study of abuse are also summarised in the next chapter.

Due to the complexity and scope of the sexual abuse literature published reviews by established authors were used wherever possible (e.g., Watkins and Bentovim, 1992; Ryan and Lane, 1991; Kendall-Tackett, Williams and Finkelhor, 1993).

This section will consider the definition and prevalence of child sexual abuse. This will be followed by a review of the literature on the effects of child sexual abuse for boys.

Historically, male victims of child sexual abuse have received far less attention in the literature than female victims. Previous studies have tended to combine girls and boys in one study sample, with no gender differentiation in reporting of results (Watkins and Bentovim, 1992). Reactions to sexual abuse may not be gender specific and a recent review suggests that consistent differences between boys and girls in their reaction to sexual abuse have been found in only a few studies (Kendall-Tackett, Williams and Finkelhor, 1993). However, given the small number of studies that have actually attempted to compare boys and girls, the verdict on gender differences remains open. There appears to be a widespread concern that today's male victim of child sexual abuse may become tomorrow's perpetrator which suggests a study of male victims of child sexual abuse is much overdue.

2.1.2 Definition

Issues of definition are paramount to the study of child sexual abuse and its effects, not least because of the impact on estimating prevalence. One widely used definition comes from Schechter and Roberge (1976), cited in Mrazek (1987) who define child sexual abuse as:

> *" the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles"*

As with any definition of sexual abuse this one raises as many dilemmas as it answers (Mrazek, 1987). Legal and medical definitions are often considered somewhat narrow for the mental health profession, however four key factors are considered essential in any working clinical definition:

i) an explicit description of the abuse that occurred, including details of the nature of sexual acts, frequency of the abuse, and use of coercion and aggression.
ii) information about the age and development of both victims and perpetrators.
iii) an understanding of the nature of the relationship between the victims and perpetrators and,
iv) a description of the attitudes and involvement of other family members and of the prevailing cultural attitudes about sexuality in the community (Mrazek, 1980, 1987).

These aspects of child sexual abuse are also important to those carrying out research into the causes and consequences of such abuse. In reality, for both clinicians and researchers such accurate information is rarely available due to ethical and societal constraints (see Chapter Three regarding methodological issues).

Many definitions of child sexual abuse, such as Schechter and Roberge's, focus on the breaking of incest taboos and largely refer to father-daughter sexual abuse. While this is arguably the most common form of child sexual abuse (e.g. Walker, Bonner and Kaufman, 1988) modern definitions need to take into account extra-familial abuse. A slightly broader definition is offered by Faller who states that:

> *"Sexual abuse is any act occurring between people who are at different developmental stages which is for the sexual gratification of the person at the advanced developmental stage"* (1988, p. 12).

This definition encompasses the possibility of both victim and perpetrator being children, and highlights the importance of developmental status rather than age per se. The use of aggression or coercion is not made explicit in this definition. Gender is usually not a factor incorporated into the definition of child sexual abuse. However, the advantage of a working definition such as that provided by Faller above, is that it is gender-neutral and does not preclude the possibility that the victim may experience some arousal or pleasure. This may be an important issue for boys, and one which may

have contributed to the relative lag in acknowledgement of boys as victims of child sexual abuse (e.g., Rogers and Terry, 1984).

A final point on the issue of definition is that if defining sexual abuse is seen as a dynamic and transitional process, the scope for including cultural perspectives and secular trends exists. Given the rapid advances in both the discovery and management of child sexual abuse over the past twenty years, the development of a definition of child sexual abuse for the purposes of both research and intervention remains in a metamorphic stage.

2.1.3 Prevalence

It is noteworthy that until as late as 1980 in Britain, child sexual abuse was not recognised as a form of child abuse by the Department of Health and Social Security, although it was by this stage a cause for concern in the United States (Mrazek, Lynch and Bentovim, 1987). This clearly influenced reporting on child sexual abuse cases, and to date there is no mandatory reporting of child abuse in the U.K.

In their review of the literature, Peters, Wyatt and Finkelhor (1986), leading authorities in the field of child sexual abuse, note that the reality of the situation with regard to the establishment of true prevalence of child sexual abuse is that there is "not yet any consensus among social scientists about the national scope of sexual abuse" (p.16, 1986). This problem extends beyond the 'national scope' for U.S populations to Britain and beyond. Prevalence studies attempt to estimate the proportion of children who have been sexually abused whereas incidence studies try to estimate the actual number of new cases in a given period, usually one year (Peters, Wyatt and Finkelhor, 1986). Watkins and Bentovim (1992), in their review of male victims of child sexual abuse, point to three key factors which have influenced prevalence studies to date: i) definitions used, ii) sample selection and iii) method of enquiry. There have been

however, advances in our knowledge of the prevalence of child sexual abuse particularly for boys over the past ten years.

Peters, Wyatt and Finkelhor (1986) reviewed the literature on prevalence studies and reported ranges of 6 - 62% in females and 3 - 31% in males. Reviews indicate that some prevalence studies have limited themselves to females (e.g. Russell, 1983) which represents an additional obstacle to estimating the prevalence of sexual abuse in boys. Finkelhor (1984), in an earlier review, concluded that estimates from surveys of adult men in the general population indicate that 2 - 9% of men were sexually abused as children. A recent survey of college males (average age: 19.7 years) indicated that 9% of the sample of 284 students reported contact sexual abuse in childhood, and 20% of the sample reported non-contact abuse (Collings, 1995). Clinical survey samples usually point to higher prevalence rates than general population rates and clinical samples usually indicate smaller differences in the ratios of girls to boys abused. Finkelhor (1993) reviewed epidemiological studies and reported that the mean ratio of girls to boys as victims across eight studies was 2.5 to 1. This may suggest evidence of under-reporting of male child sexual abuse which has been attributed to eight factors discussed below (Watkins and Bentovim, 1992).

2.1.4 Under reporting of abuse in boys

The following consideration of the reasons for under-reporting incorporates some of the literature pertaining to the characteristics of child sexual abuse, as it relates to boys:

i) Homophobic concerns: Boys may be more likely to repress or deny their victim experiences due to fear of becoming or being labelled homosexual. Although Watkins and Bentovim identify this as a factor within the boy himself, it is likely that this fear is

part of the societal denigration of homosexuality and negative connotations associated with it which might contribute to non-disclosure of abuse. Some studies show a dramatic divergence in referrals for boys and girls in adolescence (e.g. Cupoli and Sewell, 1988), which may reflect an intensifying of homophobia during adolescence, or the less likely alternative that there is a true decrease in the rate of abuse (Watkins and Bentovim, 1992). Another possible explanation may be that adolescent boys are diverted to treatment for delinquent behaviour and/or sexual perpetrating, rather than to services for victims of sexual abuse.

ii) Differential emotional response: It is commonly accepted that boys are more likely to externalise problems than girls, which is usually seen to be due to the differential effects of both biological and socialisation effects (e.g., Mussen, Conger, Kagan and Huston, 1984; Maccoby and Jacklin, 1980). A consequence of this sex difference may be that boys 'act out' following sexual abuse, rather than respond by 'internalising' the distress that accompanies abuse.

iii) Lack of supervision: This may account for the persistent finding that boys are more likely to be abused outside the family than girls (e.g. Budin and Johnson, 1989; Kendall-Tackett, Williams and Finkelhor, 1993). Watkins and Bentovim (1992) suggest that lack of supervision contributes to under-reporting as boys, particularly older boys who are more likely to be abused outside the family, may not be referred to child protection services by police. While it can be seen that lack of supervision may account for an increase in extra-familial abuse, the link with under-reporting may not be as clear. Two further possibilities are firstly, that boys may not tell their own families about sexually abusive experiences for a variety of reasons; fear that they would not be believed, they may have accepted money or goods in exchange for sexual contact, poor communication skills and poor family relationships may all contribute to the boy's silence. Secondly, it is possible that due to the many biases in identifying

male victims of sexual abuse, only the most symptomatic are referred to clinical services (Kendall-Tackett, Williams and Finkelhor, 1993).

iv) Blaming the boy: This factor is linked with the previous one, which suggests that boys may be seen as in less need of protection than girls and may be more likely to be held responsible for their abuse (Watkins and Bentovim, 1992). One study of 25 male children and 180 female children indicated that adult sex offenders were more likely to go to prison and more likely to be judged as mentally ill if they had abused a male child, rather than a female child. This observation led Pierce and Pierce to suggest that " the sexual abuse of a male child may be viewed with greater vehemence than is that of a female child" (1985, p. 197). Thus making the task of disclosing sexual abuse more daunting for boys than for girls.

A study using case vignettes of a physical child abuse victim indicated that male children received greater blame compared to females and that children described as 'provocative' were blamed more (Muller, Caldwell and Hunter, 1993). The use of case vignettes presented to male and female college students clearly limits the generalisability of the study but does highlight the concept of 'victim blaming' which, regardless of the gender of the victim, may be a key factor in both reporting abuse experiences, and their consequences.

v) Missing indicators: This may be better conceptualised as an unfavourable bias in the identification of boy victims. Signs and symptoms of sexual abuse have often been based on studies of girls although no clear 'syndrome' has emerged in victims of child sexual abuse (Kendall-Tackett, Williams and Finkelhor, 1993). Effects such as fearfulness, low self-esteem, post-traumatic stress disorder, sexualised behaviour and antisocial behaviour have been commonly identified as consequences of sexual abuse (see reviews by Kendall-Tackett et al., 1993 and those by Beitchman and his colleagues, 1991, 1992) and are now seen to apply to boys as well as girls.

Sebold (1987) estimated that only around 10% of actual cases of sexual abuse of boys are reported by professionals, and that this is largely because professionals miss the indicators of abuse in boys. Sebold suggests that these include the following nine categories: homophobic concerns, aggressive and controlling behaviours, infantile behaviour, paranoid/phobic behaviours, sexual language and behaviours, dreams, body and image changes, family and social indicators and setting fires. Clearly such a comprehensive list cannot be useful to the clinician trying to identify sexual abuse, but Watkins and Bentovim (1992) consider that some of these indicators namely, homophobic concerns, exhibitionism and sexual offending are possible signs that boys have been abused.

vi) Denial of abuse by females: The taboo of female perpetrators may further add to under-reporting by boys, although the available evidence is not clear about whether boys are more likely to be abused by female perpetrators. Faller (1989) found that boys were more likely to be abused by female perpetrators, but Russell and Finkelhor (1984) concluded that in absolute numbers, more girls than boys are victimised by women. It is also worth noting that in Faller's sample, 8% (n=7) of the total of 87 boys were abused by women, compared to 0.9% (n=2) of the girls, but that a further 28.7% of the boys (n=25) were abused cojointly by a male and female perpetrator.

vii) Denial of father-son abuse: Watkins and Bentovim (1992) highlight the anomaly that although there have been reports of mother-son abuse, there is a surprising dearth in reporting of father-son abuse. This is surprising, because fathers and step-fathers are cited as being the most likely perpetrators of male children (e.g. Pierce and Pierce, 1985; Reinhart, 1987). To some extent this can be explained by the taboos against both incest and homosexuality (e.g. Justice and Justice, 1979 cited in Watkins and Bentovim, 1992) which further compounds the problem of under-reporting in boys. To date, there appears to be no available research which has compared the effects of gender of perpetrator on male victims of child sexual abuse.

viii) Denial of child-child abuse: A further factor which may affect boy's disclosure of sexual abuse is that until recently there was little acknowledgement that children could be abused by other children (e.g. Johnson, 1988). There is very little good empirical data on this area, and the issue of identifying children and adolescents as 'perpetrators' or 'offenders' remains a challenge (Watkins and Bentovim, 1992).

The recent focus on adolescent male perpetrators of sexual abuse (e.g. Benoit and Kennedy, 1992; Becker, 1988, Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau and Murphy,1987; Fehrenbach, Smith, Monastersky and Deisher, 1986) does suggest that the abuse of children by young people is a pervasive problem. Linked with the finding that boys are more likely to be abused by younger perpetrators (Reinhart, 1987), this seems to be an important area for further research. The present study forms part of a series of research projects investigating both male victims of child sexual abuse and adolescent male perpetrators of sexual abuse.

2.1.5 Effects of child sexual abuse

The consequences of child sexual abuse are generally considered in terms of their short-term and long-term effects. Browne and Finkelhor (1986) suggest that the term 'initial' effects is preferable to the use of 'short-term' which implies that the consequences of sexual abuse do not persist, a claim yet to be substantiated. Probably the most useful conceptualisation of the impact of child sexual abuse is that proposed by Finkelhor and Browne (1986), a model which describes responses to abuse in terms of four trauma-causing factors. Finkelhor and Browne hypothesize that these 'traumagenic dynamics' explain the development of specific effects following child sexual abuse namely, sexual dysfunction, depression and low self-esteem.

The first factor, traumatic sexualisation, refers to the effect of the premature and inappropriate nature of the sexual contact on the child's developing sexuality.

Finkelhor and Browne (1986) point out that there are degrees of sexualisation mediated by various abuse variables. For example, whether the abuse included rewards for the child, eliciting of a sexual response from the child, concomitant use of force (which may become associated with sexual responses) and also the degree to which the child understood what was happening. Children who have been traumatically sexualised by their abusive experiences are said to show inappropriate sexual behaviours, confusion about their sexual identity and unusual emotional associations to sexual activities.

The second factor, betrayal, results from a discovery by the child that a person they depend on has harmed them physically and/or emotionally. This may be experienced as a direct result of the abuse, or in its aftermath. Betrayal is a likely consequence if a parent or other family member does not believe the child and therefore does not support the child, or protect him from further abuse. Children who are disbelieved, blamed or rejected are likely to suffer a greater sense of betrayal than those who are supported, and these reactions may be more common, although not unique, to male victims (Rogers and Terry, 1984).

Maternal support is one of the few variables consistently identified as mediating the effects of sexual abuse (Kendall-Tackett, Williams and Finkelhor, 1993; Everson, Hunter, Runyon, Edelsohn and Coulter, 1989). An absence of maternal support may exacerbate and the presence of such support may ameliorate the childs' feelings of betrayal. Here one can see a link with the study of parental cognitions whereby the way in which the non-abusive or 'bystander' parent, usually the mother, makes attributions about their child's victimisation is likely to influence their interactions with the child following the discovery of abuse.

Powerlessness is the third traumagenic factor and refers to the 'disempowerment' of the victim by contravening the child's wishes and sense of efficacy. Again, degrees of

powerlessness are suggested, with the most serious type of abuse commissioned by an authoritarian abuser who threatens the child thereby ensuring continued compliance. Finkelhor and Browne (1986) also propose that disclosing the abuse and not being believed heightens the powerlessness already experienced by the victim of child sexual abuse.

The final factor in Finkelhor and Browne's model, stigmatization, refers to the negative connotations associated with the victim experience. Feelings of shame, guilt and worthlessness may become incorporated into the child's self image depending on whether this is reinforced by family members and professionals. The age of the child and the degree to which they felt 'bad' as a result of the abuse are proposed to influence the degree of stigmatization experienced. In addition, those victims who remain silent about their abuse may increase the stigmatising effects by reinforcing the idea that they are different and at fault.

These four factors are proposed to account for the main sources of trauma in child sexual abuse and are seen by Finkelhor and Browne as clusters of harmful influences which are related to each other and account for the psychological impact and initial and longer term effects of child sexual abuse.

The following summary table (2.i) provides a brief overview of the initial and longer term consequences of child sexual abuse according to the major reviews in this area.

Initial effects	Long-term effects	Study
Aggression, anger and hostility, anxiety, depression, fears, sexually-inappropriate behaviour.	Anxiety, depression, difficulty in trusting others, feelings of isolation and stigma, poor self-esteem, sexual maladjustment, substance abuse.	Browne and Finkelhor (1986). Review of 27 empirical studies, both adult and child samples included.
General: Increased risk of re-victimisation, sexualised behaviour. Adolescents: Depression, low self-esteem, sexual acting out, suicidal ideation.	Women: Depression, revictimisation, sexual dysfunction. Men: Disturbed adult sexual functioning. No specific post-sexual abuse syndrome.	Beitchman *et al.* (1991) Beitchman *et al.* (1992) Review of 42 studies of sexually abused children/adolescents.
Aggression, behaviour problems, fears, post-traumatic stress disorder, sexualised behaviour, regressive behaviour. Adolescents: Depression, 'illegal acts', running away, sexual aggression, self-injurious behaviour, suicidality.	Aggression, externalising behaviours, sexual preoccupations. Absence of any specific syndrome in children who had been sexually abused.	Kendall-Tackett, Williams and Finkelhor. (1993). Review of 45 studies of children 18 yrs of age or younger.

Table 2.i: Overview of effects of child sexual abuse

The earlier reviews such as that by Browne and Finkelhor (1986) were limited to female victims of child sexual abuse due to the paucity of empirical studies considering male victims at that time. Only four studies in this review included child samples, most of them relying on adult women who had been abused as children. 40% (11 studies) did not employ any form of comparison group compared to 43% (18) in later reviews by Beitchman and his colleagues (Beitchman, Zucker, Hood, da Costa and Akman, 1991; Beitchman, Zucker, Hood, da Costa, Akman and Cassavia, 1992),

and 44% (20) in the most recent review (Kendall-Tackett, Williams and Finkelhor, 1993). The ongoing problems of identifying an appropriate comparison group are considered further in the next chapter.

In a review of studies focussing on male victims, Watkins and Bentovim (1992) consider the initial and specific consequences of child sexual abuse for boys. Only two studies are reported for the consideration of general initial effects, one of which showed that abused girls presented with more problem behaviours than boys, and that boys' self-esteem was no lower than that of a control group (Tong, Oates and McDowell, 1987). This study involved following children up to 2-3 years after the sexual abuse experience, thus caution is required in interpreting these results as indicators of initial effects. The second study reported (Kiser, Ackerman, Brown, Edwards, McColgan, Pugh and Pruitt, 1988) indicated that initially boys (aged 2 - 6 years) presented with more symptoms, however at one year follow up, girls were more symptomatic.

With regard to effects of child sexual abuse which are specific to boys, Watkins and Bentovim (1992) refer to the responses described by Rogers and Terry (1984) in their study of intervention with sexually abused boys. The three common reactions described in boys were i) confusion over sexual identity, ii) inappropriate attempts to reassert masculinity and iii) recapitulation of the victimising experience. These will be considered in more detail following a brief overview of the intervening variables which mediate the effects of abuse.

2.1.6 Intervening variables

Intervening variables are generally abuse-specific and it is commonly reported that the greater the severity of abuse the greater the symptomatology of the victim (e.g., Friedrich, Beilke and Urquiza, 1988; Kendall-Tackett, Williams and Finkelhor, 1993).

Severity of abuse is usually described in terms of duration, frequency, nature of abuse, and use of force. Wyatt and Powell (1988) suggested that abuse perpetrated by fathers, the use of force and genital contact were three factors associated with the most deleterious effects for victims of child sexual abuse.

Kendall-Tackett, Williams and Finkelhor (1993) use the term 'intervening variables' to describe factors such as age of child and other abuse-related variables which can affect both the nature and severity of symptoms. In general i) older children are more symptomatic; ii) boys and girls may show different patterns of symptoms and iii) penetrative abuse, duration and frequency of abuse are all associated with greater symptomatology, as are the use of force and a close relationship with the perpetrator.

Other important factors include maternal or family support, the child's own coping style and the response of professional and judiciary systems (e.g., Morrow and Sorell, 1989; Runyon, Everson, Edelsohn, Hunter and Coulter, 1988), as well as factors which are not abuse-related such as intelligence, coping skills, prior adjustment, a variety of family factors and attributions about why the abuse occurred.

Many of the intervening variables discussed in relation to sexual abuse are highly correlated For example, intrafamilial abuse is usually more severe (involving penetrative abuse), and normally occurs over a longer period of time. Kendall-Tackett, Williams and Finkelhor (1993) point out that no studies in their review statistically controlled for the effects of these intervening variables which may differentially affect children's ability to resolve their victimisation experiences.. Obtaining detailed descriptions of abuse experiences appears to be both a methodological and an ethical challenge facing current research.

2.1.7 Effects specific to boys

i) confusion over sexual identity

Clinical impressions that sexually abused boys become anxious about their sexuality and sexual identity have to date, not been validated (Watkins and Bentovim, 1992). This is largely seen to be due to difficulties in undertaking research of this nature, rather than due to a true absence of this consequence of abuse for boys. Studies of parents of boy victims of child sexual abuse (Rogers and Terry, 1984) and therapists working with abused boys (Sebold, 1987) indicate that they are likely to be preoccupied with sexual identity.

One manifestation of this is a reported 'homophobia' (Sebold, 1987) whereby the boy expresses revulsion and goes to great lengths to dissociate himself with effeminate activities or people. Whether this reported preoccupation is qualitatively or quantitatively different from 'normal' adolescent boys has not been addressed in the literature to date.

Finkelhor (1984) suggests that part of the traditional mythology about male victims of sexual abuse, is that it leads to homosexuality. In his study of college students, Finkelhor (1984) did in fact find a link between childhood victimisation in boys and later homosexual activity. They found that victims were over four times more likely to be currently engaged in homosexual activity than non-victims ($p < 0.01$, $n = 255$ boys), and that almost half of all boys who had been abused by an older man were currently involved in homosexual activity. A note of caution with respect to this study is that college students were asked whether they had engaged in any homosexual activity in the previous year, which may or may not indicate a later homosexual preference. One further study reported a significantly greater likelihood that boys who were abused by

male perpetrators would identify themselves as homosexual, compared to boys abused by female perpetrators (Johnson and Shrier, 1987)

Watkins and Bentovim (1992) identified sexual preference concerns in their review of adult men abused as children which confirmed their clinical experience that boys may feel that they were selected as targets for abuse because they were showing signs of homosexuality, or because they responded physically to the abuse. The link between sexual abuse and adolescent concerns about sexuality may not be specific to victims of sexual abuse but perhaps excessive sensitivity to sexual identity matters could be considered as an indicator to be investigated further.

ii) inappropriate attempts to reassert masculinity

This has been identified as the most common behavioural response to child sexual abuse for boys (Rogers and Terry, 1984) and includes aggression, destructiveness, marked disobedience and hostility. However, evidence of antisocial behaviour in boy victims, compared to girl victims, remains elusive. Studies comparing abused children on the Child Behavior Checklist (Achenbach and Edelbrock, 1983) appear not to confirm the expected prediction that boys are more likely to show externalising behaviours and girls more likely to show internalising behaviours. Other authors do suggest that in keeping with clinical observations, it appears that male victims frequently respond to victimisation with aggression and antisocial behaviour (e.g. Summit, 1983; Howes and Cicchetti, 1993).

In a major review of the area, high effect sizes were found for acting-out behaviours such as sexualised behaviours and aggression. Sexual abuse accounted for 43% of the variance in sexualised and aggressive behaviour and 32% of the variance for externalising behaviour (Kendall-Tackett et al., 1993). There was no accompanying gender analysis, however the authors report that there is insufficient evidence to

conclude that there are consistent differences in the reactions of boys and girls to sexual abuse. This may reflect a true lack of difference between boys and girls, or may be due to the lack of systematic attention paid to gender differences in most studies to date. Nonetheless, it would appear that one reliable finding with respect to the effects of sexual abuse, is that aggression and sexual acting-out are consistently identified as consequences. Further research into the gender specificity of such a finding is clearly warranted.

iii) recapitulation of the victim experience

The notion that male victims recapitulate their victim experience, with themselves in the perpetrator role is a less common, but plausible response to sexual abuse in boys (e.g. Stoller, 1975; Rogers and Terry, 1984; Freeman-Longo, 1986). This may be a reaction to the powerlessness and betrayal experienced by victims. It is hypothesized that an attempt to regain a sense of control in the role of aggressor, may lead to some short-term resolution.

Watkins and Bentovim (1992) highlight other modes, besides identification with the aggressor, which might operate for victims of sexual abuse. Coercion and modelling may be used when a child is forced to sexually abuse a younger sibling or another child (e.g. Friedrich, 1988). The appeal of single-factor theories such as the notion that sexual victimisation alone leads to perpetration of child sexual abuse has been widely believed and appears to hold intuitive appeal.

Finkelhor (1986) cautions against this inherent appeal and suggests that it may further stigmatise victims of child sexual abuse due to the potential for a self-fulfilling prophecy. He comments that this popular notion may cause even more distress as a result of the abuse, particularly for male victims of child sexual abuse and their families.

It does seem that boys are more likely than girls to act out sexually as a result of sexual abuse, but this is yet to be confirmed by well-designed empirical studies. Studies of adult sex offenders suggest that a substantial proportion, between thirty and sixty percent, have a history of sexual abuse (e.g. Groth and Burgess, 1979; Abel et al., 1987). Furthermore, studies of adolescent sex offenders report similar proportions (see Table 2.ii).

There remain a number of objections to a single-factor theory which suggests that sexual victimisation is a necessary and sufficient condition for the development of sexually abusive behaviour. The first of these objections raised by Finkelhor (1986) is that studies of adult sex offenders include incarcerated samples who represent the most pathological and recidivist samples, thus a history of sexual abuse is not surprising in this group. Secondly, where comparison groups are used, sexual offenders often have no higher rates of previous abuse than other types of offender. Thirdly, that there are serious methodological difficulties inherent in conducting research on such a transition, including unrepresentative samples, lack of adequate comparison groups and broad definitions of 'previous abuse' which sometimes included physical and/or sexual abuse histories (see section 3.4).

Finkelhor (1986) suggests that even if more rigorous studies confirmed the finding that 30 - 60% of incarcerated adult sex offenders were sexually abused, in a more representative sample the proportion might be much lower, and other explanations would be required. A rather obvious but often overlooked point is that if this theory is correct; that a victimised child becomes an abuser in order to master the trauma of the abuse, many more girls would be at risk of becoming abusers (e.g., Finkelhor, 1986). In fact, the reverse is true. There is a far greater preponderance of girls in samples of victims of child sexual abuse in all published research to date (Kendall-Tackett et al., 1993), and a far greater preponderance of male abusers (Kelly, Regan and Burton, 1992, Finkelhor, 1979).

It is also important to consider that not all adolescent perpetrators have been victims of sexual abuse. The following table (2.ii) summarises findings from studies investigating previous sexual abuse in the histories of adolescents who have committed sexual offences.

Study	Percentage of Adolescent Sex Offenders with Prior History of Sexual Abuse
Becker (1988)	19% Subjects were 139 adolescent males (mean age 15.6 yrs). The sample was biased as it was overrepresentative of minorities (56% Black, 26% Hispanic, 18% Caucasian).
Benoit and Kennedy (1992)	26% 50 incarcerated adolescent males (12 - 18 yrs). 40% of this group were reported to have a history of physical abuse.
Fehrenbach, Smith, Monastersky and Deisher (1986)	19% 286 adolescent males under 18 yrs referred to a Juvenile Sexual Offender Project. 24% of the boys were reported to have a history of physical abuse.
Longo (1982)	47% 17 adolescent males (under 19 yrs) attending a Juvenile Sexual Offender Programme. All had been sentenced in an adult court and convicted of a sexual assault.

Table 2.ii: History of child sexual abuse in adolescent sex offenders.

The studies summarised in the above table suggest that between 20 and 50% of adolescent sex offenders have themselves been victims of sexual abuse. However, the objections raised by Finkelhor (1986) in relation to adult sex offenders could also apply adolescent perpetrators as well. Without exception, the studies in Table 2.ii focus on

incarcerated boys, or those who have been caught and charged for a sexual offence, which might include raping a peer or adult.

Therefore these samples should not be considered representative of even clinic samples of children and young people who sexually abuse other children. Benoit and Kennedy (1992), in their study of 100 adolescent males, did not find any differences between groups of boys according to the sexual or non-sexual nature of their index crimes. They suggest that the relationship between prior physical or sexual victimisation and later offending is indirect, and that other factors must be operating to lead to such behaviour. It is likely that the families and social backgrounds of these boys would be fertile ground for further research (e.g. Finkelhor, 1986; Ryan, 1991a).

While understanding the need not to further stigmatise male victims of child sexual abuse by suggesting that they will become perpetrators, there is clearly a link, albeit one that is not fully understood. It is important to acknowledge that not all abused boys become abusers, and not all abusers were themselves abused. Watkins and Bentovim suggest that previous sexual abuse is "an important contributory, but not a necessary factor in the development of a perpetrator " (1992, p.221). Before turning to a discussion of adolescent sexual perpetrators, it is important to consider the potential for prevention of child abuse if mechanisms can be elucidated regarding the development of perpetrator behaviour in children who were themselves sexually abused.

2.2 Adolescent male perpetrators of child sexual abuse

Until fairly recently, adolescents were excused from sexually aggressive behaviour on the grounds that they were either experimenting, exploring, or in the case of males, just a matter of 'boys will be boys' (Miedzian, 1992). Ryan and Lane (1991) note that alongside the increase in societal recognition of the deleterious effects of sexual abuse on children's development, was a concomitant mobilisation of intervention services and a commitment to help prevent the sexual abuse of children. Thus the identification of sexual perpetrators as early as possible became a crucial issue for both service providers and policy makers.

2.2.1 Definition

Ryan defines a juvenile sex offender as " a minor who commits any sexual act with a person of any age (1) against the victim's will, (2) without consent, or (3) in an aggressive, exploitive, or threatening manner" (p.3, 1991b). Although this is primarily a legal definition and one that defines the person rather than the behaviour, it is useful to define the population under study. There is often a distinction between rape (a legal definition usually including penetrative abuse perpetrated with violence), and other forms of abuse such as non-contact offences (e.g. exhibitionism, frottage) as well as other forms of contact abuse which do not include anal, oral or vaginal penetration.

The present study does not use the term 'offender', as this has legal implications and not all adolescent sexual perpetrators are processed through the criminal justice system. The focus of this study is on the perpetration of sexual abuse on children, rather than rape of peers or older adults, or other sexually deviant and criminally offensive behaviours (such as exposure, frottage etc). Ryan (1991c) reports on data on 1000 juvenile offenders from the Uniform Data Collection System of the National Adolescent Perpetrator Network in the United States. The Network reported 46.2 %

of all offences were perpetrated against children not related to the young sex offender, and that only 15% of the crimes were committed against peers or adults.

The National Children's Home publication on young people who sexually abuse other children (NCH, 1992) reports the difficulty in discriminating between adolescent sexual behaviour which is abusive, and that which is merely inappropriate. While both extremes of this continuum are likely to be easily recognised, it is the ambiguous cases which are challenging for families, social services and area child protection committees.

The NCH report suggests that the young person's sexual behaviour needs to be considered with respect to true consent, power imbalance and exploitation. These are considered to be critical determinants in deciding whether abuse has taken place or not. Unfortunately obtaining detailed and highly sensitive information on abusive episodes is likely to remain difficult especially when different clinical or research teams assess victims and perpetrators separately.

The review of the literature refers to many studies of adolescent offenders, many of whom were incarcerated for sexual offences against children, peers or adults. As noted earlier, most of the literature relating to adolescent sexual perpetrators refers to a heterogeneous group who may have committed a broad range of sexual, violent and non-violent offences. Figures reported by Ryan (1991c) suggest that almost half of all adolescent perpetrators commit sexual acts against children. This indicates that incarcerated boys who rape or abuse peers or adults are over represented in studies of adolescent sex offenders.

There appear to be few studies referring to younger adolescents, under the age of 16 years and even fewer with an exclusive focus on the commission of sexual abuse against younger children. The present study focuses on 11 - 15 year old boys who have sexually abused another child at least two years younger than themselves.

2.2.2 Prevalence

Attempts to estimate the prevalence of sexually abusive acts by adolescents are few and far between, and it is generally considered that any recorded incidence rates are likely to be the tip of the iceberg. Many factors pertaining to the under-reporting of child sexual abuse for male victims have been referred to in the previous section (see 2.1.4), and are generally expected to lead to an under-estimation of actual prevalence.

In their review of adolescent sex offenders, Davis and Leitenberg (1987) refer to two main findings regarding the prevalence of sexual offences committed by adolescents:
i) that approximately half of adult offenders self-report that they began sexual offending in adolescence (Abel, Becker, Mittelman et al., 1987)
ii) approximately 20% of all rapes, and 30 - 50% of all cases of child sexual abuse are committed by adolescents (e.g. Deisher, Wenet, Paperny, Clark and Fehrenbach, 1982). Although this clearly points to the severity of the problem, it does not enlighten us on the numbers of young people who are engaged in sexually abusive behaviour.

As arrest statistics are even less likely to be representative of adolescent sexual offences compared to adult offenders, studies of normative samples are of particular interest. Ageton (1983) studied 863 male adolescents between the ages of 13 and 19 years. Using an anonymous questionnaire, Ageton enquired about sexual acts involving coercion or assaults. 4% reported committing one or more sexual assaults during the previous year. Davis and Leitenberg (1987) excluded this study from their review because of the broad definition of 'coercion' employed, which included verbal coercion. Thus, an adolescent male threatening a female peer with ending a relationship if she did not comply with his sexual demands, was included as a coercive sexual act. This highlights the difficulty in establishing true prevalence or incidence rates of adolescent sexual perpetrating, especially for abuse committed against children.

Roberts, Dempster, Taylor and McMillan (1991) reported that of 212 police reports of allegations of sexual abuse in Tayside, Scotland, 77 cases (26%) involved a perpetrator under 17 years of age, and that 95% of the perpetrators were male. In 66% (51) of the cases, the child victim was classified as an acquaintance or friend and in 42% (33) cases the abuse involved penetration.

In a study of child sexual abuse in Liverpool it was reported that 34.4% (n=46) of alleged perpetrators were under 18 years old and that 58% of this group were aged between 13 and 17 years. Horne, Glasgow, Cox and Calam (1991) comment that even if some of these allegations were unfounded, the incidence of young people abusing other young people represents a significant problem.

The research study of incidence of child sexual abuse in Northern Ireland (Research Team, 1990) found that in a sample of 408 established cases of sexual abuse , 36.1% (148 children) were abused by adolescent perpetrators. As this included 22 girls who were involved in sexual activity with their boyfriends, the authors revised the rate of children abused by adolescents to 29.8%. This study showed no significant differences in the age of the perpetrator of abuse between boys and girls (20% of the entire sample were boys).

The methodological difficulties inherent in studies of prevalence and incidence means that under-reporting of adolescent sexual perpetration is likely. The seriousness of abusive behaviour is slowly coming to light, and it appears that the previous reluctance to label and thus stigmatise young people needs to be redressed (Roberts et al., 1991).

2.2.3 Theories of aetiology of adolescent sexual perpetrating

The single-factor theory that sexual victimisation may be a necessary and sufficient condition in the development of sexually abusive behaviour has already been discussed in a previous section on the effects of sexual abuse on boys (see Section 2.1.1.3).

Theories of the aetiology of sexual aggression stem, primarily, from work with adult sex offenders and range from psychoanalytic to behavioural in their orientation. In her review of the area, Ryan suggests that "sexual aggression is a multidimensional problem without a clearly defined cause" (1991c, p. 41), and that the most likely causal theory is a truly integrative one incorporating a broad spectrum of theoretical approaches. The importance of cultural considerations when defining sexually abusive behaviour and the impact of the relatively recent criminalisation of sexually exploitative behaviour are relatively unexplored in the literature to date (Ryan, 1991a).

Adolescent sexual perpetrating has been associated with a history of sexual and physical victimisation as well as with conduct disorder and antisocial behaviour (e.g., Burgess, Hartman and McCormack, 1987; Kavoussi, Kaplan and Becker, 1988) and a dysfunctional family background (e.g., Fehrenbach et al., 1986); Davis and Leitenberg, 1987). Ryan presents an overview of more specific theories advanced for the understanding of adolescent sexual perpetrating, and its treatment. These are briefly presented here, but for a fuller description see Ryan (1991d); Borduin, Henggeler, Blaske and Stein (1990); Becker (1990) and Hunter, Goodwin and Becker (1994).

Ryan (1991d) reviews eight different theories put forward to explain sexual perpetrating or offending behaviour:

i) The first theory, Psychosis Theory, refers to the notion that the sexual offender is psychotic or severely psychiatrically impaired. The idea that a perpetrator is in some

way sick or mad may be more acceptable to a society which is reluctant to take on responsibility for the increasing amount of violence and sexual offending that has developed along with industrialisation in Western cultures (Abel, 1994; Ryan, 1991d). However, it is reported that only approximately eight percent of the total population of adult sex offenders is psychotic (Knopp, 1984), and the incidence of psychosis among adolescent perpetrators is probably rare. In a study investigating psychiatric diagnoses in a group of 58 male adolescent sex offenders (mean age 15.3 years), Kavoussi, Kaplan and Becker (1988) found that the most common diagnosis was Conduct Disorder (see later section on adolescent perpetration and antisocial behaviour).

In one of the few studies employing a comparison group, it was found that compared to a group of 'assaultive' (i.e. non-sexual, violent offenders), adolescent sex offenders reported more ruminative-paranoid symptoms (Blaske, Borduin, Henggeler and Mann, 1989). This sample of adolescent sex offenders (average age of 15.1 years) were selected on the basis of at least one arrest for the commission of a serious sexual offence (rape, sexual assault and attempted rape), although it is not made explicit, it appears that these offences were committed against adults or peers. Blaske, Borduin, Henggeler and Mann comment that the high rates of anxiety and estrangement (as indicated by the higher scores on the 'ruminative-paranoid' symptom of the SCL-90-R; Derogatis, 1983) reported by the sexual offenders in their sample could be an antecedent or a consequence of their sexual offending. It appears unlikely that psychosis or other serious mental illness, as opposed to types of personality disorder, contribute significantly to the commission of sexual abuse particularly in adolescent populations.

ii) A related theoretical perspective is Intrapsychic Theory which views sexual offending as a symptom of unresolved intrapsychic conflict. Ryan (1991d) notes that psychoanalytic theories of personality development such as that of Freud (1950), which incorporated both sexuality and aggression, dominated the field for many years

and relate to some of the developmental theories used to explain sexual aggression. Groth (1979) classified adult paedophiles as either 'regressed' or 'fixated'. Regressed paedophiles were those who had suffered some trauma or stress which caused a regression to an earlier stage of sexual behaviour, and the fixated paedophile was said to have suffered from a developmental arrest, which resulted in an 'arrested' sexual interest in children. Although the terms 'fixated' and 'regressed' are not likely to help us understand the aetiology of sexually abusive behaviour, they are frequently used particularly with regard to adult sex offenders in describing a primary or secondary interest in children as sexual objects which may be helpful for intervention purposes.

iii) Physiological Theory is the third theory put forward to explain sexually aggressive behaviour. Both neurological and hormonal factors are thought to be influential in the pattern of sexual arousal leading to sexual offences, and to aggressive behaviour (e.g. the hormone testosterone). As with other single-factor theories it is unlikely that all sexual perpetration will be explained by hormonal factors (Finkelhor, 1986). Hormone therapy has been used with varying degrees of success to reduce sexual arousal in adult sex offenders, but there are serious ethical issues when considering such treatment for adolescents given its questionable efficacy, and the non-specific effects of such drugs such as growth failure in immature males (Ryan, 1991d).

iv) Learning Theory is the fourth theory advanced to understand sexually abusive behaviour. Bandura's (1977) theory of observational learning added modelling and imitation to the earlier Skinnerian models of classical and instrumental conditioning (Skinner, 1969). With regard to the sex offender, learning theory has been applied to both aetiological and intervention models. At an individual level, a child who has been sexually abused may experience arousal and then sexual arousal may be paired with deviant behaviour in a classical conditioning paradigm. Instrumental conditioning may play a part if the sexual behaviour is reinforced by sexual arousal or some other non-

sexual reward (such as money or affection), or if it is inhibited by negative consequences. The inhibition of deviant sexual arousal by pairing it with noxious stimuli forms the basis of behavioural interventions with adult sex offenders.(Longo, 1982; Hunter, Goodwin and Becker, 1994).

Bandura's (1977) theory that individuals observe and imitate behaviour in their social environment implies that exposure to 'deviant models' may result in the practice and adoption of a deviant behavioural repertoire, including that of sexual aggression. Ryan (1991d) notes that the deviant models are not necessarily sexually aggressive, but may model antisocial behaviour and physical violence as normative. Although only about 35% of adolescent sex offenders would be labelled as conduct disordered (Ryan, 1991d) and up to 50% may have been sexually victimised, the learning theory models appear to contribute plausibly to an understanding of the development of sexually abusive behaviour. This does not detract from the importance of mutual cognitions within family systems between parents and children which also play an important role in the socialisation of children (see Maccoby, 1992). Ryan (1991d) suggests that learning theories also have broader implications at a societal level, in that if children are not protected from deviant models by child care and criminal law, that society is likely to be at risk of high rates of such deviance.

v) Developmental theories also need to be considered in order to understand both normal and deviant psychosexual development. Ryan (1991d) reviews the major theoretical contributions of Piaget, Erikson and Freud in relation to adolescent sexual offending.

In Piagetian terms, unsuccessful progression from one cognitive-developmental stage to another may lead to a fixation in one of the early stages of development such as sensory motor, preoperational or concrete operational (Piaget, 1928). This is comparable to Groth's concept of a 'fixated' paedophile (Groth, 1979) and to concepts

of egocentrism and failure to decentralise which manifest itself as lack of empathy in adolescent sex offenders (e.g., Ryan, 1991d).

Erikson's theory of psychosocial development (Erikson, 1963) describes a number of crises which must be resolved in order to attain autonomy as an individual. Sexual deviancy may arise as a consequence of parental dysfunction or loss, or due to some other failure to resolve control issues (see Ryan, 1991d and Erikson, 1963 for further details).

Freud's theory of personality development (Freud, 1950, 1965) describes a series of stages (oral, anal, phallic, latent and genital) which relate to sexual identity and self-image. Traumatic early sexual experiences are related to dysfunction and fixation may arise due to unresolved conflicts between the id which represents primitive instincts and impulses in the unconscious mind, and the ego and superego which master these impulses and bring them under conscious control. This requires the introjection of parental figures which may be deviant in the families of sexual perpetrators.

The message that these developmental theories puts across is that early childhood experiences, including sexual victimisation, may have an important role to play in the commission of sexual perpetrating in adolescence and beyond. The role of family beliefs and norms may also prove to be important in the development of sexual aggression.

vi) Cognitive theories have also been proposed to account for the 'thinking errors' that are commonly reported in the clinical literature on adult sex offenders (e.g. Yochelson and Samenow, 1976). Cognitive-behaviour therapy and cognitive restructuring are techniques used in interventions with sex offenders (Ryan, 1991d). These interventions appear promising, however to date there have been few published evaluation studies regarding the success of these interventions with sex offenders.

The process by which these cognitive distortions develop and are maintained and whether they are simply justifications for abusive behaviour, or have a causal role in the development of such behaviour is far from understood.

vii) The theoretical model of 'addiction' combines learning theory, cognitive theory and developmental theories to describe an addictive cycle of cognitive distortions and compulsive urges. The addictive model developed by Carnes (1983) cited in Ryan (1991d) is all encompassing. The deviant sexual addiction is seen to be part of a 'distorted view of the world' (i.e., cognitive distortions), and is seen to worsen as the individual becomes preoccupied and even obsessed with the sexual behaviours. This addictive model also includes an exploration of factors in childhood and current interpersonal relationships for evidence of lack of boundaries or deviant modelling of sexual behaviours. This model is probably more suitable for understanding and intervening with adult sexual disorders, and has led to the development of treatment 'Twelve Step' treatment programmes similar to those run by Alcoholics Anonymous (Ryan, 1991d).

viii) Finally, family systems theories. This theoretical approach is commonly used in studies of incest whereby father-daughter incest was seen to be a symptom of a dysfunctional family system (see section 2.2). Research on extra-familial abuse and the post-1960's feminist movement led to a more appropriate emphasis on the role of the perpetrator in child sexual abuse (e.g., Conte, 1985). However, family dynamics are seen to be important in the development of sexual offending in adolescence (e.g., Watkins and Bentovim, 1992) and may also be important in interventions, particularly with the younger adolescents who are likely to be living at home, or in regular contact with their families. A later section in this chapter (2.4) addresses the role of mothers and adolescent sexual perpetrators.

Ryan (1991d) points to both the individual contribution and considerable overlap of these eight theoretical approaches and maintains that each theory adds some light to understanding the genesis of sexually abusive behaviour. This clearly has implications for treatment approaches as illustrated by Judith Becker who notes that:

> *"unfortunately, no empirically validated model exists that explains the development of deviant sexual behavior in adolescents. Because the cause of deviant sexual behavior varies from individual to individual, a truly useful model must be developed that is comprehensive and includes individual, family and cultural variables"* (p.362, 1990).

Treatment packages are indeed comprehensive (e.g., Smets and Cebula, 1987; Ross and Loss, 1991; Ryan and Lane, 1991a) and to date it remains unclear which aspects of broad therapeutic intervention programmes are successful in preventing further sexual abuse of children (New and Monck, 1993).

2.2.4 Other factors relating to perpetrator behaviour

i) conduct disorder in adolescent perpetrators

The association between conduct disorder and adolescent sexual offending will be addressed further in the next chapter (see 3.2.2). Becker (1990) proposes that adolescent sexual offenders may be categorised according to whether they are acting out of a deviant sexual desire or as part of a generalised pattern of delinquency. The close association between antisocial behaviour and sexual perpetrating has been repeated throughout the literature relating to adolescent sex offenders (e.g., Horne, Glasgow, Cox and Calam, 1991).

Rates of antisocial behaviour are presented in terms of conduct disorder or delinquency and range from 44 % (Fehrenbach, Smith, Monastersky and Deisher, 1986) to 84% (Van Ness, 1984). The boys studied in Van Ness' sample included older, incarcerated offenders which may account for the higher prevalence of conduct disorder in this group.

ii) physical and emotional abuse in adolescent perpetrators

Previous sexual victimisation has been focussed on as an important contributory factor in the genesis of sexually abusive behaviour. However, it is likely that other forms of child maltreatment are also associated with the development of sexual aggression. Clinical reports suggest that sexual, physical and emotional abuse as well as neglect frequently co-exist within families (e.g., Howes and Cicchetti, 1993). Seghorn, Prentky and Boucher (1987) found that 56% of their sample of adult sex offenders including 97 incarcerated rapists and 54 child molesters reported a history of child neglect and 58% reported a history of child physical abuse.

Clinical studies of adolescent perpetrators have included findings regarding physical abuse with rates of self-reported child physical abuse ranging from 34% (Becker and Stein, 1991) to around 60% (Smith, 1988). It is likely that high rates of all forms of child maltreatment exist in clinical populations of adolescent sex offenders although few studies directly assess this. This clearly has implications for the importance of studying the family environments of adolescents who have been sexually abused and those who are sexually abusive.

2.3 Child sexual abuse: The role of mothers

2.3.1 Introduction

The increase in research and clinical experience with victims of child sexual abuse during the 1980's has been accompanied by an interest in the families of sexually abused children and in particular, the 'non-abusing parent', usually the mother. In the largely clinical literature, which has focussed on incest, various schools of thought have emerged with regard to the mother's role in child sexual abuse, ranging from being an accomplice in the abuse, either subconsciously or with full knowledge, (Browning and Boatman, 1977; Dietz and Craft, 1980; Salt, Myer, Coleman and Sauzier, 1990), to being a perpetrator herself (e.g. Wilkins, 1990). Until very recently mothers were not seen to take positive (i.e. protective) action on behalf of their children. Historically, mothers of incest victims have not been portrayed as benign, non-participative or neutral in their role in the incestuous relationship, but rather as active colluders in the commission of incest within the family.

Maternal responses, the way a mother acted following discovery of sexual abuse in her family, have become a point of therapeutic interest and importance (e.g. Goodwin, McCarthy and DiVasto, 1981; Wyatt and Mickey, 1988; Everson, Hunter, Runyon, Edelsohn and Coulter, 1989; Sirles and Franke, 1989; Wagner, 1991). However, this increased research interest in mothers, as non-abusing or 'bystander' parents, seems to have produced rather limited findings, as will be discussed in this section.

Studies have concentrated on observations or clinical ratings of maternal behaviours following disclosure and in rare cases on maternal affect. Research designed to systematically assess parental social cognitions in families where sexual abuse has taken place appears not to have been undertaken to date. Assessment of causal

attributions in mothers of sexually abused children is the major focus of the present study.

There have been concerns raised in the literature about the somewhat derisory way that mothers of victims of sexual abuse are described. For example, mothers may be referred to in terms of 'maternal responses' which is seen to characterise the way in which language might deny these women other roles or identities (Hooper, 1992). Indeed, research in this area has focussed on 'maternal support' (Everson et al., 1989), 'maternal responses' (de Jong, 1988) and 'mother's reactions' (Sirles and Franke, 1989). On reviewing the literature it appears that these authors do not necessarily view these psychological responses in isolation, and that maternal factors are critically important to study in the context of child sexual abuse. There does however appear to be a relatively pervasive 'mother blaming theme' to the early literature, particularly in relation to studies of father-daughter incest (see Mrazek, 1987; Deblinger, Hathaway, Lippman and Steer, 1993).

This section considers firstly the characteristics of mothers of male victims of child sexual abuse, followed by a review of the literature on maternal responses to the sexual victimisation of their child.

2.3.2 Demographic characteristics

Despite the abundance of literature on child sexual abuse which has emerged over the past decade, there are remarkably few studies which report on the demographic characteristics of mothers of victims of child sexual abuse. Weinberg reported a large study of 203 cases of incest and he noted a larger proportion of Black Americans and of 'foreign born whites of Polish and Italian origin' than would be expected from the general population in Illinois and rather alarmingly suggests that these groups "have acquired some tolerance for this form of behaviour [incest]" (p. 44; 1955).

In Meiselman's (1978) study of a clinic population of 58 adult incest survivors, she noted that Black patients were slightly underrepresented in the incest group, and Latin American patients were somewhat overrepresented. This was seen to be an artefact of the cooperation of a Spanish-speaking therapist in reporting the cases of incest to the research study, and Meiselman concludes that her findings "should not be interpreted as a demonstration that incest is more common in Americans of Latin American background" (p. 82, 1978). In the absence of the use of control or comparison groups and failure to replicate Weinberg's (1955) finding, contemporary research suggests that there appears to be no relation between child sexual abuse and social class or ethnicity. For example, Finkelhor and Baron report that "studies have consistently failed to find any black-white differences in rates of sexual abuse" (p.69; 1986). Kempe (1978) also notes that presenting cases of child sexual abuse represent a cross section of the community with respect to both social class and ethnicity.

Items regarding personal history were included in a postal survey of medical child care professionals in Britain (Mrazek, Lynch and Bentovim, 1987). 685 questionnaires were returned (a response rate of 42%) and of these, 39 % of professionals had seen a case of child sexual abuse at one time. The results of this survey suggested that 14% of parents had a mental illness, 10% of parents had a history of criminality and 34% had a poor marital relationship. There was alcoholism in 10% of the parents and the rate of parental unemployment was 13%. In general, high rates of alcohol and drug use and antisocial lifestyles have been anecdotally reported in the clinical literature regarding families in which sexual abuse occurs.

In the Mrazek et al., (1987) survey no distinction was made between mothers' and fathers' characteristics and socio-economic and cultural differences were not presented. In the absence of a comparison group, it is difficult to ascertain whether these figures differ from normal control groups or other clinical comparison groups. As social work departments were not able to be directly circulated in this survey, the sample was

drawn from those reported on by the medical professionals which may not be a representative sample of sexually abused children, and it is possible that the cases reported on were more 'serious' cases of child sexual abuse as they came to the attention of family doctors, paediatricians, police surgeons or child psychiatrists.

2.3.3 Mothers of victims of incest

Maternal characteristics are frequently reported in early clinical studies of father-daughter incest. This clinical literature, particularly in relation to mothers of victims of child sexual abuse from the 1950's to date, has been described as "remarkably consistent and uniformly negative" (p. 112, Salt, Myer, Coleman and Sauzier, 1990). Kelly (1988) notes the shift in research interest from children as active participants in incest (Freud, 1950) to mothers as collusive agents (e.g, Lustig, Dresser, Spellman and Murray (1966). Historically many of the causes and effects of child sexual abuse have focussed on the culpability of the victims' mother, with little interest in the actual perpetrator of the sexual abuse. This 'mother-blaming' theme is salient in the primary theoretical explanation for incest such as the family dysfunction model (e.g. Mrazek and Bentovim, 1987) in which incest is seen as a 'family survival pattern' in response to family dysfunction in which the mother plays a crucial role. Other theoretical approaches usually portray mothers in pivotal positions such as in ecological models of child abuse where mothers own childhood experiences and current relationships are seen to be important in abusive families. (Belsky, 1980; Belsky and Vondra, 1989). Attachment theories also place mother-child relationships as salient to any dysfunctional family processes (Maccoby, 1992).

Browning and Boatman (1977) have described the 'typical' family constellation in incestuous families as comprising a chronically depressed mother and a violent and alcoholic father where the eldest daughter is forced to assume many of the mother's responsibilities which leads to role confusion between the daughter and her mother.

Mothers are further implicated by the suggestion that "they played conspicuous roles in directing the husband's sexual energies toward the daughters" (p. 34. Lustig et al., 1966). Lustig, Dresser, Spellman and Murray's (1966) study of six cases of incest arose, by their own admission, out of clinical observations and staff discussions. Their 'results' may be an artefact of the fact that this was an army clinic, a tiny sample, and included some rather startling and uncorroborated 'impressions' such as their concluding statement that:

> *"despite the overt culpability of the fathers, we were impressed with their psychological passivity in the transactions leading to incest. The mother appeared to be the cornerstone in the pathological family system."* (p. 39).

In her review of contributing factors to incest, Mrazek (1987) notes that mothers are usually described as colluding and involved in actually 'setting up' the sexual relationship between father and daughter. Mrazek found that studies trying to identify contributory factors reported that the mothers' own deprivation in childhood, difficulties in expressing affection, and a previous history of sexual abuse, in addition to "frigidity and hostility" (p. 101; 1987) towards her partner may lead to the marital and sexual estrangement which paved the way for a full role reversal between herself and her daughter. These factors are apparently based on clinical observations, with no corroborating data, but are often repeated in the clinical literature as an important focus for therapeutic work.

Some of these factors will be investigated in the current study such as early childhood experiences of mothers, including experiences of child sexual abuse. A previous history of sexual abuse is often noted in studies of mothers of incest victims giving rise to 'cycle of abuse' and revictimisation models of explanation of child sexual abuse (e.g Faller, 1989; Wyatt, Guthrie and Notgrass, 1992; see also section 2.2.3).

Less is known about the role of mothers in father - son incest. That mothers are reported to have marital problems (Mrazek, 1987) in such families is a somewhat redundant finding given that i) their partner has sexually abused their child and ii) that partners are likely also to experience these marital problems.

In cases of father-son incest, mothers are seen to have a collusive role as they may not report sexual activities they are aware of, or may unconsciously repress this awareness. Mrazek notes that mothers of male victims of incest have been described as much more powerful than they acknowledge with a "castrating attitude towards men" (p. 103; 1987) as she allows men to believe they are in charge, but in fact is surreptitiously manipulating them. This is one example of how clinical impressions written over the years can develop into negative and unmitigated assumptions about mothers in cases of child sexual abuse, which have little to substantiate them but are widely accepted.

