MULTIPLE PERSPECTIVES OF FAMILY CHARACTERISTICS IN CASES OF CHILD SEXUAL ABUSE

By

CATHIE KERLEY BRISCOE

Bachelor of Applied Arts

Central Michigan University

Mount Pleasant, Michigan

1991

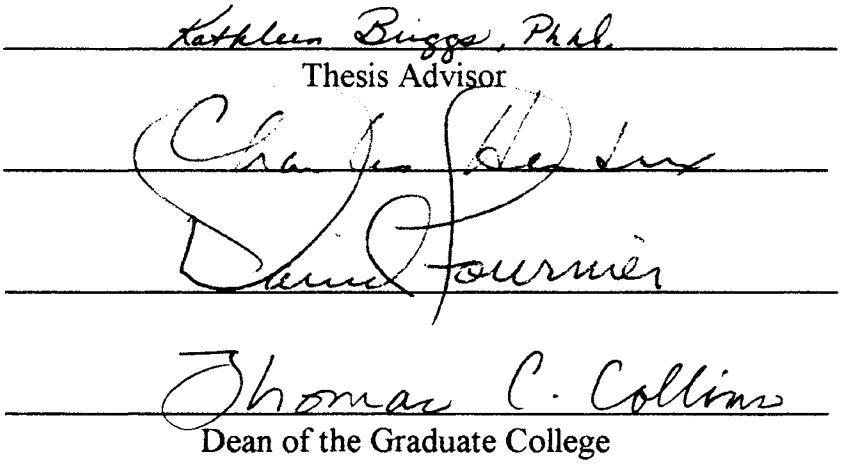
Submitted to the Faculty of the
Graduate College of
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
MASTER OF SCIENCE
December, 1994

MULTIPLE PERSPECTIVES OF FAMILY

CHARACTERISTICS IN CASES OF

CHILD SEXUAL ABUSE

Thesis Approved:



Thesis Advisor

Dean of the Graduate College

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to Dr. Kathleen Briggs, my advisor, for her countless hours of guidance and unwavering patience. Her energy seemed unending during this project, and was highly motivating. I would also like to thank my other committee members, Dr. David Fournier and Dr. Charles Hendrix, for their many suggestions and supportive comments.

My thanks is also extended to all the therapists and family members who participated in this study. I tremendously appreciate their time and willingness to be a part of this project. Without their involvement, this study would not have been possible.

And last but not least, I would like to thank my family. I am thankful to my husband Rick, who endured my many hours of stress and was still able to support and encourage me to continue this project. Finally, I would like to thank my parents Marge and Charles Kerley, for their belief in my ability to succeed. I would also like to recognize how important their understanding, of how busy their daughter could be when attending graduate school so many miles away from home, was to me.

TABLE OF CONTENTS

Chapter Page

LIST OF TABLES

LIST OF FIGURES

Figure Page

CHAPTER I

INTRODUCTION

Scope of the Problem

Research in the area of child sexual abuse has increased considerably in the past ten years, however there are still many issues regarding child sexual abuse in need of exploration. Presently, research literature focuses heavily on etiological studies, and lacks a theoretical basis. Furthermore, several studies are retrospective in nature, with almost all data on risk factors and the effects of child sexual abuse obtained from surveys of adult survivors of childhood incest (Finkelhor, 1993). Long durations of time between the abuse and the data collection can blur memories of the abuse, possibly leading to inaccurate information gathering. Specific interpretations of the abuse may also vary due to time duration. More studies are needed focusing on child sexual abuse, gathering data from the children and their families, instead of focusing mainly on adult survivors of incest. Since 1985 there have been an increase in the number of studies focusing specifically on child sample populations (Kendall-Tackett, Williams, & Finkelhor, 1993). This recent trend is a positive shift in the focus of child sexual abuse research.

Another area lacking in the child sexual abuse literature is the exploration of multiple perspectives of family characteristics in cases of child sexual abuse. The family characteristics of cohesion, adaptability, and communication have frequently been found to be associated with child sexual abuse, yet most studies were retrospective and lacked multiple perspectives (e.g. Allen & Lee, 1992; Carson, Gertz, Donaldson & Wonderlich, 1990; Cole & Woolger, 1989;. Ray, Jackson & Townsley, 1991). Hoagwood (1990), an exception to this trend, found differences in family member's perception of family

characteristics in cases of child sexual abuse, but an outsider's view of the family system was not explored. Therefore, non-retrospective studies, gathering multiple perspectives at multiple system levels (i.e., insiders' view of family, provided by parents, and the sexually abused child; and outsiders' view provided by therapists or other community members). There should also be a focus on the family characteristics of cohesion, adaptability and communication. This proposed direction for the research should fill a large gap in the sexual abuse literature.

This study focused on the following question: How do 8-16 year old sexually abused children's, their parent's, and their therapist's perspectives of the family's dynamics of cohesion, adaptability, and communication differ? This study adds to the research base of non-retrospective studies. The guiding theories behind this research, examining family dynamics in cases of identified child sexual abuse, are Finkelhor's (1986a) theory of the preconditions to the occurrence of child sexual abuse, and the Three-Dimensional (3-D) Circumplex Model (Olson, 1991). An overview of these theories is presented in the section titled Guiding Theories.

Purpose and Objectives of the Study

The purpose of this study was to explore the relationship between system level and the respondents' perceptions of family cohesion, adaptability, and communication in cases where a child had been sexually abused. There were three main objectives for this study: a) to obtain sexually abused children's perspectives of family cohesion, adaptability, and communication; b) to acquire their mother's and therapist's perspective of the family cohesion, adaptability, and communication; c) to identify dyadic discrepancies (i.e. differences in perspectives) within and between family members, and between family

members and the family's therapist. This study tested, the following four hypotheses based on these objectives.

Hypotheses

Hypothesis one: Mothers, sexually abused children, and therapists will view family cohesion, adaptability, and communication differently.

Hypothesis two: Therapists will rate families of identified child sexual abuse as less flexible than families would rate themselves.

Hypothesis three: Children who have experienced sexual abuse and their mothers, will have lower dyadic discrepancy scores, based on their perceptions of their family's cohesion, adaptability, and communication, than mothers and therapists or children and therapists.

Hypothesis four: Mothers and sexually abused children will perceive their family communication as more functional (they will rate themselves higher on the Family Communication Scale) than therapists.

Definitions of Terms

Many different research studies have defined child sexual abuse in various ways. Comparisons are often made between samples whose definitions of child sexual abuse were different, which often can lead to confusion in the literature. Finkelhor (1986b) recommended using a broad definition of abuse to include all possible cases of sexual abuse, and narrowing the definition during the data analysis phase of research so subgroups of the sample can be analyzed (Finkelhor, 1986b). For this study, child sexual abuse was defined as any sexual activity between a child 16 or younger and one or more individuals. The abuse will have also been reported to the Department of Child Welfare.

The criteria for abuse included the occurrence of coercion or force in the initiation and maintenance of the sexual activity. The abuse ranged from petting (touching or attempts at such touching of breast or genitals) to rape. Sexual experiences with a relative or peer less than 5 years age difference between child and relative, that were wanted was not included. Furthermore, non-contact behaviors such as exposure, viewing pornographic material, voyeurism and sexually suggestive talk were not included. This definition of child sexual abuse is one of the commonly used definitions in the literature (Carson, et al., 1990; Harter, Alexander & Neimeyer, 1988; Ray et al., 1991). The definition for family characteristics included the constructs of family cohesion, adaptability, and communication. All of these constructs were defined by the scales used in the study.

Summary

Child sexual abuse is one of the most traumatic events a child can endure. Considering the impact that sexual abuse can have on a child, one may wonder why more attention has not been devoted to exploring the family characteristics of these children's families. The family characteristics of cohesion, adaptability, and communication have frequently been found to be associated with child sexual abuse (e.g. Ray, Jackson & Townsley, 1991). Yet the literature frequently neglects the gathering of multiple perspectives at multiple levels, of these family characteristics. This study was designed to fill this gap in the literature.

CHAPTER II

GUIDING THEORIES

This study is supported by the following two theories. The first theory, developed by Finkelhor (1986a) examines the preconditions to the occurrence of child sexual abuse. This model of preconditions is integral to the study of sexual abuse due to the model's focus which is more on the internal characteristics of the offender, than the demographic characteristics of the potential offender. The dynamics referred to in this theory can also be used to explore the whole family and not just the offender.

The second theory, the Circumplex Model, is a mid-ranged theory of family functioning (Olson, Sprenkle, & Russell, 1979). The Circumplex Model was chosen for the following reasons: (a) the three dimensions of the model, cohesion, adaptability, and communication, have been found to be important variables in families where child sexual abuse occurs (Alexander & Lupfer, 1987; Allen & Lee, 1992; Burkett, 1991; Finkelhor, 1986; Hoagwood, 1990; Ray, Jackson & Townsley, 1991; Trepper & Sprenkle, 1988); and (b) the Circumplex model has been used in many research studies focusing on child sexual abuse (Alexander & Lupfer, 1987; Carnes, 1988; Carson, Gertz, Donaldson & Wonderlich, 1990; Harter et al., 1988; Laviola, 1992; Trepper & Sprenkle, 1988). Therefore, the choice to use the Circumplex model was made due to the relevant dimensions of the Circumplex Model and the body of sexual abuse literature which has used the model. Furthermore, every family member's perceptions of the family can be included in this model, giving a broader picture of family dynamics.

Preconditions to the Occurrence of Child Sexual Abuse

Finkelhor (1986a) posits four preconditions to incest. The first precondition is a motivation of a potential offender to sexually abuse a child. There are three components to this motivation. There must be emotional congruence between having a sexual relationship with a child and meeting the offender's emotional needs for control or power. The second component of motivation is the offender finding the child sexually arousing (Finkelhor, 1986a). England and Thompson (1988) state the offender is attracted more to the ability to control and feel powerful in relation to the child, than actually being sexually attracted to the child. The third component of motivation is blockage. The offender lacks alternative sources of sexual gratification, either due to internal restraints or lack of adult partners (Finkelhor, 1986a).

The second precondition is the potential offender's ability to overcome internal inhibitions against acting on the motivation to sexually abuse a child. The capability to cope with stress, the use of alcohol, and the ability to rationalize, can all weaken a potential offender's ability to recognize sexual relations with a child is wrong (Finkelhor, 1986a). Precondition three is the potential offender's ability to overcome external inhibitors toward child sexual abuse. Situations undermining external inhibitions are the poor supervision of children, leaving children alone or unmonitored, and crowded housing conditions (Finkelhor, 1986a, 1993).

The fourth precondition to incest is the ability of the potential offender, or another factor, to undermine or overcome the child's ability to resist the abuse. Some children are able to discourage being tricked or manipulated. Children who are insecure, lack affection and knowledge of sexuality or are over-trusting, can have their resistance to sexual abuse

easily undermined (Finkelhor, 1986a). Other factors helping to undermine a child's ability to resist sexual abuse include physical or psychological abuse. These children are more vulnerable to the ploys of potential offenders who offer attention and affection (Finkelhor, 1993).

Circumplex Model of Family Functioning

The Circumplex model is based on three dimensions, cohesion, adaptability, and communication. This model serves as a link between Systems Theory and research (Olson, Sprenkle, & Russell, 1979). Cohesion is the level of emotional bonding, and the degree to which family members feel separated from or connected to each other. Adaptability is based on the family's ability to change roles, rules, and power structures in response to stressors either developmental or situational (Olson, Portner, & Lavee 1985). Communication is viewed as the facilitating factor which helps families move in relation to the dimensions of cohesion and adaptability. These three dimensions are the crux for all the instruments developed in conjunction with the Circumplex Model.

By utilizing the instruments developed in conjunction with the Circumplex Model, family functioning can be assessed (Olson, et al. 1979). The highest functioning types were characterized as having moderate levels of cohesion and adaptability; while extremes of very high, or very low cohesion and/or adaptability are viewed as potentially problematic (Olson, et al., 1979). The updated 3-D Circumplex Model used in this study, includes twenty-five family types, increasing the number of family types characterized by moderate levels of cohesion and adaptability (Olson, 1991). The new 3-D Circumplex Model developed by Olson (1991) also integrates the dimension of communication better

than the original Circumplex model by illustrating higher functioning families as having better communication.

Summary

The dimensions of the Three Dimensional Circumplex Model used in conjunction with Finkelhor's (1986a) theory of preconditions of sexual abuse were used to focus on the family characteristics of family cohesion, adaptability, and communication in cases of child sexual abuse. The literature in the area of child sexual abused has cited extreme levels of the three dimensions of the Circumplex Model as characteristics of family systems where child sexual abuse has occurred. Examples of extremes include enmeshed family boundaries (Trepper & Sprenkle, 1988) and chaotic family environments (Alexander & Lupfer, 1987; Allen & Lee, 1992; and Ray, Jackson & Townsley, 1991). Both of these family characteristics can put a child at risk for abuse.

CHAPTER III

REVIEW OF THE LITERATURE

The early empirical studies of child sexual abuse were primarily etiological. Consequently, most of the empirical data regarding child sexual abuse focuses on the prevalence, effects, and indicators of child sexual abuse. The following is a brief overview of major etiological findings within the literature. In recent years empirical studies have focused more on specifics about the families of sexually abused children. When exploring child sexual abuse, many researchers categorize the population based on the relationship of the perpetrator to the child. The largest portion of this body of literature focuses on intrafamilial child sexual abuse, with extrafamilial child sexual abuse being researched less often. Major findings of both types of child sexual abuse are reviewed.

Overview of Child Sexual Abuse

Child sexual abuse is not merely a modern problem. Sexual abuse of children has occurred for centuries (England & Thompson, 1988), and there does not seem to be any immediate end to this abuse. Although the occurrence of child sexual abuse is not disputed, the actual prevalence is hard to estimate. Most rates of abuse are based on reported cases, but the actual number of child sexual abuse incidences is thought to be much higher (Finkelhor, 1993). One researcher estimated the number of females sexually abused to be one out of every four before age 12, and one out of every three before the age of 18 (Russell, 1983). However, after reviewing 18 recent epidemiological studies, Finkelhor (1993) reported estimated ranges of the prevalence of sexual abuse perpetrated against females as 10-60 percent while estimates for males were less than 10-20 percent.

