Published in final edited form as:

J Child Sex Abus. 2015 ; 24(5): 506–525. doi:10.1080/10538712.2015.1042186.

Experiences of Mothers Who Are Child Sexual Abuse Survivors: A Qualitative Exploration

Courtenay E. Cavanaugh¹, Bianca Harper², Catherine C. Classen³, Oxana Palesh⁴, Cheryl Koopman⁴, and David Spiegel⁴

¹Department of Psychology, Rutgers University

²University of Southern California

³Department of Psychiatry, University of Toronto

⁴Psychiatry and Behavioral Sciences, Psychiatry and Behavioral Sciences, Stanford University

Abstract

Child sexual abuse (CSA) has been associated with a number of problems affecting women over their lifespan, including difficulties with parenting. However, there is a modest number of qualitative studies examining the impact of CSA on survivors who are mothers. There is a particular need for qualitative investigations that ask survivors who are mothers general questions about the impact of CSA on their lives rather than those that specifically ask about the impact of CSA on parenting. The former approach would allow survivors to describe effects that may impact parenting, but which survivors do not consciously link to affecting their parenting. Such information may inform interventions to assist this population of survivors. This secondary data analysis examined themes revealed in interviews with 44 survivors of CSA who were mothers. Participants were seeking treatment for their CSA and completed an in-person interview where they were asked open-ended questions about the sexual abuse they experienced as a child and how their abuse affects them now as adults. The interviews were recorded, transcribed, and coded using thematic analysis. The following six themes emerged from the narratives: 1) being a parent, 2) family of origin dysfunction, 3) the impact of abuse, 4) the abuse history and response to abuse, 5) coping, and 6) hopes and desires for the future. This study highlights several ways in which CSA impacts survivors who are mothers, areas for further study, and the need for interventions to assist this population in meeting the challenges they face as mothers.

Keywords

childhood victimization; long-term sequelae of abuse; women; thematic analysis; parenting

Childhood sexual abuse (CSA) is prevalent among women and associated with numerous problems. Although prevalence estimates vary widely depending upon the definition of CSA used and other methodological variations across studies, one meta-analysis estimated the prevalence of CSA to be 30-40% for females (Bolen & Scannapieco, 1999). In a more recent

study, the prevalence of sexual assault/abuse during childhood was 27% for 17-year old females (Finkelhor, Shattuck, Turner, & Hamby, 2014). Women who are victims of CSA are more likely than those who have not experienced CSA to experience problems affecting their mental health (Molnar, Buka, & Kessler, 2001), physical health (Irish, Kobayashi, & Delahanty, 2010), sexual health (Senn, Carey, & Venable, 2008), and interpersonal relationships (DiLillo, 2001; Maniglio, 2009).

Even though many female survivors of CSA become mothers, far less attention has been given to the impact of CSA on women's parenting compared to other domains of women's health and functioning (e.g., psychological, interpersonal, and sexual). The quantitative work in this area has suggested that when compared to their non-abused counterparts, mothers who are also survivors of CSA have greater difficulty with parenting practices including maintaining appropriate boundaries with children (DiLillo, 2001), being too permissive, and engaging in harsh discipline (DiLillo & Damashek, 2003). Only a few qualitative studies have addressed the impact of CSA on women's parenting (Armsworth & Stronck, 1999; Burkett, 1991; Roller, 2011; Wright, Fopma-Loy, & Oberle, 2012) even though both quantitative and qualitative studies have been recommended in advancing the study of violence against women (Testa, Livingston, & VanZile-Tamsen, 2011).

Qualitative research focusing on the narratives of individuals can provide a contextual lens for understanding personal experience. Such research allows for in-depth exploration of personal experiences and thus the possibility of new phenomenon being revealed (Padgett, 1998; Seidman, 1998) and the identification of gaps in research and practice that might not be identified through other research methods. Qualitative research further allows the researcher to consider a humanistic and relational perspective by providing a space for sharing and immersing oneself in powerful stories of strength and adversity (Padgett, 2004). This shared experience is an opportunity for the empowerment of participants as their voices are being heard, perhaps for the first time in their lives.

We are aware of only four qualitative studies examining the impact of CSA on parenting (Armsworth & Stronck, 1999; Burkett, 1991; Roller, 2011; Wright et al., 2012). Burkette (1991) conducted a study of twenty mothers with histories of CSA committed by a family member and twenty women without such abuse histories. Women were asked how they felt about being a mother (Burkett, 1991). Results revealed that abused mothers were more likely to describe only the rewards or drawbacks while non-abused mothers described both the rewards and drawbacks (Burkett, 1991). Armsworth and Stronck (1999) conducted a qualitative study of 40 mothers who had histories of incest, were parents for at least one year, and had been to counseling or a support group for their CSA. Participants were asked questions about how their abuse may have affected their own parenting. The following four themes were revealed: 1) malevolent socializing environment of the participants' early lives, 2) issues of protection and survival, 3) disclosure and silence, and 4) perceptions of self as a parent.