Sgroi and Dana (1982) describe mothers of victims of incest as showing low self-esteem, lack of trust, isolation and a fear of developing new relationships as factors which contributed to their need for individual therapy. Low self-esteem and the expectation of failure (which is akin to the notion of 'learned helplessness'; Abramson, Seligman and Teasdale, 1978) are described as important factors in the depression that is frequently seen in mothers of incest victims. However, it is also possible to see each of these factors as consequences of the discovery of sexual abuse rather than as antecedent characteristics of mothers.

The antecedents and consequences of the discovery of child sexual abuse may not have to remain inevitably entwined. For example, medical and social records may be accessible to clarify certain important details in the mother's or family history. Studies to date have not sought to identify whether, for example, maternal depression is an antecedent or consequent factor in child sexual abuse, or whether it precedes and then is maintained by the discovery of child sexual abuse.

The enduring concept of the 'absent' mother has been regarded as important in the development of incestuous relationships in terms of both physical absence, due to death or illness and psychological absence (e.g., Meiselman, 1978).

Sgroi and Dana (1982) describe a woman who is 'psychologically absent' as both wife and mother, one who uses this absence as both a defence mechanism and as a method of escaping responsibility for the sexual abuse of her child. Their speculative conclusion was that "the mothers were usually largely responsible for the poor communication (between family members) since they themselves often served as non-communicative role models" (Sgroi and Dana, 1982, p. 194). The lack of any empirical data to corroborate this conclusion demonstrates the difficulty in establishing family factors associated with child sexual abuse, let alone their causal status, especially in small convenience samples in clinic settings.

Reviewing the area of maternal characteristics in this literature indicates an almost imperceptible shift from the mere description of characteristics of mothers, to the assumption that these characteristics are contributory to the commission of acts of child sexual abuse, particularly within the family. Clinical observations about mothers in the early literature appear unsympathetic and lack alternatives to the stereotype of accomplice or colluder. Alternatives to collusion are rarely sought even though taking into consideration the mothers own difficulties and circumstances may alter the perception of responsibility placed on the mothers. For example studies suggest a high rate of adult physical abuse (78% reported by Dietz and Craft (1980); 45% by Sirles and Franke (1989) and 57% by Deblinger et al., 1993) in the past and present lives of these women which may affect their ability to act decisively for fear of violence (Browning and Boatman, 1977).

The prevailing theme in the early literature is that mothers of incest victims may be instrumental to the sexual abuse of their child, and may respond inadequately to the disclosure of such abuse (Lustig et al., 1966; Peters, 1976; Browning and Boatman, 1977). The methodology employed in these studies is seriously flawed by small samples, lack of comparison or control groups, no attempt to differentiate between causal and consequential effects of the discovery of child sexual abuse, and assumptions based on limited clinical observations. For example, Browning and Boatman's asserted that

> *"the mother's role in father-daughter incest was noted by their physical absence, which afforded the opportunity for the incest to occur"* (p. 71, 1977).

This is supposedly substantiated by the anecdotal evidence of the absence of the mother at the time of the incest. What may be erroneously implied from these studies is that there was *intention* in the mother's actions and thus collusion in the commission of incest, when an alternative explanation is just as plausible. Browning and Boatman's description of the circumstances of incest in their small study of 14 cases, refers to mothers being out at work, having a baby in hospital, being away on a trip and being intoxicated or incapacitated in other ways. These examples demonstrate the both the ease of non-collusive alternative explanations of absences and the danger of ascribing mothers' collusive intention to these 'circumstances', which may have serious implications for the clinical practice and management of child sexual abuse cases.

Despite numerous clinical descriptions, little is known about processes involved in family dysfunction which leads to incest. Little attention appears to have been paid to the role of social cognitions in child maltreatment and it is possible that understanding more about how family members make sense of negative life experiences may contribute to models of child maltreatment which have traditionally been embedded in family systems theory, ecological models and attachment theory (see Howes and Cicchetti, 1993; Belsky, 1980).

2.3.4 Maternal responses to male victims of child sexual abuse

i) introduction

Most research in this area has focussed on mothers' responses to the disclosure of child sexual abuse, particularly in cases of incest. This belies the notion that the actual disclosure is just one part of the *process* of discovery and acknowledgement of sexual abuse, rather than being a discrete event. However most studies do focus on disclosure and Everson et al., 1989 have highlighted the critical nature of the disclosure of incest, but their conceptualisation may be equally applicable to all forms of child sexual abuse. Everson et al., (1989) see that the 'crisis' of discovery of abuse may fit Rutter's description of a "key turning point" in the child's life "when a risk trajectory may be redirected onto a more adaptive path" (p.329; Rutter, 1987).

The onset of child sexual abuse and its consequent discovery can be seen as a major life stress or crisis (Meiselman, 1978; Everson et al., 1989) which alters the developmental trajectory of the child and in which protective factors, such as self-esteem, family cohesion and social support (Garmezy, 1985) are likely to play an important role. Meiselman elaborates on this by suggesting that the long term effects of incestuous experiences as a child may not be any different from other negative life events such as parental divorce, serious illness, and other events, but that long term problems are more likely to be sexual in nature. This in turn is elaborated on by Finkelhor and Browne's conceptualisation of the effects of child sexual abuse, 'traumagenic dynamics', in particular that of traumatic sexualisation (Finkelhor and Browne, 1986).

Maternal support, in particular, is seen as highly relevant to a child's 'recovery' from sexual abuse (e.g., Kendall-Tackett, Williams and Finkelhor, 1993) and may influence the resolution process for victims of sexual abuse. It seems likely that the ability of the

non-abusive parent to provide support for her child may depend to some extent on how she interprets this and other negative events in her life, and how much she holds herself and her child responsible. Assessing such constructs as belief in allegations and maternal support by direct questioning or survey methods is unlikely to reveal valid findings. Similarly, for adolescent perpetrators of sexual abuse, parental cognitions about why their son abused may affect parental responses such as support provided. The link between parental attributions and behaviour is discussed in a later chapter (Four).

The concept of 'recovery' or resolution of the victim experience in the sexual abuse literature can be likened to Garmezy's (1985) concept of 'stress resistance'. Maternal support is likely to be a major source of social support for a child or young person and Everson et al., (1989) point out that attachment behaviour, even in adolescents and adults, becomes stronger in times of crisis (Bowlby, 1982), which supports the idea that parents, especially mothers as primary attachment figures, are important to their children's ability to cope with adverse situations.

A number of studies have emerged in the late 1980's and early 1990's which have focussed on maternal responses to child sexual abuse and will be reviewed here. Maternal responses have typically been categorised as:

i) Failure to take appropriate action to stop the sexual activity (e.g. Browning and Boatman, 1977)

ii) Denying the abuse has occurred (e.g. de Jong, 1988) and,

iii) Anger/blame towards the child (e.g. Lustig et al., 1966).

Recent studies appear to have moved away from this somewhat negative perspective, or at least challenged it to some degree. The importance of gleaning as much objective information as possible on the mother's role is vital to get a clearer picture than the case study profiles provided in the past (e.g. Lustig et al., 1966; Browning and

Boatman, 1977). This is particularly important as mothers are most often the non-abusing parent and therefore the parent on whom both the victim and protective agencies rely on for support, protection and resolution of the abuse (Sirles and Franke, 1989).

ii) maternal support to victims

The following studies focus on categorising maternal support given to child sexual abuse victims along a supportive-unsupportive dimension. It is important to bear in mind that in these studies mothers took responsibility for accompanying their child to child protection services and thus may be a selected group, showing at least some degree of supportiveness and belief in the child's allegations.

Everson, Hunter, Runyon, Edelsohn and Coulter (1989) report on a cross-sectional analysis of a longitudinal study population in order to establish whether maternal support is related to child characteristics, agency response and child mental health functioning. In this study, less than half (44%) of the mothers (of incest victims) were described as 'consistently supportive' based on a scale developed by the authors to produce a measure of parent's reaction and support following disclosure. The Parental Reaction to Incest Disclosure Scale (PRIDS; Everson et al., 1989) provides a total score derived by adding the clinical ratings of parental (i.e. maternal) support in three areas - emotional support, belief of child and action towards the perpetrator. No further details regarding the development or standardisation of this scale appear to have been published, so it must be assumed that the scale was devised on the basis of clinical observations and ratings and is indirect as it is completed by researchers on the basis of live interviews or interview records. In this study, interview records were reviewed and this method was claimed by the authors to be as reliable as original interviewer assignment of scores. On the basis of scores on the PRIDS, mothers of

sexually abused children were classified as supportive (the High Support group), ambivalent or unsupportive (the Low Support group).

Although no details of criteria were presented, the 'action towards the perpetrator' by the mother is likely to have been measured by protective action on behalf of the child (i.e., no contact with the perpetrator). Mothers rated as non-protective or 'Low Support' may have been in positions where it was difficult to take protective action or ensure that the perpetrator was removed from the home. A possible alternative explanation to that of collusion by these mothers may lie in their financial dependence on the perpetrator and lack of resources to exercise their parental responsibility effectively (Hooper, 1992). We have also seen that some of these women may have been under some form of emotional or physical threat themselves, having been victims of emotional, sexual and /or physical abuse at the hands of their abusive partner (e.g. Dietz and Craft, 1980).

In the Everson et al., (1989) study, the issue of financial dependence on the perpetrator can be indirectly assessed by looking at the correlation between PRIDS scores for the mother and rankings of mother-perpetrator relationship. They report a significant Spearman correlation of 0.45 ($p < 0.0001$) between PRIDS scores and these rankings, which were said to indicate an inverse relationship between the level of maternal support and recency and perhaps the intensity of this relationship (Ex-spouse< Biological/Step-father<Current partner). Mothers were most supportive and protective of their children when the perpetrator was an ex-spouse and least supportive when he was a current partner. Everson et al., (1989) describe this as a manifestation of the emotional involvement between mother and perpetrator but an equally plausible suggestion is that it reflects the financial power that the most recent partner has. It is also worth noting that there is no indication that the researchers sought further information on the exact nature of this relationship which is likely to be more variable than the classification (Ex-Spouse, Biological/Step father, Current partner) suggests.

A further point is that all of the birth fathers admitted guilt and all of the boyfriend-perpetrators denied the abuse, which may have influenced the mothers' reactions in addition to the nature of the relationship she had with the perpetrator. It would seem that the assessment of mothers' explanations for the abuse and its consequences may add to the findings from this study which depended on clinician's interpretations of maternal behaviour.

The impact of maternal support on the child's psychological functioning was demonstrated in this study as the Low Support group mothers had children with higher levels of psychopathology than in the High or Ambivalent Support groups. The results suggest that the level of maternal support was more strongly predictive of the child's psychological functioning than either the type or duration of the sexual abuse or the perpetrators relationship to the child, although it seems that there was very little variation in the types of abuse with 70% of the sample experiencing oral or genital penetration. In addition, there appeared to be a systematic bias in reporting by the Low and Ambivalent Support groups of mothers on the Child Behavior Checklist (CBCL, Achenbach and Edelbrock, 1983) compared with the child's scores on the Child Assessment Schedule (CAS, Hodges, 1987) based on child interviews.

There was no concordance between the CAS clinical interviews with the child, and their Low and Ambivalent Support mothers' reports on the Child Behaviour Checklist yet there was substantial concordance for Supportive mothers. One reason for such low concordance in the Low and Ambivalent groups suggested by the authors is that mothers who fail to support their child, on these criteria, may also have their own psychological problems and be out of touch with the emotional needs of their children.

This theme of 'psychological absence' of mothers of victims of sexual abuse is reiterated in the literature frequently (see section 2.3.3) and implicates the mothers in the sexual abuse of their child by this mechanism. Everson et al., (1989) further

suggest that these mothers may be consciously or unconsciously trying to shape professionals' perceptions of the children making the allegations of sexual abuse. This might include attempts to discredit their children as untrustworthy or disturbed (by falsely checking symptoms on the Child Behaviour Checklist), or to reduce the apparent severity of symptoms in order to minimise the probability that sexual abuse had occurred. It is important to recognise the negative consequences of perceived low maternal support by child protection services - most notably the removal of the child from the home. The child may be removed from other important protective influences such as school and other sources of support and protection for the child (e.g Rutter, 1987).

Dietz and Craft (1980) found that most social workers felt that mothers were *as* responsible for father-daughter incest as the perpetrator-fathers, even though they were aware that 78% of these mothers were themselves being physically abused by their spouse. This type of bias suggests the mother may feel blamed and may contribute to defensive behaviour towards professionals, a desire to keep the family away from public scrutiny and other seemingly unsupportive measures by the mother. Despite some contribution to the 'mother-blaming' literature, Everson et al. (1989) conclude more positively by suggesting that emphasis should now be placed on the mother's contribution to the *recovery* of the child rather than to the *commission* of the sexual abuse. The issue of treatment compliance is an important one for both victims and young perpetrators of child sexual abuse so it is likely that understanding more about mothers' roles in recovery will be a fruitful area to study.

One important but overlooked issue which seems to arise from descriptions of 'psychologically absent' mothers regards their own mental health needs and coping strategies. Depression and previous experience of abuse are known to be important factors in adult functioning (e.g., Downey and Coyne, 1990; Kendall-Tackett et al., 1993).

The Everson et al., study does not address the issue of whether mothers in the study had experienced child sexual abuse or other forms of abusive parenting themselves. It could be speculated that childhood sexual abuse was present at least to the same proportions as in the general population. These previous experiences of abuse may have contributed to the mothers' ability, or lack thereof, to support her child particularly if there was a bias towards the Low Support mothers having a higher incidence of childhood sexual abuse.

A further study looking at maternal support used questionnaires administered to mothers of children attending a follow-up appointment after the discovery of sexual abuse. This was an attempt to define categories of maternal response and to determine the relationship between responses and features of the abuse situation (de Jong, 1988). In this study, categories of response were identified prior to interviewing mothers based on 'observations of maternal attitudes' in a child sexual abuse centre.

Three categories of response were identified in this way:
i) Non-supportive mothers , believed the alleged abuse was a lie, a misunderstanding or primarily the child's fault.
ii) Supportive without Emotional Changes, these mothers believed the child, were supportive but did not report significant behaviour or mood changes in themselves.
iii) Supportive with Emotional Changes, these mothers believed the child, were supportive and reported significant changes in their lives secondary to behaviour and mood changes.

Forty five percent (n = 103) of the original referred sample attended this follow up appointment, but were described as similar in demographic characteristics and type and duration of abuse as the mothers who did not return for follow up. de Jong (1988) reports that on the basis of the questionnaire results, the three categories of response were nearly equally represented in this group of mothers; the criteria for categorising

the responses were based on clinical observations alone, thus running the risk of being arbitrary in nature and making the study difficult to replicate.

Mothers' expressed attitude was rated as supportive or non supportive (based on paediatricians ratings while administering the questionnaire), according to whether the mother reported changes in her own behaviour and mood, whether she sought counselling for herself and her child and whether she was pressing charges against the perpetrator. de Jong (1988) concludes that mothers experience significant stress resulting from the sexual abuse of their children. It is also suggested that individual personality and coping mechanisms appear to determine the maternal response to child sexual abuse. Neither of these variables were investigated in this study, however they are likely to be worthy of future research.

Clinical ratings of mothers of incest victims were also reported by Salt, Myer, Coleman and Sauzier, (1990) which resulted in the categorisation of four types of response:
i) mothers who directed their anger at the offender, took protective action without agency intervention and allocated no blame to the child.
ii) mothers who were more conflicted in their allegiances between child and offender/partner, who had difficulties taking strong protective action.
iii) mothers who were immobilised by the discovery of abuse, some denied or minimised the abuse but showed moderate concern for the child and no blame for the child.
iv) mothers who rejected their children, allied themselves with their partner and took no protective action towards the child.

A clear criterion based categorisation of maternal responses such as this may well prove useful in clinical settings where decisions about interventions are made. Further details of criteria used to allocate responses and reliability data would need to be provided in order to replicate this study which unfortunately were not provided. Salt

et al., (1990) report that the findings from their study looking at mothers responses to child sexual abuse challenge the notion that it is the inadequacies of mothers that may be one of the causes of sexual abuse. They do suggest that once the abuse has commenced, these inadequacies may prevent the mothers taking protective action for the child. Salt et al., conclude that mothers respond to sexual abuse in a variety of ways, with some conforming to the stereotype by disbelieving or blaming the victim and many more responding in a protective and supportive way.

These findings were based on assessments of the 156 mothers' personality and mothers' perceptions of her relationships with her child, partner and parents from self-report questionnaires. Salt et al., (1990) suggest that some of the variability in a mothers responses may be influenced by the quality of her relationship with her own parents and with her child.

Mothers who reported a poorer history of emotional nurturance in their own childhood were less able to develop nurturing relationships with their own children. The authors remind us that this phenomenon is not unique to sexual abuse and is widely recognised in child psychiatry (e.g. Fraiberg, Adelson and Shapiro, 1975; Main and Goldwyn, 1984).

iii) maternal belief in allegations of child sexual abuse

In a study addressing mother's reactions to child sexual abuse, Sirles and Franke (1989) investigated factors which influenced mother's believing their child's disclosure of incest. In this study, the majority (78%) of mothers did believe their child, but certain factors were identified as contributing to variability in degree of belief. The age of the child was important, with 95% of mothers of pre-school age (2 - 5 years) children being believed, 82% of latency aged children (6 - 11 years) and 63% of adolescents (12 - 17 years) being believed. The belief or disbelief of the mothers in this

study were rated by interviewers during the intake interviews at a child guidance centre along with other demographic and abuse details. The mother's reaction to the reported abuse was coded as 'believed' or 'not believed' the child. There are many confounding factors which may have contributed to the outcome in this study. Mothers bringing their child to a clinic, specifically to an 'Intrafamily Child Sexual Abuse Program' may be some way along the continuum of disbelief to belief. Other factors which influenced the mothers' decision to believe her child about the reported abuse included the nature (i.e. severity) of the abuse, presence of the mother in the home at the time of the abuse, relationship of the victim to the offender, prior physical abuse of the child, and alcohol abuse by the offender.

The more 'serious' the sexual abuse in terms of genital contact the *less* likely the mother was to believe the abuse. However, this needs to be qualified by the finding that children who experienced the most serious type of abuse (genital-genital contact), 70% of the mothers were reported to believe their child's disclosure. Mothers were reported to be more likely to believe their child when they were not in the home at the time of the abuse. However they found that the majority (64%) of the mothers who were at home, believed their children, in other words were able to admit to the interviewer that they were aware of the abuse. Mothers were least likely to believe the report of sexual abuse when the perpetrator was a step-father or current partner and most likely to believe their child when the perpetrator was an extended family member (grandfather, uncle, cousin). This is consistent with the findings from the Everson et al., (1989) study which found that mothers were least supportive towards their abused child when the perpetrator was a current partner.

These abuse and child-related factors, together with other situational variables which may influence the mother's reaction to discovery of sexual abuse reveal the complexity of studying maternal responses to abuse.

It is possible that some protective defence mechanisms operate when mothers learn that their child has been sexually abused, especially if this abuse is perpetrated by her partner. The possibility of the mother's own childhood experiences of sexual abuse were not addressed. Sirles and Franke did investigate current physical abuse and found that 44% of the mothers in this study were being physically abused. Looking just at the physically abused sub-group, the majority (74%) of these mothers believed their child had been sexually abused, which the authors suggest indicates that the mothers had a stronger desire to protect their child than to protect themselves.

Deblinger, Hathaway, Lippman and Steer (1993) report on a study of three groups of non-offending mothers of sexually abused children who were abused by mother's partner (n=36), other relatives (n=30) and nonrelatives (n=33). These 99 cases of substantiated contact child sexual abuse were recruited from the Center for Children's Support in New Jersey. 214 mothers were invited to participate in this study, 67 mothers did not accompany their children to the Center and 30 mothers refused to participate. 15% of the mothers who did not take part had previously had their child removed from home due to poor child protection. The authors suggest that this may indicate that some mothers may fit the negative stereotype portrayed in the literature. It is also apparent that the mothers who do fit such a stereotype are the least likely to take part in research studies investigating them.

Deblinger et al., (1993) found that 85% of the mothers who did participate in their study reported that they believed at least some aspects of their child's allegations, leaving 15% who had some doubt about the veracity of these allegations. Consistent with other studies reporting mother's own experiences of victimisation (e.g., Sirles and Franke, 1989; Wyatt, Guthrie.and Notgrass, 1992), Deblinger et al., found that 41% of mothers had a history of contact child sexual abuse, 35% had a history of child physical abuse, 57% reported that they were victims of domestic violence and 22% were victims of adult sexual abuse.

In summary, most of these studies report a high rate of maternal belief in allegations of sexual abuse. As mentioned at the outset, this is not surprising given that they consist of mothers who are attending programmes for victims of sexual abuse and their families.

2.3.5 Maternal depression

Browning and Boatman report "excessively high rates of depression in the mothers" (1977, p. 72), however their sample size was too small to generalise. Of the nine women (64% of the total of 16) who were depressed they described 4 as 'chronically depressed'. This chronic depression was seen as primary to the sexual abuse that took place within the family as it was said to explain the sexual withdrawal, passivity and emotional distance in these mothers which forced their daughters into the maternal role.

Wagner (1991) used the Beck Depression Inventory (BDI; Beck and Steer, 1987) to compare depression in mothers of sexually abused children with mothers of a group of clinic referred non-abused children. He found that there were no significant differences in the BDI scores between groups, although there was a high rate of depression overall. 50% of (n=32) mothers of intrafamilial abuse victims, 69% of (n=36) mothers of extrafamilial abuse victims and 50% of (n=46) mothers of non-abused children with other difficulties (e.g. antisocial behaviour, poor school performance) showed at least a moderate level of depression on the BDI (i.e. scores above 9).

In Wagner's (1991) study, out of 148 substantiated cases of child sexual abuse, 39% (n=58) agreed to take part in this study which could indicate that it was these mothers who felt that they were in need of help thus contributing to the high rate of depression. Given the high rate of depression amongst mothers in general (e.g., Patterson, 1980; Patterson and Forgatch, 1990) other reasons need to be considered. Another

explanation for the levels of depression found in Wagner's study is that the mothers who agreed to participate in the study were not minimising the sexual abuse that had taken place, and were depressed as a result of this discovery. Wagner's proposition that what needs to be considered is whether mothers are depressed due to the consequences of disclosure and investigation, or whether in fact the abuse is an outcome of the mother's pre-existing depression which in some way impaired her ability to prevent her child being sexually abused seems more balanced and informed than seen in the earlier literature (e.g., Lustig et al., 1966; Browning and Boatman, 1977).

Depression amongst women, particularly mothers is a common phenomenon. It is well known that non-working mothers are at particularly high risk for depression (Herbert, 1991). Rates of depression as high as 40% have been reported in mothers of pre-school children (Brown and Harris, 1978). In general population studies the rate of depression in women is around 10% (e.g., Puckering, 1989). This highlights the importance of studying depression in mothers of clinical samples who might be expected to have higher rates of depression than in the general population.

A study by Newberger, Gremy, Waternaux and Newberger (1993) investigated the psychological responses of mothers to sexual abuse. Forty four mothers and two maternal caregivers' psychological well-being was investigated over a 12 month period following the disclosure of sexual abuse. These women were mothers to 46 sexually abused 6 - 12 year old children (72% girls, 28% boys) and they were found to suffer from 'severe and extensive emotional distress' following the disclosures of sexual abuse.

As the authors point out, it is difficult to ascertain the contribution of the discovery of sexual abuse to this distress. The lack of control group adds to the difficulty of attributing causal links in this study of cross-sectional design. Newberger et al., (1993)

suggest that the trauma of disclosure may contribute to the distress experienced by these women, in part due to the actions of the child protection and legal agencies who may cause emotional distress and contribute to the mothers' feelings of anxiety, mistrust and hostility. All of these maternal responses may have been interpreted as psychological symptoms in the mother which had a *contributory* role in the child sexual abuse.

This study led the authors to conclude that mothers are also traumatised by the sexual abuse of their children and that the treatment needs of a sexually abused child should be considered from both the maternal and the child perspective, thereby contributing a new perspective within which to view mothers' responses to their child's sexual abuse (Newberger et al., 1993).

Many of the studies reviewed in this section have some methodological flaws such as small samples and lack of adequate comparison groups which compromises the findings and make comparisons across studies difficult. However, there appears to have been a gradual improvement in the sophistication of clinical research studies of mothers' roles in child sexual abuse. There is also a more cautious interpretation of mothers' own psychological needs in more recent studies (Wagner, 1991; Newberger et al., 1993). It seems that mothers roles in their child's *recovery* from sexual abuse needs further clarification and that more research is needed given their pivotal role in children's lives. Turning research around from a limited focus on maternal factors which might cause a child to be abused to a broader consideration of maternal factors which might elucidate both positive and negative pathways following abuse seems to be an important new direction.

Clinical observations and the studies reviewed here do seem to indicate that mothers of sexually abused children may be at higher risk of depression compared to mothers of non-abused children. The reasons for this are likely to be a function of many complex

processes, however two factors emerge from the literature. First, mothers of sexually abused children are more likely to have experienced psychosocial disadvantage in their own childhood (Finkelhor, 1994). Secondly, mothers of abused children appear to be more likely to have been sexually abused themselves (e.g., Deblinger et al., 1993). Both of these factors are consistently associated with adult depression (e.g., Mullen, Martin, Anderson, Romans and Herbison, 1994; Bifulco, Brown and Adler, 1991; Sedney and Brooks, 1984).

The study of factors relating to childhood experiences of care and abuse is warranted when considering the significant links between childhood experiences and later depression in women (Brown and Harris, 1978). Maternal depression is commonly associated with childhood psychopathology and is taken into consideration in the present study. As will be demonstrated in the Chapter Four there are also established links between depression and the types of causal attributions individuals ascribe to negative life events.

The literature regarding the relationship between parental depression and developmental psychopathology is voluminous and will not be reviewed separately here (see Hops, Sherman and Biglan, 1990; Rutter, 1990 and Downey and Coyne, 1990). In summary there appears to be little doubt about the negative effect of maternal depression on child development. Depression may be particularly prevalent in mothers of sexually abused children and is likely to be significant in mothers' understanding of and reaction to the sexual abuse of her child. The relationship between depression and causal attributions will be discussed in a later chapter (see section 4.1.2).

In summary, most research on non-abusing mothers of victims of child sexual abuse has focused primarily on individual characteristics which are assumed to contribute to her child's victimisation. In reality, cross-sectional designs do not allow for such

conclusions to be drawn and it appears that a focus on mother's roles in the recovery of children following sexual abuse may be a more useful avenue to explore. This should not diminish the study of the very real psychosocial difficulties which emerge in the literature on families of sexually abused children.

2.4 Adolescent perpetrators: The role of mothers

2.4.1 Demographic characteristics

Although there has been a recent surge of interest in studying adolescent sexual offending, there is a paucity of research studies published and therefore limited knowledge about demographic characteristics. In one early study, Shoor, Speed and Bartelt, (1966) interviewed parents and/or guardians of eighty cases of "adolescent child molest" (p. 783, 1966), the gender of parent is not provided but both parents were interviewed if available, as were the adolescent boys. The adolescents were described as coming from mostly lower middle class homes, and the largest single group lived with both birth parents (48%), four mothers had a criminal record and had been imprisoned for disorderly conduct or fraud. Two fathers were in prison for burglary and one for child molestation (it is not made clear how many mothers and fathers were seen in total).

Two studies by Kaplan and her colleagues present more detailed demographic information on their subjects. In the first study (Kaplan, Becker and Cunningham-Rathner, 1988), parents of adolescent incest perpetrators were studied, the twenty seven 'parents' consisted of 19 mothers (70%), 1 father, 3 step-fathers, 2 aunts, 1 grandmother and 1 sister. Forty-eight percent of those interviewed were Black, 41% were Hispanic and 11% Caucasian. Sixty-three percent were married or living with a partner, 19% were separated, 7% were divorced and 4% were single at the time of the interview. 22 of the 27 boys (81%) were living at home with one or both parents, and

52% of the 'parents' were in full-time employment. Only one parent and four family members had some criminal history for non-sexual crimes, and three of the 'parents' had been arrested for sexual crimes (however this included one older *brother* who was arrested for child molestation).

In their second study, Kaplan, Becker and Martinez, (1990) compared 48 mothers of adolescent incest perpetrators to 82 mothers of adolescent non-incest perpetrators. Of the 130 mothers interviewed, 64% were Black, 25% Hispanic and 9% Caucasian, which again suggests over-representation of Black and Hispanic populations in these samples and may be a reflection of referrals to an inner city psychiatric service, rather than a genuine representation of the demographic characteristics of adolescent sex offenders. Regarding marital status, 34% of the mothers were married, 33% were divorced or separated, 25% were single at the time of the interview, 5% were widowed and 3% were living with a partner.

Ryan (1991a) presented family variables on 1000 cases of juvenile sex offenders referred to a specialised treatment programme in Denver, Colorado. 'Parental loss' is reported in 57% of the cases. Substance abuse was reported for 27% of mothers and 43% of fathers and only 28% of the adolescents were living with both natural parents at the time of the sexual offence.

Smith and Israel (1987) studied 25 families of sibling incest perpetrators in Boulder, Colorado (80% of the 25 perpetrators were male, and the age range was 9 - 20 years), their sample consisted of 96% Caucasian families and 4 % (i.e. one family) was Spanish-American (or Hispanic). They reported that the families were either lower or middle class with the exception of two families (8%) which were described as upper class. However no criteria for classification of social class was provided by the authors so it is difficult to know on what basis these classifications were made.

Fehrenbach, Smith, Monastersky and Deisher (1986) studied 305 adolescent sex offenders (97% were male) referred between 1976-1981 to the University of Washington Juvenile Sexual Offender Project. This heterogeneous group included those who had committed rape, indecent liberties, non-contact offences as well as 'inappropriate acts' such as stealing underwear and making obscene phone calls. Again it is unclear how many of these adolescents (mean age: 14.8 years) were involved in the sexual abuse of children. Subjects were said to represent all social classes. At the time of the offence, less than one third (n=93) of the adolescents were living with both natural parents, 27% (n=81) lived with one natural parent and a step-parent, and 23% (n=71) lived with a single parent. 20% lived in some other setting such as foster care or a children's home. This study did not report any further family details of the adolescents.

Much research in the United States is based on inner city populations which includes a high proportion of Black and Hispanic populations. Without the use of control groups it is difficult to identify those demographic characteristics which are unique to families of juvenile sex offenders and those which are general to specific samples (say of inner city youth). In addition, the older, incarcerated adolescent sex offenders may have perpetrated against children, peers or adults, and are rarely differentiated in the research findings to date which makes comparisons across studies difficult.

2.4.2 Maternal responses to sexual perpetration

It is difficult to single out research findings specific to mothers, as many studies report findings on families or parents without further clarification. Research findings on families of adolescent sex offenders have been discussed previously (see Section 2.1.2) Shoor, Speed and Bartelt (1966) described parental attitudes as hostile, defensive, excusing and having little concern for the victim, and these attitudes were said to be shared by the adolescent. The twenty variables investigated in this study were not

accompanied by criteria for classification - for example, the home from which these boys came was described as "frequently disorganised" (p. 785) with no further objective clarification as to what this might mean. Shoor et al., discuss the prevention of sexually abusive behaviour in adolescent boys by increasing sex education, managing impulsive behaviour, modifying parental sexual attitudes and discouraging adolescent boys from babysitting activities and by advocating the importance of a thorough psychiatric evaluation in all cases that come to light.

Kaplan, Becker and Cunningham-Rathner (1988) summarised their findings by suggesting that the parents (of which 70% (n=19) were birth mothers) of adolescent incest perpetrators i) under-reported the physical and sexual abuse of their sons, ii) showed a high incidence of being abused (physically and/or sexually) themselves and, iii) showed a high level of denial about their son's incestuous behaviour.

For the purpose of the study, the authors defined incest as 'sexual contact' between family members, whether they were biological family or individuals considered to be family members. However the term 'sexual contact' lacks clarity and it is unclear to what extent, duration and severity of abuse took place, and who was 'considered' to be a family member in this definition of incest.

The second study by Kaplan, Becker and Martinez (1990) which compared mothers of adolescent incest perpetrators to non-incest perpetrators showed that mothers in the former group were significantly more likely to report that they had a history of physical and sexual abuse, had some form of sexual dysfunction, and had been in prior psychotherapy, than mothers of non-incest adolescent perpetrators. Kaplan, Becker and Martinez also reported that mothers of incest perpetrators were more likely to report that they believed their son had committed a sexual offence, was in need of treatment, and had a history of physical abuse.

The authors acknowledge the role of the mothers' own psychotherapy in facilitating their disclosures around their own and their son's abuse and victimisation. It is also important to note that fewer of the incest perpetrators had been involved in the juvenile justice system, which the authors believe may also have resulted in more openness on the part of their mothers, as their was less perceived risk in disclosing their son's sexual offences.

In both the Kaplan et al., (1988, 1990) studies it is worth noting that the sample consisted of mostly Black and Hispanic adolescents which may influence the generalisability of the findings to American, inner city populations. Kaplan, Becker and Martinez (1990) suggest that in the light of high rates of previous history of abuse in these mothers and possible intergenerational transmission of incest, future research needs to focus on the role of parental and familial variables in the development of sexually abusive behaviour in adolescents.

Blaske, Borduin, Henggeler and Mann (1989) investigated four matched groups of 13 - 17 year old adolescent sex offenders, assaultive (violent) offenders, nonviolent offenders and nondelinquent controls and their mothers. None of these groups were incarcerated at the time of the study. The sex offender group were reported to have committed rape and attempted rape, however it is not clear whether this group had sexually abused children younger than themselves. The self-reported family relations of the sex offender groups were reported to be quite different from those of the assaultive offenders and were more similar to the families of nondelinquent controls than other offender groups according to scores on the FACES measure of family cohesion and adaptability (Olson, Portner and Bell, 1982).

Blaske et al., (1989) suggest that although the self-reports of mothers and sons suggests that adolescent sex offenders families are relatively well-adjusted, this finding is mitigated by three alternative findings. First, that observational measures suggested

lower rates of positive communication between mothers and sons than in the nondelinquent controls (Henggeler, Hanson, Borduin, Watson and Brunk, 1985). Second, that mothers of adolescent sex offenders reported high rates of internalising symptoms, including discomfort about interpersonal relations. Third, the authors also felt that their subsequent clinical experience with these families suggested that these families were actually highly dysfunctional (Blaske et al., 1989).

Davis and Leitenberg's (1987) comprehensive review of the literature on adolescent sex offenders suggests that unstable family backgrounds, a history of witnessing family violence and experience of physical or emotional abuse are likely to be important factors in the development of sexual offending in adolescence. Although this was based on a review of largely uncontrolled studies, it appears that there is a link between family environment and sexual offending in adolescence, as there already exists between family environment and other forms of antisocial behaviour (Farrington, 1978; Robins, 1991; Patterson, Reid and Dishion, 1992).

Smith and Israel (1987) described the families of 25 sibling incest perpetrators characterised by distant and inaccessible parents, parental stimulation of the sexual climate in the home and family secrets, especially extramarital affairs. One of the difficulties with this descriptive study is that the subjects were parents to both the perpetrators and victims of child sexual abuse, and that the age of the perpetrators ranged from 9 - 20 years.

The parents were classified on the basis of physical and emotional distance on the basis of clinical observations and interviews with parents and included physical absence as well as inconsistent parenting, but criteria for these separate constructs were not provided. Although 28% of the fathers were described as physically and emotionally distant no figure is given for the mothers, and it is not clear what the absolute number of mothers and fathers was. Of the (unknown number) of mothers who were

physically and emotionally distant "one mother maintained an absorbing career which took her away from a primary parenting role, and 20% of the mothers found refuge in either drug addiction or alcoholism, mental illness, or repeated pregnancies combined with periodic absences from the home environment" (Smith and Israel, 1987, p. 103). It is not made clear what these women are seeking refuge from, and the extent of mental illness and how this is determined was not presented. The emergence of a description of emotionally distant mothers can be linked to the notion of psychological absence described in the literature relating to mothers of victims of sexual abuse (see section 2.3.3).

In summary, it seems that the only clear finding emerging from this review is the need for further research employing appropriate comparison groups and larger, more representative study samples. Studies by Kaplan and her colleagues at the New York State Psychiatric Institute indicate elevated rates of previous physical and sexual abuse in the mothers of adolescent sex offenders (Kaplan et al., 1988, 1990). This will be discussed further in the next section on the intergenerational transmission of sexual abuse. These studies also reported that mothers showed a substantial level of under-reporting and denial about their sons commission of sexual offences (Kaplan, Becker and Cunningham-Rathner, 1988). To date there are no studies which focus exclusively on mothers of younger adolescents who sexually abuse other children. This study seeks to address this gap in the literature.

CHAPTER THREE

Literature Review: Child Sexual Abuse II

3.1.1 Cycles of victimisation: Intergenerational transmission of abuse

3.1.1 Previous victimisation in mothers of victims

3.1.2 Previous victimisation in mothers of perpetrators

3.1.3 The process of intergenerational abuse

3.1.4 Adult outcomes in sexual abuse

3.2 Child sexual abuse and antisocial behaviour

3.2.1 Victims of child sexual abuse and antisocial behaviour

3.2.2 Adolescent perpetrators and antisocial behaviour

3.3 Mothers of antisocial boys

3.3.1 Demographic characteristics

3.3.2 Family factors in antisocial behaviour

3.4 Methodological issues in child sexual abuse research

III: Literature Review : Child Sexual Abuse II

3.1 Cycles of victimisation: Intergenerational transmission of abuse

3.1.1 Previous victimisation in mothers of victims

The intergenerational hypothesis states that maltreated children are likely to become abusive parents irrespective of whether the form of abuse they suffered was emotional, physical or sexual (Kaufman and Zigler, 1989). This popular belief that child abuse is transmitted intergenerationally has not been supported by empirical studies, but has steadfastly remained in clinical lore (e.g., Steele and Pollock, 1968; Faller, 1988; Egeland, Jacobvitz and Sroufe, 1988). Kaufman and Zigler (1989) review the area and conclude that parent's own experience of abuse does represent a significant risk factor.

They suggest that the 'transmission rate' is approximately 25 - 35 % between abuse in childhood and subsequent abusive parenting. This clearly represents a considerable risk factor, however Kaufman and Zigler (1989) conclude that there needs to be a shift in the focus of enquiry of intergenerational abuse research. They suggest that the question of whether 'abused children become abusive parents?' should be replaced by asking 'under what circumstances is the transmission of abuse most likely to occur?'. When considering mothers who were victims of childhood abuse who have children who are either abused and/or abusive, the mode of transmission is also likely to be an important consideration.

The two main mechanisms for such transmission come from divergent schools of psychological thought. The first is a social learning perspective which proposes that abusive parenting behaviour is transmitted by teaching children that aggression is an appropriate control strategy (e.g, Patterson, 1982, Gelles and Straus, 1979; Burgess and Youngblade, 1988).

The second approach is a psychoanalytic perspective regarding the intergenerational transmission of abuse. Attachment theorists suggest that the disruption of internal working models due to abusive early experiences leads to inadequate models of parent-child and other interpersonal relationships (Bowlby, 1980) and increases the likelihood that abuse will be transmitted from one generation to the next.

A much cited study by Main and Goldwyn (1984) indicated that women who were rejected as children were more likely to reject their own children compared to women who did not report negative childhood experiences. Kaufman and Zigler (1989) suggest that although this study does provide some support for the notion that mental representations of past relationships may mediate the transmission of abuse, it is important to consider other factors such as quality of adult relationships and the occurrence of stressful life events as potential mediators of abusive childhood experiences (e.g., Cicchetti and Rizley, 1981; Quinton and Rutter, 1988).

The intergenerational hypothesis has been almost universally applied to cases of physical child abuse and the presence of violence in the family of origin of the abusive parents (e.g., Burgess and Youngblade, 1988) Clearly, the issue with regard to child sexual abuse is more complex. In fact this model may not be appropriate for mothers of male victims of child sexual abuse, as boys are far more likely to be abused by a non-family member than girls (Watkins and Bentovim, 1992; Finkelhor, 1994).

The models put forward by social learning and attachment theorists may be applicable to transmission of physical abuse but could not fully account for the transmission of sexual abuse. In particular, the gender differentiation between victims (predominantly female) and perpetrators (predominantly male) would suggest some alternatives to modelling effects or insecure attachment to abusive parents may be needed to account for the transmission of sexually abusive behaviour between generations. One possible factor may be that erroneous attributions about abusive experiences may be

communicated to children by parents who have suffered from abusive childhoods. Although this hypothesized mode of transmission is difficult to test directly, recent conceptualisations of abusive parenting may shed light on the development and maintenance of abusive parenting (e.g., Bugental, Mantyla and Lewis, 1989; Bugental, Blue and Lewis, 1990).

A review of literature relating to mothers of victims of child sexual abuse reveals clinical observations of high rates of previous sexual abuse in mothers of these children (e.g., Goodwin, McCarthy and DiVasto, 1981; Sgroi and Dana, 1982; Faller, 1988; Egeland et al., 1988; Ryan & Lane, 1991). Theory and research to elucidate possible mechanisms by which cycle of child maltreatment operate lag behind (see Howes and Cicchetti, 1993).

Despite clinical reports of elevated rates of previous sexual victimisation in mothers of victims of child sexual abuse, there currently appears to be few studies directly assessing this issue. Goodwin, McCarthy and DiVasto (1981) reported a rate of 24% of mothers of 100 abused children (including 20 children who had been sexually abused and 80 children who were physically abused or neglected) compared to a rate of 3% in 500 women in a comparison group. The low rate of reported abuse in the 'normal control' group is perhaps explained by their recruitment from church and voluntary groups. In a recent unpublished study (Monck, Bentovim, Goodall, Hyde, Lwin and Sharland, in press), 43% of a sample of 55 birth mothers of sexually abused children reported at least one sexually abusive experience before the age of 18 years.

Hooper offers one explanation for the purported high rate of sexual abuse in mothers of victims of child sexual abuse. She states that "given the prevalence of sexual abuse amongst women, it would be surprising if this [sexual abuse in mothers of victims] were not a common experience" (p. 11, 1992). Prevalence rates vary enormously and do not give a clear picture as to how widespread abuse really is.

Prevalence rates for sexual abuse in women range from 2 - 62% (Finkelhor, 1994) depending on definitions used to include child sexual abuse and the methodology employed. Although based on clinical findings yet to be substantiated by empirical studies with appropriate comparison groups, there does seem to be a link between the sexual victimisation of mothers and of their children (e.g., Finkelhor and Browne, 1986).

3.1.2 Previous victimisation in mothers of perpetrators

In one study discussed earlier (Shoor, Speed and Bartelt, 1966), three mothers in the sample of adolescent perpetrators were said to have been molested as children, although it is not known how many total mothers were seen so a rate cannot be calculated. Kaplan, Becker and Cunningham-Rathner (1988) investigated prior physical and sexual victimisation in the mothers and found that in the sample of 27 parents (which consisted of 19 mothers), seven (27%) reported prior physical abuse either as a child or as an adult and eight (30%) disclosed previous sexual abuse either as a child or as an adult. Kaplan, Becker and Martinez (1990) report that twenty one (44%) of the mothers of incest perpetrators and twenty (25%) of the mothers of non-incest perpetrators reported being physically abused, and sixteen (34%) mothers of incest perpetrators and eleven (14%) of the mothers of non-incest perpetrators reported being sexually abused. Unfortunately the criteria for determination of physical abuse or sexual abuse are not presented, leaving it unclear how the disclosures were obtained and rated.

In a study of 25 sibling incest families, 72% of the mothers and fathers were reported to have been victims of child sexual abuse (Smith and Israel, 1987). Numbers comprising groups of mothers and fathers were not presented and it is not clear how this information was elicited or how abuse was defined. Nevertheless, it appears that

previous sexual victimisation is a common experience in mothers of perpetrators of sexual abuse.

3.1.3 The process of intergenerational transmission

There are several possible mechanisms of revictimisation/cycles of abuse which can be derived from the literature on continuities and discontinuities in developmental psychopathology. First, marrying a 'deviant' spouse that is, someone who is mentally ill, alcoholic and/or criminal, possibly in order to escape a difficult home life (Rutter, 1987). Selection of an inadequate partner has been noted in studies of adults who were sexually abused as children (e.g., Conte and Schuerman, 1987).

Second, lack of planning in general, which would increase the likelihood of early pregnancy and thus economic dependence (Rutter, 1987). This could also be linked to a 'fatalistic' approach to life, in which the individual feels that outcomes are uncontrollable to themselves. This in turn, may be related to the reformulated learned helplessness theory of depression (Abramson, Seligman and Teasdale, 1978) in which it is thought that depression is maintained by attributing negative outcomes to uncontrollable causes. Maternal depression appears to be a common feature in studies of victims of child sexual abuse (e.g., Wagner, 1991).

A third mechanism by which continuity in abusive patterns are maintained could be due to limitations in terms of cognitive ability and/or personality (Rutter, 1987). This could be a primary deficit or secondary to other factors such as poor parental care, abuse, lack of schooling or traumatic events. Fourthly, impaired sexual functioning as a result of abuse may interfere with successful partnerships in adult life (e.g., Cole and Woolger, 1989).

3.1.4 Adult outcomes in sexual abuse

Given the rather tenuous nature of the link between mothers' experiences of abuse and their sons risk of victimisation or perpetration of sexual abuse, it is worth considering the long-term effects of child sexual abuse which may contribute to the clinical finding that sexual abuse recurs intergenerationally. Hartman and Burgess (1989) suggest three major long term effects which although not explicitly stated, are likely to impact on parental functioning. First, emotional repercussions of sexual abuse such as poor self-worth and high rates of depression. Second, the impact of abuse on interpersonal relationships and sexuality including a high rate of revictimisation in adulthood. Thirdly, the effect of abuse on social functioning including high rates of drug and alcohol use and prostitution. These factors identified by Hartman and Burgess (1989) show considerable overlap with the mechanisms proposed to account for continuity in developmental psychopathology (Rutter, 1987).

Although there are some good studies emerging which investigate adult outcomes in victims of child sexual abuse (e.g., Beitchman et al., 1992; Mullen et al., 1993, 1994), very little research has investigated the parenting quality of adult survivors of child sexual abuse. In one of the few studies addressing adult outcomes in terms of parenting, Cole and Woolger (1989) showed, perhaps not surprisingly, that women who were child victims of incest (n=21) had more negative perceptions of their parents than women who were sexually abused outside the family (n=19). They also reported that incest survivors were more likely to endorse "autonomy promotion attitudes" (1989, p.414) in a questionnaire relating to their own parenting practice. These attitudes included agreeing with statements such as 'most children are toilet trained by the age of 15 months' and 'the earlier a child is weaned from its emotional ties to its parents the better'. Cole and Woolger (1989) suggest that the experience of incest influences child rearing practices to a greater extent than non-incest sexual abuse, however this appears to be confounded with experiences of poor parenting and

neglect. Their small study provided no evidence for an intergenerational hypothesis of incest however the authors do support this hypothesis to some degree by suggesting that there is 'repetition of emotional estrangement' between mothers and daughters. The recurring theme of emotional distance and psychological absence is once again described in mothers who were sexually abused as children.

Reviews suggest that children who experience emotional deprivation, parental inadequacy, parental unavailability, conflict and harsh punishment are at risk of being sexually abused (Finkelhor, 1994). This indicates that the childhood experiences of mothers of sexually abused children are important factors to study.

Further research investigating the long-term effects of child sexual abuse on adult functioning particularly with regard to parenting is required. This may add to the limited understanding of the mediating variables and individual differences in parents' response to abusive early experiences which have a later impact on their children. While the link between antisocial parents and antisocial children appears to be quite well established (see Chapter Three) the mechanisms involved in the continuities and discontinuities of harsh and abusive parenting appear to be less well understood.

Conte and Schuerman (1987) speculate that adults victimised as children may attempt to master their victim experiences by involving themselves in relationships with partners who are violent or sexually abusive towards them or their children. One could speculate that cognitive processes may mediate those who successfully resolve these adverse experiences and those who do not. Remarkably little attention seems to have been paid to social cognitions, coping mechanisms and the mediating role of causal attributions about negative life events in the sexual abuse literature despite their relative prominence in other fields of clinical psychology (cf. Brewin, 1988a).

Bugental, Mantyla and Lewis (1989) propose a transactional model of child physical abuse whereby parental attributions are proposed to mediate the reactions of physically abusive mothers to their children. Although not specifically proposed to account for intergenerational abuse this model highlights the role of parental attributions in abusive parenting. What remains to be seen is whether we can learn about processes which contribute to intergenerational abuse from the study of non-abusive parents of sexually abused children, who are the focus of the present study.

3.2 Child sexual abuse and antisocial behaviour

3.2.1 Victims of child sexual abuse and antisocial behaviour

Reviews of the literature suggest that aggression, hostility and behaviour problems are frequently reported initial and long-term effects of child sexual abuse (e.g., Browne and Finkelhor, 1986; Beitchman et al., 1991, 1992). Although consistent gender differences have not always been found (Kendall-Tackett, Williams and Finkelhor, 1993), it appears that aggressive, externalising or antisocial behaviours are common responses to sexual abuse in boys (e.g., Rogers and Terry, 1984; Watkins and Bentovim, 1992). The extent to which these behaviours are present in sexually abused children compared to normal control or other clinical comparison groups is yet to be established. Similarly, due to the cross-sectional design of many of these studies, a causal connection between sexual victimisation and antisocial behaviour remains elusive.

Lane and Davis (1987) investigated the relationship between child maltreatment and subsequent delinquency. Their review indicated that approximately 1 - 25% of abused children and 15% of neglected children committed juvenile offences. The studies included in this review focussed exclusively on child physical abuse and neglect and did

not include appropriate comparison groups thus making these rates difficult to interpret.

The prevalence rates for delinquency in the general population of male adolescents range from 18 - 20% in British populations (West and Farrington, 1977; Farrington, 1979) rising to 35% in a U.S birth cohort (Wolfgang, 1973). These prevalence rates are similar to, or higher than, those found in groups of abused or neglected children suggesting that there is no unique association between child abuse or neglect and delinquency (Lane and Davis, 1987). Clearly the methodological limitations in carrying out such studies attempting to link previous abuse with later delinquent behaviour make this contention difficult to either refute or support.

Assessing the relationship between child abuse and later offending from a different perspective, Brannon, Larson and Doggett (1989) report on their study of 63 incarcerated male juvenile offenders (mean age 16.1 years). They found that 57% (n=36) of the boys reported having been sexually 'molested' which was defined as being tricked or manipulated into sexual relations, and 13% (n=8) reported that they had been sexually abused (i.e., force was used). Although a confounding factor was that a 18% (n=11) of these boys were incarcerated for sexual offences, this study does seem to support the notion that a substantial minority of boys with antisocial, conduct or delinquency problems were victims of child sexual abuse.

It is of particular relevance to this study that many of the family factors reported to characterise families of antisocial boys such as lack of parental affection, harsh parenting, rejection and poor communication (e.g., Glueck and Glueck, 1968; Patterson, 1982; Loeber and Dishion, 1983; Patterson and Stouthamer-Loeber, 1984) have also been associated with families of children who have been sexually abused

(Finkelhor, 1994). This underscores the need for inclusion of a comparison group of antisocial boys in this study investigating maternal attributions in mothers of adolescent victims and perpetrators of child sexual abuse.

3.2.2 Adolescent perpetrators and antisocial behaviour

As noted in the previous chapter (section 2.2.4) a number of studies indicate that approximately half of all adolescent sexual offenders may have a diagnosis of conduct disorder. They are described as committing offences indicating more general adjustment difficulties, including other violent and non-violent delinquent offences (e.g., Fehrenbach et al., 1986). Adolescent perpetrators are also described as having individual, peer and family difficulties (e.g., Davis and Leitenberg, 1987; Blaske et al., 1989) as are adolescents with antisocial behaviour (e.g., Loeber and Dishion, 1983; Fagan and Wexler, 1987; Henggeler, 1990a, 1990b). Little is known about the question of whether adolescent sexual offending or more violent forms of non-sexual offending is linked with delinquency in general, or if they form distinct groups (Blaske et al., 1989).

In a large study of adolescents referred to a Juvenile Sexual Offender Project, Fehrenbach et al., (1986) found that based on information for 293 subjects, 44% (n=129) had committed at least one prior non-sexual offence including theft and/or robbery. They also reported that 70 subjects (23% of the entire sample of 297 subjects) had committed both sexual and non-sexual offences. Fehrenbach et al., conclude that sexual offending is not an isolated incident involving normally developing adolescents. Over half their sample had committed a prior sexual offence and a substantial proportion had committed non-sexual offences. They describe their sample as socially awkward children who preferred the company of younger children or adults to peers. Therefore, it would appear that this sample of adolescent sex offenders are distinct from delinquent or antisocial adolescents who are often

characterised by their strong association with peer groups, albeit deviant ones (e.g., Snyder, Dishion and Patterson, 1986).

Henggeler (1989c) suggests that if maltreatment is associated with juvenile delinquency it is likely that several parental factors may be relevant. For example, child maltreatment is associated with characteristic patterns of weak parental control and poor affective relationships (e.g. Wolfe, 1985) that are similar in nature to patterns found in those families of juvenile delinquents.

There are frequent but tenuous links made between both victims and adolescent perpetrators of child sexual abuse and antisocial behaviour. Reviews and studies to date have lamented the lack of comparison groups of antisocial or non-sexual offending groups (e.g., Fehrenbach et al., 1986; Davis and Leitenberg, 1987; Blaske et al., 1989).

In summary, there appears to be a strong link between antisocial behaviour and child sexual abuse, whether experienced as a victim or a perpetrator. What remains unclear is direction of this link. The last section of this chapter reviews the literature on mothers of antisocial boys who serve as the comparison group in the present study.

3.3 Mothers of antisocial boys

Introduction

The comparison group for this study is a group of antisocial boys. Alternative terms to 'antisocial' behaviour include conduct disorder and delinquency. These boys prove a difficult group to distinguish in the literature and come under a variety of guises. As a group, they may be termed 'juvenile delinquents' or 'violent/non-violent offenders' (legal terms) or have a psychiatric diagnosis of 'socialised or unsocialised conduct

disorder' or 'oppositional defiant behaviour' as classified in ICD-10 (World Health Organisation, 1992).

In this case it may be more appropriate to label the *behaviour* rather than the child (Patterson, 1982) and researchers have favoured the term 'antisocial behaviour'. For the purposes of this study the term 'antisocial behaviour' will be used which includes aggression towards self, others and objects/property, as well as boys involved in multiple and petty offences or transgressions. This group forms a useful comparison for the study as there is a certain behavioural style (antisocial) or identifiable event (offence) around which maternal attributions can be explored. This may be important in light of the similarities in family characteristics noted earlier (see section 2.3.2). It is also of interest to investigate the backgrounds of boys who act out non-sexually compared to those who do act out sexually.

There may be some confusion over the behavioural manifestations or 'symptoms' of conduct disorder and Robins (1991) points out that in order for the psychiatric diagnosis of conduct disorder to apply, at least two of the following symptoms must be present for at least six months: 1. Running away, 2. Firesetting, 3. Robbery, 4. Sexual coercion, 5. Cruelty to animals and 6. Cruelty to people. However, for this study, boys were excluded from the comparison group if they were victims or young perpetrators of child sexual abuse.