Males appear to be under-rated, probably due to the greater stigma incurred when abuse is disclosed (Finkelhor, 1993).

Males are not the only group which is under-represented in reported cases of child sexual abuse. Sexual abuse cases involving upper-class families are also under-reported. Although, sexual abuse has been found to occur in families from all socioeconomic brackets, levels of education and ethnic groups (Alexander & Lupfer, 1987; Finkelhor, 1993).

Some people who are thought to be looking out for the welfare of children are actually the ones abusing children. Indeed, most child molesters are known to their victims. Russell (1983) in a non-clinical sample of 930 women found past abuse by the following perpetrators: Immediate or extended family members (29%), friends of the family or care-givers of the child (60%), and strangers (11%). Other studies, using both male and female subjects, have found that males are more likely to be abused by a non-family member, than by a family member (Finkelhor, Hotaling, Lewis, & Smith 1990; Hunter, 1991). The abuser is usually a male who is loved and trusted by the child (Faller, 1989; Finkelhor et al., 1990; Margolin & Craft, 1990).

Overall, abuse usually occurs during an on-going relationship between the child and the perpetrator (Finkelhor, 1987). Child sexual abuse usually does not occur as a single, and/or violent incident; although Margolin and Craft (1990) found a higher likelihood of violence and high intensity abuse (intercourse accompanied by physical assault) when the perpetrator was a young non-parental caregiver.

Effects of Child Sexual Abuse

Since the prevalence of child sexual abuse is so high, many people are affected by histories of childhood sexual abuse. There are a number of effects of child sexual abuse which have been identified in both clinical and non-clinical samples of children. In a study of sexually abused children, Friedrich, Beilke, and Urquiza (1987) found increased occurrence of sexual behavior problems, and anxious behaviors. According to Browne and Finkelhor (1987) sexually abused children have reactions of fear, anxiety, anger, and hostility. Other effects of child sexual abuse include feeling less loved by parents (Hotte & Rafman, 1992), regression of behavior, withdrawal, physical pain, and problems sleeping (Conte, 1987). Furthermore, many researchers have found the following effects of child sexual abuse: Depression, (Browne & Finkelhor, 1987; Friedrich, et al., 1987; Wozencraft, Wagner & Pellegrin, 1991), suicidal ideation (Wozencraft, et al., 1991; Hotte & Rafman, 1992), low self-esteem (Hotte & Rafman, 1992), and sexually acting out (Friedrich, et.al., 1987; Hotte & Rafman, 1992). In a study of sexually abused children age 4-12, Black, Dubowitz, and Harrington (1994) found younger children exhibited less behavioral problems than the older children, possibly due to their limited knowledge of what had occurred. When the mother was the individual reporting the effects of child sexual abuse, she reported more behavioral problems associated with the abuse when the abuse experienced was by someone close to the child and when the abuse involved genital contact (Black, et.al., 1994).

Similar to Black and colleagues (1994) findings of influences of increased effects, Ribordy (1989) found long term effects of child sexual abuse worsen or increase if any of the following are true: (a) The abuser was known to the victim; (b) use of force or serious

threats; (c) an age difference of five years or more between the victim and the offender; (d) the type of abuse was more severe and intrusive (intercourse vs. fondling); and/or (e) the abuse lasts over a long period of time. Furthermore, Hunter (1991), found in a retrospective study that both male and female survivors of child sexual abuse reported less satisfaction with intimate relationships and a higher occurrence of sexual dysfunctions compared to non-abused counterparts. Cole, Woolger, Power and Smith (1992) also found female sexual abuse survivors to be less satisfied with spouse, but the dissatisfaction was reported specifically based on being a parental partner. Other studies have also supported the negative impact of sexual abuse including lower self concepts/self-esteem (Alexander & Lupfer, 1987; Hunter, 1991; Nash, Hulsey, Sexton, Harralson & Lambert, 1993), somatic problems (Nash, et al., 1993), depression, (Nash, et al., 1993), dissociative experiences (Nash, et al., 1993), and less confidence in parenting skills (Cole & Woolger, 1989; Cole, et al., 1992). Nash et al. (1993) caution that the sexual abuse should not be viewed as an isolated causal link in the impairment of adult survivors; the family environment in which the abuse took place should also be considered.

When studying males, Hunter (1991) found specific impacts for males sexually abused as children, males reported struggling with their sexuality and masculinity, especially if abused by another male. England and Thompson (1988) reported another long term effect for males molested as children is a higher probability than the non-abused population, of becoming a child molester themselves. The stigma attached to the sexual abuse of male children hinders interventions with these children. Furthermore, lack of interventions may influence the increased chance of male sexual abuse survivors becoming perpetrators.

Lack of interventions may also lead to self-destructive attempts to cope with the sexual abuse. Many previously sexually abused females abuse drugs and become involved in sexual relations (other than the abuse) at an earlier age than their non-abused counterparts (Alexander & Lupfer, 1987; Johnson & Kenkel, 1991). Another study found that over 70% of female drug addicts and prostitutes had a past history of child sexual victimization (England & Thompson, 1988). Females who were sexually abused as children also report a significantly higher rate of subsequent sexual assaults against them, than among women who were not sexually abused as children (Alexander & Lupfer, 1987). Alexander and Lupfer (1987) also found adult incest survivors had more negative memories of their families, than women who were never sexually abused. Negative memories of family life are often associated with an unhappy family life, which Finkelhor et al. (1990) found to be a risk factor for child abuse both inside and outside the home. Therefore, the negative images these women have of their families of origin suggests the importance of considering family characteristics in cases of childhood sexual abuse (Alexander & Lupfer, 1987; Finkelhor et al., 1990).

Indicators of Child Sexual Abuse

There has been a plethora of studies which have focused on the effects of child sexual abuse, which has helped to increase knowledge about possible indicators of child sexual abuse. There are numerous physical, behavioral, and verbal indicators of child sexual abuse. Gupta and Cox (1988) described the following indicators of child sexual abuse. Physical indicators can include: Difficulty sitting or walking, vaginal and rectal bleeding or bruises, vaginitis or vulvitis, the presence of sexually transmitted diseases, or even pregnancy. Behavioral indicators include, but are not limited to, any or all of the

following: Regressive behavior, anxiety, personality changes, and fear of certain places or people. Other behavioral indicators include seductive behaviors, depression, substance abuse and running away from home. Verbal indicators can be as straight forward as the child telling someone about the abuse, the perpetrator admitting to the abuse, or as innocuous as the child indicating not liking a specific gender, to talking about sexual acts.

Overall, demographic variables regarding families, have not been helpful in predicting families who are vulnerable to having children at risk for child sexual abuse. Alexander and Lupfer (1987) found family characteristics and values more capable than demographic variables in predicting families at risk for child sexual abuse. Therefore researchers have begun to focus on specifics about the families of sexually abused children.

Child Sexual Abuse Family Characteristics

An important area of the literature requiring more research is family characteristics of sexually abused children. Researchers have agreed on the need to focus on the characteristics of all family members to help achieve a better picture of the overall family environment. Most studies to date, which have addressed the family dynamics of the mother, father, and child are in reference to cases of father-figure/daughter incest. This focus leaves an enormous gap in the literature, since fathers are not the only people who molest children and females are not the only survivors of abuse. Hoagwood (1990) emphasized this need to move away from exclusively examining family dynamics in cases of intrafamilial child sexual abuse, to examining family characteristics in cases where non-family members were also perpetrators. Proportional to the number of research studies on

incest, there are few studies which deal with the gaps in the child sexual abuse literature. Major finding of family characteristics found in the literature are reviewed.

There are many stereotypes about the environments where child sexual abuse occurs (e.g. perpetrators are strangers). Stereotypes often interfere in the quest for knowledge and hamper our understanding of a population. Empirical research can help expand our comprehension of certain populations. Several studies have focused on families vulnerable to abuse by not only family members, but also perpetrated by non-family members (Alexander & Lupfer, 1987; Allen & Lee, 1992; Hoagwood, 1991; & Ray, Jackson, Townsley, 1991). Subsequently, researchers are starting to find some patterns common to families of children who were sexually abused. The literature on family characteristics in cases of child sexual abuse includes some of the subsequent themes: family cohesion, adaptability and communication.

Family Cohesion. Family cohesion includes emotional bonding, marital and parent/child relationship, family involvement, and boundaries, both internal and external to the family (Olson & Killorin, 1985). Gordon (1989), in cases of biological father-daughter incest, found the family environment characterized by high levels of stress both socially and economically, marital problems or instability and alcohol or drug abuse. Several studies have found that many incestuous families had internal boundaries between family members that were inadequate (Alexander & Lupfer 1987; Hoagwood & Stewart, 1989; Hulsey, et al., 1992; Trepper & Sprenkle, 1988) , and the boundaries between the family and the external environment were too strong (Burkett, 1991; Hulsey, et al., 1992; Trepper & Sprenkle, 1988). Trepper and Sprenkle also (1988) found that blurred boundaries were influenced by the parent's lack of parenting skills and inability or

unwillingness to protect their children. These same parents often equated the desire for privacy with a lack of love toward family members (Trepper & Sprenkle, 1988). Sexual interactions within these families were usually nonviolent and affectionate and the child often viewed the incest as love and/or affection (Trepper & Sprenkle, 1988). This family type, which is characterized as enmeshed with rigid rules, is probably the most common in cases of incest (Trepper & Sprenkle, 1988).

Although Trepper and Sprenkle (1988) and Alexander and Lupfer (1987) agree there are boundary problems in cases of child sexual abuse, there is a disagreement that these families are enmeshed. In their study, Alexander and Lupfer (1987) found a high percentage of women who were sexually abused as children, characterized their families of origin as significantly less cohesive than women who had not been sexually abused. The families were not considered to be enmeshed even though in cases of father/daughter incest internal boundaries between the father and the daughter were not maintained. These families did not exhibit the sense of high emotional bonding, interdependency and hypersensitivity characteristic of extremely cohesive families (Alexander & Lupfer, 1987). Many researchers agree with Alexander and Lupfer, that families where child sexual abuse occur are not cohesive (Cole, et al., 1992; Hulsey, et al., 1992; and Nash, et al., 1992). Trepper and Sprenkle's (1988) study seemed to have defined cohesion differently, possibly accounting for the discrepancy in findings.

A frequently highlighted theme in the literature regarding the lack of internal family boundaries, is the role reversal between the mother and daughter. In this situation the daughter becomes the father's emotional support against the perceived cold, and rejecting mother/wife (Ribordy, 1989). Cole and Woolger (1989) in a study of adult female child

sexual abuse survivors, reported these women viewed their mothers as lacking involvement in child-rearing. These same women highly encouraged autonomy in their own children and were frequently inconsistent in their parenting demands (Cole & Woolger 1989; Cole, et al., 1992). Cole and Woolger (1989) believe this distance between mother and daughter may have helped facilitate the development and accessibility of an inappropriate sexual relationship between an emotionally needy daughter and husband.

The mother is most likely not purposefully putting her child in this situation. In a study by Truesdell, McNeil, and Deschner (1986), 73% of the mothers in cases of father-figure/daughter incest were victims of wife battering. This could have contributed to the mothers' difficulty in protecting their children. Elbow and Mayfield (1991) found that many mothers of children who were sexually abused were viewed as villains, co-perpetrators, or at best inadequate mothers who were unable or unwilling to protect their children from abusive partners. Furthermore, Ribordy (1989) found some mothers of incest victims were viewed as cold and rejecting by their children and husbands. Many of the husbands in this study subsequently turned to alcohol and drugs to help them feel more powerful and/or used sexual dominance over children to meet this need.

Elbow and Mayfield (1991) reported the mothers of incest victims have not always been viewed as villains or inadequate parents; some mothers are willing and able to protect their children, after discovering the abuse. They concluded that some mothers responded calmly and quickly, while other mothers were not able to do so, possibly due to being paralyzed or exhibiting symptoms of shock, confusion, and disbelief. These symptoms can contribute to or limit the mother's ability to take immediate protective action on behalf of

her child (Elbow & Mayfield, 1991). This inability may have contributed to the mother being considered passive, weak, or even collusive (Elbow & Mayfield, 1991).

Family Adaptability. Family adaptability includes flexibility regarding control, discipline, negotiation, roles, and rules (Olson & Killorin, 1985). In a study comparing three groups (incest, extended family perpetrator and no abuse), Alexander and Lupfer (1987) found female incest survivor's families of origin significantly more traditional with respect to parent-child and male-female relations, than the other two groups. The fathers in these families viewed women as subservient to men, and viewed children as subservient to adults. Many other researchers have also found authoritarian, highly controlling family types associated with child sexual abuse (Cole, et al, 1992; Hulsey, et al., 1992; and Nash, et al., 1993).

When focusing on child sexual abuse perpetrated by non-family members researchers have found one common family characteristic, a chaotic family system (Alexander & Lupfer, 1987; Allen & Lee, 1992; and Ray, Jackson & Townsley, 1991). Alexander and Lupfer (1987) predicted children from families which were characterized as chaotic were more at risk for extrafamilial abuse than children from rigidly organized families. Allen and Lee (1992) found children from families with chaotic or random structures experienced a higher rate of extrafamilial abuse (84.6%) than children from closed or rigid families (33.3%). Allen and Lee (1992) also found chaotic families were characterized as having weak or nonexistent external boundaries and failed to monitor their children. When studying family member's perceptions, Hoagwood (1990) found that mothers of extrafamilially abused children perceived their families to be less functional in defining and maintaining role boundaries than mothers in the non-abused comparison

group. However, Hoagwood and Stewart (1989) found greater role confusion in families with intrafamilial child sexual abuse. These characteristics were all viewed as risk factors for potential child sexual abuse.

