Doctor of Clinical Psychology Degree

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REPORTED ANXIETIES CONCERNING INTIMATE PARENTING IN WOMEN SEXUALLY ABUSED AS CHILDREN

and

RESEARCH PORTFOLIO

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CHAPTER 1: MAJOR RESEARCH PROJECT LITERATURE REVIEW

The sexually abused child as mother :
A review of parenting attitudes, feelings and behaviour

This paper was written according to the guidelines of Child Abuse Review. A copy of the authors' notes can be found in Appendix 1.

The Sexually Abused Child as Mother:

A review of parenting attitudes, feelings and behaviour.

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The Sexually Abused Child as Mother:

A review of parenting attitudes, feelings and behaviour.

Abstract

Childhood sexual abuse (CSA) has been associated with a wide range of later psychological and psychiatric problems. There has, however, been comparatively little empirical research into the potential impact of a history of child sexual abuse on a woman's feelings, attitudes and behaviour as a mother. Initially, research focussed on investigating relatively simple connections between CSA and parenting. Many of these studies relied entirely on self-report measures although increasingly observational methods were used. More complex models, based on attachment theory are now being employed to examine the unique and separate contribution of family of origin characteristics to later parenting . Several studies show that the sexual abuse experience and the relationship with parents have distinct effects on parenting. The research concludes that the joint impact of sexual abuse and the nature of family interaction which frequently accompanies it, affects the confidence and satisfaction of mothers and the level and nature of engagement they have with their children. The practical implications of the research are discussed.

Key Words: mothers; child sexual abuse; parenting skills

Empirical studies using self-report measures

The potential impact of incest on later parenting was explored by Cole and Woolger (1989). CSA women abused by fathers and step-fathers were compared with CSA women abused by unrelated men in respect of their retrospective perceptions of their parents and their own attitudes towards parenting. On these self-report measures incest survivors viewed their fathers as less accepting, more negatively controlling and as stricter disciplinarians than non incest victims. Incest victims perceived their mothers as less involved and more negatively controlling than non incest victims. In terms of parenting, women abused by their fathers had stronger attitudes towards autonomy promotion in their children, that is they believed that their children should grow up quickly. Cole and Woolger suggest that this is possibly because these women have had no positive models for loving parental control and may lack

strategies for being responsive to their children's dependency. In later research Cole, Woolger and Power and Smith (1992) compared three groups: women with a history of father-daughter incest, women whose fathers had been alcoholic but not sexually abusive and a non risk group. Mothers who were incest victims reported significantly less confidence and less sense of control as parents than the non risk group. No differences were found in attitudes about nurturance and discipline of the children. The mothers abused by their fathers said that they felt less consistent and organised as parents and that they made fewer maturity demands on their children. This later finding seems to contradict Cole et al (1989) who found that incestuously abused mothers stressed autonomy promotion in their children. Cole et al (1992) attempts to reconcile these apparent differences by suggesting that mothers with a history of incest do not seem to know how to promote autonomy in their children that is, expecting too much or too little. The quality of the relationship with their spouse, however, predicted mothers' feeling of confidence and control, suggesting that a positive parental relationship may mediate the negative long term effects of incest on parenting.

Grocke, Smith and Graham (1995) investigated the impact of a mother's experience of child sexual abuse on her discussion about sex with her child. Significantly more CSA women said that they had more detailed discussions with their children about sexual development and contraception than a control group. There was no difference between the two groups of children in their overall sexual knowledge. However, children in the abused mother's group were significantly more likely to respond with child abuse or abduction stories to ambiguous pictures.

Cohen (1995) compared a clinical group of CSA mothers with a group of non-abused professionals from the community, on a Parenting questionnaire. CSA women reported having significantly more difficulty as parents on all seven scales. The largest differences were in the areas of "role support" which looked at parental cohesiveness, that is agreement versus disagreement between parents regarding parenting, and "communication" which looked at the ability of the parent to communicate in an open and direct manner with the child. There is a problem, however, in knowing whether the differences she found were due to

the sexual abuse background or to the mental health issues not related to their abuse histories.

The same difficulty exists in a pilot study by Picton (1990). She compared a treatment group of women with a history of sexual abuse with a community control group. She specifically looked at the difficulties that women reported of themselves or their partners in the areas of the physical care and physical affection with their children. Women with a history of child sexual abuse reported significantly more difficulties for self and partners in these areas than the non-abused group. Women were also asked details about their abuse experience including whether they had found it painful. They were asked to rate this on a 5 point scale which ranged from 1, "pleasurable" to 5, "painful". Women who rated their abuse as "pleasurable" reported significantly more parenting difficulties than women who reported their abuse as "painful". It could be argued that pleasurable is not the opposite pole from painful and "not painful" would be a more appropriate marker. Nevertheless, it is of interest that women who did not associate their abuse experience with physical pain reported most difficulties in the physical care and affection of their children. It may be that these women were more anxious that they might feel aroused when caring for their children. However, further research is needed to separate the dimensions of "not painful" from "pleasurable" as answers.

None of the above studies attempted to look at whether mothers with a history of abuse reported specific difficulties with sons or daughters. The children in the studies also covered a wide age range : Cole et al (1989) specified "one child living at home", Picton (1990) and Cohen (1995) included any age whereas Cole et al (1992) restricted to ages two to fourteen years.

The difficulty with all the above studies is their reliance on self report measures which may or may not correlate with the mothers actual behaviour with their children. An exception is Grocke et al (1995) who included one measure of the actual behaviour of children. There is a need for observational research to see if mothers stated anxieties are reflected in their behaviour. Those studies that have used observational methods are reviewed below.

Empirical studies using observational methods

There are very few studies that specifically observe the actual parenting behaviour of mothers with a history of child sexual abuse and those that do draw on populations in contact with health and/or social services. Burkett (1991) videotaped a family interaction task with a sample of mothers with a history of intrafamilial child sexual abuse and compared them with a group of mothers with no history of abuse. Both groups were recruited through their therapists, mothers already in the study, parent education classes or newspaper advertisements and were matched for marital status and for history of being in therapy. They did not differ significantly in education , income or employment status. In the abuse history group the average age of boys was 6.8 years and girls 8.1 years. In the comparison group boys average age was 6 years and girls 6.6 years. There were more daughters than sons in the abuse group. The CSA mothers were significantly more likely to be self-focussed than child focussed in their communications In addition they gave significantly more messages communicating belittling and blame than the comparison group and significantly fewer messages communicating affirmation and understanding. Children of abused mothers were significantly more likely to be parent focussed than self focussed and to take a leadership role with their mothers. Mothers with a history of abuse were significantly more likely to talk about their child as a close friend or primary companion and to rely more on their children for emotional caretaking than non-abused mothers.

There are two main problems with this study: the subjects volunteered to take part and this group may differ from those who did not volunteer. Secondly, the CSA mothers may differ from the control group on variables other than their abuse history, for example quality of relationship with their own mother, and these other variables may account for their specific behaviour.

The behaviour of a group of mothers with their 42 month old children was observed by Sroufe, Jacobiyz, Magelsdorf, DeAngelo and Ward (1985). The mothers were a subset of a larger study of an urban poor population. They had all sought public assistance for pre-natal care, the majority were single parents whose pregnancies were unplanned. This was a follow-up from an earlier study

when the children were two years old (Sroufe and Ward 1980). In that earlier study a pattern of behaviour was identified in mothers towards their infants (90% male) which they had labelled "seductive". These behaviours took the form of physical contact that was seen as inappropriate and non-responsive to the needs of the child as well as being overly stimulating. The follow-up study looked at mother child behaviour in four parent-child teaching tasks. They found that mothers who were "seductive" with sons at 24 months were significantly more likely than the comparison group to show inappropriate physical contact . They were also significantly more likely to show behaviour associated with role reversal or mother and child behaving as peers. They were not, however, likely to be sarcastic or make belittling comments to their sons.

When they looked at the behaviour of the index mothers with daughters at 42 months they found that mothers did not tend to show inappropriate physical contact. In contrast they showed significantly less physical intimacy and made significantly more belittling and sarcastic comments than the comparison group. While this study was not restricted to mothers with a history of childhood sexual abuse, it was found that 42% showing role reversal or behaving as a peer of their child, had been sexually abused compared with only 8% of the larger sample. This study is interesting in that it differentiates mother's behaviour with sons and daughters and also attempts to see if behaviour is consistent over time. Once again there are problems in generalising beyond this sample of mothers who had multiple economic and social difficulties.

Lyons-Ruth and Block (1996) observed the behaviour of mothers from a variety of abusive and non-abusive backgrounds with their 18 month old infants. The behaviour of the infants was also observed. Like the previous study the mothers were from low income families who were in regular contact with the social services. CSA mothers were significantly more likely than other mothers to show decreased involvement with their children. Severity of the sexual abuse was particularly strongly related to scores for "time not in the room with the infant", "disengagement when with the infant", and "flatness of affect". Infant distress was also significantly linearly related to the severity of trauma in the mother's childhood. These reports of lack of maternal involvement with the child are similar to what Sroufe et al (1985) observed with mothers and their daughters.

However, Lyons-Ruth et al (1996) did not observe a gender effect. It may be that some differences in mothers' behaviour are accounted for by the age of the child . One problem with the above study is that depressive symptoms in the mother were not measured and it is possible that depression may have contributed to the flatness of affect observed.

In conclusion, it is difficult and unwise to generalise beyond these studies which drew on populations with multiple past and present deprivations. Within these populations, however, there is some evidence that mothers with a history of sexual abuse behave in distinctive ways. It is premature to attribute these differences solely to the history of abuse. It is possible that other variables historic or current may account for their parenting style. Community studies with mothers from a wider range of backgrounds may help to elucidate some of these points.

Models of parenting

Belsky (1984) proposed a model of parenting which incorporated the impact of the parent's developmental history, her relationship with her parents when growing up, as well as the influence of current relationships with spouse and social network, plus the impact of the specific characteristics of her child. Alexander (1992) suggested that attachment theory provided a useful conceptual framework for understanding the familial antecedents and long term problems associated with a history of sexual abuse. Bowlby (1969/1982,1977),suggested that an individual constructs working models as he/she grows up based on his/her attachment experiences with his/her parents or caregivers. Internal working models are thought to include representations of "other" as well as "self". On becoming a parent it is suggested that childhood representations of "other" guide the parent's interaction with his or her own child (Main and Goldwyn 1984, George 1996). George (1996) suggests that the attachment system focuses on seeking protection and care for the self. However, when people become parents the emphasis shifts to providing protection for the children. She suggests that this working model is called the caregiving system.

Rholes, Simpson, Blakely, Lanigan and Allen (1997) asked unmarried college students about their models of parenting and parent-child relationships. They found that people with more avoidant and anxious-ambivalent models of close adult relationships held more negative models of parenthood and parent-child relationships.

Main et al (1984) showed that a mother's apparent experience of her own mother as rejecting, was systematically related to her rejection of her own infant (as observed in laboratory conditions).

There is a move in current research to try and discriminate between the long term impact of sexual abuse characteristics, such as severity, and other potentially pathological factors in the woman's family of origin such as parental conflict, paternal dominance and lack of maternal warmth. These studies will be reviewed below.

The relative impact of sexual abuse and general family characteristics on later parenting

A frequent problem with studies that attempt to differentiate these variables is the fact that sexual abuse and family dysfunction are often highly correlated (Edwards and Alexander 1992). Statistical analyses using multiple regression analysis are being used in an attempt to disentangle these variables (Edwards et al 1992).

Increasingly studies are finding that sexual abuse variables and family characteristics contribute independently to long term psychological and psychosocial adjustment. For example Edwards et al (1992) in a study of CSA students found that parental conflict, paternal dominance and sexual abuse made independent contributions to the subjects psychosocial development. Alexander (1993) used a self-report measure of attachment with a sample of CSA women from the community. She found that sexual abuse severity and attachment each predicted significant but distinct effects on long-term adjustment. Classic PTSD symptoms were associated with abuse severity, whereas adult attachment was not. Adult attachment predicted a range of personality disorders. It could be argued, however, that the Relationship Questionnaire and the questionnaire measuring personality disorders are, in fact

measuring the same areas of underlying difficulty. Alexander, Anderson, Brand, Schaeffer, Grelling and Kretz (1998) recognised this methodological problem and in the above study used the Family Attachment Interview to elicit the woman's' attachment history. They looked specifically at the impact of sexual abuse severity and women's remembered attachment relationships with their parents, on their current attachment relationships and mental health. They found that abuse severity was not significantly related to adult attachment. However, attachment and abuse severity each made significant contributions to the prediction of later symptoms. Attachment insecurity specifically predicted distress and depression over and above any effects of abuse severity. Classic PTSD symptoms were uniquely explained by abuse severity. Alexander et al (1998) suggest that a comparison of the parenting abilities of CSA women with non-abused controls, all of whom have been assessed in terms of their attachment models, could help researchers differentiate those aspects of parenting which are due to the residual effects of trauma from those which are due to insecure attachment.

Banyard (1997) looked at the impact of child sexual abuse and family functioning on women's later parenting. The index mothers were drawn from a group involved with child protection agencies and compared with a matched group, with no history of abuse attending other agencies. She found that CSA mothers reported higher levels of dissatisfaction with themselves as parents and reported greater use of physical strategies for handling parent/child conflict. These differences remained even after parcelling out the effects of other negative family of origin experiences. Family of origin characteristics can therefore be seen as independently affecting women's later parenting behaviour. In some cases family characteristics appear to mitigate or exacerbate the impact of the abuse.

The family as mediator of abuse effects

Wind and Silvern (1994) studied a group of women who had been victims of intrafamilial sexual abuse in an attempt to identify mediators that might influence the relationship between child abuse and later adjustment. They found that survivors who had perceived their parents as providing little support and

acceptance had elevated levels of depression and low self esteem. So unsupportive parenting mediated the relationship of child abuse to adult depression. Parenting, however, had no effect on mediating trauma symptoms. Once again, they suggest that both aspects of the abuse experience, that is the abuse itself and the failure in family relationships may contribute independently to long term problems. In an earlier study Peters(1988) found that level of maternal warmth was a stronger predictor of psychological problems in adulthood than abuse variables such as duration and frequency, although they did contribute independently to later problems.

Practical implications of research

When working therapeutically with a mother who has a past history of sexual abuse it is essential to take into account her remembered relationships with her parents and her models of attachment and caregiving. The research shows that they may influence her own parenting behaviour. These models will provide the clinician with a framework within which to assess any difficulties she reports with her own children. In addition, however, it will be important to be aware of the characteristics of the abuse itself as they may also create specific phobic and post-traumatic symptoms which may interfere with the intimacy of parenting. Finally, it should be noted that a progression from an experience of poor parenting and sexual abuse to becoming a neglectful or abusive mother is far from inevitable. Research now is focusing on the area of resilience and the factors which prevent the transmission of trauma from one generation to the next (Romans, Martin, Anderson, O'Shea and Mullen 1995).