3.3.1 Demographic characteristics

In a major review of delinquency in adolescence, Henggeler (1989c) points to the conceptual difficulties associated with the measurement of social class. The studies under review employed a wide range of measures and do not control for the numerous covariates of social class, such as family size, father absence and IQ, all of which may have an independent effect on delinquency.

As with studies on child sexual abuse, social class effects on delinquency seem to vary according to sample characteristics and measurement techniques rather than to the construct under study (in this case, delinquency). However, Henggeler (1989c) concludes that there is probably some association between lower social class and self-reported delinquent behaviour and arrest statistics, and that this association is stronger for more serious crimes. Fagan and Wexler (1987) reported that their sample of 98 violent adolescent offenders fell into a wide range of socioeconomic status but over half of them were on income support or living below the poverty line.

With regard to ethnicity, there have been fairly consistent findings that Black adolescents have higher rates of arrest and custodial care (incarceration), but do not have higher rates of delinquent behaviour than White youths in both American and British populations (Rutter and Giller, 1983a).

A study of 67 juvenile delinquents, of whom 73% were Black (Henggeler, Hanson, Borduin, Watson and Brunk, 1985), reveals the extent of the overrepresentation of Black adolescents in juvenile crime statistics. This may be suggestive of some bias in the way Black adolescents are treated by the police and by society in general. The finding that self-reported delinquency was not higher for Black adolescents in a study by Henggeler (1989a) led him to suggest that although a plausible explanation was that this was a reflection of lower validity of self-report measures for Black adolescents it was important to consider the prejudice which Black youth face when it comes to juvenile crime. It appears that Black adolescents are dealt with more punitively for less serious crimes and therefore represent the majority of incarcerated samples of juvenile offenders.

3.3.2 Family factors in antisocial behaviour

In contrast to the previous sections on mothers of victims and adolescent perpetrators of child sexual abuse, there is an abundance of literature on the families of juvenile delinquents, aggressive youth and children with conduct disorder (e.g., Fagan and Wexler, 1987; Farrington, 1978; Robins, 1991). Much of the literature refers to parenting practices particularly in relation to punishment and control, and the development of antisocial behaviour in children (Patterson, 1982; Patterson, Reid and Dishion, 1992). It is difficult to distil information specifically regarding mothers from this literature, although they often make up the total or majority of samples of 'families' or 'parents' reported in studies of antisocial boys.

There are four broad areas of interest pertaining to the families of antisocial boys, as delineated by Henggeler (1989c) in his review of delinquency in adolescence, all of which have been identified in the child psychiatry literature as important in the development of child psychopathology.

i) family affect

Broadly speaking, juvenile delinquency has been shown to be associated with high rates of marital and family conflict (e.g. Gove and Crutchfield, 1982; Patterson, Reid and Dishion, 1992) and low levels of parental acceptance and affection (e.g. West and Farrington, 1973). Hanson, Henggeler, Haefele and Rodick (1984) studied the emotional and intellectual functioning of 112 adolescent boys and their families. They showed that family relations accounted for approximately 20% of the variance in adolescent arrest history. Using multiple regression analysis , Hanson et al., (1984) controlled for association with deviant peers and age at first arrest which were the strongest predictors of later delinquency and found that 'mother-son affect' and 'maternal supportiveness' still contributed a significant proportion of variance.

In a later study on the same data set, Henggeler et al., (1985) looked at 67 mother-son dyads in father-absent families of violent and non-violent offenders and a normal control group. The mother-son relationships in offender groups were less warm and were observed to have less positive communication and more negative communication than non-offender dyads. However, there was only tentative support based on "marginally significant results" (p. 942, referring to p values < 0.52) for the notion that the violent offender dyads showed even poorer relationships than the non-violent offenders.

Patterson and Stouthamer-Loeber (1984) also found that a composite measure of supportive mother-child relations was negatively associated with self-reported delinquent behaviour, but was not associated with police contacts in 206 10 - 16 year old boys. Similarly, Loeber and Dishion (1983) found that the families of those children and adolescents who were aggressive at home and at school showed low acceptance from both mothers and fathers and poor marital adjustment.

Patterson, Reid and Dishion (1992) point out that the high level of negative interactions and stressful events in families of antisocial boys often have the greatest effect on mothers. The link between maternal depression and aggressive behaviour in children has been established (e.g, Patterson, 1980) and has been further confirmed by studies showing an improvement in child behaviour problems when maternal depression is addressed (Griest, Forehand, Rogers, Breiner, Furey and Williams, 1982).

A different perspective on the relationship between maternal depression and antisocial child behaviour has been proposed in studies by Hops and his colleagues, cited in Patterson, Reid and Dishion (1992). Maternal depression may have a functional role in families with high rates of negative interactions. Hops, Sherman and Biglan (1990)

noted that 'depressive maternal behaviours' were more likely to be followed by a reduction in negative interactions in the family.

In summary, there is consistent evidence that several aspects of family affect are associated with antisocial behaviour, even when the effects of demographic and psychosocial variables are controlled. Henggeler (1989c) notes that there has been a theoretical shift from explanations which assumed that variables such as maternal depression, parental rejection, low family cohesion and marital conflict cause delinquent behaviour. Current theoretical perspectives highlight the bidirectional and reciprocal nature of the relationship (e.g. Bell and Harper, 1977). In other words, that there is an ever-increasing feedback loop whereby parental affect, communication and behaviour influences the child's behaviour which in turn influences the parents' behaviour.

ii) parental control strategies

Loeber and Dishion's (1983) review of early predictors of male delinquency concluded that composite measures of family management techniques including parental supervision and discipline were among the strongest predictors of delinquent behaviour.

Patterson and his colleagues at the Oregon Social Learning Center conducted an impressive series of studies to investigate the determinants of aggressive behaviour in children. Aggressive children showed high rates of aversive behaviour such as whining and hitting when interacting with other family members (Patterson, 1982). The punishments meted out by parents of these children were characteristically inconsistent and unsuccessful and which only served to exacerbate the child's antisocial behaviour. This acceleration in aggressive behaviour in the child and subsequent increase in

punitive behaviour by their parents is called the 'coercive family process' (Patterson, 1982). Four important features of this process are:

i) Lack of house rules, or 'normlessness'; results in children being unclear as to how they were expected to behave.

ii) Lack of parental monitoring; affects parents ability to respond to the behaviour of their children.

iii) Lack of effective contingencies and poor differentiation between praise and punishment and,

iv) Lack of techniques for dealing with family crises; results in escalation but not resolution of conflict within the family.

The poor behaviour management practices in these families are said to place the adolescents in the family at risk for the development of antisocial and delinquent behaviour (Patterson, 1982; Rutter and Giller, 1983b; Henggeler, 1989c).

iii) parental deviance

Major reviews by Rutter and Giller (1983b), Loeber and Dishion (1983) and Henggeler (1989c) suggests that delinquency in adolescence and parental criminality are consistently associated across a number of studies.

In a major prospective study of juvenile delinquents, West and Farrington (1973) found that 39% of boys with criminal fathers were delinquent compared to 16% of those with non-criminal fathers. Rutter and Giller (1983b) also note the association between persistent social difficulties such as parental substance use, reliance on welfare and poor employment record, in addition to delinquency in boys. Parental criminality is also associated with these psychosocial characteristics (Rutter and Giller, 1983b).

This is echoed by Henggeler (1989c) who notes that delinquent behaviour in adolescence is associated with parental antisocial behaviour which is less overt than actual parental criminal behaviour. He cites a study by Canter (1982) of a general adolescent sample in which 'family normlessness' was associated more strongly with adolescent delinquency than other measures of family affect and parental control strategies.

It is also interesting to note that whereas the relationship between externalising behaviours of parents (antisocial behaviour and criminality) and juvenile delinquency are well established, the same does not hold true for parental internalisation of problems. Hanson et al., (1984) found that mothers and fathers self-reports of neurotic behaviour were not associated with delinquent behaviour in their children. Blaske et al., (1989) showed that the mothers of sixty juvenile offenders did not differ on standardised measures of self-reported psychiatric symptoms compared to mothers of non-offenders.

There is also indirect evidence regarding the association between parental deviance and the development of antisocial behaviour stemming from the child abuse literature (Henggeler, 1989c). This is based on the assumption that parents who perpetrate physical or emotional abuse on their children are deviant and thus deviant parental behaviour is linked to delinquency.

iv) family structure

There is fairly consistent evidence that the risk for juvenile delinquency is higher for adolescents that come from 'broken homes' (e.g. Canter, 1982). Henggeler (1989c) concludes from his review that adolescents from such homes do engage in relatively higher rates of antisocial behaviour as a result of certain mediating variables. These

adolescents are more autonomous, less involved with their parents and more susceptible to peer pressure (e.g., Snyder, Dishion and Patterson, 1986).

The importance of the protective function of the *nature* of the parent-child relationship, over and above the influence of the *structure* of the family has been emphasised (Rutter, 1971; Quinton and Rutter, 1988). Children who have a good relationship with one parent are less likely to develop antisocial behaviour than children who have poor relationships with both parents. In other words it is the amount of parental discord rather than parental separation per se which is crucial (Rutter and Giller, 1988b).

In summary, there is good evidence in the literature (Rutter and Giller, 1983b; Patterson, 1982) that family factors are crucial in the development of aggression, conduct disturbance and delinquency (Rutter and Rutter, 1993). The direction of this relationship is not completely clear (e.g. Henggeler, 1989c) however the existence of protective mechanisms which mediate this association are coming to light (Rutter, 1987).

Harsh parenting and antisocial behaviour

It is important to at least briefly consider what factors lead to the type of parenting that places children at risk for negative developmental outcomes such as antisocial behaviour or conduct disorder. This is particularly important given the stability of antisocial behaviour over time (Patterson, Reid and Dishion, 1992). Simons, Whitbeck, Conger and Chyi-In (1991) reviewed and investigated the notion of intergenerational transmission of harsh parenting. Simons et al., (1991) note that the search for causes of harsh parenting practices led some researchers to conclude that the most significant determinant of abusive child rearing is having experienced harsh parenting as a child (e.g. Steinmetz, 1987). Simons et al., (1991) point to the

methodological shortfalls of the research which led to this contention, such as the use of non-representative samples, lack of comparison groups and lack of observer-blind studies.

The study conducted by these authors holds up to most of this methodological scrutiny, as their study involved a sample of 451 families to which they applied a theoretically based model to test various hypotheses. However it is worth bearing in mind that they carried out a study of white, middle-class, two-parent families, one-third of whom were farmers from Iowa which might seem unrepresentative compared to other groups in which harsh parenting is studied. A social learning model was used to test different processes by which harsh parenting might be transmitted across generations.

Parent and adolescent self-report measures were used to assess the 'harsh parenting construct'. Using structural equation modelling the authors showed that grandparents who had been aggressive parents produced current parents who were likely to use aggressive practices. This effect was stronger for mothers than for fathers, and there was also evidence that similarities across generations regarding the harsh discipline of male children were in part a function of socioeconomic characteristics being transmitted across generations (Simons et al., 1991).

This paper highlights the importance of identifying aspects of parenting that relate to parents' own experience of care during childhood even though the actual correlations between harsh parenting by grandparents and parenting beliefs of the adult children were small and did not account for much of the variance. While not necessarily invoking a 'parenting philosophy' the effects of harsh parenting may alter beliefs and attitudes even if the behavioural manifestations of harsh parenting are not obvious. High levels of tolerance of violent, delinquent or less severe 'normless' behaviour need not necessarily be directed at the children but is likely to form part of the family milieu.

It is unlikely that a single or even complex series of causes will be identified solely within the family given the context within which an adolescent is developing involving interacting peer and family systems. However two important points remain. First, the family is often the context for intervention and in many cases, particularly for antisocial boys and boys who are victims or perpetrators of sexual abuse, this often involves mother-headed families. Second, parent-child relationships form the cornerstone of studies of developmental psychopathology and the social cognitive models applied to the study of parent-child interactions with conduct disordered and abused children (see next chapter) may be informative in elucidating the complex relationship between family factors and psychopathology in childhood and adolescence.

3.4 Methodological issues in child sexual abuse research

The literature reviewed in this chapter reveals a number of methodological issues and practical problems in carrying out research on child sexual abuse. The persistent methodological difficulties found in research concerned with the study of victims and perpetrators of sexual abuse can be summarised into three main areas as follows:

i) definitional issues

The importance of definitions has been referred to in this chapter with regard to prevalence issues. Haugaard and Emery (1989) showed that the prevalence rate of sexual abuse dropped from 9.3% to 7.0% in a sample of over one thousand college undergraduates when a more narrow definition was used thus demonstrating the effect of varying definitions. Kinard (1994) highlights the importance of using specific definitions in order to select appropriate samples for research and also to facilitate comparisons across studies. This is particularly important given the small sample sizes that often characterise studies of victims and young perpetrators of sexual abuse.

However, Kinard goes on to point out that researchers must choose the definition most appropriate for their research aims which may make the acceptance of one universally agreed upon definition of sexual abuse more difficult.

What is clear is that definitions need to be made explicit in published studies as it appears that the nature and type of abuse experienced or perpetrated may be important factors in implementing therapeutic intervention programmes.

Clinicians may feel that it is more important to assess the impact of the abuse on the child or young person compared to the legal, medical and research needs for clear descriptions of the nature of the sexual abuse. Clinical samples tend to have narrower definitions applied to them than general population studies (e.g. Collings, 1995). The use of more stringent definitions seems to be favoured by researchers who study adolescents who sexually abuse other children, as the consequences of being labelled a child molester, or Schedule One offender are likely to be lifelong (e.g. Horne, Glasgow, Cox and Calam, 1991).

ii) study sample issues

The selection of the appropriate study sample should be guided by the purposes of that study (see Kinard, 1994), however in practice the study sample is usually one of convenience to the researchers due to pragmatic considerations. It is clearly important for cross-study comparisons and for appreciating the restrictions on the generalisability of study findings that study samples are well defined and that full demographic information is presented in research papers.

One further issue relating both to study and to comparison group samples is the issue of gender effects. Many of the studies reviewed in this chapter contain mixed gender samples of victims and their perpetrators. The mediating effect of gender with regard

to effects of sexual victimisation are not clearly established (Kendall-Tackett, Williams and Finkelhor, 1993) which leaves gender as a possible confound in studies which include girls and boys.

Given the preponderance of male perpetrators of child sexual abuse, the absence of studies relating to boys in relation to both their sexual victimisation and perpetration is all the more noticeable. To date most published work on young perpetrators has focussed on adolescent male perpetrators (e.g. Becker, 1990; Ryan and Lane, 1991), however, the importance of selection of study samples is still relevant. Finkelhor (1986) noted that with respect to adult sex offenders, study samples may be unrepresentative due to the fact that most studies included groups of incarcerated child molesters who represent only a proportion of all sex offenders. As these studies have been used to support single-factor theories that suggest that sexual victimisation alone leads to sexual perpetration, it is important to question the representativeness of this group of sex offenders who are likely to be the most pathological, and therefore are more likely to have suffered sexual abuse (Finkelhor, 1986).

Study samples of adolescent perpetrators frequently rely on 'captive audiences' to increase sample sizes and thus focus on incarcerated samples of adolescents (e.g., Brannon, Larson and Doggett, 1989) or adolescents arrested or cautioned for their offences (e.g. Blaske, Borduin, Henggeler and Mann, 1989). It is possible that those adolescents recruited through the criminal justice system will have committed more serious sexual offences which may have included non-child victims such as peers or adults thus making generalisability across studies difficult.

iii) comparison sample issues

The inclusion of appropriate comparison groups is a fairly recent methodological advance in research concerning victims of child sexual abuse research (Beitchman et al., 1991; Kendall-Tackett, Williams and Finkelhor, 1993) and is even rarer in research concerning adolescent perpetrators (see review by Davis and Leitenberg, 1987; and comparative study by Blaske, Borduin, Henggeler and Mann, 1989).

Kinard (1994) notes that it is important to investigate sexual abuse in any comparison group in studies of child sexual abuse. It is also important to acknowledge that a certain amount of child abuse may go undetected in such groups due to the difficult nature of enquiring about sexual victimisation or perpetration.

Many studies reviewed in this chapter demonstrate that inadequate designs plague research on child sexual abuse, perhaps more than other fields of developmental psychopathology. As studies have typically been exploratory in purpose, and perhaps also due to the sensitive nature of the research topic and the ethical minefield that must be negotiated, methodological sophistication is relatively slow in this area.

The three main areas of methodological difficulties are ones that seem to compromise findings in many areas of developmental psychopathology. However, a more serious flaw concerns what Kendall-Tackett, Williams and Finkelhor conclude from their influential review of child sexual abuse research of a "nearly universal absence of theoretical underpinnings in the studies being conducted on this subject to date" (p. 175, 1993).

There appear to have been few theoretical advances since Browne and Finkelhor's (1986) proposed 'traumagenic dynamics' model to understand the effects of child sexual abuse (Finkelhor, 1990; Kendall-Tackett et al., 1993). The study of adolescent

perpetrators also appears to lack a developmental approach to understanding the genesis of sexual aggression and has applied adult models with limited success.

In order to understand the development of perpetrating behaviour in adolescent boys, some progress needs to be made in understanding what factors mediate the effects of child sexual abuse on boys. This study forms part of a research programme which aims to begin to do this, and focuses on the study of maternal attributions. The following chapter reviews the literature relating to the study of causal attributions.

CHAPTER FOUR

Literature Review: Causal Attributions

IV: Literature Review: Causal Attributions

" There is occasions and causes whys and wherefore in all things"

(Shakespeare, 1564 - 1616)

Introduction

Research investigating the links between parental thought and parental action has long been a focus of interest in developmental psychology (Sigel, 1985). However, a long-standing criticism regarding research into parental cognitions has been its somewhat atheoretical approach (Goodnow, 1988). This is now starting to be addressed by considering theories from social psychology which provide innovative research methods and directions for developmental research into parental thoughts and behaviours (e.g. Miller, 1988; Sigel, 1992).

The aim of this chapter is to introduce attribution theory, which offers a well-formulated set of concepts with which to develop a social-cognitive approach to the understanding of parental cognitions, and their role in child sexual abuse. First there will be a brief overview of attribution theory and the functions and consequences of attributions. This is followed by a review of the growing literature on parental attributions and finally a discussion of the measurement of attributions.

4.1 Attribution theory: A brief overview

4.1.1 Introduction

The field of social psychology which examines how people make sense of their environment, or how they explain events in their world, is known as attribution theory. According to attribution theory, people have an instinctive wish to explain their world, primarily in order to try and gain control over the environment (Heider, 1944, 1958).

The way thoughts and beliefs are construed in attribution theory are as causal attributions or explanations. Social cognitions refer to the way people perceive and interpret information about themselves and others and in this study refers specifically to causal attributions. Kelley and Michela (1980) note the increase in research on the perception of cause and the consequences of such perceptions, that is, the study of causal attribution.

A causal attribution is an explanation for a particular event or behaviour that is or has been processed by an individual. Brewin (1988a) defines a causal attribution as the process people go through to decide which causal factors have produced a certain event or outcome. This definition indicates the highly subjective nature of causal attributions, while recognising the complexity of this process. The subjective nature of attributions is usually described in terms of attributional 'error' or 'bias'.

Historically, Heider (1958) is identified as the major proponent of attribution theory, with his 'man-the-scientist' analogy whereby ordinary people's approach to understanding their world was proposed to be scientific in nature. Social psychologists such as Kelley (1967) and Nisbett and Ross (1980) built on Heider's original concepts to form contemporary attribution theory. This framework considers that people arrive at explanations by observing the covariation of putative causes and effects. Individuals are said to consider a variety of causes and their relationship, and in this way causal explanations are arrived at for events and outcomes in a person's life. This process is essentially describing an intrapsychic rather than interpersonal construct (Hilton, 1990).

Therein lies the difficulty in applying the theoretical constructs of causal attributions in their 'pure' form to psychological research. The intrapsychic nature of cognitive processing may have resulted in the highly experimental and analogue nature of attempts to study these implicit cognitions.

There are both philosophical and pragmatic considerations in the approaches to social cognitions reviewed in this chapter. Causal attributions are construed as part of a social interactional or interpersonal phenomenon thus attributions are rated according to what is presented to the researcher in an attempt to measure an essentially implicit construct.

This has led to applications of attribution theory focussing on the study of social cognitions in the form of causal attributions. The study of attitudes appears to have been replaced by an interest in causal attributions which appears to form the cornerstone of social-cognitive theory and research (see Brewin, 1988a; Hewstone, 1989).

The theories of covariation and configuration (Kelley, 1973) marked the beginning of a more formal approach to attributional analysis and further contributed toward a more formal conceptualisation of the types of information people use to determine causality, the kinds of causality they identify, and the rules they use for going from information (input) to inferred cause (Hewstone, 1989).

While attribution theory research has focused on perceived causes of others' behaviour, there has been a parallel interest in the study of perceived causes of one's own behaviour. This application of attribution theory to self and other causes, is of particular interest to developmental psychologists in understanding parent-child relationships. The vast literature on attribution theories and models and its many applications in the domains of social-cognitive, developmental and clinical psychology is too broad to review here. This chapter will focus primarily on parental attributions, following an introduction to some of the important concepts in attribution theory (for detailed reviews see Kelley and Michela, 1980; Brewin, 1988a; and Hewstone, 1989).

The functions and consequences of attributions

The broad categories of functions and consequences of causal attributions are classified following Hewstone's (1989) comprehensive review. Examples of causal attributions are provided which conform to the convention of a cause (underlined) linked to an outcome (e.g. *I failed the exam <u>because I didn't study hard enough)</u>*. For clarity, these examples are drawn from the work on attributions for success and failure (e.g. Weiner, 1988).

4.1.2 Functions of attributions

The move away from motivation-based models of attitudes and behaviour to a more cognitive approach (Taylor, 1981) was seen to influence the earlier theoretical literature on attributions which took into account motivational concerns (Heider, 1958). Hewstone (1989) notes that since that time there has been very little focus on the functions of attribution, but summarises two reviews (Forsyth, 1980; Tetlock and Levi, 1982) which showed two primary functions of attributions.

i) The control function; this function refers to the role of attributions in perceived control over one's environment. In this way, common-sense explanations allow cognitive control over both past and present events, as well as affording some anticipatory role in future events. For example, attributions of failure to controllable causes such as effort, (e.g. *I failed the exam <u>because I didn't study hard enough</u>*), may lead to a sense of control over the outcome, and therefore a sense of efficacy about changing the outcome in future.

Self-blame too, is seen to help people understand how an otherwise inexplicable event could be avoided in the future if it is seen to originate from internal and controllable causes (e.g. *<u>I didn't study hard enough)</u>*. However, studies investigating women who blamed themselves for having been raped showed they were less likely to make a good

emotional recovery than women who did not blame themselves (e.g., Meyer and Taylor, 1986). This suggests that while attributing the cause of assaults or other such negative events to oneself may lead to a sense of control over such an outcome in the future, it will ultimately lead to a dsyfunctional view of oneself, or at the very least one which is incompatible with emotional well-being (Hewstone, 1989).

Hewstone (1989) highlights the importance of the control function of attributions in understanding some of the counter-intuitive attributional phenomena that exist, such as the social phenomena of 'victim blaming'. That is, when victims of negative events are seen to be responsible for events such as accidents (Bulman and Wortman, 1977) and rape (Medea and Thompson, 1974). In attribution theory terms, this involves attributing causality to internal and controllable factors (e.g. *she shouldn't have worn such a short skirt when she was out late*). In this way if people see the victim as 'deserving' the outcome, they can maintain a belief that such negative events would not happen to them, which is also known as the 'just world hypothesis' (Lerner and Miller, 1978). This theory can be linked to the consistent observation that people tend to focus on external or situational factors when ascribing causes for negative events. This 'fundamental attributional error' (Hewstone, 1989) leads to a tendency to attribute causes for negative events to situational factors for Self and internal factors for others.

ii) the self-protective function; this refers to the function of attributions in maintaining a positive self-image by enhancing feelings of personal worth and self-efficacy. Attributions are seen to serve this function when people attribute success to internal causes (*I did well in the exam because I really worked hard*), and failure to external causes (*I failed the exam because the questions were too hard).* Thus, attributions may be seen to be jointly influenced by an objective need to make sense of the environment, and by a more subjective need to preserve self-esteem (Larrance and Twentyman, 1983).

A similar function is that of 'self-presentation' (Brewin, 1988a) which refers to the interpersonal context of a conversation or other social interaction in which attributions are presented. People may communicate attributions in order to present a certain view of the self, usually a self-enhancing one.

4.1.3 Consequences of attributions

The distinction between attribution theories, concerned with the antecedents of attributions and attributional theories, concerned with consequences has been made in the literature on causal attributions (primarily in Kelley and Michela's (1980) review). However, in practice this distinction does not seem to have been upheld, and for the purposes of this study, both antecedents and consequences are of interest.

Reviews of the field suggest an abundance of literature covering consequences of causal attributions (e.g. Brewin, 1988a; Hewstone, 1989). Hewstone (1989) reviews three of the most relevant areas to the social-psychological study of attributions:

i) Cognitive-judgemental consequences; referring to such cognitive processes as memory which may be reconstructed using attributions (e.g. Hastie, 1984). Causal attributions also influence belief perseverance independently of the original information on which the explanation was based (Anderson, Lepper and Ross, 1980). Attributions can also influence judgements, or decisions. For example, Carrol, Perkowitz, Lurigio and Weaver (1987) showed that, when making parole decisions, subjects who attributed crimes to Internal and intentional (Controllable) factors of the criminal made more punitive judgements than those who attributed the crimes to external and unintentional factors.

Such attributions may also influence other 'change agents' (Weiner, 1988) as doctors, teachers and therapists in their decisions about pupils and clients.

It is important to consider that while attributions have cognitive-judgemental consequences, there also exists the possibility that such cognitive processes may have an effect on attributions in the opposite direction (e.g., Hewstone, 1989). For example, it may be that memory can influence attributions and that the type of decisions one usually makes may in turn influence the way in which events are explained (see also Brewin, 1989).

ii) Behavioural consequences of attributions; refers to the actions that are likely to result from attributing cause in a certain way. Attributing causality to Internal and Controllable factors (*I failed the exam because I didn't study hard enough)* is likely to lead to a different course of action in future exams than attributing failure to External and Uncontrollable causes (*I failed the exam because the questions were too hard*). Similarly, when considering parental attributions, a parent attributing the cause of their child making a mess to Internal and Controllable factors *(e.g. Billy spilled orange juice all over the mat, he's always doing things to annoy me)* may be more likely to react angrily than if they attribute causality to External and Uncontrollable factors *(e.g. Billy is only five so he can't help it)*. (See section 4.2 on parental attributions).

iii) Emotional consequences of attributions; the way a person explains an event, particularly a negative or unexpected one, is seen to be an important mediator of the emotional response to such an event (e.g. Weiner, 1985). Hewstone (1989) highlights two important strands to this work, one focuses on attributions for success and failure, and the other is the role of affective consequences of attributions in depression.

4.1.3.1 Attributions for success and failure

The work on reactions to success and failure is the major contribution of Weiner and his colleagues, (Weiner, Russell and Lerman, 1978; Wong and Weiner, 1981; Weiner, 1986, 1990) who have highlighted the role of attributions in the production of differential emotional responses. This is one of many theoretical models explaining the relationship between cognition and affect, and testing this model has produced some evidence for the primacy of causal attributions in this relationship, (Weiner, 1985).

The distinction between 'outcome-related' and 'attribution-linked' emotional consequences is also seen to be important contribution of Weiner's work, (Hewstone, 1989). Outcome-dependent affects refer to primary emotional states such as happy, sad, or angry and are dependent on non-attainment of a desired outcome. For example, a person might feel sad when hearing that they have failed an exam. However it is a specific type of appraisal, namely a causal attribution, for an event, which is seen to produce 'attribution-linked' emotional states. Returning to the example, if a cause is seen to be Internal, Controllable and Unstable (*I didn't study hard enough)* the consequent emotion may be guilt, or if it is seen to be External, Uncontrollable and Stable (*I failed the exam, because I am stupid)* the person may feel hopeless. However, if the cause of the negative event is seen to be External and Uncontrollable (*I failed the exam, because they didn't set the right questions)*, the person may feel angry.

The importance of such appraisals are thought to be especially pertinent for events which are negative or unexpected. The causal role of attributions in producing both negative affect and negative behaviours is slowly being established in important clinical domains such as distressed marital relationships (e.g., Fincham and Bradbury, 1988) and in parent-child interactions (e.g., Dix, Ruble, Grusec and Nixon, 1986). Weiner (1986) proposed that causal attributions and their underlying causal dimensions,

namely Locus, Stability and Controllability are likely to produce more sophisticated or varied emotions (such as surprise or rage). In his general theory of motivation and emotion, Weiner (1986) described the roles of each of the underlying causal properties or dimensions of attributions in the following way:

i) Locus; this refers to the attribution of success to Internal causes such as ability or effort (*e.g. I studied really hard to pass that exam)* which results in greater self-esteem or pride than success attributed externally (*e.g. I was really lucky that they set easy questions).*

ii) Stability; this refers to the expectation of success or failure in the future and is seen to be linked to the emotional response of hopelessness when failure is attributed to Stable causes (e.g., *I failed the exam because I am stupid).*

iii) Controllability; the function of this dimension relates to the perception of others intentions to act. If personal failure is seen to be Controllable by others (e.g., *they didn't set the right questions),* then the likely affective response is anger, whereas if it were seen to be Uncontrollable (e.g., *they didn't know we hadn't studied algebra)* one might feel more sympathetic to that person.

An earlier example of parental attributions is also relevant to perception of control. The child's young age should mitigate against blame for spilling food (Dix and Grusec, 1985), however if the parent has unrealistic expectations or perceives a power imbalance (e.g., *he never does what I tell him),* the parent may perceive that the child can control the outcome and thus feel angry towards the child. The anger may manifest itself by the use of inappropriate discipline or punishment which is likely to affect future interactions between parent and child (e.g. Patterson, 1982).
This illustrates the importance of parental attributions and their subsequent effect on children's developmental outcomes, which forms the basis of the current study.

Following the work of Weiner, the role of evaluating negative events is seen to be important in coping with negative life events. Lazarus and his colleagues (Lazarus, Kanner and Folkman, 1980; Lazarus and Folkman, 1984) have focussed on the importance of cognitive appraisal in producing affective responses to threatening or stressful events. Lazarus, Kanner and Folkman, cited in Brewin (1988a) highlight the role of such appraisals, and the individual nature of such explanations for events by saying:

> *" that not only do emotions arise as a result of evaluation of the transaction or encounter, but the ongoing appraisals are themselves an integral and intrinsic component of the emotion. Anger, for example, includes the attribution of blame for a particular kind of injury or threat, and guilt also involves such attribution of blame to oneself, with the further implication that one has not only done harm but has acted badly in accordance with personal standards of behavior. These attributions are forms of cognitive appraisal that are more than initial evaluations, they become an ongoing and critical dynamic in the experience of anger and guilt"* (1980, p.198)

4.1.3.2 Attributions and depression

The second major area in the study of emotional consequences of attributions, is that of the social-cognitive approach to clinical depression. The role of persistent negative attributions has been a major focus of the reformulated learned helplessness theory of depression (Abramson, Seligman and Teasdale, 1978). This attributional reformulation states that the experience of uncontrollable, negative events will lead a person to think about why such events have happened to them. The realisation of 'noncontingency' (i.e. independence) between response and outcome is hypothesized in this model to lead to expectations of future non-contingency which will lead to feelings of helplessness, a primary feature of clinical depression (Peterson and Seligman, 1984; Brewin, 1985).

This model of depression proposes that people who make Internal, Stable and Global attributions for negative outcomes are predisposed to depression (Abramson et al., 1978). Internal causes for negative events *(it's my fault)* would lower an individual's self-esteem. Furthermore Stable causes *(it's going to last forever)* would add to the chronicity of the helpless bias associated with such pessimistic explanatory style. Attributing negative outcomes to Global causes *(it's going to undermine everything I do)* would result in these deficits generalising across different situations (Peterson and Seligman, 1984; Hewstone, 1989)

The debate on the direction of the causal relationship between depressive attributional style (characterised by Internal, Stable and Global explanations) and clinical depression is ongoing (Brewin, 1985; Peterson and Seligman, 1984; Coyne and Gotlib, 1983), but the link between them is established and the therapeutic spin-off from this debate has led to considerable advances in the cognitive-behavioural treatment of depression. A meta-analysis of 104 studies by Sweeney, Anderson and Bailey (1986) showed that the more Internal, Stable and Global attributions were for negative outcomes, the higher the rate of depression. While confirming the predicted association between attributions and depression, this review does not add to the resolution of the debate on direction of causality. Brewin (1985) reviewed the evidence on this debate and concluded that "attributions, like other cognitions, are probably influenced by clinical states" (p. 307). This review provides tentative support for the hypothesis that once a person is depressed, causal attributions may be significant in maintaining that state or contributing to its chronicity.

The issue of consistency in individual patterns of attributions has been presented in the literature in a traditional trait versus state paradigm. It has been suggested that there is a consistent explanatory or attributional style which persists over time, that is, a stable personality trait (Burns and Seligman, 1989; Schulman, Castellon and Seligman, 1989). However other studies have reported only weak evidence of a consistent

attributional style across situations (Cutrona, Russell and Jones, 1985). This study also concluded that the Attributional Style Questionnaire scores were actually poor predictors of causal attributions for actual negative events (see also section 4.4.1 on measurement of attributions).

It may also be important to consider that the emotional consequences of attributions are affected by related phenomena such as attributional 'errors'. For example the actor-observer bias, which influences attributions for negative events may add to the complexity of the relationship between depression and attributions (e.g., Brewin, 1988b; Hewstone, 1989).

Another aspect of the relationship between affect and cognition comes from the stress and coping literature and focuses on the mediating role of attributions in response to illness and severe stress (e.g., Lefcourt, Miller, Ware and Sherk, 1981). It has been shown that certain patterns of attributions, such as attributing negative events to stable and global factors (e.g., *I am stupid* or *I am boring*), was associated with a perception of reduced availability of social support resources (Brewin, McCarthy and Furnham, 1989). It is possible that this pattern of attributions is likely to affect a person's willingness to accept help to change in a therapeutic setting.

Bugental (1992) highlights the important finding that individuals with a high 'perceived control' tend to cope better with illness, and other stressors (e.g., Taylor, Lichtman and Wood, 1984). Parents with a high perceived control may also cope better with the illness of their children (e.g. Affleck, Allen, McGrade and McQueeney, 1982). Brown and Siegel (1988) noted that the relationship between attributions for negative events and depression should include a consideration of the role of perceived control. In a study of adolescent girls from an affluent socioeconomic background, they found that attributions to Internal, Stable, Global and Uncontrollable causes for negative events were positively related to higher depression. They also found that

negative events attributed to Internal, Stable and Controllable causes were inversely related to negative affect. Depression was measured using the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) which is a 20-item self-report inventory.

Perceptions of control were salient in the original Learned Helplessness theory of depression and are seen to be critical in distressed parent-child relationships (Bugental et al., 1993). The notion of perceived control with respect to parental attributions will be considered in more detail later in this chapter.

Before moving on to consider the importance of studying causal attributions, it is worth considering that alternative explanations for the relationship between cognitions and emotion have been made. The reviews by Coyne and Gotlib (1983) and Brewin (1985) have already been mentioned in relation to the specific relationship between depression and causal attributions. These reviews have led to the argument that it is the influence of affect on subsequent cognitive processing which would be worthy of further study. Depression and other negative affective states have been shown to deplete cognitive resources and thus limit information-processing capacities (e.g. Isen, 1984). There is also reported to be an effect of enhanced recall of memories congruent with depressed affect (Brewin, 1989; Dalgleish and Watts, 1990; Brewin, Andrews and Gotlib, 1993).

4.1.4 Why is it important to study causal attributions ?

Before focussing specifically on parental attributions, the potential role of causal attributions in the understanding of distressed family situations will be briefly considered. Brewin notes that:

> *"..the act of explanation is not a matter of idle armchair reflection. In times of trouble it is an attempt to re-establish control over the world and to determine what changes need to be made. Sometimes the changes will need to*

> *be to the person and sometimes to the environment, and sometimes no changes will be possible. Sometimes people may fall back on explanations that relieve them from the burden of taking any action at all. In any event, explanation is almost certain to be an integral part of any reaction to adversity."*
> (1988a, p. 108)

This, together with the literature reviewed thus far, helps set the stage for *why* we should look at causal attribution. It is important to appreciate the truly subjective nature of the process of attributing causes to negative events, and to acknowledge that as a cognitive process it is subject to error and bias (Brewin, 1988a). This may have contributed to the confusion mentioned in the introduction to this chapter (see section 4.1). For example, there have been contrary findings regarding the association between attributions and adjustment to illness. Some studies indicate that actually making a causal attribution about illness may have a positive effect on physical or emotional well-being (Turnquist, Harvey and Andersen, 1988). However, there have been some studies which indicate that attributing the cause of illness to internal factors predicts poor outcome (Affleck, Tennen, Croog and Levine, 1987, Bulman and Wortman, 1977), and others which suggest that there is no relationship between causal attributions and physical or psychological adjustment (Brewin, 1984).

The past decade has seen the emergence of empirical studies establishing the relationship between causal attributions and their influence on marital satisfaction and negative behaviours within marital relationships (e.g. Fincham and Bradbury, 1988). Attributions are thought to play an important role as a mediator of perceptions, motivation, affect and behaviour (Dix, Ruble, Grusec and Nixon, 1986; Harvey, Turnquist and Agostinelli, 1988; Bugental, Mantyla and Lewis, 1989; Bugental et al., 1993). Of relevance to the current study is the application of attributional analysis to the fields of interpersonal relationships, particularly distressed marital relationships (e.g. Fincham, 1985, Harvey, Weber, Yarkin and Stewart, 1982), mental health (Brewin and Antaki, 1987), parenting (e.g. Bugental, Blue and Cruzcosa, 1989,

Bugental et al., 1993; Larrance and Twentyman, 1983; Bauer and Twentyman, 1985), and domestic violence (Andrews and Brewin, 1990; Andrews, 1992; Holtzworth-Munroe, 1992). Of particular interest to the present study, is the application of attribution theory to understanding more about the role of parental cognitions in difficult parenting situations.

4.2 Parental Attributions

Introduction

In general, theories of social development have moved towards interactional and now transactional (i.e., multiple and dynamic interactions) models in order to understand more about the reciprocal influences in the parent-child relationship.

Theories relating to child maltreatment, particularly physical abuse, have focussed on the interaction between so-called 'difficult' child and their abusive parents, invariably mothers. Much of the work on reciprocal influences in parenting contexts has been focused on the behaviour of the child and parent (Bugental, Mantyla and Lewis, 1989). Patterson and his colleagues (Patterson, 1982; Patterson, Reid and Dishion, 1992) describe a coercive cycle which develops when non-compliance in the child leads to increasing levels of coercive parental control strategies, which in turn fosters and maintains a vicious cycle of further non-compliance in the child and coercion by the parent. This model illustrates the reciprocal nature of the effects of child behaviours and parental responses.

With the renewed interest in the cognitive processes involved in interactional analyses of social development, the focus on parental thoughts, ideas and actions have once more become paramount (e.g. Goodnow, 1988). Bugental, Mantyla and Lewis (1989) highlight the restricted nature of studies of cognitive processes in parent-child interaction literature. Firstly, there has been an almost exclusive focus on cognitions in

the child, and secondly, they investigated intellectual and other purely cognitive functions without redress to the arena of social cognitions. Social cognitions, which include attributions, refer to how a person makes sense of their interpersonal world and are now an important focus for research in socialisation.

Maccoby (1992) elegantly charts the developing role of parents in the socialisation of children. She notes the theoretical diversity in approaches ranging from behavioural and psychoanalytic viewpoints to more specific theories of language acquisition (Chomsky, 1959) in the socialisation literature. Theories of language acquisition were characterised by the relatively low importance of parents whereas attachment theory (Bowlby, 1980) which conversely elevated the role of parents, particularly mothers.

Developmental theories now focus on the interactional nature of parent-child relationships and on more cognitive aspects of the socialisation process which are reflected in the theories termed social learning (Bandura, 1962), social cognitive (Bandura, 1985) and social interactional (Belsky, 1984; Patterson, Reid and Dishion, 1992).

The shift in focus from the early behavioural and psychoanalytic theories to a more integrated developmental theory has led to a renewed interest in parental attitudes and beliefs (Bugental, Mantyla and Lewis, 1989; Newberger and White, 1989). This interest has been influenced by a more sophisticated construction of parental cognitions, that is, attribution processes in caregiving relationships and the consequences for children of such processes.

Recent studies indicate that parental beliefs about their own parenting or about child behaviour may have a marked effect on the way parents perceive and respond to their children's behaviour (e.g. Bugental and Shennum, 1984; Dix and Grusec, 1985; Dix, Ruble and Zambarano, 1989; Goodnow, 1988; Geller and Johnston (in press)). In an

attempt to integrate the literature on parental attributions, the following review is divided into three areas relating to behavioural consequences, emotional consequences and the concept of perceived control within parent-child relationships.

The field is dominated by the work of Daphne Bugental and her colleagues (e.g., Bugental and Shennum, 1984; Bugental, Blue and Cruzcosa, 1989; Bugental, Mantyla and Lewis, 1989; Bugental, Blue and Lewis, 1990; Bugental et al., 1993) and by Theodore Dix and his colleagues (e.g., Dix and Grusec, 1985; Dix, Ruble and Zambarano, 1989; Dix, 1991). Both have undertaken extensive empirical studies to support their theoretical advances and their publications provide thoughtful reviews addressing the complex field of parental attributions applied to distressed and maltreating families from a developmental perspective as advocated by Howes and Cicchetti (1993).

4.2.1 Parental attributions and affect

As research into parental attributions has developed, attention has been directed to the influence of such cognitions on affect, within both normally functioning and 'distressed' families (Bugental et al., 1993). The main theme of this research has been that parental responses to their child are mediated by parental interpretations of the child's behaviour, not merely by how the child acts. Studies show that negative affect in parents may follow from their interpretations of children's behaviour (e.g. Dix et al., 1986, 1989; Geller and Johnston, in press).

In comparative studies of adult relationships, individuals in highly distressed marital relationships are more likely to blame their partner for negative events in the relationship, and minimise their own responsibility for such difficulties (Fincham, Beach and Baucom, 1987). Similarly, in parent-child relationships, it has been shown that parents' emotional response may be dependent on the inferences made about the

child's intentions to behave badly and control over such 'difficult' or negative behaviours (Dix and Grusec, 1985). For example, mothers reported that they would feel more upset when they attributed the child's behaviour (represented in a series of vignettes of child misconduct) to dispositional and controllable causes (Dix and Grusec, 1985). Dix (1991) suggests that parents from distressed families experience high levels of negative emotion due, in part, to how parents appraise negative child behaviour.

Studies indicate that abusive mothers and mothers of antisocial boys attribute negative child behaviours to dispositional (Internal and Stable) factors more often than do comparison groups of 'normal' mothers regardless of whether they are explaining their own child's behaviour, or an analogous child described in a vignette (Bauer and Twentyman, 1985; Larrance and Twentyman, 1983; see also Patterson, 1982).

Maternal depression is a commonly associated feature of distressed families (e.g. Radke-Yarrow, 1990; Hops et al., 1990; Dix, 1991) and has been shown to have an effect on parental attributions about child behaviour. Studies have shown that, compared with non-depressed mothers, depressed mothers see their children's behaviour as more aversive and maladjusted (Griest, Wells and Forehand, 1979; Schaughency and Lahey, 1985). Once established, these negative attributions may induce negative emotion in parents even when the child's behaviour is not particularly negative (Mash and Johnston, 1982, 1990).

In a recent study of mothers of 5 - 12 year old children with conduct problems, maternal depressed mood was associated with attributing children's negative behaviour to causes which were Internal and Controllable to the child. Mothers who attributed causes in this way also indicated more negative anticipated behavioural responses to the child. In this study (Geller and Johnston, in press), mothers were given vignettes of mother-child situations resulting in a negative consequence for either mother or

child. Mothers were then asked to provide attributional ratings regarding the cause of each problem situation, along dimensions of internality, stability and controllability. Anticipated behavioural responses were measured by asking mothers what they would do if each of the situations actually occurred.

The authors acknowledge that the predicted relationship between mothers attributions and behavioural responses was only partly supported due to the ambiguous nature of the problem situation, unlike previous research, where the description of the child's behaviour is clearly inappropriate. For example, Dix and Grusec (1985) used clear 'norm violation' behaviour such as stealing, lying or fighting, and failures to be altruistic such as not helping, sharing or being sensitive to others.

As with most studies investigating the relationship between parental attributions and affect or behaviour, this study is hampered by the authors' own admission, by the analogue nature of the research paradigm. However, studies such as Geller and Johnston's point to the heuristic value of undertaking research on the relationship between maternal depression, maternal attributions and behavioural responses.

4.2.2 Parental attributions and behaviour

Dix and his colleagues (Dix and Grusec, 1985, Dix et al., 1989) found that mothers indicated they would use more 'power-assertive' discipline strategies when they inferred, from vignettes of child behaviour, that the child was responsible for the negative outcomes. Dix (1991) reports that there is emerging evidence, primarily from research with distressed mothers, that strong negative emotions (usually depression) have a negative effect on parental cognitions and subsequently affect parenting judgements and parental behaviour. Depressed mothers have been shown to be less attentive and monitor their children less than non-depressed mothers (e.g., Cox, Puckering, Pound and Mills, 1987), although whether this is mediated by causal

attributions is not addressed in these studies (see section 2.3.5 regarding maternal depression).

Parental beliefs about the causes of 'difficult' (non-compliant) child behaviour may also influence how well they cope with their child's behaviour (e.g., Affleck, Allen, McGrade and McQueeney, 1982; Stratton and Swaffer, 1988). Bugental et al., (1993) link such research with that of the social information-processing models developed in the study of the peer and other interpersonal relationships of children. This model essentially construes attributions (hostile attributional bias) as a central organiser of aggressive responses within such relationships (Dodge and Coie, 1987).

The role of attributions in distressed interpersonal relationships, particularly marital couples is relatively well-established (e.g. Holtzworth-Munroe and Jacobson, 1985; Fincham, 1985; Fincham and Bradbury, 1988; Miller and Bradbury, 1994), however studies of parental attributions ha been less productive. Some of the findings from research on distressed couples attributions have shed light on a number of issues which are relevant to the study of parental attributions.

First, attributions may be related to the emotional impact of partner behaviour, which in turn affects behavioural responses to partners (e.g. Fincham and O'Leary, 1983; Bradbury and Fincham, 1990, 1992). The importance of emotional appraisals on coping has also been described (see section 4.1.2). Second, dimensions of causal attributions have been found to distinguish between distressed and non-distressed marital couples (e.g. Holtzworth-Munroe and Jacobson, 1985, Fincham, 1985).

Third, the actor-observer bias (Jones and Nisbett, 1972) whereby people attribute their own actions to situational (external) factors and others actions to internal causes, may not hold true for attributions about significant others, such as partners or family (e.g., Larrance and Twentyman, 1983; Fincham, Beach and Baucom,

1987). Fourth, the link between 'maladaptive' attributions and behaviour within marital relationships has been confirmed (Fincham and Bradbury, 1988), however there remains some ambiguity about the exact nature of this relationship. Some studies suggest that the association is stronger in nondistressed couples (Fincham, Beach and Baucom, 1987) and others suggest it is stronger in distressed spouses (Miller and Bradbury, 1994).

Finally, the importance of considering attributions for partner behaviour *relative* to those for one's own behaviour is another important contribution to the study of attributions in distressed relationships. The related concept of a 'negative attributional bias' in which less benign attributions for partners are made than for self (Fincham, Beach and Baucom, 1987) may also apply to parent-child relationships.

Parental attributions as 'organisers' of behaviour

When considering maladaptive parental beliefs, the notion of attributions as 'organisers' or mediators of behavioural responses in caregiving situations is central to the research linking parental beliefs to parental behaviours. The following studies support this link and provide evidence for a transactional model of child physical abuse proposed by Bugental, Mantyla and Lewis (1989) which highlights the role of parental causal attributions.

It has been shown that the beliefs parents hold about the causes of 'difficult' child behaviour may influence the success of their coping responses (Affleck, Allen, McGrade and McQueeney, 1982). Mothers of 43 infants with severe perinatal complications were asked about their beliefs regarding the causes of these medical problems. They found that maternal parity was related to causal attributions, with mothers of first-born babies more likely to blame others and to attribute the complications to external factors, than mothers of later-born children, who were more

likely to blame themselves for the infant's condition. The mothers who blamed their own behaviour (e.g. smoking, exertion during pregnancy) for their infant's medical problems reported more positive mood states and expected to have less difficulty coping with the infant, than mothers who attributed the causes to others (e.g. obstetric error, delay in special care procedures).

The authors link this to the 'just world' hypothesis (Lerner and Miller, 1978), whereby blaming and feeling resentful to others for negative events is seen to threaten a just world view leading to more negative perceptions of events, and poorer coping responses, than those who take responsibility for negative outcomes. The relevance to the present study is that mothers expected to cope better with their child's disability in the long term when they attributed the cause to Internal factors. It is possible that perceived control over the outcome had more to do with this effect, however the Control dimension of causal beliefs was not specifically measured in this study. Much of the research referring to attribution theory employs the dimensions of Control and Internality interchangeably, when arguably, they address different facets of causal beliefs.

Parental attributions and child abuse

The following studies address parental attributions in the context of child abuse. They focus on maternal causal attributions and the distinction between abusive and non-abusive groups. Larrance and Twentyman (1983) compared the attributions for children's behaviour in three groups of 10 abusive, neglecting and non-abusive mothers. Mothers in this study were asked to respond to a series of standardised photographs depicting their own and an unrelated child (mean age 4.5 yrs) in various situations, some involving child transgressions or misbehaviour (such as broken toys, drawing on walls). Following presentation of the photographs, mothers were asked to

tell a story about their child's behaviour in the photographs and then asked to predict what had happened.

In order to assess causal attributions, mothers were then asked to explain why their child would behave in certain ways in these situations. Attributions were coded for Internal and Stable dimensions on a scale of 1 to 9 (1 = Internal, 9 = External). Using these two dimensions only, Larrance and Twentyman (1983) found support for their hypothesis that there would be a significant tendency for abusing and neglectful mothers to make more internal and stable attributions than comparison mothers for negative child behaviours (i.e. when their own child had transgressed). They did not find the expected difference in attributions between the abusive and neglectful mothers.

Larrance and Twentyman (1983) suggest that their findings indicate that there are systematic differences in the attributions made by abusive and non-abusive mothers, with abusing/neglectful mothers making attributions to dispositional (internal and stable) causes for child transgressions. This combined with negative expectations for children's behaviour are seen to represent a cognitive bias or distortion which may contribute to child abuse. This distortion can be seen in the attribution of negative behaviours to dispositional causes in young children for whom there should be a protective bias (Dix and Grusec, 1985).

There are some methodological criticisms of this study that need to be addressed, however, the importance of the finding that there are differences between abusive and non-abusive mothers in their causal explanations for child behaviours need not be negated. Firstly, the process of extracting and coding attributions from taped interviews was not made explicit, and it was implied that their reliance on the experience of the authors in the field of attribution research which may limit its applicability to other studies. Secondly, the number of causal attributions on which ratings were made was not presented. Mothers were asked for explanations about five

specific, hypothetical situations, however it remains unclear how many causal statements were extracted. Thirdly, it is not clear that attributions about hypothetical situations relate to attributions about real-life negative events. Fourthly, dimensions such as Controllability and Globality were not included in the coding of attributions. Given the importance of control and power, particularly in abusive families, it is unfortunate that a dimension for control over outcome was not included in this analysis. This relates to the final criticism which is that attributions for the mothers' own behaviour in different caregiving situations were not sought or examined.

A further study by Bauer and Twentyman (1985) revealed attributional differences between physically abusive and neglectful mothers (n=24) and non-abusive mothers (n=12), using taped vignettes of parent-child situations. The attributional measure in this study consisted of asking mothers to what extent they thought their child had acted malevolently in the different situations, (such as the child being hurt, or child engaging in 'intentional rule breaking'). Bauer and Twentyman (1985) suggest that their findings indicate that the abusing mothers were most likely to believe that their child was acting intentionally to annoy them, and that this finding is linked to the previous research (Larrance and Twentyman, 1983) indicating that physically abusive mothers 'misattribute' their children's behaviour, which in turn increases the likelihood of violence towards the child. This study is subject to the same criticisms as above, however the authors suggestions that abusive parents may display some form of cognitive bias towards their child and a greater reactivity to negative child behaviours are plausible.

The notion of high reactivity to unresponsive or difficult children has been confirmed in a study by Bugental et al., (1993). In a study of 160 mothers of school age children, those mothers who felt that they had low control over negative outcomes (as measured by the Parent Attribution Test) were highly reactive to negative child behaviours, and showed high levels of 'defensive arousal' (increased heart rate and skin conductance).

Although this study did not specifically look at abusive mothers, previous studies have indicated that mothers who attribute low control to adults for negative parent-child interactions are more likely to have parenting difficulties, including child physical abuse (e.g., Bugental, Mantyla and Lewis, 1989; Bugental, Blue and Lewis, 1990).

Stratton and Swaffer (1988) used the Leeds Attributional Coding System (LACS) (Stratton, Munton, Hanks, Heard and Davidson, 1988) to investigate causal attributions in abusive and non-abusive mothers, and a further group of mothers of handicapped children. The abusive mothers were more likely to make Internal attributions for child behaviour and External attributions for their own behaviour. In addition, abusive mothers were twice as likely to ascribe Control to their child for child behaviours. Stratton and Swaffer suggest that the pattern of attributions (Internal and Controllable) by abusive mothers would lead to a "powerful tendency to blame the child when things go wrong" (1988, p.210). Unfortunately, the valence of the outcomes of the attributional statements coded was not presented, and so it is unclear whether both positive and negative outcomes were coded separately or together. As most of the literature to date has focussed on attributions for child *mis*behaviour or caregiving *failures*, it would have been helpful for data relating to negative and positive attributions to be analysed separately. The study by Stratton and Swaffer does support the growing literature indicating the importance of investigating parental attributions in families where abuse has taken place. In addition, Stratton and Swaffer (1988) used a systematic coding system, the Leeds Attributional Coding System to identify and code causal attributions, and highlights the importance of investigating parental attributions for self, as well as for child, particularly on the dimension of controllability.

A further study by Silvester and Stratton (1991) showed attributional discrepancies in a small group of abusive (n=9) compared to non-abusive mothers (n=15). Mothers were interviewed and the LACS (Stratton et al., 1988) was used to code attributions

on five dimensions (Stable, Global, Internal, Personal and Controllable). This study focussed on negative outcomes only, and indicated that the abusive mothers attributed more control to their child than to themselves for negative outcomes, suggesting that the dimension of Controllability is an important variable in attributional studies in child abuse research.

The work of Fincham, Beach and Baucom (1987) highlighting the importance of relational attributions and of Bugental et al., (1993) which focuses on the control dimension suggests that the discrepancy of control attributed to parent compared to child is an important direction for future research in parental attributions.