Even when risk factors are known to families, they may not always act to protect their children. Margolin (1991) found parents often allowed their children to be supervised by individuals who had histories of victimizing women and children. The parents' unwillingness to protect their children from potentially abusive situations affected the occurrence of sexual abuse by non-related care-givers (Margolin, 1991). Families which inadequately supervised (Ray, et al., 1991), were generally chaotically functioning (Cole, et al., 1992; and Hulsey, et al., 1992), and did not foster personal growth within their children (Hulsey, et al., 1992; Ray, et al., 1991), had children who were unable to stand up to abusive adults. These same children were found to engage in sexual activity with adults in an attempt to satisfy needs for intimacy (Peterson, Basta, Dykstra, 1993; Ray, et al. 1991).

Family Communication. Family communication can include empathy, attentive listening, self-disclosure, clarity and respect (Olson & Killorin, 1985). Family communication is an important component in children's adjustment to child sexual abuse. Maternal reactions to a child's allegations of sexual abuse are a significant predictor of how the child will adjust after the abuse is exposed (Esparza, 1993; Johnson & Kenkel, 1991; Kendall-Tackett, Williams & Finkelhor, 1993). Consequently, when some mothers question if the abuse occurred, this can be detrimental to a child's adjustment. Many women believed children were lying; this was easier to comprehend than believing the man she loves or fears could abuse her child (Elbow & Mayfield 1991; Sirles & Franke, 1989).

Much of the literature supports the idea that children rarely lie about being sexually abused (England & Thompson, 1988; Rieser, 1991). When children do recant allegations of abuse, the withdrawal of allegations is usually due to the additional trauma the child is experiencing, coupled with the lack of support, and possible pressure from family members to recant (Rieser, 1991). Therefore, maternal support is essential, although showing empathy, a component of support, can be difficult when communication skills are low. Problem-solving is another communication skill, which can be important to children's adjustment to child sexual abuse (Hulsey, et al., 1992). Insufficient problem solving skills can lead to blaming others (Nash, et al., 1992), and high levels of conflict (Cole, et al., 1992; and Nash, et al., 1992), which may contribute to low levels of expressiveness (Nash, et.al. 1992).

Families often have different views about their functioning. Hoagwood (1990), examined the differences between the mother's, father's, and the child's view of family functioning, in cases of sexual abuse and a non-abuse comparison group. The findings suggested that mothers of extrafamilially abused children perceived their families to be less functional in problem-solving than mothers in the comparison group (Hoagwood, 1990). Sexually abused children reported their families as having less affective responsivity and behavioral control than their mothers reported (Hoagwood, 1990). Furthermore, the perceptual similarities between extrafamilial sexually abused children and their mothers were greater than in cases of incestuously abused children reported in the literature (Hoagwood, 1990). Hoagwood (1990) found that the perceptual agreement regarding family characteristics ended with the mothers and extrafamilial sexually abused children. Parental perceptual agreements in families of extrafamilial abuse were lacking. There was

a significant difference between the mothers' and the fathers' view of the family functioning in reference to problem-solving, communication, and general functioning. Mothers viewed the family as more dysfunctional in each area (Hoagwood, 1990). Hoagwood (1990) viewed the parental perceptual discrepancies of extrafamilial sexually abused children as a lack of parental coalition. Cole and colleagues (1992) also viewed the parental alliance as lacking in cases of child sexual abuse. This may be a factor influencing the parents inability to protect their child from victimization (Hoagwood, 1990).

Summary

The above mentioned literature highlights the importance of research in the area of child sexual abuse family characteristics. Furthermore, since family cohesion, adaptability, and communication have been shown to be predictors of a child's adjustment to the abuse, and possible risk factors for subsequent abuse, further research in the area of family characteristics is warranted. The move from etiological studies to studies focusing more on the family characteristics of children who were sexually abused would be an important contribution to the body of child sexual abuse literature.

The following hypotheses were tested in this study. Hypothesis one: Mothers, sexually abused children, and therapists will view the family's cohesion, adaptability, and communication differently. Hypothesis two: Therapists will rate families of identified child sexual abuse as less flexible than families would rate themselves. Hypothesis three: Children who have experienced sexual abuse and their mothers will have lower dyadic discrepancy scores, based on their perceptions of family cohesion, adaptability, and communication, than mothers and therapists or children and therapists. Hypothesis four: Mothers and sexually abused children will perceive their family communication as more

functional (they will rate themselves higher on the Family Communication Scale) than therapists would view the family communication.

CHAPTER IV

METHODOLOGY

This study used the Family Adaptability and Cohesion Evaluation Scale (FACES III) in both perceived and ideal forms (Olson, Portner, & Lavee 1985), the Family Communication Scale (FCS) (Barnes & Olson, 1982) and the Clinical Ratings Scale (CRS) (Olson & Killorin, 1985) to examine the family characteristics of family cohesion, adaptability, and communication in cases of child sexual abuse. Together these scales are considered the Circumplex Assessment Package because they were all developed to tap the same constructs, but in different ways (Olson, 1993). These scales allowed for the surveying of multiple perspectives, and at multiple system levels (more than one family member gave an insiders view of the family, while the family's therapist gave an outsiders view of the system).

Sample of Participants

The unit for analysis for this study was the sexually abused child age 8-16, his/her mother, and the family's therapist. The sample was recruited from 6 mental health outpatient facilities in both rural and urban areas of a southwestern state. In order to qualify as a unit of analysis, families were to have completed a Family Demographic form, at least one FACES III perceived and ideal and FCS questionnaire, and the family's therapist were to have completed a Semi-structured interview about the child sexual abuse, and the CRS. The sample for the study consisted of 10 families and therapists of which there were, 10 children who completed FACES III perceived and ideal, and the FCS; 9 mothers who completed FACES III perceived and ideal, the FCS and a

demographic form; and 10 therapists who completed the Semi-structured interview, and the CRS.

The mean age of participating children identified as sexually abused was 11.3 years (*SD*=2.01), ranging from 8-16 years. The sample consisted of 80% female children and 20% male children, with 90% of the children being Caucasian and 10% being Native American. The highest grade level for children in the sample was second (11.1%), fourth (33.3%), fifth (11.1%), seventh (22.2%), eighth (11.1%), and tenth (11.1%). The mean age of the mothers included in the study was 38.1 years (*SD*=10.6), ranging from 28-66 years (one mother was a grandmother who had adopted her grandchild), all of the mothers were Caucasian. The family's reported religious affiliation was: Protestant (40%), Catholic (10%), Other (30%), and No Affiliation (20%).

Responses indicated the current marital status, of the mothers in the study, was indicated to be married (30%), divorced (40%), and separated (30%). Overall, 66.7% of the mothers sampled had been divorced at least once. Of those sampled, the current family income was the subsequent: 9,999 or less (33.3%), 10,000-19,000 (33.3%), 20,000-29,000 (11.1%), and 30,000-39,000 (22.2%). Furthermore, the highest level of education attained by the sampled mothers was (33.3%) less than high school, (44.4%) high school or GED, and (22.2%) 1-4 years of college, but did not graduate. Respondents also indicated the following employment status (20%) unemployed; looking for work , (20%) employed part-time, (50%) employed full-time, and (10%) other.

Research Instruments

The Family Adaptability and Cohesion Evaluation Scale (FACES III) (Olson, Portner, & Lavee 1985) and the Clinical Rating Scale (CRS) (Olson & Killorin, 1985) define cohesion as the degree to which individuals perceive family members as separated from or connected to each other (Olson, Portner, & Lavee 1985). FACES III (Olson, Portner, & Lavee 1985) and the CRS (Olson & Killorin, 1985) define adaptability as the degree to which the family system is flexible and able to change (Olson, Portner, & Lavee 1985). The Family Communication Scale (FCS) (Barnes & Olson, 1982) and the CRS (Olson & Killorin, 1985) define family communication as the degree to which family members can openly discuss issues, thoughts and feelings (see Appendix B for a copy of each scale).

Family Adaptability & Cohesion Evaluation Scale. FACES III in both the perceived and ideal form is a, 20-item, five-point Likert-type scale, pencil and paper questionnaire measures family cohesion and adaptability. The possible range of scores on the scale is from 10 to 50. The authors of the scale reported norms for cohesion and adaptability which were established on a large number of parents and children (N=2,412). The mean score for cohesion was 37.1 (SD= 6.1) and 24.3 (SD=4.8) for adaptability (Olson, et al., 1985). Based on this sample of 19 family members, the internal consistency reliability coefficient (Cronbach's alpha) was .65 for adaptability, and .89 for cohesion. The scale authors reported Cronbach's alpha reliabilities for adaptability to be .62, for cohesion to be .77, and a range from .67 to .68 for the total scale. FACES III has been shown to have good predictive validity (Olson, 1986). Furthermore, there is little correlation (r=.03) between cohesion and adaptability, a weak correlation between

cohesion and social desirability (r=.35), and no correlation between adaptability and social desirability (r=0).

The Family Communication Scale. The FCS is a 10 item, five-point Likert-type scale, pencil and paper questionnaire which assesses family communication. Barnes and Olson (1982) have adapted the FCS from the Parent-adolescent communication scale, but have yet to publish the scale. The validity of the scale is lacking, although experts in the field have reported that the scale has good face validity. Based on this sample of 19 family members, the internal consistency reliability coefficient (Cronbach's alpha) was .79.

The Clinical Ratings Scale. The CRS is a therapist and/or researcher observational checklist assessing the family's cohesion, adaptability, and communication on an eight-point Likert-type scale. The reliability testing was done on a sample of 182 families (n=324 parents, n=298 children). Inter-rater reliability is adequate, (r=.75) for adaptability, (r=.83) for cohesion, and (r=.94) for communication. The percentage agreement, within one point, had an acceptable reliability ranging from (r=.89) for adaptability, (r=.91) for cohesion, and (r=.97) for communication. Cronbach alpha reliabilities ranged from (r=.94) for adaptability, (r=.95) for cohesion, and (r=.97) for communication. Based on this sample of 10 families (n=9 mothers, n=10 children), the internal consistency reliability coefficient (Cronbach's alpha) was (r=.88) for adaptability, (r=.94) for cohesion, and (r=.80) for communication. The authors of the scale also conducted a factor analysis of this scale revealed excellent construct validity; 81.4% of the total variance was accounted for by eigenvalues of the three factors which were 4.7 for adaptability, 8.0 for cohesion, and 2.8 for communication. The scale also has high

predictive validity. Clinical families fell in the extreme ranges of the Circumplex Model more often than non-clinical families (Olson & Killorin, 1985).

Insert Table 1 about here

Demographic Questionnaires. Additional questionnaires used in the study assessed child sexual abuse variables, and family demographics. The two questionnaires were developed for this study and experts in the field have found the questionnaires to have good face validity. The semi-structured interview checklist was utilized to assess the child sexual abuse variables. The family's therapist completed this checklist, providing information regarding the perpetrator, frequency, duration, and intensity of the abuse. The family demographic questionnaire asked information regarding gender, ethnicity, education, income, and marital status of family members (a copy of the instruments used in this study can be found in Appendix B).

Data Collection

Packets which included all the materials were given to the therapists at each site by the researchers during a training session. Administration procedures for the scales were reviewed with the therapists and questions were answered. The identification numbers (ID#s) for the families and the site's ID#s were marked on the material to ensure that no names appeared on any of the questionnaires. Each family member was given an individual packet labeled child or mother, therapists received a separate packet. The therapist reviewed with the family the informed consent form, and the release of information form (see Appendix C for a copy). The release of information form allowed

the researchers to access information regarding the sexual abuse and any diagnosis of the child from the therapist.

Once each family signed the consent and release of information forms, the therapist went over the standardized instructions for each scale with the family members and clarified any questions. The mothers completed the family demographic form. The FACES III scale, and the FCS were completed by the mothers and children. Each therapist completed the CRS and the Semi-Structured interview checklist. Family members provided an insider's view while the family's therapist contributed an outsider's view of the family's characteristics. Each family member was asked to complete the forms without conferring with other family members. Therapists were asked to assist any children who needed help completing the scales, since some children may have a difficult time reading the scale. All scales were assessed for reading level and were found to be adequate for children as young as eight. Finally, once the forms were completed, the questionnaires were mailed to the researchers

Research Design

This exploratory study was designed to examine the family characteristics of cohesion, adaptability and communication in cases of child sexual abuse. The research method used in the study was descriptive comparative. This design was chosen to explore and to tap ideas, since the population of sexually abused children will not be manipulated by the researchers. Although this type of design is non-experimental, the design does allow the researcher to explore trends and patterns between and within the groups.

Data Analysis

Once the questionnaires were completed by the sexually abused child, their mother, and the family's therapist, the scores were calculated for FACES III perceived and ideal, the FCS, and the CRS. The data was checked for accuracy, and descriptive statistics, correlations, and item analysis of the data were done. Correlations were run to explore the relationship between the present sample's responses to the research instruments with the national norms for the research instruments. Dyadic discrepancy scores, utilizing absolute scores, were calculated to access the differences within and across families. Discrepancy scores were also calculated for each mother and child in the study to examine differences between his/her FACES III perceived and ideal scores.

Limitation of the Study

This study did not involve a random sample of sexually abused children, their mothers, or the family's therapists. The sample selection was limited in that all were acquired through a clinical setting. Furthermore, families who choose to participate in therapy may be different with respect to their family adaptability, cohesion, and communication than families who do not seek therapy. Similarly, those few who did take part in the study may also in some way be different from the other families at the data collection sites who did not choose to participate. The small sample size, made up of mostly Caucasian females, also makes generalizations to the larger population difficult. Although the reliability of the scales used in the study suggest the researcher can reliably describe the present sample.

Another limitation of the study has to do with self-report data. The scales used in the study called for self-report information from this sample of sexually abused children

and their mothers; and individuals often rate themselves favorably on self-report measures. Furthermore, since a small sample was used, and descriptive statistics and correlations were utilized, generalizations to a larger population is difficult. Although there were limitations to this study, this exploratory study was important because a child sample population was used. The study was also important because of the multiple perspectives used to assess family characteristics of cohesion, adaptability, and communication.