3083 words

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CHAPTER 2: MAJOR RESEARCH PROJECT PROPOSAL

Reported anxieties concerning intimate parenting in women sexually abused as children

Reported anxieties concerning intimate parenting in women sexually abused as children.

Anne R. Douglas.

Summary

A wide range of problems have now been linked with a childhood history of sexual abuse (CSA) including depression (Peters 1988), poor self-esteem (Bagley and Ramsey 1986), eating disorders (Waller 1993) and sexual dysfunction (Meiselman 1978). Women with a history of sexual abuse are also more likely than a control group to have children who are sexually abused (Finkelhor 1993, Mian 1994 et al). Difficulties in parenting have been described in the clinical literature (Douglas 1988, Hall and Lloyd 1993) but there has been virtually no empirical research in this area. In a pilot study Picton (1990) found that women with a history of childhood sexual abuse reported significantly greater parenting problems than a control group.

Parenting is an important area of study because of its influence on child development. Women sexually abused as children, often by parents, report feeling confused and anxious about the normal range of intimate touch between mother and child. Their anxieties may lead them to distance themselves from these aspects of parenting and this in turn might leave their children vulnerable to abuse.

Belsky(1984) proposes three main influences on parenting; the personality/psychological well-being of the parents, the characteristics of the child and contextual sources of stress and support including the marital relationship.

The present study will examine parenting anxieties in women with a history of sexual abuse. The subjects will be recruited from patients referred to mental health out-patient services across Scotland. They will be compared with a clinical, non-sexually abused group also referred to mental health out-patient services. The study will explore the potential relationship of sexual abuse to

parenting anxieties while also assessing other factors postulated as influencing parenting, in particular the woman's own history of parenting and her current mental health. Parenting has multiple determinants, this study aims to examine the relative importance of C.S.A. as a predictor of later parenting anxieties.

Introduction

Little has been written about parenting in women with a history of childhood sexual abuse. The attention of the literature has largely been directed to the abused woman's family of origin (Wind and Silvern 1994), her history of sexual abuse and their impact on her mental health, rather than her influence on her family. A few empirical studies, however, have explored the women's' relationship with her own children. Burkett (1991) found that women with a history of CSA were more self-focused than child focussed in video-taped family interaction tasks compared to a control. The women also relied more on their children for emotional support. Cohen (1995) reported that adults survivors of CSA were less skillful in their maternal functioning as assessed by the Parental Skills Inventory. Particularly high differences were found on the scales of role-support, communication and role-image.

Grocke et al (1995) found that sexually abused women said that they had significantly more detailed discussions with their children about sex education than a control group. Their children were also more likely to respond with child abuse or abduction stories to ambiguous pictures.

In a pilot study Picton (1990) focussed on reported anxieties to intimate parenting behaviours such as toilet-training, bathing and undressing. She found that a pleasurable physical response to the abuse was associated with significantly greater reported parenting difficulties. She drew her experimental group from women who had sought clinical or agency help for problems related to their past history of abuse. She compared this group, however, with a non-clinical control group. It is possible that some of the parenting difficulties she reported were due to mental health problems rather than to the abuse per se. The present study would use a clinical control group of women with no past history of abuse. It would attempt to replicate with this group Picton's finding

that pleasurable ratings of the abuse are associated with later parenting difficulties.

Another criticism of her study is that she included women whose children were in a wide age range. The questions could therefore be referring to either past or present feelings about parenting. She also did not distinguish between mother's feelings to sons or daughters. The current study will restrict its sample to women with children aged ten or younger. It will also separately assess anxieties about sons and daughters.

It could be argued that women with a history of intra-familial abuse might be more vulnerable to later parenting anxieties than those with a history of extra-familial abuse. The intra-familial group have often had the model of their own parent acting in a sexually abusive way which may lead to doubts about their own capacity to parent. Mian et al (1994) studied mothers of sexually abused girls. She found that women abused by a member of their own family showed worse spousal relationships and inadequate boundaries with their own children than women abused extra-familially. The present study will differentiate intra and extra-familial abuse in a clinical sample.

Finally, Belsky (1984) suggested that an important influence on parenting is the person's relationship with their own parents. This study will also assess the women's retrospective account of her relationship with her own parents.

Aims and Hypotheses.

The current study aims to investigate what factors are associated with parenting anxieties in women with a past history of CSA and how these differ from a clinical control group who have not been abused. It also aims to investigate which of the factors have the greatest power to predict parenting anxieties.

The aim of the study is to address the following questions.

1. Do women with a history of CSA report greater anxieties about intimate aspects of parenting than a clinical control group?
2. Do women with a history of intra-familial abuse report greater parenting anxieties than women abused by non-family members or strangers?
3. Does sexual abuse associated with physical pleasure lead to greater parenting anxieties?

4. Irrespective of a history of CSA are relationships with the women's own parents related to parenting anxieties?

Method.

Experimental group - Inclusion criteria.

1. Women with a history of physical contact sexual abuse referred to Mental Health out-patient services.
2. Women with a child aged 10 or younger.

Clinical control group.

1. Women referred to Mental Health out-patient services.
2. Presenting with problems of anxiety, depression, (mild or moderate) sexual dysfunction or other neurotic difficulties.
3. At least one child aged ten or younger.
4. No reported history of childhood sexual abuse.

Exclusion criteria for both groups.

1. Psychotic illness, current or past.
2. Major substance abuse.
3. Referral for help with parenting problems.

Numbers of subjects required.

The number of subjects required for this study was calculated by referring to Picton's data (Table 3, p 8) and working out the standardized difference of her Mother scores, this came to 1.2. Assuming that comparing two clinical populations may lead to a smaller standardized difference, a conservative estimate being 0.6 , a sample size of 32 per group would be required (Machin & Campbell 1987).

Measures

All data will be collected in the form of self-completed questionnaires.

1. **Demographic data.**

Information will be collected on the following: Age, occupation and partners occupation, age and sex of children. Area of residence.

2. **Sexual abuse data.**

This will be gathered from an adapted version of the Survey of Sexual Abuse (Tsai et al 1979). The definition of sexual abuse will be limited to abuse involving

physical contact and occuring before the age of 16. Single episodes of rape will not be included.

3. **Intimate Aspects of Parenting Questionnaire.**

Anxieties about parenting will be assessed using a revised version of Picton's (1990) questionnaire. The measure contains 22 items looking at different aspects of physical care or affection. Each item asks if the individual "has problems with/feels uncomfortable about/feels uneasy about" various aspects of intimate parenting care. Each item is rated on a 5 point scale ranging from "Never" to Always". This questionnaire provides an overall Parent score(range 23-115) with a high score indicating greater perceived difficulties in parenting tasks involving physical care and affection. The questionnaire also provides subscales for how the woman feels about her partner's involvement in these tasks (this section will not be used in the current study). This measure clearly differentiated an abused group of mothers from an non-abused group . The measure will be revised to drop one item which Picton (1990) found was not always applicable to the populations studied, that is the item referring to breast-feeding. In addition mothers will be asked to fill in one section of the questionnaire for daughters and another for sons.

3. **The Parenting Stress Index- Short Form (Abidin 1990)**

This questionnaire is a brief measure of stress in the parent-child system. There are three subscales : parental distress, parent-child dysfunctional interaction and difficult child. These scales combine to give a total stress score which is an indication of the overall level of parenting stress the person is experiencing.

4. **The General Health Questionnaire(G.H.Q.28; Goldberg, 1978).**

This test is used to detect psychiatric disorder and distinguishes between psychological well-being and psychological distress. A threshold score of 5 can be used to assess psychiatric caseness.

5. **The Parental Bonding Instrument (PBI: Parker, Tupling and Brown 1979).**

This questionnaire developed by Parker et al 1979 consists of two 25 item parts which ask the subject to rate how they remember their mother and father's attitudes and behaviour towards them. The questionnaire includes two scales; parental care and over-protection or control.

Members of the clinical sample group completed the inventory on two occasions three weeks apart to assess test-retest reliability . A Pearson correlation co-efficent of 0.761 ($P<0.001$) was obtained for the'care' scale and 0.628($P<0.001$) for the 'overprotection' scale.

After joint interview with 65 of the subjects two raters independently assigned a 'care' and 'protection' score for each parent. The inter-rater reliability co-efficient on the 'care' dimension was 0.851 ($p<0.001$) and 0.688($p<0.001$) on the 'overprotection' dimension. As a test of the concurrent validity of the scales the raters' scores of 'care' and 'overprotection' obtained at the interview were correlated with those determined by the scales. The questionnaire, developed in Australia, has since been used with a British population (Rodgers 1996).

Design and Procedure

The basic experimental design is a between groups study comparing anxieties concerning intimate parenting in a clinical group of women with a history of sexual abuse with a clinical group of women with no history of abuse. Comparisons between groups will be made on measures of mental health, anxieties about intimate parenting, overall parenting stress and reported relationship with their own parents . Both of the groups will be considered separately and together to assess which of the measures is most strongly associated with intimate parenting anxieties.

Location

Data will be gathered in Mental Health out-patient clinics in Scotland.

Data Analysis.

Data will be stored in the Psychology Department, Stobhill Hospital.

The data will be analysed using SPSS.7 for Windows. After examining the descriptive statistics, if the assumptions are met, some form of generalised linear modelling will be used. Both ANOVA and multiple regression can be seen as specific examples of linear modelling.

Practical Applications

The continuity of sexual abuse across generations is a frequent, although not invariable, finding that has generated a number of explanations (Cohen 1995). A potential area of influence focuses on the women's relationship with her own child. Women who are anxious about close physical contact with their young

children because of their own experience of sexual abuse may avoid a range of activities that involve touch e.g. bathing, toilet-training, hugging. The growing child, deprived of maternal touch may be more vulnerable to the approaches of an abuser. It is therefore important to know which mothers with a history of CSA are most anxious about intimate parenting so that early intervention may be offered. This study could form the basis for a treatment intervention package for mothers with a history of sexual abuse. Preliminary discussions with Christine Puckering, Consultant Clinical Psychologist, Adolescent Service and Dr Anne Sneddon, Consultant Child Psychiatrist, Possilpark Health Centre, suggest enthusiasm for such a programme. Considerable funding is also available for preventative research in this field of study.

Publication

The completed paper will be submitted to Child Abuse and Neglect-The International Journal.

Ethical approval

This will be sought from the Trust's Ethics Committee.

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CHAPTER 3: MAJOR RESEARCH PROJECT PAPER

Reported anxieties concerning intimate parenting in women sexually abused as children

This paper was written according to the guidelines of Child Abuse and Neglect. A copy of instructions for authors and further relevant information can be found in Appendix 2.

Reported anxieties concerning intimate parenting in women sexually abused as children

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Running title: Intimate parenting
Key words: Mothers, child sexual abuse, parenting concerns

REPORTED ANXIETIES CONCERNING INTIMATE PARENTING IN WOMEN SEXUALLY ABUSED AS CHILDREN

ABSTRACT

Objective: The study had two aims: (1) To investigate whether mothers with a history of contact child sexual abuse were anxious about the intimate aspects of parenting compared with a clinical comparison group. (2) To determine if there was any relationship between the mother's anxieties and the kind of parenting they recalled receiving themselves.

Method: Two groups of mothers in mental health out-patient care were interviewed; 34 women with a history of contact child sexual abuse and 29 women with no history of sexual abuse. They completed the Intimate Aspects of Parenting Questionnaire, The Parenting Stress Index (Short Form), The Parental Bonding Instrument and The General Health Questionnaire-28. The index group also completed a sexual abuse history questionnaire.

Results: Mothers with a history of child sexual abuse were significantly more anxious about intimate aspects of parenting than the comparison group.

They also reported significantly more overall stress as parents. The index group recalled that their own parents were significantly less caring and that their fathers more controlling than the comparison group. A low score on Father Care was significantly associated with concerns about intimate parenting, but not with total parenting stress. By contrast, a low score on Mother Care was significantly associated with higher stress experienced as a parent, but not as strongly with anxieties about intimate parenting.

Conclusions: Mothers with a history of contact child sexual abuse are often worried that their normal parenting behaviours may be inappropriate or seen as such by other people. These anxieties seem associated with their history of childhood sexual abuse.

Key words- Mothers, child sexual abuse, parenting concerns.

INTRODUCTION

Child sexual abuse (CSA) has now been associated with a wide range of long term problems including depression (Peters, 1988), poor self-esteem (Bagley & Ramsay, 1986) and eating disorders (Waller, 1993). Comparatively little research, however, has focussed on the potential impact of a history of child sexual abuse on a person's later parenting abilities. Parenting problems reported by women have been described in the literature (Douglas, 1988; Hall & Lloyd, 1993) but there are few empirical studies. Self report studies have shown that women with a history of incest describe feeling less confident and less in control as parents than a comparison group (Cole, Woolger, Power & Smith, 1992). Grocke, Smith & Graham, (1995) found that sexually abused mothers reported more detailed discussions about sex education with their children than a control group. Although there was no difference when the children's knowledge was compared, children in the abused mother's group were significantly more likely to respond with child abuse or abduction stories to ambiguous pictures. Cohen (1995) showed that CSA mothers reported having significantly more difficulty as parents on the Parental Skills Inventory.

A few observational studies have been carried out in this area. Burkett (1991) reported that CSA mothers were more self focussed than child focussed in videotaped family interaction tasks compared to a control. Lyons-Ruth and Block (1996) observed the behaviour of mothers from a variety of abusive and non-abusive backgrounds with their 18 month old infants. Mothers with a history of CSA were significantly more likely than other mothers to show decreased involvement with their children, such as spending more time out of the room, or showing flatness of affect. Unfortunately the mother's mental state was not concurrently assessed and may have been a confounding factor.

Intimate touch is an essential aspect of child care, especially with infants. It seems reasonable to hypothesise that mothers who have been sexually abused, often by their own parent, may have complicated feelings about everyday routines such as changing nappies, bathing their child, taking their child into bed or generally showing affection. As far as the author is aware there are no published empirical studies in this area. In an unpublished pilot study, however, Picton (1990) found that women seeking help for problems related to CSA

reported significantly more difficulties in the areas of intimate child care and affection than a community control group. There is a problem in knowing whether the differences she found were due to the sexual abuse or mental health factors. Mothers in her study also had children in a wide age range and therefore many of their reports were retrospective. No attempt was made to distinguish their feelings towards sons and daughters.