The perception of control, and in particular, the discrepancy between control to child and control to parent, is central to the transactional model of child abuse proposed by Bugental and her colleagues (Bugental, 1987; Bugental, Mantyla and Lewis, 1989), (see Figure 4.i below). This model is based on Bugental and Shennum's (1984) model of parent-child interaction which identifies causal attributions as modifiers of communication within caregiving situations. They showed that mothers with low self-perceived power as caregivers were selectively reactive to child unresponsiveness, and that the parental communication pattern (characterised by negative affect and low assertion) maintained unresponsive child behaviour.

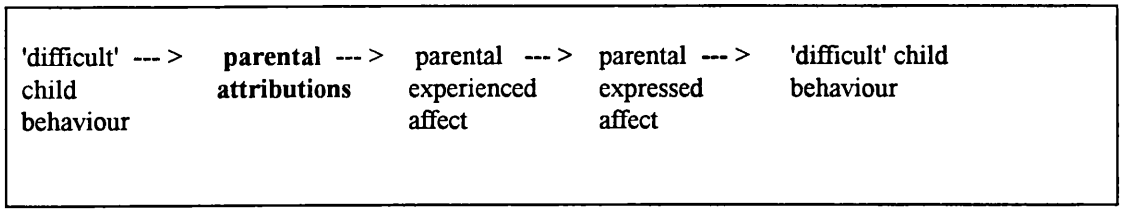

Figure 4.i: Model for role of attributions as 'moderators' in parent-child interactions. (Bugental, 1987).

In extending this model to abusive parental behaviour, Bugental (1987) suggests that certain parental causal beliefs (low control to self and high control to child for

negative outcomes) may sensitize the parent to negative child behaviour, thus increasing the risk of abuse. In keeping with attribution theory, Bugental, Mantyla and Lewis (1989) suggest that attributions are likely to be of most importance in caregiving situations which are ambiguous or aversive.

Attributions are seen to moderate parental reactions to the stressful situation at two levels, at an initial preconscious level and at a controlled level of cognitive appraisal (Bugental, 1992). Precognitions are suggested to operate at an automatic or unaware level and may heighten parental sensitivity to certain negative behaviours of the child. In this way, the role of early experiences of the mother may be seen to be an important influence on the way she interprets ambiguous or negative caregiving situations.

This is consistent with ecological models of child abuse (Belsky, 1980; Belsky and Vondra, 1989) which highlight the role of an individual's own history of care in their subsequent parental functioning. Similarly, childhood experiences have been shown to lead to depression and to selective recall of negative life events (Brewin, 1989), which may influence their attributions regarding current life events.

Bugental (1992) suggests that parents who have a schematic representation of the parent-child relationship which consistently places them in a position of low power will show more adverse reactions, that is, defensive arousal and negative affect, than parents who do not show this 'chronically accessible schema' (Bugental, 1992). It appears that, in this model, the automatic cognitions which produce the physiological reactivity to negative child behaviour (Bugental and Cortez, 1988), may 'prime' the mothers to appraise these behaviours in a negative light, thus maintaining this distressed pattern of interacting and culminating in physical abuse of the child.
In summary, although it seems unlikely that all situations in which there are power discrepancies will lead to physical abuse, the consideration of other dimensions of causal beliefs may be enlightening.

The model proposed by Bugental, Mantyla and Lewis (1989) provides a useful framework within which to conduct research on parental attributions in abusive families.

Consistent with ecological and other transactional models of child maltreatment, Bugental et al., (1989) also incorporate the role of external stressors (such as social and economic disadvantage) in exacerbating the chances of actual abuse. Bugental et al., (1993) have focussed on the perceived power held in the parent-child relationship, as a particularly salient feature of parent's cognitive constructions of their relationship with their child. They highlight the important concept of control over outcomes, particularly negative or 'failure' events. Although it is unlikely that a perceived power disadvantage necessarily leads to abuse, it has been shown to predict defensive arousal and negative affect towards the child (Bugental, Blue and Lewis, 1990) and is related to other negative caregiving outcomes (see next section 2.3.3 on Parental attributions and perceived control).

4.2.3 Parental attributions and perceived control

Perceptions of control over negative events have been central to much of the work applying attributional theory to clinical problems and were an important component of the original reformulated learned helplessness theory of depression (Abramson et al., 1978). Generalised beliefs about control are seen to be important influences on how a person appraises stressful life events (e.g. Lazarus and Folkman, 1984). Parents may experience stronger negative emotion with children if they feel they are out of control or unable to cope with their child and 'distressed' mothers evaluate their own parenting less favourably than non-distressed mothers and believe that they are unable to control parent-child situations (Bugental et al., 1993).

Bugental and her colleagues (Bugental and Shennum, 1984; Bugental, Blue and Lewis, 1990; Bugental et al., 1993) have highlighted the importance of interpersonal power in parent-child interactions. They developed the concept of 'perceived control' within family relationships, referring to the *relative* power a parent feels she has compared to her child. The parent-child relationship schema is conceptualised within an attributional framework in terms of Control attributed to self versus Control to child. This model emphasise the relational nature of perceived control, and the concept of low perceived control persisting due to the presence of 'chronically accessible schema' (Bugental, 1992). It is hypothesized that these schema operate automatically in their influence on both emotional and autonomic processes. In a study of 160 mothers, categorised as high or low in perceived control (PC) according to their scores on the Parent Attribution Test (PAT) (Bugental, Blue and Cruzcosa, 1989), it was shown that women with low-PC were more reactive to computer-simulated child interactions as measured by increased negative affect and higher heart rate and electrodermal activity than high-PC subjects (Bugental et al., 1993).

The Parent Attribution Test (Bugental, Blue and Cruzcosa, 1989) was designed to measure perceived causes of caregiving outcomes and provides scores categorising parents as high or low on perceived control, on the basis of the extent to which parents feel that events are under their own control, or their child's. Parents who attribute high control to children and low control to adults for hypothetical caregiving 'failures' were more likely to have parenting difficulties, including child physical abuse (e.g. Bugental, Blue and Cruzcosa, 1989, Bugental, Blue and Lewis, 1990). Limitations of the PAT are discussed in a later section regarding measurement of attributions..

Studies show that abusive mothers often feel they have less power than their children do (Bugental, Blue and Lewis, 1990; Silvester and Stratton, 1991). This perceived power reversal can lead to increased sensitivity and reactivity to negative child behaviours and increasingly coercive parental control strategies (Bugental et al., 1993).

Although not directly tested, it is conceivable that mothers who perceive this power imbalance, may react negatively to fairly neutral child behaviours because they develop negative expectations about interactions with their child (e.g. Mash and Johnston, 1990), possibly due to the presence of negative schema which are accessed automatically (Bugental, 1992).

Beliefs about control over children's behaviour can distinguish distressed from non-distressed mothers. For example, Rosenberg and Reppucci (1983) showed that abusive mothers were more self-critical than non-abusive mothers. Interestingly, in this study, the authors found no group differences between abusive and non-abusive mothers in attributions of intent (Control) and disposition to three vignettes of negative child behaviour (child crying, child breaking an object, disobedience). The small sample size (total of 24 mothers) makes this finding difficult to generalise. It is also difficult to ascertain the nature of the comparison, or non-abusive group, who were identified by social workers as having 'problems in parenting', although they were not suspected of abuse or neglect.

Physically abusive mothers have also been described as feeling that they had less control over outcomes in parent-child interactions (Bugental, Blue and Cruzcosa, 1989). Given the difficulty that coercive and distressed parents have eliciting compliance from their children (Patterson, 1982), these parents may also develop beliefs about their own lack of efficacy and parental competence (Dix, 1991).

Most research on parental attributions in child abuse have focussed on the difference between abusive and non-abusive mothers. One difficulty with this is that some of the 'abusive mothers' have included mothers who had a child registered for physical abuse or neglect, but may not have perpetrated the abuse themselves (e.g. Stratton and Swaffer, 1988). There may additionally be 'undiscovered' abusive behaviour perpetrated by mothers in the 'non-abusive' group. Another issue is that non-abusive

mothers were the default or comparison group, rather than the main focus of the research, so their attributional patterns may not have been presented. In the field of child sexual abuse, it is often the non-abusive parent (mostly mothers) who are the primary caregivers after the abuse has come to light.

The focus of all the research presented so far, in the field of parental attributions and child abuse, has focussed on physical abuse and neglect. When studies address attributions and sexual abuse, they tend to use analogue methods such as asking professionals or college students to rate vignettes. To date, there has been no published work specifically addressing the important arena of parental attributions, in families where children have been sexually abused. In particular, there appear to be no studies addressing the attributions of non-abusive parents, i.e. the parent who is likely to be the primary caregiver following abuse. This is likely to be a reflection of the difficulty in carrying out such research.

This review has highlighted some of the difficulties in applying attribution theory to clinical fields, while stressing its relevance, particularly in the field of child maltreatment. Historically, research on parental attributions has relied on simplistic constructions of blame and responsibility. There have been few attempts to address the full range of dimensions of causal beliefs, or to employ systematic methods to identify and code spoken attributions. The work of Bugental et al., (1993) who have developed both theoretical and empirical advances, and the use of coding systems to identify attributions (Stratton et al., 1988) are important developments in this field.

4.3 Attributions and sexual abuse

Some studies have looked specifically at attributions in the field of sexual abuse and are summarised in Table 4.i. This review included unpublished studies (such as Celano, Webb and Hazzard, 1992) as no other studies addressing parental attributions

in child sexual abuse were found. One further study by Dietz and Craft (1980) sent a survey to 200 child protection workers in Iowa, but did not report on the response rate, or on the number of families about whom surveys were returned. Subjects were asked to agree or disagree with statements about incestuous families (which were not reported in the study), and therefore it is unclear whether this study investigated attributions.

Most studies assessed attributions by asking professionals or college students to make attributions about why child sexual abuse had occurred, predominantly in hypothetical cases of father-daughter incest. Only one study (Morrow, 1991) included a sample of victims of sexual abuse. In this study, a relationship was found between girls who were said to make Internal attributions for sexual abuse (e.g., *I was just unfortunate, I was dressed improperly*) also reported low self-esteem and greater depression (as measured by the Beck Depression Inventory, Beck and Steer, 1987). The criteria used for rating attributions on dimensions of internality and situation or offender characteristics was not made explicit, but clearly other dimensions such as Control may be important mediators in the reported maladjustment of girls who reported Internal attributions for their own abuse. For example '*I was just unfortunate*' indicates an Uncontrollable attribution, whereas '*I was dressed improperly*' indicates a degree of Control over the outcome (i.e., this is a complex attribution).

Authors	Field of study	Sample	Measures
Celano, Webb and Hazzard, 1992.	Parental attributions of responsibility for child sexual abuse. Pilot study for the Parent Attribution Scale.	n = 41 Primary caretakers of school age female victims of child sexual abuse.	Non-standardised PAS. 53-item self-report scale yielding subscales of Child Blame, Perpetrator Blame, Self-Blame and Negative Impact.
Collings and Payne, 1991.	Attributions to victims of father-daughter incest.	n = 480 psychology undergraduate students, 17 - 33 years of age.	Case vignettes followed by 2 single items to measure Causal Responsibility and Moral Blame. Items scored on a 5-point Lickert scale.
Doughty and Schneider, 1987.	Attribution of blame in incest among mental health professionals.	n = 106 students, psychology graduates and clinical psychologists.	Jackson Incest Blame Scale of 20 statements scored on a scale of 1 to 6.
Jackson and Ferguson, 1983.	Attributions of blame in incest. Development of the Jackson Incest Blame Scale (JIBS).	n = 412 psychology undergraduate students (201 male and 211 female).	JIBS devised to investigate four factors of blame in incest: situation, society, victim, offender. 20 item questionnaire as above.
Morrow, 1991.	Attributions of blame in female adolescent incest victims.	n = 84 female victims of incest, 12 - 18 years of age.	S's asked to respond to *'when I ask myself why this happened to me...'*; answers content analysed.
Reidy and Hochstadt, 1993.	Attribution of blame in father-daughter incest.	n = 101 mental health professionals.	20 item JIBS questionnaire used.
Ringwalt and Earp, 1988.	Attribution of responsibility in father-daughter incest.	n = 313 child protection service workers.	Vignettes of cases rated by S's on degree of responsibility to father and daughter

Table 4.i: Review of studies on attributions in child sexual abuse.

Most studies have used a simplistic notion of blame or responsibility as unitary concepts which can be measured using questionnaire methods. The Jackson Incest Blame Scale (Jackson and Ferguson, 1983) has been used in a number of studies to investigate the particular case of incest. It contains items such as *'There is a strong connection between the current morality and the crime of incest'* and *'Offenders are driven to incest by internal factors'*.

While it is worthwhile investigating the attributions of mental health professionals for both hypothetical and abstract cases of incest, our knowledge of mediating factors in child adjustment following such abuse is unlikely to be enhanced by these studies.

Studies investigating attributions for adult sexual abuse or rape have also used student populations to identify attributions of blame. For example, Whatley and Riggio (1993) used a vignette describing male rape to investigate gender differences in attributions of blame in 160 psychology undergraduate students (mean age: 19 years). A select few studies have used actual clinical samples investigating attributional processes in marital violence involving victims of marital violence (e.g., Andrews, 1992; Andrews and Brewin, 1990), and victims of non-marital rape (e.g., Janoff-Bulman, 1979; Medea and Thompson, 1974).

This thesis seeks to address the gap in the literature which has failed to directly explore parental attributions in families where child sexual abuse has taken place.

4.4 Measuring causal attributions

Introduction

To date, the research in attribution theory, has depended heavily on questionnaire-based approaches to measure attributions. As noted earlier, when attribution theory has been applied to clinical areas such as child sexual abuse, vignettes and rating scales are by far the most common method used to assess causal beliefs. These provide parsimonious but somewhat simplistic constructions of individual attributions, and may reflect the experimenter's beliefs about which causes are important more than they do the respondent's.

Following a brief review of the questionnaires used in attribution research, this section considers the measurement of spoken attributions and an introduction to the Leeds Attributional Coding System (Stratton, Munton, Hanks, Heard and Davidson, 1988).

4.4.1 Questionnaire based approaches

Rating scales have been used in attribution research largely because they have the methodological advantage of interval properties which allows the use of parametric statistical tests (Hewstone, 1989). The criticisms of this approach focus on the lack of validity and neglect of the usual way in which people make explanations on a daily basis (e.g. Kelley and Michela, 1980). These criticisms might also apply to the questionnaires used to measure attributions in various groups.

4.4.1.1 Attributional Style Questionnaire

The Attributional Style Questionnaire (ASQ) is perhaps the best known of questionnaire approaches to the measurement of causal attributions, developed by Martin Seligman and colleagues at the University of Pennsylvania.

Attributional style is seen as a personality characteristic in which a person has a tendency to attribute cause in a certain and similar way, across situations. (Peterson, Semmel, von Baeyer, Abramson, Metalsky, and Seligman, 1982; Seligman, Abramson, Semmel, von Baeyer, 1979). In the reformulated learned helplessness theory, Abramson et al., (1978) argue that three attributional dimensions are crucial for understanding the depression: internal - external, stable - unstable and global - specific. The ASQ asks respondents to explain twelve hypothetical events along these three dimensions of cause for six positive and six negative situations (see Figure 4.ii), after being asked to 'vividly imagine' themselves in the situation.

Example of item from ASQ:

YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME:

1. Write down one major cause

2. Is the cause due to something about you or something about other people or circumstances? (Circle one number).

1	2	3	4	5	6
Totally due to other people or circumstances					Totally due to me

3. In the future, will this cause again be present? (Circle one number)

1	2	3	4	5	6
Will never again be present					Will always be present

4. Is the cause something that just influences this cause, or does it also influence other areas of your life? (Circle one number).

1	2	3	4	5	6
Influences just this particular situation					Influences all situations in my life

Figure 4.ii: Sample item from ASQ (Seligman et al., 1979).

The nature of the situations include: becoming very rich, applying successfully for a job, getting a pay rise, being complimented on appearance, being treated lovingly by a partner, giving an important talk, going on a date etc. These situations may only be applicable to certain normative populations, and have proven difficult to use with some clinic populations (e.g., Stratton and Swaffer, 1988) although others have found it useful (e.g., Gold, 1986).

One disadvantage is that only a small number of attributions (6 positive and 6 negative) based on hypothetical outcomes are sampled from each person. There is a danger that the outcomes will be rated on the three dimensions provided, rather than the cause generated by the respondent, as the instructions may not be easy to follow for non-college graduate populations on which the questionnaire was constructed.

The depressive attributional style, described by Seligman and his colleagues (Seligman et al., 1979; Peterson and Seligman, 1984) of Internal, Stable and Global causes for negative outcomes has been correlated with higher scores on depression as measured by the short form Beck Depression Inventory (BDI; Beck, 1967) and the Multiple Affect Adjective Check List (MAACL; Zuckerman and Lubin, 1965) as reported by Seligman et al., (1979).

The value of the ASQ as a measure, and the concept of a stable 'attributional style' has been questioned by the lack of evidence for cross-situational consistency of attributional patterns within individuals (Cutrona, Russell and Jones, 1985). However, Burns and Seligman (1989) recently suggested that individual attributional styles for negative events persist across the lifespan. The relationship between attributions to Internal, Stable and Global causes for negative events and depression has been reported to be a reliable one by Sweeney, Anderson and Bailey (1986) in their meta-analytic review of this relationship.

What remains unclear from this review is how the different attributional measures are used to rate each of the three causal dimensions. The reported effect sizes between the depressive attributional style and depression were greater for psychiatric patients than for college students or non-students who were depressed however, Sweeney, Anderson and Bailey (1986) point out that the correlations between attributions and depression do not help with the debate over the causal role of attributions in depression (see Brewin, 1985 for a review of the relationship between causal attributions and depression).

4.4.1.2 Parental Attribution Test

The Parent Attribution Test (PAT; Bugental, Blue and Cruzcosa, 1989) is a questionnaire designed to measure perceived causes of positive and negative outcomes

in parent-child situations. The original PAT (Bugental and Shennum, 1984) was based on free responses by parents (mothers only) to questions about causes of caregiving outcomes. The revised PAT is based on a multidimensional scaling analysis of these responses and the two primary attributional dimensions which emerged relate to control and locus (i.e. internal-external). The PAT yields separate scores for Perceived Control (PC) for the mother and child and respondents may be categorised as high PC or low PC, depending on whether they are above or below the group median scores. Attributions for negative or failure outcomes have been found to be predictive of dysfunctional interactions with children by Bugental and her colleagues (e.g., Bugental, Blue and Cruzcosa, 1989; Bugental, Blue and Lewis, 1990). The questionnaire has just two items which involve a hypothetical babysitting situation with two outcomes (positive and negative). The item asks '*Suppose you took care of a neighbour's child one afternoon, and the two of you did not get along well/ had a really good time together'*. Respondents are then asked to rate on a Likert-type scale how important they believe the factors listed are as possible reasons for such an outcome. These factors relate primarily to two dimensions of Locus and Perceived Control.

The reliability of the PAT has been demonstrated by the careful observational studies of Bugental et al., (1989, 1990, 1993). However, the analogue nature of this research limits the validity of the PAT, and the consideration of only two dimensions (Internal and Controllable) narrows its utility. Although the use of hypothetical situations may mean that the measure is not tapping into causes that are meaningful to individual respondents, the situation appears more readily imaginable by mothers than some of the items in the ASQ.

The Attributional Complexity Scale (Fletcher, Danilovacs, Fernandez, Peterson and Reeder, 1986) and the Causal Dimension Scale (Russell, 1982) were developed to look at individual differences in causal attribution, but do not appear to have been widely

used. This is likely to be due to the problems of trying to measure attributional style, or a consistent explanatory style, as a stable feature of personality.

A more appropriate method has been devised that takes into consideration that attributions are made in a social context and are thus likely to be well measured by an instrument that takes account of the dynamic quality of social interaction.

4.4.2 Spoken attributions

Hewstone (1989) and others (e.g., Harvey, Turnquist and Agostinelli, 1988) point to the disadvantages of directly requesting attributions from respondents for events nominated by the experimenter. In particular, it is difficult to assess how people attribute normally or spontaneously in everyday language. Weiner (1985) reviewed the literature on 'spontaneous' causal thinking by looking at studies in which normal (verbal) behaviour was studied unobtrusively. This involved the following type of studies: i) Coding of written material, ii) Experimental subjects being asked to 'think aloud', and iii) Causal search inferred from cognitive processes, in which information was more likely to be selected when events were unexpected (Pyszczynski and Greenberg, 1981). Harvey, Yarkin, Lightner and Town (1980) introduced another method of measuring spontaneous or 'unsolicited' attributions, by asking subjects to write down any thoughts they had while watching a video of actors behaving in unusual or negative ways.

While these methods all seem rather unsophisticated, they helped clarify under what conditions attributions most likely to be produced. That is, when the events being explained are novel, unexpected and unpleasant (e.g. Hewstone, 1989; Weiner, 1985) . Weiner's (1985) review suggests that spontaneous attributions are important in everyday life and that certain factors are more likely to instigate attributions than

others, this has led to an important development in the study of social cognitions as they occur in interactions.

The term 'spontaneous' attributions may be misleading, especially with the development of more cognitive models of parental attributions (Bugental, 1992), which include the concept of 'automatic' causal schema. A better term is 'spoken attributions' which are as they imply, those explanations provided by individuals in interactions with others.

One method of measuring attributional style from spoken attributions was developed in a similar way to the Attributional Style Questionnaire. The CAVE (Content Analysis of Verbatim Explanations) was developed by Seligman and his colleagues to assess explanatory style in populations that "cannot or will not take questionnaires" (Schulman, Castellon and Seligman., 1989, p.505). The nature of such resistant populations is not expanded upon, but questionnaires can be intrusive and threatening to clinical or other sensitive populations under study and the development of more naturalistic measures of attributions made in conversation seem to be a useful way forward.

An advantage of identifying attributions from free response is that they are less likely to be influenced by the highly structured nature of questions designed to elicit causal beliefs thereby reducing response bias. Harvey, Turnquist and Agostinelli, (1988) suggest that 'free response' methodology is particularly useful to identify attributions, when the topic under consideration is to be studied with resistant populations or sensitive topics. Harvey et al., (1988) highlight the importance of confiding, as a process in which an individual can assimilate a traumatic experience in much the same way that making sense of negative events (i.e. making attributions) can alleviate a sense of uncontrollability about one's environment, thus making account-giving a sensitive research tool for the study of causal attributions.

Hewstone (1989) points to an increasing interest in the study of social cognitions and attributions in more naturalistic settings, and this is a major advantage of the Leeds Attributional Coding System (Stratton et al., 1988) developed to measure and code attributions produced in natural discourse.

4.4.3 Leeds Attributional Coding System: Coding causal beliefs in natural discourse.

The LACS was developed by the Leeds Family Therapy and Research Centre (Stratton et al., 1988) in their clinical work with dysfunctional families. It represents a major breakthrough in the coding and analysis of causal attributions in natural discourse and in clinical settings, and was developed with psychology clinicians and researchers in mind. Based on the reformulated learned helplessness theory (Abramson et al., 1978), the LACS was designed to analyse spontaneous or spoken attributions in natural discourse.

The most common dimensions used in attribution theory research originated from the work of Heider (1944, 1958) and Weiner (1986) in their work on the underlying dimensions of causal beliefs. These dimensions of Global-Specific, Stable-Unstable, Internal-External and Controllable-Uncontrollable are used in the LACS, in addition to a new dimension, Personal-Universal. This dimension is an extension of the internal-external dimension and measures the extent to which a person believes that any aspect of an attribution (cause, link or outcome) is unique to the person being rated (i.e. Personal) or is shared by most other people in their reference group (i.e.Universal). Another unique feature of the LACS is that it allows for dimensions of cause to be rated for the speaker of the attribution, as well as for the target (i.e., the person nominated by the speaker in the outcome or event) of the attribution.

Table 4.ii. provides a summary of the main features of the LACS

LACS dimensions	**Brief Description**
1. Stable - Unstable	This dimension refers to the enduring nature of the cause and whether such a cause is likely to operate for future outcomes of similar nature. *e.g. I failed the exam <u>because I am stupid</u>* would be rated Stable, whereas *I failed the exam <u>because I had a cold</u>* would be rated as Unstable as the same cause is unlikely to operate in the future
2. Global - Specific	This refers to the importance of the cause and its impact, in terms of outcome. *e.g. I can't get a job <u>because of my looks</u>* would be coded as Global as the outcome (unemployment) is a broad one, whereas *Billy can't tie his shoelaces <u>because he has still got his coat on</u>* would be coded as Specific, referring to a limited range of outcomes.
3. Internal - External	If the cause originates within the person being rated (*e.g. <u>because of his personality)</u>* it is coded as Internal. If the cause is situational (*e.g. <u>due to the rain)</u>* then it is coded as External.
4. Personal - Universal	If the cause is seen to indicate something unique to the person being rated (*e.g. <u>because of the way she talks)</u>* then it is a Personal cause. If the cause would apply to most people, it is rated as Universal (*e.g. <u>because he's only five)</u>*.
5. Controllable - Uncontrollable	A cause is coded as Controllable when the person being rated is seen by the Speaker to have control over the outcome *(e.g. <u>he refused to answer)</u>*. A cause which is Uncontrollable is one where the person being rated could not normally influence the outcome *(e.g.<u>he was feeling so poorly</u> that we didn't go out)*.
Identification of roles in the attribution	**Brief Description**
1. Speaker	The person actually making the causal attribution
2. Agent	The person nominated by the Speaker in the cause.
3. Target	The person nominated in the outcome.

Table 4.ii.: LACS dimensions and categories.

While acknowledging that 'unstructured' approaches provide the only means of studying certain groups of people, especially when dealing with sensitive areas, Harvey et al., (1988) points to some challenges in using approaches which involve coding dimensions of cause in natural discourse:

i) The possible difficulty of quantification of data. The LACS uses highly structured coding dimensions which does allow for statistical analysis.
ii) Laborious to train coders. This is partially true, the LACS does have a manual but training is recommended in view of the complex nature of the content analysis, and the possibility of adapting the guidelines for use on particular studies.
iii) As with structured methods, the issue of response bias, in the form of self-presentation may be influencing explanations given, especially in face-to-face interviews. While this is a valid concern, the response bias is reduced in the case of coding using the LACS as it is difficult to discern what the 'demand characteristics' (Orne, 1962) of the situation are. A further advantage is that the LACS can be used on retrospective material.
iv) Sample bias may be another consideration as there may be a certain amount of self-selection involved if people are asked to give accounts, or write them down. This is less relevant for a clinical group who are highly selected by nature.

In summary, the coding framework provided by the LACS represents an important methodological advance in the study of causal attributions, as they occur in conversation. It has now been used in research in family therapy (Munton and Antaki, 1988), comparing groups of mothers (Stratton and Swaffer, 1988; Silvester and Stratton, 1991), with families of schizophrenic patients (Brewin, MacCarthy, Duda and Vaughn, 1991; Brewin, 1994) and in studies investigating post-traumatic stress disorder in disaster victims (Joseph, Brewin, Yule and Williams, 1991, 1993).

One major development in attribution research is in the identification of agents and targets of attribution within the LACS enabling the study of attributions made about others to be studied. The subjective nature of social cognitions such as attributions makes them amenable to study by social methods such as interview. As causal explanations are most likely to occur in conversation, it is difficult to justify the use of vignettes and questionnaire methods used in previous research. This is particularly relevant for studies in sensitive areas such as child sexual abuse.

The research on social cognitions, and in particular, on parental cognitions regarding child behaviour, has now developed to the extent where they are seen to be important moderators of communication between parents and their children (e.g. Bugental, 1987; Bugental et al., 1993). Despite some of the methodological limitations discussed, the importance of investigating dimensions of attributions such as perceived control, and dispositional versus circumstantial causes are likely to have consequences for the way mothers respond to their children. The study of causal attributions therefore seems an important focus of research in the contribution to our understanding of the effects of child sexual abuse. The potential offered by advances by coding frameworks such as the Leeds Attributional Coding System will be critically examined in this thesis.

To conclude this chapter, it has been argued that parents in distressed or abusive families may develop negative beliefs about their children and their own parental functioning which perpetuates negative affect (e.g., Dix, 1991). In turn, such negative cognitions may lead to maladaptive communication patterns, which may further undermine distressed mothers sense of control (Bugental, Mantyla and Lewis, 1989).

The role of causal attributions as organisers or mediators of maternal affective responses to children, has considerable support, and offer models at the 'cutting edge' of research on distressed interpersonal relationships within families. The methodological challenge to studies attempting to identify meaningful causal beliefs,

with a sensitive population has been identified, and new developments in the measurement of causal attributions, provide optimism for empirical progress. Given the prevalence of and concern surrounding child maltreatment in general, and child sexual abuse in particular, the study of maternal cognitions can be seen to be important to the understanding of children's developmental outcomes following abuse.

What is of interest in the current study, is to examine the attributions of non-abusive mothers who are in a 'distressed' family situation, by virtue of the fact that their child is facing a developmental challenge, that of child sexual abuse. The next brief chapter aims to integrate the diverse theoretical perspectives presented thus far.

CHAPTER FIVE

The Study

5.1 Integration of the literature

5.2 Aims of the study

5.3 Research hypotheses

V: The Study

5.1 Integration of the literature

It is no longer controversial to suggest that sexual abuse represents a developmental challenge to children. However, child sexual abuse is not a unitary phenomenon, it can vary along a number of dimensions of severity such as duration, age of onset, nature of abuse, and relationship to perpetrator. Research has tended to focus on how these variables increase symptomatology in abused children, yet a number of methodological issues undermine progress in this area. To date, little is known about which of these factors mediate the harmful effects of child sexual abuse, particularly for boys who are commonly described as responding to such abuse with aggressive and sexualised behaviour. The literature on adults who were sexually abused as children, centred around adult women abused in childhood, seems to suggest that being believed and supported is an essential component of recovery, presumably because of the impact on self-esteem and subsequent coping strategies.

Studies of child sexual abuse have previously focused on mothers roles in the onset of child sexual abuse. The potential role of mothers in a child's *recovery* from child sexual abuse is a relatively new perspective, as discussed in Chapter Two.

Developmental psychopathology theories have tended to conceptualise pathways, or trajectories of risk following adverse environmental experiences. The sexual abuse literature has focussed on the behavioural responses of mothers to their children, primarily using cross-sectional designs. For example, researchers have asked whether mothers acted in such a way as to indicate that they believed and supported their child, or did they contribute in some way to their child's abuse by being depressed, or psychologically or physically absent?

Intuitively, these appear to be important areas to study. A recent shift has been seen from the study of parental attitudes and behaviours to that of parental cognitions as important markers of the parent-child relationship (Dix, 1991; Bugental, 1992).

How might maternal attributions affect the child's risk trajectory as depicted in the simplified model below?

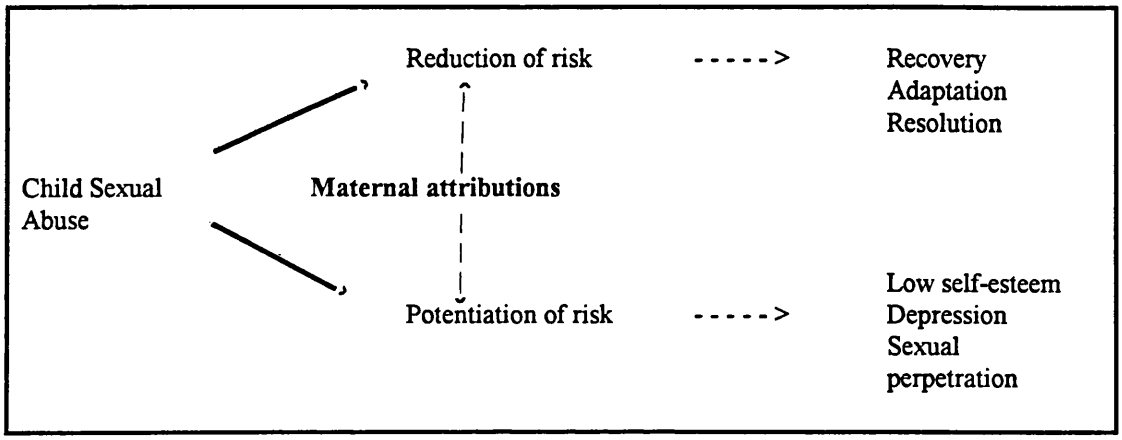

Figure 5.i: Proposed model of pathways following child sexual abuse

Attributing negative events, such as abuse, to Unstable or transitory causes (such as 'it only happened once or twice'; or 'I told him not to go round to his house that day'), may indicate minimisation of abuse which is likely to impact on a number of important factors. Low self-esteem is commonly reported in victims of child sexual abuse and may be exacerbated in children whose abuse is minimised, which in turn is a risk-factor for further psychopathology. Assuming that attributions do represent markers of parent-child interaction, minimising the effects of abuse may also influence protective action which might alter the boy's exposure to further risk of revictimisation. This demonstrates one way in which maternal attributions in non-abusive parents might lead to increased vulnerability to poor outcome for the sexually abused child.

Another example would be if negative events such as sexual abuse were attributed to causes which were Internal and Controllable to the boy.

For example is 'he is so friendly to strangers, I'm not really surprised this happened'). This may reflect a pattern of blaming the child inappropriately. Even blaming the child for his own victimisation which is traditionally seen as an inherently uncontrollable experience, this in turn may be communicated to the child. The effects of blaming and minimisation of child sexual abuse could be seen to exacerbate the child's response to abuse via the hypothesized traumagenic effects of traumatic sexualisation, betrayal, powerlessness and stigmatisation.

Obversely, a proposed positive function of maternal attributions may interrupt the negative chain of events that is described for male victims of sexual abuse. We know that not all boys who are sexually abused will be traumatically sexualised or develop into perpetrators of abuse. It is conceivable that the promotion of self-esteem and self-efficacy which are to a large extent, dependent on the availability of supportive personal relationships, is in turn influenced by the way in which mothers interpret negative events in their child's life.

It is important to recognise that establishing a definitive link between parental cognitions and parental behaviour is beyond the scope of this, and other cross-sectional studies, and remains an ongoing dilemma in the fields of social and developmental psychology. Similarly, although the model outlined above (5.i) indicates the role of attributions in a causal sequence of events, one important limitation of this study is that the direction of influence cannot be determined.

This study was designed to improve our knowledge of maternal attributions, and their potential role in the negotiation of the 'risk situation' by the male victim of child sexual abuse. It has been shown that certain types of maternal attributions act as markers of 'distress' in the parent-child relationship. It is known that parental beliefs about child antisocial behaviour can lead to and maintain patterns of family interactions involving progressively more aggressive and antisocial behaviour.

Attributions may also have an important role to play in the development and maintenance of antisocial or other maladaptive outcomes for male victims of child sexual abuse.

Mechanisms by which maternal attributions might influence sons' response to child sexual abuse are likely to be complex. A number of different theoretical perspectives are drawn on in this thesis to help establish the proposition that maternal attributions are likely to have an enduring and important role in mothers affective and behavioural responses to their child.

It is important to recognise that the model above (5.i) is over-simplified and that a number of intervening variables have not been included. Factors such as abuse variables, and individual characteristics are likely to affect the child's response to abuse. However, as already noted, the specific contribution of these variables remains vague and are therefore limited in their application to the development of intervention programmes with children who have been sexually abused.

One factor which has repeatedly been found to characterise mothers of both victims and young perpetrators of child sexual abuse is their own history of sexual and physical abuse. This has rarely been addressed systematically and is one aim of this current study. The potential influence of mother's own abuse has been shown to be of relevance in parenting failures, such as child abuse. Early experiences of childhood abuse have also been shown to influence subsequent mental health and cognitive processes such as memory. The influence of childhood experiences on maternal attributions about negative events has recently begun to be addressed and may provide an important link to current attributions.

It is proposed that a study of maternal attributions in this clinical group of boys provides an original contribution to the study of attributions and distressed families.

A methodological approach was sought to overcome difficulties with previous research in this area. As discussed in the previous chapter, attribution research has been hampered by the use of questionnaires, analogue methods and laboratory-based observations, which has left the question of how parents explain actual events in their own and their children's lives unanswered.

The study of parental attributions, that is, the way parents interpret their own and their child's behaviour has been shown to affect emotional reactions and in turn, their responses to their child. The study of parental attributions has been extended to the study of mothers of physically abused and neglected children, however this model of parental cognitions has yet to be applied to the complex field of childhood sexual abuse.

There has been little in the way of sensitive and reliable methods with which to systematically identify and rate causal attributions spoken in natural discourse. The previous chapter addressed attribution theory and introduced an innovative and ecologically valid coding system to rate causal attributions in the study of adjustment in victims of disasters, families with schizophrenic patients, and to both distressed and non-distressed mother-child relationships.

This thesis seeks to address the apparent gap in the literature, in the study of child sexual abuse and parental attributions, which has failed to directly explore attributions in families where child sexual abuse has taken place. Given the central role of mothers as primary caregivers, the trend towards mother-only households and the possibility of confounding the design of the study by including fathers who were perpetrators, this study focused exclusively on attributions made by mothers.

5.2 Aims of the study

The first broad aim was to describe the characteristics of mothers of adolescent male victims and perpetrators of child sexual abuse, in comparison with a group of mothers of antisocial boys.

Secondly, the aim was to identify and describe causal attributions in mothers of these groups of boys. The purpose was to draw out differences in maternal attributions in four groups of boys. The four groups were victimised perpetrators, non-victimised perpetrators, victims and a comparison group of antisocial boys. This was intended to add to our understanding of how maternal attributions might be involved in a) the transition from victims to perpetrators of sexual abuse in adolescent boys and b) the difference between boys who act out sexually compared to those who act out aggressively, in the absence of sexual victimisation.

The influence of depression on the pattern of negative attributions has been a source of controversy in the social-cognitive literature. A third aim was to elucidate this relationship further, by using a more reliable and sophisticated measure of attributions than has been previously employed. Other influences, notably the mothers' own experience of abuse, will also be investigated as likely factors influencing the association between depression and negative attributions.

It is hoped that by furthering our knowledge of parental attributions in mothers of adolescent male victims and perpetrators of child sexual abuse, there will be a contribution to the development of interventions with these high-risk groups of adolescents.

The four group design (described in the next chapter) was based on previous evidence that sexual victimisation is a powerful predictor of later perpetrator behaviour and that antisocial behaviour may also contribute to the genesis of sexual perpetration.

In order to propose specific hypotheses studies relating to attributions in physically abusive mothers and mothers of antisocial boys were drawn upon. The measurement of attributions in these studies depended on rating scales and questionnaires, but serve as a good basis for exploring maternal attributions in clinical populations.

5.3 Research hypotheses

The review of the literature brings together two disparate areas of psychological study. First, the social-cognitive, theory-driven approach of attribution research with its history of empirical and highly structured research designs. Second, the applied field of child sexual abuse consisting of a mixture of developmental and clinical studies, often using less rigorous methodology. One aspect of the latter field of study has been the lack of attention to social-cognitive aspects of the multi-causal and multi-consequential problem of child sexual abuse. The primary objective of the present study was to examine maternal attributions in an at-risk population of adolescents, using an innovative methodology from social psychology theory.

The analysis of causal attributions made by non-abusive caregivers (mothers) is a novel approach to understanding of the impact of child sexual abuse on boys. Hypotheses were able to be specified on the basis of previous work pertaining to attribution theory and specific studies regarding parental attributions described in the literature review.

Hypotheses regarding maternal depression

Maternal depression features ubiquitously, as both cause and effect, in the child sexual abuse literature. In addition there has been controversy over the concept of a 'depressive attributional style' in the development and maintenance of depression in adults. In the present study, the Beck Depression Inventory and Beck Hopelessness Scale were used to examine the association between depressed mood and types of attributions made.

Hypothesis 1: (a) It was expected that there would be evidence of mild (sub-clinical) and clinical depression in all four groups of mothers in the study. (b) It was also predicted that birth mothers would be more likely to be depressed, than non-birth mothers. Foster mothers were likely to be selected by social service departments for their ability to parent successfully, and thus it was expected that they would be less likely to suffer from depression.

Hypothesis 2: It was predicted that mothers of sexually victimised boys (victim perpetrator (VP) and Victim (V) groups) would be more depressed than mothers of non-victimised boys (non-victimised perpetrators (NVP) and antisocial comparison (AC) groups). This hypothesis stems from the clinical literature which suggests that mothers of child sexual abuse victims are more likely to have a history of child sexual abuse than mothers of non-abused children. A history of childhood sexual abuse is associated with adult depression and other mental health difficulties. (cf. Mullen et al., 1993, 1994).

Hypothesis 3: It was hypothesized that depressed mothers would make more negative attributions than non-depressed mothers. As depression is likely to be associated with flat affect and reduced verbosity, it was the proportion of negative attributions that was hypothesized to differentiate the depressed group from the non-

depressed group. Negative attributions were those where causes were attributed to negative outcomes.

Hypothesis 4: 'Self-blame' has been conceptualised as the attribution of negative outcomes to causes within the person. It was hypothesized that (a) depressed mothers would be more likely to identify themselves as Agents of negative outcomes, in other words that they were instrumental in effecting the negative outcome and, (b) that depressed mothers would be more likely to identify themselves as Targets of negative outcomes, that is, the person to whom the negative event happens.

Hypothesis 5: (a) It was hypothesized that there would be group differences between the proportion of attributions where the mother identified herself as Agent, and the proportion where she identified her son as Agent of negative outcomes. (b) It was expected that mothers of victimised boys (V and VP) would be more likely to identify their sons as Targets of negative outcomes. (c) It was expected that mothers of perpetrator boys (both victimised and non-victimised) would be more likely to make attributions identifying their son as Agents of negative outcomes.

Hypothesis 6: It was predicted that depressed mothers (as measured by the Beck Depression Inventory) would be more likely to blame themselves for negative events, compared to non-depressed mothers. Thus, depressed mothers were expected to be more likely to attribute causes to Internal, Personal or Controllable causes for self where they nominate themselves as Agents of negative outcomes, compared to non-depressed mothers.

Hypothesis 7: Depression or depressed mood, as measured by questionnaire methods has been associated with a pattern of attributing negative events to Internal, Stable and Global causes, this is also known as the 'depressive attributional style' (Seligman et al., 1979). It was predicted that depressed mothers (according to their scores on the Beck

Depression Inventory) would be more likely to show this pattern of attributions than non-depressed mothers.

Hypothesis 8: It was hypothesized that a 'helpless attributional pattern', characterised by attributions that were Stable, Global and Uncontrollable for negative outcomes, would distinguish depressed from non-depressed mothers.

Hypothesis 9: Recent studies have shown that maternal depressed mood is associated with attributing children's negative experiences to causes within the child and within the child's control (Geller and Johnston, in press). It was hypothesized that depressed mothers would be more likely than non-depressed mothers to make attributions that were Internal or Personal or Controllable to the boy as Target of negative outcomes.

Hypothesis 10: It was predicted that Internal, Stable, Global and Uncontrollable attributions for negative events would be positively related to depression, and Internal, Stable and Controllable attributions would be inversely related to depression (based on Brown and Siegel's (1988) findings).

Hypotheses relating to perceived control

Hypothesis 11: It was hypothesized that a high negative discrepancy between Control to Self as Agent and Control to Boy as Agent would indicate higher blame attributed to the boy for negative outcomes.

Mothers who attributed more 'blame' (as indicated by a high negative discrepancy score for perceived control) to Boy as Agent were predicted to be less depressed than mothers who attributed blame for negative events to themselves as Agent.

Hypothesis 12: It was predicted that a) for the entire sample there would be differences in the amount of Control mothers attributed to themselves for the outcome of negative events compared to Control to their sons and b) that mothers of Victim Perpetrators would be less likely to feel they have Control over negative outcomes and would show higher 'child blame' than mothers of Victims.

Other factors

Hypothesis 13: It was predicted that mothers of Victim Only boys would be more likely to identify their sons as Targets of negative attributions about sexual abuse, than mothers of Non-victimised perpetrators.

Hypothesis 14: It was further predicted that mothers of Victim Perpetrators would be more likely to make attributions about sexual abuse to Unstable or transitory causes, than mothers of Victims Only.

Hypothesis 15: The literature suggests that a history of interacting with a 'difficult' child can lead to negative feelings about the causes of such behaviour. It was predicted that mothers of the comparison group of antisocial boys would be more likely to attribute negative events to long lasting (Stable) and pervasive (Global) causes, than the other groups of boys.

Hypothesis 16: It was further predicted that mothers of antisocial boys would be more likely to attribute negative child behaviours to Internal and Controllable causes. This is based on previous work which suggests that mothers of antisocial boys are more likely to attribute their sons negative behaviour to dispositional causes (Geller and Johnston, in press) and to controllable causes (Johnston, Patenaude and Inman, 1992).

Previous history of sexual and physical abuse in mothers

Hypothesis 17: It was predicted that there would be differences in attributional patterns of mothers who had been previously abused and those who had not. Previous work suggests that childhood sexual abuse leaves a legacy of low self-efficacy and poor mental health outcomes. (a) It was predicted that women who had been sexually abused in childhood would be more likely to indicate current depression than women who were not abused in childhood. (b) It was predicted that there would be a higher rate of child sexual abuse amongst mothers of victimised boys (VP and V) than non-victimised boys (NVP and AC). (c) It was predicted that mothers who themselves had been sexually abused would make fewer attributions about their son's sexual victimisation than mothers who had not been abused.

Other explanatory variables

Hypothesis 18: It was hypothesized that a self-reported history of depression, assessed during the maternal semi-structured interview would be associated with a previous history of sexual abuse.

Hypothesis 19: It was hypothesized that a self-reported past history of depression would also be associated with a current depressive attributional pattern characterised by Internal, Stable and Global causes.

CHAPTER SIX

Design and Methodology

VI: Design and Methodology

6.1 Design of study

Maternal attributions in four groups of mothers of adolescent boys were examined in a cross-sectional design study. The current study was part of a larger research programme investigating the influence of early experience of sexual abuse on the development of sexually abusive behaviour during adolescence. The boys were assigned to one of the following four categories based on information at referral to a large children's hospital.

Sexual Perpetrator	**Victim of Child Sexual Abuse**	
	YES	**NO**
YES	Victim Perpetrator (VP)	Non-victimised Perpetrator (NVP)
NO	Victim (V)	Antisocial Comparison (AC)

Table 6.i: Design of study.

Victims were defined as boys who had been involved in sexually explicit behaviour, involving at least genital contact, with an adolescent or adult at least two years older than themselves. Criteria for sexual abuse were outlined in the main study and might include all forms of penetrative abuse, oral-genital contact, masturbation or fondling. Non-victimised perpetrators (NVP) were defined as boys who engaged in sexually explicit behaviour, involving at least genital contact, with a child at least two years younger than themselves. Sexual perpetration included all of the above-mentioned types of abuse committed against a younger child. Adolescents who solely committed rape or indecent assault against a same age peer or adult were not included in this group. These boys were identified as not being prior victims of child sexual abuse from information provided by social workers at the assessment interview.

Victim Perpetrators (VP) were boys who had been both sexually abused and were known to have sexually perpetrated against another child. Boys who were sexually abused subsequent to sexual perpetration were not included in this group. The comparison group (AC) were boys who were not known to have been sexually abused or perpetrated against other children, but were identified as aggressive or antisocial boys. Boys were recruited into the latter group by canvassing social service departments and schools in South East England.

Boys accepted into the research programme completed a three stage assessment procedure. The sample recruited for the present study was from Stage II of the design.

Stage I: Referral to Child Sexual Abuse Team, Department of Psychological Medicine at the Great Ormond Street Hospital for Children NHS Trust. Assessment by multidisciplinary team to assure eligibility criteria met for age and referral problem, and child protection issues addressed. (N = 150)

Stage II: Individual assessments of boys including standardised psychiatric assessment, cognitive functioning and peer relationships. Individual assessments of mothers including in-depth interviews and assessment of mental state. (N = 80)

Stage III: Intensive individual assessments on four groups of 12 boys within a psychodynamic framework. (N = 48)

Figure 6.i: Three stage assessment design of main study

6.2 The research sample

6.2.1 Recruitment of sample

A letter was sent out from the researchers on the Early Adolescent Study (see Appendix 1) informing social services departments in London and the South East of

England of a programme of individual assessments for adolescent male victims and/or perpetrators of child sexual abuse. This programme was available for boys aged between 11 years 0 months and 15 years 11 months who were eligible for assessment by the Child Sexual Abuse Team in the Department of Psychological Medicine at the Great Ormond Street Hospital for Children NHS Trust in London. Antisocial comparison group boys were recruited from the same social service departments and supplemented from schools. These boys were case managed by Dr David Skuse and the present author. Boys in the antisocial comparison group completed the three stage assessment procedure in the same way that the three case groups (V, NVP and VP boys did.

Following a team discussion, a decision was made as to whether the boy could be referred to the research programme, or whether further child protection issues needed to be addressed. These included establishing that the child was no longer at risk from sexual abuse, or abusing other children, and that the child could best be managed in an outpatient setting. Cases were accepted into the research programme between August, 1992 and August, 1994. Exclusion criteria for the main study (of boys) and the present study (of their mothers) is given below.

Early Adolescent Development Study	**Maternal Attributions Study**
Failure to meet criteria for contact abuse for abuse groups.	No contact with boy for more than 2 years.
Violent or dangerous behaviour (not suitable for outpatient management)	Current major psychiatric problems (hospitalised)
Total denial of victimisation or perpetrating behaviours.	Total denial of victimisation or perpetrating behaviour of boy
No contact with any recognised education system for more than one year	Known to have been directly involved in sexual abuse of child at time of referral.

Table 6.ii: Exclusion criteria for study

6.2.2 Subjects

The subjects were 80 mothers consisting of 68 birth mothers (85%) and 12 non-birth mothers (9 foster mothers, 2 step-mothers and 1 adoptive mother). The sample was predominantly white and of low socioeconomic status. Data collection occurred during the period September 1992 to September 1994.

Mothers were divided into four groups on the basis of referral information about their sons provided by social workers to the Department of Psychological Medicine. The final sample group consisted of 21 mothers of Victimised Perpetrators (86% birth mothers), 20 mothers of Non-victimised Perpetrators (85% birth mothers), 23 mothers of Victims (83% birth mothers) and 16 mothers of the Comparison group of antisocial boys (94% birth mothers).

For 12 boys in the study it was not possible to interview birth mothers. This was primarily due to lack of contact with their sons as boys were in long-term foster placements.

In the total sample of 80 mothers (mean age = 38.25 years, s.d. = 5.60, range: 28.00 to 52.00 years), there were no between group differences on maternal age ($F = 1.61$, $df = 3$ n.s.). There were group differences for age of boy ($F = 4.19$, $df = 3$, $p < 0.01$). A post-hoc Bonferroni test indicated that the non-victimised perpetrators (mean age = 13.85 years, s.d. = 1.04) were significantly older than the antisocial comparison group (mean age = 12.31 years, s.d. = 1.20). The foster mothers were significantly older (mean = 44.33 years, s.d. = 7.13) than the birth mothers (mean = 37.18 years, s.d = 4.56) ($t = 2.12$, $p < 0.05$).

Ethnicity of sample:

Of the eighty mothers who took part in the study, 77 (96.3%) were European White, 2 were non-European White and one was Afro-Caribbean.

Socioeconomic status of sample:

These data were collected for the main study and included the use of the Office of Population Censuses and Surveys (OPCS, 1980) to classify occupation of the head of household. Traditionally this was taken to be the father or father-figure, except in cases of mother-headed households. The following table indicates the frequency of subjects in each social class classified according to OPCS guidelines. Data were collected on 84 mothers, the extra four boys were included in the main study but their mothers did not participate in the maternal semi-structured interview (two declined to participate and two entered the study after data analysis on this project was completed).

OPCS Social Class	Number	Percent of Total
Class I	3	3.57
Class II	8	9.52
Class III Non-manual	6	7.14
Class III Manual	33	39.29
Class IV	17	20.24
Class V	11	13.10
Long term unemployed	5	5.95
Missing	1	1.19

Table 6.iii: OPCS classification of social class (n=84).

The Osborn Social Index (OSI; Osborn, Butler and Morris, 1984) was used to create a continuous measure of social class for use in the main study in order to investigate factors such as intelligence while controlling for socioeconomic status in the boys. This index includes the following items which were incorporated into the maternal semi-structured interview: i) highest qualification of either parent, ii) classification of father's occupation (using OPCS classification), iii) persons per room ration, IV) type of accommodation, v) tenure (home ownership), vi) telephone availability and Vii) car ownership.

A score of 50 on the OSI is roughly equivalent to the OPCS classification of social class III Manual. The overall mean OSI for this sample was 46.70 (s.d = 8.74). The mean and standard deviations for each group are presented in the following table:

GROUP	n	Mean OSI	S.D
Victim Perpetrator	23	46.96	7.82
Non-victimised Perpetrator	21	47.38	9.64
Victim	24	46.38	8.21
Antisocial Comparison	16	45.75	10.22

Table 6.iv: Osborn Social Index continuous measure of social class x Group

A one-way analysis of variance procedure indicated that there were no significant group differences on the OSI measure of social class (F = 0.12, df =3, n.s).

Of the 80 mothers who took part in the maternal semi-structured interviews, 45 of them (56.35%) reported that they were currently receiving Income Support. The following table (Table 6.v) gives frequencies of mothers on Income Support by group, there was no statistically significant difference between the four groups (χ^2 = 4.87, df =3, n.s). However, it is interesting to note that almost three-quarters of the mothers of

victims were on Income Support whereas only one third of the mothers of non-victimised perpetrators were on Income Support.

GROUP	Number on Income Support	Percent of group total
Victim Perpetrator (n=21)	12	57.14
Non-victim Perpetrator (n=20)	7	35.00
Victim (n=23)	17	73.91
Antisocial Comparison (n=16)	9	56.25

Table 6.v: Mothers on Income Support x Group (n =80).

6.3 Procedure

An initial clinical assessment of the referred boy, social worker and primary caregiver took place in the Department of Psychological Medicine with a consultant psychiatrist (Dr A. Bentovim) or psychotherapist (Dr J. Hodges). Wherever possible, the author met with the mothers at this time to explain the purpose of the interview and arrange a time. Due to time constraints as the study progressed, the consultant case manager explained to the mothers that a psychologist would be contacting them at home to arrange a time to meet individually.

Social workers were asked to complete Screening Instruments (see Appendix 2) and send Teacher Report Forms of the Child Behavior Checklist (Achenbach and Edelbrock, 1984) to teachers at the boys' schools. The screening questionnaire provided information about where the boy and mother were living, and the nature of the referral problem. Mothers were contacted by telephone, after consenting via their social worker. In the few cases where there was no allocated social worker, mothers were contacted directly.

Mothers were asked where they would like the interview to take place, and a convenient time and date was arranged. It was requested that wherever possible mothers would be interviewed without family members present. Liaison with allocated social workers was undertaken for those who had difficulties with child care arrangements.

Interviews took place at the Department of Psychological Medicine at Great Ormond Street Hospital for 58 mothers (73%) and the rest at local venues such as Children's Homes, residential schools, day schools, social service departments or at the subject's home, depending on the subject's choice. A maximum of three appointments was offered to each subject by telephone or letter. If they failed to attend all three appointments, it was assumed that they no longer wished to take part in the study.