CHAPTER V

RESULTS

The purpose of this study was to explore the relationship between system level and the respondents perceptions of family cohesion, adaptability, and communication in cases where a child had been sexually abused. There were three main objectives for this study. First, to obtain the child's perception regarding family cohesion, adaptability, and communication. Second, to acquire their therapist's perspective of the family cohesion, adaptability, and communication. Third, to identify dyadic discrepancies (i.e. differences in perspectives) within and between family members, and between family members and the family's therapist. This section includes descriptions of (a) the abuse the children in the study experienced and (b) the multiple perceptions of family cohesion, adaptability, and communication.

Description of the Sexual Abuse

For this study, child sexual abuse was defined as any sexual activity between a child 16 or younger and one or more individuals, which was reported to the Department of Child Welfare. The criteria for abuse included the occurrence of coercion or force in the initiation and maintenance of the sexual activity. The abuse ranged from petting (touching or attempts at such touching of breast or genitals) to rape. Sexual experiences with a relative or peer less than 5 years age difference between child and relative, that were wanted were not included. Furthermore, Non-contact behaviors such as exposure, viewing pornographic material, voyeurism and sexually suggestive talk were not included. The age at onset of the sexual abuse was (M=6.9, SD=2.73), and the age at last incident of abuse was (M=7.9, SD=3.06). The frequency and duration of abuse ranged from two

incidents over a few months time, to weekly over a period of about three years. The types of abuse included forced penetration (50%), non-forceful petting (78%), and forced petting (37.5%). The following were used by the perpetrator to either initiate or maintain the sexual abuse: Force (37.5%), threat (50%), or bribes (28.6%). In ten percent of the cases the sexual abuse stopped when another family member discovered the abuse; twenty percent stopped due to discontinued contact with the perpetrator; ten percent stopped when a sibling told someone about the abuse, and in sixty percent of the cases the sexual abuse stopped when the child told someone about the sexual abuse. Children in this study first disclosed the sexual abuse to a parent (20%), other family member (60%), a school official (10%) or a mental health professional (10%). Eighty percent of the children were believed when they reported the abuse, while twenty percent were not believed initially. This finding is supported by Wozencraft et al. (1991), in their sample 66% of the children were believed, while 17% were not. All of the perpetrators in this study were males known to the children (2 biological fathers, 2 stepfathers, 1 live-in-boyfriend of mother, 1 grandfather, 1 uncle, 1 neighbor, 1 family friend, and 1 spouse of a babysitter). The mean age of perpetrators was 37.2 (SD=15.42). Twenty-five percent of the perpetrators lived in the same home as the child, fifty percent lived in close proximity to the child and the remaining twenty-five percent lived elsewhere.

Perceptions of Family Characteristics

Based on the sexually abused children's scores on the perceived version of FACES III the children's families were plotted on the 3-D Family Circumplex Model. Children's perceptions among the twenty-five types of families on the 3-D Family Circumplex Model were as follows: Very Flexible, Somewhat Cohesive (10%), Very Flexible Cohesive

(10%), Structured Somewhat Cohesive (10%), Structured Cohesive (20%), Very Flexible Disengaged (10%), Rigid Somewhat Cohesive (10%), Structured Disengaged (20%), and Rigid Enmeshed (10%). Overall, based on the children's perceptions eight of the possible twenty-five family types were characterized by at least one family. The families in the study were also plotted on the 3-D Family Circumplex Model based on the mothers scores on the perceived version of FACES III. The distribution of family types, based on the mother's perception were the following: Very Flexible Somewhat Cohesive (10%), Very Flexible Cohesive (10%), Very Flexible Very Cohesive (10%), Flexible Somewhat Cohesive (20%), Structured Somewhat Cohesive (10%), Structured Cohesive (10%), Flexible Disengaged (10%), and Rigid Disengaged (10%). Overall based on the mother's perception eight of the possible twenty-five family types were characterized by at least one family. Furthermore therapist's perceptions on the CRS were used to plot the families in the 3-D Family Circumplex Model. The distribution of family types based on therapist's perceptions were: Very Flexible Somewhat Cohesive (30%), Very Flexible Cohesive (10%), Flexible Cohesive (20%), Structured Somewhat Cohesive (20%), and Rigid Disengaged (20%). Therapists only characterized families in five of the possible twenty-five family types.

Insert Figure 1 about here

Considering the multiple perceptions from sexually abused children, their mothers and the family's therapist, the family type which was most frequently represented was Very Flexible Somewhat Cohesive. Five of the twenty-nine respondents characterized the

families as being this type. The second most frequently represented family type was Structural Somewhat Cohesive and Rigid Disengaged, both family type were characterized by four out of twenty-nine respondents. Finally twenty respondents scores fell into the balanced range, five were in the mid-range and four were in the unbalanced range of the 3-D family Circumplex Model. Overall, most of the families in the study fell in flexible ranges on the 3-D Circumplex Model.

Discrepancy Scores

Discrepancy scores, the absolute difference between scores, were calculated for each sexually abused child's, and his/her mother's perceptions between FACES III perceived and ideal versions of cohesion and adaptability. Discrepancy scores were also calculated for differences between children and their mothers, differences between mothers and therapists, and differences between children and therapists perceptions. The theoretical range on the total scales was 10 to 50 points, with discrepancies ranging from 0-40 points. While the theoretical range on item discrepancies was 0-4 points.

Dyadic Discrepancies Between Mothers and Sexually Abused Children.

FACES III scores on the perceived cohesion dimension for the sexually abused children in this sample ranged from 23 to 42 (M=35.9). Scores on the ideal cohesion dimension for the children ranged from 36 to 45 (M=40.1). The discrepancy between the sexually abused children's perceived and ideal cohesion score was (M=4.6, range=1-13). The FACES III scores on the perceived dimension for mothers in this study ranged from 24 to 50 (M=38.56). While the scores on the ideal cohesion dimension ranged from 30-50 (M=45.22). The discrepancy between the mother's perceived and ideal cohesion scores was (M=8, range=0-23). Therefore, the dyadic discrepancies between the sexually abused

children and their mothers on the perceived cohesion dimension was (*M*=6.8, range=2-18); and the dyadic discrepancies between sexually abused children and their mothers on the ideal cohesion dimension was (*M*=8, range=2-13).

Insert Table 2 about here

The FACES III scores on the perceived adaptability dimension for sexually abused children in this study ranged from 14-37 (*M*=23.7). While the scores on the ideal adaptability dimension ranged from 25 to 42 (*M*=34.2). The discrepancy between the sexually abused children's perceived and ideal adaptability score was (*M*=10.9, range=2-22). The FACES III score on the perceived adaptability for mothers in this study ranged from 12 to 39 (*M*=26.67). While the scores on the ideal adaptability dimension ranged from 27 to 39 (*M*=34). The discrepancy between the mother's perceived and ideal scores was (*M*=7, range=1-16). Therefore, the dyadic discrepancy between sexually abused children and their mothers on the perceived adaptability dimension was (*M*=7, range=0-20); and the dyadic discrepancy for the ideal adaptability dimension was (*M*=5.11, range=2-12).

Insert Table 3 about here

Furthermore, dyadic discrepancy scores were also calculated for the sexually abused child's, and their mother's perception of family communication. The dyadic discrepancy was (*M*=2.1, range= 0-9). Dyadic discrepancy scores were also calculated on

selected items for the dimensions of cohesion, adaptability, and communication. The items were selected based on the overlap between categories on FACES III and the CRS. Selected items for cohesion consisted of the following: Emotional bonding, supportiveness, family time, and family boundaries. The dyadic discrepancy between children and their mothers for emotional bonding was (M=1.2), for supportiveness (M=1.2), for family time (M=1.1) for family boundaries (M=1.4). Selected items for adaptability included the following: Control, discipline, roles, and rules. The dyadic discrepancy scores between mother and child for control were (M=1.3), for discipline (M=1.4), for roles (M=1.4), and for rules (M=1.4). Selected items for communication consisted of respect, clarity, listening, and self-disclosure. The discrepancy scores between mother and child for respect was (M=1), for clarity (M=1.1), for listening (M=.6), and for self-disclosure (M=1.1).

Dyadic Discrepancies Between Mothers and Therapists. Discrepancy scores were calculated based on the total scores for cohesion, adaptability, and communication; and on the selected items from each scale. The discrepancy between the mothers and the therapists were for cohesion (M=17, range=0-34), for adaptability (M=14.3, range 3-33), for communication (M=11, range 4-28). The dyadic discrepancy scores between mothers and therapists for selected items of cohesion were, emotional bonding (M=2.1), for supportiveness (M=1.8), for family time (M=1.6), and for family boundaries (M=2.2). Dyadic discrepancies for selected items of adaptability were, control (M=1.5), for discipline (M=1.3), for roles (M=1.5), and for rules (M=2). The discrepancy scores between mothers and therapists for selected items on communication were, respect (M=1.5), for clarity (M=1.6), for listening (M=1.3), and for self-disclosure (M=1.6).

Dyadic Discrepancies Between Sexually Abused Children and Therapists.

Discrepancy scores were calculated based on the total scores for cohesion, adaptability, and communication; and on the selected items from each scale. The discrepancy between the children and the therapists were for cohesion (M=12.8, range=2-32), for adaptability (M=12, range 2-22), for communication (M=11.5, range 5-22). The dyadic discrepancy scores between children and therapists for selected items of cohesion were, emotional bonding (M=2.1), for supportiveness (M=1.1), for family time (M=1.4), and for family boundaries (M=1.5). Dyadic discrepancies for selected items of adaptability were, control (M=1.4), for discipline (M=1.8), for roles (M=1.4), and for rules (M=1.4). The discrepancy scores between children and therapists for selected items on communication were, respect (M=1.7), for clarity (M=1.3), for listening (M=1.5), and for self-disclosure (M=1.5).

Insert Figures 2-5 about here

Summary

The finding of this study revealed that there were many dyadic differences across and between sexually abused children, their mothers, and the family's therapist, regarding the family characteristics of cohesion, adaptability, and communication. The possible theoretical difference was 0-3 for items, and 0-49 for total scales. Furthermore, within this sample the discrepancy scores were highest between mothers and therapists (range= 0-44) and lowest between mothers and children (range=0-20). The selected items of family boundaries (M=2.2, range=0-4.4), rules (M=2.1, range=.2-3.8), and emotional

bonding (M=2.1, range=0-3.8) received the largest discrepancy scores between mothers and therapists. While the selected item of listening (M=.6, range=0-2), respect (M=1, range=0-3), and the total scale of communication (M=2.1, range=0-9) had the smallest discrepancy scores between mothers and children. Overall, mothers and children had less discrepancies in their view of family cohesion, adaptability, and communication than therapists and either mother or children. Although, this finding was understandable since individuals often rate themselves favorably on self-report scales, while outsiders are more likely to offer a more objective view.

CHAPTER VI

CONCLUSIONS AND IMPLICATIONS

Discussion of the Results

The primary objectives of this exploratory study were to obtain multiple perspectives of family characteristics in cases of child sexual abuse and to examine the dyadic differences among those perspectives. Therefore, since few absolute agreements were found among the respondents, this study lends support to the plea made by Hoagwood (1990) and Black et al. (1994) for the need to obtain multiple views of family characteristics in cases of child sexual abuse. Furthermore, hypothesis one (mothers, sexually abused children, and therapists viewed the family's cohesion, adaptability, and communication differently) was supported. The family's perspective (insider's view) and the therapist's perspective (outsider's view) both gave valuable information. Although, as in this study, the views frequently seem to propose very different pictures of the family's functioning. However, when the data is used together they help to create a more holistic view of the family system (Olson, 1993).

Hypothesis two was not supported by the research findings: Therapists did not rate families of identified child sexual abuse as less flexible than families rated themselves. Mothers (66.6%) and therapists (60%) perceived approximately the same amount of family flexibility. While only (30%) of the children perceived high family flexibility. The present sample was projected to be mostly intrafamilially sexually abused. Furthermore, families where intrafamilial child sexual abuse occurred, are frequently characterized as rigid with respect to control, rules, and discipline (Cole, et al. 1992; Hulsey, et al. 1992; and Nash, et al., 1993). While families where extrafamilial child sexual abuse occurred

are often characterized as chaotic regarding control, rules, and discipline (Alexander & Lupfer 1987; Allen & Lee, 1992; and Ray et al., 1991). Since the present sample was 70% intrafamilial and 30% extrafamilial the researcher is unsure of the reason for the level of flexibility reported in this sample. A possible reason for the high levels of flexibility reported may be the stage of crisis the families was in (Olson, 1993), since many of the families in the study (50%) had just recently reported the sexual abuse to authorities.

Hypothesis three was also supported: Children who have experienced sexual abuse, and their mothers, had lower dyadic discrepancy scores, based on their perceptions of family cohesion, adaptability, and communication, than mothers & therapists or children & therapists (see figure 5). This finding may possibly be explained by the fact that the child and the mother both live in the same environment and therefore have a similar outlook regarding family functioning, unlike the therapist who only has limited contact with the family. Hoagwood (1989) in a study of sexually abused children, and their mothers and fathers, also found mothers and children to have similar perspectives of their families, although the two had very different perspectives than the non-abusing fathers in the sample.

Finally, hypothesis four was also supported by the research finding: Mothers and sexually abused children perceived their family communication as more functional (they rated themselves higher on the Family Communication Scale) than therapists viewed the family communication (see figure 4). Families often view high levels of communication, adaptability, and cohesion as socially desirable characteristics for a family, therefore families frequently rate themselves high on these characteristics (Olson 1991). Furthermore, therapists are rating the family on observational accounts of the family's

communication during therapy sessions, which could possibly be very different in other environments.