Women who have been sexually abused have often experienced a range of other pathological influences in their childhood such as parental discord, or general family dysfunction . Recent research has tried to evaluate the relative influence of sexual abuse characteristics compared to other family characteristics, and found that they contribute independently to long term outcome (Edwards & Alexander, 1992). Attachment theory provides a useful conceptual framework for the above findings (Alexander, 1992). Bowlby (1969/1982,1977) suggested that an individual constructs working models as he/she grows up based on attachment experiences with parents or caregivers. These models are thought to include representations of "other" as well as "self". It is suggested that on becoming a parent, childhood representations of "other" guide the parent's interaction with their own child. For a comprehensive review of this area see (Douglas,1998).

The present study aims to investigate whether women with a history of contact child sexual abuse report greater anxieties about intimate aspects of parenting compared with a clinical comparison group. It also explores whether CSA women are more stressed in general as mothers. The mothers are also asked to recall their relationship's with their parents to see if these internal models are associated with their feelings about intimate care.

METHODS

Subjects

Women with a history of contact child sexual abuse before the age of 16, and at least one child aged 10 or younger, were interviewed at mental health out-patient clinics in Scotland. The comparison group were women without a history of child sexual abuse who were attending for out-patient therapy with a range of

problems such as generalised anxiety disorder, posttraumatic stress disorder, eating disorders (See Appendix 2). In the consent form for the study the comparison group were asked to sign a statement that said they had not been abused. If they were unable to do this they were transferred to the CSA group. Women with a current or past psychotic illness, major substance abuse, or those referred for specific help with parenting problems were excluded from the study. In the CSA group 43 women were asked to take part in the study, 1 declined and 42 agreed. The uptake rate was 97.67%. Nine women failed to attend for their interview so the response rate was 76.74%. In the comparison group all 38 women approached agreed to take part. Two women were excluded on the grounds of past psychotic illness, 1 woman was transferred to the CSA group and 6 women failed to attend for interview. The comparison group, therefore, was made up of 76.31% of the women who had originally agreed. The people who failed to turn up for interview in both groups did not differ from those who attended. The final total sample size consisted of 63 women, 34 in the index group and 29 in the comparison group.

Demographic and personal details

There was a significant difference in the mean age of the CSA group and the comparison group ($t= -2.29$, $df=61$, $p<0.005$). The CSA group had an average age of 31.7 (SD, 5.72) which was younger than the control group who had an average age of 35.8 (SD, 5.51). A deprivation score was calculated using the woman's postcode (McLoone 1991). The index group were significantly more likely to live in an area of greater deprivation than the comparison group (Chi square = 6.67, $df=1$, $p<0.01$). Significantly more women in the index group reported an upbringing disrupted by parental death, separation or divorce (Chi square = 6.54, df 1, $p<0.01$). For more details see Appendix 2.

There was no significant difference in the total number of children in each group or in the ages of the youngest son or daughter which for both groups was just under 5. Mothers in the CSA group had 22 sons and 22 daughters and comparison group mothers had 18 sons and 20 daughters. There was no significant difference in marital status with the majority of the CSA group (85.3%) and the comparison group (79.3%) either married or living with their partners. No significant differences were found in educational achievement, nor in the

proportion of women working outside the home, or in the number of therapy sessions received prior to the research interview (see Appendix 2).

The sexually abused group.

The majority of women (97.1%) were abused by someone known to them, only one woman was abused by a stranger. The largest single group of abusers were fathers accounting for 32.4%. When step-fathers and foster fathers were included the total came to 41.2%. Intra-familial abuse was defined as abuse by someone related by blood, marriage or a partner of a parent. Using this definition 73.5% of abuse was intra-familial. Only one perpetrator was female, 97.1% were male.

The age of onset of the abuse ranged from 3 years to 12 years (mean = 6.6 years, median 6.5 years). Three people were abused on one occasion. If they are removed from the analysis, the duration of abuse ranged from 3 months up to 13 years (mean = 5 years and 3 months, median = 5 years). The majority of women (73.5%) reported that they had been abused on a daily or weekly basis.

As well as the index abuse episode, 44.1% of the sample reported that they had been sexually abused by another person when they were under 16 years of age.

(For further details of the above, see Appendix 2).

Measures

1. **Intimate Aspects of Parenting Questionnaire (IAP).**

   This measure is a revised version of Picton's (1990) questionnaire. The measure contains 11 items (repeated twice) looking at different aspects of physical care and affection. Each item asks if the individual feels "uncomfortable about, uneasy with, or avoids" various parenting tasks. The mother was asked to fill in the first half with their youngest son in mind, and the second half thinking of their youngest daughter. Initial pilot work led to the inclusion of a new item, "putting cream on the nappy area" as several women said they found this the most difficult task. The words "or avoids" were also added to the instructions as women stated that they did not feel uncomfortable, for example, when drying a child because they did not look.

At the end of each section of the questionnaire the women were asked if there were any additional comments they would like to make.

2. **Parenting Stress Index - Short form (PSI; Abidin, 1990).**
   This questionnaire is a brief measure of stress in the parent-child system. There are three sub-scales: parental distress (PD), parent-child dysfunctional interaction (P-CDI) and difficult child (DC). These scales combine to give a total stress score which is an indication of the overall level of parenting stress an individual is experiencing. A score of 90 or above indicates clinically significant levels of stress. The measure also has a defensive responding scale to assess individuals trying to present in a socially desirable way.

3. **The Parental Bonding Instrument (PBI; Parker, Tupling & Brown,1979).**
   This measure consists of two 25 item parts which ask the subject to rate how they remember their mother and father in their first 16 years. The questionnaire includes two scales for each parent; parental care and parental over-protection. The measure has been widely used and it has been shown to have high test-retest reliability and does not show a response bias with mood state (Parker 1990).

4. **The General Health Questionnaire (GHQ-28; Goldberg, 1978).**
   This test is used to detect psychiatric disorder and distinguishes between psychological well-being and psychological distress. A threshold score of 5 can be used to asses probable psychiatric caseness.

5. **Survey of sexual abuse(Tsai, Feldman-Sumers & Edgar, 1979)**
   An adapted version of this questionnaire was used to gather information about the sexual abuse episode. The definition of sexual abuse was limited to physical contact abuse occurring before the age of 16.

Data was analysed using the SPSS 7 computer programme.

RESULTS

Intimate Aspects of Parenting Questionnaire

Women in the CSA group reported significantly more anxieties on the Intimate Aspects of Parenting Questionnaire than the comparison group. On the son subscale), on the daughter subscale, and on the grand total (Table 1). In neither

the CSA group (Z= -.89, p,n.s) nor in the comparison group (Z= -1.342, p,n.s) were there any significant differences in anxieties by gender of the child. Additional comments were made by 73.52% of the CSA group and 34.48% of the comparison group. The qualitative data was sorted into main themes. The complete list of additional comments can be found in Appendix 2.

INSERT TABLE 1 HERE

Parenting Stress Index Short Form

The CSA group reported significantly more overall parenting stress on the Parenting Stress Index (t=2.36, df 61, p<.02). The CSA group also scored significantly higher on two out of the three subscales: PCDI (t=2.30, df 61, p<0.02), DC (t=2.04, df 61, p<0.04). There was, however, no significant difference on the PD subscale (t=1.80, df 61, p n.s). The groups did not differ on the Defensive Responding subscale, with only one subject in each group answering in a defensive manner.

Recalled relationships with parents on the Parental Bonding Instrument

The comparison group recalled their mothers as significantly more caring than the CSA group (Table 2). There was no significant difference between the groups on Mother Control. The comparison group also rated their fathers as significantly more caring than the CSA group. The CSA group, however, rated their fathers as significantly more controlling than the comparison group .

INSERT TABLE 2 HERE

Correlations between scores on the Parental Bonding Instrument and scores on the Intimate Aspects of Parenting Questionnaire.

The degree of Mother Care recalled on the Parental Bonding Instrument was not significantly associated with concerns about the intimate parenting of a girl. This

was true both for the whole sample and the CSA and comparison groups when considered separately (Table 3). Mother Care was, however, significantly correlated with anxieties about the intimate parenting of a son (Table 3). The more maternal care recalled the less the anxieties about parenting a son. This correlation, however, was not upheld when either group was considered separately. Mother Control was not significantly associated with intimate parenting anxieties.

INSERT TABLE 3 HERE

Father Care recalled was significantly correlated with both intimate aspects of parenting a son, and parenting a daughter (Table 3) when the sample was considered as a whole. The correlation with the son score was not upheld when the two groups were considered separately. The correlation with the daughter score was explained by a highly significant correlation in the CSA group. There was not a significant correlation in the comparison group when considered alone. Father Control was not significantly linked to anxieties about parenting a son or a daughter, for either group. The total score on the IAP was correlated with Mother Care ($r = -.300$, $p<0.05$) for the whole sample, this correlation was not upheld when the groups were considered separately. Father Care was significantly associated with total IAP score for the whole sample ($r=-.467$, $p<0.01$) and for the total IAP score in the CSA group ($r = -.425$, $p<0.05$), but not for the total score in the comparison group ($r= -.243$ n.s). Neither Mother Control or Father Control scores correlated significantly with any of the total IAP scores.

Correlation between scores on the Parental Bonding Instrument and the Parenting Stress Index Short Form

There is a significant correlation between Mother Care and the Total Stress Score (Table 4) when the sample is considered as a whole. Father Care recalled did not correlate with Total Stress Score. Neither Mother Control or Father Control correlated with the Total stress score.

INSERT TABLE 4 HERE

Specific aspects of the abuse

There was not a significant association between the woman's reports of abuse rated as "not painful" or "pleasurable" on the Sexual Abuse Questionnaire and high (23 and above) scores on the IAP questionnaire ("not painful": Fisher's exact df=1, p=0.58; "pleasurable": Fisher's exact, df=1, p=.625).

Intra-familial and extra-familial abuse compared

When the CSA women were divided into those who suffered intra and extra-familial abuse no significant differences were found between these sub-groups on either the IAP or the PSI. The duration of the abuse was greater in the intra-familial group ($t=2.03$, $df=29$, $p<0.05$), as was the frequency ($Z=-3.25$, $p<0.001$).

Duration of abuse

The CSA group was divided into those with "short" duration of abuse, up to and including 5 years, and those whose abuse lasted 6 years or more ("long"). The "long" duration of abuse was significantly associated with higher scores on the Intimate Aspects of Parenting Questionnaire (Chi square = 4.94, df=1, $p< 0.02$).

Other abuse

Women who reported abuse by more than one person were compared with those who recalled one abuser only. There was no significant differences in total scores on the Intimate Aspects of Parenting Questionnaire ($Z= -.194$, $p<.846$ n.s).

Mental health and parenting stress

A comparison of the two groups on the GHQ total score showed a significant differences between the two groups ($Z= -3.127$, $p<0.002$) and on 3 out of 4 of the subscales including depression ($Z= -4.436$, $p<0.001$). These results show that the CSA group showed significantly higher levels of psychological distress than the clinical comparison group. An examination of "caseness" scores of 5 or above showed that 37.93% (11/29) of the comparison group , and 61.76%

(21/34) of the abused group met caseness levels of significant psychological distress.

Correlation between GHQ-28 and Intimate Aspects of Parenting Questionnaire

When the sample was considered as a whole, GHQ total score and total score on the IAP were significantly correlated (r=.321, p<0.05). Likewise, there was a significant correlation (r=.440, p<0.01) between score on the Depression subscale and total IAP score. Neither of these correlations were significant , however, when the CSA and comparison group were examined separately.

GHQ-28 and Parenting Stress Index Short Form

There was a significant correlation (r=0.488,p<0.01) between the Depression subscale and total Parenting Stress score. This was true for the total sample and also each group (CSA r= 0.403, p<0.05; comparison group r= .376, p<0.05) considered separately. There was no significant correlation between total GHQ score and Parenting Stress score for either group alone or the total sample.

DISCUSSION

Women with a history of contact child sexual abuse are significantly more anxious about the intimate parenting of their sons and their daughters than a control group. Their anxieties seem closely linked to their own experiences of abuse. One possible explanation is that when the mother is engaged in an activity, such as putting cream on her baby's nappy area, she identifies with the child who is being touched in an intimate place and, as the person who is doing the touching, can feel an uncomfortable identification with her own abuser.

> *Sometimes in the beginning I didn't clean her properly because I was afraid to. I didn't want to in case I might abuse her. I was really scared I might do something. I didn't like to look when I was putting cream on the nappy area, I know what could happen.*

On other occasions the child seems to be identified with the abuser leaving the

mother feeling she is once again the victim of an abusive encounter. This can also lead the mother to distance herself from her child.

When we are in the bath together and he is pointing, I feel embarrassed. I feel it's dirty him looking at me. I'm scared to play with him, in case... I think ,is this leading up to something?

When I was toilet training him and had to hold his "wee man" (penis) I felt squeamish, it reminded me of my dad.

Distant care or neglect from the sexually abused mother may leave her child more vulnerable to abuse (Mian, Marton, Lebaron & Birtwhistle, 1994). Two women in the CSA group mentioned that their own young daughters had recently been sexually abused. One of them said,

Even when they were babies I felt uncomfortable about kissing them, the thought (of the abuse) was always there, it spoiled it. I thought if I was too affectionate with them they would think it is o.k for others to kiss them so I backed off.

CSA mothers were also significantly more likely to report more overall parenting stress than the controls. This may have been due to a number of factors such as their relatively younger age, greater socio-economic deprivation, higher levels of depression or their disrupted upbringing which may have left them with fewer social supports. Low care received from mother, but not father, was associated with significantly higher levels of general parenting stress. As the CSA group reported low care from their mothers they may have internalised a working model of non-responsive mothering. This could add to their overall stress in being a mother. The comparison group, by contrast report a much more caring model of mother. Their average Mother Care score (24.79) was very similar to that obtained in a non-abused community sample (27.98) in New Zealand (Mullen., Martin., Anderson., Romans & Herbison, 1993).

Low care from father was specifically linked to anxieties about intimate parenting. It seems that sexual abuse between an adult male and a female child leads to specific anxieties when the child becomes a mother. If the women had recalled caring relationships with their mothers (or fathers) this might have provided them with a helpful alternate model of physical care. However, this was not the case, the sexually abused group's scores on the Parental Bonding Instrument are characterised by low care and higher control from both parents. This pattern, described by Parker et al (1997) as "affectionless constraint" has been viewed as an antecedent risk factor for many neurotic disorders (Parker, 1990). By contrast, the pattern showed by the comparison group of high care and lower control scores is what has been described as "optimal bonding" (Parker et al ,1979).

Specific abuse characteristics, with the exception of duration, were not linked with parenting anxieties. Intra-familial abuse did not lead to any greater anxieties than extra-familial abuse. It may be that because this was a clinical population a ceiling effect was in operation, that is, for a group whose average duration of abuse was 5 years, few within group differences might be expected.

