2007

The Impact of Childhood Sexual Abuse on a Woman's Attitudes, Perceptions, and Behaviors as she Transitions to Motherhood

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The Impact of Childhood Sexual Abuse on a Woman's Attitudes, Perceptions, and Behaviors as she Transitions to Motherhood

A Dissertation Presented to the College of Education and Human Services

Seton Hall University

In Partial Fulfillment of the Requirements for the Degree

Doctor of Philosophy

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SETON HALL UNIVERSITY
COLLEGE OF EDUCATION AND HUMAN SERVICES
OFFICE OF GRADUATE STUDIES

APPROVAL FOR SUCCESSFUL DEFENSE

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The Impact of Childhood Sexual Abuse on a Woman's Attitudes, Perceptions, and Behaviors as she Transitions to Motherhood

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Abstract

Negative consequences of child sexual abuse have been well documented; however, little information is available on how a history of childhood sexual abuse influences a woman's attitudes, perceptions, and behaviors as she transitions to motherhood. This study examine depressive symptoms, parenting stress, sense of parenting competence, and perceived family functioning in 265 women who ranged in age from 20 to 44 using archived data from the National Data Archive on Child Abuse and Neglect (1998). Results suggest that women with a history of childhood sexual abuse do have increased levels of depressive symptoms as measured by the CES-D, but the results did not reveal any identifiable pattern of differences between women who were and were not sexually abused with regards to parenting stress. Results indicate that women who were sexually abused reported significantly better parenting competence (M=36.7, SD=3.4) than women who were not abused (M=38.0, SD=3.8; $F(2, 260)$= 8.34, p=0.004). Lastly, there were significant differences in family functioning between women who were sexually abused and women who were not sexually abused where women with a history of sexual abuse were found to be significantly more satisfied with family help than women without abuse history (p=0.01).

CHAPTER I

Introduction

Over the past several decades, there has been an increased awareness of the negative effects of child maltreatment on one's physical and emotional status. Cicchetti and Toth (2000) identify four categories of child maltreatment which are typically distinguished from each other: (a) physical abuse, involving infliction of bodily injury on a child in a way that is deliberate and not accidental; (b) sexual abuse, which includes sexual contact or attempted sexual contact between a caregiver or other perpetrator; (c) neglect; and (d) emotional abuse, which involves chronic and pervasive neglect of a child's basic emotional needs. Each of these types of abuse has the potential to become a significant trauma to a child's life. Because there is also a high degree of co-morbidity among maltreatment subtypes, the experiences of children who have been negatively impacted by several traumas can be complex (Cicchetti & Toth, 2000). For the purposes of this exploration, childhood sexual abuse will be reviewed.

Definitions of Childhood Sexual Abuse

The National Center on Child Abuse and Neglect (NCCAN, 1978) describes childhood sexual abuse as:

> Contacts of interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. Sexual abuse may also be committed by a person under the age of 18, when that person is either significantly older than the victim or when the perpetrator is in the position of power or control over another child (p.2).

A similar definition of childhood sexual abuse put forth by the National Data Archive on Child Abuse and Neglect (2001) includes:

> Women who had reported at least one contact or non-contact episode before the age of eighteen; those who did not were considered controls. The perpetrator could have been either family or non-family. Generally the perpetrator had to be five years older than the victim except in the case where women reported that force was used (p. 5).

Both definitions are inclusive of contact and non-contact episodes, familial and extrafamilial abuse, and are widely recognized and accepted in the literature on childhood sexual abuse.

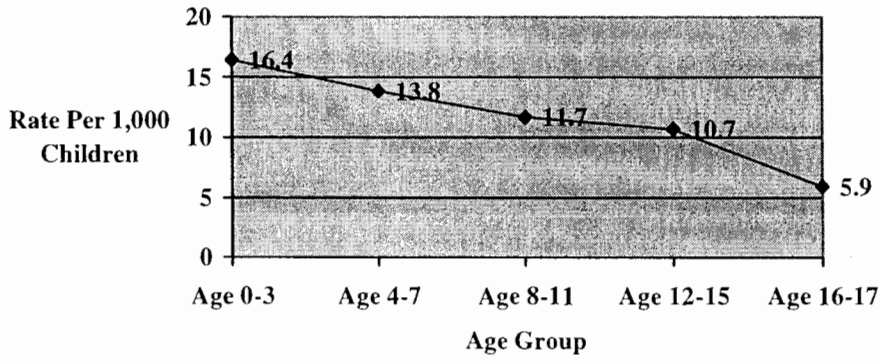
Incidence of Child Sexual Abuse

In one of the most recent statistics from the National Clearinghouse on Child Abuse and Neglect (2004) an estimated 906,000 children were found to be victims of child abuse or neglect, approximately 12.4 per 1,000 children nationally. While this number has dropped from its levels ten years prior, there is no doubt that childhood abuse, and childhood sexual abuse in particular, continues to be a significant problem in the United States.