In recent years, two qualitative studies examined the experiences of female CSA survivors who were pregnant and/or mothers (Roller, 2011; Wright et al., 2012). Roller (2011) sought to develop a theoretical framework describing how CSA survivors managed intrusive re-

experiencing of their CSA during the perinatal period. The study participants were pregnant or had given birth in the past year; Participants were asked to describe their CSA experiences and how those experiences affected them during the perinatal period. Roller (2011) identified three phases: reliving it, taking charge of it, and getting over it. In addition, Wright and colleagues (2012) used grounded theory to analyze narrative data collected through mothers' responses to open-ended questions that among other things, prompted participants to discuss parenting problems they felt were related to their CSA. Participants were 79 adult mothers with histories of CSA and findings were used to develop an overarching model of mothering for survivors of CSA. Their model describes various processes encountered while parenting by mothers who are survivors of CSA including committing to the work of mothering and evaluating their work as mothers.

The four aforementioned qualitative studies asked survivors questions about their feelings about being a mother (Burkett, 1991), the impact of CSA on their parenting (Armstrong & Stronck, 1999; Roller, 2011), or how they see the relationship between their experiences of CSA and being parents (Wright et al., 2012). However, there may be effects of CSA which impact survivors' parenting that survivors do not consciously link to their parenting. Thus, there is a need for qualitative studies that ask CSA survivors who are mothers to construct their own narrative and describe the nuances of their individual experiences that are not specific to parenting. Broad, open-ended questions promote deeper analysis and understanding than specific and/or close-ended questions (Creswell, 2007; Maxwell, 2005). This qualitative and archival study sought to examine themes revealed by adult female survivors of CSA who were mothers in their responses to open-ended questions regarding CSA and its perceived impact on them. Our aim was to better understand the treatment needs of this population, especially related to parenting, as this may benefit both survivors and their children.

Method

Parent Study

This study is a secondary data analysis of baseline data from a randomized, controlled trial regarding the efficacy of trauma-focused and present-focused group psychotherapy on reducing trauma symptoms and risky behaviors among adult female survivors of CSA (Classen et al., 2011; Ginzburg et al. 2009). The parent study was conducted after being approved by the appropriate institutional review board. Participants were recruited through advertisements in the San Francisco Bay Area, and 166 of those who responded to advertisements met the following inclusion criteria and consented to participate in the parent study: 18 years or older; female; with at least one explicit memory involving contact CSA occurring between the ages of four and 17; English speaking; able to discuss abuse in group psychotherapy; and with at least one of the following risky behaviors in the past year [i.e., sexually revictimized, engaged in risky sexual behavior, or met the criteria for an alcohol or drug abuse or dependence according to the Diagnostic and Statistical Manual of Mental Disorders – Fourth edition) (American Psychiatric Association (APA), 1994)].

The baseline interview for the parent study was an in-person interview consisting of both paper-and-pencil questionnaires as well as a brief trauma interview that was recorded.

During the trauma interview, interviewers read participants standardized instructions that informed them that the interview would be audio and video recorded, data would be kept confidential, and that they would be asked about their child sexual abuse history. Participants were informed that they would have ten minutes to answer the first question, "Please tell me what happened to you when you were sexually abused as a child," and five minutes to answer the second question, "How do you feel this experience affects you now, as an adult." Interviewers informed participants that after they asked the questions, they would sit quietly and let the participant speak. Participants were also told that they could take their time to respond. They were specifically informed that they could remain silent, relax, and see what comes to mind. They were also told that they could end the interview if at any time they wished to stop. Once the interview began, the only prompts interviewers used were as follows: 1) to ask the participant if there was anything more she would like to say, 2) to tell her to take as much time as she needed, and 3) to ask her to sit for another minute to see if anything else came to mind. Upon completion of this task, interviewers asked participants if they had anything else they would like to say and about their experiences of addressing these questions in this format. Participants were remunerated \$25 for completing this interview.

Present Study Participants

Of the 166 participants in the parent study, 110 trauma interviews had been transcribed at the time of this study. Given the authors' interest in examining themes revealed by mothers, this study was restricted to 44 of the 110 participants who also reported having one or more biological children. Participants with non-biological children were not included since we lacked the data to know when these survivors became parents. Participants ranged from 20-58 years of age. The average age of participants was 42 (SD=9.08). The majority of participants in the present study were White/European American (58.1%; 20.9% Hispanic/Latina, Mexican or Chicana, 14% Black/African American; and 7% other) and had at least a high school education (86.4%). Participants' total household income was as follows: 31% less than \$20,000; 19% \$20,000-\$39,000; 17% \$40,000-\$59,000; 10% \$60,000-\$79,000; 24% \$80,000.

Present Study Procedures

Two reviewers, both of whom had doctoral degrees and clinical experience working with trauma survivors, reviewed and analyzed participants' transcribed trauma interview responses. Thematic analysis and open coding were utilized in order to provide a rich description of the data (Braun & Clarke, 2006). Line by line coding was used for the first two interviews followed by sentence by sentence coding. Axial coding was used to examine differences within and between categories and also provided a comparative analysis of codes and categories. The codes of all interviews were reviewed and themes were identified within the data. Themes were reviewed, compared, and categorized and a thematic map was created. Themes were further refined and named. The final step of analysis involved extracting excerpts of the narratives to illustrate the themes that emerged from the data. The reviewers utilized memo writing throughout data analysis in order to document ideas, patterns, discrepancies, and potential coding and thematic ideas. An audit trail was used to highlight how data analysis unfolded including how categories emerged and concepts were

developed. Internal consistency was met by the co-analysis of the data by two experienced reviewers as well as peer debriefing and reflexivity.