The sexually abused group scored significantly higher on the total GHQ score and the GHQ Depression subscale. These scores, however, were not significantly linked to scores on the Intimate Aspects of Parenting Questionnaire. Their anxieties in this area, therefore cannot simply be attributed to mental health differences. Depression is, however, strongly associated with the total stress experienced in the parenting role (Parenting Stress Index) for both groups of parents.

There are limitations to the current study, notably the Intimate Aspects of Parenting Questionnaire which emphasises subjective feelings about parenting, and it is not known if these correlate with the mother's actual behaviour with the child. In this study the mother answered the questions with respect to her youngest child and although this ensured contemporary responses, if she had more than one child, information could be missed. Some mothers mentioned

what seemed to be a habituation effect, that is, they felt anxious about touching their first child , but not their second. The questionnaire also puts the mother in the role of active agent, for example, "kissing my child". This can miss the mothers who become anxious when their child is the active agent, for example the child running up to give them a kiss may elicit more anxiety. The current study also did not ask the mother about her feelings about her partner caring for the child. As can be seen in the qualitative data section (Appendix 2) some mothers said that they had no worries themselves about intimate care but they were very anxious if their partner got involved. This may be due to a difference in attributional style, some mothers being more likely to see themselves as potentially abusive and others making external attributions to their partners. The qualitative data, however, showed that some woman are concerned about their own behaviour and that of others.

The Parental Bonding Instrument was used in its original 1979 form which includes 5 items which use double negatives. Some individuals were unable to understand these and it was necessary for the researcher to complete this questionnaire with all the women. Gamsa (1987) modified the PBI to positively reword these items and this would have been a useful version to employ.

Conclusion

Women with a history of contact child sexual abuse report greater anxieties about intimate aspects of parenting than a clinical comparison group and also higher overall stress as parents. They recall their own parents as significant less caring and their fathers as significantly more controlling than the comparison group. As mothers they have few, if any, internal working models of appropriate, loving parent /child physical intimacy. Mothers uncomfortable about touching their infants can distance themselves from their child. In order to intervene in this negative cycle it would be helpful if parenting classes could focus on the normal range of adult/child physical intimacy. Education, and discussion with non-abused mothers would be useful here to normalise typical maternal feelings. Prospective mothers who have been sexually abused might be helped to initially desensitise themselves to the fear of physical intimacy with

their babies antenatally. It may also be helpful to allow expectant mothers to discuss their thoughts about becoming a mother and give them an opportunity to explore some of their unresolved feelings about the abuse. It is suggested that such a programme might reduce some anxiety and permit greater physical and emotional closeness between mother and child.

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Table 1: Mean scores on Intimate Aspects of Parenting Questionnaire by group

	CSA Group n=34		Comparison Group	
	mean	**s.d**	**mean**	**s.d**
Total score	35.29	18.36	23.14	3.18 [1]
Son score	17.55	8.07	11.83	2.04 [2]
Daughter score	20.09	12.28	11.35	1.35 [3]

1. Z= - 4.24, p<.001
2. Z= - 3.07, p<.002
3. Z= - 3.84, p<.001

Table 2: Group means for Mother Care, Mother Control, Father Care, Father Control scores on the Parental Bonding Instrument.

	Comparison group		CSA group n=34			
	mean	**s.d**	**mean**	**s.d**	**T-value**	**Sig**
Mother Care	24.79	10.43	12.03	9.31	- 5.13	p<0.001
Mother Control	14.45	7.90	16.76	10.26	.990	ns
Father Care	22.83	11.23	13.50	11.60	- 3.23	p<0.002
Father Control	11.83	7.74	19.50	11.54	3.04	p<0.003

Table 3: Correlations between Mother and Father scores from the Parental Bonding Instrument with scores on the Intimate Aspects of Parenting Questionnaire (daughter and son scores)

	Son CSA Group	Son Comparison Group	Son Total Sample	Daughter CSA Group	Daughter Comparison Group	Daughter Total Sample
Mother Care	-.064	-.343	-.343*	.348	-.236	-.124
Mother Control	-.263	-.196	-.131	-.299	-.059	-.066
Father Care	-.321	-.218	-.433**	-.566**	-.400	-.577**
Father Control	.024	-.083	.236	-.211	.234	.194

* Correlation is significant at the.05 level (2-tailed).

** Correlation is significant at the .01 level (2-tailed).

Table 4: Correlations between Mother and Father scores on the Parental Bonding Instrument and total Stress scores on Parenting Stress Index.

Parenting Stress Index			
	CSA Group n=34	**Comparison Group**	**Total sample**
Mother Care	-.268	-.283	-.372 **
Mother Control	.190	.130	.202
Father Care	-.019	-.290	-.228
Father Control	-.064	.357	.242

** Correlation is significant at the 0.01 level (2-tailed).

CHAPTER 4: SMALL SCALE SERVICE EVALUATION PROJECT

A gender based analysis of one year's referrals to a Clinical Psychology Department

This paper was written according to the guidelines of Health Bulletin. A copy of the notes for contributors and other relevant information can be found in Appendix 3.

A gender based analysis of one year's referrals to a Clinical Psychology Department

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A gender based analysis of one year's referrals to a Clinical Psychology Department

Abstract

The prevalence of some psychological and psychiatric problems differs by gender. Some differences may be due to varying presentations, help-seeking behaviour or selective biases in referrers. In other cases the pattern may reflect real dissimilarity in incidence of problems between the sexes. Increasingly there is a call for gender sensitive, or in some cases, gender specific health services. This study analyses one year's (1,282) referrals to a Clinical Psychology department by gender. The results are compared with community and clinical prevalence studies. The importance of an awareness of gender as a variable when designing and monitoring services is discussed.

Objective.

Gender is a variable of continuing and increasing interest to sociologists, epidemiologists, clinicians and health service managers [1]. Prevalence rates of mental illnesses in community surveys have been shown to differ by gender. Depression for example, is often reported as twice as common in women than in men [2]. A community survey in Great Britain showed that women were more likely to report a history of childhood sexual abuse than men and significantly more likely to report that they felt damaged by their abusive experiences[3]. Eating disorders such as anorexia nervosa and bulimia nervosa are more frequently detected in female patients in a primary care setting [4]. By contrast alcohol dependency [5] and dissocial personality disorder [6] are noted in community surveys to be more frequent in men. Finally some disorders such as obsessive compulsive disorders are equally represented in women and men [7]. While it is not possible to extrapolate directly from community to the referred population, it is of interest to know whether these gender differences are reflected in the pattern of referrals to a Clinical Psychology service.

It has been argued that clinical psychologists are not sufficiently aware of gender issues in their clinical practice [8]. For example, most services for adults sexually abused as children are based on a model of woman as patient, whereas such a service might not be acceptable to men [9]. Programmes for substance abusers

are now recognising that single gender groups are more useful for the treatment needs of women [10].

Recent publications have highlighted the particular mental health problems of women [1,11] and the government have proposed that local multi-agency mental health services should address the special needs of women [12]. Other writers have emphasised the difficulty men may have in expressing their need for mental health services due to social stereotypes [13]. It has also been suggested that men may present their distress differently, for example with alcohol problems or irritability [14]. Current thinking suggests that there is a need for gender sensitive services that are aware of the differing ways men and women may present for help with mental health problems, and their potential differing preferences and needs within mainstream mental health services. In short, a mental health service that is both practically and psychologically accessible to both men and women.

The current study analyses one year's (1996) referrals to a Clinical Psychology department by gender, looking at differences in overall referral rate, types of problems and age of patients. The objective was to get a clear picture of gender differences in referral pattern, to see whether this reflected the general population differences in gender rates for disorders, and to consider if this might have any implications for the organisation of the service.

The Clinical Psychology Service is only one of many mental health services provided in the catchment area. There are three locality Community Mental Health teams designed to meet the needs of adults aged between 16 and 64 suffering from severe and enduring mental health problems. A comparable service exists for older adults aged 65 and above. In addition there are a number of specialist services including Addictions, Psychotherapy and a Sexual Abuse and Assault Clinic. Clinical Psychology also contributes to the above services (with the exception of Psychotherapy). There are therefore many pathways to care and the pattern of referrals to Clinical Psychology need to be understood within the complete range of mental health services. In the year studied the specialist Psychology posts in the Old Age service and the

Addictions Service were vacant. It might be expected that referrals to these services might be reduced as a result.

Design

Basic demographic data, on new referrals to the Clinical Psychology Department were routinely recorded on a computerised data base (Microsoft Excel). The data studied was for referrals received during the calendar year 1996. The database, however, did not include information on gender, presenting problem nor age of the patients in years. It was therefore necessary to retrieve this data from a variety of other primary sources, including case notes, original referral letters and the written records held by the department on every referral received. In order to undertake a gender based analysis it was first necessary to add a column for Gender on the department's data base . An additional column was inserted and the 1282 cases scrutinised and an F or M entered in the column as appropriate. In 15 cases it was not possible to tell from the name alone the gender of the patient, these were mainly names from ethnic minorities that were unfamiliar to the researcher. It was therefore necessary to obtain the cases notes to establish the gender.

The written records made on each new referral by the psychologists in each geographical locality (locality books) were then scrutinised. Beside the majority of patients' names was a brief diagnostic label for example, 'bulimia', based on the description given in the referral letter. The primary presenting problem was identified and entered for each of the 1282 patients in a new column on the spread sheet. All three localities had at least two books for urgent and non-urgent referrals. One locality also had a third book which separately logged Community Mental Health Teams referrals. In addition, there was a separate book for referrals of those patients aged 65 and over. There was therefore a considerable amount of searching required to match the name and date of birth on the spread sheet with the same in the locality book before the problem could be entered. If the referrer mentioned more than one problem, the one that would take priority in the ICD10 as primary diagnosis was entered. In the case of missing data in the locality books the original referral letter was obtained from

the case notes and the diagnostic label entered. This was necessary in 154 cases.

In order to obtain the ages of the referred population an extra column was added on the spread sheet and a calculation performed which subtracted the date of birth from the date of referral. A filter was then applied to the data to consider the male and female population separately. Each year of age from 16 to 94 was then filtered to find the total referred of each age per year. A total of 63 types of problems had been entered (Appendix 3). Filters were applied to each one to find the total number of each problem referred by gender.

Setting

The setting is a Clinical Psychology Department serving the North of Glasgow. The North Sector of the Greater Glasgow Community and Mental Health Services NHS Trust has a total population of 178,104 [15]. Children up to the age of 15 account for 36,492, and the adult population aged between 16 and 64 is 116713. Those aged 65 and above are 24,899.

The sector covers a large geographical area from inner city districts to suburban towns and rural outskirts. The sector has some economically underprivileged areas with high levels of unemployment.

Results

A total of 1282 patients were referred to the Clinical Psychology Department, 761 women and 521 men. Women therefore made up 59% of total referrals (16 and over) and men 41%. In the total adult population for this geographical area (16-64) women accounted for 52% and men for 48% [15]. In the under 65 referred adult population women made up 60% of referrals and men 40%. In the 65 and over age group 53% of referrals were women and 47% men. In the same age band in the general population 62% are women and 38% men.

Age of referred patient by gender.

The average age of the women referred was 36 years (median=33, range 16-94) and the men 38 years (median 36, range 16-87). The age distribution of female and male referrals showed a similar pattern (Figure 1) with both genders skewed towards the younger end of the distribution. Men were more likely to be referred

than women in the 40-49 and the 60-69 age band, however, in the majority of age bands women accounted for more referrals than men. In the 70+ age band men and women were equally represented.

Status of referrals

The majority of both men and women were out-patients (97% and 99% respectively) the remainder being in-patients.

Source of referrals

The main source of all referrals for both women and men was from General Practitioners (77% and 74% respectively). The second most common source of referral was from the Psychiatric Services accounting for 18% of women and 21% of men. General Medicine referred 2% of both male and female referrals. Other sources of referral accounted for 3% of both male and female referrals.

Most frequent problems referred for men and women compared

The ten most frequently referred problems for women and men are shown in Figures 2 and 3 . In order to compare the relative frequency of the problems, the most commonly referred problems for each gender were expressed as a percentage of the total referred population for that gender (Figures 4 & 5). It was interesting to note that depression accounted for 15% (n=76) of male referrals and 17% (n=131) of female referrals . A similar percentage was also seen for generalised anxiety disorder, 9% (n=49) of male and 8% (n=62) of female referrals, and panic disorder 7% (n=40) of male referrals and 8% (n=61) of female . Referrals for men and women with mixed anxiety and depression were also very similar with 6% (n=32) and 7%(n=52) of the referred population respectively. Adjustment disorders accounted for 6% (n=43) of female referrals and 4% (n=21) of male referrals. Agoraphobia was the reason for referral in 4%(n=27) of female referrals and 2% (n=11) of male. Finally obsessive compulsive disorder accounted for 2% of both male(n=12) and female (n=14) referrals. Chi square tests showed no significant differences between the proportions of male and female referrals for any of the above problems (see Appendix 3).

Significant differences between problems referred for men and women

The significant differences in the proportions of men and women referred were seen in problems relating to sexual abuse or assault, eating disorders, post-traumatic stress disorder, anger control problems and alcohol problems (Figure 6) . While 8% (n=56) of female referrals related to sexual abuse, sexual assault and rape only 2%(n=9) of male referrals stated this as a reason for referral (Chi square = 20.38, df=1, $p<0.001$). Once again eating disorders (including anorexia, bulimia and unspecified eating problems) made up 6% (n=47) of female referrals and accounted for only 1% (n=3) of male referrals (Chi square = 25.88, df=1, $p<0.001$).

Looking at problems which were more common in men, post traumatic stress disorder was the reason for referral in 11% (n=58) of men and 6% (n=47) of women (Chi square = 10.10, df=1, $p<0.002$). Anger control problems accounted for 7% (n=40) of male and 3% (n=21) of female referrals (Chi square =16.50, df=1, $p<0.001$). Requests for organic assessments made up 7% (n=35) of male referrals and 3% (n=20) of female referrals (Chi square =12.60, df=1, $p<0.001$). Referrals for alcohol problems constituted 3% (n=15) of male referrals and 1% (n=9) of female (Chi square =4.84, df=1, $p<0.02$). Sexual dysfunction made up 4%(n=22) of male referrals and 2% (n=16) of female referrals (Chi square = 4.83, df=1, $p<0.02$).

Finally, women were significantly more likely 3% (n=21) to be referred for problems with relationships in their primary support group than men, 0.1% (n=5), (Chi square =5.04, df=1, $p<0.02$).

Conclusion

The gender based analysis of one year's referrals to the Clinical Psychology Department led to some interesting findings.