Refusals:

One mother declined to participate in the interview following a brief meeting to introduce the study (mother of a non-victimised perpetrator). One mother (of a victimised perpetrator) was seriously physically ill and unable to be interviewed. Five mothers of the comparison group of antisocial boys failed three appointments arranged by telephone contact and letter. A total of 87 mothers were approached, and 80 were interviewed (92% acceptance rate). Four mothers agreed to provide some basic demographic data in order that socioeconomic status could be assessed for the main study, but were not included in the current study.

Ethical approval:

Ethical permission for the main study was obtained from the Hospitals for Sick Children and Institute of Child Health Standing Committee on Ethical Practice. Signed consent forms were obtained from each subject, following an introduction to the study and the nature of the interviews and questionnaire measures (see Appendix 3).

Interview procedure:

Subjects were brought into an interview room in the hospital, or local venue and the interviewer introduced herself and a brief introduction was made (see Appendix 4). Mothers were asked for written consent to audiotape the interview, and confidentiality within the research team was assured (subjects were asked not to use last names throughout the interview). The interviews lasted approximately two hours, including a 10-minute break if required. The Beck Depression Inventory and Beck Hopelessness Scale self-report questionnaires were administered. Two mothers were unable to read and they had the questionnaires read aloud to them.

At the end of the interview, subjects were given a list of helping agencies (see Appendix 5) and the interviewer's contact telephone number to ring if they had concerns following the interview. If, during the course of the interview, it became apparent that the subject was distressed, follow-up appointments were made, or with permission, social workers or the mother's general practitioners were contacted. This was the case for six mothers.

6.4 Measures

Teacher Report Form: The Teacher Report Form (TRF; Achenbach, 1991) was used in the main study to obtain teacher's ratings of the boys competencies and problems. For the purposes of this study, the TRF scores indicate that the antisocial comparison boys had the highest mean Total Problem Score (67.90, s.d = 4.18). There were no significant differences between the four groups of boys on the Total Problem Scores of the TRF (H = 1.43, df=3, n.s). Similarly, boys in the antisocial comparison group had the highest mean score for Total Externalising Score (68.40, s.d = 5.95). There were no significant group differences (F =0.59, df =3, n.s). Boys in the antisocial

comparison group were classified in the borderline clinical range of Externalising problems (score range 67 - 70).

6.4.1 Maternal semi-structured interview

A number of interview schedules were consulted on which to base the construction of the interview, these are listed below.

1. The Parent Clinical Interview. Devised by M. Kaplan (1991) at the New York State Psychiatric Institute. This interview was devised to assess parents of adolescent sex offenders referred to this institution. Areas covered include detailed demographic information, development of child, details of sexual offences and sexual knowledge questions for the parent.

2. The Measure of "Lack of Care" in Childhood. (Andrews, Brown and Creasey, 1990; Harris, Brown and Bifulco, 1986; Bifulco, Brown and Harris, 1987). Semi-structured interview covering early separation and loss, quality of parental care in childhood, early experiences of abuse and parental indifference and control.

3. Family Life Study - Mother's Interview. Devised by M. Smith and M. Grocke (1990) for use in the Self-Concepts and Cognitions about Sexuality in Abused and Non-Abused Children: An Experimental Study.

4. Wyatt Sexual History. Devised by G. Wyatt (1984) at the Neuropsychiatric Institute, University of California, Los Angeles. This is an extremely detailed series of questionnaires pertaining to early sexual experiences, sexual abuse and rape, adolescent and adult sexual history and comprehensive demographic and family of origin items. The maternal semi-structured interview devised for this study was largely based on these four schedules and covered the following areas (see Table 6.vi). One

additional item, the Blame Cake, was devised for use at the Gracewell Clinic for adult sex offenders (now called The Faithfull Trust, Birmingham, UK). This item asks respondents to ascribe responsibility for the sexual abuse they perpetrated and was adapted for use with the mothers in the current study. For example, mothers were asked 'who do you give responsibility to for what happened to Jimmy?' and asked to fill in a circle or 'cake' accordingly.

It was thought this would provide a direct measure of the responsibility ascribed to Agents and Targets of negative events (including sexual abuse, perpetration of abuse, and antisocial acts).

6.4.1.1 Areas covered by maternal semi-structured interview

A brief summary of the major content areas covered by the interview is presented in the following table (Table 6.vi). As the interview was over 80 pages long, it is not reproduced in full in this thesis. Appendix 6 contains a full description of major content areas. Interviews are available from the author.

Interview Topic	Items
Demographic	Age; family tree; marital status; educational and occupational history; social class data; cultural group and religion.
Individual history	Criminal history; drug, alcohol and palliative use; medical and psychiatric history; social support network.
Target boy history	Pregnancy and childbirth; early development; descriptions of boy as young child and currently; reactions to discovery of abuse/perpetration, or to misdemeanours for antisocial group. Ratings of expressed warmth, criticism and hostility were made following this section.
Family of origin	Family demography; early loss and separation; early experience of abuse and neglect, including child sexual abuse.
Adult abuse	Experiences of adult physical and sexual abuse.

Table 6.vi: Content area of maternal semi-structured interview.

Modifications were made to the interview for the mothers of comparison group boys, however these mothers were also asked about any sexual abuse experiences in their son's lives ('As far as you know has your son ever been a victim of any unwanted sexual experiences?', 'As far as you know has your son ever been accused of touching or interfering with another child?'). This situation did not arise in the present study, all comparison group mothers reported that, to their knowledge, their sons had not been victims or perpetrators of sexual abuse. One mother reported that her son may have been tickled inappropriately by a priest during an outing, however the team decided that this did not fulfil the criteria for sexual abuse and he remained in the comparison group.

Ratings of expressed criticism, hostility and warmth:

Three expressed emotion variables (based on Brown and Rutter, 1966) were rated during the interviews with mothers (see Appendix 7 for rating criteria). Expressed criticism, hostility and warmth towards the index boy were rated by the author after the interview,while subjects were completing self-report questionnaires. No reliability study was undertaken, however the author had limited previous experience of these ratings in the context of working with families of chronic psychiatric patients at the District Services Centre, Maudsley Hospital, London from October to December, 1987.

Family of origin data:

This section focussed on quality of parental care in childhood which was based on the Measure of "Lack of Care" in Childhood (Andrews, Brown and Creasey, 1986). Four measures of early experience were derived (composite variables) on the basis of questions at interview. i) **Parental control;** coded as 1 (high control) to 3 (lax control). This refers to the level of supervision of the child and rules and discipline enforced by parents; ii) **Parental discord;** coded as 1 (marked discord) to 4 (little or no discord). This refers to the subject's perception of the amount of arguing and domestic violence in the house, and the marital history of the subjects parents; iii) **Parental functioning;** coded from 1 (markedly poor functioning) to 4 (little or no poor functioning). This was based on subject's description of parental alcohol use, mental illness and general functioning in social and family life; iv) **Parental antipathy;** coded from 1(marked antipathy) to 4 (little or no antipathy). This rating was based on the degree of dislike, hostility or disapproval by parents towards the subject as a child. (see Appendix 7 for further details)

Maternal sexual abuse experiences:

The questions used to ask about sexual abuse in both childhood and adulthood at interview were asked towards the end of the interview period. Mothers were asked whether they had ever been sexually approached against their wishes. If they said no, they were asked again following further clarification of the question. If the answer was no a second time then the interviewer proceeded to end the interview (see Appendix 8) and administered the questionnaires.

Subjects who reported that they had been approached against their wishes were then asked to give details of each abuse episode by answering the following questions: (i) how old were you when that happened? (ii) was it someone in your original family? (iii) can you tell me who it was? (iv) did it involve touching? (v) did it involve intercourse? (vi) could I ask you to look at this page and tell me which ones applied to you? (see Appendix 9) (vii) did anybody else know that it happened? (viii) what did they do? (ix) is this the first time you have told anyone about what happened to you?

Other questions were asked where appropriate in order to ascertain that a detailed account was obtained of the type of abuse, age of victim, relationship to perpetrator, tactics used by the perpetrator, and whether the abuse was reported on and how the victim was treated (see Appendix 10).

A prevalence study based on a community sample of women by Anderson, Martin, Mullen, Romans and Herbison (1993) included criteria for rating sexual abuse. These criteria were used in the present study to determine whether sexual abuse had taken place and was categorised by six types of sexual abuse (see p. 913, Anderson et al., 1993).

i) Non-contact sexual abuse: This category includes spying, indecent suggestions, and pornography.

ii) Non-genital contact: Touching of non-genital areas including breasts/buttocks, kissing, sexual 'attacks' which were stopped.

iii) Genital contact/ being touched: Being touched or fondled in the genital area.

iv) Genital contact/ touching perpetrator: Forcing or persuading child to touch perpetrator's genital area or oral-genital abuse.

v) Attempted intercourse: Includes physical contact and degree of force.

vi) **Sexual intercourse:** Actual vaginal and/or anal penetration.

Oral-genital contact was the only form of abuse not specified in the Anderson et al., (1993) definition, and it was included under category iv).

This definition or classification of child sexual abuse is similar to others used in the literature (e.g., Peters, Wyatt and Finkelhor, 1986), and is comprehensive. Clearly it also provides an indication of severity of sexual abuse experiences which is important given that abuse experiences including intercourse usually have a more deleterious effect on adult outcomes than sexual abuse which does not include intercourse (e.g., Mullen, Martin, Anderson, Romans and Herbison, 1993).

Similar criteria were used to establish adult sexual abuse. Slightly more stringent criteria were applied to adult experiences. For example in the second category, non-genital contact, a clearly defined sexual 'attack' was included, but an unwanted kiss, if it involved no physical coercion was not included. Coercion was an important factor in assessing adult sexual abuse and included verbal pressure, threats of harm, use of weapon, physical restraint and actual physical harm (see Sorenson, Stein, Siegel, Golding and Burnam, 1987).

Definitions of child physical abuse were taken from that used in research projects reported on by Brown and his colleagues (e.g., Andrews, Brown and Creasey, 1990; Bifulco, Brown and Harris; 1994). This definition is comparable to that used in the Severe Violence index of the widely used Conflict Tactics Scale (CTS; Straus, 1979; Straus and Gelles, 1980) and includes any incidence of violence towards a child by an adult, usually parents. Physical abuse covers beatings, kicking, burning, hitting with objects, being threatened with knives or other weapons.

Adult physical abuse was defined in a similar way, with reference to the Conflict Tactics Scale which operationalises the concept of violence or physical aggression. Violent acts include throwing an object, pushing or shoving, kicking, biting, punching and use or threat of weapons (guns, knives). The abuse is defined by the violent act rather than the extent of the injury, although more severe violence usually causes injuries which were also asked about (cuts, bruises, broken bones and hospitalisation). As in the case of sexual abuse, this is an extremely sensitive area of enquiry during interviews. A card was provided for mothers (see Appendix 11) in order for them to identify which experiences they had, without having to actually describe the abuse if this was too distressing.

Piloting:

During the early stage of this study, it became increasingly clear that despite canvassing all social service departments in the South East of England, the number of referrals was less than expected. Therefore, a formal pilot study was not carried out and it was decided that when mothers of boys of the correct age group were referred, they would be approached to take part in the actual study.

For this reason, the interview could not be piloted fully, but was based on well-established interview schedules which have been used for interviewing mothers of a

similar clinical group regarding sensitive areas such as sexual abuse and early experiences. One mother was seen who had a son outside the eligible age range (16 years 9 months), and was interviewed as a pilot subject.

The Attributional Style Questionnaire (ASQ, Seligman et al., 1979) was completed for the first 10 subjects and the 'pilot' mother but had to be abandoned when it became clear that subjects were unable and unwilling to proceed with the questionnaire. The ASQ involves asking subjects to 'vividly imagine' situations (see Section 4.4.1), which were clearly out of these women's experience (such as dating or getting a pay rise). Furthermore, the task of rating causes of events was not clearly understood, thus making the results unreliable.

6.4.2 Leeds Attributional Coding System

The LACS (Stratton et al., 1988) was specifically designed to measure causal attributions as they occur in natural discourse (see section 4.4.3 and LACS Manual for details of rationale and background of this coding system). The major advantage of the LACS for examining maternal attributions in this study was that it is an unintrusive technique for measuring attributions in a more natural context than previous methods have offered.

The LACS improves on the validity of questionnaire methods by identifying attributions which are presented by the subjects rather than by the experimenters. This is particularly important in the study of parental attributions and child maltreatment where there is so little knowledge about non-abusing or 'bystander' mothers (see Chapter 2).

One major advantage of the LACS is that attributions are coded from the perspective of the Speaker (mother) about herself and about the Agents and Targets of the

attributions. In other words, attributions can be coded when someone else, besides the Speaker of the attribution, is involved in either the cause or the outcome.

The Agent refers to the person nominated in the cause of the attributions, i.e. the person who brings about the outcome.The Target refers to the person nominated in the outcome, to whom the event happens. Taking some examples of attributions made by mothers in the study illustrates the utility of separately coding for Agents and Targets. (see Figure 6.ii below).

"Gary makes so much trouble, he likes to embarrass me, I don't like being seen with him anymore"
(Mother of 14 year old antisocial comparison boy 'Gary')

"I get so stressed, I just can't cope with anything, I just lashed out at 'Ian'
(Mother of 13 year old victim perpetrator boy 'Ian')

Figure 6.ii: Examples of Agents and Targets of attributions

The mother making the attribution in the first example attributes the outcome to a cause which is Internal to 'Gary' (Agent) and External to Mother (Target). In the second example, the mother is making an attribution for hitting her son 'Ian' and attributes the cause as Internal to the mother (Agent) and External to her son (Target). This enables analysis of the attributions beyond the traditional Self vs. Other comparison, which does not take into account whether the person is taking an instrumental role in the outcome, or has a more passive role. The attributions are then rated as they apply to Speaker, Agent and Target along five separate dimensions (see next section 6.4.2.1)

6.4.2.1 Extraction and coding of causal statements

There were eight training sessions carried out by Dr J. Silvester, Department of Psychology, University of Leeds. These sessions included training in identifying attributions from transcripts and coding attributions according to guidelines in the LACS Manual.

Some modifications had to be made to rate the attributions produced by mothers during the semi-structured interviews. The authors of the LACS suggest that some flexibility may be required when applying it to different studies and that it is a developing system rather than a finished product. In the interest of reliability, the LACS guidelines were adhered to but further guidelines were taken from the notes devised by Brewin (1988c). For example, a cause is rated Stable according to the LACS manual if it is likely to apply in the future in the topic of the outcome. Brewin (1988c) notes that unstable events (e.g. car accidents) may have a persistent effect on outcomes in the future. This is seen to form a 'causal chain' in which an unstable event may lead to lasting changes (e.g.serious injury) which then acts as a cause in its own right. This scenario applies to sexual abuse whereby the abuse is unlikely to recur in the future but has an ongoing effect.

An example of the Stable-Unstable dimension of cause is made by a mother of an 11 year old antisocial boy, 'Greg'. *"he was alright until his teacher changed, she was a woman, from when he was five, when she came, he got really disruptive, throwing chairs around, kicking teachers, breaking the glass".* The cause (*his teacher changed)* is one that is unlikely to recur however the effects are seen to be long lasting and was coded Stable.

Attributions were extracted from verbatim transcripts of the maternal semi-structured interviews according to guidelines in the LACS manual. Stratton et al., (1988)

acknowledge that the definition of an attributional statement may be a contentious issue. However, for the purposes of this study, an attributional statement was identified as a cause linked to an identifiable outcome. Some statements appear to be attributions but have no discernible outcome, for example, "*I think it's all down to what happened to him*". If the Speaker does not clarify what 'it' is, then this statement could not be coded. The convention used in extracting and coding attributions is to underline the cause, and the rest of the statement consists of the link word and the outcome, for example, *'he is lazy, so he doesn't help me at home'.*

Transcripts were searched for causal statements and extracted statements were recorded separately for coding purposes. The importance of coding from the Speaker's perspective cannot be underestimated and forms an important part of the training process. For example, it might generally be believed that child abuse has long lasting effects. One might expect that negative events following sexual abuse would be attributed to Global (far-reaching) causes. However a mother saying that '*since Pete was abused, he don't go to football'* may *imply* a broad range of outcomes but as the Speaker (mother) does not make them explicit, the cause would be rated as Specific.

Initially all attributions were extracted and coded but only those for negative events were used in analyses. Studies to date have only found predictive relationships for negative outcomes (e.g. Munton and Antaki, 1988; Bugental et al., 1993).

Following extraction of the causal statements, the attributions were coded along each of five dimensions of cause: i) Stable - Unstable, ii) Global-Specific, iii) Internal-External, iv) Personal-Universal, v) Controllable-Uncontrollable (see section 4.4.3 for a brief description of these dimensions; also the LACS Manual for further details). The Stable-Unstable and Global-Specific dimensions are rated on the attribution as a whole, from the perspective of the Speaker and are not seen to be influenced by who is nominated as Agent and Target.

The other three dimensions were coded separately for Speaker, Agent and Target (see section 4.4.3 for descriptions of coding categories).

Causal dimensions are treated as dichotomous in the LACS, i.e. attributions are rated as either Stable (1) or Unstable (2). A further code (9) was used when an attribution was unable to be rated on a particular dimension (Brewin, 1988c).

Outcomes of attributions were also rated according to the valence of the event (positive, neutral or negative) and the topic of the cause and outcome were coded separately for the purposes of this study. Topics were categorised as sexual abuse, physical abuse, emotional abuse, child behaviour, other behaviour.

Other considerations

Sometimes attributions were made which did not identify a *person* in the outcome: for example, *"It was that lampost, it got in the way, so he had to hit the oncoming car, he ended up in prison for that one"*. In this instance the Agent was coded as the Target (the person who hit the car) but was rated as External, Universal and Uncontrollable to Agent. This also raises the issue of the seriousness of the outcomes, in this example, although the cause may seem trivial, the outcome (hitting a car, and going to prison) was serious. The issue of the importance of the outcome to the Speaker should be reflected by rating causes on the Stable and Global dimensions in the LACS system. In the lampost example, the cause is Unstable and is seen by the Speaker to have led to a range of outcomes including imprisonment leading to a Global rating of cause.

The interview focused on aspects of the mothers and their sons lives and all attributions for negative events were included. The issue of triviality in attributions is one which is not easily addressed in the LACS system and will be discussed further in

Chapter Eight (8.4). The vast majority of attributions were negative, that is, the outcome was believed by the Speaker to be undesirable. If the outcome was believed to be positive or desirable, the attribution was coded positive, and if it was neutral or it was not possible to ascertain the valence, the attribution was rated as neutral and not used in further analyses in the current study.

One further category was added to the coding sheet in order to identify the victim of abuse. This was important to separate the index boy's abuse from mother's own abuse. Causal dimensions were not coded separately for the victim of abuse.

6.4.3 Maternal Depression

Maternal depression was measured using the Beck Depression Inventory (BDI; Beck and Steer, 1987) and the Beck Hopelessness Scale (BHS; Beck and Steer, 1988).

The BDI is a 21- item scale designed to measure severity of depression in adolescent and adult populations. This measure is one of the most widely used instruments in the assessment of depression both in psychiatric and normal populations (e.g., Steer, Beck and Garrison, 1985) and is reported to have good psychometric properties (Beck and Steer, 1987).

Items are rated on a four point scale ranging from no experience of a symptom (0) to most severe experience of a symptom (3). Items include the primary features of clinical depression such as irritability, crying, tiredness, changes in libido and appetite, suicidal ideation, body image and somatic perception. Originally intended to measure symptom severity, it is also used as a screening instrument to assess presence of depression. A cut-score of 15 has been advised to detect clinical depression in normal populations (Beck and Steer, 1987).

The BDI may be administered orally, which is an advantage in clinical groups where literacy may be a problem. The BDI is scored by summing the ratings given by the subjects for each of the 21 items. A score below 9 is said to be in the normal or asymptomatic range, a score above 9 indicates mild depression and a score above 15 indicates clinical depression (Beck and Steer, 1987).

The BHS is a twenty item scale for measuring pessimism or the extent of negativity towards the future. It was originally devised by Beck and his colleagues to measure pessimism in psychiatric patients to assess their suicide risk, but has been subsequently used with adolescent and adult normal populations (Greene, 1981). The concept of hopelessness is closely related to depression and is seen to be characterised by a negative expectancy about short and long-term future outcomes. The definition of hopelessness includes a feeling that nothing will turn out right, that important goals can not be achieved, that a bad situation will not improve. This definition corresponds to the third component of the negative triad in Beck's (1967) cognitive model of depression consisting of (1) a negative view of the self, (2) a negative view of present functioning and (3) a negative view of the future. The BHS is reported to have good validity and reliability in detecting both pessimism and suicide risk (e.g. Beck and Steer, 1988).

6.5 Statistical analysis

6.5.1. Interview data

Interviews were coded and composite variables were calculated for specific topics. Some of the variables relating to the mother's own childhoods were derived from previous research investigating childhood experiences (e.g., Harris, Brown and Bifulco, 1986; Andrews, Brown and Creasey, 1990). Similarly, indices of sexual abuse were derived from previous studies of adult women abused as children (e.g.

Anderson, Martin, Mullen, Romans and Herbison, 1993). The main composite variables relate to the major content areas (see Table 6.iii) and were primarily analysed using descriptive statistics. Some variables were recoded into binary variables (e.g., presence or absence of sexual abuse in childhood) and added to the data files containing summary variables from analysis of attributions. In this way it was possible to examine the relationship between background variables and patterns of maternal attributions. (See Appendix 6 for description of main variables)

6.5.2 LACS coding data

A data base set up using the Statistical Package for the Social Sciences for Windows (SPSS for Windows, Version 6.0, 1993). Individual data files were set up and each subject's attributional codes were entered separately, files were then copied and merged so that analysis of attributions could take place at an individual and at a group level.

Comparisons were made between groups using analysis of variance, or the non-parametric version where appropriate. Comparisons between two groups (such as depressed/non-depressed) were made using t-tests, or their non-parametric equivalent.

Some composite variables based on combinations of causal dimensions yielded highly skewed variables which were analysed using non-parametric tests. These included the Kruskal-Wallis one-way analysis of variance, Mann-Whitney test of differences between two groups, chi-square tests of association and Spearman's rank correlations.

6.5.3 Power considerations

The clinical population investigated in the present study represents a group of boys and their mothers about whom highly sensitive and confidential material was collected.

Ideally, sample sizes would have been determined by a priori power calculations which would provide guidelines for optimal sample sizes in order to detect statistically significant group differences (Cohen, 1992).

In order to identify large, medium or small effect sizes (that is 0.4, 0.25 or 0.1 standard deviations) between four groups with 80% power at the 5% significance level, it would be necessary to recruit sample sizes of 18, 45 or 274 into each of the four groups. Similarly, for two-group comparisons, in order to identify effect sizes of 0.8, 0.5 or 0.2 s.d's, it would be necessary to recruit 16, 64 or 393 subjects into each of the two groups (Cohen, 1992).

Pragmatic considerations such as time and financial constraints restricted the actual determination of sample sizes. In the present study, which was funded for three years, it was decided that boys and their mothers would be accepted into the research programme for a study period of two years (September, 1992 - September, 1994). The aim was to recruit 25 subjects into each of the four cells in the design (VP, NVP, V and AC), in order to detect effect sizes of at least 0.8 s.d's for two group comparisons and 0.4 s.d's for four group comparisons.

The next chapter presents the results from the study.

CHAPTER SEVEN

Results

VII: RESULTS

7.1 Introduction to Results

Results from data analysis will be presented together with their related hypotheses given in Chapter Five. The main dependent variable was the mothers' attributions for negative events only, in keeping with other studies investigating causal attributions (e.g., Brewin et al., 1991; Joseph et al., 1991). Proportions of negative attributions are presented as percentages in the results section.

The data from the maternal semi-structured interviews are presented first and are divided into three sections comprising, respectively, demographic data, family of origin data and history of abuse data. Several composite variables were computed by aggregating maternal responses to relevant items into ordinal variables. In some cases they were recoded into binary format or into nominal variables where there was no obvious hierarchy of responses, such as 'perpetrator of adult abuse'.

Following this, the data on maternal depression are presented and discussed as a separate section. This includes results from the standardised questionnaires and data from the maternal interviews regarding past history of depression. Results regarding the relationship between depression and previous abuse experiences of the women are also reported here.

Finally, the main section of the results is devoted to maternal attributions, including a discussion of the reliability of the coding system and the nature of attributions produced. The relationship between attributions and depression is discussed, including the concept of 'depressive attributional style' and findings on patterns of helpless attributions. The issue of perceived control in mother-child relationships is addressed by considering the discrepancy between mother's sense of control over negative

outcomes compared to their son's. Finally, the relation of attributions to other factors such as previous sexual abuse experiences is discussed.

7.2 Maternal semi-structured interview

Data from the maternal interviews are presented in five sections: i) demographic and descriptive variables, ii) data regarding mothers' family of origin, iii) history of child abuse in mothers, iv) adult abuse experiences and v) mothers' response to boy including expressed emotion variables and response to discovery of sexual abuse,

Several cumulative or composite variables were calculated on the basis of these data, which were often recoded into binary variables (present/absent) in order to test hypotheses regarding their association with patterns of maternal attributions. Binary variables were used in most cases where there was low frequency data in order to make the data amenable to statistical analysis. In other cases, a continuous score such as depression as measured by the BDI was treated as a binary score (depressed/not depressed) in order to test for differences in attributional patterns between these two groups. Results relating to attributions are presented in section 7.4 (on maternal attributions).

7.2.1 Demographic data

Details of the sample can be found in the methods chapter (see section 6.2). Descriptive data referring to the subjects own personal histories are presented here, relating to education, religious background, criminal history and relationship and childbearing histories.

Of the eighty mothers who took part in this study, 43 of them (53.8%) were living with the index boy in the study at the time of the interview, and 37 (46.2%) were not, but had regular (at least once weekly) contact. Overall, there was no association between

which group the boy was in (VP, V, NVP or AC) and whether the boy was living at home with his mother or not ($\chi^2 = 5.53$, df=3, n.s). When considering the 68 birth mothers only, there was a significant association between boy's group and whether the boy was living at home or not ($\chi^2 = 10.92$, df=3, $p < 0.02$). Birth mothers of antisocial boys were more likely to have their son at home with them (73.3%), compared to 57.9% of birth mothers of victims and 52.9% of birth mothers of non-victimised perpetrators. Birth mothers of victim perpetrators were least likely to have their sons at home with them (17.6%).

Personal history data:

***Religious type*:** Out of eighty mothers, 50 (62.5%) of them reported that they were or had been brought up in the Church of England religion and 10 as Catholic (12.5%). The remainder were Jehovah's Witness (2.5%), Jewish (1.3%), Baptist (1.3%). The remaining 20% reported that they had no religion.

***Educational history*:** Out of the eighty mothers, 39 of them reported leaving school before the age of 16 years (48.8%), including 7 (8.8%) who had left school by the age of 14 years. A further 35 women (43.8%) left school at the age of 16 years. Six women (7.7%) stayed on at school after the age of 16 years.

Birth mothers (n = 68) left school at a slightly younger mean age (mean = 15.52 years, s.d. = 1.02) than the non-birth mothers (n =12) (mean = 16.33 years, s.d. = 1.67) however, this difference was not statistically significant (Mann-Whitney $U = 314.5$, n.s). Fifty-four out of the 80 mothers (67.5%) reported taking no examinations before they left school. Of the remaining 26 mothers, 21 mothers reported passing between one and six CSE examinations (Certificate of Secondary Education) and five mothers reported passing between seven and twelve CSE examinations.

61 mothers (76.3%) reported taking no further qualifications after they left school and the remaining 19 (23.7%) gained further qualifications in the form of City and Guilds examinations.

Relationship history: The table below shows the ages at which the women in this study first married or entered into a long-term cohabitation. The mean age for all mothers for their first marriage or cohabitation was 20 years 3 months (s.d = 3 years 7 months).

Age of Mother (years)	n	% of total
15 - 17 years	13	16.25
18 - 21 years	47	58.75
22 - 25 years	11	13.75
25 - 30 years	7	8.75
30+ years	1	1.25
Never married/cohabited	1	1.25

Table 7.2.1.i: Age of first marriage or cohabitation (n = 80).

A Kruskal-Wallis one-way analysis of variance procedure was used to test for group differences. There were no significant differences between the four groups in terms of age of first marriage/cohabitation (H = 1.75, df =3, n.s).

The majority of mothers (53.8%) had married/cohabited twice, 30 (37.5%) married once and 6 (7.5%) had married more than twice. 17 (21.25%) of the mothers remained married/cohabited with their first partner for 2 - 24 months, 13 (16.25%) did so for 2 - 5 years, 15 (18.75%) for 5 - 8 years, and 34 (42.5%) remained married to their first partner for 10 years or more.

At the time of the interview, 49 mothers (61.25%) were currently married or living with a long-term partner, 6 mothers (7.50%) were single and in a current relationship, and 25 mothers (31.25%) were single with no current partner.

***Pregnancy and childbirth history*:** 14 (17.5 %) of the mothers had their first child by the age of 17 years, and 55 of the mothers (68.8 %) had their first child by the age of 21 years. The table below shows the number of children borne by mothers in this study which ranged from none (for two foster mothers) to eight (for one birth mother).

Number of Children	n	% of total
None	2	2.50
1	6	7.50
2	24	30.00
3	25	31.25
4	13	16.25
5 or more	10	12.50

Table 7.2.1.ii: Number of children of mothers in study (N = 80).

There was no significant difference between the four groups in terms of the number of children the mothers reported they had ($H = 3.64$, df =3, n.s). Regarding pregnancy histories, 34 mothers (42.5%) reported having at least one miscarriage. Thirteen mothers (16.3%) reported having one termination of pregnancy and 3 mothers (3.8%) reported having more than one termination. 4 mothers (5%) reported having one stillborn child and 4 mothers (5%) reported giving up a child for closed adoption. Thirty five (43.8%) of the 68 birth mothers reported at least one unplanned pregnancy. Kruskal-Wallis one-way analysis of variance tests revealed that there were no significant group differences between the four groups on number of miscarriages

(H = 6.15, n.s), number of terminations (H = 3.19, n.s), number of stillbirths (H = 4.99, n.s) or number of adoptions (H = 0.07, n.s).

***Substance use*:** 52 (65%) of the eighty mothers reported that they were current cigarette smokers at the time of the interview and 85% of smokers reported smoking 15 or more cigarettes a day. 23% of the smokers said they felt that they had smoked more since their son's abuse, perpetration or other misdemeanour (in the case of the antisocial comparison group) had come to light.

29 (36.25%) of the total number of 80 mothers reported that they were regular drinkers and 11 (13.75%) of the mothers reported total alcohol abstinence. 40 mothers (50%) reported that they only drank on special occasions, a few times a year. A small minority (6.25%) of all mothers reported that they had more than six alcoholic drinks a week, and only 3 mothers (3.75%) reported that they drank more as a result of their discovery of their son's abuse, perpetration or other misdemeanour.

The majority of mothers (93.75%) said that they had never used illegal drugs or substances, two mothers (2.50%) reported experimenting with drugs when in their adolescence, and three mothers (3.75%) reported that they were regular users of illegal drugs (two mothers used marijuana, and one mother was a registered heroin addict).

***Criminal history*:** Mothers were asked to report on their criminal histories from adolescence, as summarised in the following table (Table 7.2.1.iii). Mothers were also asked to report on the criminal history of the index boys' father, or where this was not applicable, for their partners' (boy's father figure) criminal history.

Mother reported criminal history	Mothers		Fathers or father figures	
	n	% of total	n	% of total
No criminal history reported	63	78.75	42	52.50
Crime committed during adolescence	7	8.75	6	7.50
Crime committed after age 17 years	8	10.00	19	23.75
Crimes committed before and after age 17 years	2	2.50	12	15.00

Table 7.2.1.iii: Criminal histories of mothers and fathers.

Only two of the mothers (2.5%) reported that they had been imprisoned for criminal offences. Mothers reported that 11 of the fathers or father figures (13.8%) had been imprisoned once and a further 7 fathers (18.75%) had been imprisoned two or more times. 61 fathers (76.3%) had never been imprisoned. The total number of fathers or father figures adds up to 79 rather than 80, as one mother reported that she did not know who the father of her child was and therefore could not answer any questions relating to him.

In summary, approximately 20% of mothers and 47% of fathers had a criminal history according to maternal reports.

Considering criminal histories between groups, the following table shows that there were no significant differences between the four boy groups. It was expected that the parents of antisocial boys would be more likely to have criminal histories, but this was not borne out by the data.

Boy Group	Mothers		Fathers or father figures	
	n	% of total	n	% of total
Victim Perpetrators (n = 21)	5	23.81	12	60.00
Non-victimised Perpetrators (n = 20)	5	25.00	8	40.00
Victims (n = 23)	5	21.70	10	43.50
Antisocial Comparison (n = 16)	2	12.50	7	43.80
Significance	n.s		n.s	

Table 7.2.1.iv: Criminal histories of mothers and fathers x Group.

There were no differences between the four groups for mother's criminal history ($\chi^2 = 0.99$, df =3, n.s), or for father's criminal history ($\chi^2 = 1.93$, df =3, n.s). The four cells for mother's criminal history by group had expected values of less than 5, but greater than 4. Although it has been recommended that all expected frequencies be at least 5, this is now thought to be too stringent and the chi-square statistic can be reported for expected values below 5 (Everitt, 1977; Norusis, 1992).

The types of offences committed by parents of these boys are summarised in the table below:

Type of Criminal Offence	Mothers		Fathers or father figures	
	n	% of total	n	% of total
Sexual offences	0	0.00	9	11.54
Violent offences Against property or persons	3	3.75	8	10.25
Non-violent offences e.g. theft, fraud, prostitution	11	13.75	16	20.51
Traffic offences Not parking offences	3	3.75	3	3.85
No offences reported	63	78.75	42	53.85

Table 7.2.1.v: Types of criminal offences.

Data was missing on two fathers (one as before; one mother did not know about the nature of her ex-partner's crime). When asked about further offences, mothers reported that of the 78 fathers, four (5.13%) were arrested for a sexual offence and five (6.41%) were arrested for non-violent offences as their second offence. No fathers were reported to have been charged with third offences.

7.2.2 Family of origin data

***Age of leaving home*:** The mean age overall for mothers leaving their parental home was 18 years 6 months (s.d = 2 years 8 months). 27 of the eighty mothers (34.2%) had left home by the age of 17 years and 71 mothers (88.8%) had left home by the age of 21 years. There were no significant differences in mean ages at which mothers in the four groups left their parental home ($H = 0.37$, df =3, n.s).

***Early experience of loss and separation*:**

i) mothers in care

The majority of mothers (90%) reported that they had never been in care. Seven mothers (8.8%) reported that they had been in social services care, primarily in children's homes, for a period of 1- 4 years (there was missing data for one mother).

ii)loss of parents

Overall, few mothers reported loss of mother or father due to death or divorce/separation. Ten mothers (12.5%) reported that they were separated from their mother before the age of 17 years due to divorce or separation and 12 (15.0%) reported that they had been separated from their fathers due to divorce or separation. Parental death before the subject's 17th birthday was as follows: One subject (1.5%) reported mother's death and 8 (10.0%) reported father's death.

The following table summarises the findings regarding parental loss and separation by group.

GROUP >	Victim Perpetrators (n=20)	Non-victim Perpetrators (n=20)	Victims (n=23)	Antisocial Comparison (n=16)	Significance
Loss of Father Separation/ Divorce	2 (10.0%)	5 (25.0%)	5 (21.7%)	0 (0.0%)	n.s
Loss of Mother Separation/ Divorce	3 (15.0%)	3 (15.0%)	3 (13.0%)	0 (0.0%)	n.s
Loss of Father to Death	4 (20.0%)	1 (5.0%)	2 (8.7%)	1 (6.3%)	n.s
Loss of Mother to Death	0 (0.0%)	0 (0.0%)	1 (4.3%)	0 (0.0%)	n.s

Table 7.2.2.i: Number of mothers reporting parental loss and separation x Group.

Kruskal-Wallis one-way analysis of variance procedures were used to test for group differences. There was no difference on the groups in terms of loss of father to separation (H = 5.47, df =3, n.s), or death (H = 2.30, df=3, n.s), loss of mother to separation (H = 0.79, df=3, n.s) or to death (H = 2.43, df=3, n.s).

iii) experience of parental care

Mothers were asked about their own experience of parental care during childhood (see method section 6.4.1.1 for details) relating to antipathy, control, parental discord and parental functioning. The following table (7.2.2.ii) summarises the mean ratings on each of these variables which were rated from 1 (marked or severe) to 3 or 4 (little or none), in keeping with the ratings described by Andrews, Brown and Creasey (1986).

GROUP >	Victim Perpetrators (n=20)	Non-victim Perpetrators (n=20)	Victims (n=23)	Antisocial Comparison (n=16)	Significance
Parental Antipathy 1 = marked/severe 4 = no antipathy	3.10	2.85	3.22	3.75	$p < 0.08$
Parental Control 1 = high control 3 = lax control	2.15	2.15	2.04	2.06	n.s
Parental Discord 1 = marked discord 4 = no discord	2.95	2.60	2.96	3.44	n.s
Parental Functioning 1 = marked/poor 4=high functioning	3.20	2.90	2.91	3.31	n.s

Table 7.2.2.ii: Mean ratings family of origin variables x Group.

Kruskal-Wallis one-way analysis of variance procedures were used to test for group differences on mean ratings of family of origin variables. There were no significant differences between the four groups on the four ratings, however on Parental Antipathy there was a non-significant trend suggesting that mothers of non-victimised perpetrators indicated that they had experienced more antipathy than other groups ($H = 6.83$, df =3, $p < 0.08$).

The following table (7.2.2.iii) gives the Spearman's correlation coefficients (rho) for the association between these ratings of family of origin variables and current depression, as measured by the Beck Depression Inventory. All these variables were significantly correlated to each other which is to be expected given that they are all measuring an aspect of the family environment. However only Parental Control was significantly associated with current depression. Significance tests are one-tailed, as it was anticipated that a lower rating (i.e relating to high control) would be associated with greater current depression.

	Antipathy	Control	Discord	Functioning
Depression (BDI)	.06	-.39**	.06	.12

Table 7.2.2.iii: Correlations between ratings of family of origin variables x depression. (n = 73)(** $p < 0.001$).

7.2.3 History of child abuse in mothers

Mothers were asked about unwanted sexual experiences before and after the age of 17 years. Further details of definitions used and interview items can be found in Chapter Six (method section 6.4.1.1). Mother's reported experiences of child sexual abuse will be abbreviated as MCSA.

7.2.3.1 Mothers reported child sexual abuse

42.5% (n=34) of the entire sample reported childhood experience of sexual abuse. As expected, there was a significant difference between birth mothers and non-birth mothers in their self-reported sexual abuse experiences (MCSA). None of the non-birth mothers reported unwanted sexual experiences as a child compared to 50.7 % (n = 34) of the sample of 67 birth mothers (missing data on one birth mother) ($\chi^2 = 8.72$, df=1, $p < 0.004$).

The apparent association between mothers reported MCSA experiences and boy's group failed to reach conventional levels of significance ($\chi^2 = 6.42$, df =3, $p < 0.10$). The table below summarises reported MCSA by mothers in the four groups. One mother declined to answer this question, therefore the table below (7.2.3.i) and all others pertaining to reported sexual abuse refer to 79 mothers.

Boy Group	n	% of group total
Victim Perpetrators (n = 20)	9	45.0
Non-victimised Perpetrators (n = 20)	13	65.0
Victims (n = 23)	7	30.4
Antisocial Comparison (n = 16)	5	31.3

Table 7.2.3.i: Reported child sexual abuse in mothers x Group.

As can be seen from this table, the mothers of non-victimised perpetrators were the most likely to report sexual abuse experiences in their own childhood and the mothers of victims were no more likely to report MCSA than mothers in the antisocial comparison group.

***Nature of reported MCSA of mothers*:** Mothers reported the age at which they were first molested as children ranging from age 2 years to age 16 years. 18 mothers (52.9 %) reported age of onset before the age of 11 years and 16 (47.1 %) reported age of onset from age 11 - 16 years.

22 of the abused mothers (64.7 %) reported that the abuse lasted less than 6 months and 19 of these mothers reported experiencing a single episode of abuse. One mother reported a duration of 6 - 12 months and 11 mothers (32.4%) reported a duration of more than 12 months. 25 (73.5%) of the 34 abused mothers reported that they had been sexually abused by one perpetrator and 9 mothers (26.5%) reported that they had been abused by two or more perpetrators.

16 mothers (47.1 %) reported that they were abused by their father or a close male relative (brother, uncle or grandfather). One mother reported that she was abused by a

female teacher, this being the only reported female perpetrator. One mother reported experiencing 'date rape' at the age of 16 years and the remaining 16 mothers reported being abused by family friends (n=9) or by strangers or casual acquaintances (n=7).

Only six mothers disclosed their own abuse as a child, and 82.4% (n=28) did not disclose MCSA until they were adults, when they were most likely to disclose to a partner or spouse.

For the 34 mothers who reported MCSA, the severity of their abuse was categorised according to the criteria used in previous studies of adult women abused as children (Anderson et al., 1993). The table below (7.2.3.ii) summarises the severity of MCSA experiences. Where women reported more than one episode of abuse, the 'most severe' episode was categorised (cf. Anderson, Martin, Mullen, Romans and Herbison, 1993).

Type of Child Sexual Abuse reported	n	% of total abused mothers (n = 34)
Non-contact abuse	4	11.77
Non-genital contact abuse	4	11.77
Genital abuse - being touched	6	17.65
Genital abuse - touching abuser	4	11.77
Attempted intercourse	4	11.77
Actual intercourse (vaginal, anal)	12	35.30

Table 7.2.3.ii: Severity of mothers reported child sexual abuse experiences

In summary, 42.5% of the sample of eighty mothers reported some form of unwanted sexual experience as a child and 15.0% of the entire sample reported that they had experienced vaginal or anal penetrative abuse. This type of abuse is generally considered to be the most severe and likely to have the most lasting effects.

***Reported child abuse of fathers*:** Mothers were asked if they knew if the boy's father had been sexually abused as a child. 65 mothers (81.3%) said that no and only 2 (2.5%) said definitely yes. A further 13 mothers were either unsure, or in 2 cases, were not asked as they had never been married or reported that they did not know the identity of the boy's father.

***Child physical abuse*:** 27 mothers (33.75%) reported some form of parental physical abuse as a child. 18 of these mothers reported severe physical abuse including daily or weekly beatings and bruising or cuts to the skin as a result of the abuse. There were no significant differences between the four groups on reported physical abuse as a child ($H = 3.95$, df = 3, n.s).

7.2.4 History of adult abuse in mothers

***Adult sexual abuse*:** 14 mothers (17.5%) reported unwanted adult sexual abuse, which in 12 cases included anal or vaginal penetration, 1 case was of attempted intercourse and 1 case of genital contact abuse (but not penetration). There were no significant differences between the four boy groups on reported adult sexual abuse ($H = 3.25$, df =3, n.s).

***Adult physical abuse*:** 47 of the eighty mothers (58.75%) reported that they had experienced physical abuse or been assaulted since the age of 18 years, mostly by a spouse or partner. 39 of these women reported severe assaults including attacks with a knife, injuries during pregnancy leading to hospitalisation and being hit with a weapon (such as a telephone cord or wet towel). There were no significant differences between the four groups in reported adult physical abuse ($H = 5.69$, df =3, n.s).

7.2.5 Maternal responses to boy

***Expressed emotion variables*:** Three expressed emotion variables were rated by the author following interviews with mothers (see method section 6.4.1.1 for further details). Each of the three variables was rated on a four-point scale from 0 (none) to 3 (marked/severe). Mean ratings of expressed criticism, hostility and warmth are summarised in the table (Table 7.2.5.i) below.

GROUP >	Victim Perpetrators (n=21)	Non-victim Perpetrators (n=20)	Victims (n=23)	Antisocial Comparison (n=16)	Significance
Expressed Criticism (0 = no criticism 3 = high criticism)	1.48	1.05	1.00	1.44	n.s
Expressed Hostility (0 = no hostility 3 = high hostility)	0.91	0.45	0.22	0.31	$p < 0.02$
Expressed Warmth (0 = no warmth 3= high warmth)	1.05	1.40	1.30	1.44	n.s

Table 7.2.5.i: Mean ratings of expressed emotion x Group.

A Kruskal-Wallis one-way analysis of variance procedure was used to test for group differences. Mothers of victims and of antisocial boys expressed the least hostility when describing their sons and there were group differences on this rating ($H = 11.27$, df=3, $p < 0.02$). There were no significant group differences on expressed criticism ($H = 5.01$, df =3, n.s), or expressed warmth ($H = 3.58$, df =3, n.s). Mann-Whitney non-parametric tests were used to test for pairwise comparisons between mothers of victims (V and VP groups) and mothers of non-victims (NVP and AC groups). There were no differences on mean ratings of criticism ($U = 454.0$, n.s), hostility ($U = 513.0$, n.s), or warmth ($U = 515.0$, n.s).

Mothers of perpetrators (NVP and VP groups) were rated as significantly higher on the expressed hostility rating (mean rating = 0.68, s.d = 0.88) than mothers of non-perpetrators (mean rating = 0.26, s.d = 0.60), (U = 561.0, $p < 0.01$). There were no differences between these two groups on expressed criticism (U = 735.0, n.s) or expressed warmth (U = 707.5, n.s).

The following table (Table 7.2.5.ii) summarises the association between current depression, as measured by the BDI, and ratings of expressed criticism, hostility and warmth for all mothers (n = 73 mothers, due to missing data on BDI scores). Significance levels refer to one-tail tests as it was predicted that higher depression would be associated with higher ratings of expressed criticism and hostility and lower levels of expressed warmth.

	Depression (BDI)
Criticism	0.19
Hostility	0.21*
Warmth	-0.03

Table 7.2.5.ii: Spearman's rank correlation coefficients for depression scores x expressed emotion variables. (* $p < 0.05$).

There was, as expected, a significant positive association between depression and expressed hostility. The relationship was in the predicted direction between depression and expressed criticism but failed to reach conventional levels of significance ($p < 0.10$).

Response to abuse:

i) response to victimisation

Mothers of boys who were sexually abused (V and VP) were asked, during the course of the interview, to respond to questions relating to the discovery of their son's victimisation. Table 7.2.5.iii summarises results from these items, and includes results of testing for group differences using the Mann-Whitney test.

	Victims (n=23)	**Victim Perpetrators (n=21)**	**Sig.**
Number of mothers who reported knowing about abuse prior to son's disclosure	1 (4.3%)	1 (4.8%)	n.s
Number of mothers who reported being most angry with their son (victim)	2 (8.7%)	1 (4.8%)	n.s
Number of mothers who reported feeling that their son (victim) could have stopped the abuse	9 (39.1%)	12 (57.1%)	n.s

Table 7.2.5.iii: Number of mothers reporting selected maternal responses to victimisation of boys.

The 'Blame Cake' technique was used to assess the mother's apportioning of blame in the victimisation of their son. Mothers were asked to fill in sections of a cake or pie, to indicate who they blamed for the sexual abuse of their sons. The table below (7.2.2.iv) summarises the results.

	Victims MEAN	**Victim Perpetrators MEAN**	**Sig.**
Percentage blame to perpetrator of abuse	66.25	70.81	n.s
Percentage blame to son (victim of abuse)	8.51	4.61	n.s
Percentage blame to mother (self)	7.30	8.78	n.s

Table 7.2.5.iv: Mean percentage blame to victim, perpetrator and mother for boys victimisation.

The non-parametric Mann-Whitney test showed that there were no significant group differences between mothers of victims and victim perpetrators in the percentage responsibility ascribed to perpetrators of their son's abuse, their sons as victims or themselves.

ii) response to perpetration

Mothers of perpetrators (VP and NVP) were asked, during the course of the interview, to respond to questions relating to the discovery of their son's perpetration of child sexual abuse. The results from these questions are summarised in the table below (7.2.5.v):

	Non-victim Perpetrators (n=20)	**Victim Perpetrators (n=21)**	**Sig.**
Number of mothers who reported knowing about perpetration prior to disclosure	0 (0.0%)	1 (4.8%)	n.s
Number of mothers who reported being most angry with son (perpetrator)	14 (70.0%)	8 (38.1%)	$p < 0.05$
Number of mothers who reported feeling that their sons' victim could have stopped the abuse	10 (50.0%)	8 (38.1%)	n.s

Table 7.2.5.v: Number of mothers reporting selected maternal responses to perpetration by boys.

Mothers of non-victimised perpetrators were significantly more likely to report that they felt angry with their sons for perpetrating compared to mothers of victimised perpetrators. It is possible that mothers of victimised perpetrators felt that the sexual abuse of another child was mitigated by the boy's own sexual victimisation.

The 'Blame Cake' technique was used to assess the mother's apportioning of blame in their son's perpetration of child sexual abuse. Mothers were asked to fill in sections of a 'cake' or pie, to indicate who they blamed for the perpetration of child sexual abuse . The table below (7.2.5.vi) summarises these results.

	Non-victim Perpetrators MEAN	Victim Perpetrators MEAN	Sig.
Percentage blame to son (perpetrator of abuse)	62.25	33.61	$p < 0.01$
Percentage blame to boy's victim	7.75	15.18	n.s
Percentage blame to mother (self)	9.25	0.00	$p < 0.03$
Percentage blame to perpetrator of boy	not applicable	43.00	n/a

Table 7.2.5.vi: Mean percentage blame to victim, perpetrator and mother for boys perpetration.

Mann-Whitney non-parametric tests revealed that mothers of non-victimised perpetrators apportioned significantly more blame to their son for their sexual perpetrating than mothers of victimised perpetrators ($U = 91.0$, $p < 0.01$).

Mothers of non-victimised perpetrators apportioned significantly more responsibility to themselves for their son's sexual perpetration than mothers of victimised perpetrators who did not apportion any responsibility to themselves ($U = 127.5$, $p < 0.03$).

7.3 Maternal Depression

First, a general discussion of the preliminary results from the two standardised questionnaires will be presented. This will be followed by those hypotheses pertaining to maternal depression which do not include attributional analysis. Relevant hypotheses will be presented with results. Results from computing composite scores derived from the maternal semi-structured interviews relating to past history of depression will be presented and discussed. Finally results relating to mother's own experience of abuse and depression will be presented.

7.3.1 Current depression

Current depression was measured using standardised questionnaires, the Beck Depression Inventory to assess depressed mood, and the Beck Hopelessness Scale to assess pessimism (see section 6.4.3 for further details of questionnaires).

73 mothers (91% of the total sample of 80 mothers) completed the Beck Depression Inventory (BDI) and 64 mothers (80% of the total sample of 80 mothers) completed the Beck Hopelessness Scale (BHS). These two scales were developed to measure different but related aspects of depressed mood and the questionnaire scores were significantly correlated ($r = 0.59$, $p < 0.001$). The construct of pessimism measured by the BHS is described as the third component of the negative triad in Beck's (1967) cognitive model of depression, which includes a negative view about the self, the world and the future, so it is not surprising that the scores are correlated with the BDI. Beck and Steer (1988) present correlation coefficients of 0.49 to 0.74 (all significant at the 0.001 level) between the BHS and the BDI in various clinical samples.

Thirty-six percent (n = 26) of the 73 mothers scored above the cut-off point (total score >15) for clinical depression on the BDI, and fifty-eight percent (n = 42) scored above the cut-off point (total score >9) for mild depression. Eleven percent (n = 8) of the mothers scored above 30, indicating 'extremely severe' clinical depression. The rate of sub-clinical or mild depression is comparable to the rate of 50% reported in mothers of victims of sexual abuse (Wagner, 1991).

Although there is no established cut-off point for the Beck Hopelessness Scale (BHS), a score above nine indicates at least moderate hopelessness and has been used in validity studies predicting suicide attempts (Beck and Steer, 1988). Thirty-one percent (n = 20) of the 64 mothers who completed the BHS scored above 9. Twelve percent of the mothers (n = 8) scored above 14, indicating severe hopelessness or pessimism. Of those mothers (n = 8) who were severely depressed, as measured by the BDI, all were birth mothers and half of them also scored in the severe range on the BHS. Further analyses regarding depression and attributions are presented in the next section (see section 7.4.4).

For these analyses, two levels of depression (mild and clinical) were calculated.
i) Mild depressed vs. non-depressed. Mothers who scored above nine on the BDI were assigned to the Mild depressed group (n = 41) and those scoring nine or below were assigned to the Non-depressed group (n = 31).

ii) Clinical depressed vs. non-depressed. Mothers who scored above fifteen on the BDI were assigned to the Clinical depressed group (n = 26) and those scoring 15 or below were assigned to the non-depressed group. Where relevant, both levels of stringency for the BDI cut-off points were used to test hypotheses relating to depression.

Hypothesis 1: a) It was expected that there would be evidence of mild (sub-clinical) and clinical depression in all four groups of mothers in the study. b) It was also predicted that birth mothers would be more depressed than non-birth mothers, as foster mothers were likely to be selected for their ability to parent successfully and thus would be less likely to suffer from depression.

a) The means and standard deviations for BDI and BHS are presented in Table 7.3.i

Group	n	Mean	s.d	95% C.I. for mean
BDI				
Victim Perpetrators	16	17.25	10.69	(11.55, 22.95)
Non-Victimised Perpetrators	21	12.48	8.28	(8.29, 16.67)
Victims	20	14.85	10.49	(9.94, 19.76)
Antisocial Comparison	16	10.62	10.82	(4.86, 16.39)
BHS				
Victim Perpetrators	14	9.21	4.82	(6.69, 11.74)
Non-victimised perpetrators	16	6.12	5.11	(3.62, 8.63)
Victims	18	7.78	4.83	(4.19,11.37)
Antisocial Comparison	16	7.35	4.30	(5.14, 9.36)

Table 7.3.i: BDI and BHS scores for sample. Scores above 15 on the BDI and above 9 on the BHS indicate clinical levels of depression and pessimism respectively.

The distributions of the scores on both the BDI and BHS were tested for Normality using the Kolmogorov-Smirnov goodness of fit test (SPSS for Windows 6.0) which indicated that the distribution of BDI scores was not significantly different from normal, but the distribution of scores on the BHS was. Logarithmic data transformation of the BHS scores was carried out and the oneway analysis of variance procedure was carried out on the logarithm of BHS scores.

A oneway analysis of variance procedure was used to test for group differences, there was no difference on mean BDI scores (F = 1.30, df =3, n.s) or mean log (BHS) scores (F=1.17, df =3, n.s). All four group means were above the cut-off point for sub-clinical depression of 9 on the BDI and the mean for mothers of Victim Perpetrators was in the clinical range of depression (mean = 17.25, s.d = 10.69). Mean scores on the BHS were above 4 indicating at least mild hopelessness or pessimism on this scale.