The highest rate of victimization was assessed at ages 0-3, a time when the young child is most fragile, powerless, dependent on adults for careful and specialized care, and regrettably, when they are least likely to be able to protect themselves (National Clearinghouse on Child Abuse and Neglect, 2004). During this time a child's sense of self and other is shaped by the interactions that he may have with his caregivers, and dependable relationships which aid in healthy emotional development play an

immeasurable role. Thus, it is not difficult to understand how the life of a young child can be marked and drastically altered by incidences of sexual abuse. Yet the incidence of sexual abuse is not only high for young children. Figure 1 illustrates the rate of childhood sexual abuse per 1,000 children according to age group, as reported by the National Clearinghouse on Child Abuse and Neglect (2004) in their latest census.

Figure 1. Rate of Childhood Sexual Abuse



Moreover, when you consider that the above referenced figures are likely an underestimate (because so many incidents of childhood sexual abuse do not get reported) the statistics become even more discouraging.

Consequences of Childhood Sexual Abuse

While not all children who have experienced abuse or neglect suffer fatal consequences, or even develop psychological problems as a result of the trauma, the after affects of childhood sexual abuse can be potentially chronic and pervasive throughout ones life. Paolucci, Genuis, and Violato (2001) conducted a meta-analysis to better understand the effects of childhood sexual abuse, and found high incidents of internalizing disorders (notably, depression and anxiety), externalizing disorders (aggression, conduct disorder, sexualized behaviors), as well as other "multifaceted

effects" (p. 33) such as loss of self-esteem, prostitution, suicide/suicide attempts, and other interpersonal problems. Carter (1988) also considered the effects of childhood sexual abuse, and looked in particular about how the trauma can affect developing self-esteem and sense of mastery of the world.

Consistent with the findings from Paolucci, Genuis, and Violato (2001), other studies have supported the notion that women who have experienced childhood sexual abuse report higher levels of psychological symptoms, as well as a number of physiological and interpersonal reactions (Ramirez, 1998). More specifically, survivors tend to report higher rates of depression (Bagley & Ramsey, 1985; Peters, 1984), self-injurious behavior and suicidality (Sedney & Brooks, 1984), and posttraumatic stress (Brown & Anderson, 1991). Depending on how one chooses to cope with such feelings, or seek services to aid in processing the event, there may be different levels of experiencing the aforementioned symptoms. For those who feel the after-effects of the trauma in a chronic way, they can continue to be plagued by complex emotional pain, intense distress, and psychic discomfort for an indefinite period of time.

Issues around trust (and mistrust), self-blame, posttraumatic stress, depression, anger, and feelings of isolation and abandonment could also manifest as permanent fixtures in a survivor's daily life. As a girl begins to grow and develop, these feelings may affect how she understands her trauma, bonds with her peers in school, relates to her parents at home, and how she engages in healthy (or unhealthy) relationships with her self, her body, and her community (Ramirez, 1998). As she progresses into adulthood, it would follow that a female survivor of childhood sexual abuse may have difficulty

feeling worthy of finding (or keeping) a partner, understanding and controlling anger, or feeling comfortable in social situations.

Researchers have also found particular cognitive and neuropsychological changes which can occur following a traumatic event. Specifically, these neurophysiologic changes can be understood best by exploring reviewing literature on the developing brain. Ramirez (1998) notes:

> It is now known that a child's brain is acutely vulnerable to trauma. Because the brain continues developing long after a child is born, forming the microscopic connections responsible for feeling, learning, and remembering, early-childhood experiences exert a great and precise impact, physically determining how the neural circuits of the brain are wired. Thus, trauma can literally provide the organizing framework for a child (p. 3).

In fact, it has been shown that particular regions of the brain which are responsible for later emotional functioning, such as the amygdala and locus coeruleus, are twenty to thirty percent smaller in children who experienced abuse in comparison to their non-abused counterparts (Begley, 1997). Thus, the child who has been abused is placed at a significant risk for emotional dysregulation not only because of the actual traumatic event, but further, because of the brain was not given the opportunity to develop on a healthy trajectory (as it would typically in a non-abused counterpart).