Compared with the total adult population for the area where 52% are women, in the referred population (aged 16-64) women were over represented at 60%. Conversely, men who make up 48% of the general population were under represented in the referred population at 40%.

It is difficult to reach conclusions about the 65 and over referred population as, during the year in question, the old age service was reduced due to a staff

vacancy. There is, however, a considerable drop in referrals in the 50 and over age groups. This may be due to a number of factors, the staff vacancy in the elderly service in the year of study or possibly a failure to detect psychological problems in the elderly at the primary care level. McGarry and Bhutani for example, found that whereas general practitioners could identify severe mental health problems in the elderly within their limited consultation time, they failed to recognise mild to moderate psychological distress [16]. A repeat audit is necessary to see if the referral rate increases with a fully staffed service, or if the low rate in referrals is due to problems in identification at a primary care level.

A comparison of referred problems between the genders showed that depression was the most frequent reason of referral for both men and women and there was no significant difference in the rate of referral. In some ways this was a suprising finding as women have a higher lifetime prevalence of unipolar major depression than men [17]. A recent study, however, has shown that after a first episode of major depression, the overall recurrence rate and the chronicity of depressive symptoms may not differ between the sexes [18]. It has been suggested that the lists of symptoms used to diagnose depression may also omit some that are most likely to accompany depressed mood in men such as irritability, recklessness or anger [19]. It is interesting to note that alcohol problems and anger control problems were more frequent reasons for men to be referred to the Psychology service than women. It is possible that in some of these referrals there may also have been co-morbid depression, but a follow-up study comparing reason for referral with the outcome of an initial assessment would be necessary to clarify this point.

Sexual abuse, sexual assault and rape taken together accounted for 8% of referrals of women, and 2% of men. Childhood sexual abuse alone is represented in 6% of female referrals and 2% of male referrals. A survey of a nationally representative sample of men and women in Great Britain showed that 12% of females and 8% of men reported that they had been sexually abused before the age of 16. The definition of abuse was a broad one and included non-contact abuse [3]. There is evidence, however, that men are more reluctant

to disclose a history of childhood sexual abuse than women [20]. It is likely that we need to consider how our referrers can be alerted to the likelihood of this problem in men and how our services can be made more user friendly for men.

Eating disorders have a marked female predominance. Surveys have suggested prevalence rates of 1% among girls at a private school [21]. Research in a Dutch primary care setting found that out of a sample of 101 detected patients who met the DSM III R criteria for anorexia nervosa, bulimia nervosa or both, 96 were female and 5 were male [4]. In the present study no cases of male anorexics were referred. Bulimia nervosa is also more frequent in girls and young women with the community prevalence thought to be up to about 1% in the most sophisticated samples [22].

In the current survey significantly more women were referred with eating problems or disorders than men, 6% of all female referrals were eating problems or disorders as against only 1% of male referrals. The gender differences are again in the expected direction given community and primary care prevalence studies.

Post-traumatic stress disorder was more frequently the reason for referral in men than in women with 11% of male referrals and 6% of female referrals. This may be because men are more likely to be in situations of potential risk for PTSD . A recent community study in Canada [23] found that certain types of traumatic events were significantly more common for women (rape and sexual molestation) and certain other classes were significantly more common for men (combat, witnessing severe injury or death, being threatened with a weapon , and being involved in a serious motor vehicle accident). They found that the one month period prevalence rate for full or partial PTSD was 6% in women and 1.5% in men, a ratio of 4:1. Once again, initial assessment of women referred to Clinical Psychology for problems relating to sexual assault, domestic violence or rape might lead to a re-allocation to the PTSD group and an inflation of the PTSD figures for women. In some cases it may be an arbitrary distinction whether these problems are referred to as PTSD or as problems arising from a past history of child sexual abuse or domestic violence.

Of those people referred to Clinical Psychology for alcohol problems 62% were men, this constituted 3% of all male referrals as against 1% of female referrals. Many more people with alcohol problems would have been referred directly to the Addictions Service so this is only a partial picture. It is interesting, however, to note that the 1% of the referred female population is comparable with figures obtained in a study in Clydebank [5]. A 10% probability sample of the population showed that 5% of adult males and 1.1% of adult females could be classified as problem drinkers, and 5.2% and 0.5% respectively could be labelled as alcoholic 25.

It can be seen that a relatively crude assessment of the gender differences in referrals to clinical psychology revealed many findings that are similar to community prevalence studies. There are, however, a number of limitations with the current study. The psychologist on assessing the patient may find that his/her diagnosis differs from the referrer. A follow-up study would be necessary to see if the referred problem remained the same after this point. A second problem is that in summarising the reason for referral in the Referrals book, the psychologist condenses the referrers letter into one or two words, thus introducing a potential source of bias. In addition with 154 cases there was no 'reason for referral' recorded and the author had to go back to the referral letter and make the entry. It is therefore difficult to know how valid the results are, but interesting to note their similarity with prevalence studies. Finally, it must be noted that there are also other adult mental health services in the area: three Community Mental Health Teams, a Psychotherapy service, and an Addictions service, so there are many pathways to care. The referrals to Clinical Psychology only represent a part of the referred population.

In conclusion, it is suggested that it is important to include gender as a variable when routinely recording intake information on clients referred. This recommendation has also been made in the development plan of the Women's Health Policy Working Group of the Greater Glasgow Health Board [26]. This would allow monitoring of the relative frequency of problems by gender and an awareness of under or over referral of particular groups. It could also aid in

service planning by predicting numbers of men and women likely to be referred with particular problems. There is some evidence that gender specific treatments are more suitable for some groups of patients [10]. It is, however, desirable that all mental health services are gender sensitive. This may mean including questions on quality monitoring questionnaires that evaluate the comfort of the patient with a clinician of the same or opposite gender. It may mean providing child care facilities to enable women to attend therapy groups. It could also be useful to consider the educational materials that are commonly used by psychologists such as handouts on coping with panic attacks and think about their particular relevance to men and women. Education may also be helpful to alert general practitioners to the differing ways women and men may present for help with psychological problems.

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Figure 1: Number of referrals by age and gender

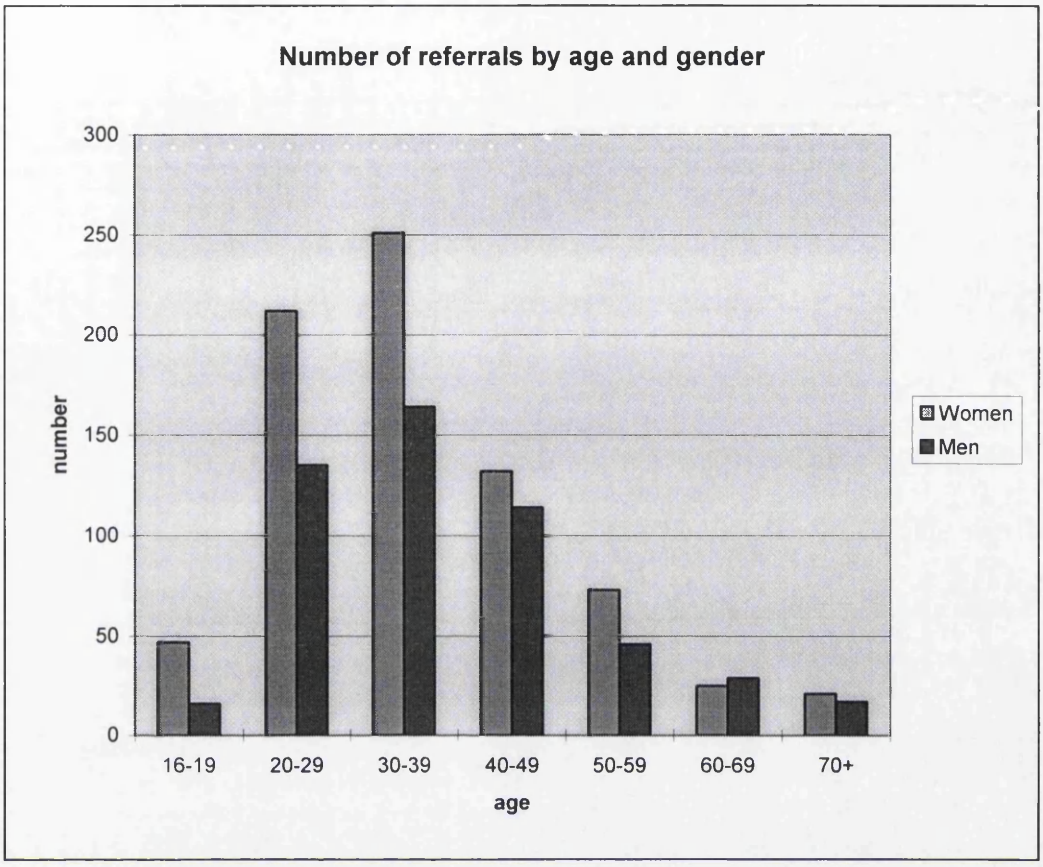


Figure 2: The ten most frequently referred problems for women

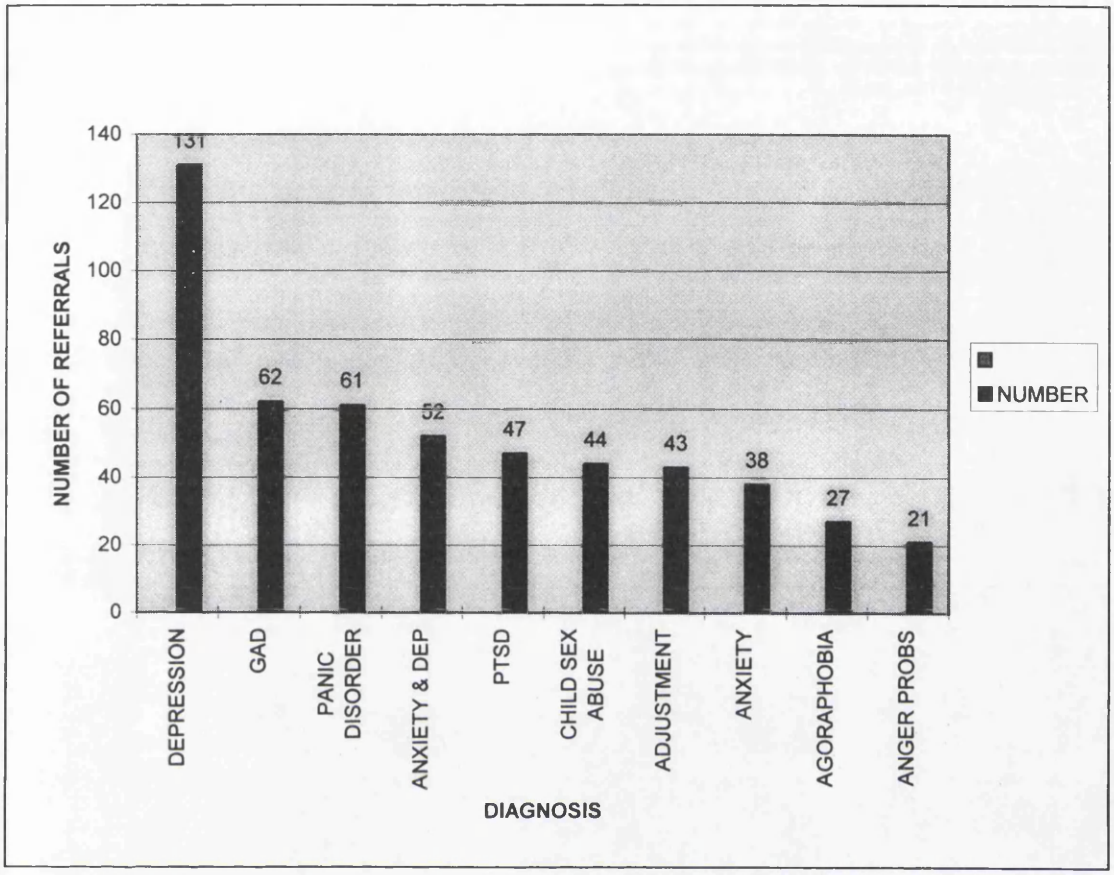
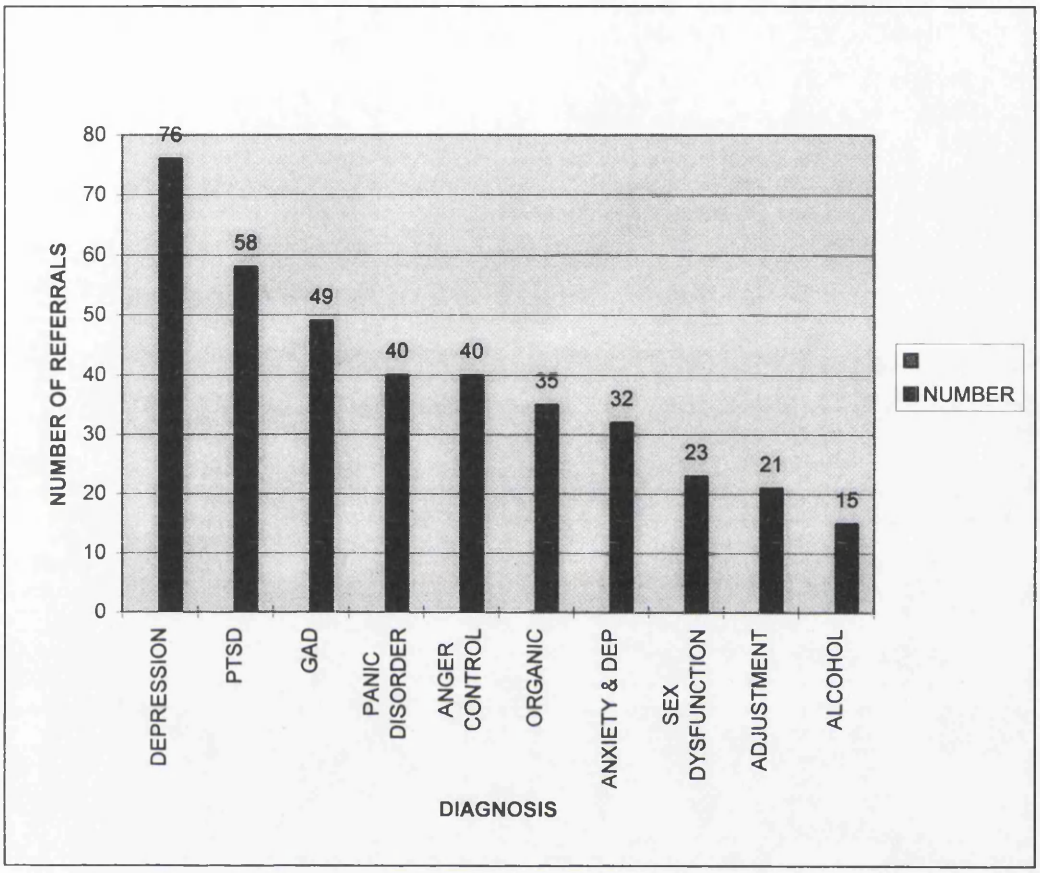