Recommendations for Further Study

Future studies can benefit from the results of this study which suggests the importance of gathering multiple perspectives of family characteristics in cases of child sexual abuse. Studies which could produce a larger sample than the current study would be able to run more complex analysis and generalize their findings to a larger population. A larger sample would also allow the researcher to divide the sample into groups based on the types of abuse, either intrafamilial or extrafamilial. The literature suggests different levels of cohesion and adaptability based on this type of grouping. Studies focusing on the family characteristics of cohesion, adaptability and communication could also benefit from dividing the age range in the sample into 8-12 and 13-17, since these children would be experiencing different developmental tasks. Families are often found in different quadrants of the Circumplex model depending on their timing in the family life cycle. Families with young children often fall in the structurally-connected area of the model, while families with adolescents fall in the flexibly-separated area of the model (Olson, 1993). Furthermore, studies which had a control group could help explore the relationship between the occurrence of identified child sexual abuse and the family characteristics of cohesion, adaptability and communication. Unfortunately, without being able to control for the occurrence of child sexual abuse, there is difficulty in predicting if the family characteristics lead to the occurrence of child sexual abuse, or if the occurrence of child sexual abuse lead to the present family characteristics. A causal leap is impossible since there are so many factors impacting a family. Nonclinical samples can also help avoid the

weakness of clinical samples only giving us information regarding individuals who are not functioning well after the abuse. How are the individuals who do not seek counseling different from those who seek counseling? How are these individuals able to cope with the abuse and function without the help of a therapist? Using nonclinical samples may help us learn more about those individuals who are functioning without the help of clinicians, This information could be useful to professionals in helping their clients deal with the abuse.

The problem with small sample sizes has to do with the fact the sample will probably lack ethnic and socioeconomic diversity. These types of samples lose generalizability and could decrease thier benifit to a diverse group of people. Findings made using small samples can not be viewed in the same light as those from larger samples.

Implications

Therapeutically this study has the following implications. Identifying the differing perspectives and clarifying what works for each family and what context the perceptions have for the family could be helpful in therapy. There is no perfect level of cohesion or adaptability in relationships, but extreme levels of cohesion and/or adaptability for long periods of time can be problematic (Olson, 1993). Although when family member's desire more extreme patterns, families can function well, as long as all family members are satisfied with this mode of operation (Olson, 1993). Family member's often have differing perspectives regarding the family's functioning. Exploring the similarities and differences in family member's perceptions can be therapeutically beneficial. Exploring family members' similarities and differences of their ideal view of the family could also be helpful

(Olson, 1993). Even when dyadic discrepancy scores are low, clarification of family view points is important. If therapists are aware of dyadic discrepancies, possible alienation of family members with differing views can be addressed and dealt with therapeutically. Furthermore, exploring how family members view the family's cohesion, adaptability and communication compared to the therapist's perceptions, can help give the therapists information about how to relate to different family members. Another implication is the knowledge of differences in perceptions may also aid in the setting of goals and identifying of therapy outcomes.

Additionally, when working therapeutically with families where child sexual abuse has occurred the following should be kept in mind. The household is probably experiencing other stressors besides the reported sexual abuse, such as alcohol abuse, physical abuse, and the possible sexual abuse of other family members (Laviola, 1992). Another important aspect to remember is that the parents of sexual abuse survivors may themselves be survivors of child sexual abuse (Cole & Woolger, 1989; England & Thompson, 1988).

Child sexual abuse does not effect a child in isolation, every family member is effected by the child's trauma in some way. Family therapy is a useful mode of treatment (Kiser, Pugh, McColgan, Pruitt, & Edwards, 1991). Sesan, Freeark, and Murphy (1986) recommended crisis intervention with families as soon as the abuse is uncovered. Therapists who allow the family to express their feelings regarding the abuse, and are both supportive and informative on what the family may expect regarding the child's reaction to the trauma can be of tremendous help to the family (Sesan, et al., 1986).

Other goals therapists can help families attain include regaining control over the family's live; increasing cohesion, normalizing the child's present behavior, promoting family competencies, and exploring coping strategies (Kiser, et al., 1991). Families and abused children often feel powerless regarding the abusive situation. Helping them understand that they have control over how the abuse is dealt with can help the family feel more powerful (Kiser, et al., 1991). Increased communication could help the family support one another throughout the crisis (Kiser, et al., 1991) This increased communication could help build a parental coalition and problem solving skills; both of which are lacking in families of child sexual abuse (Hoagwood, 1990). The goals of normalizing behaviors, and promoting family competencies/strengths are not specific to cases of child sexual abuse. Helping families see themselves as non-pathological and able to function well in some areas is very important. Family strengths can also be drawn upon to help the family cope with the crisis, and aid the family in preventing further abuse from occurring. Families should be encouraged to analyze their functioning before the abuse and explore possible changes which may decrease further abuse from occurring. Increasing parental supervision and keeping consistent rules may help decrease risk of abuse (Cole, et al., 1992; Hoagwood, 1990). Families should be reminded that overprotecting could be just as harmful to a child's development as not protecting the child at all. Children should be viewed as resilient and not as victims who need to be sheltered from everything (Kiser, et al., 1991).

REFERENCES

Alexander, P.C. & Lupfer, S.L. (1987). Family characteristics and long-term consequences associated with sexual abuse. *Archives of Sexual Behavior, 16*(3), 235-245.

Allen, C. M. & Lee, C. M. (1992). Family of origin structure and Intra/Extrafamilial childhood sexual victimization of male and female offenders. *Journal of Child Sexual Abuse, 1*(3), 31-45.

Barnes, H. & Olson, D.H. (1982). *Parent-adolescent communication. Family Inventories.* St. Paul, MN.: University of Minnesota, Family Social Science.

Black, M., Dubowitz, H., Harrington, D. (1994). Sexual abuse: Developmental differences in children's behavior and self-perception. *Child Abuse and Neglect, 18* 85-95.

Browne, A. & Finkelhor, D. (1987). Impact of child sexual abuse: A review of the research. *Annual Progress in Child Psychiatry and Child Development,* 555-584.

Burkett, L.P. (1991). Parenting behaviors of women who were sexually abused as children in their families of origin. *Family Process, 30*, 421-434.

Carnes, P.J. (1988). Sexually addicted families: Clinical use of the circumplex model *Journal of Psychotherapy and the Family, 4*(1-2), 113-140.

Carson, D.K., Gertz, L.M., Donaldson, M.A., & Wonderlich, S.A. (1990). Family-Of-Origin characteristics and current family relationships of female adult incest victims. *Journal of Family Violence, 5*(2), 153-171.

Cole, P.M. & Woolger. C. (1989). Incest survivors: The relation of their perceptions of their parents and their own parenting attitudes. *Child Abuse and Neglect, 13*, 409-416.

Cole, P.M., Woolger. C., Power, T.G. & Smith, K.D. (1992). Parenting difficulties among adult survivors of father-daughter incest. *Child Abuse and Neglect, 16*, 239-249.

Conte, J.R. (1987). The effects of sexual abuse on children: Results of a research project. *Annals of the New York Academy of Sciences, 528*, 310-326.

Elbow, M. & Mayfield. J. (1991). Mothers of incest victims: Villains, victims or protectors? *Families in Society, 72*(2), 78-86.

England, L.W. & Thompson, C.L. (1988). Counseling child sexual abuse victims: Myths and realities. *Journal of Counseling and Development, 66*, 370-373.

Esparza, D. (1993). Maternal support and stress response in sexually abused girls age 6-12. *Issues in Mental Health Nursing, 14* 85-107.

Faller, K.C. (1989). Characteristics of a clinical sample of sexually abused children: How boy and girl victims differ. *Child Abuse and Neglect, 13*, 281-291.

Finkelhor, D. (1986a). Sexual abuse: Beyond the family systems approach. *Journal of Psychotherapy and the Family, 2*, 53-65.

Finkelhor, D. (1986b). *A Source on Child Sexual Abuse*. Beverly Hills CA: Sage Publications, Inc.

Finkelhor, D. (1987). The trauma of child sexual abuse: Two models. *Journal of Interpersonal Violence, 2*(4), 348-366.

Finkelhor, D. (1993). Epidemiological factors in the clinical identification of child sexual abuse. *Child Abuse and Neglect, 17*, 67-70.

Finkelhor, D., Hotaling, G., Lewis, I.A. & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect, 14*, 19-28.

Friedrich, W.N., Beilke, R.L. & Urquiza, A.J. (1987). Children from sexually abusive families: A behavioral comparison. *Journal of Interpersonal Violence, 2*(4), 391-402.

Gordon, M. (1989). The family environment of sexual abuse: A comparison of natal and stepfather abuse. *Child Abuse and Neglect, 13*(1), 121-130.

Gupta, G.R. & Cox, S.M. (1988). A typology of incest and possible intervention strategies. *Journal of Family Violence, 3*(4), 299-312.

Harter, S. Alexander, P.C. & Neimeyer, R.A. (1988). Long-term effects of incestuous child sexual abuse in college women: Social adjustment, social cognition, and family characteristics. *Journal of Consulting and Clinical Psychology, 56*(1), 5-8.

Hoagwood. K. (1990). Parental functioning and child sexual abuse. *Child and Adolescent Social Work, 7*(5), 377-387.

Hoagwood, K. (1989). Sexually abused children's perception of family functioning. *Child and Adolescent Social Work, 6*(2), 139-149.

Hotte, J.P. & Rafman, S. (1992). The specific effects of incest on prepubertal girls from dysfunctional families. *Child Abuse and Neglect, 16*, 273-283.

Hulsey, T.L., Sexton, M.C., & Nash, M.R. (1992). Perceptions of family functioning and the occurrence of childhood sexual abuse. *Bulletin of the Menninger Clinic, 56*(4), 438-450.

Hunter, J. A. (1991). A comparison of the psychosocial maladjustment of adult males and females sexually molested as children. *Journal of Interpersonal Violence, 6*(2), 205-217.

Johnson, B.K. & Kenkel, M.B. (1991). Stress, coping, and adjustment in female adolescent incest victims. *Child Abuse and Neglect, 15*(3), 293-305.

Kendall-Tackett, K.A., Williams, L.M. & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*(1), 164-180.

Kiser, L.J., Pugh, R.L., McColgan, E.B., Pruitt, D.B., & Edwards, N.B. (1991). Treatment strategies for victims of extrafamilial child sexual abuse. *Journal of Family Psychotherapy, 2*(1), 27-39.

Laviola, M. (1992). Effects of older brother - younger sister incest: A study of the dynamics of 17 cases. *Child Abuse and Neglect, 16*, 409-421.

Margolin, L. (1991). Child sexual abuse by non-related caregivers. *Child Abuse and Neglect, 15*, 213-221.

Margolin, L. & Craft, J. L. (1990). Child abuse by adolescent caregivers. *Child Abuse and Neglect, 14*, 365-373.

Nash, M.R., Hulsey, T.L., Sexton, M.C., Harralson, T.L. & Lambert, W. (1993). Long-term sequelae of childhood sexual abuse: Perceived family environment, psychopathology, and dissociation. *Journal of Consulting and Clinical Psychology, 61*(2), 276-283.

Olson, D.H. (1986). Circumplex model VII: Validation studies and FACES III. *Family Process, 25*, 337-351.

Olson, D.H. (1991). *Three-Dimensional (3-D) Circumplex Model: Theoretical & methodological advances*. Paper presented at National Council of Family Relations Theory Construction and Research Methodology Workshop, Denver, Colorado.

Olson, D.H. (1993). Circumplex model of marital and family systems: Assessing family functioning. Ch 3 in Froma Walsh (Ed.) *Normal Family Processes* (2nd ed.). New York: Guilford Press.

Olson, D.H., & Killorin, E. (1985). *Clinical Rating Scale for the Circumplex Model of Marital and Family Systems)*, Family Social Science, University of Minnesota, St. Paul, MN.

Olson, D.H., Portner, J. & Lavee Y. (1985). *FACES III*. St. Paul: Family Social Science, University of Minnesota.

Olson, D.H., Sprenkle, D.H., & Russell, C.S. (1979). Circumplex model of marital and family systems: I. cohesion and adaptability dimensions, family types, and clinical applications. *Family Process, 18*(1), 3-28.

Peterson, R. F., Basta, S. M. & Dykstra, T. A. (1993). Mothers of molested children: Some comparisons of personality characteristics. *Child Abuse and Neglect, 17*, 409-418.

Ray, K. C., Jackson, J. L. & Townsley, R. M. (1991). Family environments of victims of intrafamilial and extrafamilial child sexual abuse. *Journal of Family Violence, 6*(4), 365-374.

Ribordy, S.C. (1989). Treating intrafamilial child sexual abuse from a systemic perspective. *Journal of Psychotherapy and the Family, 6*(3-4), 71-88.

Rieser, M. (1991). Recantation in child sexual abuse cases. *Child Welfare, 70*(6), 611-621.

Russell, D.E. (1983). The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect, 7*, 133-146.

Sesan, R., Freeark, K., & Murphy, S. (1986). The support network: Crisis intervention for extrafamilial child sexual abuse. *Professional Psychological Research and Practice, 11*(2), 138-146.

Sirles, E.A. & Franke, P.J. (1989). Factors influencing mother's reactions to intrafamilial sexual abuse. *Child Abuse and Neglect, 13*, 131-139.

Trepper, T.S. & Sprenkle, D.H. (1988). The clinical use of the circumplex model in the assessment and treatment of intrafamilial child sexual abuse. *Journal of Psychotherapy and the Family, 4*(1-2), 93-111.

Truesdell, D.L., McNeil, J.S. & Deschner, J.P. (1986). Incidence of wife abuse in incestuous families. *Socialwork, 31*, 138-140.

Wozencraft, T., Wagner, W. & Pellegrin, A. (1991). Depression and suicidal ideation in sexually abused children. *Child Abuse and Neglect, 15*, 505-511.