Palmer (1995) explored the impact of stress and trauma to a child's developing neurocognitive system. It was hypothesized that children who experienced prolonged psychological trauma would be more likely to demonstrate difficulties in the areas of memory, executive functioning, attention, and higher integrative functions when

compared to children without a history of trauma. Palmer found that children who experienced sexual abuse had difficulty in the areas of attention (sustained attention, in particular), encoding of verbal information, and the recall of verbal information.

Aside from more long-term neurophysiological changes, there are brain regions which receive input from the central nucleus of the amygdale which can also be affected. Table 1, adapted from Carlson (1998), depicts the behavior or physiological response that can occur secondary to the activation of a particular brain region during a traumatic event.

Table 1. Brain Regions and their Physiological Responses

Brain Regions	Behavior/Physiological Response
Lateral Hypothalamus	Sympathetic activation: increased heart rate and blood pressure, paleness
Dorsal Motor Nucleus of Vagus	Parasympathetic activation: ulcers, urination, defecation
Parabrachial nucleus	Increased respiration
Ventral tegmental area	Behavioral arousal (dopamine levels)
Locus coeruleus	Increased vigilance (norepinephrine)
Dorsal lateral tegmental nucleus	Cortical activation (acetylcholine)
Nucleus reticularis pontis caudalis	Augmented startle response
Periaqueductual gray matter	Behavioral arrest (freezing)
Trigeminal, facial motor nuclei	Facial expressions of fear
Nucleus basalis	Cortical activation

In sum, our mind and body operate with one another, affect one another, and move together with our every thought, idea, feeling, and movement. Not only can the mind remember the trauma, but the whole body can remember, and be affected by, the trauma.

It would logically follow that if the brain (the control center for every activity in our body) can be affected by a trauma, a trauma survivor is likely to operate in the world somewhat different than someone who has not been sexually abused. Here again, please

take note that one does not have to operate or experience life differently because of trauma—trauma is not the prescription for physiological and emotional disruption; rather, what is being presented is an account of what can happen, both physically and psychologically.

While some children do not continue to experience symptoms from the trauma into their adulthood, there is a wide gamut of research which focuses on the development of the aforementioned symptoms as a female survivor of childhood sexual abuse matures. Bennett, Hughes, and Luke (2000) initially proposed that trauma symptoms following sexual abuse may depend on factors related to the severity of the actual abuse (how long it lasted, the amount and type of force used, the relationship that the survivor had with the perpetrator, and the age at which the abuse occurred. Gil (1991) added that the emotional climate of the child's family prior to the abuse, and the parental response to the victimization are also important determinants of whether or not symptoms become present and how pervasive and intense they are in the survivor's life.

Similarly, researchers have discerned that the actual context in which the abuse took place has an effect on the ways in which one copes after the incident. Namely, childhood sexual abuse victims with positive family environments and high levels of support seem to develop less intense, more short-term symptoms than do their counterparts who lack the aforementioned resources (Merrill, Thomsen, Sinclair, Gold, & Milner, 2001).

Impact of Childhood Sexual Abuse on Mothering

Yet despite all that is known about the development of symptoms during the course of a survivors' life, little is known about the presentation of psychological

symptoms as a survivor transitions into a parenting role. Studies suggests that as female survivors of childhood sexual abuse begin to transition into a maternal role, they may experience feelings of increased depression and uncertainty about their competence as a mother (over and above what would be experienced by woman without a history of abuse) as a result of unresolved issues from their childhood trauma (Fraiberg, 1980; Goodwin et al., 1981; Miller, 1984). Ramirez (1998) concurs with such findings, noting:

> For the parent who is a survivor of childhood sexual abuse, parenting can be overwhelming. Most survivors did not experience a normal childhood, did not have a good model of parenting, and thus have few life experiences to draw on in parenting. In addition, many survivors are dealing with unresolved issues and effects from childhood and the defenses they built in order to survive. In essence, the survivor still has many unmet needs and may not be able to give to her own child, who may actually bring up unresolved feelings and re-stimulate memories from the survivor's past. (p. 3-4).

Thus, it would seem critical that this special population be further explored, not only for the sake of the mothers, but for the sake of her family and unborn child as well.