Examination of the boxplots of the BDI and BHS for the four groups indicated the presence of both an outlier value and an extreme value within the comparison group. When these two subjects were excluded from the analysis of variance group mean differences reached significance ($p < 0.05$) on BDI scores. The post-hoc Bonferroni test for multiple comparisons of means revealed a significant difference ($p < 0.05$) between the Victim Perpetrator group and the Antisocial Comparison group.

b) As predicted, the birth mothers scored significantly higher on both the BDI and BHS when compared with non-birth mothers. On average, the birth mothers (n=64) scored near the clinical cut off point of 15 (mean = 14.75, s.d.= 10.46) on the BDI, whereas the non-birth mothers (n = 9) scored below the sub-clinical cut-off point of 9 indicating that they were not depressed (mean = 6.78, s.d = 5.85). This difference was statistically significant (t = 3.40,df = 16.41*, $p < 0.01$).

Similarly, on the BHS, birth mothers (n=55) scored within the mild/moderate range of hopelessness (mean = 8.05, s.d = 4.84) whereas non-birth mothers (n = 9) scored in the low/mild range (mean = 4.44, s.d. = 3.09). This difference was statistically significant (t = 2.96, df = 15.36, $p < 0.01$). As 75% of the non-birth mothers were foster mothers, it is not surprising that they scored lower on measures of maternal

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* Levene's test for equality of variances revealed significant group differences in the variance, thus the corrected, unequal t-value and corrected degrees of freedom, which often results in fractional values, is reported.

depression and hopelessness. Foster mothers are likely to be selected by social service departments on the basis of a history of successful parenting, stability and ability to provide a stable and nurturing environment for distressed children.

Hypothesis 2: It was predicted that mothers of sexually victimised boys (VP and V) would be more depressed than mothers of non-victimised boys (NVP and AC).

When the sample was aggregated into two groups, mothers of victimised and non-victimised boys, there was a tendency for mothers (n = 36) of victimised boys (mean BDI = 15.92, s.d. = 10.50) to be more depressed than mothers (n = 37) of non-victimised boys (mean BDI = 11.67, s.d. = 9.84), however this failed to reach conventional levels of significance ($t = 1.78$, $df=71$, $p < 0.08$).

When BDI scores for birth mothers only were considered the expected relationship was shown. Birth mothers (n = 31) of victimised boys were significantly more depressed (mean BDI scores = 17.59, s.d. = 10.30) than mothers (n = 33) of non-victimised boys (mean BDI score = 12.12, s.d. = 10.07), ($t=2.13$, $df = 62$, $p < 0.05$). The 95% confidence intervals for the mean depression score of mothers of victims were (12.49, 19.35) and for the mothers of non-victims (8.49, 14.85). These indicate that although the difference between the means of the two groups was not statistically significant, it may be of clinical relevance that while the mothers of non-victims were more likely to be only mildly depressed, mothers of victims were more seriously depressed.

Comparing all mothers on the BHS between the two groups showed a similar pattern which failed to reach statistical significance (Mann-Whitney $U = 399.0$, n.s). Another way of making pairwise comparisons was to aggregate the sample in order to compare mothers of perpetrators (VP and NVP) with mothers of non-perpetrators (V and AC). This comparison did not reveal any differences on the BDI ($t = 0.65$, $df=71$, n.s) or

BHS ($U = 373.5$, n.s). Looking at the 95% confidence limits for the means of the two groups there was considerable overlap for the intervals for mothers of perpetrators (11.31, 17.77) and mothers of non-perpetrators (9.47, 16.46). However this does reveal that both groups were at least mildly depressed (i.e. scored above 9 on the BDI).

7.3.2 Past depression

A composite score of self-reported episodes of past depression was calculated from the semi-structured interviews. Mothers were asked four questions regarding treatment for psychiatric complaints since the age of 18 years. The results are presented in the table below:

Self-reported symptoms of depression	**Yes**		**No**	
	n	**%**	**n**	**%**
At least one episode of depression since age 18 yrs	28	35.0%	52	65.0%
Received medication for depression	18	22.5%	62	77.5%
Treatment from psychiatrist/psychologist	10	12.5%	70	87.5%
Hospitalisation for depression	3	3.8%	77	96.2%

Table 7.3.ii: Self-reported symptoms of past depression (n = 80).

Women who reported at least one episode of depression in the past were asked for details of symptoms in order to establish the validity of this question. Responses which were rated as meeting clinical criteria for an episode of depression included clear evidence of depressed mood, disorders of eating, sleep and libido and interference with daily functioning. These scores were combined to form a composite variable by summing one point for each symptom producing an ordinal variable with scores of 0 to 4.

There was no significant difference on past depression between mothers of the four groups of boys (Kruskal-Wallis $H = 0.32$, df=3, n.s). Pairwise comparisons between mothers of victimised boys and non-victimised boys (Mann-Whitney $U = 726.5$, n.s) and mothers of perpetrator and non-perpetrator boys ($U = 769.5$, n.s) did not reveal any group differences. Although there were differences in current depression, as measured by the BDI, between birth mothers and non-birth mothers there was no such difference on this measure of past depression ($U = 394.5$, n.s).

7.3.3 Depression and previous abuse

Independent samples t-tests were used to test for group differences on all mothers for whom there was data relating to their own reported previous child sexual abuse (hereafter summarised as MCSA, for maternal child sexual abuse) and current depression as measured by the Beck Depression Inventory (n=72). Mothers who reported MCSA were significantly more depressed than mothers who did not ($t = 2.32$, $df = 56.33$, $p < 0.03$). The table below shows that mothers who reported MCSA had a mean BDI score in the clinically depressed range (above 15).

	n	Mean BDI	s.d	95% C.I for mean
No MCSA	40	11.13	8.67	(8.44, 13.81)
Reported MCSA	32	16.81	11.50	(12.83, 20.80)

Table 7.3.iii: Table of mean BDI scores x MCSA

The Beck Hopelessness Scale, measuring current pessimism or hopelessness, did not distinguish between mothers who reported MCSA (mean BHS = 8.68, s.d. = 5.67) and those who did not (mean BHS = 6.66, s.d. = 3.95) ($t = 1.55$, $df = 39.21$, n.s). Using the composite variable of past depression from the maternal semi-structured interview there was a significant association between past depression and reporting

previous sexual abuse (χ^2 = 11.23, df=4, p < 0.03). The chi-square test of association suggested that the more factors of past depression reported (self-reported episode, pharmacological treatment, intervention by psychiatrist, and/or hospitalisation) the more likely that previous CSA was reported. Some cells (i.e. those where mothers reported 3 or 4 factors of past depression) had expected frequencies below 5, but above 1.

The nature and severity of child sexual abuse has been linked to severity of impact and its effect on later mental health functioning. The mothers' own child sexual abuse experiences were recoded into two different variables to identify those experiences involving contact abuse and those involving vaginal or anal intercourse. These variables were then used to compare group differences in current depression as measured by the BDI.

There was no statistically significant difference on the BDI between the 24 mothers who reported previous contact sexual abuse (mean BDI = 18.75, s.d = 11.41) and those 9 mothers who reported non-contact abuse (mean = 12.00, s.d = 10.10) (t = 1.56, df =31, n.s). The 95% confidence intervals around the means for each group show that mothers who had experienced contact abuse had mean BDI scores which were in the clinical range of depression (14.18, 23.31) compared to those few who experienced non-contact abuse (5.40, 18.59) who had mean scores which included scores in both the non-depressed range and the clinically depressed range.

The 11 mothers who reported that their abuse had included sexual intercourse were significantly more depressed (mean BDI = 22.46, s.d = 12.21) than those 22 mothers whose abuse did not include actual penetration (mean BDI = 14.13, s.d = 10.03) (t = 2.09, df =31, p < 0.05). Those mothers whose MCSA experiences had included intercourse were highly likely to be clinically depressed at the time of the interview for this study (95% confidence limits around mean BDI (15.24, 29.67)). Mothers who

experienced MCSA which did not include penetration were also likely to be depressed but at a milder level (95% C.I (9.95, 18.33)).

There appeared to be no association between past depression (recoded into a binary variable) and either experience of contact child sexual abuse (χ^2 with Yates correction for continuity = 0.00, df = 1, n.s), or for experience of intercourse (χ^2 with Yates correction for continuity = 0.00, df=1, n.s).

7.4 Maternal Attributions

7.4.1 Reliability of the Leeds Attributional Coding System

Reliability was assessed for the extraction of causal statements and for the coding of dimensions. The reliability of coding for the principal dimensions of the Leeds Attributional Coding System (LACS) was assessed by two raters, the first rater (Dr Joanne Silvester, University of Leeds) was experienced in both training other raters and coding the LACS. Rater 1 was blind to all subject details. The second rater (Michelle New, present author) was trained to use the LACS for the purposes of this study.

7.4.1.1. Reliability of coding causal attributions

Attributions were defined as a statement of cause linked to outcome, with unambiguous causal relationship between cause and outcome. Reported attributions, where the Speaker is reporting on someone else's explanation, (*e.g. 'John thinks that he's lazy ')* or discounted attributions, where the Speaker discards a previously held belief *(e.g. I used to think that it was because of his illness,')* attributions were not included for coding.

A subset of 150 attributions from five randomly selected transcribed interviews were independently coded for the reliability assessment. The kappa statistic (Cohen, 1960) was used to compute inter-rater agreement over and above chance agreement, using the computer program HANDY KAPPA written in Microsoft BASIC (Jackson, 1983). Kappa values are shown in Table 7.4.1.i together with percentage inter-rater agreement. Kappa values are generally considered to be acceptable between 0.4 and 0.7 (Fleiss, 1981). All Kappa values were significant at less than 0.0001 level.

LACS Dimension	Reliability
Stable-Unstable	kappa = 0.56, 80% agreement
Global-Specific	kappa = 0.51, 75% agreement
Internal-External	
Speaker	kappa = 0.44, 85% agreement
Agent	kappa = 0.67, 85% agreement
Target	kappa = 0.46, 76% agreement
Personal-Universal	
Speaker	kappa = 0.53, 85% agreement
Agent	kappa = 0.33, 70% agreement
Target	kappa = 0.49, 74% agreement
Controllable-Uncontrollable	
Speaker	kappa = 0.52, 90% agreement
Agent	kappa = 0.55, 77% agreement
Target	kappa = 0.49, 82% agreement

Table 7.4.1.i: LACS dimensions and reliabilities.

The Personal-Universal dimension for Agent had a kappa value of 0.33 which although significant at the 0.00003 level is not an acceptable kappa level and was not used in further analysis. A disproportionate number of attributions were rated as Personal by both raters. See final chapter (8.4) for further discussion.

The reliability data presented in the LACS manual was based on an overall test of agreement between five judges for each dimension for 217 attributional statements. Kappa values range between 0.07 for the Global - Specific dimension to 0.56 for the Internal - External dimension, and they report a kappa value of 0.30 for the Personal - Universal dimension, which is comparable to that found in this study. Subsequent reliability studies reported by Stratton et al., (1988) indicate good inter-rater agreement but do not report kappa values. Stratton et al., (1988) conclude that reliability was adequately established using early versions of the LACS manual which

was subsequently improved, thus increasing the applicability of the coding system. Other studies using the LACS have demonstrated good inter-rater percentage agreement and acceptable kappa values (e.g., Brewin et al., 1991; Joseph et al., 1991) indicating that it is a reliable technique.

7.4.1.2 Extraction of statements

Statements were extracted according to the guidelines in the LACS Manual (see Chapter 4 of Manual: Identifying causal beliefs; Stratton et al., 1988). All statements indicating a belief or cause linked to an identifiable outcome were extracted from the verbatim transcripts. For the purposes of reliability, three transcripts, chosen at random, were extracted independently by Rater 1 and Rater 2. The following table indicates the number of extracted statements agreed upon by Rater 1 and Rater 2 for three subjects chosen at random.

Statements Agreed	Rater 1 Only	Rater 2 Only	Percentage Agreement
91	19	29	65.0 %
27	6	11	61.0 %
118	25	30	68.0 %

Table 7.4.1.ii : Number of extracted statements and percentage agreement among raters.

This yields an overall percentage agreement score of 64.7 % between the two raters. It is difficult to establish how acceptable this level of agreement is. An attributional statement may have been discarded at the coding stage if it was decided that the statement was not an attribution, or if there was a cause but no discernible outcome. (e.g., "*it may have been just because he was tired*" where no clarification of 'it' was made by the Speaker). This guards against coding a statement that is in fact not a

causal attribution and places more emphasis on the importance of reliability of coding the dimensions of the attributions (discussed in section 7.4.1.1).

The LACS manual used five raters to independently extract statements from family therapy sessions, they reported that by taking the rater with the fewest statements identified, their statements were extracted by *at least one other rater* in 140 out of 161 cases (i.e. 88% of attributional statements). Stratton et al., (1988) conclude that 'false positives' (identifying a statement which is not an attribution) is not a major problem and would prove uncodable in the next phase of the process, as was the case in the present study. For the remainder of the analysis to establish reliability of the coding system, Stratton et al., (1988) adopted the conservative use of statements only if they were agreed upon by two raters.

In the present study this approach was not adopted as Rater 1 did not have access to the same information about the Speaker (mother) that Rater 2 (MN) did. Rater 2 carried out the interviews and transcribed them and thus had a much fuller knowledge of the subject. As Rater 2 consistently identified more attributional statements than Rater 1, this extra knowledge may have increased the identification of causal statements. The LACS is a flexible system and the Manual recommends that certain adaptations may need to be made. The rating of certain dimensions may be influenced by the design and aims of the study which may also have resulted in Rater 2, who had knowledge of these aims, identifying more attributional statements than Rater 1.

As the level of chance agreement is likely to be very low when extracting causal statements from transcribed interview material, the Cohen's (1960) K (kappa) coefficient was not calculated on extracted statements.

7.4.1.3 Associations between dimensions

The correlations between dimensions of the LACS are presented in Table 7.4.1.iii. Correlations are presented for negative outcomes only and are reported for Speaker, Target and Agent. The LACS manual presents correlations between dimensions, presumably aggregating across Speaker and Target as coding separately for Agents had not yet been incorporated into the study of validity. In the present study, standardised scores (*z*- transformed) for Internal, Personal and Controllable dimensions were added together across Speaker, Agent and Target to yield an overall score on each dimension. Pearson's correlation coefficients were calculated for these dimensions and the Stable and Global dimensions to examine inter-correlations between dimensions. Correlation coefficients are reported together with two-tailed levels of significance. The table below summarises these results:

	Global	**Internal**	**Personal**	**Controllable**
Stable	.04	-.25*	-.18	-.21
Global		-.11	.19	.05
Internal			.26*	.14
Personal				.11

Table 7.4.1. iii : Correlations between dimensions of attributions. (n=79 mothers, negative attributions only, * $p < 0.05$, ** $p < 0.01$, ***).

The highest correlation was between Personal and Internal dimensions which indicates that these dimensions were not truly orthogonal dimensions. This is not surprising as Personal causes (e.g.., *I failed the test because I was having a really bad day)* are almost invariably Internal (although not necessarily vice versa).

The use of the Personal - Universal dimension may require more refinement before it can add anything to the rating of Internality. Other studies employing the LACS have also found significant correlations between the Personal and Internal dimensions

(Brewin, MacCarthy, Duda and Vaughn, 1991 report a correlation coefficient of $r = 0.42$, $p < 0.01$). The Personal dimension also had poor reliability and was not used in subsequent analyses.

There was also a significant negative association between the Stable and Internal dimensions which indicates that attributions to Internal causes were more likely to be viewed as Unstable (*e.g. 'he had a really bad cold, so he was in a filthy mood')* that is, to causes which are unlikely to apply to future negative events.

The validity study presented by Stratton et al., (1988) reports a strong correlation between Internal and Personal dimensions ($r = 0.83$, $p < 0.001$). However, when these dimensions were looked at by considering Speakers and Targets separately on Internal and Personal dimensions for different outcomes, the dimensions were considered to be sufficiently different to warrant separate coding (Stratton et al., 1988, p.100).

7.4.2 Nature of maternal attributions

Out of the eighty mothers, seventy-nine of them had full verbatim interviews transcribed (one subject was interviewed but did not give consent to audiotape the interview). Attributional statements were extracted according to guidelines in the LACS manual (Stratton et al., 1988). The 79 mothers in the sample made a total of 2,770 attributions for events covered by the interview pertaining to personal histories of themselves and their sons. Attribution theory suggests that causal attributions are made for unwanted and unpredictable events in people's lives, and this was borne out by mothers in this study making primarily negative attributions. 82.5% (2,285 attributions) in total, were for negative events, and 4.9 % (135 attributions) were for positive, or desirable outcomes. The remainder were either neutral (12.6 %) or unrateable (0.1%).

For all attributions made there was no clear bias towards either of the two main dimensions of Stable-Unstable and Global-Specific. 49% (1357) of all attributions were Stable and 47.4% (1313) of all attributions were Global.

Consistent with previous work in this area attributions for negative outcomes only were included in further analysis. For the sake of brevity, these will be referred to as negative attributions throughout this thesis. Of the 2285 negative attributions, the overall frequency of different types of attribution was as follows. Negative attributions were approximately equally Stable and Unstable (1116 vs. 1161) and were also approximately equally Global and Specific (1107 vs. 1176).

With respect to the mother's attributions (Speaker attributions), negative attributions were mostly External (83%), Universal (82%), and Uncontrollable (86%). This in fact tells us very little and it is the attribution of cause to self and other as reflected by the Speaker's nomination of Agents and Targets which are analysed in this study.

The LACS does not categorise topic of outcome, apart from the valence or 'desirability' of outcome (negative, neutral or positive). In this study, attributions about sexual abuse were seen to be of particular importance and the topic of the attribution was coded. The topic of the attribution, for cause and outcome, and the percentage of negative attributions which were rated in these categories are presented below:

Topic	**Topic of Cause**	**Topic of Outcome**
Sexual abuse	12.6%	14.2%
Physical abuse	2.0%	5.3%
Emotional abuse	0.5%	0.5%
Boy's behaviour	34.6%	31.3%
Other	50.2%	48.7%

Table 7.4.2.i. Topic of negative attributions produced.

Thus, for all negative attributions, only an average of 13.4% specifically mentioned sexual abuse as the topic of the attribution. When considering mothers of case group boys only (Victim perpetrators (VP), Non-victimised perpetrators (NVP), and Victims, (V)), this average rose slightly to 16.6%. This finding is noteworthy given that the focus of the interview was about these mothers responses to their son's sexual abuse, and for the case groups, this was the primary reason for referral to the clinical department. This will be discussed further in the next chapter (Chapter 8).

This study explored negative attributions in general, rather than specifically addressing only those attributions for child sexual abuse. With respect to the unit of analysis, the *proportion* of negative attributions comprised the primary dependent variable, rather than absolute numbers of negative attributions. Converting absolute numbers to proportions allows comparability across subjects who may have made different numbers of attributions. The range in absolute numbers of negative attributions produced was 6 to 75, with a mean number of 28.92 (s.d. = 13.61).

The following figure (7.i) provides a brief reminder of LACS guidelines for coding causal attributions as well as an indication of the nature of negative attributions made by mothers in this particular study. According to convention, italics symbolise verbatim transcribed material and causal factors are underlined.

" I think it was all just part of growing up , I think 'Mark' did it, but I don't think it was done to hurt her" (Birth mother of 13 yr old 'Mark'., who abused his neighbour's five year old daughter).
This attribution was coded Unstable, Specific, and Internal, Universal and Uncontrollable to Boy ('Mark') as Agent and Target.

"I suppose because 'Ron' had been abused and was experimenting with something he learned himself, he abused the others" (Birth mother of 15 yr old 'Ron', who was sexually abused by his own father, and sexually abused his two younger sisters, and younger brother).
This attribution was coded Stable and Global, and External, Universal and Controllable to Boy ('Ron') as Agent and Target.

" 'Ann' must be incredibly insensitive to 'Jay' or just stupid, it wasn't fair (on Jay) to let 'Louise' run around without any (pants) on, I just couldn't believe it"
(Foster mother of 15 yr old 'Jay', who sexually abused Ann's 2-year old daughter, 'Louise').
This attribution was coded Stable, Global and Internal, Personal and Controllable to "Ann' as Agent and External, Universal and Uncontrollable to 'Jay'.

Figure 7.i: Examples of coding causal attributions

7.4.2.1 Distribution of negative attributions

A Kolmogorov-Smirnov Goodness of Fit Test indicated that negative attributions were approximately normally distributed, as were the proportions of negative attributions. There was no difference in the proportion of negative attributions made by birth mothers compared to non-birth mothers.

The Levene Test indicated that homogeneity of variance between the four groups on proportions of negative attributions could not be assumed, so the non-parametric Kruskal-Wallis one-way analysis of variance technique was used. This indicated that there were significant differences between the four groups ($H = 10.92$, df=3, $p < 0.02$), and that the antisocial comparison group made the highest proportion of negative attributions out of all the groups.

There was no significant difference in the proportion of negative attributions made between the mothers of victimised boys (V and VP; mean proportion = 83.21, s.d = 10.00) and mothers of non-victimised boys (NVP and AC; mean = 84.19, s.d = 11.49), ($t = 0.41$, df=77, n.s). However, mothers of perpetrating boys (NVP and VP; mean = 81.30, s.d = 12.16) did make a significantly *lower* proportion of negative attributions than mothers of non -perpetrating boys (V and AC; mean = 86.10, s.d = 8.36), ($t = 2.04$, df=77, $p<0.05$).

The relationship between attributions and depression is considered in section 7.4.4 and the relationship between boy's group and proportions of negative attributions will be discussed further in that section.

7.4.3 Agents and Targets of attributions

According to the LACS manual, Agents are those persons nominated by the Speaker (mother) in the cause of the attribution and Targets are the persons to whom the outcome happens. Previous research has not coded Agents separately, but this is now considered to be an important focus for attributional coding (Stratton et al., 1988). The table below (7.4.3.i) lists persons identified by Speakers for all negative attributions (n = 2285 attributions).

Person nominated by Speaker/Mother	AGENT (%)	TARGET (%)
Mother/Subject	19.7	40.9
Boy	37.3	38.4
Father/Partner	15.1	8.0
Subject's own parents	8.0	2.9
Sibling	5.1	5.8
Professional	2.8	0.1
Perpetrator of Boy	2.1	0.7
Perpetrator of Mother	1.3	0.1
Victim of Boy	1.0	1.4
Other	8.0	1.8

Table 7.4.3.i: Agents and Targets of all attributions for negative outcomes (n=79 mothers).

This table illustrates the range of personnel identified in the attributions produced by mothers in this study. It also indicates that most of the attributions produced included mothers speaking about themselves or their sons as Agents in 56% of attributions and as Targets in 79% of negative attributions. As the maternal semi-structured interview was focused around events in the mothers and sons lives this was expected. Findings regarding Agents and Targets in analysis of negative attributions specifically about sexual abuse will be considered in section 7.4.5.

7.4.4 Attributions and depression

Hypothesis 3: It was hypothesized that depressed mothers would make more negative attributions than non-depressed mothers. As depression is associated with flat affect and reduced verbosity, it is the proportion of negative attributions that was hypothesized to differentiate the depressed group from the non-depressed group.

Maternal depression was measured using the Beck Depression Inventory (BDI), and were divided into one of two groups. Mothers who scored above 9 on the BDI were

assigned to the Mild Depressed group (n = 41) and those scoring 9 or below were assigned to the Non Depressed group. Mothers who scored above 15 on the BDI were assigned to the clinically depressed group (n = 26) and those scoring 15 or below were assigned to the Non-clinically depressed group (n = 46).

As can be seen from table 7.4.4.i, independent samples t-tests showed that there was no significant difference between the mean proportion of negative attributions produced for negative outcomes, between depressed and non-depressed mothers (t = 1.58, n.s).

Group	Mean proportion of negative attributions	95% C.I. for mean	Significance
Clinically Depressed (>15 on BDI)	86.97 %	(83.15, 90.80)	n.s
Not Depressed (≤ 15 on BDI)	83.10 %	(80.22, 85.90)	

Table 7.4.4.i: Proportions of negative attributions x Depression

The BDI scores were also recoded into two groups of mild depression (score > 9) and not depressed (≤ 9), and there was no significant difference between these two groups in the mean number of proportion of negative attributions (t = 0.40, n.s). The mild depressed group produced a mean proportion of 84.91 % negative attributions and the non-depressed group had a mean proportion of 84.0% negative attributions.

It was expected that the worse the depression (higher the BDI scores) the higher the proportion of negative attributions. Using Pearson's correlation coefficient with one-tailed significance testing, the association was in the expected direction, but failed to reach conventional levels of significance ($r = 0.18$, $p < 0.07$). It is interesting to note that when considering the absolute number of negative attributions, there was a similar

association in the expected direction which failed to reach conventional levels of significance ($r = 0.22$, $p < 0.06$).

The Kruskal-Wallis one-way analysis of variance procedure was used to test for differences in the proportions of negative outcomes between the groups. This was significant at the 0.02 significance level (see previous section 7.4.2.1). The antisocial comparison group had the largest average rank indicating that this group produced a higher proportion of negative attributions than any other group. By contrast, this group had the *lowest* mean depression score (mean BDI = 10.63, s.d =10.82), although this was not significantly different from the mean scores for the other three groups (see Section 7.3.i).

The following table (7.4.4.ii) provides a summary of means and standard deviations for the proportion of negative attributions produced by each group.

Group	N	Mean	S.D.
Victim Perpetrators	19	83.43	10.95
Non-victimised Perpetrators	21	79.37	13.12
Victims	23	83.03	9.40
Antisocial Comparison	16	90.52	3.48

Table 7.4.4.ii. Table of mean proportion of negative attributions x Group.

As the interview focussed on negative events, namely abuse and adverse experiences of mothers and sons, it is not surprising that mothers made an overall high rate of attributions to causes of negative events.

In order to analyse the relationship between negative attributions, maternal depression and group effects, a two-way analysis of variance test was carried out. This indicated that the main effect of depression (as measured by the BDI using the clinical cut off point of 'above 15' to indicate depression) had a significant effect on the dependent

variable (proportion of negative attributions). The table of means indicates that the depressed group produced proportionately more negative attributions than the non-depressed group (Table 7.4.4.iii). This is consistent with attribution theory which suggests that attributions are more likely to be negative when depressed, or that there is selective attention to negative outcomes. Each mother was interviewed using the same semi-structured interview format and it is important to bear in mind that these interviews were focused on negative life events.

There were significant group differences in the proportions of negative attributions produced. In keeping with findings from the Kruskal-Wallis one-way analysis of variance, the table of means indicates that the antisocial comparison group appear to produce proportionately more negative attributions (see Table 7.4.4.iii). A summary of the 4 x 2 analysis of variance is given in Table 7.4.4.iv. Mothers of the antisocial comparison group boys produced the highest proportion of negative attributions in both the depressed and the non-depressed groups. However the interaction effect between boy group and depression was not significant.

	Clinically Depressed			Non Depressed		
GROUP	**N**	**MEAN**	**S.D.**	**N**	**MEAN**	**S.D.**
Victim Perpetrator	8	89.64	6.93	7	82.49	7.42
Non-victimised Perpetrator	8	84.30	13.76	13	76.34	12.27
Victim	7	84.01	8.96	13	83.54	9.25
Antisocial	3	93.83	2.66	13	89.75	3.26

Table 7.4.4.iii: Means and standard deviations for proportion of negative attributions x Depression x Group.

The results of the two-way analysis of variance are presented in the following table (7.4.4.iv).

Main Effects	DF	Mean Square	F	Significance
Boy Group	3	303.61	3.57	$p < 0.02$
Maternal Depression	1	351.75	4.13	$p < 0.05$
2-Way Interaction	3	51.97	0.61	n.s.

Table 7.4.4.iv: x 2 ANOVA table. Effects of boy group and maternal depression on dependent variable (proportion of negative attributions).

The two-way analysis of variance procedure was used to examine the effects of maternal depression and either victim or perpetrator status of the boys. There were no significant main effects of victim status ($F = 0.00$, $df = 1$, n.s.) or clinical depression ($F = 2.36$, $df = 1$, n.s.) and no interaction effect ($F = 0.00$, $df = 1$, n.s.) on the proportion of negative attributions produced. Similarly, there were no significant main effects of perpetrator status ($F = 2.77$, $df = 1$, n.s.) or clinical depression ($F = 0.26$, $df = 1$, n.s.), and no interaction effect ($F = 0.01$, $df = 1$, n.s).

Using the less stringent cut-off point of 9 on the BDI, two-way analyses of variance revealed no significant differences for either independent effects of depression ($F = 0.10$, $df = 1$, n.s.), or victim status ($F = 0.04$, $df = 1$, n.s.), or for interaction effects ($F = 0.36$, $df = 1$, n.s). This is not surprising given that the more severe level of depression did not differentiate groups according to victim status of boy on the proportion of negative attributions produced. However, the following tables (7.4.4.v and vi) indicate that when considering mothers of perpetrators compared to non-perpetrators, there is a significant main effect of perpetrator status. There is also an interaction effect between mild depression in the mothers and perpetrator status of the boy.

	Mildly Depressed			Non Depressed		
GROUP	**N**	**MEAN**	**S.D.**	**N**	**MEAN**	**S.D.**
Perpetrator (VP, NVP)	23	85.02	10.78	13	77.38	11.83
Non-Perpetrator (V, AC)	18	84.77	8.82	18	88.70	6.15

Table 7.4.4.v: Table of means of proportion of negative attributions x perpetrator status x mild maternal depression

The results of the two-way analysis of variance are as follows:

Main Effects	**DF**	**Mean Square**	**F**	**Significance**
Perpetrator Status	1	529.55	5.81	$p < 0.05$
Mild Maternal Depression	1	59.36	0.65	n.s.
2-Way Interaction	1	578.59	6.34	$p < 0.05$

Table 7.4.4.vi 2 x 2 ANOVA table. Effects of perpetrator status and maternal depression on dependent variable (proportion of negative attributions).

It appears that the mildly depressed mothers of perpetrating boys produce a higher proportion of negative attributions than non-depressed mothers of these boys, but this effect is reversed for mothers of non-perpetrating boys where the mildly depressed mothers produce a lower proportion of negative attributions.

The results regarding Hypothesis 3 are not easily interpreted. There is some evidence of an association between depression and the proportion of negative attributions when boy's group is taken into consideration.

Hypothesis 4: (a) 'Self-blame' has been conceptualised as the attribution of negative outcomes to causes within the person. It was hypothesized that (a) depressed mothers would be more likely to identify themselves as Agents of negative outcomes and, (b) that depressed mothers would be more likely to identify themselves as Targets of negative outcomes.

(a) The distributions of all the variables relating to dimensions of cause in attributions where the mothers identified themselves as Agents (e.g. proportion of Internal to Agent) and the Kolmogorov-Smirnov test revealed that all were approximately normally distributed, this was repeated for attributions where mothers identified themselves as Targets and all variables were approximately normally distributed. Independent samples t-tests were used to test this hypothesis, which was confirmed for both levels of severity of depression.

Clinically depressed mothers were significantly more likely to nominate themselves as Agents of negative outcomes compared to non-depressed mothers ($t = 2.71$, $df = 63.37$, $p < 0.01$). This difference held true for the mildly depressed mothers compared to the non-depressed mothers ($t = 2.03$, $df = 70$, $p < 0.05$). An example of a mother nominating herself as Agent is *"I think I led him on, I blame myself...at 13 you try to lead them on a bit don't you...I was a bit scared really, they held me down while he did it to me round the school buildings"* (description of why Ms A., mother of 15 year old non-victimised perpetrator 'Nicky', was raped at age 13 years by two older boys at school).

Computing a new variable of proportions of negative attributions where the mother identified herself as the Agent and attributed the cause to Internal factors made it possible to test for differences between the depressed and non-depressed groups on this definition of 'self-blame'. In fact, there was no correlation between the proportion of such attributions (Internal to Mother as Agent) and scores on the BDI ($r = .03$, n.s).

In order to test mean differences between depressed and non-depressed mothers on this variable, the binary code of depressed/non-depressed based on BDI scores above and below 15 was used. This analysis also showed that there were no significant differences on this Internal to Agent (for mother) variable for depressed (mean = 63.96%, s.d = 31.87) and non-depressed (mean = 66.96%, s.d = 22.79) groups of mothers (t = 0.42, df=67, n.s). Although Internal to Agent seemed to be a more valid measure of 'self-blame' than previously identified, it is likely that considering other dimensions such as Personal and Controllable may help refine the construct of 'self-blame'. Coding the Personal dimension for Agent was not reliable in this study.

(b) Clinically depressed mothers were significantly more likely to nominate themselves as Targets of negative outcomes than non-depressed mothers ($t = 2.68$, $df = 67$, $p < 0.01$). This difference remained for the mildly depressed mothers compared to the non-depressed mothers ($t = 2.51$, $df = 70$, $p < 0.02$). An example of a mother identifying herself as Target of negative attributions is: " *I am the black sheep of the family now, because my kids have been taken away from me*" (Mother of 15 year old victimised perpetrator, James).

As in 4 (a), a new variable was computed in order to calculate the proportion of negative attributions where mothers identified themselves as Targets and attributed causes for negative outcomes to Internal factors (Internal to Target). There was no correlation between this variable and BDI scores (r = -.02, n.s). Using the binary code of depressed/non-depressed based on BDI scores above and below 15, also indicated that there were no significant differences on this Internal to Target (for mother) variable for depressed (mean = 27.25%, s.d = 19.82) and non-depressed (mean = 27.00%, s.d = 19.29) groups of mothers (t = 0.05, df=67, n.s).
Thus, depressed mothers, at levels of both clinical and mild depression, were significantly more likely to nominate themselves as Agents and Targets of undesirable events.

This is consistent with the cognitive models of depression which identify a depressed view of the self and the world. It would seem that an attribution to Internal causes for Self as Agent or Target of negative events may constitute a more refined construct of 'self-blame' (e.g. bad things happen because of something about me, rather than due to external or circumstantial causes). However, the expected relationship with depression was not found.

Although Internal to Agent seemed to be a more valid measure of 'self-blame' than previously identified, it is likely that considering other dimensions such as Personal and Controllable may add to this conceptualisation of 'self-blame'. (See Hypothesis 6).

Hypothesis 5: (a) It was hypothesized that there would be group differences between the proportion of attributions where the mother identified herself as Agent and the proportion where she identified her son as Agent of negative outcomes. (b) It was expected that mothers of victimised boys (V and VP) would be more likely to identify their sons as Targets of negative outcomes. (c) It was expected that mothers of perpetrator boys (both victimised and non-victimised) would be more likely to make attributions identifying their son as Agent of negative outcomes.

Although this hypothesis does not pertain to maternal depression, it is presented here with results as it relates to the next hypothesis concerning the relationship between depressed mood and nominating Agents and Targets of negative attributions.

(a) Using oneway analyses of variance to test for group differences it was found that there were no significant differences between any of the four groups in the proportion of negative attributions where mothers nominated themselves as the Agent of negative attributions ($F = 0.04$, $df = 3$, n.s.). There were no group differences for attributions in which mothers nominated their son as the Agent of negative outcome ($F = 1.26$, $df = 3$, n.s.). Similarly, there were no group differences for mother as Target of negative

outcome (F = 1.88, df =3, n.s.), or boy as Target of negative outcome (F = 0.94, df=3, n.s.).

(b) Mothers of victimised boys (V and VP) were no more likely to identify themselves as Agents (t = 0.07,df=77, n.s.) or Targets (t = 1.44,df=77, n.s.) than mothers of non-victimised boys (NVP and AC). Similarly, mothers of victimised boys were no more likely to identify their sons as Agents (t =1.41,df =77, n.s.), or Targets (t = 0.65,df=77, n.s.) of negative outcomes than mothers of non-victimised boys.

(c) Mothers of perpetrator boys (VP and NVP) were no more likely to identify themselves as Agents (t = 0.24, df=77, n.s.) or Targets (t = 0.58, df =77, n.s.) than mothers of non-perpetrator boys (V and AC). Similarly, mothers of perpetrator boys were no more likely to identify their sons as Agents (t = 0.75, df=77, n.s.) than mothers of non-perpetrator boys.

This hypothesis was not confirmed. This is contrary to expectations that mothers of boys who were perpetrators or antisocial may be more likely to be identified as Agents of. negative outcomes and that mothers of victimised boys would be more likely to identify their sons as Targets of negative outcomes.

By looking at only those attributions where the boy was identified as Agent of negative outcomes, some interesting associations emerged. Syntax statements were used to select out only those attributions where boy was Agent for negative outcomes, which yielded a sub-sample of 852 attributions produced by 79 mothers (mean = 10.78). For those attributions where boy was identified as Agent, he was also identified as Target of negative outcomes in 52.5% of attributions and mother identified herself as Target in 33.2% of attributions. There was no association between whether boy or mother was identified as Targets for these attributions between the four groups (χ^2 = 2.77, df =3, n.s) for these attributions where boy was Agent of negative outcome. The rest of the Targets (14.3%) consisted of others including siblings, fathers or father figures.

In only 2.1% of these negative attributions where boy was Agent, the Target was the victim of the boy's perpetration of sexual abuse.

When looking at the dimensions of cause for these attributions, there was an association between group for each dimension studied (the Personal dimension was not included due to poor reliability, see Section 7.4.1). On the Stable-Unstable dimension, there was a highly significant association between boy group and attributing causes to Stable factors ($\chi^2 = 29.99$, df =3, $p < 0.001$).

Approximately 75% of the mothers of antisocial boys attributed causes for negative outcomes, where their son was Agent of this outcome, to Stable causes. The two examples below show maternal attributions to Stable causes when the boy is nominated as Agent:

a) " *he had quite a history of thieving, Alan has had a lot of emotional trauma over the past couple of years which has resulted in this excessive attention getting and I really see the thieving as part of this attention getting"*
(Mother of 11 year old 'Alan' : Antisocial Comparison group).

b) " *Robert has got this tendency that when he gets upset, he will try and harm himself..bang his head on the wall and he gets himself into such a temper"*
(Mother of 12 year old 'Robert': Antisocial Comparison group)

There was also a highly significant association between group and attributions to the Global-Specific dimension ($\chi^2 = 20.17$, df =3, $p < 0.01$). Mothers of antisocial boys and mothers of victims were more likely to attribute causes of negative outcomes where boy was Agent, to specific rather than global causes. The two examples below illustrate maternal attributions to specific causes, that is the causes have limited effects from the perspective of the Speaker (mother).

a) " *Joe is a very determined character we had to give him the key that time, he broke something, he broke the glass"* (Mother of 15 year old 'Joe': Antisocial Comparison group).

b) " *Leo was just so upset (about the abuse) that he had to do something, he went and stole the ball from the Post Office"* (Mother of 11 year old 'Leo': Victim group).

There was a significant association between boy group and the Internal-External dimension ($\chi^2 = 11.93$, df =3, $p < 0.01$). Mothers in all four group were attributed high rates of negative outcome, however there were significant group differences with over 90% of the mothers of Antisocial boys making attributions to Internal causes when their son was nominated as Agent.

a) *"Alex is basically lazy, that is what concerns me about him, he won't put any effort into his school work, if he was just dumb I could understand, but it is sheer laziness"* (Birth mother of 14 year old antisocial comparison group boy).

b) " *he goes into deviLish mode, his eyes flare black and off he runs, he has got no worries about himself or anyone else...he is really insecure and paranoid you can't whisper without him going off the deep end, he is very wearing to keep up with"* (Birth mother of 11 year old Antisocial Comparison group boy).

Finally, there was an association between group and attributions to Controllable causes ($\chi^2 = 29.54$, df =3, $p < 0.001$). Visual inspection of the data showed an even distribution of attributions to Controllable and Uncontrollable causes for mothers of victim perpetrators, non-victimised perpetrators and victims, but that the mothers of antisocial boys were more likely to attribute negative outcomes, where boy was Agent, to Controllable causes. The following are examples of maternal attributions where boy

is Agent, and the cause of negative events is attributed to causes that are Controllable by the boy.

a) *" Tony is very angry with me a lot of the time, he turns everything around so it's my fault, he is aggressive to me and to his sisters and brother, he picks fights with me too"* (Mother of 11 year old 'Tony': Antisocial Comparison group)

b) *" Andrew is argumentative, a con artist... don't sound very nice does it, he just won't do as he's told, he's really difficult, he loves to argue with his father, he tries to get off school, he don't like waking up , he don't like washing up"* (Birth mother of 13 year old 'Andrew', a victim of child sexual abuse).

Hypothesis 6: It was predicted that depressed mothers would be more likely to blame themselves for negative events compared to non-depressed mothers. Thus, depressed mothers would be expected to be more likely to attribute causes to Internal, Personal or Controllable outcomes than non-depressed mothers where they nominate themselves as Agents of negative outcomes, compared to non-depressed mothers.

Each dimension was assessed separately for those attributions where Mother was Agent of negative outcomes. Analyses were not conducted on Personal to Agent data due to low reliability. Clinically depressed mothers tended to make proportionately more Internal attributions for themselves as Agents of negative outcomes, but this was not significantly different from the non-depressed group ($t = 0.42$, $df = 67$, n.s.). There were no significant differences found for mothers as Agents on the Controllable dimension. When comparing the mildly depressed group (BDI > 9) with the non-depressed group, there were no differences for mothers as Agents of negative outcomes on the Internal or Controllable dimensions.

The negative findings here suggest that attributions of cause to other dimensions (namely Stable and Global) may be more instructive in understanding the relationship between 'self-blame' and depression (Janoff-Bulman, 1979).

The findings might also suggest that the *relational* nature of attributions needs to be considered as suggested in other studies of distressed relationships (see Fincham, Beach and Baucom, 1987). In particular, the relation between Control attributed to Self versus Other for negative outcomes has been identified as critically important in parent-child relationships (Bugental, 1992; Bugental et al., 1993). Hypotheses 13 and 14 address this further.

Hypothesis 7: Depression has been associated with a pattern of attributing negative events to Internal, Stable and Global causes, this is known as the 'depressive attributional style' (Seligman et al., 1979). It was predicted that depressed mothers would be more likely to show this pattern of attributions than non-depressed mothers.

The number of mothers who made any attributions with this pattern for negative events was small. This is contrary to the hypothesis which suggests that this pattern of attributing negative outcomes to Internal, Stable and Global causes is characteristic of depressive thinking. A majority of subjects in this study (58%) were at least mildly depressed according to their scores on the BDI at the time of their interview from which attributions were coded.

Number of negative attributions with 'depressive attributional style'	**Frequency**	**Percentage**
None	32	40.5 %
One	28	35.0 %
Two	13	16.3 %
Three or more	6	7.6 %

Table 7.4.4.vii: Table of frequency of depressive attributions for all mothers (n = 79).

The distributions of both the number and proportion of depressive attributions was highly skewed and significantly different from the normal distribution. Non-parametric statistical tests were used to test for the hypothesized association between depressed mood, as measured by the BDI, and depressive attributions. There was no significant association between the number of attributions and depression (Spearman's rho = 0.09, n.s.) or the proportion of depressive attributions (rho = 0.06, n.s.).

There was some association between depressive attributions and pessimism (or 'hopeless depression') as measured by the Beck Hopelessness Scale, with the total number of depressive attributions increasing as pessimism increased (rho = 0.24, $p < 0.08$). An increase in proportion of depressive attributions was associated with an increase in pessimism (rho = 0.24, $p < 0.06$). These associations failed to reach conventional levels of significance.

The expected relationship between depression and depressive attributions was not found. The Mann-Whitney 'U' test was used to test for differences between proportions of depressive attributions. There was no significant difference between depressed and non-depressed mothers for both levels of severity of depression (clinical and mild) in terms of the proportion of depressive attributions for negative outcomes (see Table 7.4.4.viii below).

Maternal Depression	N	Mean	S.D.	Significance
Clinical Depression	26	3.55	4.99	n.s.
Not Depressed	46	2.51	2.83	
TOTAL	72			
Mild Depression	41	3.02	4.23	n.s.
Not Depressed	31	2.70	3.07	
TOTAL	72			

Table 7.4.4.viii: Table of mean proportions of 'depressive attributions' produced x Depression.

The total numbers in the two levels of depression do not add up to the total number of mothers (n=79) as some mothers did not make any 'depressive attributions'. This table indicates that there was no relationship between depressed mood and the proportion of depressive attributions produced. Further, when the number of depressive attributions was recoded into a categorical variable there was no association with depression (as indicated by the chi-square measure of association (with Yates' correction for continuity, $\chi^2 = 0.44$, df=1, n.s.).

There were no significant differences between the four groups in the proportion of depressive attributions produced ($H = 2.79$, n.s.). Mothers of non-victimised boys (NVP and AC) made proportionately more depressive attributions than mothers of victimised boys (VP and V) however this difference failed to reach significance (Mann-Whitney $U = 623.0$, n.s). It was also found that birth mothers made proportionately more depressive attributions than non-birth mothers, again this was not statistically significant ($U = 288.0$, n.s.).

The hypothesis regarding attributional style and depression was not confirmed for Speaker attributions. The LACS offers a more sensitive and detailed account of attributions than the Attributional Style Questionnaire (ASQ, Peterson et al., 1982) and may account for this finding. Additionally, the ASQ sums scores within causal dimensions. The claim that depressive attributions are characterised by a pattern of attributing to Internal, Stable *and* Global causes implies that a composite attributional score adding across dimensions is linked to depression which does not appear to be a well established finding. This will be discussed further in the final chapter.

These findings and the finding that Speaker attributions were found to be largely External (83%) for negative events, suggested that it may be more informative to focus on negative attributions where mothers were the causal agents. A new variable was calculated to identify those attributions where mothers identified themselves as Agents

of negative attributions and causes that were Internal, Stable and Global. This new variable was used as an alternative to the previous analysis based on all Speaker attributions for negative outcomes (where mothers need not have identified themselves as Agents), This yielded a modest association with depression, with the Yates corrected chi-square value of 3.26 failing to reach conventional levels of significance ($\chi^2 = 3.26$, df =1, $p < 0.08$).

Hypothesis 8: It was hypothesized that a 'helpless attributional pattern' characterised by attributions that were Stable, Global and Uncontrollable for negative outcomes would distinguish the depressed from the non-depressed mothers.

This was an attempt to further unpick the relationship between depression and individual patterns of attributions for negative events. Although this exact pattern of attributions has not been described in the literature, the concept of control for outcome has received much attention in the literature relating attributions to depression (e.g. Brewin, 1985, Peterson et al., 1982, Bugental, 1992).

Many more 'helpless attributions' were made than 'depressive attributions' (see Table 7.4.4.ix on depressive attributions) and the distribution was much broader. This might indicate that incorporating a dimension of Controllability into the pattern of attributing for negative outcomes was more fruitful than the Internal dimension. Table 7.4.4.ix below indicates the frequency and percentage of 'helpless attributions' produced for all negative attributions produced.

Number of negative attributions with 'helpless attributional style'	Frequency	Percentage
None	1	1.3
1-5	40	50.6
6-10	21	26.7
11-15	9	11.3
16-20	4	5.0
21-25	3	3.8
26+	1	1.3

Table 7.4.4.ix: Frequency of 'helpless' attributions for negative outcomes (n = 79).

There was no significant difference between the clinically depressed and non-depressed mothers on the proportions of helpless attributions they made (t=1.16, df=67, n.s.). There was also no association between the proportion of helpless attributions and scores on either the Beck Depression Inventory (r = -0.12, n.s.) or the Beck Hopelessness Scale (r = -0.09, n.s.). Further, when the number of helpless attributions was recoded into a categorical variable, there was no association with depression (clinical vs. non-depressed), using a chi-square measure of association (with Yates' correction for continuity, $\chi^2 = 0.07$, df =1, n.s.). Thus a 'helpless' attributional pattern was not related to depression, as measured by the BDI, in this study.
There were no significant group differences in the proportion of helpless attributions made (F=2.10,df=3, n.s.).

Mothers of non-victimised boys (NVP and AC) made a significantly higher proportion of helpless attributions, compared to mothers of victimised boys (VP and V) (t = 2.45, df=77, p<0.05). Mothers of non-victimised boys showed a tendency to be less depressed than mothers of victimised boys, however this difference failed to reach conventional levels of significance (t = 1.78, df =71, p < 0.08).

There was no significant difference between proportions of helpless attributions produced by mothers of perpetrator boys (both victimised and non-victimised) compared to mothers of non-perpetrator boys (t = 0.70, df=77, n.s.).

Support for this hypothesis was very limited and it appears that in this study no relationship was found between proportion of helpless attributions and depression.

Hypothesis 9: Depressed mothers would be more likely than non-depressed mothers to make attributions that were Internal or Personal or Controllable to the boy (son) as Target of negative outcomes.

A series of independent samples t-tests were conducted to test this hypothesis. There were no significant differences on proportions of attributions to Internal (t = 0.47, df = 67, n.s.), Personal (t = 0.34, df=67, n.s.), or Controllable (t = 1.52, df=67, n.s.) causes for the index boy as Target of negative outcomes between the clinically depressed and non-depressed mothers (see Table 7.4.4.x for descriptive statistics).

In addition, between group differences were investigated. There were no group differences for causes attributed to Internal causes for boy as Target (F = 1.25, df=3, n.s) or for causes attributed to Personal causes (F = 0.75, df=3, n.s). On the Controllable dimension there were significant group differences (F=3.22, df=3, p < 0.03). A post-hoc Bonferroni test indicated that the mothers of Antisocial comparison boys made a significantly higher proportion of attributions to Controllable causes when their son was Target (mean = 41.16%, s.d = 22.48) than mothers of Non-victimised perpetrators (mean = 22.62%, s.d = 18.25).

The following table (7.4.4.x) summarises the mean proportions of negative attributions to Internal, Personal and Controllable causes for boy as Target.

Causal Dimension	Mean Proportion	s.d	95% C.I for mean
Internal to Boy			
Depressed	47.55	24.86	(37.99, 57.10)
Non -depressed	50.18	21.20	(43.83, 56.51)
Personal to Boy			
Depressed	50.78	25.43	(40.99, 60.53)
Non-depressed	52.83	23.62	(45.77, 59.89)
Controllable by Boy			
Depressed	22.67	18.46	(15.58, 29.77)
Non-depressed	30.36	21.44	(23.95, 36.77)

Table 7.4.4.x: Mean attributions for boy as Target of negative outcomes.

Hypothesis 10: It was predicted that Internal, Stable, Global and Uncontrollable attributions for negative events would be positively related to depression, and Internal, Stable and Controllable attributions would be inversely related to depression.

New variables were calculated by writing command statements within SPSS for Windows (Version 6.0) on the data set containing all 2,770 attributions. These syntax statements contained a series of conditional 'if' statements to select out those attributions where the mother identified herself as Agent for negative events, and attributions were either to Internal, Stable, Global and Uncontrollable causes (uncontrollable pattern), or to Internal, Stable and Controllable causes (controllable pattern). Both the number and proportion of such attributions resulted in highly skewed distributions that were significantly different from the normal distribution, thus it was appropriate to carry out non-parametric tests of significance.

Chi-square tests, with Yates correction for continuity (for a 2x2 table), revealed that there was no association between controllable patterns of attributing and depression ($\chi^2 = 0.00$, df=1, n.s.). There was a non-significant association between uncontrollable patterns of attributing and depression, with non-depressed mothers

more likely to make no uncontrollable patterns of attributions than depressed mothers ($\chi^2 = 2.35$, df=1, $p < 0.07$).

Non-parametric correlations between proportions of 'uncontrollable' and 'controllable' attributions and scores on the BDI and BHS are summarised in the following table (Table 7.4.4.xi) significance levels refer to two-tailed tests.

	Uncontrollable attributions	**Controllable attributions**
Depression (BDI)	.23	.02
Pessimism (BHS)	.34**	-.01

Table 7.4.4.xi: Spearman's rank correlation coefficients (rho) for association between controllability and BDI, BHS. (n=79; *p < 0.05, **p < 0.01).

This hypothesis was only partially confirmed, with the positive association between proportion of uncontrollable attributions (for negative events with Internal, Stable and Global causes) and current depression (as measured by the BDI) failing to reach conventional levels of significance ($r = 0.23$, $p < 0.06$). There was however no association between controllable attributions and decreased depression, as predicted by Brown and Siegel (1988).

7.4.5 Attributions and Perceived Control

Hypothesis 11: It was hypothesized that a high negative discrepancy between Control to Self as Agent and Control to Boy as Agent would indicate higher blame attributed to the boy for negative outcomes. Mothers who attributed more 'blame' (as indicated by a high negative discrepancy score for perceived control) to Boy as Agent, were predicted to be less depressed than mothers who attributed blame for negative events to themselves as Agent.

A perceived control discrepancy score was calculated by subtracting the proportion of attributions where the mother identified her son as the Agent of negative outcomes (where cause was rated as Controllable by Agent) from the proportion of attributions where the mother identified herself as Agent of such outcomes (where cause was rated as Controllable by Agent). For the Control dimension, this variable was not significantly different from the normal distribution (Kolmogorov-Smirnov Goodness of Fit Test, K-S z = 0.067, n.s), thus it was appropriate to carry out parametric statistical tests.

The following examples from transcripts with mothers indicate examples of both Controllable and Uncontrollable dimensions of cause (see Figure 7.ii).

" 'Lenny' will come round and pick and pick until in the end I could really hammer his brains out...it can take him hours to get me into that state"
Mother of 11 year old 'Lenny', referred for antisocial behaviour. 'Lenny' is the Agent; outcome is attributed to Controllable cause.

" 'Ian' is very emotionally unstable, he can break at the drop of a pin"
Mother of 11 year old 'Ian' who is the Agent; outcome attributed to Uncontrollable cause.

"for four years I wrapped him in cotton wool..(over protected him), ...I did the wrong thing, I wouldn't do it again with what I know now" . Mother of 15 year old 'Chris', who identifies herself as Agent. Attribution to Controllable cause.

"because I was holding the baby, apart from dropping him to push him away, there was nothing I could do to stop him (grandfather) from touching me". Mother of 13 year old 'John' who nominates herself as the Agent; outcome attributed to Uncontrollable cause.

Figure 7.ii: Examples of Control to Agent attributions

There was no significant relationship between the perceived control discrepancy score and scores on the Beck Depression Inventory ($r = -0.04$, n.s.) or with the Beck Hopelessness Scale ($r = -0.06$, n.s.). Using t-tests to look at this relationship revealed that the non-depressed mothers (mean discrepancy =-7.61, s.d. = 44.78) had a lower mean discrepancy score than the clinically depressed mothers (mean = -15.09, s.d. = 29.63) however this difference failed to reach significance ($t = 0.83$, $df = 66.38$, n.s.). The wide variation within the groups is indicated by the large standard deviations.

Further analysis showed that birth mothers (mean discrepancy = 10.33, s.d. = 38.33) had smaller discrepancy scores than non-birth mothers (mean = -25.84, s.d. = 43.91), indicating that the non-birth mothers attributed more 'blame' to their 'sons' than birth mothers, however this difference did not reach statistical significance ($t = 1.26$, $df=77$, n.s.). This may be related to the finding that the non-birth mothers were significantly more likely to identify their 'sons' as Agents ($t = 3.48$, $df=77$, $p< 0.01$) compared to

birth mothers, who were more likely to identify themselves as Agents of negative outcomes ($t = 3.34$, $df=77$, $p < 0.01$).