Figure 3: The ten most frequently referred problems for men



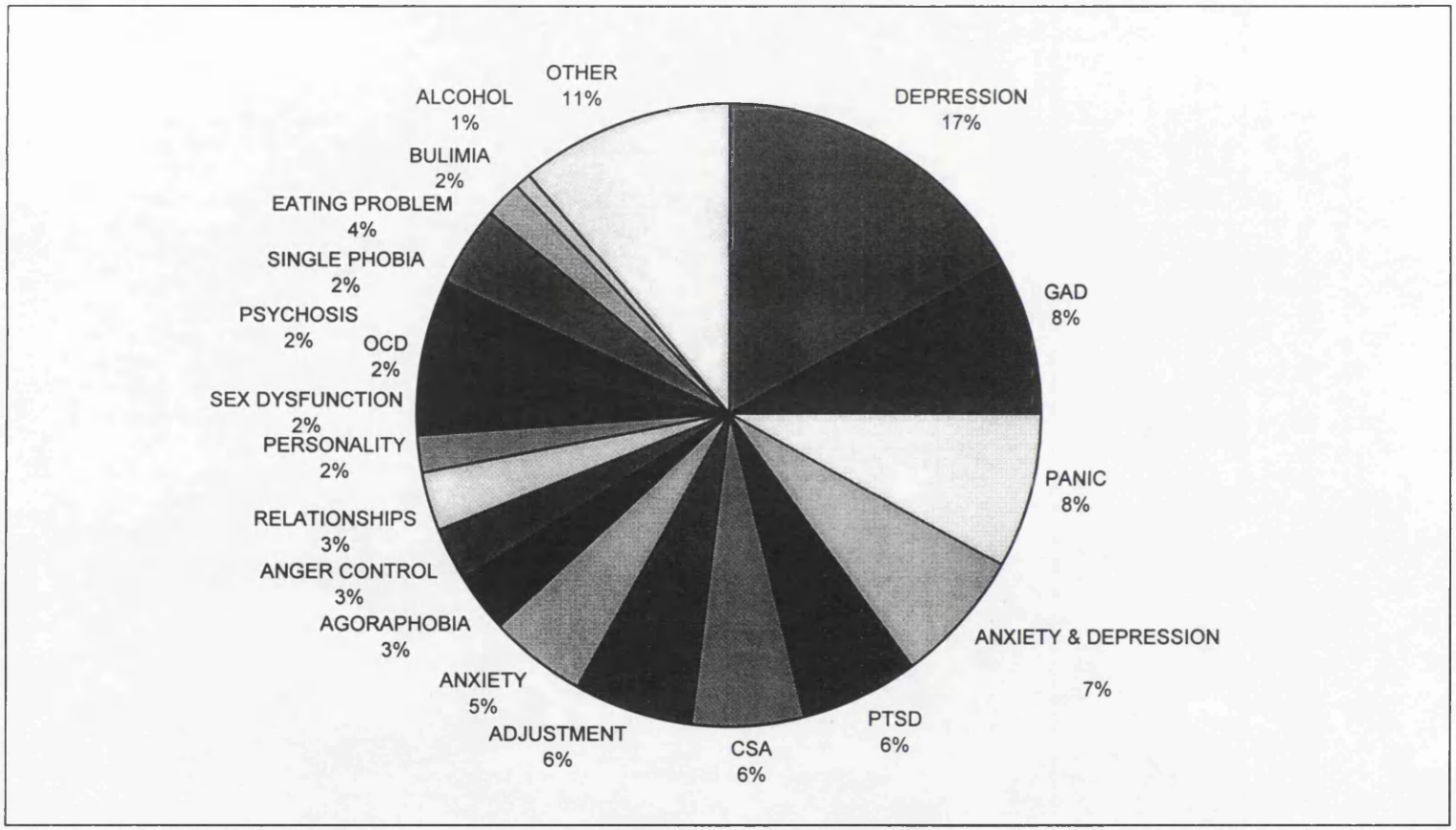


Figure 4: Most frequently referred problems for women as a percentage of the total referred female population

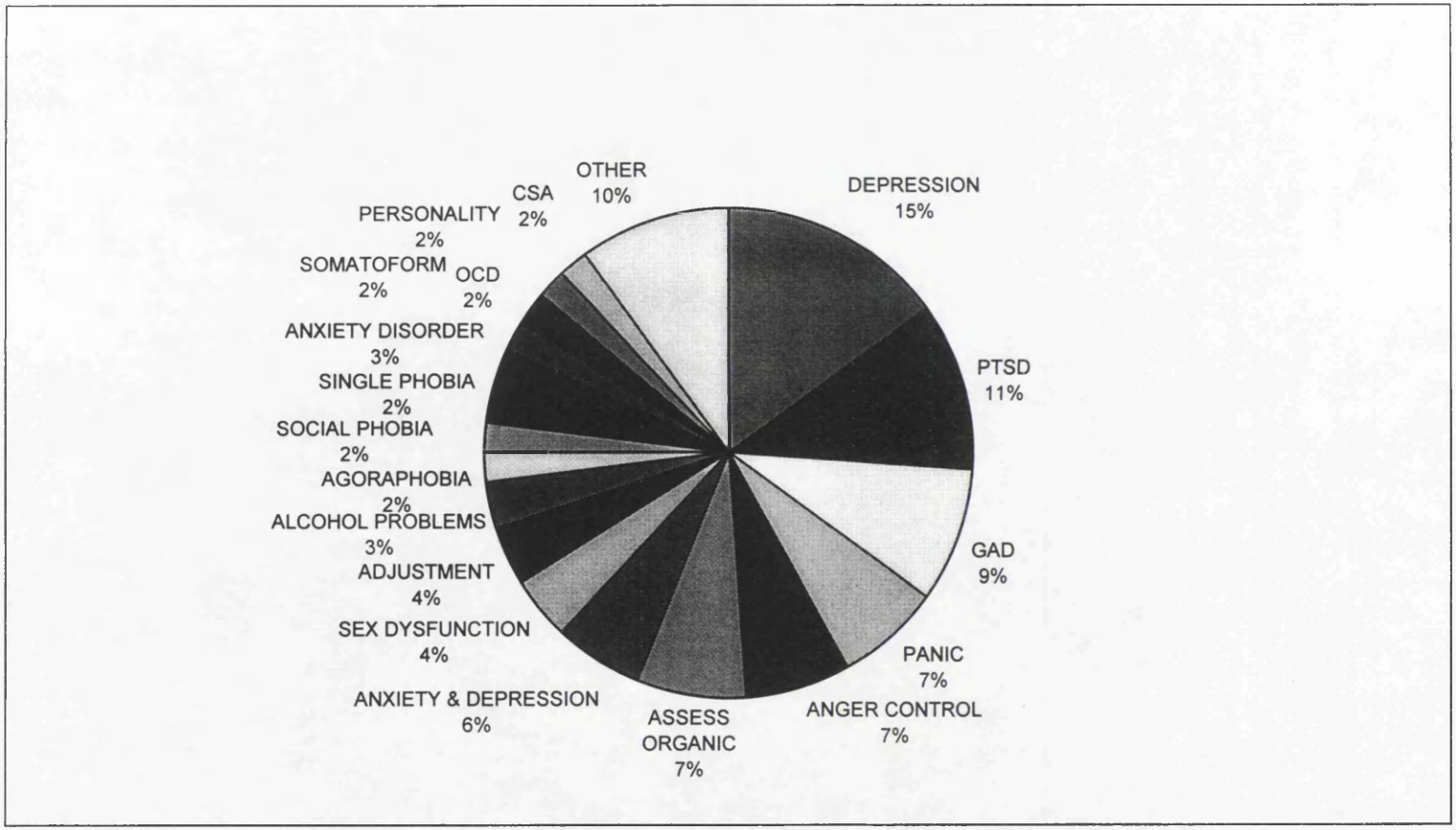


Figure 5: Most frequently referred problems for men as a percentage of the total population

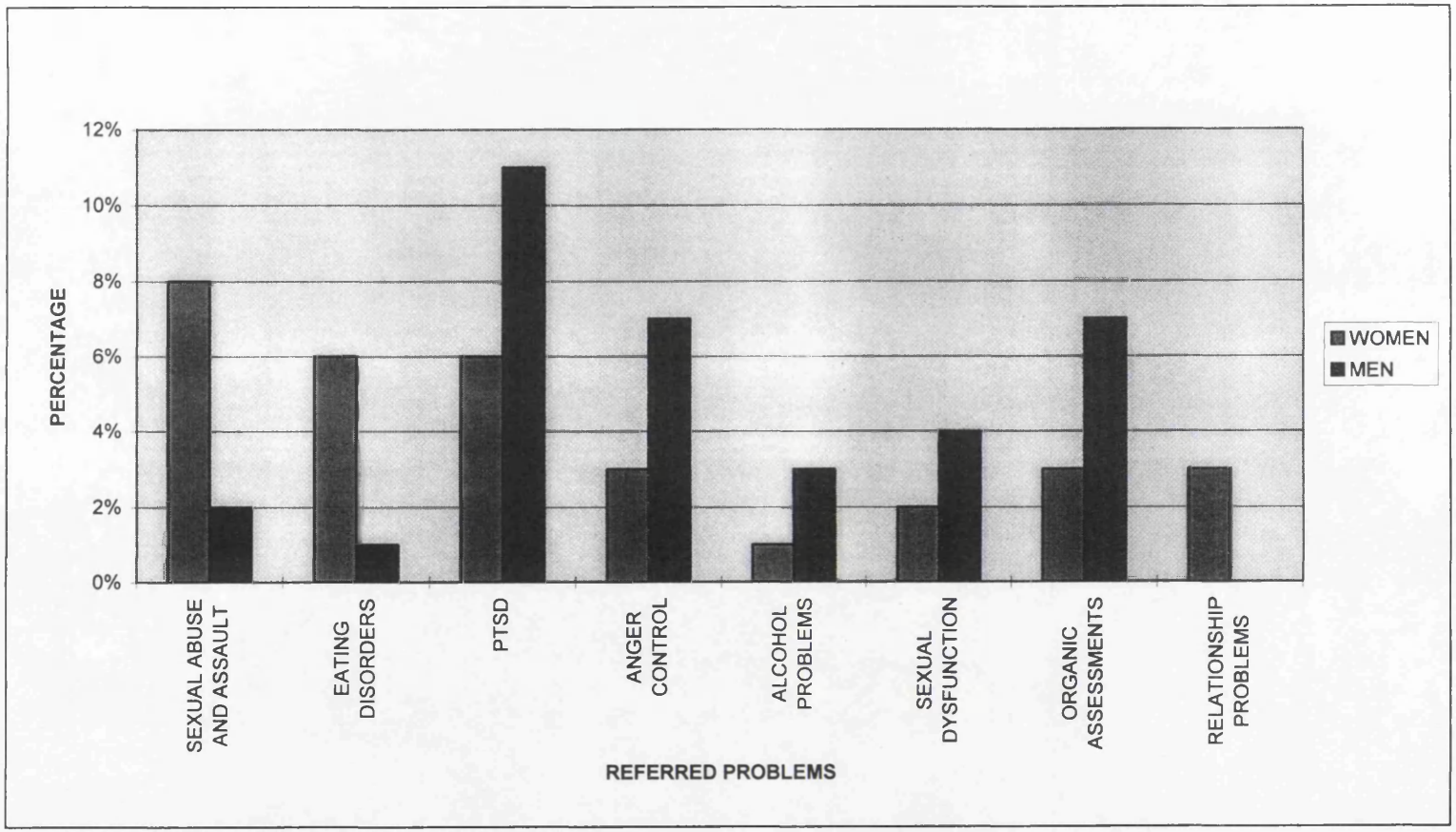


Figure 6: Percentage of problems by referred female and male populations.

CHAPTER 5: SINGLE CLINICAL CASE RESEARCH STUDY (1)

Is exposure therapy suitable for a patient with a psychotic disorder and post-traumatic stress disorder ?

This paper was written according to the guidelines of Behavioural and Cognitive Psychotherapy. A copy of instructions for authors can be found in Appendix 4.

Is exposure therapy suitable for a patient with a psychotic disorder and post-traumatic stress disorder ?

Abstract.

There is a high prevalence of a history of childhood sexual abuse and rape in women with psychotic disorder. Such exposure to trauma may lead to symptoms of post-traumatic stress disorder which can go undiagnosed. Traditional exposure-based treatment has not been used with this population. It has been thought that this may be too stressful and might precipitate a relapse of the psychotic illness. This paper details the exposure-based therapy of a 32 year old women with a psychotic illness and chronic post-traumatic stress disorder. The patient's symptoms diminished and there was no acute psychotic relapse, but it is concluded that the therapeutic procedure was too distressing. It is suggested that further modifications of therapy are necessary for this population.

In the interest of confidentiality the complete research case study has been bound separately.

CHAPTER 6: SINGLE CLINICAL CASE RESEARCH STUDY (2)

Mild head injury - major deficits:
Psychological assessment of the post-concussional syndrome

This paper was written according to the guidelines of the Journal of Psychosomatic Research. A copy of instructions for authors can be found in Appendix 5.

Mild head injury - major deficits:
Psychological assessment of the post-concussional syndrome

Abstract.

The complex range of symptoms that sometimes follows mild head injury has been termed the post-concussional syndrome. Experts are divided as to the relative importance of organic and psychogenic factors in the genesis and maintenance of the syndrome. This theoretical tension can cause problems for the psychologist assessing and managing such a patient. This case study illustrates this process in the assessment of a 47 year old woman two years after a mild head injury.

In the interest of confidentiality the complete research case study has been bound separately.

CHAPTER 7: SINGLE CLINICAL CASE RESEARCH STUDY (3)

Child sexual abuse, low self-esteem and compulsive sexual behaviour

This paper was written according to the guidelines of Behavioural and Cognitive Psychotherapy. A copy of instructions for authors can be found in Appendix 6.

Child sexual abuse, low self-esteem and compulsive sexual behaviour

Abstract.

Child sexual abuse can lead to low self-esteem which in turn may be associated with a range of self-destructive behaviours including compulsive sexual behaviour. It is hypothesised that prolonged involvement in an abusive relationship can lead to the formation of negative attributions about self which in turn generate a sense of low self-esteem associated with self-destructive behaviour. In order to change this behaviour it is suggested it is first necessary to focus on identifying and challenging sexual abuse related cognitions about self and others. This in time can lead to a raising of general self-esteem and an associated decrease in compulsive sexuality. A case study illustrates these points in the therapy of a 46 year old woman.