Results

The following six themes emerged from the narratives: 1) being a parent, 2) family of origin dysfunction, 3) the impact of abuse, 4) the abuse history and response to abuse, 5) coping, and 6) hopes and desires for the future. As shown in Table 1, each theme was comprised of 2-6 categories. The themes are discussed in more detail below.

Being a Parent

The following five categories comprised the theme of being a parent: 1) efforts to protect their children, 2) reactions to real or imagined abuse, 3) their children as victims, 4) children prompting positive change, and 5) difficulties. One woman discussed preventing her child from having contact with a grandparent since the grandparent was the mother's perpetrator. A number of women mentioned educating their children about child abuse and trying to protect their children (e.g., by being strict and preventing alone time with men or not allowing sleep-overs).

...thing which worries me most is worrying about my daughters and wanting to make them safe and I have taken some steps to educate them, but it happens so much and most people don't even know about it, could be my neighbor (#209).

Another described efforts to protect her child from being abused, but feeling unable to do so.

It [the abuse] also changed my way of thinking when it comes to what parental protection actually means...it taught me that you have to have your daughter on some type of birth control pills no matter what because you can't prevent what they can't prevent, but you can teach them how to protect themselves (#257).

Many women reported feeling worried and fearful about their child being abused, and fear and discomfort with their husbands' contact with children. One woman reported being scared about the possibility that her husband could abuse her daughter and another reported feeling extremely uncomfortable with her husband's seemingly innocent physical contact with her daughter. Several women mentioned their children had also been victims of abuse. Two women's daughters were abused. One woman's perpetrator also abused the woman's daughter and another woman reported that her own children had sexually abused each other.

Other subthemes in this category included children prompting positive change and parenting difficulties. Mothers also discussed their children prompting them to learn and change as well as motivating them to get help.

These children are teaching me, showing me unconditional love and I didn't know that before, learning about that is really scary. It's made me realize how many feelings I still have that I haven't worked through. I haven't worked through ah feelings of loneliness, of helplessness, of anger and so I don't know how to; I am realizing how important it is to deal with these things because I have children (#273).

Another reported:

If I didn't get help for myself before, just for me, I have to do it now. Uhm, again going back to the thing that now I have somebody to be responsible for and I don't want them to go through what I go through (#615).

While having children prompted positive change, it also presented difficulties. Women described difficulty bonding and being affectionate with their children and grandchildren. One woman specifically mentioned difficulties in bonding with male children.

I have three children and I have a tough time being affectionate with them, showing them the love they deserve.....I couldn't really form a real close bond because there is a child in me that I believe I haven't accepted. Until I can accept that part and learn to be a child again I just don't believe I will be able to, be blessed to hold my grandson in the manner, though it is getting better and better. The more I hold him easier it becomes. I have two male children and the bonding with them has been very difficult (175).

Another woman who bore a child as a result of her CSA gave up her child for adoption. A few women recognized that their protective behaviors could feel suffocating to their children and isolate them. One woman described being fearful of having daughters due to fear of not being able to protect them from CSA. She reported, "I was hoping to God that I wouldn't have any daughters of my own just because I was fearful of how I was gonna be able to uh, uhm, protect them (#599)." Finally, a few women described feeling responsible that their problems and behaviors (e.g., being overly protective) could negatively impact their children.

Family of Origin Dysfunction

This theme was comprised of the following five categories: 1) family disruption, 2) poor boundaries, 3) other abuse, 4) mental health problems, and 5) additional family stressors. Women discussed changes in family composition (e.g., parental divorce, out of home placements, step parents, and the absence or the loss of parents or siblings) that affected their family of origin. They also discussed having been poorly supervised as children and either themselves or a sibling taking on adult responsibilities. A number of women also described poor sexual boundaries within their families of origin (e.g., witnessing parents' sexual behavior, having a sibling express sexual interest in her, having access to pornographic material, and having her mother dress her sexually inappropriately). Another woman described her mother having expressed interest in a daughter-father sexual relationship:

...my mother ...always got excited when there would be pictures of, photographs of my dad and I together. She would always get this weird, oh, sort of sexual type of silliness about my dad and I having a photo taken together like I was his girlfriend or something (#181).

Participants described other types of abuse against them or their siblings during their childhoods including childhood physical abuse or witnessing their mothers being physically abused. The predominant mental health problem mentioned within their family of origin was

parental substance abuse. However, parental mood disturbances were also described (e.g., rage, emotional volatility, and depression). Family stressors mentioned included poverty, family inconsistency, and interpersonal conflicts with parents or siblings (e.g., being estranged from mother, hatred towards brother, and feeling unwanted by dad).

Impact of Abuse

The categories that emerged for the impact of abuse were 1) difficulties with trust, 2) sexual problems, 3) interpersonal difficulties, and 4) emotional impact. The majority of women identified difficulties in trusting others, including their mothers, partners, family and perpetrators, as well as men in general. A number of women discussed symptoms of sexual disorders including being hyposexual and hypersexual or having compulsive sexual behavior. Others described being numb during sex, having traumatic memories triggered during sex, having to drink before having sex, and being uncomfortable with sex.

As soon as it started it became too familiar, sex became familiar. It wasn't that I didn't want to have sex. I was appalled by it, disgusted by it. In my current relationship it definitely is a factor. You know we talk about it, but when we come right down to it I just feel like my relationship is the same as that one [the relationship with the perpetrator (#209)].