APPENDIXES

APPENDIX A

TABLES 1-3

Table 1

Values of Cronbach's Alpha for Family System Characteristics

Scale	No. of Items	Alpha[1]	n^1	Alpha[2]	n^2
FACES III Adaptability	10	.62	2,412	.65	19
FACES III Cohesion	10	.77	2,412	.89	19
FCS Communication	10			.79	19
CRS Adaptability	6	.94	622	.88	10
CRS Cohesion	13	.95	622	.94	10
CRS Communication	9	.97	622	.80	10

Alpha[1], n^1 = As reported by scale author
Alpha[2], n^2 = As found in the current study
No reliability score was provided by the author for the FCS

Table 2

Mother's and Children's Total Scores and Discrepancy Scores on FACES III Perceived (P) and Ideal (I) for Family Cohesion

	Mothers			Children			M-C (P)	M-C (I)
Family	Cohesion (P)	Cohesion (I)	Discrepancy	Cohesion (P)	Cohesion (I)	Discrepancy	Discrepancy	Discrepancy
1	24	47	23	42	45	3	18	2
2	40	50	10	34	37	3	6	13
3	50	50	0	38	43	5	12	7
4	40	48	8	38	36	2	2	12
5	36	30	6	41	42	1	5	12
6	43	47	4	41	42	1	2	5
7				35	42	7		
8	42	48	6	33	38	5	9	10
9	39	47	8	34	40	6	5	7
10	33	40	7	23	36	13	2	4
	M=38.56	*M*=45.22	*M*=8	*M*=35.9	*M*=40.1	*M*=4.6	*M*=6.8	*M*=8

Discrepancy scores are based on the absolute difference between actual scores.

Table 3

Mother's and Children's Total Scores and Discrepancy Scores on FACES III Perceived (P) and Ideal (I) for Family Adaptability

	Mothers			Children			M-C (P)	M-C (I)
Family	Adapt. (P)	Adapt. (I)	Discrepancy	Adapt. (P)	Adapt. (I)	Discrepancy	Discrepancy	Discrepancy
1	27	39	12	37	35	2	10	4
2	23	38	15	23	41	18	0	3
3	39	38	1	19	40	21	20	2
4	27	36	9	30	34	4	3	2
5	25	27	2	22	25	3	3	2
6	33	37	4	20	33	13	13	4
7				20	30	10		
8	21	32	11	22	26	4	1	6
9	33	31	2	30	42	12	3	11
10	12	28	16	14	36	22	10	12
	M=26.67	*M*=34	*M*=8	*M*=23.7	*M*=34.2	*M*=10.9	*M*=7	*M*=5.11

Discrepancy scores are based on the absolute difference between actual scores.

APPENDIX B

INSTRUMENTS

FACES III (Olson, Portner, and Lavee, 1985)

1	2	3	4	5
Almost Never	Once in a While	Sometimes	Frequently	Almost Always

DESCRIBE YOUR FAMILY NOW:

_____ 1. Family members ask each other for help.

_____ 2. In solving problems, the children's suggestions are followed.

_____ 3. We approve of each other's friends.

_____ 4. Children have a say in their discipline.

_____ 5. We like to do things with just our immediate family.

_____ 6. Different persons act as leaders in our family.

_____ 7. Family members feel closer to other family members than to people outside the family.

_____ 8. Our family changes its way of handling tasks.

_____ 9. Family members like to spend free time with each other.

_____ 10. Parent(s) and Children discuss punishment together.

_____ 11. Family members feel very close to each other.

_____ 12. The Children make the decisions in our family.

_____ 13. When our family gets together for activities, everybody is present.

_____ 14. Rules change in our family.

_____ 15. We can easily think of things to do together as a family.

_____ 16. We shift household responsibilities from person to person.

_____ 17. Family members consult other family members on their decisions.

_____ 18. It is hard to identify the leader(s) in our family.

_____ 19. Family togetherness is very important.

_____ 20. It is hard to tell who does which household chores.

FACES III IDEAL VERSION (Olson, Portner, and Lavee, 1985)

1	2	3	4	5
Almost Never	Once in a While	Sometimes	Frequently	Almost Always

IDEALLY, how would you like **YOUR FAMILY TO BE**:

_____ 1. Family members would ask each other for help.

_____ 2. In solving problems, the children's suggestions would be followed.

_____ 3. We would approve of each other's friends.

_____ 4. The children would have a say in their discipline.

_____ 5. We would like to do things with just our immediate family.

_____ 6. Different persons would act as leaders in our family.

_____ 7. Family members would feel closer to each other than to people outside the family.

_____ 8. Our family would change its way of handling tasks.

_____ 9. Family members would like to spend free time with each other.

_____ 10. Parent(s) and Children would discuss punishment together.

_____ 11. Family members would feel very close to each other.

_____ 12. Children would make the decisions in our family.

_____ 13. When our family got together, everybody would be present.

_____ 14. Rules would change in our family.

_____ 15. We could easily think of things to do together as a family.

_____ 16. We would shift household responsibilities from person to person.

_____ 17. Family members would consult each other on their decisions.

_____ 18. We would know who the leader(s) was in our family.

_____ 19. Family togetherness would be very important.

_____ 20. We could tell who does which household chores.

FAMILY COMMUNICATION SCALE
(Barnes & Olson, 1982)

Almost Never	Occasionally	Sometimes	Often	Very Often
1	2	3	4	5

How well do your family members communicate with each other?

_____ 1. We are satisfied with how family members communicate with each other.

_____ 2. Family members are good listeners.

_____ 3. Family members express affection to each other.

_____ 4. Family members avoid talking about important issues.

_____ 5. When angry, family members say things that would be better left unsaid.

_____ 6. Family members discuss their beliefs and ideas with each other.

_____ 7. When we ask questions of each other, we get honest answers.

_____ 8. Family members try to understand each other's feelings.

_____ 9. We can calmly discuss problems with each other.

_____ 10. We express our true feelings to each other.

CLINICAL RATINGS SCALE (Olson & Killorin, 1985)

ADAPTABILITY FAMILY SCORE		**RIGID** 1 2	**STRUCTURED** 3 4	**FLEXIBLE** 5 6	**CHAOTIC** 7 8
LEADERSHIP (control)		Authoritarian leadership. Parent(s) highly controlling.	Primarily authoritarian but some equalitarian leadership.	Equalitarian leadership with fluid chnages.	Limited and/or erractic leadership. Parental control unsuccessful; Rebuffed.
DISCIPLINE (for families only)		Autocratic "law & order". Strict, rigid consequences. Not lenient.	Somewhat democratic. Predictable consequences. Seldom lenient.	Usually democratic. Negotiated consequences. Somewhat lenient.	Laissez-faire and ineffective. Inconsistent consequences. Very lenient.
NEGOTIATION		Limited negotiations. Decisions imposed by parents.	Structured negotiations. Decisions made by parents.	Flexible negotiations. Agreed upon decisions.	Endless negotiations. Impulsive decisions.
ROLES		Limited repertoire, strictly defined roles; Unchanging routines.	Roles stable, but may be shared.	Role sharing and making. Fluid chnages of roles.	Lack of role clarity, role shifts and role reversals; Few routines.
RULES		Unchanging rules. Rules strictly enforced.	Few rule changes. Rules firmly enforced.	Some rule changes. Rules flexibly enforced.	Frequent rule changes. Rules inconsistently enforced.
GLOBAL ADAPTABILITY RATING (1-8)*		Very Low.	Low to Moderate.	Moderate to High.	Very High.

*The global rating is based on your overall evaluation, not a sum score of the sub-scale.

CLINICAL RATINGS SCALE (Olson & Killorin, 1985)

COHESION	FAMILY SCORE	DISENGAGED 1 2	SEPARATED 3 4	CONNECTED 5 6	ENMESHED 7 8
EMOTIONAL BONDING		Extreme emotional separateness. Lack of family loyalty.	Emotional separateness: limited closeness. Occasional family loyalty.	Emotional closeness, some separateness. Loyalty to family expected.	Extreme emotional closeness, little separateness. Loyalty to family demanded.
FAMILY INVOLVEMENT		Very low involvement or interaction. Inferquent affective responsiveness	Invovlement acceptable; personal distance preferred. Some affective responsiveness.	Involvement emphasized personal distance allowed. Affective interactions encouraged and preferred.	Very high involvement. Fusion; over-dependency; High affective responsiveness and control.
MARITAL RELATIONSHIP		High emotional separateness; limited closeness	Emotional separateness; some closeness.	Emotional closeness, some separateness.	Extreme closeness, fusion; limited separateness.
PARENT-CHILD RELATIONSHIP		Rigid generational boundaries; Low parent-child closeness	Clear generational boundaries; some parent-child closeness.	Clear generational boundaries; High parent-child closeness.	Lack of generational boundaries; Excessive parent-child closeness.
INTERNAL BOUNDARIES		**Separateness dominates**	**More separateness than togetherness**.	**More togetherness than separateness.**	**Togetherness dominates**
TIME (physical & emotional)		Time apart maximized; Rarely time together.	Time alone important Some time together.	Time together important. Time alone permitted.	Time together maximized. Little time alone permitted.
SPACE (physical & emotional)		Separate space needed and preferred.	Separate space preferred; sharing of family space.	Sharing family space. Private space respected.	Little private space permitted.
DECISION MAKING		Individual family decision making. (Oppositional)	Individual decision making but joint possible.	Joint decisions preferred.	Decisions subject to wishes of entire group.

CLINICAL RATINGS SCALE (Olson & Killorin, 1985)

COHESION FAMILY SCORE		**DISENGAGED** 1 2	**SEPARATED** 3 4	**CONNECTED** 5 6	**ENMESHED** 7 8
EXTERNAL BOUNDARIES		**Mainly focused outside the family.**	**More focused outside than inside family.**	**More focused inside than outside family.**	**Mainly focused inside the family.**
FRIENDS		Individual friends seen alone.	Individual friendships seldom shared with family.	Individual friendships shared with family.	Family friends preferred; limited individual friends.
INTERESTS		Disparate interests.	Separate interests.	Some joint interests.	Joint interests mandated.
ACTIVITIES		Mainly separate activities.	More separate than shared activities.	More shared than individual activities.	Separate activities seen as disloyal.
GLOBAL COHESION RATING (1-8)*		Very Low.	Low to Moderate.	Moderate to High.	Very High.

*The global rating is based on your overall evaluation, not a sum score of the sub-scale.

CLINICAL RATINGS SCALE (Olson & Killorin, 1985)

COMMUNICATION	FAMILY SCORE	LOW < 1 2	FACILITATING 3 4	> HIGH 5 6
LISTENER'S SKILLS **Empathy** **Attentive Listening**		Seldom evident Seldom evident	Sometimes evident Sometimes evident	Often evident Often evident
SPEAKER'S SKILLS **Speaking for Self** **Speaking for Others***		Seldom evident **Often evident (reverse scored)**	Sometimes evident **Sometimes evident (reverse scored)**	Often evident **Seldom evident (reverse scored)**
SELF-DISCLOSURE		Infrequent discussion of self, feelings and relationship.	Some discussion of self, feelings and relationships.	Open discussion of self, feelings and relationship.
CLARITY		Inconsistent and/or unclear messages. Frequent incongruencies between verbal and non-verbal messages.	Some degree of clarity; but not consistent across time or across all members. Some incongruent messages.	Verbal messages very clear. Generally congruent messages.
CONTINUITY/ TRACKING		Little continuity of content. Irrelevant/distracting non-verbals and asides frequently occur. Frequent/ inappropriate topic changes.	Some continuity but not consistent across time or across all members. Some irrelevant/distracting non-verbals and asides. Topic changes not consistently appropriate.	Members consistently tracking. Few irrelevant/distracting non-verbals and asides; facilitative non-verbals. Appropriate topic changes.
RESPECT and REGARD		Lack of respect for feelings or message of other(s); possibly overtly disrespectful or belittling attitude.	Somewhat respectful of others but not consistent across all members. Some incongruent messages.	Consistently appears respectful of other's feelings and message.
GLOBAL FAMILY COMMUNICATION RATING (1-6)*				

*The global rating is based on your overall evaluation, not a sum score of the sub-scale.

DEMOGRAPHIC INFORMATION

Date _____

SECTION I: Answer the following questions the best you can.

1. Your relationship to child (check one of the following):

_____ 1. Father
_____ 2. Mother
_____ 3. Stepfather
_____ 4. Stepmother
_____ 5. Other (Please explain)_____

2. Your current age: _____

3. Race/Ethnic Group (check one of the following):

_____ 1. Asian
_____ 2. Black
_____ 3. Caucasian
_____ 4. Hispanic
_____ 5. Native American
_____ 6. Other (Please explain)

4. Religious preference (check one of the following):

_____ 1. Protestant
_____ 2. Catholic
_____ 3. Jewish
_____ 4. None
_____ 5. Other (Please explain)_____

5. Highest grade completed (check one of the following):

_____ 1. Less than high school (grade 12)
_____ 2. High school or passed equivalency test
_____ 3. Vocational or technical school
_____ 4. One to four years of College, but did not graduate
_____ 5. Bachelor's degree (e.g., B.A., B.S.)
_____ 6. Master's or post graduate degree (e.g., M.A., M.S., M. S.W.)
_____ 7. Doctoral degree (e.g., Ph.D., D.D.S., M.D., Ed.D.)

6. Employment status (check one of the following):

_____ 1. Retired
_____ 2. Unemployed; not looking for work
_____ 3. Unemployed; looking for work
_____ 4. Employed part-time
_____ 5. Employed full-time
_____ 6. Other (Please explain)_____

7. If unemployed, for how long?_____

8. Household's total income before taxes (check one of the following):

_____ 1. $9,999 or less
_____ 2. $10,000-19,999
_____ 3. $20,000-29,999
_____ 4. $30,000-39,999
_____ 5. $40,000-49,999
_____ 6. $50,000-or more

9. Current martial status (check one of the following):

_____ 1. Married
_____ 2. Divorced
_____ 3. Widowed
_____ 4. Remarried
_____ 5. Engaged
_____ 6. Married but separated
_____ 7. Never married
_____ 8. Other (Please explain)_____

10. If currently married, for how long? _____

11. Have you ever been divorced?
____ 1. Yes
____ 2. No

12. Number of children from present marriage: _____

13. Number of children from previous marriage, if any: _____

14. Number of children living with you in the home: _____

15. Household composition: (List age, gender and your relationship of all members currently living in your home. Do not list any names.)