Significance of the Study

The purpose of this study is to explore, describe, and understand how a history of childhood sexual abuse impact's a woman's attitudes, perceptions, and behaviors as she transitions into a maternal/parenting role. Levels of maternal depression, stress around parenting, perceived competence in a maternal role, and perceived family functioning in survivors will be explored in comparison to women who did not experience a childhood sexual abuse trauma.

Considering the aforementioned research which presents difficulties that a survivor can have around feeling competent, worthy, and capable, it is important to see how these thoughts and feelings may translate when a survivor decides to become a parent. Currently there are only nominal amounts of literature which seek to understand how attitudes and perceptions of mothering differ between women who were survivors of childhood sexual abuse and their counterparts who do not have a sexual abuse history, so this study will aim to fill in a gap in the literature.

Statement of the Problem

Brazelton and Greenspan (2001) assert that a child's early, formative years are the most critical, yet also paradoxically the most vulnerable, time in development. To document and explore a child's basic needs and rights during this time, Brazelton and Greenspan composed, *Irreducible Needs of Children: What Every Child Must Have to Grow, Learn and Flourish.* These needs that are discussed relate to the ways in which a child should be nurtured, and the ways in which their parents and/or caregivers should introduce them to a healthy environment. The book also addresses the types of experiences that the child should be exposed to. Specifically, Brazelton and Greenspan's seven irreducible needs are: the need for ongoing nurturing relationships; the need for physical protection, safety, and regulation; the need for experiences tailored to individual differences; the need for developmentally appropriate experiences; the need for limit setting, structure, and expectations; protecting the future.

These irreducible needs address, among many other things, the ways in which a mother gently cradles her child in her arms and smiles lovingly when given the opportunity to provide food, warmth, and tenderness. They allude to the ways in which a

parent may sit down with their child after she gets home from school to check-in on her day, help with homework, and become connected through open communication. Some needs address the importance of a parent embracing a child before they head off to school, or a parent talking with their child calmly yet firmly when needed to discipline or encourage moral behavior. The last need, the need to protect the future, embraces all that one must do to shelter a child from harm and protect them from experiences which may seriously impede growth.

When asked to comment on the consequences for children who have been sexually abused, and if they would be able to "rebound" from the extraordinary trauma Brazelton (2001) responded,

> There is research on trauma, showing the physiological and emotional reactions of children who are highly stressed. This kind of extreme stress is the same seen in babies who haven't had the pleasurable secure base. When an experience is overwhelmingly scary, like in a child who's been sexually or physically abused, you can get the stress system taking over. Children can get vigilant and hyperfearful. These patterns are not necessarily irreversible. If you provide nurturing warmth and expose the child to security and comfort, although it takes a lot longer, the child will often integrate those negative experiences as part of relationships and do quite well (if the stress hasn't gone on too long or if it hasn't derailed motor development, cognition, or several developmental phases). Of course, where stress has been chronic, the recovery process can take years (p. 20).

Thus, Brazelton and Greenspan (2001) give hope that a child can recover if provided with a secure base and consolation from a loving caregiver. Yet, they also

acknowledge that, if the problem has been left latent or if the stress symptoms have been chronic, there is potential for pervasive, chronic psychological and physiological issues that can persist through childhood and into adulthood. It seems reasonable, then, to conclude that symptoms will persist as one grows if intervention is not sought. Further, it would also be a logical inference that as a woman grows and seeks to become a mother, these untreated symptoms can certainly have an impact on the parenting process and maternal feelings.

This study will seek to not only explore the potential impact of childhood sexual abuse on maternal attitudes, perceptions, and behaviors, but it will also attempt to provide direction for psychological intervention to help expectant mothers decrease unwanted psychological symptoms and increase resilience.

Objectives

Objectives of this study are four-fold. First, in this study I will examine depressive symptoms in women who have experienced sexual abuse and who are expecting their first child, in comparison to an expectant mother who does not have a sexual abuse history. Next, I will investigate perceived parenting competence in survivors as compared to women without a sexual abuse history. Perceived family functioning will be looked at using the same two groups, and lastly, levels parenting stress will be examined between survivors and women without a sexual abuse history.

Questions

The following questions are offered for the purpose of organizing this exploration and analysis:

Research Question I: Is there a statistically significant difference in levels of depressive symptoms in women who have a history of sexual abuse who are expecting their first child when compared to women who do not have a history of abuse, and who are also expecting their first child?