A number of women mentioned being promiscuous and engaging in risky sex. A few described having sexual fantasies involving their perpetrator or liking sex that was similar to their sexual abuse. Many women mentioned feeling that their only value was as a sexual object and that men only care about or want sex. Some described rarely having sex within the context of love while others described sex as love.

At one point I thought sex was love and then I found out that it wasn't. And I mean it, it um me and my fiancé we fight a lot cause I guess cause he says our sex life is boring, which I think it is too and I think that has a lot to do with it. Um, when we have sex I just lay there. I don't do nothing. Um, um, but when I was using drugs I wasn't like that, but now that I'm off drugs, I could care less if I have it or not. And I think that has a, that has affected me a lot. And because at one point, like I said at one point I thought sex was the only way somebody. See when I was growing up I thought that was the way my [perpetrator] was telling me how, how he loved me was having sex with me (#400).

Women reported a range of interpersonal difficulties including making poor choices in their relationships, feeling insecure in relationships, and having difficulty setting boundaries with others. Women also described conflicting emotions towards men including having both animosity towards them but also seeking their attention. For example, participant #209 stated, "I think it is kind of love hate relationship with men, I hate them, I don't need them, they are disgusting pigs, but really need them, really want them, really need the attention." Women also described difficulties with intimacy and feeling that their romantic partner reacted undesirably when women disclosed their abuse to them. Others described difficulties with women including feeling uncomfortable with females and having no female friends.

Women expressed various emotional impacts of abuse. Anger, shame, self-blame, and fear were common as were reports of depression and anxiety symptoms. Many women also reported feeling “dirty,” feeling damaged, and having low self-esteem. As one woman explains, “...inside I really feel that I’m just I have no self-worth. I feel that I am a worthless human being and that I can’t do anything right (#70).” Another woman struggled to convey the emotional impact.

Do you like to know how it affects my...my life? Ahh ... I want ... I feel confused... I don’t want to die early because I don’t want to live alone but I am not happy. I didn’t ...I think... my dad... I am not really happy because I didn’t ... ahh ... it did affect my life too much...I tried everyday... .I tried.... but it is no use... I feel guilty. I didn’t... it affect me ...emotional...I don’t like the way I am...you understand me?(#276).

Several women also mentioned feeling the abuse had ruined their lives or that they had lost their innocence and years of their lives. For example, one woman reported, “I feel that fifty years of my life have been lost and that my inability to be successful is directly correlated to the abuse that I suffered as a kid (#575).”

Abuse History and Response to Abuse

This theme was comprised of the following six categories: 1) abuse characteristics, 2) coercive dynamics, 3) own attempts to resist or stop abuse, 4) post-abuse disclosure, 5) reactions from others when they learned of abuse, 6) and perceptions related to abuse. The majority of perpetrators described included family members (e.g., parents, cousins, siblings, grandparents). Other perpetrators included mothers’ boyfriends; a handyman; neighbors, including those that were doctors; family friends and colleagues; and a church member. Women reported being between two and eleven years old when they were abused and their abuse occurring from one year to twelve years. They also reported having one to four perpetrators and being fondled, forced to give or receive oral sex, and forced into intercourse. Others reported being forced to have enemas, clean the perpetrator’s anus after he defecated, the perpetrator inserting objects into them (e.g., a coke bottle), and other types of inappropriate genital contact. For example, one participant reported:

They told me that we were going to an island [name removed] and it is hot there and and [sic] we, we needed to shave pubic hair because ... it was hot over there and you sweat if you have hair on it [genitals]. So my dad and I, I think he had already shaved my mother’s, so he shaved my pubic hair and I felt really uncomfortable and my mother was there (#181).

Others described abuse that progressed in severity. For example, one woman discussed her perpetrator first applying vaginal ointment on her claiming it was to prevent menstrual cramps. Over time, the abuse became more aggressive and the perpetrator eventually raped her years later (#175).

Women’s abuse involved many different coercive dynamics including being silenced (e.g., told or forced to be silent), drugged, and physically punished if they did not comply. For example, one woman said, “I had to go to the doctors three different times because my mom

beat me so badly because I wouldn't have sex with her boyfriends (#257)." The majority were threatened by the perpetrator. For example, perpetrators told the victims they would kill them, kill or leave their mothers, and one threatened to tell her mother that she did not do chores she had actually done in order for her to be punished. Perpetrators also began inappropriate discussions with victims around the perpetrators' sexual behavior (e.g., "your mother never wants to do it [have sex, #181]," the victims' sexual behavior, and victims' bodies. Others discussed being coerced by kindness (e.g., gifts, emotional support), the perpetrators telling them their abusive behavior was a form of love, or their perpetrators' attempt to build a closer relationship with the victim, which the victim longed for.

I thought he told me that that was cause he loved me and that's what you do when you love somebody so I thought that's normal and he always told me not to tell and I never did because I would be beat and he would be mean (#586).

Another reported:

The first time he came in the room he made that comment and said he wanted to be closer and then I remember hugging and going to sleep and having that feeling of peace and relaxation. The next time was uh 2-3 days later, little questions and things started coming up, did I like sex? What did I think about it? Remember I was around seven, I remember I was afraid to answer but knew that if I didn't our relationship wouldn't be great (#175).