	Age at last Birthday	Gender (Male/Female)	Relationship to you (e.g., child, stepchild, boyfriend, girlfriend, mother, cousin, etc.)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

SECTION II: Answer the following questions on the child participating in the research.

1. Gender of child

_____ 1. Male
_____ 2. Female

2. Age of your child: _____

3. Education: Current grade of child. (Check one of the following.)

_____ 1. First
_____ 2. Second
_____ 3. Third
_____ 4. Fourth
_____ 5. Fifth
_____ 6. Sixth
_____ 7. Seventh
_____ 8. Other: (Please explain.)_____

4. Race/Ethnicity of child. (Check one of the following.)

_____ 1.	Asian	_____ 4.	Hispanic
_____ 2.	Black	_____ 5.	Native American
_____ 3.	Caucasian	_____ 6.	Other (Please explain)_____

5. Who referred you/child to therapy?

_____ 1.	Self	_____ 5.	Protective Services
_____ 2.	School	_____ 6.	Insurance Company
_____ 3.	EAP	_____ 7.	Friend
_____ 4.	Police/Sheriff	_____ 8.	Other (Please explain)

6. How did you first discover child was sexually abused (check one of the following):

_____ 1.	Child told you	_____ 5.	Police/Sheriff told you
_____ 2.	Family member told you	_____ 6.	Abuser told you
_____ 3.	Friend told you	_____ 7.	You discovered it
_____ 4.	School told you	_____ 8.	Other (Please explain)

7. People currently involved with your child's case (check all that apply):

_____ 1.	Police/Sheriff	_____ 6.	Judge
_____ 2.	Child Protective Services	_____ 7.	Social worker
_____ 3.	District Attorney	_____ 8.	Therapist/Psychologist/Coun.
_____ 4.	Court Appointed Lawyer	_____ 9.	School
_____ 5.	Retained Lawyer	_____ 10.	Other (Please explain)

SEMI-STRUCTURED INTERVIEW

Use the following as a guide:

Who attended therapy session, check all that apply.

_____ Father
_____ Mother
_____ Step-Father
_____ Step-Mother
_____ Live in Boy/Girlfriend
_____ Child
_____ Brother(s) (put number)
_____ Sister(s) (put number)
_____ Friend of family
_____ Other, Please explain _____

List each incident by different perpetrator separately. Describe sexual abuse (refer to descriptive sheet as needed):

Relationship of perpetrator to child:

Age of child at onset:

Age at last incident:

Frequency (how often sexual abuse occurred):

Duration (how long did the sexual abuse continue):

Gender of perpetrator: _____Male _____Female

Age of perpetrator at time of, onset of abuse, of child:

Living arrangement of perpetrator at time of onset of abuse of child:
_____ same home as child _____ close proximity _____ other explain

Living arrangement of perpetrator since disclosure of sexual abuse:
_____ same home as child _____ close proximity _____ other explain

Was there any physical force used? _____ Yes _____ No
If yes, how often and how severe:

Was the child threatened to participate? _____ Yes _____ No
If yes, how?

Was the child bribed or given favors in exchange for the abuse? _____ Yes _____No
If yes, how?

How did the abuse stop?

Who did the child first disclose the abuse to (no names)?

_____ School teacher
_____ School Official
_____ Peer
_____ Neighbor
_____ Family Member
_____ Prevention Specialist
_____ Mental Health Professional
_____ Police
_____ Parent
_____ Other, Please explain _____

Was the child initially believed? _____ Yes _____ No

Type of sexual abuse. Check all that apply.

_____ Forced penile penetration
_____ Forced vaginal pentration
_____ Forced anal pentration
_____ Forced fellatio pentration
_____ Attempted penile penetration
_____ Attempted vaginal penetration
_____ Attempted anal penetration
_____ Attempted fellato pentration
_____ Exposure
_____ Intentional sexual touching
_____ Forced kissing
_____ Showed pornographic material
_____ Took pictures of child unclothed
_____ Forced digital pentration of vagina
_____ Forced digital pentration of anus
_____ Attempted digital pentration of vagina
_____ Attempted digital pentration of anus
_____ Forced masturabation
_____ Attempted masturbation
_____ Mutual masturbation
_____ Simulated intercourse
_____ Non-forceful petting of breasts (unclothed)
_____ Non-forceful petting of genitals (unclothed)
_____ Non-forceful petting of breasts (clothed)
_____ Non-forceful petting of genitals

_____ Other, Please explain _____

Additional information regarding the sexual abuse incident: _____
_____
_____

Were there multiple perpetrators? _____Yes _____ No

APPENDIX C

PARTICIPANT CONSENT & RELEASE OF INFORMATION FORM

Child Sexual Abuse: Parental Acceptance-Rejection and Support

Drs. Kathleen Briggs and Charles Hendrix of the Department of Family Relations and Child Development, Oklahoma State University, request your participation and your child's participation in a research study of parent-child dynamics, specifically parental acceptance and support. The purpose of the study is to assess levels of parental support and family dynamics, from the parent and child's perspectives, of families where a child has reported being sexually abused. Parent's participation will include completing three questionnaires regarding family dynamics, your perception of your behavior toward your child regarding acceptance/support, and a demographic questionnaire. Your child's participation will involve answering questions about how he/she perceives parental behavior and family dynamics. There will be four questionnaires for your child to complete. You have the option to permit a six and twelve month follow up to be conducted with both you and your child. If you agree to participate in the followup, questionnaires will be mailed directly to you at the appropriate times.

One benefit to participation in this study comes from the additional information available to your therapist. With this information, your therapist will be better able to serve both your needs and your child's needs. The possible benefits to society from your participation will include the ability to identify parent-child dynamics and factors of family support to help child victims of sexual abuse become more resilient. The only potential negative effect from participation in this study for your child could be psychological discomfort and becoming tired due to the length of the questionnaires.

If there are any questions you or your child are unwilling to answer, you may skip them. Also, you may withdraw from the study at any time you choose. The results of the study will be published, but no names or other identifying information will be revealed. To maintain confidentiality, all data collected will be labeled with a numerical code, no names will be on the information. All completed forms will be stored in a locked filing cabinet.

If you have any questions about your rights or your child's rights, or if you feel you or your child have been placed at risk, you can contact University Research Services, 001 Life Sciences East, Oklahoma State University, Stillwater, OK 74078; (405) 744-5700. Any questions you have regarding the study or your participation, should be directed to Drs. Kathleen Briggs and Charles Hendrix, Oklahoma State Univeristy at (405) 744-5057.

Informed Consent for Parents and Minors

I agree to participate in the research and further consent to my child's participation in the research. I have read the above informed consent. The nature of the study and chances of both positive and negative effects have been explained to me. I understand the risks involved and that I can withdraw my or my child's participation at any time without loss of benefit to myself or my child. In signing this form I am not waiving any legal rights. A copy of this form will be given to me.

Date: _____

Parent's (Legal Guardian) Name: _____

Parent's Signature: _____

Parent's Name: _____

Parent's Signature: _____

Child's Name: _____

Child's Signature: _____

Clinician's Name: _____

Clinician's Signature: _____

Release of Information

I, _____, hereby authorize _____
(Legal guardian) (Clinician/therapist)

of _____ to release the following information to Drs. Kathleen
(Agency name)

Briggs and Charles Hendrix for their research project examining parent-child interactions and family dynamics of families with a child who has been sexually abuse.

a. Information regarding the type of sexual abuse incurred by the child.

b. Information as to age when abuse happened, age at disclosure, age and relationship of perpetrator, use of force in abuse.

c. Any diagnosis of the child.

d. A rating of the family on family factors (adaptability, cohesion, and communication) and parental support (acceptance and rejection).

I also understand that the clinician will provide this information, one time only.

I Consent to have the above mentioned information released and understand it will remain confidential.

(NOTE: All family members participating MUST sign.)

Date: _____

Parent's (Legal Guardian) Name: Child's Name:

_____ _____

Parent's Signature: Child's Signature:

_____ _____

Parent's Name: Clinician's Name:

_____ _____

Parent's Signature: Clinician's Signature:

_____ _____

APPENDIX D

FIGURES 1-5

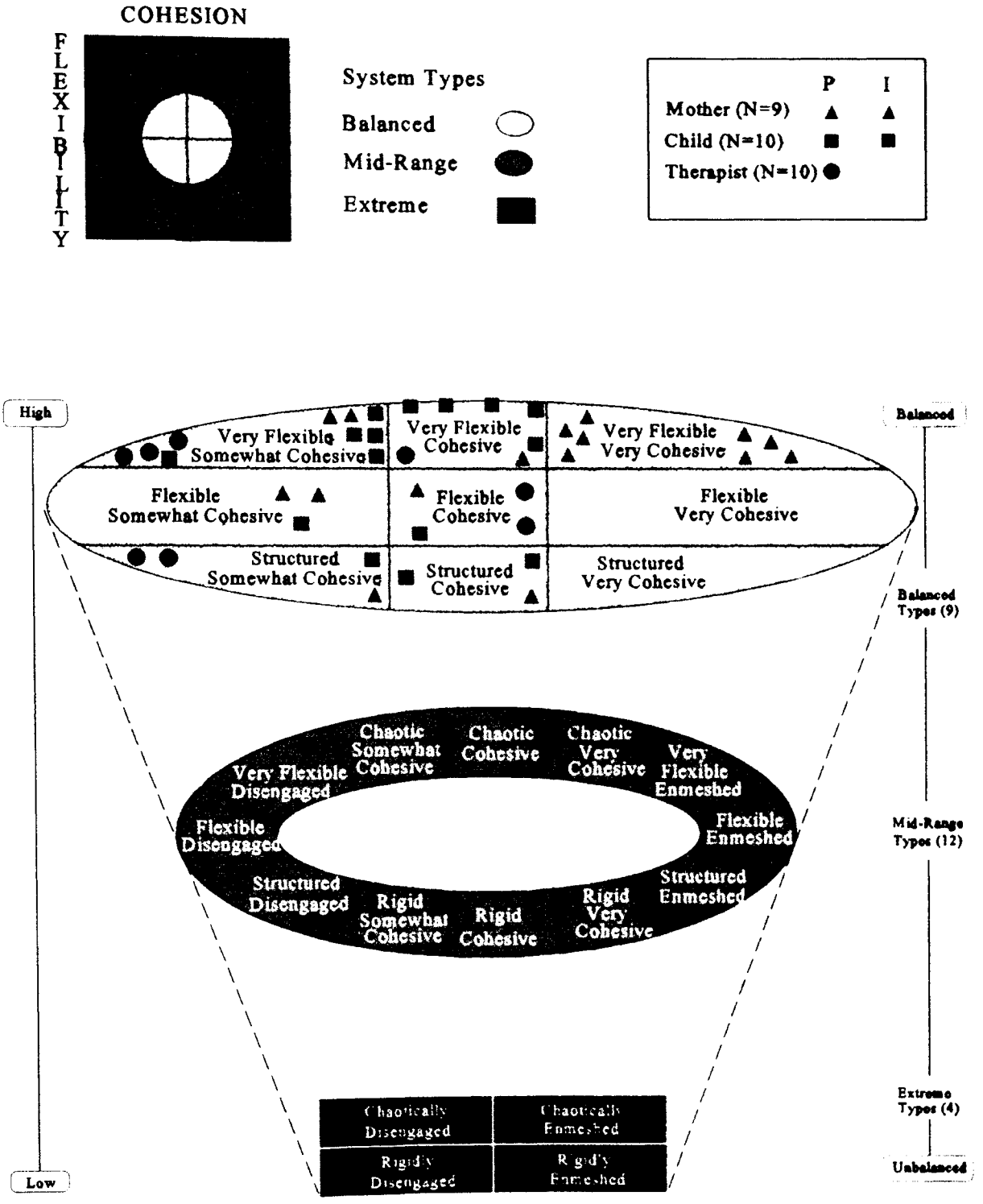


Figure 1. Distribution of family members' and therapists' perceptions on the 3-D Circumplex Model. (P=perceived, I=ideal)