Hypothesis 12. It was predicted that a) for the entire sample, there would be differences in the amount of Control mothers attributed to themselves for the outcome of negative events compared to Control to their sons and b) that mothers of Victim Perpetrators would be less likely to feel they have control over negative outcomes, and would show higher 'child blame' than mothers of Victims only.

(a) Paired samples t-tests indicated that mothers were significantly more likely to rate their sons as having Control over negative outcomes, than themselves (see Table 7.4.5.i below) This in itself may not be surprising, as to some extent, as all four groups are referred clinic groups, and high control to child is indicative of distressed relationships (e.g. Silvester and Stratton, 1991; Bugental et al., 1993).

Variable	Mean proportion of attributions rated Controllable	s.d	Significance
Control to mother as Agent.	40.76	29.38	2-tailed sig. test $p < 0.01$ ($t = 2.87$)
Control to boy as Agent	53.45	24.75	

Table 7.4.5.i: Mean proportions of negative attributions with cause identified as Controllable by Agent. (n = 79 mothers).

In order to look at multiple dependent variables a multivariate analysis of variance procedure was used to test for mean differences between the four groups on proportions of control attributed to boy and to mother. The MANOVA results indicated that the multivariate test of group differences did not reach conventional levels of significance ($F = 1.94$, $_{(6, 150)}$, $p < 0.08$). The univariate results indicated that

it was the proportion of attributions with Control to Boy as Agent rather than Control to Mother which contributed significantly to the overall difference between the four groups ($F=3.12$, $_{(3, 75)}$, $p < 0.05$).

(b) The discrepancy score between Control to Mother and Control to Boy which was used to test the previous hypothesis relating to perceived control (see Hypothesis 11) was used to test this hypothesis. Mothers of victimised boys (V and VP) produced attributions with less 'child blame' (mean discrepancy = -8.24, s.d. = 40.45) than mothers of non-victims (mean = -17.74, s.d. = 37.92), however, this failed to reach statistical significance ($t = 1.07$, df=77, n.s.). A one-way analysis of variance test revealed a significant difference between the four groups on 'child blame' ($F = 2.89$,df=3, $p < 0.05$). The post-hoc Bonferroni test of multiple comparisons indicated that the antisocial comparison group mean was significantly lower, indicating more 'child blame' than in the victim group (see Table 7.4.5.ii below). The expected difference between mothers of victims and victimised perpetrators was not found.

	n	Mean	s.d	95% C.I for mean
Victim Perpetrator	19	-10.12	42.82	(-30.76, 10.52)
Non -victimised Perpetrator	21	-2.98	37.31	(-19.96, 14.01)
Victim	23	-6.70	39.27	(-23.67, 10.29)
Antisocial Comparison	16	-37.13	29.81	(-53.01, -21.24)

Table 7.4.5.ii: Descriptive statistics for 'child blame' scores x Group.

7.4.6 Attributions and other factors

7.4.6.1 Attributions about sexual abuse

Hypothesis 13: It was predicted that mothers of Victim only boys (V) would be more likely to identify their sons as Targets of negative attributions about sexual abuse, than mothers of Non-victimised perpetrators (NVP).

The following table indicates those persons identified as Agents and Targets when the negative attributions were specific to sexual abuse (324 attributions).

	AGENT (%) **Cause is sexual abuse**	**TARGET (%)** **Outcome is sexual abuse**
Mother/Subject	17.4	29.3
Boy	43.8	42.9
Father/Partner	10.1	4.7
Sibling	3.8	10.5
Perpetrator of Boy	7.3	2.2
Perpetrator of Mother	4.2	0.6
Victim of Boy	2.4	7.7
Other	11.2	2.1.

Table 7.4.6.i: Agents and Targets of sexual abuse.

The following summary table (7.4.6.ii) indicates, for each group of boys, the percentage of negative attributions about sexual abuse for which mothers identified salient Agents and Targets. Nominations are mutually exclusive, that is, either Mother or Boy or some other person could be nominated but no more than one Agent and one Target is identified per attribution.

The aim was to explore who mothers nominated as Agents and Targets in these attributions. The findings were unexpected. Mothers of *non*-victimised boys were just as likely to identify their son as a Target of sexual abuse, as mothers of victims.

	AGENT (%) **Cause is sexual abuse**	**TARGET (%)** **Outcome is sexual abuse**
Victim Perpetrators		
Mother	14.3	25.6
Boy	46.2	45.3
Perpetrator of Boy	7.7	1.7
Victim of Boy	3.3	5.1
Non-victimised Perpetrators		
Mother	14.6	24.5
Boy	57.3	43.1
Victim of Boy	3.3	18.6
Victims		
Mother	21.6	28.9
Boy	32.4	46.7
Perpetrator of Boy	12.7	4.4

Table 7.4.6.ii: Summary of Agents and Targets of sexual abuse attributions.

Some examples of attributions where a boy perpetrator was coded as Target are provided in the figure (7.iii) below.

"William was a victim of circumstances, if his Dad had left him alone, William would never have done it (the abuse), it would never have happened..." (Mother of 15 yr old Victim Perpetrator 'William' who abused his nine and eleven year old sisters).

"She must be incredibly insensitive to Jay or just stupid it wasn't fair on Jay to let Louise run around without any pants on, I just couldn't believe it"
(Foster mother of 15 yr old Non-victimised Perpetrator, 'Jay', who sexually abused Ann's 2-year old daughter, 'Louise').

" I should have been the other way around (not so closed about sex), and been a bit more open with Mike, then he may not have been so inquisitive about it all...he is supposed to have abused my neighbour's little girl" (Mother of 13 year old Non-victimised Perpetrator, 'Mike' who sexually abused his neighbour's daughter and his baby half-brother 'Colin'.

Figure 7.iii: Examples of attributions with boy as Target.

7.4.6.2 Attributions about physical abuse

Although no specific hypotheses were proposed regarding physical abuse, negative attributions for physical abuse were explored. 51 mothers (65%) mentioned physical abuse as a topic of cause, or outcome, in attributions for negative events. Mothers identified themselves as Agents in 4.4 % of attributions when physical abuse was the cause of the attribution (45 attributions) and identified their son in 4.4% of these attributions. Partners and/or husbands were identified as causal agents in 53.3% of attributions specific to physical abuse and the mothers' own parents were identified as causal agents in 17.7% of such attributions.

Mothers identified themselves as the Targets of physical abuse in 57.9% of attributions where physical abuse was the topic of outcome (121 attributions). They identified their sons as Targets in 14.9% of such attributions. Siblings were identified as Targets of physical abuse in 8.2% of attributions, and partners/husbands in 12.4%.

Hypothesis 14: It was predicted that mothers of Victimised Perpetrators (VP) would be more likely to make attributions about sexual abuse to Unstable, or transitory causes than mothers of Victims (V).

A new variable was calculated (as in section 7.4.4., for hypothesis 10) by selecting negative attributions about sexual abuse where the boy was identified as the victim and the outcome was attributed to Unstable causes. The proportion of Unstable attributions was highly skewed and the distribution was significantly different from normal, thus it was appropriate to carry out non-parametric statistical analysis.

This hypothesis was not confirmed, and in fact there was a tendency for mothers of Victim Perpetrators to make *fewer* attributions of this type than mothers of Victims (Mann-Whitney $U = 152.0$, $p < 0.10$). When considering birth mothers only, this tendency was more marked, but failed to reach conventional levels of significance ($U = 90.0$, $p < 0.07$).

Hypothesis 15: It was predicted that mothers of the comparison group of antisocial boys would be more likely to attribute negative events to Stable and Global causes.

Attributions were examined at both an individual and at a group level to look at this relationship. The causes and outcomes of attributions produced by individual mothers in this study, were coded into separate categories for behaviour of child, physical abuse and sexual abuse. The LACS manual suggests that Global causes are more often associated with negative outcomes, but there is no such tendency for Stable causes. In the present study, it was the Stable-Unstable dimension of cause which was associated with various categories of cause and outcome in the negative attributions produced, but no such association existed for the Global-Specific dimension.

It is likely that the different relationship between constructs in this study may relate to the nature of the material, and context of this study, rather than due to the procedure itself being unreliable. The relationships between Stable and Global dimensions and these categories of outcome and cause are shown in the table (7.4.6.iii) below. All correlations are reported with significance levels for two-tailed tests. Correlations between physical abuse as topic of cause or outcome and the two dimensions involved non-parametric tests of association (Spearman's rho), due to the nature of the distribution of variables for physical abuse. All other correlations between topic of attribution and the two dimensions are Pearson's correlation coefficients.

	Topic of Cause			Topic of Outcome		
	Sexual Abuse	**Physical Abuse**	**Boy's Behaviour**	**Sexual Abuse**	**Physical Abuse**	**Boy's Behaviour**
Stable	-.16	-.21	.37**	-.22*	-.30**	.38**
Global	.13	-.06	-.10	.19	-.01	-.05

Table 7.4.6.iii: Correlations between Stable and Global dimensions and categories of cause and outcome of negative attributions. ($n = 79$; * $p < 0.05$, ** $p < 0.01$).

There was a strong, positive correlation between the Stable dimension and the boys behaviour as a cause of negative outcomes. This indicates that the boys behaviour, would be expected to be identified in future causes of negative events. One might expect mothers to frequently identify their son's behaviour in causes of negative outcomes especially when the outcome was also an aspect of the boys behaviour. There was a highly significant association between behaviour being nominated as both the topic of cause and outcome ($r = 0.47$, $p < 0.001$). There was a similar positive association between behaviour as the topic of outcome and stability of cause. This finding may be an indication that these mothers were likely to 'blame' their child for negative outcomes and expect them to continue to be responsible for such outcomes.

The significant negative correlations between stability of cause and both sexual abuse and physical abuse as outcomes indicates that these outcomes were attributed to Unstable causes.

To test the hypothesis, addressing attributions at a group level, a oneway analysis of variance between all four boys groups and Stable attributions for negative outcomes revealed significant differences ($F = 4.37, df=3, p < 0.01$). The Bonferroni post-hoc analysis of variance revealed significant differences (at the 0.05 level) between the comparison group of antisocial boys and the group of victims in the expected direction. The mothers of comparison group boys made a significantly higher proportion of negative attributions to Stable causes (mean = 59.62, s.d. =14.84) than the mothers of victims (mean = 42.40, s.d. = 15.47).

The same procedure was used to look at group differences in attributions to Global causes for negative events ($F = 5.18$, $df=3$, $p < 0.01$). The Bonferroni post-hoc analysis of variance indicated that the mothers of comparison group boys made a significantly lower proportion of Global attributions (mean = 38.04, s.d. = 16.07) than mothers of non-victimised perpetrators (mean = 55.02, s.d. = 11.48) and that these mothers made a significantly higher proportion of Global attributions than the mothers of victims (mean = 39.65, s.d. = 18.03).

This hypothesis was partially supported in that mothers of the comparison group of antisocial boys made a significantly higher proportion of attributions for negative outcomes to Stable, or persistent causes.

Examples of some Stable causes made by comparison group mothers for negative child behaviours are given in the figure below (7.iv).

"ever since he was a baby, he has always been uncontrollable, he goes into devillish mode...and off he runs, he has got no worries about himself or anyone else"
Mother of 11 year old 'Leo', referred for repeated expulsions from school, aggression and being beyond parental control.

"I put it down to the mess up I have made of my life, because of the domestic violence...he has severe temper tantrums, that started at about five...'Greg' kicks out, kicks the room, "
Mother of 11 year old 'Greg', referred for concerns about his angry outbursts, lying and stealing.

"'Joe' has got a very selfish streak...self-protection, looking after himself he will manipulate a situation beautifully, it can be distressing when you find out..."
Foster mother of 15 year old 'Joe', referred for running away and destroying property.

Figure 7.iv: Examples of causal attributions made by mothers of antisocial comparison group boys.

Hypothesis 16: It was predicted that mothers of antisocial boys would be more likely to attribute negative child behaviours to Internal and Controllable causes than other groups of mothers.

Two new variables were calculated by selecting i) negative attributions for child behaviour where the boy was nominated as Agent and the cause was rated as Internal and ii) negative attributions for boy's behaviour where the boy was nominated as Agent and the cause was rated as Controllable. A oneway analysis of variance was carried out to test for group differences on these patterns of attributions. The table below (7.5.6.iv) indicates the mean proportions for Internal and Controllable patterns of negative attributions.

Internal Pattern			Control Pattern		
Group	**N**	**Mean**	**S.D.**	**Mean**	**S.D.**
Victim Perpetrator	19	18.58	13.48	10.82	8.95
Non-victimised Perpetrator	21	20.29	13.40	11.48	9.09
Victim	23	21.23	12.14	13.66	10.97
Antisocial Comparison	16	35.94	15.86	27.57	13.95

Table 7.4.6.iv: Means for proportions of negative attributions to Internal and Controllable causes for boy as Agent.

There were significant differences on both the proportion of the Internal pattern of attributions ($F = 5.89, df = 3, p < 0.01$) and on the Controllable pattern ($F = 9.10$, df=3, $p < 0.001$). The post-hoc Bonfer test indicated that the mothers of the antisocial comparison group made a significantly higher proportion of both Internal and Controllable attributions to boy as Agent of negative boy behaviours than each of the other three groups.

Hypothesis 17: It was predicted that there would be differences in attributional patterns of mothers who had been previously abused and those who had not. Previous work suggests that childhood sexual abuse leaves a legacy of low self-efficacy and poor mental health outcomes. (a) It was predicted that women who had been sexually abused in childhood would be more likely to indicate current depression than women who were not abused in childhood. (b) It was predicted that there would be a higher rate of child sexual abuse amongst mothers of victimised boys (VP and V) than non-victimised boys (NVP and AC). (c) It was predicted that mothers who themselves had been sexually abused would make fewer attributions about their son's sexual victimisation than mothers who had not been abused.

(a) As predicted, an independent samples t-test showed that mothers who reported childhood experiences of sexual abuse (MCSA) were significantly more depressed than mothers who did not report such abuse ($t = 2.32$, $df = 56.33$, $p < 0.03$) (see section 7.3.3 for table of means).

Mothers ($n = 32$)* reporting child sexual abuse (MCSA) had a mean depression score within the clinical depression range of the BDI (score above 15), and the non-MCSA mothers ($n = 40$) had a mean depression score in the mild depression range of the BDI (score above 9). Abused mothers had a higher mean score (8.68, s.d. = 5.67) than non-abused mothers (6.66, s.d. = 3.95), on the Beck Hopelessness Scale however, this failed to reach statistical significance ($U = 387.5$, n.s).

(b) A chi-square test indicated a non-significant association between boy's group and abuse status of mothers ($\chi^2 = 6.42$, $df = 3$, $p < 0.10$). The observed frequencies are indicated in the table below.

Boy Group	Number of mothers reporting MCSA	Percentage of mothers reporting MCSA
Victim Perpetrator (n=20)	9	45.0
Non-victim Perpetrator (n=20)	13	65.0
Victim (n=23)	7	30.4
Antisocial comparison (n=16)	5	31.3

Table 7.4.6.v: Number of mothers reporting MCSA x Group.

Contrary to expectations, mothers of victims in fact had the *least* numbers of reported childhood sexual abuse experiences and mothers of non-victimised perpetrators reported the highest number of such experiences.

* Although n=34 mothers reported child sexual abuse, two mothers did not complete BDI questionnaires thus data is presented on 32 mothers.

Comparing mothers of victimised (VP and V) to non-victimised boys revealed no group differences. A chi-square test indicated no significant association between abuse status of boy, as indicated by recruitment information, and abuse status of mothers, as indicated by self reported CSA. (χ^2 with Yates' continuity correction = 0.84, df=1, n.s). In fact, fewer mothers of victimised boys were abused than mothers of non-victimised boys. 16 of the 43 mothers of victimised boys (37.2%) reported childhood sexual abuse and 18 of the 36 non-victimised boys (50.0%)

Comparing mothers of perpetrating boys (NVP and VP) to non-perpetrating boys, a chi-square test indicated some association between boy's perpetrator status and mother's reported CSA (χ^2 with Yates continuity correction = 3.80, df =1, $p < 0.06$). Although this association failed to reach conventional levels of significance, it is worth noting that 55% (n=22) of the mothers of perpetrators reported CSA compared to 30.8% (n=12) of mothers of non-perpetrators.

(c) An independent samples t-test showed that mothers reporting CSA made a lower proportion (mean = 82.18%, s.d. = 11.35) of negative attributions than mothers not reporting CSA (mean = 84.53%, s.d. = 10.07), however this failed to reach statistical significance (t = 0.97,df=76, n.s). See later section (7.4.6.1) for further post-hoc analysis of the relationship between previous child sexual abuse and attributions.

Other explanatory variables:

Hypothesis 18: It was hypothesized that a self-reported history of depression, assessed during the maternal semi-structured interview, would be associated with a previous history of sexual abuse.

Section 7.3.1 presents the data regarding the composite variable on self-reported depression constructed from the maternal interviews. A Mann-Whitney non-

parametric test was used to test differences between the two groups (those reporting MCSA and those not reporting MCSA). Women who reported having been sexually abused as a child reported significantly more indicators of past depression which included self-reported past episode of depression, contact with mental health services, anti-depressant medication and hospitalisation for depression ($U = 546.0$, $p < 0.03$).

Data was also collected during the interview relating to self-reported physical abuse as a child. Mothers who reported having been physically abused as a child ($n = 27$) reported more indicators of past depression than mothers who did not report such a history, however this failed to reach conventional levels of significance ($U = 152.0$, $p < 0.06$).

Hypothesis 19: It was hypothesized that a self-reported history of depression would be associated with a current 'depressive attributional style' characterised by negative attributions to Internal, Stable and Global causes.

As in the previous hypothesis (Hypothesis 7) relating to 'depressive attributional style', the proportion of depressive attributions was calculated by using a series of command or syntax statements (in SPSS for Windows Version 6.0) on the data set containing all 2, 770 attributions. A series of conditional statements selected out those attributions for negative outcomes where the cause was attributed to Internal, Stable and Global causes by the Speaker (mother). This yielded a highly skewed variable with a distribution which was significantly different from the Normal distribution (see section 7.4.4., results for Hypothesis 7).

Past depression was measured on the basis of maternal interviews (see section 7.3.2 on the measurement of past depression). Mothers who reported past depression ($n = 32$) (mean = 2.25%, s.d = 2.45%) did not differ significantly on the mean proportion of

depressive attributions about negative events, compared to those mothers who did not report past depression (n = 47) (mean = 3.24%, s.d = 4.31%).

Similarly, there was no significant difference between mothers who reported past depression (mean = 20.17%, s.d. = 10.07%) and those who did not (mean = 19.88%, s.d = 10.27%) on the mean proportion of helpless attributions made for negative attributions (t = 0.12, df =77, n.s). Helpless attributions were those where causes for negative events were attributed to Stable, Global and Uncontrollable causes.

7.4.7 Post-hoc analyses

Post-hoc analyses on the effects of previous child sexual abuse experiences on maternal attributions, and other variables such as expressed emotion will be presented in this final section of the results.

7.4.7.1 Maternal child sexual abuse:

i) proportion of negative attributions

As reported in a previous hypothesis (Hypothesis 17), the difference between the mean proportion of negative attributions made by mothers who reported previous child sexual abuse (mean = 82.19 %) compared to mothers who did not report previous MCSA (mean = 84.53 %) failed to reach statistical significance.

When considering maternal depression as a covariate, with previous sexual abuse as a factor, there was a trend for mothers who reported MCSA to make a lower proportion of negative attributions than mothers who did not report a history of MCSA. One-way analysis of covariance (ANCOVA) suggested that there was a main effect of MCSA and the proportion of negative attributions made ($F_{(1,68)} = 5.47$, $p < 0.03$)*. The adjusted means indicate that mothers who reported MCSA made significantly lower proportions of negative attributions (mean = 81.32%) than mothers who did not report MCSA (mean = 86.92%) when their depression scores were controlled for (BDI as covariate).

ii) depressive and helpless attributional pattern

Mothers who reported previous CSA made a significantly higher proportion of depressive attributions (mean = 3.74%, s.d = 4.43%) than mothers who did not report

* Univariate homgeniety of variance tests (Cochrans and Bartlett-Box) indicated that the proportion of negative attributions variable had significantly different variances. However, these tests are highly sensitive to departures from homogeneity and the standard deviations presented appear to be relatively homogeneous.

previous CSA (mean = 2.12%, s.d = 2.89%) (U = 521.0, $p < 0.02$). However, the mean proportions of depressive attributions is very low in both groups.

Regarding the proportion of helpless attributions made, there was no difference between mothers who reported CSA (mean = 19.54%, s.d = 9.66%) and mothers who did not report CSA (mean = 21.07%, s.d = 10.56%) (t = 0.67, df = 76, n.s).

iii) perceived control

The relationship between the perceived control variable (the discrepancy between control attributed to mother as Agent of negative outcomes and control attributed to the boy as Agent) and previous sexual abuse was investigated. The following table summarises the analysis which indicated no significant difference on the perceived control variable between mothers who reported child sexual abuse (MCSA) and those who did not (t = 1.17, df = 76, n.s). A negative score indicates more control to boy than to self, which can be termed 'low perceived control' (see Bugental and Shennum, 1984, Fincham, Beach and Baucom, 1987) or 'negative control bias'.

	n	Mean Discrepancy	Standard Deviation	95 % C.I. for Mean
Mother reported child sexual abuse	34	-6.62	36.53	(-18.89, 5.67)
No MCSA	44	-17.14	41.56	(-29.42,-4.85)

Table 7.4.6.vi: Mean perceived control scores x previous sexual abuse of mother.

Expressed emotion variables

a) proportion of negative attributions

Spearman's rank correlation coefficients were calculated between ratings of expressed criticism, hostility and warmth and the proportion of negative attributions produced. It was expected that a high rating of expressed criticism and hostility would be associated with a higher proportion of negative attributions and the converse for expressed

warmth. The table below indicates that none of these associations were significant, using one-tailed tests.

	Proportion of negative attributions
Expressed Criticism	.08
Expressed Hostility	.11
Expressed Warmth	.06

Table 7.4.6.vii : Spearman's rank correlation coefficients (rho) between ratings of expressed emotion variables and proportion of negative attributions.

b) expressed emotion variables and perceived control

It was expected that there might be some relationship between expressed criticism, hostility and warmth and the perceived control variable. Mothers who attributed relatively more control to their sons, or 'child blame', might be expected to express more criticism and hostility, and less warmth. The following table (Table 7.4.6.vii) shows the Spearman's rank correlation coefficients for these associations with one-tailed significance tests.

	Perceived Control
Expressed Criticism	-.25*
Expressed Hostility	-.04
Expressed Warmth	-.06

Table 7.4.6.viii : Spearman's rank correlation coefficients (rho) between ratings of expressed emotion variables and perceived control (* $p < 0.05$).

The only significant relationship was between expressed criticism and perceived control ($p < 0.02$). This indicates that as the perceived control score decreases, the level of expressed criticism increases as indicated by the negative correlation coefficient. This is consistent with the expected effect which was that as the

discrepancy score lowered (i.e. 'child blame' increased) the level of criticism would be higher.

Although this might seem circular, i.e. that a highly critical mother would also be likely to blame her child more than herself for negative events, the finding does provide some validation for the perceived control variable as it was calculated in this study. Mothers who were rated as 'severely critical' (n=4) had a mean perceived control score of - 42.42 (s.d. = 9.27) which indicates high 'child blame' and may be indicative of high distress within the relationship. Mothers rated as 'moderately critical' (n =27) also indicated moderate 'child blame' with a mean perceived control score of - 17.19 (s.d = 27.93). Mothers who were 'mildly critical' (n = 30) also indicated a negative control bias (mean perceived control score -18.71, s.d. = 41.74) and mothers who were rated as not critical at all (n = 18) had a positive mean perceived control score (10.76, s.d. = 45.00) indicating higher Control to mother than to boy.

Current reported social support

Mothers were asked briefly about the number of people they could count on in times of stress. 10 mothers (12.7%) reported that they could currently count on no-one for support and 14 mothers (17.7%) reported that they could count on only one person for support. There were no significant differences between the four groups on the number of people mothers could rely on for support ($H = 4.16$, df =3, n.s). Non-birth mothers reported that they could count on significantly more people for support (mean = 7.08) than birth mothers (mean = 3.63) ($U = 194.0$, $p < 0.01$).

There was a significant difference between the number of people reported to be available for support by the non-depressed mothers (mean number = 5.43) compared to those mothers who were clinically depressed according to their scores on the BDI (mean = 1.68) ($U = 166.5$, $p < 0.001$).

Note on results

Although potentially a good deal more analyses were possible given the nature of the data set, it was felt that the results emerging from the hypothesis testing were both broad ranging and at times contradictory to the hypotheses drawn from the literature regarding parental attributions. A decision was taken for the purpose of this thesis to attempt to integrate the findings presented in this chapter based on the original hypotheses of the study rather than to explore the data further at this stage.

The results presented here are comprehensive and cover a number of issues which will be discussed in the next chapter in an attempt to integrate and interpret the main findings.

CHAPTER EIGHT

Discussion and Conclusions

VIII. DISCUSSION

8.1 Introduction to discussion

The purpose of this study was summarised into four broad aims in Chapter Five. First, to describe maternal characteristics in a clinical sample of adolescent male victims and perpetrators of child sexual abuse. Second, to identify maternal attributions in this group. Third, to address the theoretical approach of the study of causal attributions and finally to contribute to the development and refinement of interventions with sexually abused and abusive young people.

Apart from describing this unique clinical sample of mothers of adolescent male victims and perpetrators of child sexual abuse, the central aim was to examine maternal causal attributions for negative events in their own and their sons' lives. More specifically, to identify attributional dimensions or patterns which were expected to differentiate between the four groups of mothers in the present study.

It was hoped that this may shed light on mothers' roles in the recovery of their child from sexual victimisation. Given the link between family factors and antisocial behaviour, it was thought that such factors, as reflected by maternal attributions, might also be associated with sexual perpetrating behaviour in adolescent boys. Further elucidation was sought by examining attributions in a group of mothers of non-victimised perpetrator boys and a group of antisocial boys.

The success with which this thesis was able to address these aims is considered in the following chapter. First, a brief overview of results is presented, followed by a discussion of the methodological limitations of the study. Results of the main findings regarding mothers childhood experiences and the attributional analyses will then be discussed in more detail, in light of these limitations. The implications of these results

will be considered in a discussion of the methodological and theoretical considerations arising from the main findings. This is followed by a discussion of recommendations for future research in parental attribution and finally, a brief general conclusion ends this chapter.

8.1.1 Overview of results

The results suggest that few of the expected group differences in maternal attributions were found. The four groups of mothers in this study were defined on the basis of the absence or presence of sexual victimisation and/or the sexual perpetration of their sons. The design was informed by the literature suggesting that both sexual victimisation and antisocial behaviour are linked to the perpetration of child sexual abuse. However, in this study only thirteen percent of all maternal negative attributions were specific to sexual abuse. This figure rose slightly to sixteen percent when considering the three groups relating to sexual abuse and perpetration only, referred to as the 'case groups'.

This finding clearly has implications for any between group comparisons given that groups were assigned on the sole basis of the presence or absence of sexual victimisation and perpetration. Why is it that mothers did not make attributions about sexual abuse? Do factors relating to their own childhood experiences of abuse and their current mental health inform this finding? These issues will be discussed in the main section of this chapter (see section 8.3).

The sample: summary of main findings

Overall, the study sample consisted of eighty mothers of boys aged between 11 and 15 years who were either victims and/or perpetrators of child sexual abuse, or an antisocial comparison group. Approximately equal numbers of mothers were recruited into each of the four groups described in Chapter Six, with slightly more in the victim

only group and slightly fewer in the antisocial comparison group. This reflected the referral pattern rather than a deliberate feature of the design. The four groups were equally matched on socioeconomic status and educational history. There were also no differences between the four groups in terms of the personal history variables measured in this study such as age at first marriage and number of children.

The findings suggest few group differences in the mothers childhood experiences of care and abuse however it is worth considering the overall rate of negative childhood experiences compared to other studies. Of particular significance to the overall findings is the high rate (42%) of previous sexual abuse in the mothers. A trend for mothers of non-victimised perpetrators to report the highest rate of previous child sexual abuse (65%) was contrary to expectations, based on fairly simplistic intergenerational models, that mothers of victimised boys would show the highest rates of such abuse.

A frequently reported finding in the literature is the high rate of substance use in parents of victims and perpetrators of child sexual abuse and of antisocial boys. This was not found in the current study where alcohol and recreational drug use were reported to be minimal.

Although it is not easy to directly assess the veracity of self-reported drug and alcohol use there appear to be good reasons for arguing against the explanation that social desirability and self-presentation were motivating factors. The overall impression given to the interviewer was of a distinct lack of social desirability (albeit from the perspective of the author) in the general responses given. This may, to some extent, be supported by excerpts from verbatim transcripts of interviews presented in this chapter and the previous chapter of results. In summary, consistent with other studies (e.g., Kaplan et al., 1988, 1990) self-reported substance use was taken at face value.

The findings which suggest relatively low levels of substance use raises the question of whether parents in this study are less antisocial than anticipated? Contrary to expectations, mothers reports of their own and the boys' fathers' criminal history were not highest in parents of the antisocial comparison boys. This measure represents the only one investigating antisocial behaviour in parents and was not corroborated with actual criminal records. Furthermore, the more covert antisocial behaviours and social difficulties discussed by Rutter and Giller (1983b) and Henggeler (1989a) were not measured in this study. The study of such factors would usually require the inclusion of observational measures which were beyond the scope of this study.

There were no significant group differences on the measure of parental criminal behaviour, however rates of reported criminal activity were actually higher in the three case groups than the antisocial comparison group. Thus, despite low reported substance use, families in this study could be considered 'antisocial' given the overall rate of 47% criminal history in fathers and 20% self-reported criminal history in mothers. These rates are high compared to studies of parents of juvenile delinquents where the rate is around 17% for fathers (Rutter and Giller, 1983b). One factor that could have contributed to the high rate of arrests for fathers was that 11% of all fathers were arrested for sexual offences.

As suggested in Chapter Three (3.3.2), it may be that 'family normlessness', characterised by less overt antisocial behaviour than actual criminal activity, is critical. It seems plausible that a lack of family rules and lack of boundaries will be as critically important for boys who are victims and/or perpetrators of sexual abuse as it is in the development of antisocial behaviour. Further research into the communication of family norms and values is warranted given the intergenerational nature of harsh, aggressive and abusive behaviour. It may be particularly relevant for families where sexual and non-sexual violence are considered normative.

Mothers' responses: summary of main findings

With regard to the expressed emotion variables measured in this study there were no group differences with respect to expressed warmth or criticism. Although this aspect of the study was exploratory, it was expected that mothers of antisocial and perpetrating boys would express the most hostility towards their sons. Mothers of perpetrating boys did express significantly more hostility when describing their sons than mothers of non-perpetrating boys. Mothers of antisocial boys in fact did not express as much hostility as mothers of perpetrating boys.

It is also worth considering that mothers of victimised perpetrators expressed more hostility when describing their sons than mothers of victim only group. It could be argued that this is consistent with the notion that 'child blame' may exacerbate victims' sense of powerlessness and betrayal and may impede resolution of the victim experience. While this study cannot confirm such a mechanism, it does highlight the potential value of measuring parental expressed emotion variables, particularly expressed hostility, in future studies.

i) mothers' responses to sons' victimisation

The item regarding how many mothers reported feeling that their son could have stopped his own sexual victimisation arose from suggestions in the literature that boys were less likely to be viewed as victims. In turn this may increase boys' risk of resolving their victim experience by abusing others. In fact, the findings were rather muted and contradictory. Not wishing to overstate non-significant findings suffice it to say that it remains a point of note that over half of mothers of victimised perpetrators and over a third of mothers of victims reported that they felt their sons could have stopped the abuse. Most mothers reported that they felt that their son could have stopped the abuse by disclosing it. This is illustrated in the following excerpt from an

interview with the mother of a 13 year old boy 'Ken' who was sexually abused (including anal penetration) for two years by his step father, 'Dave'.

> *" I was angry with Ken for not coming to me, he should have come to me, he should have come to me and said something, if he had come to me and said about it (the abuse)...we could have stopped it. When it was going on with Dave, funnily enough, Dave has turned around and said that he seems as though Ken was enjoying it."*

This is one of many examples of a mother in this study qualifying a response that her son could have stopped the abuse. Are mothers actually saying that their sons could not have prevented the onset of abuse but that mothers may have been able to respond if they knew of the abuse? The Blame Cake was used to assess blame/responsibility constructs and showed that most mothers did in fact appropriately blame the perpetrators of their sons' abuse.

It was expected that mothers in the victimised perpetrator group would have shown higher 'child blame'. This was only partially supported by the finding that over half of these mothers reported that they felt their son could stop their own victimisation. The fact that this group of mothers was the least likely to have their sons living at home with them may be indirect support for the proposal that mothers blamed their sons for his victimisation. Child protection workers may have been more likely to remove a child from home if their mothers were seen to be unsupportive or blaming.

However, mothers of victim perpetrators did not apportion 'blame' to their son as victim in the Blame Cake item. It is possible that mothers were able to respond to the demand characteristics of the Blame Cake where it may have been seen to be clearly inappropriate to blame their sons who were the victims of abuse.

ii) mothers' responses to sons' perpetration

There were no significant differences between the two groups of perpetrators. Mothers in the non-victimised perpetrator group did report more anger towards their son than victimised perpetrators. It is possible that mothers saw their sons' own experience of abuse as a mitigating factor in the victimised perpetrators' abusive behaviour. This was substantiated to some extent by the Blame Cake results which showed that mothers of victimised perpetrators tended to blame the perpetrator of their sons' victimisation whereas mothers of non-victimised perpetrators apportioned the highest blame to their sons.

Mothers of victimised perpetrators were however significantly *less* likely to report that their sons' victim could have stopped the abuse. One example of a mother indicating that she felt the victim ('Johnny') could have stopped the sexual abuse perpetrated by her son, 'Pete' was:

> *"Johnny could have run away from Pete couldn't he, he could have run into the front room or something, anything like that".*

One interesting finding was that mothers of victimised perpetrators gave themselves significantly less blame for their sons' perpetration than mothers of non-victimised perpetrators. Mothers of all three case groups ascribed very little (under 10% in all cases) blame to themselves for their sons victimisation or perpetration.

It has been suggested that distinguishing between constructs of cause, responsibility and blame may add to our understanding of adjustment or coping with threatening events (e.g., Fincham and Jaspars, 1980), however it remains unclear to what extent individuals make this distinction when explaining negative events in their own and their children's lives (cf. Tennen and Affleck, 1990). At the present time it appears that until we know more about whether this distinction is a valid one for understanding

how we adjust to negative life events, it may add only conceptual confusion when trying to consider all these dimensions together.

In summary, there was little support for the notion that mothers of victimised perpetrators were more likely to blame their sons for abuse than mothers of victims. Mothers of victimised perpetrators did express significantly more hostility when discussing their sons than the other three groups and over half did report that they felt their sons could have stopped their sexual victimisation, however this finding was not statistically significant.

Maternal depression: summary of main findings

Evidence was presented in the literature review which emphasised the importance of considering maternal depression in both the study of developmental psychopathology and in studies of maternal attributions.

Over half the current study sample (58%) scored in the symptomatic range of depression and over a third (36%) of the entire sample scored above the cut-off point for clinical depression in normal populations on the BDI. Although there were no striking group differences on maternal depression, this finding supports the hypothesis that all four groups were experiencing high rates of depression. There were no significant differences between the four groups of mothers on their reports of past depression since the age of 18 years. The validity of self-reported episodes of depression is unclear and would benefit from corroborative reports, for example, from general practitioners.

It is tempting to speculate that with greater statistical power the trend shown in which mothers of victimised perpetrators had the highest levels of both depression and pessimism and that the mothers of antisocial boys had the lowest levels would have

achieved statistical significance. This group difference in maternal depression did become statistically significant when two outliers were excluded from analysis.

The results regarding maternal depression are consistent with previous studies indicating that approximately half of mothers of victims of child sexual abuse suffer from at least mild depression. The results regarding perpetrators of abuse can be seen as an original contribution to the field of adolescent sex offenders in which maternal depression has not been reported.

One measure of mother's childhood experiences, that of high parental control, was positively associated with current depression. This suggests that i) perceptions of control are significant for these mothers and ii) that childhood experiences might be causally implicated in current depression.

Consistent with previous research, it was found that mothers who reported that they had been sexually abused in childhood were significantly more depressed than mothers without such a history. Additionally, mothers who reported that this abuse had included intercourse were significantly more depressed than those mothers who experienced abuse but not intercourse. This finding adds weight to the already established literature suggesting that child sexual abuse may have lasting effects on mental health and that penetrative abuse has more severe consequences than non-penetrative abuse (e.g., Mullen et al., 1993).

In summary, the finding regarding current depression provides support for the argument that mothers must be included in intervention programmes with these clinical groups, especially when she is the sole or primary caregiver. Finding ways of engaging these mothers and their families represents a major challenge for clinicians as they may be 'resistant' to offers of therapeutic intervention.

Maternal attributions: summary of main findings

The findings concerning maternal attributions are complex, and at times contradictory. The most important finding was that despite a high rate of negative attributions produced during the interview setting, only thirteen percent were specific to sexual abuse. Given the context of the interviews, namely a meeting with a clinical psychologist in a hospital or social service department setting and its specific focus on sexual abuse this finding is worthy of further discussion.

There were few positive findings when considering between group means on causal dimensions. This is probably explained by the design of the study which centres on the sexual abuse experiences of the boys assigned to each of four cells. Given the finding that there was 'low mention' of sexual abuse in the negative attributions of mothers this design is unlikely to hold up to between group comparisons.

The most interesting finding relates to the dimension of Control attributed by mothers to themselves and their sons for negative events. This analysis was informed by the work outlined in Chapter Four relating to perceptions of control over negative outcomes. The methodological advantage afforded by the LACS of being able to distinguish between Agents and Targets of negative attributions was demonstrated by these findings. Applied attribution research has resulted in an extension of the construct of perceived control by considering its relational nature (Fincham, Beach and Baucom, 1987; Bugental et al., 1993). Perceived control has been described as an important influence on subsequent behaviour and is seen to be particularly relevant in times of stress (Skinner, 1995). In the current study, a discrepancy score was calculated which revealed some interesting findings. Mothers in all four groups attributed greater Control to their sons than to themselves.

Additionally, mothers of antisocial boys had a significantly higher discrepancy score indicating high 'child blame' than mothers of non-victimised perpetrators. The implications of this finding and a further discussion of the main findings regarding maternal attributions will be discussed following a consideration of the limitations of the present study.

8.2 Limitations of present study

8.2.1 Post-hoc power considerations

Statistical power

One major limitation of this study which pervades most clinical research is that of statistical power, or sample size. Cohen (1992) suggests that in order to identify medium effect sizes between four groups sample sizes of 45 in each group would be required to achieve 80% power at a 5% significance level. As discussed in the methods section (6.5.3) the current study depended on the availability of a unique clinical sample within a time-limited period and lamentably was not able to meet these research requirements.

Recruitment of a larger sample may have led to more support for the research hypotheses and an increase in significant findings between groups on attributional dimensions which were expected to differentiate the four groups.

The low power of the current study means that between group differences may not be detected when they do occur (Type II error). This was considered and may apply to some findings. Further research with larger sample sizes would qualify this, however a number of other factors should be taken into account before advocating replication of this study with a primary focus on coding and analysing causal attributions.

Small sample sizes also meant that it was not possible to carry out extensive analysis on some of the low-frequency variables which were rated by the interviewer/author such as those relating to mothers responses to boy, expressed emotion variables and some of the family of origin and childhood experience data. These were presented as largely descriptive data.

8.2.2 Methodological limitations

Absence of pilot study

A pilot study to test out the reliability of the methods, the interview and to ensure that sufficient attributions would be produced was not able to be carried out. With the benefit of hindsight, this would seem to be a considerable advantage in future studies, particularly in light of the finding that less than one sixth of all negative attributions were specific to sexual abuse.

As discussed in Chapter Six, pragmatic concerns superseded the need for a pilot study and it was decided that it was important to recruit all appropriate referrals into the study sample. The absence of piloting prevented the anticipation of the observed low mention of sexual abuse in either the cause or outcome of negative attributions. However, the 'low mention' finding has a number of important implications and will be discussed further in the next section (8.3).

Nature of sample

Due to the high profile of Great Ormond Street Children's Hospital, it may be thought that the mothers interviewed in this study were in some way unrepresentative which would have implications for the generalisability of results. In fact, local social service

departments and schools were canvassed for referrals of adolescent boys and their mothers covering most of the South of England (primarily London, Kent and Essex). In other words, the study did not rely on the usual referral sources for the sample. It is noteworthy that the sample was predominantly White and of low socioeconomic status. It is likely that Black and Asian youth were underrepresented in this study, which may reflect a sampling bias.

In terms of presenting clinical problems, this group did in fact appear to be representative of adolescent victims and perpetrators of sexual abuse. This is based on the author's own clinical experience and that of the considerable experience of the Child Sexual Abuse Team at Great Ormond Street Hospital. During the early part of this study, the author was involved in a national evaluation study of victims and young perpetrators of child sexual abuse (Monck, New and Frangoulis, in preparation). Preliminary findings from this study suggest that compared to a national study, ethnic minority groups were underrepresented in the Great Ormond Street Hospital sample but that presenting clinical problems were similar in nature.

Measurement issues

Issues relating to the LACS will be considered in a later section. A brief consideration of some of the interviewer rated variables and measures of depression will be discussed here.

i) measurement of depression

The assessment of depression or depressed mood is essential in studies relating to developmental psychopathology given the consistent findings regarding maternal depression and child outcomes (see section 2.3.5). Additionally, the attributional reformulation of the learned helplessness model of depression has resulted in a large

number of studies investigating depressive attributional patterns in the development and maintenance of depression (e.g., Sweeney, Anderson and Bailey, 1986). The Beck Depression Inventory has been extensively used in these areas of research and has been demonstrated to have good reliability and validity. However, in retrospect, the use of multiple measures to assess depression would be advantageous in order to minimise the common method variance arising from self-reports by a single agent (Patterson, Reid and Dishion, 1992).

Methods of analysing attributional data are varied and in this study individual and group analyses were conducted primarily on proportional data. This clearly represents just one method of analysis. This study was concerned with adjusting for individual differences in verbosity. One way of adjusting for actual numbers of attributions produced was to convert scores on the dichotomous attributional dimensions to proportional scores. This also allows for the use of parametric statistical analysis on continuous measures for each subject.

The Beck Hopelessness Scale was used in this study to assess pessimism. In this study the BHS did not add to the assessment of depression as measured using the Beck Depression Inventory. Scores on the two questionnaires were high correlated which suggests that the construct of pessimism may not be conceptually different from more generalised depression.

ii) interviewer based measures

A number of measures in this study were interviewer based such as the assessment of expressed emotion variables and the ratings of childhood experiences of the mothers. A precedence for these types of measures has been established in studies reported on in Chapter Six (6.4.1). Additionally, recent studies report a preference for interviewer based measures (e.g., Andrews, Brown and Creasey, 1992; Bifulco, Brown and Harris,

1994). In the current study reliability of these measures was not established although the published criteria for assessing both expressed emotion and childhood experience measures were closely adhered to. It would be important to establish interviewer reliability on these measures before they can be interpreted more fully. Future studies investigating the effects of childhood experiences on attributional processes would benefit from establishing reliability on such measures.

Findings from this study suggest that further investigations would benefit from a systematic consideration of the effects of these childhood experiences on cognitive processes. Recently published studies suggest that cognitive processes such as memory (specifically bias in retrieval and access to affect-related events), coping styles and the automatic versus controlled processing of current negative events may be mediated by negative childhood experiences (Kuyken and Brewin, 1994; Myers and Brewin, 1994; Bugental, 1992, 1995).

Cross-sectional design

The study design was cross-sectional in nature and was designed to assess maternal attributions in four groups of boys at a single time point. Presenting correlational data can only inform us about associations and in no way adds to the understanding of causal pathways between constructs such as maternal attributions and for example, the onset of perpetrator behaviour. This represents a major limitation of this thesis, one which is shared by many studies investigating the development of psychopathology. Although a hypothetical model indicating pathways was presented in Chapter Five this study could not address the question of whether maternal attributions might act as mediators in the recovery of a child who has been sexually abused. It must be considered that it is equally plausible that mother's attributions reported on in this study are a result of her experience of these negative events about which attributions are made.

A longitudinal study design would address many of the questions concerning causality however, the role of maternal attributions is not sufficiently established to warrant such a time-consuming and expensive study. However, as taped interviews or observations represent a common modus operandi for psychology clinicians and researchers, it might be possible to identify sections of interviews retrospectively which could then be coded and analysed for attributional material. The use of archival taped interviews would also be of use in addressing the direction of cause in the association between parental attributions and child outcomes (Bugental, 1995).

Given the relatively low base rate of both victim experiences and perpetrator behaviour in the general population (see sections 2.1.3 and 2.2.2), a longitudinal study with the specific aim of identifying the causal relationship between maternal attributions and adaptation following child sexual abuse in boys is unlikely to represent a parsimonious approach to understanding the role of parental attributions in non-abusive or 'bystander' parents.

Controlling for physical abuse

Further studies focussing on parental attributions and sexual abuse would need to include an assessment of other forms of child maltreatment, particularly physical abuse. This is important for a number of reasons. In this study, mothers are referred to as non-abusive or 'bystander' parents, in other words they were not known to be directly involved in the sexual abuse of their sons. However, we do not know if these mothers were involved in other forms of abuse such as emotional or physical abuse and neglect. Investigations of this type are essential but in practice are extremely difficult to conduct.

Statistically controlling for factors such as physical abuse would be a considerable advantage in understanding the development of sexual perpetrating behaviour.

Although this would necessitate larger sample sizes, a number of points support this idea.

A prospective follow-up study may represent a pragmatic way of increasing statistical power if sample sizes were sufficiently large. The idea would be to study groups of children who were already identified as victims or young perpetrators of abuse. Although this might shed light on the complex and multiple pathways involved in the transition from victim to perpetrators of child sexual abuse, it would not fully account for this process. As discussed in section 2.2, studies suggest that approximately half of adolescent perpetrators have not been sexually abused. A prospective study would therefore have to include boys who were exposed to major risk factors such as other forms of child maltreatment which are proposed to be associated with sexual perpetration.

The rates of both child and adult physical abuse found in the mothers of boys in this study suggests that exposure to and direct experience of physical abuse is likely to be associated with externalising behaviours in adolescence. As it is unlikely that maternal attributions would be assessed before and after abusive episodes and no pre-abuse variables would have been taken of the child, the ability to identify causal relationships would still be limited in a prospective design. Recent advances in the use of retrospective interview methods may assist in the difficult task of identifying causal factors in maladaptive outcomes for different types of adverse childhood experiences.

The absence of studies relating to attributions in sexual abuse led to hypotheses generated from studies of abusive parents of physically abused children (see section 4.2). The present study of non-abusive or 'bystander' parents represents an original contribution to the research on parental attributions in distressed families. However, one important limitation arises in that data were not collected regarding these other forms of maltreatment in the children of subjects in the current study.

Further research on the main study sample of boys may elucidate such findings. This would need to be corroborated by Child Protection Register records. However, as mandatory reporting of child maltreatment is not a legal requirement in Britain, this would only provide partial confirmation of such abuse. Physical abuse in particular has been identified as an important factor and the finding that comorbidity in child maltreatment is likely to be common (Manly, 1995) is a further reason for investigating physical abuse in future studies.

8.3 Discussion of main findings

Introduction

This section will first consider the main findings regarding the childhood experiences of this unique sample of mothers. Thereafter the findings regarding maternal attributions will be presented in two sections. First, the findings regarding maternal attributions and depression and second, a discussion of patterns of maternal attributions and the findings regarding Perceived Control.

8.3.1 Childhood experiences of subjects

As far as is known this study represents one of the first to describe mothers of male adolescent victims and/or perpetrators of child sexual abuse, with an appropriate comparison group of antisocial boys. The findings regarding childhood and adult experiences of sexual and physical abuse will be discussed here.

In this study, 42% of the entire sample reported childhood experiences of sexual abuse and 15% of the entire sample reported that this had included penetrative abuse. A third of all mothers also reported experiences of physical child abuse and a substantial majority referred to daily or weekly physical abuse from parents.

In a recently published study of inner city London women, Bifulco, Brown and Harris (1994) reported that 18% had experienced child sexual abuse and 9% had experienced child physical abuse. This is one of a few studies employing criterion-based interviewer ratings and is a useful guide to findings regarding prevalence of abuse in community samples. Previous studies have reported wide ranging prevalence rates for child sexual abuse of between 6 and 62% in the general population (e.g., Peters, Wyatt and Finkelhor, 1986).

Rates of child sexual abuse (42%) are compatible with previous studies involving clinical samples of mothers of victims of child sexual abuse (generally around 30 - 40%). The rate of reported child physical abuse (34%) was also similar to those reported in other studies of around 35%. These findings suggest that this study sample is comparable with studies of mothers of abused and abusive adolescents from North America which leads the field in the study of child maltreatment.

One finding of note was that over 80% of mothers did not disclose their own childhood sexual abuse until they reached adulthood. An anecdotal finding is that many women said during interviews that the first time they disclosed their own abuse was when social workers questioned them directly upon the discovery of their son's abuse/perpetration. A common reaction to the powerlessness and betrayal experienced by *male* victims of child sexual abuse is to 'act out' or recapitulate the experience in the role of aggressor (e.g., Watkins and Bentovim, 1992). Perhaps women are socialised not to react in this cathartic style. This in combination with the powerful reinforcers for not disclosing sexual abuse may lead to a coping style which includes active repression and avoidance of the abuse (cf. Kuyken and Brewin, 1994; Myers and Brewin, 1994; Davis, 1990).

A number of mothers reported adult experiences of sexual abuse (17%) and a substantial number reported adult physical abuse (59%). There were no significant group differences on rates of adult abuse. Previous studies reporting on mothers of abused children have tended to report similarly high rates of domestic violence or adult physical abuse. These rates of reported adult abuse support an attenuated claim regarding revictimisation in adulthood. The findings in this study suggest that revictimisation is a common but not inevitable experience for female victims of both physical and child sexual abuse.

Two other findings are worth considering. First, it was found that 16% of the non-birth mothers reported childhood experiences of physical abuse although none of them reported child sexual abuse. A quarter of all the non-birth mothers, primarily foster mothers, also reported adult physical abuse or domestic violence. This leads to a suggestion that professionals who place high-risk young people with foster carers need to be sensitive to the high rate of domestic violence which prevails, even amongst selected caregivers.

A second finding regarding abusive experiences of mothers concerns the group differences in childhood experiences which failed to reach statistical significance. Contingency tables show that half of the mothers of the non-victimised perpetrator group reported child physical abuse, compared to 25% of the victim and victim perpetrator groups and 38% of the antisocial comparison group. Furthermore, it was the mothers of non-victimised perpetrators who reported the highest rate (65%) of child sexual abuse. Regarding adult experiences of abuse three-quarters of the mothers of non-victimised perpetrator boys reported adult physical abuse which was the highest rate amongst all three groups.. Given the pervasiveness of abuse in the lives of the women in this study, the finding relating to 'low mention' of sexual abuse as a topic of negative attributions supports the notion of a proposed coping style characterised by avoidance and repression of abusive experiences.

A recently published study suggests that depressed women who reported childhood experiences of physical and sexual abuse reported high levels of intrusive memories and high levels of avoidance. (Kuyken and Brewin, 1994).

Women in this study who reported childhood sexual abuse were significantly more likely to be clinically depressed. The overall 'low mention' of abuse in a context which was intended to identify attributions about sexual abuse could reflect a 'defensive' coping style. Avoidance of processing of or thinking about sexual abuse may represent an adaptation to the ongoing effects of childhood experiences. Further studies would need to over-recruit samples of clinically depressed women and women who were known to have suffered from physical and sexual abuse in order to test this suggestion further. This would enable more careful investigation of the influences of childhood experiences on current cognitive processes.

This is related to the distinction between automatic and controlled processing of events (e.g., Bugental, 1992), which led to the hypothesis that an active causal search may not be invoked to explain sexual abuse by mothers who themselves had experienced such abuse. While it was confirmed that abuse is commonplace in the lives of these women, this hypothesis was given only limited support by the data. When depression was statistically controlled for, it was found that there was a trend for mothers who reported that they had been sexually abused to produce a lower proportion of negative attributions than mothers who did not report such a history. It may be that analysing proportions of attributions may in fact mask the effect being investigated that is, previous experience of abuse would lead to fewer attributions specific to sexual abuse. In this case analysis of the absolute numbers of attributions may have revealed interesting findings. However as so few specific attributions were produced for the topic of sexual abuse of the index child and/or for the mother's own experiences this remains to be tested in future studies.

This raises the ethical question of soliciting attributions about sexual abuse and may point to the need to incorporate a hypothetical component into research methods to elicit such attributions (see section 8.4).

The qualitative data obtained in this study can also inform the suggestion that the 'low mention' in the attributions of mothers regarding sexual abuse is mediated by a defensive or avoidant coping style. In this excerpt from the birth mother of a 12 year old victimised perpetrator, the subject avoids referring to the term 'sexual abuse' although she is clearly describing such an experience. This mother spontaneously said she frequently felt 'spacey' which could be interpreted as feelings of depersonalisation or dissociated thinking.

> *" I asked my sister Edith, she said all my brothers and sisters were in a Home through my Dad (abusing them) ... they were all in a Home in Clacton and when I was born in 1959, the house was empty. There was just me, my Mum and Dad..that is all, and the lodger...I don't know ...I was about five I think (when the abuse started)...I don't really know much about it...but it was him I think..."*
>
> Interviewer: " was that your father who was involved?"
>
> *" everyone was, anyone, old men and stuff, I don't really know to be honest with you."*

When asked about her own son Ricky's sexual victimisation by his father and then his subsequent sexual perpetration of his younger brother, Jason, this mother was able to talk about the abuse and attempts to explain why she did not respond to the abuse of her youngest son by his older brother:

> *" Claire (my daughter) came in and said Ricky's doing something to Jason, but being the husband I thought he (their father) might do something about it, but he just didn't, I left it to him, being a man I thought he would understand, I*

knew myself being that I had it done to me...it shocked me...I knew what happened to me but I didn't know what to do".

In this instance, the husband had been arrested for sexually abusing two daughters and Ricky (referred to the project) and so was not present to 'do something' about Ricky's abuse of Jason. This mother reported that she had been unable to act when she discovered that her husband had abused Ricky and had similarly felt at a loss to know what to do on discovering her son's subsequent sexual perpetration. At the time of the interview, Ricky was living at home with his mother as was Jason, the younger brother. When asked about whether she was able to discuss recent events with her sons, Mrs S. replied

"I never had it(the facts of life) explained to me...I would be a bit embarrassed to talk to Ricky about it...I never knew myself about it (sex) so I never taught it to them (my children)".

Another mother referred to her total disbelief on discovering that her oldest son 'Jake' was sexually abused by a lodger and subsequently sexually abused his younger brother

" my reaction was just total disbelief...it had been going on under my nose...but I didn't see it...because I was abused, how could this happen to my kids as well".