A number of women explicitly mentioned the word "escape," and they discussed physical attempts to do so. Physical attempts involved resisting, fleeing, and moving away from the perpetrator. A number of women also mentioned being unable to do anything to stop the abuse. Participant #74 reported, "You know it's like being caught unaware all of a sudden, like a spider been caught in a web, don't know how to get out. So I was like trapped, can't get out." Several participants reported disclosing their abuse to someone while several others reported they never told anyone. For example, one woman only disclosed her abuse after learning her daughter had been abused by the same perpetrator. For those that reported disclosing their abuse, they reported telling a number of different individuals including mothers (sometime multiple times), friends, husbands, teachers, sisters, individuals within a related court proceeding, and the wife of a perpetrator. There was also mention of regretting disclosure. While most women discussed disclosure in the context of seeking support, one woman described disclosing in attempt to prevent others from being abused.

Anyway, I had discovered that he (perpetrator) had got married again and had another son and at the time I found out I think the son was 10 or 11 and I called the wife and told her my story. I said you may not believe it, but I just have to tell you and she didn't believe me, but was very kind and supportive and she listened. After that I felt a lot better, I felt I have saved somebody and at that point I knew that if he was going to be abused he wouldn't (#209).

The majority of reports regarding the reactions from others after abuse disclosure were negative. Women described the reactions of others as involving disbelief, denial, blame, anger, as well as a lack of support, action, or protection.

My mom had said to me, she said, “you know (name of participant), I am old. You have your life ahead of you and I am afraid of being alone. I can only tell you that I will try not to let this [the abuse] happen again but I am not going to leave him [the abuser] (#475).

Only five participants mentioned positive responses following disclosure and these responses included parents protecting them and stopping the abuse, receiving counseling after disclosure, and the authorities being contacted. Women wondered about why they had been the target of abuse and some perceived themselves to be easy targets and responsible for the abuse. While some reported confusion about whether what they experienced was abuse and whether it was “normal,” others reported knowing that what happened to them was wrong.

Coping

Coping consisted of both negative and positive coping strategies with the majority being positive coping strategies. A number of women discussed efforts to maintain sobriety, seek treatment services (e.g., psychotherapy, antidepressant medication, 12 step program), and attempts to forgive. Women also mentioned confronting their problems, improving their communication skills, and setting better boundaries. Descriptions of poor coping strategies included women discussing their use of alcohol and drugs as well as overeating to cope. Others described hiding their feelings from others, keeping their abuse a secret, and avoiding thinking about their abuse through dissociation. One woman who reported seeking integration of her fragmented self described dissociative strategies that helped her to cope with having been abused.

I could go inside and live in a fantasy world or I could count all the little dots in the acoustic, like I would count those dots. I would figure out how many dots there were in that thing like I’ve done a lot of that where I would ya know (makes sound) ya know... I think I used the time of being of punished or being him doing things to punish me or whatever to just focus in and just find like a prison camp survivor would...it made me very strong and I think that’s probably why I didn’t become a drug addict or an alcoholic like some of the girls in my family did uhm because I knew how important my mind was for my like to me it’s my friend it made me survive ya know the ability for me to focus and to go somewhere else in my mind so maybe in some ways it gave me strength (#166).

While most of the emotional consequences that were reported were negative, there was mention of posttraumatic growth. Some women reported that they had survived, their coping made them strong, and they were making efforts to take better care of themselves.

Hopes and Desires for the Future

The sixth category that emerged was hopes and desires for the future for self and others. Women discussed their desire to heal, learn better coping strategies, gain understanding, become more integrated, move forward, and help others. One woman stated, “I just want someone to really hear me and to acknowledge that that was horrible thing that happened

that that would be upsetting to anyone else (#45).” Others hoped that other women and children will not experience abuse.

And I’m going to be definitely more protective of my children, whenever I see little girls I kind of just staring and making sure they’re you know not touched or moving around by themselves, even though it’s not my business, you know I kind of making it my business, because I’m just, I’m just watching out for the guys out there (#595).”

Discussion

This study used archival data and thematic analysis to understand experiences of 44 mothers who are survivors of CSA. These rich themes consisted of multiple categories and highlighted the significant and lasting impact CSA had on the survivors’ functioning as adults. The impact on parenting theme revealed a multitude of ways CSA affects survivors’ thoughts, feelings, and behaviors regarding parenting.

The theme of being a parent included discussion of women’s efforts to protect their children, reactions to real or imagined abuse, their children as victims, children prompting positive change, and parenting difficulties (e.g., bonding with children and being affectionate, bearing a child as a result of CSA and giving the child up for adoption, feeling that protective behaviors and concerns for child could negatively impact children). Women reported efforts to protect their children including educating them about CSA, prohibiting them from contact with their perpetrator of CSA, and keeping a daughter on birth control pills because “you can’t prevent what they can’t prevent.” The latter highlighted the sense of hopelessness one mother felt in ultimately being unable to protect her daughter from harm. Many women expressed concern and worry about their children being harmed and some had children who became victims of CSA. Women described ways in which their CSA affected their ability to bond with their children or even their desire to have female children because of fears about protecting daughters from abuse. In sum, the parenting difficulties reported herein, along with findings from previous qualitative research in this area (Armsworth & Stronck, 1999; Burkett, 1991; Roller, 2011; Wright et al., 2012) and quantitative research (DiLillo, 2001; DiLillo & Damashek, 2003) suggest the need for interventions to help survivors of CSA who are mothers with problems in parenting (e.g., bonding with children, effectively addressing concern and worry about protection, and educating their kids). We are unaware of any parenting interventions specifically for mothers with histories of CSA who are having difficulties with parenting. Interventions that treat some of the common sequelae of abuse, such as posttraumatic stress disorder and dissociative disorders (Cloitre et al., 2010; Maldonado, Butler, et al., 2002; Resick, Suvak et al., 2012) may be helpful in improving affect and interpersonal regulation more generally, as well as in relation to their children. Furthermore, attachment-based parenting interventions (Suchman, DeCoste, Castiglioni, McMahon, Rounsaville, & Mayes, 2010) may help survivors who are mothers with some of their parenting difficulties, including strengthening their attachment bonds with children and expressing more affection.