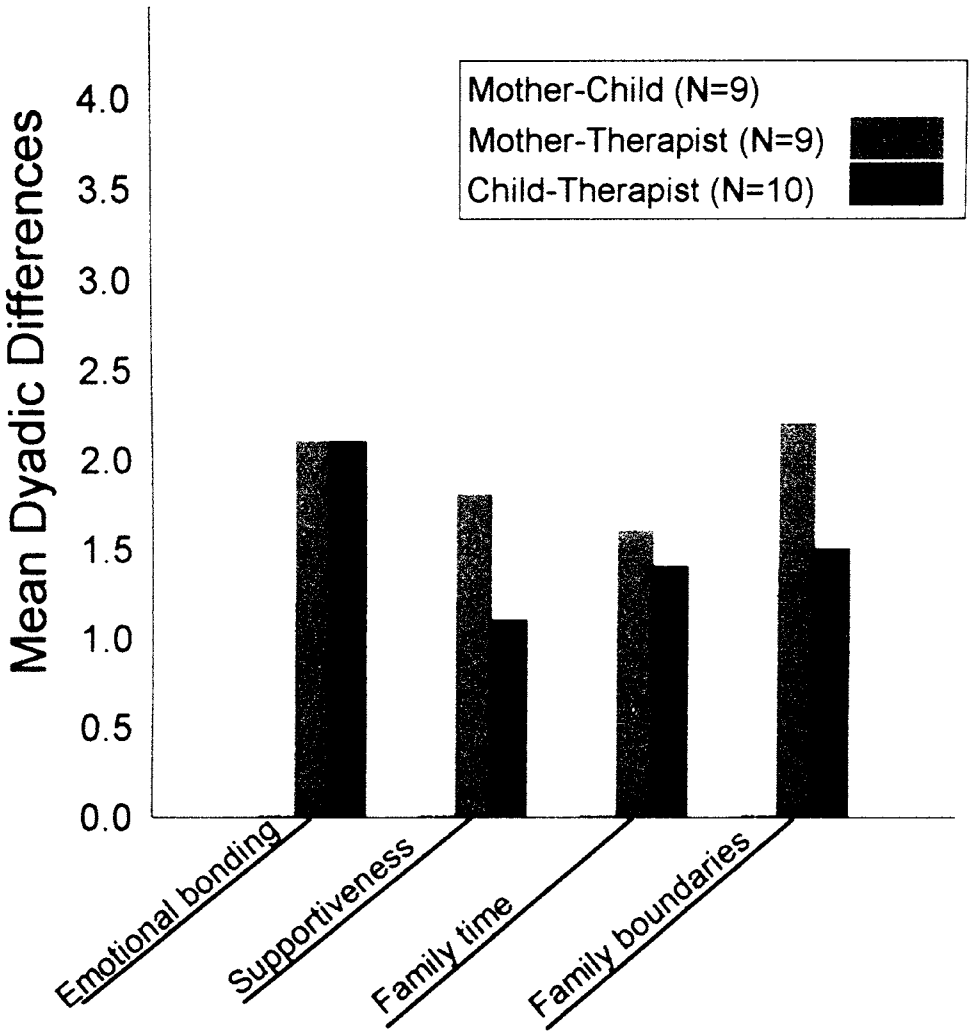


Figure 2. Family cohesion: Selected item dyadic differences

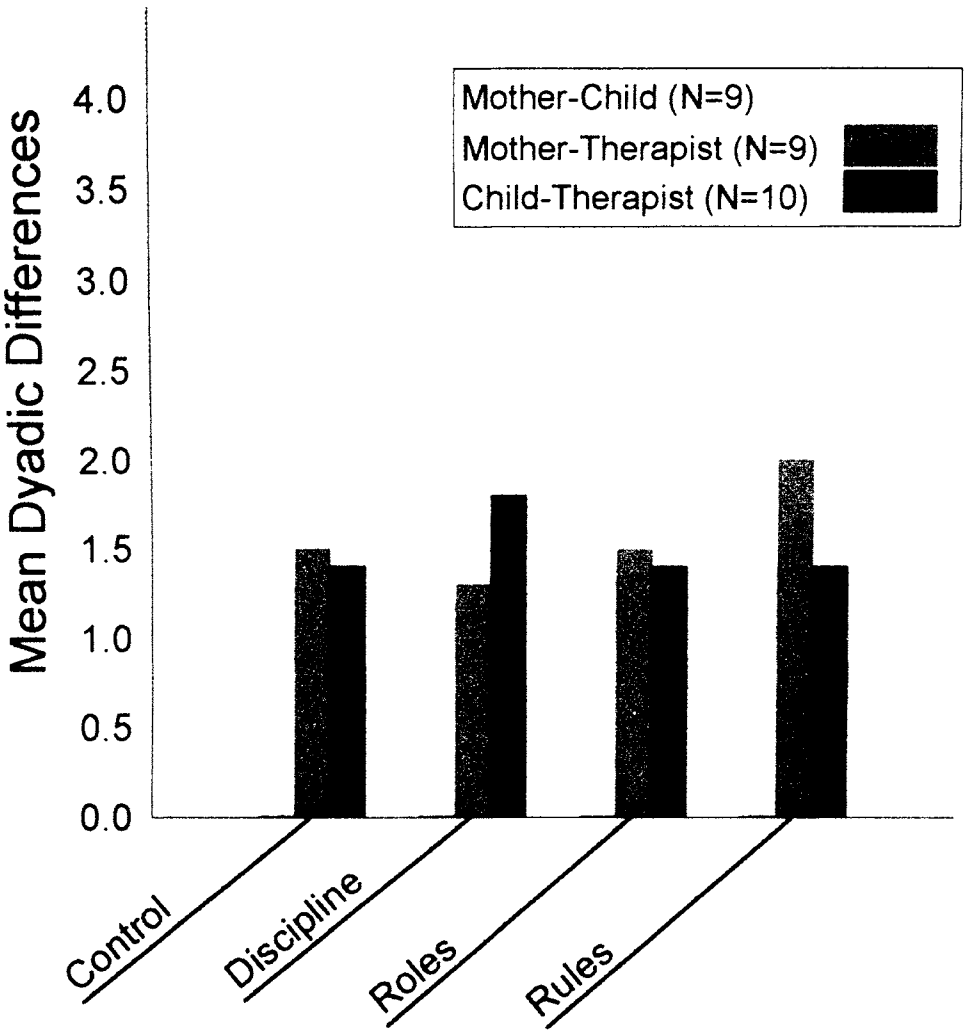


Figure 3. Family adaptabillity: Selected Item dyadic differences

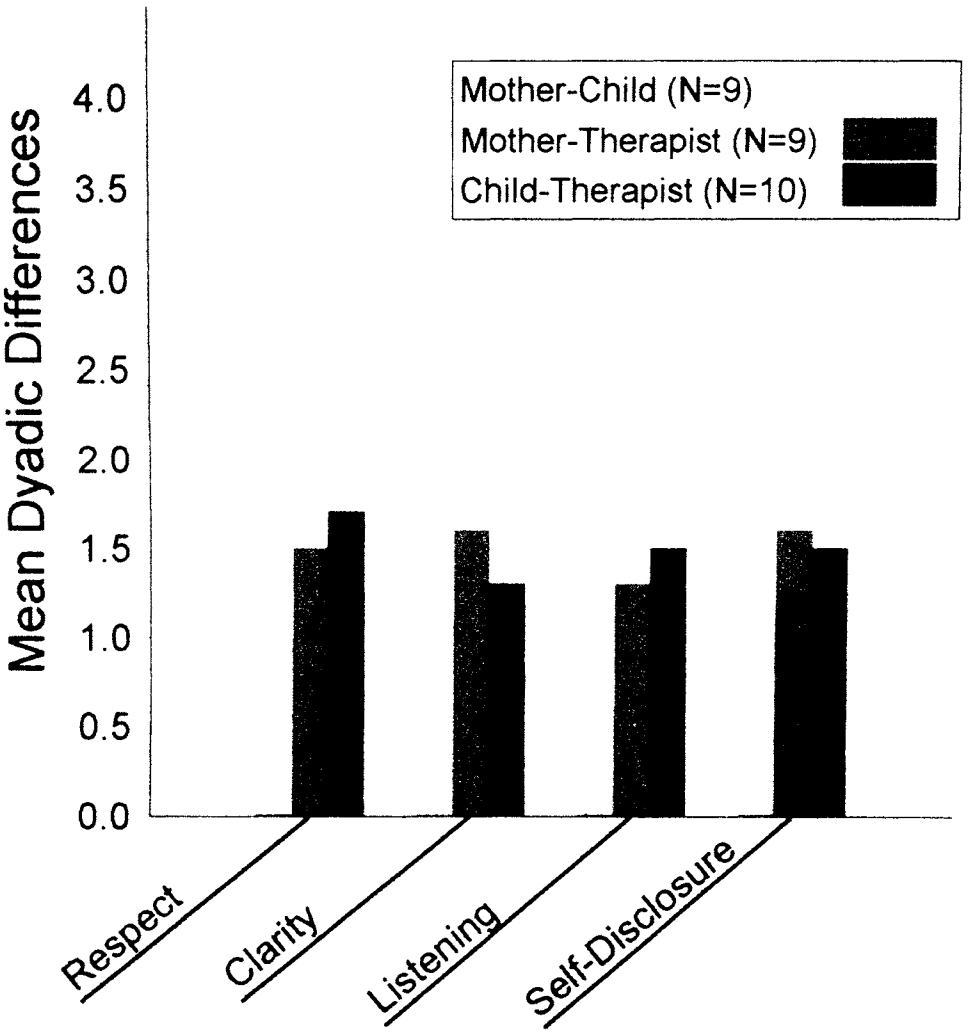


Figure 4. Family communication: Selected item dyadic differences

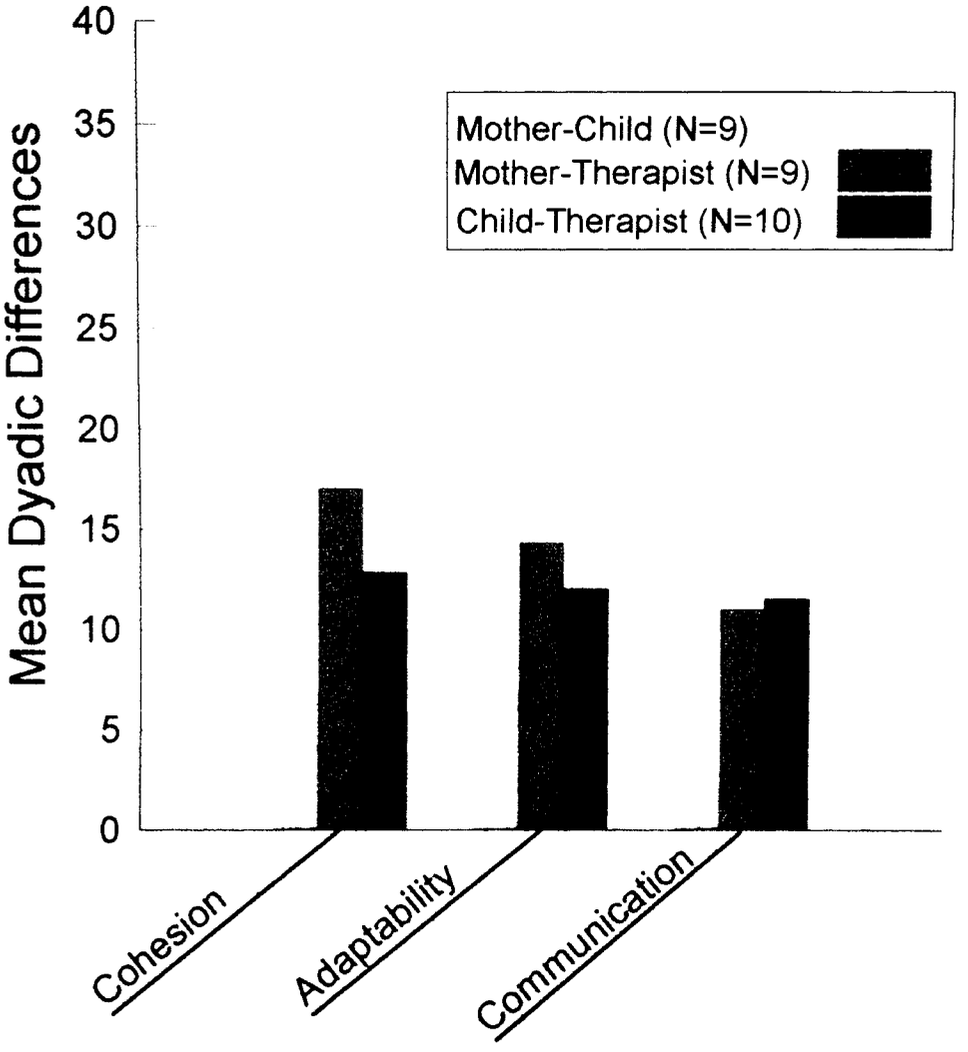


Figure 5. Family characteristics: Total score dyadic differences

APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL FORM

**OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
FOR HUMAN SUBJECTS RESEARCH**

Date: 07-21-93 **IRB#:** HES-93-032

Proposal Title: CHILD SEXUAL ABUSE: PARENTAL ACCEPTANCE AND REJECTION

Principal Investigator(s): Dr. Katheleen Briggs, Dr. Charles Hendrix

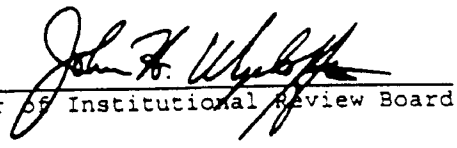
Reviewed and Processed as: Full Board

Approval Status Recommended by Reviewer(s): Approved

APPROVAL STATUS SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL. ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Revisions received and approved.

Signature:  Date: July 21, 1993

Chair of Institutional Review Board

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 09-12-94 **IRB#:** HE-93-032A

Proposal Title: CHILD SEXUAL ABUSE: PARENTAL ACCEPTANCE AND REJECTION

Principal Investigator(s): Kathleen Briggs

Reviewed and Processed as: Continuation

Approval Status Recommended by Reviewer(s): Approved

APPROVAL STATUS SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING.
APPROVAL STATUS PERIOD VALID FOR ONE CALENDAR YEAR AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Reasons for Deferral or Disapproval are as follows:

Modification to original project also approved.

Signature: _____ Date: September 19, 1994
Chair of Institutional Review Board

VITA

Cathie Kerley Briscoe

Candidate for the Degree of

Master of Science

Thesis: MULTIPLE PERSPECTIVES OF FAMILY CHARACTERISTICS IN CASES OF CHILD SEXUAL ABUSE

Major Field: Family Relations and Child Development

Biographical:

Personal Data: Born in Jackson, Michigan, On December 18, 1968, the daughter of Marge and Charles Kerley.

Education: Graduated from East Jackson High School, Jackson, Michigan in May 1987; received Bachelor of Applied Arts in Individual and Family Studies from Central Michigan University, Mount Pleasant, Michigan in May 1991. Completed the requirements for the Master of Science Degree at Oklahoma State University in December, 1994.

Professional Experience: Research Assistant, Department of Family Relations and Child Development, Oklahoma State University, September, 1992 to May, 1994; therapy intern Center for Family Services, Oklahoma State University February, 1993 to present; therapy intern Moore Family Institute, Moore, Oklahoma, February, 1994 to present.

Professional Memberships: American Association for Marriage and Family Therapy, Oklahoma Association for Marriage and Family Therapy, National Council on Family Relations, and Oklahoma Council on Family Relations.