Hypothesis I: There will be a statistically significant rise in levels of depressive symptoms in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Research Question II: Is there a statistically significant difference in levels of parenting stress in women who have a history of childhood sexual abuse who are expecting their first child when compared to women who do not have a history of abuse, and who are also expecting their first child?

Hypothesis II: There will be a statistically significant rise in levels of parenting stress in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Research Question III: Is there a statistically significant difference in levels of perceived parenting competence in women who have a history of childhood sexual abuse who are expecting their first child when compared to women who do not have a history of abuse, and who are also expecting their first child?

Hypothesis III: There will be a statistically significant decrease in levels of perceived parenting competence in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Research Question IV: Is there a statistically significant difference in levels of perceived family functioning in women who have a history of childhood sexual abuse

who are expecting their first child when compared to women who do not have a history of abuse, and who are also expecting their first child?

Hypothesis IV: There will be a statistically significant decrease in levels of perceived family functioning in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Definition of Terms

History of Childhood Sexual Abuse: Childhood sexual abuse, as defined by the National Data Archive on Child Abuse and Neglect (2001), includes:

> Women who had reported at least one contact or non-contact episode before the age of eighteen; those who did not were considered controls. The perpetrator could have been either family or non-family. Generally the perpetrator had to be five years older than the victim except in the case where women reported that force was used (p. 5).

For the purposes of this investigation, all such women who met the aforementioned definition were included in the abuse group. In the comparison group were women who reported situations that appeared to be consensual or adolescent experimentation, even if described as unwanted. Women whose only experience occurred when they were 18 or older were also put in the comparison group even recognizing that there may have been sequelae to their experiences (National Data Archive on Child Abuse and Neglect, 2001).

Depressive symptoms: Level of depression is defined by the Center for Epidemiologic Studies Depression Scale (CES-D; Ensel, 1986).

Family Functioning: Family functioning is defined by scores obtained from the Family APGAR Scale (Smilkstein, 1978).

Parenting Competence: Parenting competence is defined by scores on the Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978).

Parenting Stress: Parenting stress is defined by one's score on the Parenting Stress Index (PSI; Abidin, 1979).

CHAPTER II

Review of the Literature

The review of the literature will be organized according to the aforementioned hypotheses. Thus, this chapter will begin with an exploration into the existing literature on depression in adult female survivors of childhood sexual abuse, paying particular attention to the possible impact of such symptoms as a woman transitions into motherhood. Next, a review of literature which seeks to understand parenting stress in adult female survivors of childhood sexual abuse will be presented. Existing research which has focused on understanding a survivor's perceived competency in a parenting role will be offered, followed by studies which have explored perceived family functioning in adult female survivors. It is hoped that the literature review will support the need to better understand the need for more research focused on the impact of childhood sexual abuse on maternal attitudes, perceptions, and behaviors. Additionally, the literature will be reviewed in order to show how the trauma of childhood sexual abuse can impact the ways in which a woman experiences herself and her own body, operates psychologically, forms attachments with her child, and understands her own parenting behaviors and level of competence in the role

Emotional Symptoms

Women who have experienced childhood sexual abuse report higher levels of negative emotional symptoms, as well as a number of physiological, interpersonal, cognitive, and behavioral reactions (Ramirez, 1998). Survivors tend to report higher rates of depression (Bagley & Ramsey, 1985; Peters, 1984), anxiety (Briere, 1984), self-mutilation (Sedney & Brooks, 1984), suicidality (Sedney & Brooks, 1984), substance

abuse (Brown & Anderson, 1991), and dissociation (Chu & Dill, 1990) than non-abused counterparts. Further, these symptoms typically do not occur in isolation (Briere, 1992). Combinations of symptoms often meet criteria for diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), such as post-traumatic stress disorder (PTSD), acute stress disorder, and dissociative disorders. Yet it is unclear what, if any, effect that pregnancy has on the activation of these symptoms. Pregnancy is a time which, even for the most physically and psychologically healthy, can be emotional, complicated, and even difficult. Thus, it would logically follow that parenting may be profoundly different, perhaps overwhelmingly difficult, for a survivor who is still processing her own trauma (or for the survivor who has psychological sequalea secondary to her trauma).