It is possible that in this mother's attempts to cope with her own undisclosed child sexual abuse she was not able to identify signs in her sons that they had been sexually abused by a young adult lodger which led to the oldest son abusing his brother. This type of speculation does go beyond the data which showed a 'low mention' of sexual abuse in negative attributions. However, suggestions such as this may have therapeutic value by deconstructing the notion of emotionally estranged and psychologically absent mothers of sexually abused children.

One mother described her reluctance to discuss her 14 year old son's sexual victimisation and subsequent perpetration of his brother

> *"I feel like some sort of ogre in all this, I don't talk about my past, I never have and I never will...and no-one can get inside my head no matter how much they try. I don't let people in, I don't want to get close to anyone...my husband don't know half the things he ought to because I don't tell and then I can't get hurt"*

Thus, it could be argued that the 'psychological absenteeism' reported in many studies of mothers of incest victims may reflect a coping style characterised by active avoidance and repression of intrusive memories. In the current study, a vast majority of the mothers who reported child sexual abuse did not disclose the abuse until adulthood. The above excerpt also has implications for the findings regarding disclosure of abuse during the interviews and suggests that the rate of 42% of women reporting child sexual abuse in this study could in fact be higher. If women said that they did not want to discuss unwanted sexual experiences they were not pressed. If as is argued here, the avoidance of explanations about sexual abuse represents a coping style, then it would be unethical to challenge such a strategy by attempting to further solicit attributions about sexual abuse in the context of a research interview. However, an avoidant coping style could be addressed in a therapeutic context.

It has been suggested that the process of confiding can help assimilate traumatic experiences and is thought to help alleviate feelings of uncontrollability following these events (e.g., Harvey et al., 1988). It is possible that the proposed 'defensive coping style' is associated with long standing experience of uncontrollable events as indicated by one mother's description of repeated physical abuse by her father:

> *" when I came home late, Mum got cross, Dad just hit six kinds of crap out of us, it was Dad who took pleasure in hitting us, sometimes just for the sheer hell of it he beat the hell out of us, no, (I didn't always do something wrong) sometimes it (Dad hitting us) was for sheer fun...me, and my brothers and*

sisters would get beaten..unless Mum managed to get us to bed, then she would cop it...when he was pissed they used to argue a lot...with a lunatic like that for a father there was plenty of violence".

In this example, one can see how the reality of uncontrollability and unpredictability were pervasive features of this mother's experience of physical abuse.

The concept of early childhood experiences influencing perceptions of control and affect regulation such as passivity and avoidance which can be seen to be reflected in current coping styles is an interesting one worthy of further research. Findings regarding attributions of Control over outcome are discussed in the next section.

In summary, the findings from this study are consistent with previous reports of high rates of child abuse amongst mothers of victims of sexual abuse. Rates of child sexual abuse were particularly high and over one third of mothers reported child physical abuse at the hands of their parents. This suggests that there is a need for further research into the intergenerational nature of child maltreatment.

Howes and Cicchetti have described a "global dynamics characterising maltreating families" (p. 250, 1993). They suggest that complex and developmental models which are probabilistic rather than mechanistic are required to account for the multi-generational and multi-faceted nature of child abuse. Clearly a direct linear association does not fully explain such links, especially in the current study sample of non-abusive mothers of sexually abused and abusing boys. However, global theoretical concepts may be limited in their application to current concerns regarding intervention and prevention of child maltreatment. This study suggests that further examining the influences of early experience on later cognitive styles may be useful.

8.3.2 Maternal attributions

A synthesis of the findings regarding causal attributions is somewhat complex given the variety of hypotheses tested. Those referring to depression and attributional style will be considered first.

Maternal attributions and depression

Hypotheses presented in Chapter Five regarding maternal attributions were drawn from literature relating to studies using a wide variety of measures of attributions including questionnaires and analogue methods. Specific hypotheses relating to attribution theory and the attributional reformulation of the learned helplessness model of depression described in section 4.1.2 were not confirmed in this study. A number of explanations account for the lack of an association between depressive attributional patterns and depression as measured by questionnaire methods despite the robust association reported on in Chapter Four (e.g., Sweeney, Anderson and Bailey, 1986).

One of these explanations was referred to in the previous section on limitations of the study referring to possible low power resulting in Type II errors. At least three other explanations arise from a consideration of the development of the model for reformulated learned helplessness theory. First, the Attributional Style Questionnaire (ASQ) was used as the main measure of causal attributions in the model building. This allows for a maximum of six negative attributions about hypothetical events across a variety of domains which may or may not be relevant to the respondent. Scores for dimensions of causal attributions are summed across domains (but within dimensions) to obtain separate scores on the Internal, Stable and Global dimensions. In this study, the LACS was used to obtain ratings of dimensions of cause for a wide variety of actual negative events. Individual subjects were given summary scores for negative attributions to Internal, Stable *and* Global causes, rather than to each dimension separately.

This was influenced by the attributional literature regarding attributional style and depression which suggests that all three causal dimensions are associated with depression (Seligman et al., 1979).

Second, attributions for hypothetical events as measured by the ASQ have been shown to lack association with causal attributions for actual negative events. Third, although Seligman and his colleagues have argued consistently (and persistently!) for the stability of explanatory style over time, this is likely to be far more situation-dependent than was first proposed. Despite the robust findings of the association between depressed mood and depressed thinking, there is unlikely to be consistency of attributional style across situations.

Common method variance may also be an issue here. It is possible that attributing Internal, Stable and Global causes to negative outcomes is one way of conceptualising the construct of depression or a negative coping style. High BDI scores represent another way of conceptualising this construct. Their consistent association in previous literature may be a demonstration of common method variance. The problem lies in the difficulty in partialling out the shared method variance when considering the linear relationship between the variables of 'depressive attributional style' and 'depressed mood'.

To summarise, this study did not support the idea of an attributional style as a stable personality feature of depressed individuals. Reviews of attribution theory suggest that depressed mood may be more strongly associated with attributions concerning hypothetical rather than actual events (Coyne and Gotlib, 1983) which may also explain the lack of association in this study. It is also possible that events for which attributions were made by mothers in this study were not ones which were of critical importance to the mothers. This is partially reflected by the 'low mention' of abuse finding however further confirmation would be needed. For example, future studies

could utilise a shorter interview followed by a mutual feedback session in which subjects rated events in extracted attributions for personal importance. Although the use of the LACS is likely to improve on the ecological validity of previously used experimenter-generated attributions, this issue may need to be addressed more fully.

The issue of validity brings us to the concept of 'self-presentation' or impression management. This is a difficult concept to address in a study such as the present one . The interview material from this study seemed to suggest (to the author) that mothers did not successfully employ presentational strategies in order to 'fake good' or respond in socially desirable ways.

Perhaps high rates of previous and current abuse, as well as a substantial rate of depression reduces the personal resourcefulness to create a good impression. The findings regarding low perceived control in the three case groups may hint at the use of supplication rather than self-promotion as an impression management strategy (Arkin and Shepperd, 1990). The supplicant is said to present a view of the self as helpless or weak in order to influence others to 'caretake' or nurture the individual. This is seen to be a 'last resort' tactic and one generally adopted by individuals who perceive themselves as powerless. The self-presentation function of attributions (see section 4.1.1) may well be used by these subjects. Just how conscious a strategy this is remains a point of conjecture.

Patterns of maternal attributions

Two subsets of attributions were considered and are discussed here. First, negative attributions where mothers nominated their son as the causal Agent and second, negative attributions specific to sexual abuse.

In the first of these subsets, there were significant associations between boy group and dimensions of cause. Mothers of the antisocial comparison group were most likely to attribute negative outcomes to causes that were Internal, Stable and Controllable for her son as Agent.

This is similar to findings reported in Chapter Four regarding mothers of children with attention deficit and hyperactivity disorders (Geller and Johnston, in press). This finding suggests that mothers of 'difficult' children were more likely to attribute negative outcomes to dispositional and long-lasting causes which were seen to be Controllable by the son. It has been suggested that this pattern of attributions is maladaptive (e.g., Silvester and Stratton, 1991) and attributions of high control to child has been shown in physically abusive families.

Geller and Johnston (in press) refer to the attribution of negative outcomes to Internal and Stable causes in parents of 'difficult' children. In this study, a highly significant association was found between negative child behaviour and attributions to Stable causes. This may reflect reality in that these adolescents were reported to have long histories of difficulties leading to a referral. However, it has also been noted that despite the expectation of a 'protective bias' towards children, parents with a long history of interacting with 'difficult' children may attribute benign behaviour to malevolent causes which are Stable and Global, that is long-lasting and pervasive.

What remains for future research is the investigation of observed interactions in these distressed parent-child relationships. This may reveal patterns of maladaptive communications which cannot be identified from an exclusive focus on maternal attributions. Observational studies may add empirical support to the contention that maternal attributions reflect a coping style which negatively influences interactions with her child. The belief-behaviour connection will remain elusive and hypothetical without such observational studies.

Mothers in the three case groups did not indicate a consistent pattern of attributions when their son was identified as the causal agent. This raises one of the limitations in the present study of analysing subsets of attributions which is that the attenuated data set limits statistical power further.

One finding which hints at a 'minimising' style of attributions was that mothers of non-victimised perpetrators were more likely to make attributions for negative events to Unstable or transitory causes. Due to low power, it was not feasible to carry out further analyses considering those attributions for sexual abuse alone where the son was Agent of abuse. However, examination of the qualitative data leads to the hypothesis that attributions to Unstable and Specific causes may reflect a coping style that maintains parental self-esteem by minimising her child's behaviour:

> *" Some of the things Frank got up to, well I suppose the stealing, hanging the dog, that was another thing and he was alleged, supposed to have abused my neighbour's little girl...that is why Frank was referred to Great Ormond Street, I think it was all just part of growing up if you like, that's what I think anyway, I think he did it but I don't think it was done to abuse her".*

Frank is a 13 year old non-victimised perpetrator who was known to have killed a dog and been cruel to animals, he also sexually abused a neighbour's five year old daughter and his one year old half brother.

A second subset of negative attributions studied were those where the topic of the attribution was sexual abuse. Due to the small proportion of attributions about sexual abuse, Agent and Target data were considered instead of trying to analyse causal dimensions separately. One finding that is difficult to interpret is that mothers of perpetrator boys were just as likely to identify their sons as Targets of negative attributions about sexual abuse as mothers of victims. Excerpts in Chapter Seven (7.4.3) relating to this finding suggest that some mothers saw their perpetrating sons as

'victims' and the victims as Agents of the abuse. The example of a foster mother of 15 year old 'Jay', a non-victimised perpetrator is expanded on here to illustrate that this foster mother does not identify her 'son' as an Agent of abuse. The victim was the foster mother's two year old grand-daughter, 'Louise'.

> *"There was no protest you know, she wasn't distressed, Louise could have told him to stop, or shouted or ...she's very grown up for two. I am not saying she enjoyed it, but she didn't protest and I am quite sure Jay wouldn't have done it if she had, he is very fond of her, it wasn't traumatic like my daughter made out...it was not fair on Jay to have a little girl running around, who is allowed to lie on the floor and kick her legs in the air..."*

This also lends support to the proposal that attributions reflecting a coping style which may be functional in the sense that such a style may prevent the mother taking responsibility for her son's behaviour and also mediates against a rejection of her son. This may be important for this foster mother who was charged with an adolescent boy who had come from a disrupted family background, thus leading to a minimising or defensive explanatory style.

In summary, there were few group differences on the specific attributional dimensions or patterns hypothesized. The dimension of Control will be discussed separately. Despite the number of negative findings it may still be possible to add to our understanding of individual differences in the study of spoken attributions.

It appears that using a four group design to categorise mothers on the basis of whether they were parents of victims, perpetrators, victimised perpetrators or antisocial comparison boys fails to address the importance of individual variation within these groups. As noted in Chapter Two, variation may arise due to a number of factors or intervening variables which were not able to be controlled for in the present study.

Further work on integrating findings from this study and related findings from the main study at Great Ormond Street Hospital regarding peer and individual factors in this study sample may begin to address some of these variations. Although it has been suggested that abuse is classified into various dimensions of subtypes, severity, frequency, age of child (e.g., Manly, 1995) this would entail much larger sample sizes than this study can provide.

Two further points will be made regarding the negative findings for hypotheses examining group differences on maternal attributions. One is that attributions of non-abusive or 'bystander' mothers may be distinct from those of the abusive mothers referred to in studies reviewed in Chapter Four upon which hypotheses were based. Without knowledge of the physical abuse status of these adolescent boys it would be unwise to comment further on this interpretation.

Secondly, it has been suggested that the attributions made about sexual abuse may be qualitatively different from those made about physical abuse and that further studies may need to attempt to uncouple the effects of the role of the parent (abusive or non-abusive) and types of abuse (Bugental, 1995). Again this would suggest that large samples would be required in future studies.

Perceived Control

The importance of the Control dimension has been emphasised in the work on parental cognitions (e.g., Bugental et al., 1993) which suggests that from an attributional perspective, relationship schemas can be thought of in terms of the amount of Control attributed to self versus other. The following quote from Eleanor Maccoby's recent review of the role of parents in socialisation eloquently expresses the importance of Control in the caregiving context.

> *" parents derive authority from their greater power and competence and they cannot abdicate this authority without endangering the children...families become dysfunctional if roles are reversed so that children become the ones who nurture or control parents"* (p.1015, 1992).

Using the LACS, the Control dimension is coded according to the extent to which the mother feels the person being rated could have influenced the outcome. In this study, mothers of antisocial boys were significantly more likely to attribute negative events caused by their son to Controllable causes.

In order to consider the proposition that high Control to child is indicative of distress in the parent-child relationship the findings regarding the discrepancy in perceptions of Control will be considered. As noted in Chapter Four (4.2.1), a negative discrepancy, that is higher Control to Child than Mother has been identified as a marker of distress in parent-child relationships. The relational concept of Perceived Control as described by Bugental and her colleagues has been shown by them to be associated with a defensive reactivity to negative child behaviour. This defensive arousal is seen to be a response to caregiving failure manifested as a threat or challenge to parental efficacy. In this study, moment-by-moment interaction was not studied, however all four groups of boys were expected to challenge parental efficacy by virtue of having been victims and/or perpetrators of child sexual abuse, or due to antisocial behaviour.

As expected, mothers in all four groups showed a negative bias towards their child and low perceived control. That is they attributed more Control to their sons for negative events than to themselves. One caveat in interpreting this finding is that the score was necessarily based on different outcomes as the Agent category is mutually exclusive, that is one person can be nominated as Agent per attribution.

Mothers of the antisocial boys showed the highest negative discrepancy indicating that these mothers attributed significantly more Control to their sons than to themselves for negative events. Contrary to expectations, it was found that mothers of non-victimised perpetrators showed the *least* discrepancy. The proposed link between delinquency and sexual perpetrating in adolescents outlined in Chapter Three led to the expectation that mothers of antisocial and perpetrator boys would show similarities in Perceived Control.

The findings of low Control to mother (self) or boy in the three case groups and particularly in the non-victimised perpetrators supports the idea that attributions may represent a reflexive coping style, one which avoids ascribing control to either the mother or the child thereby reducing the threat to the parent's sense of efficacy posed by having a son who sexually abused another child. This points to a functional, albeit maladaptive, pattern of attributing low Control to self and low Control to child. It is conceivable that this could influence parental motivation to engage in treatment for herself and her son.

An alternative and complementary explanation is that this is another reflection of the 'low mention' of abuse finding. In other words that mothers were showing an avoidant or repressed coping style which would obscure findings based on between group differences as discussed earlier.

The pattern of maternal attributions of high Control to child in the antisocial group is similar to that found in previous studies of physically abusive mothers. It suggests that these boys are likely to have been physically abused, at risk for physical abuse, or at the least be the recipient of harsh parenting. This hypothesis would need to be investigated in future studies.

8.4 Methodological implications

It became apparent during the course of this project, that attribution dimensions may provide a rather incomplete account of cognitive processes in the explanation of abuse and negative events. It may be more useful to employ the LACS to code attributions arising from parent-child interaction and from hypothetical vignettes rather than an exclusive focus on coding mothers attributions for events in an interview setting.

When assessing adults' childhood experiences an attenuated semi structured interview could be used. It appears that there has been no research on fathers or father-figures own childhood experiences of abuse in such families. This is a glaring inadequacy in the child abuse literature and is probably a reflection of the high proportion of single mother families on which most research into child maltreatment is conducted (cf. Cicchetti and Manly, 1990).

In order to clarify the potential role of studying maternal attributions in families where child abuse has occurred it would be useful to establish that attributions reflect maladaptive communications in parent-child relationships. One possibility would be to rate affective aspects of communication. Expressed emotion ratings have been used in previous research and reliable criteria for making such ratings have been established.

The use of hypothetical vignettes has been marginalised in attributional research recently due to the preference for 'naturally occurring' attributions. The study of parental attributions in sensitive context called for a system such as the LACS to code attributions as they occurred during in the interviews. However, although the high yield of negative attributions indicates the richness of extracting attributions from verbatim transcripts, there were actually few attributions specific to sexual abuse, the topic under investigation.

It is possible that a combination of vignettes of negative child behaviours and examples of sexual abuse victimisation and perpetration by an analogue child could be used to generate attributions made by parents while obviating the arousal of a defensive coping style which may have precluded mothers in this study from making attributions about sexual abuse. This avoids using experimenter-generated attributions which are of limited use and may also represent a more parsimonious approach to obtaining relevant and focussed attributions specific to sexual abuse. In addition, it has been suggested that the use of hypothetical vignettes may elicit 'summary cognitions' which represent overlearned or 'true' explanations for negative events (Bugental, 1995). Adding in a hypothetical component to future studies and using the LACS system to code attributions may be a useful way forward.

Suggested refinements to the LACS

A number of proposed refinements to the LACS are suggested arising from its use in this study:

i) The use of Agents and Targets has been demonstrated to be useful and could be included in future studies employing the LACS.

ii) The Personal-Universal dimension which is unique to the LACS was not reliable for Agent data in this study. Ratings were heavily, but inconsistently, skewed towards the Personal end of the dimension. The validity of this rating could be influenced by the fundamental attribution error in that raters may have attributed primarily to proximal factors (that is to the person being rated). The Personal dimension appears to be one of potential value given the importance of attributing blame for negative events and further validation of this dimension may be needed.

One further point regarding the Personal-Universal dimension is that in order to make full use of this dimension it may be useful to establish the referent group about which the Speaker of attributions is referring to prior to coding.

iii) Further validity may also be sought on the Global-Specific dimension although acceptable reliability was achieved in this study. However there are shortcomings in the present study relating to the personal importance of events produced during interview or therapy sessions about which attributions are made. As previously mentioned, it may be feasible to ask individuals to rate events for their relative importance following an interview.

In general, validity of the LACS system has not been sufficiently addressed. Future studies could improve on this by the use of observational and psychophysiological measures of concomitant emotion (cf. Bugental et al., 1993). It might also be fruitful to ask subjects to rate their own attributions along dimensions of cause, although this may be less successful with clinical groups as it requires similar conceptual abilities to rating causes in the ASQ which has proven difficult in this and other clinical studies.

A number of references have been made to the need for larger sample sizes in order to detect clinically and statistically significant effect sizes. It is possible that researchers investigating parental attributions could collaborate in order to increase the power of studies which generally fall short of acceptable power.

In summary, the methodological implications can be seen fall into three areas of development i) that a hypothetical component to eliciting attributions may reduce the apparent defensive coping style found in this study when threatening events are discussed, ii) that assessing accompanying emotions using observational and psychophysiological measures would be useful and iii) that observational studies would further our understanding of the connection between attributions and parent-child interaction.

Recommendations for future research

In light of the findings from current research specific recommendations can be made for future studies investigating parental attributions.

It is possible that the current study sample involved a number of confounding variables which may have contributed to the lack of group differences. The design included birth and non-birth mothers and also included mothers who had their sons living at home and those who did not. Further confounds may arise from the inclusion of boys who were abused intrafamilially and those who were abused extrafamilially. In order to partial out these effects, collaborative studies would need to be designed in order to have sufficient sample sizes.

It is also of note that virtually no published work reports on fathers or father-figures in studies of parental attributions. This would be an important omission to address. Given the importance now placed on the relational aspects of attributions, rating attributions made by all family members, including fathers and children would be important. Furthermore, empirical studies investigating intergenerational styles of communication may shed light on the multi-generational nature of child maltreatment. This would entail empirical studies which may include other family members.

As already mentioned a recommended research paradigm for further study could include a brief, focussed interview with mothers and fathers . This could include a vignette task of attributing causes for negative outcomes in appropriate hypothetical situations. A primary focus of the interview would be parents' own childhood experiences of parental care and maltreatment.

Ideally some observational methods of parent-parent and parent-child interactions could be included, and attributions made by each family member could be rated from taped material. It would also be useful to rate concomitant emotional responses

including expressed emotion and psychophysiological measures. Where appropriate, a useful exercise in validity would be to ask participants to rate attributions following a taped session. Events could then be rated for personal importance and analyses could then focus only on 'important' events if desired.

For studies of sexually abused children, it would be particularly important to include measures of physical abuse. The use of the Conflict Tactics Scale (Straus and Gelles, 1980) may be a useful measure of such abuse and further corroboration from Child Protection Registers could be sought to confirm the absence of abuse in comparison groups.

The LACS could be used to code attributions as it allows for flexibility in coding attributions made in a variety of settings in natural discourse. Some recommendations have been made to modify the system including a need to further address the validity of causal dimensions. The LACS could also be put to good use in longitudinal study designs which were not necessarily intended to assess attributions made by family members over time.

In summary, there remain good reasons for employing a system such as the LACS to code attributions made by the sample under study. Limitations to this and existing research studies have been discussed followed by recommendations for future research.

8.5 Theoretical considerations

Shared method variance is a problem referred to in the work of Patterson, Reid and Dishion (1992) in their discussion of building a theory to account for antisocial behaviour in boys. Much of the problem stems from using data from a single agent, in this case, mothers. Studies have found that mothers of oppositional children have higher depression scores (e.g., Griest, Wells and Forehand, 1979; Patterson, 1982)

and that maternal depression scores correlated with maternal reports of deviant child behaviour (Griest et al., 1979).

Consistent with the notion that depressed mothers might have a depressive bias which distorts their descriptions of child behaviour, these studies found no significant correlations between independent observations of oppositional behaviour and maternal depression scores. This suggests that maternal reports may be heavily influenced by their mood (Patterson, Reid and Dishion, 1992). A recent study by Fergusson, Lynskey and Horwood (1993) found small to moderate correlations between maternal depression and maternal reporting errors of child behaviour, indicating a tendency for depressed mothers to over-report child behaviour problems.

Clearly, multi-method, multi-agent methodologies are desirable in testing out theoretical models. However, the findings regarding shared method variance do not necessarily undermine the importance of maternal depression in the interpretation of her child's behaviour. If depression sensitizes mothers to negative child behaviours, and a negative control bias is shown in her attributions to causes of these behaviours, these may operate *independently* of the child's actual behaviours. This has been borne out to some extent by other findings suggesting that mothers may react negatively to even quite neutral behaviours (Mash and Johnston, 1982,1990).

Further theoretical implications of this study can be summarised in the following three points. First, findings from this study add some support for construing attributions in terms of a reflexive coping style rather than a stable personality trait. Further attention needs to be paid to the social function of attributions or 'communicated beliefs'. Second, findings suggest that further investigations into the effects of childhood experiences on cognitive processes such as memory is warranted. This could be enhanced by including psychophysiological measures such as skin conductance and heart rate.

Finally, the distinction between victims and perpetrators of child sexual abuse may not be a theoretically or clinically relevant one. In terms of maternal attributions, the three case groups appeared to be more similar to each other than was expected and dissimilar to the antisocial comparison group. Further integration with the findings from the main study may shed light on this suggestion. Labelling groups is usually supported by the need to organise policy and services for families and to assist research programmes. Further research is clearly needed to identify similar and distinct psychological needs in this group of high-risk adolescents and their families.

In summary, it must be stated that all of these implications are tentative given the methodological limitations presented earlier. A number of areas for further work have been identified throughout this chapter, namely that controlling for exposure to and experience of physical violence may be informative when considering models of developmental psychopathology and child sexual abuse. Further work is also needed to confirm the thesis that cognitive style characterised by repression/avoidance is likely to be a harmful context for a child, particularly when considering the recovery process following child sexual abuse.

8.6 Concluding remarks

The four broad aims identified at the beginning of this chapter will be reviewed first. Description of this interesting clinical sample were provided in terms of maternal childhood experiences, demographic factors and mothers responses to sexual abuse. Maternal attributions were identified and the 'low mention' of sexual abuse finding was discussed in light of the preponderance of negative findings for hypothesized group differences.

The methodological and theoretical implications of the findings from this study were presented as tentative in light of the limitations of the present study. A number of points were made throughout this chapter which could have implications for intervention with groups of high-risk adolescents. The overall impression being that mothers of all three case groups and the antisocial comparison groups showed high rates of adverse childhood experiences and current mental health problems. These would need to be addressed alongside direct intervention with adolescents.

Although not testable in this study, findings were interpreted as providing support for a representation of attributions as a reflexive and dynamic coping strategy which emerge in interactions. A defensive coping style was hypothesized alongside the finding that there was a 'low mention' of sexual abuse among maternal attributions for negative events. It was also noted that a proposed cognitive style characterised by avoidance and repression of 'difficult' topics might affect motivation to engage in therapeutic assistance. Further research into the effects of childhood experience on memory and other cognitive processes appears to be warranted.

As we saw in Chapter Four, the role of maternal attributions has been established to some extent in physically abusive families at a microsocial or moment-by-moment level and using analogue methods. However, although intuition and clinical experience would lead to a hypothesis that maternal attributions may also 'organise' affect in families where other forms of child abuse have taken place, this remains a speculation. It seems important to uncouple the effects of types of child abuse and the role of parents as abusers or as 'bystanders' (Bugental, 1995). Recommendations were made for future research which included attributional measures of all family members in conjunction with observational measures.

Causal attributions have been proposed to reflect a coping style rather than act as event-specific mediators of affect and behaviour. Perceptions of control may be particularly relevant to the affective and behavioural dimensions of distressed parent-child relationships and may be most amenable to change using cognitive-behavioural therapeutic techniques.

This research project has led to invaluable experience in interviewing and coding in a highly sensitive clinical context. It has also revealed the major limitations of an approach attempting to measure implicit cognitions. My findings have led me to believe that observations of parent-adolescent interactions and investigation of communication of family norms and coping styles would be valuable in cases of multi-generational abuse. Attributional analysis would be a useful adjunct to such studies and a refined version of the LACS would be an ideal and ecologically valid system to employ.

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APPENDICES

List of Appendices

PLEASE NOTE DOUBLE SIDED PAGES FOR APPENDICES

APPENDIX 1

Great Ormond Street Hospital for Children NHS Trust

and the Institute of Child Health

The child first and always

DEPARTMENT OF PSYCHOLOGICAL MEDICINE

Great Ormond Street
London WC1N 3JH

Telephone: 071-405 9200

13 July 1992.

Dear

The Child Sexual Abuse team at Great Ormond Street Hospital is currently in a position to offer a limited number of places for assessment and short-term intervention with adolescent boys, both victims of sexual abuse, and/or perpetrators.

The treatment programme being offered includes a research component, through which it is hope to gain a greater understanding of the genesis of sexual abuse committed by adolescents. The research protocol included individual, family and school based assessment. It will run from August 1992 until November 1993, in the first instance.

Due to our limited resources, we are only able to offer places for boys aged between 11 and 15 years. We are particularly interested in receiving referrals of both abused perpetrators, non-abused perpetrators, as well as male victims of sexual abuse in this age range who not know to have sexually abused.

In line with the current policy of the Special Health Authority, there will be no charge for the service being offered.

Boys accepted into the programme will receive an initial assessment, followed by 12 individual weekly sessions conducted by psychotherapists at Great Ormond Street Hospital. In addition to their individual sessions, the boys may be offered a short-term group therapy, following their individual work, depending upon their particular needs.

Each case will be managed by Dr. Arnon Bentovim, Consultant Child Psychiatrist and his team. The CSA team may also liaise with and provide clinical support for the family and/or support network where necessary. A condition of our accepting a child for assessment and treatment within this programme must include the commitment of the social services department and/or family to escort the young person to and from the hospital for every session.

APPENDIX 1

The research component of this project will be coordinated by Bryn Williams, Research Psychologist, under the direction of Dr. David Skuse, Senior Lecturer in the Institute of Child Health, University of London. Family assessment will be conducted by Michelle New, Clinical Psychologist.

If you have any questions or would like further information please contact Dr. Arnon Bentovim at Great Ormond Street Hospital (071-405-9200) to discuss clinical matters, and Bryn Williams at the Institute of Child Health (071-831-0975) to discuss the research part of the project.

Yours sincerely,

Arnon Bentovim
Consultant Child Psychiatrist

David Skuse
Senior Lecturer

Jill Hodges
Principal Psychotherapist

Bryn Williams
Research Psychologist

Michelle New
Clinical Psychologist

APPENDIX 2

SCREENING QUESTIONNAIRE

Date of referral: dd mm yy | | | | | | | | Case No: | | | |

Name: _____

Date of birth: dd mm yy | | | | | | | | Age: | | |

Current address: _____

_____

_____

_____

Tel no: _____

Social Services

Social Worker's name: _____

Address: _____

_____

_____

Tel no: _____

Legal status (write in): _____

Domicile: (0=no; 1=yes)

- at home with natural parent(s) ☐
- in foster care ☐
- adopted ☐
- children's home ☐
- other local authority residence ☐
- other (specify) ☐

_____

When was this child first known to social services:

dd mm yy

Reason for referral:

_____

_____

_____

_____

Victim Status

Has this boy been sexually abused? (0=no; yes=1) ☐

When was first known episode of abuse?

dd mm yy

When was last known episode of abuse?

dd mm yy

What is the boy's relationship to the perpetrator: (0=no; 1=yes)

father ☐

mother ☐

brother ☐

step-brother ☐

sister ☐

step-sister ☐

other family member (specify) ☐

_____

outside family (specify) ☐

_____

step/foster/parent ☐

Perpetrator status

Has this boy been engaging in sexually abusive behaviour?
(0=no: 1=yes) ☐

When was first known episode of abuse? dd mm yy ☐☐ ☐☐ ☐☐

When was last known episode of abuse? dd mm yy ☐☐ ☐☐ ☐☐

What is the boy's relationship to the victim?

		Contact abuse	Age of victim	Sex of victim
brother	☐	☐	☐	☐
sister	☐	☐	☐	☐
other family member (specify) _____	☐	☐	☐	☐
outside family (specify) _____	☐	☐	☐	☐

Intervention

Has this child had any previous referral to:
(0=no; 1=yes)

		Are they being seen currently?
child psychiatrist	☐	☐
psychotherapist	☐	☐
educational psychologist	☐	☐
clinical psychologist	☐	☐
other therapist/counsellor (specify) _____	☐	☐

If a period of treatment were to be offered, would your department undertake to bring the child to appointments? (estimate: maximum of 15 visits over 3 months)

0=no; 1=yes ☐

Similarly, if a period of treatment were offered, would you be willing to work with the child to complete a small number of homework tasks?

0=no; 1=yes ☐

Mother

Name: _____

Address: _____

_____

_____

Tel no: _____

School

Name: _____

Head: _____

Address: _____

_____

_____

Tel no: _____

Contact teacher: _____

APPENDIX 3

The Hospitals for Sick Children Special Health Authority
GREAT ORMOND STREET, LONDON WC1N 3JH
Telephone: 071-405 9200 Ext.
Telegrams: GREAT LONDON WC1
PATRON: HER MAJESTY THE QUEEN
CHAIRMAN: MRS. C. BOND, S.R.N., S.S.I.J.
GENERAL MANAGER: SIR ANTHONY TIPPET, K.C.B., C.B.I.M.

Department of Psychological Medicine

EARLY ADOLESCENT DEVELOPMENT STUDY

I am the parent/guardian of .....

I have had the purpose of the Early Adolescent Development study explained to me, and I understand that all the information I give to the researchers will be confidential to the study.

I am willing / unwilling * to help by being interviewed about myself and my child, and completing questionnaires to help the research.

Signed..... Date.....

Parent's Name.....

Address.....

.....

.....

Telephone Number (if any).....

* delete as necessary

APPENDIX 4

Introduction to Interview

Thank you for coming today. I am Michelle New, a clinical psychologist working on the adolescent development study in which your son, , may take part. I would like to use this tape recorder to tape our meeting today so that I don't have to write down everything you say. These tapes are confidential to the study and if at any time you would like me to stop the tape, or wipe anything I will do so.

I would like to begin by asking you if you would mind if I called you by your first name, as it is important that there are no last names on the tape. This interview is confidential, however concerns about a child's welfare need to be shared with the clinical case manager. It may also be important to share other issues which may be helpful for your son's case manager or therapist to know, to contribute to their understanding of his difficulties.

If at any time you would like to take a break, please let me know and following the interview there will be some brief questionnaires to complete.

APPENDIX 5

USEFUL TELEPHONE NUMBERS

Main helping agencies

*VICTIM SUPPORT
Contact for local branch
39 Brixton Road, London SW9 6DZ
(071) 735 9166

*RAPE CRISIS
Tel: (071) 837 1600

ALCOHOL AND DRUGS

*ADFAM
82 Old Brompton Road, London SW7 3LQ
(071) 823 9313. [Mon - Fri 10 am - 5 pm]

*SCODA - Standing Conference on Drug Abuse
1 -4 Hatton Place, Hatton Garden
London EC1N 8ND
(071) 430 2431 [Supply up to date lists of helping agencies]

CARING ORGANISATIONS

*NACAB - National Association of Citizens, Advice Bureaux
Myddelton House, 115 - 123 Pentonville Road,
London N1 9lZ
(071) 833 2181

*SALVATION ARMY
Avalon, Summerhill, Chislehurst
Kent, BR7 5NU
(071) 985 1181

APPENDIX 5

CHILDREN AND CHILD CARE

*BARNARDO's
Tanners Lane, Barkingside,
Essex, IG6 1QG

*CHILDLINE
50 Studd Street, Islington
London, N1 0QJ
(071) 239 1000

*NCB - National Children's Bureau
8 Wakley Street, London EC1V 7QE
(071) 278 9441

*NCH- National Children's Home
85 Highbury Park, London N5 1UD
(071) 226 2033 [Run NCH CARELINES around the country]

*NSPCC- National Society for Prevention of Cruelty to Children
67 Saffron Hill, London EC1N 8RS
(071) 242 1626

RELATIONSHIPS

*RELATE - Marriage Guidance
Herbert Gray College, Little Church Street,
Rugby, Warwickshire CV21 3AP
(0788) 573241 [Counselling service, and publications]

*EXPLORING PARENTHOOD
41 North Road, London N7 9DP
(071) 607 9647 [Telephone advice and counselling service, groups and publications]

*FAMILIES NEED FATHERS
BM Families, 27 Old Gloucester Street
London WC1N 3XX [Advice, informal walk-ins, publications]

MENTAL HEALTH

*MIND
22 Harley Street, London W1N 3ED
(071) 637 0741

APPENDIX 5

PARENTS

*NEWPIN
Organisation involving networks of women in difficulty.
Walworth Road, London SE5
(071) 703 6326

*PARENT NETWORK
44 - 46 Caversham Road, London NW5 2DS
(071) 485 8535 [Runs support groups]

*PARENTLINE OPUS
Rafya House, 57 Hart Road,
Thundersley, Essex SS7 3PD
(0268) 757077 [Groups around the UK]

SINGLE PARENTS

*GINGERBREAD
35 Wellington Street, London WC2E 7BN
(071) 935 1651 [Groups and literature]

*NATIONAL COUNCIL FOR ONE PARENT FAMILIES
255 Kentish Town Road, London NW5 2LX
(071) 267 1361 [Advice and publications]

OTHER HELPFUL AGENCIES

*STEPFAMILY
72 Willesden Lane, London NW6 7TA
(071) 372 0846 [Counselling service]

APPENDIX 5

INFORMATION / RESOURCES FOR INCEST SURVIVORS

B = BLACK WOMEN
C = INDIVIDUAL COUNSELLING
D = DROP-IN
G = GROUP
H = HELPLINE
L = LESBIANS
Y = YOUNG WOMEN

C D H Y 1) OFF CENTRE
25 Hackney Grove, E8. Tel 081 986 4016
Individual counselling for adolescents.
Helpline on Thursdays + Drop-in

C Y (G?) 2) LONDON YOUTH ADVICE CENTRE
29 Prince of Wales Road, NW5. Tel 071 267 4792
Counselling for 12 - 25 year olds.

C G L Y 3) NORTH LONDON LINE PROJECT
Contact Maureen Hand 071 607 8346
No address given for obvious reasons. Offers a network for incest survivors for 14-24 year olds. Individual counselling.

C H 4) RAPE CRISIS CENTRE
PO BOX 69 WC1X 9JN Tel 071 837 1600
Telephone Counselling line Mon - Fri, 10 am - 11 pm.
Weekends 9am - 12

C 5) WOMEN'S COUNSELLING PROJECT
c/o Sisterwrite, 190 Upper Street N1 Tel 081 960 6376
Individual counselling for periods of up to 6 months. Available on Tuesday nights, by appointment only.

C G 6) WOMEN'S THERAPY CENTRE
Manor Gardens Centre, 6-9 Manor Gardens N7
Tel 071 263 6200
List of therapists for individual counselling (not on the premises). Therapeutic workshops and ongoing groups.

7) BRENT CONSULTATION SERVICE (for adolescents)
Winchester Avenue, NW6. Tel 071 328 0918

8) SPECTRUM INCEST INTERVENTION PROJECT
7 Endymion Road, London N4 1EE. Tel 081 348 0196

9) BRANDON CENTRE FOR COUNSELLING & PSYCHOTHERAPY (for adolescents)
26 Prince of Wales Road, NW5 (Kentish Town)
Tel 071 267 4792 (ex-youth Advisory Centre)

APPENDIX 5

B C	21)	SOUTHALL BLACK WOMEN'S CENTRE (Ealing) Tel: 081 843 0578 or 081 574 5123 Accomodation, advice and counselling.
C Y	22)	TEENAGE INFORMATION NETWORK Tel: 071 403 2444 General counselling.
B C G H	23)	WOMEN & GIRLS' NETWORK BCM 8887, WC1N 3XX Tel: 081 978 8887 Counselling and information service. Recognises the distinct needs of black women and girls who are survivors.
C	24)	WOMEN IN MEDICAL PRACTICE 66 High Road, N17 Tel: 081 885 2277 Individual counselling.

APPENDIX 6

Main content areas covered by maternal semi-structured interviews (Chronological order)

Basic Demographic and Descriptive Variables

Mother status - refers to whether the mother is a birth/biological mother or a non-birth mother (foster, step or adoptive).

Age of mother/subject in years

Current living situation describes who is living at home with the mother at the time of the interview.

Family tree. Tree drawn with subject to depict all family members.

Demographic data : Social Class ratings for Osborn Social Index includes number of rooms, home, car and telephone ownership. Also whether mother is currently on Income Support. Employment status (past and present) of mother and father.

Relationship information

Marital status at time of interview
Months married to first husband/partner
Age of first sexual intercourse (not child sexual abuse)
Age first married/cohabited
Number of times married/cohabited

Pregnancy history

Age Mother had first baby
Age Mother had target child
Number of terminations
Number of miscarriages
Number of stillbirths
Number of own children adopted out
Number of own children died (not stillborn)
Number of unplanned pregnancies

Education/School history

Age mother left school
Number of CSE's passed
Further qualifications

APPENDIX 6

Cultural

Ethnic group of mother and father/partner
Religious affiliation of mother, father and mothers family of origin

Past Depression

To aggregate scores on four areas:
NO = 0, YES = 1.

i) Subjective report of past episode(s) of depression
ii) Subjective report of past hospitalisaition
iii) Subjective report of past contact with psychologist or psychiatrist for depression
iv) Subjective report of medication for depression at any time since the age of 18 years

Current stress

Includes typical stress variables such as headaches, colds, stomach aches, sleep difficulties.

Also amount of cigarettes, alcohol and drug use and subjective report of whether mother thinks this has got worse since discovery of abuse, (or in the case of the comparison group, since the time of the 'worst misdemeanour'),

Criminal history

Descriptive information on criminal history of both mother and boy's father/father figure. Types of offences, age at first offence, age at repeated offences, arrest record and imprisonment.

Early development

Items regarding pregnancy, childbirth and early development of boy. Descriptions elicited of boy's behaviour during early childhood through to current behaviour. Ratings of expressed emotion (warmth, criticism and hostility) were made primarily from mothers' descriptions of child behaviour.

Mothers response to victimisation of boy

Items included:
Did mother know of abuse before boy disclosed/abuse discovered?

Number of reported responses to abuse (e.g., shock, anger, numbness).

APPENDIX 6

'Blame' questions regarding sons victimisation

Who did mother feel most angry with?

Does mother think boy could have stopped abuse?

Blame cake item: " In order to see how much responsibility you give to each person involved in your son's abuse I would like us to draw a circle, or pie, and divide it into segments, this is called the Blame Cake. Divide the circle into segments and give a percentage number for anybody who you believe was responsible for your son's abuse, As long as it adds up to 100%, it does not matter how many people you identify".

Blame cake - % responsibility to Perpetrator
- % responsibility to Boy/Victim
- % responsibility to Mother

Response to sons perpetration of abuse

Did mother know of perpetration of abuse by her son prior to discovery/disclosure?

Number of reported responses to perpetration of abuse.

'Blame' questions regarding sons perpetration of abuse

Who was mother most upset with?

Does mother believe boy's victim could have prevented abuse?

Blame cake -% resp to Son/Perpetrator
-% resp to Victim
-% resp to boy's perpetrator (for victimised perpetrator group)
-% resp to Mother/self

Social support

How many relatives does mother/subject see currently
Would mother like to see more relatives?
How many can mother/subject can count on?

APPENDIX 6

Childhood experiences of mother
Subjective report of experience of early loss of either parent by divorce or death.

Four variables pertaining to early loss and separation. Aggregate score, score of 1 or more is a disadvantage.

Physical abuse of mother

Physical abuse as child

Physical abuse as adult

Child physical abuse defined as violence by a household member (usually adult) towards the child. Covers child being beaten, kicked, burnt, hit with belts or other objects, or being threatened with knives or other objects. Comparable to criteria used in the Severe Violence index of the Conflict Tactics Scale (Straus and Gelles, 1980). Scale used by Bifulco, Brown and Harris (1994) was simply Presence or Absence of physical abuse and was recoded as present or absent for data analysis.

Adult physical abuse was defined in a similar way, with reference to the Conflict Tactics Scale which operationalises the concept of violence or physical aggression. Violent acts include throwing an object, pushing or shoving, slapping, kicking, biting, hit with a fist, hit with an object, burning, choking, threatened with a knife or gun and actual use of weapon.

Although pushing or shoving could be seen as qualititatively different from kicking or biting, any one incident would be enough for inclusion, and in practice, women experiencing pushing or shoving also tended to experience the more severe forms of physical aggression.

Variables relating to quality of care

(Criteria from Andrews, Brown and Creasey, 1990).

Parental control

High, Moderate, Lax

Refers to the level of supervision of the child as well as parental enforcement of rules and discipline. Items about rules, strictness of parents and about parental control strategies such as grounding etc. Rating based on relevant questions.

APPENDIX 6

Parental discord

Marked, Moderate, Some, Little/None

Amount of rowing and arguing in the family of origin home including whether police called for disturbances etc.

Parental functioning

1 = Marked to 4 =Little/No poor functioning.

Based on ratings of parental alcohol use, parental mental illness (particularly depression) and general functioning as reported by subject. Assessment by subject of marital satisfaction of parents.

Parental antipathy

Marked, Moderate, Little, None.

Degree of dislike, criticism , hostility or coldness shown by parental figures towards the child, includes scapegoating, rejection, favouritism of other sibs etc. Combined this with rating of parental indifference, which included a global rating of how happy/unhappy they report their childhood to have been..

Sexual abuse

See next section (Appendix 10) for actual interview questions and Appendix 9 regarding items presented on cards to subjects to describe sexual abuse experiences.

Method section (Chapter Six) describes sexual abuse criteria.

End Appendix 6.

APPENDIX 7

Ratings for expressed warmth, criticism and hostility

Ratings of Warmth, Hostility and Criticism, based on criteria developed by Brown and Rutter (1966). Rated on basis of questions regarding boy's early history and development from pregnancy to current descriptions of behaviour.

Critical comments are negative in tone, have a negative verbal content and are specific to behaviours. Hostile comments are also negative in tone and content, but are generalised and may even be generated from a positive comment (e.g. *'well, yes, he does do the washing up every day, but he goes and breaks everything and refuses point blank to do anything else around the house'*). The score for Hostility is also elevated by the spontaneous (vs. elicited) nature of comments.

Warmth is scored when comments are made about the boy which are both positive in tone and in content. The score for Warmth is also elevated if comments are spontaneous rather than elicited.

A four point rating scale was used to score mothers on these dimensions:

0 - None (no emotion detected during interview)
1- Mild
2- Moderate
3- Marked

None (0): This rating was given when no comments were detected on any of the three dimensions of expressed emotion being rated. In other words, factual responses were given to the questions regarding the mother's relationship with her son. Descriptions of behaviour given in neutral tones with no elicited emotion would also lead to a zero score. Example: *'he was a sleepy baby, yes, slept a lot, not much bother'.*

Mild (1): When tone or content indicated mild warmth, criticism or hostility but is elicited rather than spontaneous, a score of 1 was assigned.
Example: *'he was always a quiet baby...yes, I suppose he was a good baby, quite sweet actually'* (example of mild warmth).

Example: *'he as always in his sister's toys - and breaking things, a bit of a pain if truth be known'* (example of mild criticism).

Moderate (2): Tone and content were both negative,and may be spontaneous.
Example: *'he's not always been like that, he's very loving and caring underneath'* (example of moderate warmth).

APPENDIX 7

Example: *'he's quite well behaved, but when he lies he does it to hurt me, he's always telling lies that child'* (example of moderate criticism)

Example: *' he's been good on occasion, but basically he doesn't care about others and is only looking out for himself, and I think he'll stay that way whatever you do'* (example of moderate hostility)

Marked (3): As above, but spontaneous comments and stronger in tone or content.
Example: *'he's only done that once, but he's such an angel indoors, he is a good an caring boy deep down'* (example of marked warmth)

Example: *'he's done okay at school, but he doesn't do his best, he's never really put any effort into his school work, and he never brushes his hair or looks smart'* (example of marked criticism)

Example: *'he's such a pain, he is a devious, cunning little rat, and he knows exactly what he is doing, I think he enjoys hurting other people, that's just the sort of person he is'* (example of marked hostility).

Global ratings were made after completing the interview.

APPENDIX 8

Termination of Interview

Those are all my questions, thank you very much for taking the time to answer them. The things you have been able to tell me about will be very helpful for our study. Is there anything you would like to ask me about, or anything I've forgotten to mention that you think is important? If there is anything that you have talked about with me today that you find upsets or worries you at a later time, you can contact me at the number on this page. There are also some other numbers that you might find helpful to have.

APPENDIX 9

1. Rude suggestions
2. Asked for sex
3. Touched your body
4. Touched your vagina
5. Touched your bottom
6. Made to touch his/her body
7. Made to touch penis/ masturbate him
8. Made to touch vagina/ masturbate her
9. Made to put penis in mouth
10. Penis in bottom (anal sex)
11. Penis in vagina (intercourse)
12. Made to watch while he touched himself
13. Made to watch while she touched herself
14. Finger put in your vagina
15. Finger put in your bottom
16. Other

APPENDIX 10

Okay, I'd like to move on to something else now. At some time, many women have been sexually approached against their wishes or interfered with.

Q. 229. Has that ever happened to you, either as an adult or as a child?

Yes [ ]

No [ ]

We would like to know about this because a lot of women have been approached against their wishes (or even when they were too young to be able to say no, or understand what was going on), and so we want to learn about the different experiences that women have had. We want to learn about the sorts of situations in which women have been sexually approached against their wishes or interfered with.

Q. 229. Has that ever happened to you, either as an adult or as a child?

Yes [ ]

No [ ]

If no - end interview.

OK, I'll move on then,
(Complete Beck Depression Inventory, Beck Hopelessness Scale)

Perhaps if you remember any time that you've been approached against your wishes then we could talk about that another time/ later on.

Those are all my questions, thank you very much for taking the time to answer them for me.

The things you have been able to tell me about will be very helpful for our study. Is there anything you would like to ask me, or anything that I've forgotten to mention that you think is important?

If there is anything that you have talked about with me today that you find upsets or worries you at a later time, you can contact me at this address or telephone number.

There are also some other numbers you may find helpful to have.

APPENDIX 10

230. How old were you when that happened?

a) Age_____years

Child, under 5	=1	
Child, under 10	=2	
Child, under 15	=3	
Under 20	=4	
Adult	=5	[ ]

b) Age_____years

[ ]

c) Age_____years

[ ]

Can you tell me about what happened to you?
(or, I would like to ask you some questions about what happened to you)

231. Was it someone in your original family?

Yes =1
No =2 [ ]

232. Can you tell me who it was?

_____

Mother (S's mother)	=1	Other female primary carer	= 13	
Father	=2	Other female relative	= 14	
Step-father	=3	Other (female)	= 15	
Step-mother	=4	Other (male)	= 16	
Brother	=5			
Other primary carer	=6 (male)			[ ]
Grandfather	=7			
Uncle	=8			
Male Cousin	=9			
Other male relative	=10			
Family friend	=11			
Male Stranger	=12			

APPENDIX 10

233. Did it involve actual touching?

Yes =1
No =2 [ ]

234. Did it involve intercourse?

Yes =1
No =2
Other =3 [ ]

235.

[card # 6]

Could I ask you to look at this page and tell me which ones applied to you:
{YES = 1; NO = 2}

1. Rude Suggestions	yes/ no	[ ]
2. Asked for sex	yes/ no	[ ]
3. Touched your body	yes/ no	[ ]
4. Touched your vagina	yes/ no	[ ]
5. Touched your bottom	yes/ no	[ ]
6. Made to touch his/her body	yes/no	[ ]
7. Made to touch penis/mast. him	yes/ no	[ ]
8. Made to touch vagina/ mast. her	yes/ no	[ ]
9. Made to put penis in mouth	yes/ no	[ ]
10. Penis in bottom (anal sex)	yes/ no	[ ]
11. Penis in vagina (intercourse)	yes/ no	[ ]
12. Made to watch him touch himself	yes/ no	[ ]
13. Made to watch her touch herself	yes/ no	[ ]
14. Finger in your vagina	yes/ no	[ ]
15. Finger in bottom	yes/ no	[ ]
16. Other	yes/ no	[ ]

---

236. Did anybody else know that it happened?

Yes =1
No =2
Not sure =3
Other =4
n/a =5

APPENDIX 10

237. Who knew?

{YES = 1; NO = }

Mother	yes/ no	[ ]
Father	yes/ no	[ ]
Sib	yes/ no	[ ]
Other relative	yes/ no	[ ]
Friend	yes/ no	[ ]
Teacher	yes/ no	[ ]
Other	yes/ no	[ ]

(If no-one knew , go to **Q. 239**)

238. What did they do?

{YES = 1; No =2}

Helped	Yes/ No	[ ]
Told family	Yes/ No	[ ]
Told services	Yes/ No	[ ]
Protected from perp.	Yes/ No	[ ]
Nothing	Yes/ No	[ ]
Other	_____	

239. Do you think it happened to anyone else in your family?

Yes	=1	
No	=2	
DK	=3	
n/a	=4	[ ]

(IF NO - go to **Q. 243)**

IF YES (happened to someone else in family)

240. Who was that?

Mother (S's mother)	=1	
Father	=2	
Brother	=3	
Sister	=4	
Other relative	=5	
DK	=6	
n/a	=7	[ ]

APPENDIX 10

241. Was it by the same person?

Yes =1
No =2
DK =3
n/a =4 [ ]

242. How did you find out about it?

---

243. At the time, did you tell anyone about what happened to you?

Yes =1
No =2 [ ]

(IF YES go to **Q. 247**)

IF NO:(did not tell anyone at the time)

244. Why was it hard to tell someone at the time?

Threatened, violence =1
Threat to withdraw love/attent. =2
Threat with perp. go to prison =3
Told wouldn't be believed =4
Other threat =5
Other non-threat =6
Didn't want it to stop =7
Told not to tell anyone =8
Other =9 [ ]

245. Did you tell someone about it later?

Yes =1
No =2 [ ]

APPENDIX 10

246. Is this the first time you've told anyone about what happened to you?

Yes =1
No =2 [ ]

[IF YES: - Discuss support available/ Help Agencies)

If abuse happened as a child:-

247. Did you tell someone at the time it happened?

Yes, same time =1
Yes, much later =2
Yes, as an adult =3 [ ]

248. Who did you tell?

Non-abusing parent(s)=1
Non-abusing sibling(s)=2
Friend/ friend's parent =3
Partner =4
Teacher =5 [ ]
Other relative =6
Other =7

249. Did they believe you?

Yes , immediately =1
Yes, later =2
No, not until 'proved' =3
No =4 [ ]

250. Were they sympathetic?

Yes =1
No =2
Other =3 [ ]

APPENDIX 10

251. Was anyone like a doctor or social worker involved?

Yes =1
No =2
DK =3
n/a =4 [ ]

If doctor/ social worker involved:-

252. Were they helpful or sympathetic?

Yes =1
No =2 [ ]

253. Were the police ever involved?

Yes =1
No =2 [ ]

If police were involved:-

254. Were they helpful or sympathetic?

Yes =1
No =2
[ ]

255. Was there a court case?

Yes =1
No =2 [ ]

IF YES:
256. How did that go?

Perpetrator imprisoned =1
Perp. not imprisoned =2
Subject put in care =3
Other =4 [ ]

APPENDIX 10

257. Why do you think this happened to you?

---

258. In order to see how much responsibility you give to each person involved in what happened to you as a child/as an adult, I would like us to draw a circle and divide it into segments, the Blame Cake.

Divide the circle into segments and give a percentage number for the amount of responsibility you give to each person involved.

This may be a hard question to answer:-

259. Do you think there was anything you could have done at the time to stop what happened, or to stop it continuing?

Could have stopped it =1
Could not have stopped it =2
Not sure if could have =3
Cannot remember =4
Other =5 [ ]

a) did you stop it continuing?

Yes =1; No =2; other =3; d/k =4; n/a =5 [ ]

260. Do you know if anything like this happened to your husband/ Partner, boy's father?
(Sexual abuse)

Yes =1
No =2
Unsure=3
dk =4
n/a =5 [ ]

APPENDIX 10

Those are all my questions. thank you very much for taking the time to answer them for me. The things you have been able to tell me about will be very helpful for our study. Is there anything you would like to ask me about, or anything that I've forgotten to mention that you think is important?

[Complete Questionnaires]

If there is anything that you have talked about with me today that you find upsets or worries you at a later time, you can contact me at the number on this page.
There are also some other numbers that you may find helpful to have (Helping Agencies).

APPENDIX 10

1. Throwing
2. Pushing/Shoving
3. Slapping
4. Hitting with object
5. Kicking or punching
6. Burning
7. Choking
8. Using a weapon
9. Threatening to use a weapon
10. Other