While this study did not directly ask women to discuss the impact of their abuse on themselves as parents, it is interesting that in these interviews about CSA and its impact on these survivors, all of whom were mothers, only half of them (22 of 44) mentioned their children or themselves as parents. The interview required participants to discuss their childhood abuse, which one might think would spur participants to now consider that their children could also be victims of abuse. That half of the participants did not acknowledge any impact of CSA on themselves as parents raises further questions. Is this because they felt they were competent parents and their CSA had no effect on their parenting? Or, had they learned to become better parents as a result of the abuse and thus parenting was not a concern for them? Or, does it reflect a lack of awareness about its impact on their parenting? Further research is needed to answer these questions.

The parenting theme was associated with other themes revealed in this study including dysfunction in women's family of origin, impact of abuse, abuse history, and future hopes and desires. Women described having experienced multiple traumas and hardships that included multiple experiences of CSA with multiple perpetrators and CSA that occurred in addition to other types of childhood adversity, including family dysfunction (e.g., parental divorce, parental mental illness), and childhood abuse (e.g., witnessing domestic violence and childhood physical abuse). Given the nature of dysfunction and the problems they had experienced in relation to their CSA, it is not surprising that a theme emerged around wanting to protect their children from harm or that some had difficulty bonding with their children or trusting others not to harm their children.

Other themes that emerged have been previously noted among survivors, but we considered them in light of their impact on survivors who are mothers. For example, many women noted having sexual difficulties, a problem that has been identified in previous research with CSA survivors (Leonard & Follette, 2002; Loeb et al., 2002), but may have been more pronounced in the current sample given the risky behavior inclusion criteria of the parent study (i.e., sexual revictimization, risky sexual behavior, or substance abuse or dependence). Nevertheless, these difficulties raise questions as to what degree these mothers feel competent or prepared to help teach their children about sex. If a mother is struggling to identify normal or healthy sexual behavior for herself, how will she be able to teach her children about healthy or safe sexual practices? Difficulty in promoting healthy sexual behavior has also been reported in another sample of mothers with histories of CSA (Wright et al., 2012). Survivors who are mothers may benefit from effective interventions that improve parental communication about sex (Akers, Holland, & Bost, 2011).

This study's limitations should be considered when interpreting its results. This study draws on archival data from a larger study, which was not designed to address the issue of CSA survivors as mothers. Further, the inclusion criteria targeted women who were seeking treatment to address their CSA and who had been engaging in risky behaviors. Thus, participants may have been experiencing distress at the time that they participated in the study, which may have affected their responses. Participants were video recorded at the time that they were interviewed, and that may have affected their ability to discuss their history of CSA and its impact on them.

Implications

This study adds to the modest number of qualitative studies aimed to understand the experiences of CSA on survivors who are mothers. It is novel in that general questions were asked to elicit narrative responses, which allowed survivors to reveal a range of experiences and were not limited to their role as parents. Many of the themes revealed by the data were consistent with problems previously noted among samples of CSA survivors and, thus, were not restricted to survivors who were also mothers (e.g., difficulties coping, distrust, and sexual difficulties). However, the present study's sole focus on survivors of CSA who are also mothers contributes to the existing literature by documenting experiences among survivors at this stage of life and in relation to their role as mothers. Themes and subthemes other than those related directly to being a parent (e.g., poor coping and impact of CSA on survivors trust and interpersonal problems) are also likely to impact these survivors' parenting practices. From a practice standpoint, when practitioners are working in clinical settings with CSA survivors who are mothers, they need to consider whether the sequelae of CSA contribute to parenting difficulties, irrespective of whether the survivor links their symptoms as impacting their parenting, and intervene accordingly. When necessary, survivors of CSA who are mothers may need referrals for parenting classes. These survivors may benefit from gaining parenting skills while simultaneously working with therapists to reduce their symptoms and better understand how their CSA and its effects may influence their parenting and children. At the same time, parenting may offer opportunities for post-traumatic growth, providing an occasion for survivors of CSA to provide a safer upbringing than they themselves experienced.

Future Research

Additional studies are needed to understand the long-term impact of CSA on survivors who are mothers. Such studies need to consider impacts of CSA on parenting that may be revealed by survivors as well as those that may not be described by survivors, but which may still impact their parenting. Many survivors may not realize how some of the difficulties they experience may interfere with their parenting practices. Given the literature suggesting that mothers play a crucial role in sex communication with daughters (Cavanaugh & Classen, 2009), there is a need for further investigation into the impact of CSA on survivors' communications about sex with their children and whether these mothers may benefit from a parenting intervention that may help them to engage their children in healthy discussions about sex.