In the interest of confidentiality the complete research case study has been bound separately.

APPENDICES

APPENDIX 1: MAJOR RESEARCH PROJECT PAPER LITERATURE REVIEW

Author notes for Child Abuse Review 72

Child Abuse Review - Notes to Contributors

1.Five copies of manuscripts should be submitted to **Margaret A. Lynch, Child Abuse Review, Optimum Health Services, Newcomen Centre, Guys Hospital, St Thomas Street, London, SE1 9RT, Fax number: 0171 955 8759.** No responsibility is taken for damages or loss of papers submitted. (Papers will not normally be returned unless specifically requested). In order to enable the publisher to do everything to ensure prompt publication, the full postal address should be given for the author who will check the proofs, as well as telephone, telex and telefax numbers where possible.

2. Electronic Submission

When a paper is in its final form and has been **accepted** for publication, it would be helpful to the Publisher if you were to supply 2 disks containing the final version. These **MUST** be accompanied by an identical hard copy printout. The disks should be clearly labelled with the file name (e.g.:

CARMHL The first three letters represent the Wiley journal code and the next three letters the author's initials (if an author only has two initials the middle letter should be X)

the date, the author's name , the hardware and software package used.

The preferred medium is a 5.25 or 3.5 inch disk in Macintosh or MS-DOS. We are able to deal with most standard software packages currently available, although our preference is for WordPerfect, Word or TEX (and/or one of its derivatives).

The disks must be accompanied by a hard copy printout. If the disk and the paper copy differ, the paper copy will be treated as the definitive version.

3. Only *original* papers will be published . Submission of a paper will be taken to imply it is not being considered for publication elsewhere.
4. Papers must be in the English language. Authors whose mother tongue is not English are requested to have their manuscripts checked for linguistic correctness before submission.
5. Manuscripts should be typed double-spaced with a wide margin on one side of the sheet only, on A4 quarto paper. Pages should be numbered consecutively. Length should be between 2,000 and 3000 words (Case studies and Notes between 1,000 and 1,500). Manuscripts of over 3,500 words (not including References, Figures and Tables will be returned. All authors should indicate the length of their manuscript at the end.
6. The title page typed on a separate sheet, should contain: (a) titles of submission, (b) author(s), (c) affiliation(s), (d) running head and (e) mailing address.
7. Manuscripts should be accompanied by an abstract (max. 200 words and four key words) which should be a summary of the entire paper and not of the conclusions only.
8. The paper should be reasonably divided into sections, and, if necessary, sub-sections.
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10. Tables must be typed on separate sheets and have a (short) title and an arabic number. References to tables in the text and the indication of their approximate location is the same as for figures.
11. References should follow the convention indicated in the *Publication Manual of the American Psychological Association,* and the bibliographic information in the list of references should not be abbreviated. Multi-authored citatons should be given in full on their first appearance in the text, for example: Smith, Jones and Harris (1958). Subsequently the following form should be used : Smith *et al.* (1958). The following entries illustrate the appropriate style for references. *The complete reference list should be typed double-spaced on a separate sheet.* See examples:

    Bentovim, A., Elton, A., Hildebrand J., Tranter, A., and Vizard, E. (1988). *Child sexual abuse within the family: Assessment and Treatment.* Butterworth, London.

    Conte, J.R., and Schuerman, J.R. (1987). Factors associated with an increased impact of child sexual abuse: *Child Abuse and Neglect, 11,* 201-211.

    Garabarino, J. (1981). An ecological approach to child maltreatment.
    In H. Pelton (Ed.), *The social context of child abuse and neglect (pp17-44). New York: Human Sciences Press.*
12. Footnotes should be listed on a separate sheet. Footnotes to the text should be numbered consecutively throughout the text with superscript arabic numerals. Acknowledgements should be given in an unnumbered, asterisked footnote on the cover page. The use of footnotes should be kept to a minimum.
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APPENDIX 2: MAJOR RESEARCH PROJECT PAPER

Table A 2.1 Diagnoses of comparison group

Diagnosis	Frequency	Percentage of total
Depression	5	17.2
Agoraphobia	1	3.5
Social Phobias	2	6.9
Panic disorder	3	10.3
Generalised anxiety disorder	6	20.7
Mixed anxiety and depression	1	3.4
Obsessive-compulsive disorder	1	3.4
Post-traumatic stress disorder	3	10.3
Adjustment disorder	1	3.4
Somatoform disorder	1	3.4
Eating disorders	2	6.9
Insomnia	1	3.4
Sexual Dysfunction	1	3.4
Relationship Problems	1	3.4
Total	29	99.6

Table A 2.2 Description of disruption in childhood by group

	Child sexual abuse group n = 34 *		Comparison Group n =29	
	N	**%**	**N**	**%**
Maternal death	2	5.88	2	6.89
Paternal death	2	5.88	1	3.44
Parental separation/divorce	6	17.64	2	6.89
Reconstituted family	2	5.88	0	0
Institutional care	4	11.76	0	0

* There are 3 missing cases in CSA group.

Demographic data which showed non-significant differences

Table A 2.3 Number of children by group

	CSA group		Comparison Group	
	mean	**s.d**	**mean**	**s.d**
Total children	2.47	1.44	2.00	.89

t = 1.52, df=61, p, n.s

Table A 2.4 Age of youngest son and daughter by group

	CSA group		Comparison group	
	mean	**s.d**	**mean**	**s.d**
age of son	4.86	3.23	4.50	3.26
age of daughter	4.68	2.28	4.75	2.63

age of youngest son: t = .353, df=38, p,n.s

age of youngest daughter: t = -.090, df=40, p, n.s

Table A 2.5 Educational attainment by group

No certificates	
CSA group n = 30 *	**Comparison group n = 29**
56.7 %	34.5 %

Chi 2 = 2.92, df=1, p, n.s
* 4 missing cases

Table A 2.6 Number of therapy sessions at point of research

	CSA group n = 31*		Comparison group n = 28*	
	mean	**s.d**	**mean**	**s.d**
number of sessions	9.29	12.06	5.11	4.25

Z= -.534, p, n.s

* 4 missing cases from CSA group and 1 from comparison group

Table A 2.7 Description of the index abuser

Abuser	Frequency	Percent	Cumulative percent
Father	11	32.4	32.4
Step-father	2	5.9	38.2
Foster-father	1	2.9	41.2
Mother's partner	1	2.9	44.1
Uncle	4	11.8	55.9
Aunt	1	2.9	58.8
Male cousin	1	2.9	61.8
Grandfather	1	2.9	64.7
Step-grandfather	1	2.9	67.6
Brother	1	2.9	70.6
Step-brother	1	2.9	73.5
Male acquaintance	1	2.9	76.5
Male neighbour	2	5.9	82.4
Male lodger	1	2.9	85.3
Male family friend	4	11.8	97.1
Stranger	1	2.9	100.0
Total	34	100.0	

Table A 2.8 Details of other abuse history in CSA group

Index Abuser	Other Abuser
Family friend	Older children (one incident)
Family friend	Unspecified
Father	Stranger (one incident)
Foster father	Father
Tenant	Unspecified
Step-grandfather	Father
Uncle	Unspecified
Father	Priest (one incident)
Father	Older boy (rape)
Father	Family friend
Father	Neighbour
Grandfather	Uncle
Aunt	Male acquaintance
Uncle	Unspecified
Father	Uncle

INTIMATE ASPECTS OF PARENTING QUESTIONNAIRE

PARENTS QUESTIONNAIRE

Could you please tell me how old your children are at the moment.

I have..... girl(s) aged ....

I have ..... boy(s) aged ....

Could you please fill in this questionnaire thinking only about your youngest son and daughter.

Many parents at some time or another can feel uncomfortable about some aspects of the physical care of their child.

Have you ever felt uncomfortable about / felt uneasy about / or avoided any of the following?

SON

Please circle the number that best describes your feelings

1. Changing your son's nappies/ taking your son to the toilet

NEVER 1 2 3 4 5 **ALWAYS**

2. Putting cream on the nappy area

NEVER 1 2 3 4 5 **ALWAYS**

3. Bathing your son

NEVER 1 2 3 4 5 **ALWAYS**

4. Dressing your son

NEVER 1 2 3 4 5 **ALWAYS**

5. Undressing your son

NEVER 1 2 3 4 5 **ALWAYS**

6. Cuddling your son

NEVER 1 2 3 4 5 **ALWAYS**

7. Kissing your son

NEVER 1 2 3 4 5 **ALWAYS**

8. Touching your son

NEVER 1 2 3 4 5 **ALWAYS**

9. Showing your son affection

NEVER 1 2 3 4 5 **ALWAYS**

10. Having your son sit on your lap

NEVER 1 2 3 4 5 **ALWAYS**

11. Letting your son get into bed with you.

NEVER 1 2 3 4 5 **ALWAYS**

Is there anything else that you would like to comment on?

DAUGHTER

Most parents at some time or another can feel uncomfortable about some aspects of the physical care of their child.

Have you ever felt uncomfortable about / felt uneasy about / or avoided any of the following?

Please circle the number that best describes your feelings

1. Changing your daughter's nappies/taking your daughter to the toilet

NEVER 1 2 3 4 5 **ALWAYS**

2. Putting cream on the nappy area

NEVER 1 2 3 4 5 **ALWAYS**

3. Bathing your daughter

NEVER 1 2 3 4 5 **ALWAYS**

4. Dressing your daughter

NEVER 1 2 3 4 5 **ALWAYS**

5. Undressing your daughter

NEVER 1 2 3 4 5 **ALWAYS**

6. Cuddling your daughter

NEVER 1 2 3 4 5 **ALWAYS**

7. Kissing your daughter

NEVER 1 2 3 4 5 **ALWAYS**

8. Touching your daughter

NEVER 1 2 3 4 5 **ALWAYS**

9. Showing your daughter affection

NEVER 1 2 3 4 5 **ALWAYS**

10. Having your daughter sit on your lap

NEVER 1 2 3 4 5 **ALWAYS**

11. Letting your daughter get into bed with you

NEVER 1 2 3 4 5 **ALWAYS**

Is there anything else that you would like to comment on?

Table A 2. 9 Themes of additional qualitative data obtained from Intimate Aspects of Parenting Questionnaire

Additional comments made on Intimate Aspects of Parenting Questionnaire				
	n = 25		n = 10	
	CSA GROUP		COMPARISON GROUP	
THEMES	n	%	n	%
1.Concern that own touch is inappropriate	6	24	2	20
2. Concern about partner or others harming child	8	32	0	0
3. Worries about what others might think.	6	24	1	10
4. Anxieties about the child's behaviour	3	12	1	10
5.Worries about their other children	7	28	0	0
6. Depressed	0	0	2	20
7. Simple anxiety	0	0	1	10
8. Bad habit	0	0	1	10
9. No problems	0	0	3	30
10. Unclassified	3	16	0	0

Qualitative data obtained from Intimate Aspects of Parenting Questionnaire

Mothers with a history of child sexual abuse.

1. Concern that own touch is inappropriate

Subject 4. I feel uncomfortable touching, putting cream on her flower. I feel it's wrong even though I know it's my job. When I dry her after her shower I don't look at her. (Index girl aged 4).

Subject 6. I can't put cream on my daughter's body because that is what my father did to me. (Index girl, aged 5)

Subject 9. Sometimes I think in the beginning I didn't clean her properly because I was afraid to, I didn't want to in case I might abuse her. I was really scared I might do something. I don't like to look (putting cream on the nappy area), I know what could happen. (Index girl aged 2).

Subject 10. When I'm changing his nappies or putting cream on I get a funny feeling , like it's not quite right. (Index boy 17 months).

Subject 24. I was nervous about putting cream on the nappy area. I was scared that folk might think I was overdoing it or getting pleasure from it. I was worried that I might abuse her. (Index girl 7). Also coded under number 3).

Subject 27. I felt uncomfortable about putting cream on the nappy area . I got touched there and it made me feel uncomfortable. I didn't want her to feel uncomfortable. Bathing them was easier when they were babies. I knew I had to do it. The older they are the more difficult it becomes. I don't want them to have any problems. Am I going to do anything that will make them feel uncomfortable? Even when they were babies I felt uncomfortable about kissing them. The thought (of the abuse) was always there, it spoiled it. (Index girl aged 7).

2. Worries about partner or others harming their child

Subject 2. I worry about other people harming the kids, even my husband although I know he's o.k. (Index child girl aged 4).

Subject 11. I have no worries about my self, but I worry about my partner being in the bath with her. (Index girl aged 8 months).

Subject 21. I feel uncomfortable about my son having close physical contact with males. If he is sitting on my partner knee or is kissing him I feel paranoid. I won't change my daughter's nappies if men are in the room . I'm scared that they might look at her. (Index girl aged 3months).

Subject 22. I'm very suspicious of others, don't let the boys stay over with friends. If my husband goes up to their room and is longer than I expect, I suspect something. (Index boy aged 9)

Subject 12. I'm nervous and overprotective when my child is with my partner. (index girl aged 6)

Subject 25. Nobody ever changed her nappy but me, I'm worried about everyone else. (Index girl aged 8).

Subject 15. Although I have said I don't have a problem doing any of these things with my daughter if I was answering about a male with the above questions I would have answered "always" to every question. (Index girl aged 4).

Subject 17. If she touches herself I worry that she might have been abused. (Index girl aged 5).

3. Worries about what other people might think

Subject 4. If I took too long changing her nappies I thought people might think I'm abusing her or touching her. I've heard people say that people who are abused can abuse. Even alone I did not feel comfortable about changing her nappies. (Also coded under 1).

Subject 12. I'm nervous about letting my daughter get into bed with me, people might think that I'm abusing her. (Index girl aged 6).

Subject 20. I'm scared to pat his bum in case someone walks in and thinks...especially as my husband knows about my abuse (Index boy aged 2).

Subject 23. I'm uncomfortable changing his nappies or putting cream on when other mothers or my boyfriend is there. I feel he might think I'm touching him, doing something wrong. (Index boy aged 4 months).

Subject 24. I was nervous about putting cream on the nappy area. Scared that folk might think I was overdoing it or getting pleasure from it. (Index girl aged 7).

Subject 25. If she had redness down below, I was scared she might talk at school and people might think I was doing something wrong. (Index girl aged 8)

4. Anxieties about the child's behaviour

Subject 20. When we are in the bath together and he is pointing, I feel embarrassed. I feel it's dirty him looking at me. I'm scared to play with him, in case...I think, is this leading up to something? When he comes into bed to sleep sometime his foot goes in between my legs, I feel that shouldn't happen. I don't want him to think everything is all right. I don't want him to get the wrong idea. (Index boy aged 2).