Future studies may also examine whether the themes revealed in this study are similar to survivors who are not mothers. Nevertheless, how survivors who are mothers understand the impact of CSA on their lives is uniquely important given the implications for how this may affect their role as mothers. Additional studies are needed to understand why so many survivors who are mothers did not acknowledge any impact of CSA on themselves as parents. Finally, given the parenting difficulties noted among survivors of CSA, studies are needed that evaluate interventions that aim to assist this population of mothers with the challenges they face. Interventions designed to assess and treat the effects of CSA among mothers and assist them with parenting challenges may be particularly beneficial, as women

in this study describe their experiences of motherhood as a source of motivation to heal from CSA.

Acknowledgments

The parent study from which data for this study was taken was funded by grant RO1MH60556 from the National Institute of Mental Health, David Spiegel, Principal Investigator.

This study used archival data from a randomized, controlled trial examining the efficacy of two different group psychotherapy interventions for adult female survivors of childhood sexual abuse who were also at risk for HIV. Prior publications from this data have focused on the quantitative findings. The only qualitative study resulting from the parent study was the first author's dissertation.

Biographies

Courtenay E. Cavanaugh received her Ph.D. in Clinical Psychology from CSPP-San Francisco and completed NIDA-funded postdoctoral fellowships at Yale and Johns Hopkins Universities. She is an assistant professor of psychology at Rutgers University in Camden, NJ. Her research focuses on violence against women, mental health problems and HIV/STIs.

Bianca Harper is a clinical assistant professor at the University of Southern California in the School of Social Work. She received her doctorate at the University of Pennsylvania. Bianca is a licensed clinical social worker and her primary research interests include child maltreatment, interpersonal violence, traumatic stress, trauma informed treatment, and pedagogy.

Dr. Catherine Classen is an associate professor in the Department of Psychiatry at the University of Toronto, director of the Women's Mental Health Research Program at Women's College Research Institute, and academic leader for the Trauma Therapy Program at Women's College Hospital. Her research examines the efficacy of psychotherapeutic interventions for women who have experienced stressful life events such as child abuse, violence, or serious illness. She is also interested in advancing trauma-informed care within the health care system.

Oxana Palesh received her PHD in Clinical Psychology from CSPP-San Diego and her MPH from the University of Rochester. She completed her postdoctoral training at Stanford University and is currently an Assistant Professor of Psychiatry at Stanford University. Dr. Palesh's research interests are in health and stress. More recently, Dr. Palesh's work has been understanding etiology of psychiatric side effects in cancer and development of interventions to address them.

Cheryl Koopman, Ph.D is Professor (Research) of Psychiatry and Behavioral Sciences at Stanford University. Her research focuses on mental and physical health outcomes associated with acute and chronic illness and other stressors, social support, and psychosocial intervention. Dr. Koopman completed her undergraduate and graduate education at University of California, Berkeley, University of California, Los Angeles, and University of Virginia, followed by post-doctoral fellowships at Harvard Medical School and

Massachusetts General Hospital, Columbia Teachers College, and in International and Public Affairs at Columbia University.

Dr. David Spiegel is Willson Professor and Associate Chair of Psychiatry & Behavioral Sciences, Director of the Center on Stress and Health, and Medical Director of the Center for Integrative Medicine at Stanford University School of Medicine, where he has been a member of the academic faculty since 1975. He has published twelve books, 372 scientific journal articles, and 165 book chapters on psychosocial oncology, stress physiology, trauma, hypnosis, and psychotherapy. He received his B.A. from Yale in 1967, his M.D. from Harvard Medical School in 1971, and did his psychiatry residency and fellowship at the Massachusetts Mental Health Center, Cambridge Hospital, and the Laboratory of Community Psychiatry, Harvard.

References

- Akers AY, Holland CL, Bost J. Interventions to improve parental communication about sex: A systematic review. *Pediatrics*. 2011; 127:494–510. DOI: 10.1542/peds.2010.2194 [PubMed: 21321027]
- American Psychiatric Association (APA). *Diagnostic and statistical manual of mental disorders (DSM-IV)*. Washington, DC: Author; 1994.
- Armsworth MW, Stronck K. Intergenerational effects of incest on parenting: Skills, abilities, and attitudes. *Journal of Counseling & Development*. 1999; 77:303–314. DOI: 10.1002/j.1556-6676.1999.tb02453.x
- Bolen RM, Scannapieco M. Prevalence of Child Sexual Abuse: A Corrective Metanalysis. *Social Service Review*. 1999; 73:281–313. DOI: 10.1086/514425
- Burkett LP. Parenting behaviors of women who were sexually abused as children in their families of origin. *Family Process*. 1991; 30:421–434. DOI: 10.1111/j.1545-5300.1991.00421.x [PubMed: 1790786]
- Cavanaugh CE, Classen CC. Intergenerational pathways linking childhood sexual abuse to HIV risk among women. *Journal of Trauma & Dissociation*. 2009; 10:151–169. DOI: 10.1080/15299730802624536 [PubMed: 19333846]
- Classen CC, Palesh OG, Cavanaugh CE, Koopman C, Kaupp J, Kraemer H, Spiegel D. A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial. *Psychological Trauma: Theory, Research, Practice, & Policy*. 2011; 3:84–93. DOI: 10.1037/a0020096
- Cloitre M, Stovall-McClough KC, Noonan K, Zorbas P, Cherry S, Jackson CL, Gan W, Petkova E. Treatment for PTSD Related to Childhood Abuse: A Randomized Controlled Trial. *American Journal of Psychiatry*. 2010; 167:915–924. DOI: 10.1176/appi.ajp.2010.09081247 [PubMed: 20595411]
- DiLillo D. Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review*. 2001; 21:553–576. DOI: 10.1016/S0272-7358(99)00072-0 [PubMed: 11413867]
- DiLillo D, Damashek A. Parenting characteristics of women reporting a history of childhood sexual abuse. *Child Maltreatment*. 2003; 8:319–333. DOI: 10.1177/1077559503257104 [PubMed: 14604178]
- Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health*. 2014; 55:329–333. DOI: 10.1016/j.jadohealth.2013.12.026 [PubMed: 24582321]
- Ginzburg K, Butler LD, Giese-Davis J, Cavanaugh CE, Neri E, Koopman C, Spiegel D. Shame, guilt, and posttraumatic stress disorder in adult survivors of childhood sexual abuse at risk for human immunodeficiency virus: Outcomes of a randomized clinical trial of group psychotherapy