Subject 24. I feel uncomfortable if my daughter tries to kiss me. She'll say, "I'll kiss you like they do on T.V", and try and kiss me with her mouth open". (Index girl aged 7).

Subject 25. When I was toilet training him and had to hold his wee man (penis) I felt squeamish, it reminded me of my dad. If my son stood up (to urinate) it was difficult, not if he was sitting down. I always tried to show him I was not afraid so he wouldn't be. (Index boy aged 6).

4. Worries about non-index children

Many of these anxieties could be subsumed under the above headings but concerns about non-index children were not the direct focus of the research.

Subject 22. When I had my oldest boy, when he was 3 or 4 I thought, what if I do something to him? The thought went away. (Non- index boy aged 14).

Subject 8. I had many more anxieties about my first son. When I changed his nappies I was always supervised. I felt someone could say, "that's abuse". (Non-index boy aged 10)

Subject 10. With my first son I completely avoided changing nappies, or putting cream on. (Non-index son aged 5).

Subject 14. When I felt the sensation of milk coming down it reminded me about the abuse, I felt dirty. I kept her at a distance. I didn't want to cuddle her. When I breast fed my second daughter I had read in books that the sensation was normal. (Non-index girl aged 10).

Subject 19. When my oldest child was 3 I felt he was evil and possessed, touching him scared me. It's getting worse as he gets older, I feel he is watching me. It gives me the creeps, makes me feel dirty. (Non-index son aged 12).

Subject 24. When my son was small I didn't cuddle him for 6 months. I worried if people saw me they might take him away from me. I couldn't pull his foreskin back to clean under it, it felt too personal, it took me 6 months to get used to it. (Non-index boy 15).

Subject 30. With my daughter I always felt uncomfortable changing her nappies if someone was in the house. I felt uncomfortable if males were looking at her. (non-index girl aged 12)..

Unclassified.

Subject 17. Now that she is 5 I feel uneasy about having my daughter sit on my lap, that is how my abuse started. (Index girl aged 5).

Subject 28. Didn't like the idea of touching her there (nappy area), it felt uncomfortable. With both children I don't like physical closeness, makes me feel closed in and anxious. (Index girl aged 3, index boy aged 1).

Subject 29. I feel uncomfortable about putting cream on the nappy area. (Index boy aged 6).

Subject 7. As my son gets older I feel uneasy kissing him or cuddling him, although I still love him it gives me this uneasy feeling. (Index boy aged10).

Comparison group.

1. Concern that own touch is inappropriate

Subject 3. I'm just aware with the media. I hope he doesn't grow up and think I've been groping him. I hope she doesn't think later on I've been fumbling with her. (Index boy aged 4, index girl aged 6).

Subject 6. When I was changing their nappies I was scared to touch them too much in case they would feel things they shouldn't feel. When my wee boy got an erection I thought why has he got it this time? Have I touched him too much? I want them to be clean down below. (Index boy aged 3, index girl aged 5).

(This subject had no history of child sexual abuse, but had been raped as an older teenager).

2. Worries about what other people might think

Subject 25. When I am changing his nappies in a public place I'm aware people might think I'm a bit abrupt. (Index boy 10 months).

3. Anxieties about the child's behaviour

Subject 25. When I kiss and cuddle him and he's distressed and pushing me away I am aware of his body language. If I am feeling low I take it personally. (Index boy 10 months).

4. Depressed

Subject 5. Sometimes I can't be bothered bathing her when I'm too tired. (Index girl 11 months).

Subject 23. I have no problems cuddling her now, but when she was a baby I did, I was a bit depressed then. (Index girl aged 6).

5. Simple anxiety

Subject 15. When I'm bathing her I'm scared she might drown. I think it's because I lost a baby. (Index girl aged 5 months).

6. Bad habit

Subject 14. I don't let my son get into bed with me, I think it is a bad habit. (Index boy aged 3).

7. No problems

Subject 7. I was never hugged as a child but I can hug my children. (Index girl aged 6, index boy aged 9).

Subject 8. God help anyone who answers aye to these, they must be weirdoes (Index boy aged 5).

Subject 16. I don't have any problems (with touch), we're a very close family. (index boy aged 5).

C.S.A Questionnaire

This questionnaire asks you a few questions about your history of sexual abuse. It asks you a little about how you felt as a child or teenager, and also how you feel now.

1. How many therapy sessions have you had so far ? .....

2. At what age were you first sexually abused ? .....

3. What was the relationship of the person to you? .....
(If he/she was not a relation please state who it was, e.g baby-sitter, next door neighbour, etc.)

4. How long did the sexual abuse go on for ? .....
(i.e. number of weeks, months or years)

5. How often did the sexual abuse occur ? .....
(i.e. number of times per week, month or year)

People who have been abused may remember having a mixture of feelings at the time. The next few questions ask you about your feelings as a child or teenager. Please circle the number which best describes your feelings at the time.

6. How would you describe your feelings towards that person then?

Very positive 1 2 3 4 5 very negative

7. What was your physical response during the abuse?

a) Not painful 1 2 3 4 5 very painful

b) Not pleasurable 1 2 3 4 5 very pleasurable

8. How much effect do you think the sexual abuse has had on your life?

No effect 1 2 3 4 5 a large effect

9.Were you sexually abused by anyone else as a child or teenager? YES/NO

Patient Information Sheet (for CSA group)

You have been asked to take part in a research project. The statement below explains in everyday language what will happen if you agree to take part.
You should not take part if you do not wish to do so . If you decide not to take part, your decision will not affect the treatment that you are already receiving from the clinic.

What is the study about?
Many things may affect how we feel about being mothers. This may be our own family background, or our mental health. Difficult or upsetting things that happened to us in our own childhood may also affect how we feel about being a mother. I am trying to learn more about what kinds of things affect how a person feels about being a mother.

Why have I been asked to take part?
I am asking a lot of women from a number of different clinics to take part to get as many different points of view as possible.

What does the study involve?
If you agree to take part in the study, your usual treatment will not change in any way. However, you will be asked to fill in 4 or 5 short questionnaires. This should not take you longer than one hour. You can fill them in the privacy of a room at the clinic and then give them back to your therapist or to the researcher. Your names will not be on any questionnaire so the information is confidential.

Who will know that I am taking part in the study?
Your therapist and your Consultant will know. We will also let your G.P know you are taking part, although the results of your questionnaire will not be sent to him/her.

What happens to the information collected about me during the study?
All the information collected during the study will be as confidential as your medical records. Your name will not be on any questionnaire and they will be kept in a securely locked place.

What if I have any questions?
If you have any questions you would like to ask , please do not hesitate to ask your therapist or Ms A Douglas, Consultant Psychologist who is the researcher. Thank you for taking the time to read this information sheet. If you would like to be involved please sign the consent form and give it back to your therapist.
Anne R Douglas Consultant Clinical Psychologist, Stobhill General Hospital.

Patient Information Sheet (for comparison group)

As on previous page, and then this section.

Yes, I am interested in taking part in the study

Thank you for expressing your interest. Are you able to answer YES to the following statement?
I am a mother
I have a child aged 10 or younger
I was not sexually abused as a child.

If you can answer yes to the above statement, please sign the consent form and give it back to your therapist.
If you are unable to answer yes to the above questions and feel you may like help for worries or problems about past sexual abuse, please sign below and this will be arranged for you by your own therapist.

Signed..... Date.....

Thank you for your time

Anne R Douglas.
Consultant Clinical Psychologist. Stobhill General Hospital

CHILD ABUSE & NEGLECT

Instructions for Authors

AIMS AND SCOPE: *Child Abuse & Neglect, The International Journal*, provides an international , multi-disciplinary forum on all aspects of child abuse and neglect, with special emphasis on prevention and treatment. The scope extends further to all those aspects of life which either favour or hinder child development. While contributions will primarily be from the fields of psychology, psychiatry, social work, medicine, nursing, law enforcement, legislature, education, and anthropology, the Journal aims to encourage the concerned lay individual and child oriented advocate organisations to contribute.

TYPES OF CONTRIBUTIONS:

1. Original, theoretical and empirical contributions. The main text of the manuscript should be 16-20 pages, typed double spaced: should include a clear introductory statement of purpose; a historical review when desirable; a description of method and scope of observations; a full presentation of the results, a brief comment or discussion on the significance of the findings, and any correlation with those of others in the literature; a section on speculation and relevance or implications; and a summary in brief which may include conclusions.
2. Brief Communications. Shorter articles of 5 to 7 pages (abstracts and/or references are optional).
3. Articles on clinical practice. Case studies (but not just a single case), commentaries, process and program descriptions, clinical audit and outcome studies, original clinical practice ideas for debate and argument.
4. Invited reviews. Plans for proposed reviews are invited to be submitted to the editor in draft outline in the first instance. The editor will commission reviews on specific topics.
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6. announcements or notices regarding events of national or international multidisciplinary interests are subject to editorial approval and must be submitted at least 8 months before you wish the notice to appear.

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FORMAT OF MANUSCRIPT: Each manuscript should contain the following information in correct order:

1. **Title page:** The title page should list (1) title of article; (2) each authors' name and affiliation at the time the work was conducted; (3) corresponding author's address, telephone, and fax number; (4) a concise running title; (5) at least three and no more than 5 key words for indexing purposes; and (6) an unnumbered footnote giving address for reprint requests and any acknowledgements.
2. **Abstract:** All articles (except Brief Communication; see Types of Contributions section) must have a synopsis-type abstract not to exceed 250 words in length covering the main factual points and statement of the problem, method, results and conclusions. Example: (from Welch, S.L., & Fairburn, C.G. (1996). Childhood sexual and physical abuse as risk factors for the development of bulimia nervosa: A community-based case control study *Child Abuse & Neglect,* **20,** 663-642).

Abstract

Objective: There were two aims : First, to determine whether sexual or physical abuse in childhood or adolescence increases the risk of developing bulimia nervosa, and second, to see whether any increase in risk is specific to bulimia nervosa rather than being common to psychiatric disorders in general.

Method: A case control design with individual matching was used . There were two related case control comparisons based on community samples. One hundred and two young adult women with bulimia nervosa were compared with 204 control subjects without an eating disorder, and with 102 control subjects with other psychiatric conditions, all recruited from the same community source. An investigator-based interview was used to assess sexual and physical abuse.

Results: Sexual abuse involving physical contact was reported by 35% of the cases of bulimia nervosa. It was more common among this group than the normal controls. Physical abuse was also reported by a minority of the cases of bulimia nervosa, and was more common among this group than the normal controls. However, there were no significant differences between the cases of bulimia nervosa and the controls with general psychiatric disorder, except in the category of repeated severe sexual abuse: This was more common among the cases of bulimia nervosa although present only in small numbers within these two groups.

Conclusions: The findings indicate that sexual abuse and physical abuse are both risk factors for the development of bulimia nervosa. However, they are not present in the majority of cases. This indicates that other risk factors must operate in these cases. Sexual and physical abuse do not appear to be risk factors specific to bulimia nervosa; rather they seem to be risk factors for psychiatric disorders in general in young, adult women.

3. **Main text:** Should be clearly organised , with headings and subheadings as needed (3) weights of headings maximum). The journal does not utilise footnotes - these should be incorporated into the text itself if needed.
4. **References:** Citation of references should follow APA (American Psychological Association) style. References cited in the text should read thus: (Brown, Jones, & Krugman, 1995; Brown, 1995). The letters a, b, c, etc., should distinguish citations of different works by the same author(s) in the same year. (Brown, Jones, & Krugman, 1955a, 1995b). All references cited in the text should appear in an alphabetical list at the end of the text and should adhere to APA style (please refer to the *Publication manual of the American Psychological Association* (4^{th} ed.), 1994 for specifics.
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APPENDIX 3: SMALL SCALE SERVICE EVALUATION PROJECT

Table A3.1 Number of referrals by gender and diagnosis

	Women	Men
Organic Mental Disorders	20	35
Alcohol Problems	9	15
Drug Problems	3	4
Schizophrenia	1	5
Schizo-affective	1	0
Unspecified Psychosis	10	3
Bipolar Affective Disorder	3	1
Depression	131	76
Mood swings	2	0
Agoraphobia	27	11
Social Phobia	8	11
Specific phobias	15	10
Panic Disorder	61	40
Generalised Anxiety Disorder	62	49
Mixed Anxiety and Depression	52	32
Anxiety Disorder Unspecified	38	14
Stress Unspecified	3	2
Obsessive-Compulsive Disorder	14	12
Acute Stress Reaction	1	0
Post-traumatic Stress Disorder	47	58
Adjustment Disorders	43	20

Table A3.1 Number of referrals by gender and diagnosis

	Women	Men
Dissociative Conversion	0	1
Somatization Disorder	1	1
Hypochondriacal Disorder	2	3
Health Anxieties	1	3
Illness behaviour	0	1
Neurosis Unspecified	0	1
Anorexia	3	0
Bulimia	15	2
Eating problem	14	0
Eating Disorder Unspecified	15	1
Sleep Problem	1	6
Sexual Dysfunction	16	23
Personality Disorder	8	5
Pathological Jealousy	4	2
Compulsive Gambling	0	1
Compulsive Spending	1	0
Trichotillomania	1	0
Habit Disorder	0	1
Anger Control Problems	21	40
Transsexualism	1	0
Gender Identity Disorder	1	1
Disorder of Sexual Preference	0	2
Specific Development Disorder	1	0
Asperger's Syndrome	1	0
Conduct Disorder	0	3

Table A3.1 Number of referrals by gender and diagnosis

	Women	Men
Intentional Self-harm	1	1
Problems related to primary support group	21	5
Job Problems	0	1
General medicine	4	2
Coronary Heart Disease	0	1
Post-viral fatigue	3	1
Pain	1	0
Low self-esteem	9	0
Low motivation	0	1
Social Skills Problem	2	2
Negative Life events in Childhood		
Alleged sexual abuse	44	9
Alleged physical abuse	1	0
Sexual Assault	10	0
Rape	2	0
Domestic Violence	2	0
Epilepsy	1	0
Head injury	0	1
Incontinence	1	0
No Psychiatric diagnosis	0	2
Missing Diagnosis	1	0
Total for 3 parts of Table A3.1	**761**	**521**

Table A3.2 Diagnosis by gender (non-significant results)

Diagnosis	Chi-square	df	p
Depression	1.57	1	n.s
Generalised Anxiety Disorder	0.145	1	n.s
Panic disorder	0.049	1	n.s
Anxiety & Depression	0.241	1	n.s
Adjustment Disorders	1.711	1	n.s
Agoraphobia	2.219	1	n.s
Obsessive-compulsive disorder	0.334	1	n.s

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