- treatment. *Journal of Nervous and Mental Disease*. 2009; 197:536–542. DOI: 10.1097/NMD.0b013e3181ab2ebd [PubMed: 19597362]
- Irish L, Kobayashi I, Delahanty DL. Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology*. 2010; 35:450–461. DOI: 10.1093/jpepsy/jsp118 [PubMed: 20022919]
- Leonard LM, Follette VM. Sexual functioning in women reporting a history of child sexual abuse: Review of the empirical literature and clinical implications. *Annual Review of Sex Research*. 2002; 1(1):346–388.
- Loeb TB, Williams JK, Carmona JV, Rivkin I, Wyatt GE, Chin D, Asuan-O'Brien A. Child sexual abuse: Associations with the sexual functioning of adolescents and adults. *Annual Review of Sex Research*. 2002; 13(1):307–345.
- Maldonado, JR., Butler, L., Spiegel, D. Treatments for dissociative disorders. In: Nathan, P., Gorman, J., editors. *A Guide to Treatments that Work*. New York: Oxford University Press; 2002. p. 463–496.
- Maniglio R. The impact of child sexual abuse on health: a systematic review of reviews. *Clinical Psychology Review*. 2009; 29:647–657. DOI: 10.1016/j.cpr.2009.08.003 [PubMed: 19733950]
- Molnar BE, Buka SL, Kessler RC. Child sexual abuse and subsequent psychopathology: results from the National Comorbidity Survey. *American Journal of Public Health*. 2001; 91(5):753–760. [PubMed: 11344883]
- Padgett, DK. *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA: Sage; 1998.
- Padgett, DK. Finding a middle ground in qualitative research. In: Padgett, DK., editor. *The qualitative research experience*. Thousand Oaks, CA: Sage; 2004. p. 1–17.
- Resick PA, Suvak MK, Johnides BD, Mitchell KS, Iverson KM. The impact of dissociation on PTSD treatment with cognitive processing therapy. *Depression and Anxiety*. 2012; 29:718–730. DOI: 10.1002/da.21938 [PubMed: 22473922]
- Roller CG. Moving beyond the pain: Women's responses to the perinatal period after childhood sexual abuse. *Journal Of Midwifery & Women's Health*. 2011; 56:488–493. DOI: 10.1111/j.1542-2011.2011.00051.x
- Seidman, IE. *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. 2nd. New York, NY: Teachers College Press; 1998.
- Senn TE, Carey MP, Venable PA. Childhood and adolescent sexual abuse and subsequent sexual risk behavior: Evidence from controlled studies, methodological critique, and suggestions for research. *Clinical Psychology Review*. 2008; 28:711–735. DOI: 10.1016/j.cpr.2007.10.002 [PubMed: 18045760]
- Suchman NE, DeCoste C, Castiglioni N, McMahon TJ, Rounsaville B, Mayes L. The mothers and toddlers program, an attachment-based parenting intervention for substance using women: Post-treatment results from a randomized clinical pilot. *Attachment & Human Development*. 2010; 12:483–504. DOI: 10.1080/14616734.2010.501983 [PubMed: 20730641]
- Testa M, Livingston JA, VanZile-Tamsen C. Advancing the study of violence against women using mixed methods: Integrating qualitative methods into a quantitative research program. *Violence Against Women*. 2011; 17:236–250. DOI: 10.1177/1077801210397744 [PubMed: 21307032]
- Wright MOD, Fopma-Loy J, Oberle K. In their own words: The experience of mothering as a survivor of childhood sexual abuse. *Development and Psychopathology*. 2012; 24:537–552. DOI: 10.1017/S0954579412000144 [PubMed: 22559129]

Table 1

Themes and Subcategories Revealed by Grounded Theory Analysis of Interviews

Theme	Category	
Being a parent	1	Efforts to protect
	2	Reaction to real or imagined abuse
	3	Their children as victims
	4	Children prompting positive change
	5	Difficulties
Family or origin dysfunction	1	Family disruption
	2	Poor boundaries
	3	Other abuse
	4	Mental health problems
	5	Additional family stressors
Impact of abuse	1	Difficulties with trust
	2	Sexual problems
	3	Interpersonal difficulties
	4	Emotional impact
Abuse history and response to abuse	1	Abuse characteristics
	2	Coercive dynamics
	3	Own attempts to resist or stop abuse
	4	Post-abuse disclosure
	5	Reactions from others when learned of abuse
	6	Perceptions related to abuse
Coping	1	Positive coping
	2	Poor coping
Hopes and desires	1	For self
	2	For others