Depression. Depression is a common symptom reported by female survivors (Browne & Finkelhor, 1986). Because of the frightening nature of the abuse, survivors often experience chronic depressive symptoms (Briere & Runtz, 1988) which, in most cases, can warrant a DSM-IV diagnosis. While there are several different types of depressive disorders, according to the National Institute for Mental Health (2005) there are several common symptoms, which include the following: persistent sad, anxious, or "empty" mood; feelings of hopelessness, pessimism; feelings of guilt, worthlessness, helplessness; loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex; decreased energy, fatigue, feelings of being slowed down; difficulty concentrating, remembering, making decisions; insomnia, early-morning awakening, or oversleeping; appetite and/or weight loss or overeating and weight gain; thoughts of

death or suicide; suicide attempts; restlessness, irritability; persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, or chronic pain.

Depressive symptoms tend to vary in degree, which may be due to the type of abuse, as well as its duration and severity (Gorey & Leslie, 1997). Thus, some women may not experience symptoms which interfere with their ability to maintain their normal daily routine, or that do not affect their lives in a pervasive way. However, many women are affected deeply by such symptoms. Sometimes these symptoms can be severe enough to include suicidal ideations or attempts (Briere, 1992; Browne & Finkelhor, 1986).

A study conducted from 1988-1990 assessed 103 children who were survivors of sexual abuse being held in Child Protection Units (CPU) at two children's hospitals in Sydney, Australia. After nine years, researchers attempted to measure the psychological adjustment of these young people (M=19.1 years) as compared to peers of similar age who did not have a history of childhood sexual abuse (Swanston, Plunkett, O'Toole, Shrimpton, Parkinson & Oates, 2003). Specifically, they hoped to identify individual predictors of outcomes, while controlling for the abuse exposure. Of the participants who remained active participants throughout the study, four died by the end of the nine years (two died after committing suicide, one died of a drug overdose, and one had been murdered). Upon review of data from the follow-up assessment and interview, it was found that sexually abused young people were significantly more depressed than those in the non-abused group. They also reported significantly lower self-esteem, more anxiety, and more hopeless and anguished than those in the comparison group (Swanston, Plunkett, O'Toole, Shrimpton, Parkinson & Oates, 2003).

There are many different theories as to why depressive symptoms are so common in this population. For example, Kumar, Steer, & Deblinger (1996) explained the expression of depressive symptoms using the life events model. In this paradigm, a negative life event is thought to cause onset of psychological symptoms. Thus, in the case of the aforementioned study, the live events model would say that the experience of the sexual abuse (as the event) would elicit a survivors symptoms of distress.

Other authors note that this relationship is not so simply explained, as there are other variables which affect the relationship between the trauma and the expression of symptoms. Kendler, Kessler, McNeale, Heath, and Eaves (1993) attempted to create an etiologic model for the prediction of major depressive episodes in a sample of women. The authors hypothesized that there were nine potential predictor variables which could cause a major depression or a major depressive episode: genetic factors, parental warmth, childhood parental loss, lifetime traumas, neuroticism, social support, past depressive episodes, recent difficulties, and recent stressful life events. The best-fitting model predicted slightly over 50% of the variance in the liability to major depression, with the strongest being stressful life events (Kendler, Kessler, McNeale, Heath, and Eaves, 1993).

Thus, this study suggests that while it may be likely that women who have experienced the trauma of sexual abuse during their childhood will experience depression (as stressful life events was the strongest predictor), there is not a simply explained causal relationship between childhood sexual abuse and depression. One could imagine, however, that if a child had experienced abuse and was also predisposed to depression because of genetic factors, the likelihood of positive symptoms to show would appear to be quite strong. While this study did acknowledge several salient predictor variables, it

did not examine how one's overall family functioning (beyond parental warmth and availability) can impact predisposition to a major depressive episode.

Further, Gorey, Richter, and Snider (2001) concurred with this hypothesis, noting that almost 50% of the survivors interviewed at intake could be classified as moderately to severely depressed, with approximately 33% having made at least one suicide attempt. Moreover, the author's noted that women sexually abused in childhood have been estimated to attempt suicide four to nineteen times more often than others (Gorey, Richter, and Snider, 2001). This troubling reality speaks to the high prevalence and severe impact that sexual abuse can have on a woman's life. However, because this sample was drawn from a clinical population, it is unclear whether the general population of women who have a sexual abuse history may be impacted in the same way.

In another study of 109 women recruited from a small community, one third of whom were survivors of childhood sexual abuse, researchers attempted to find other variables which influenced whether or not a person who had experienced sexual abuse would suffer depressive symptoms (Whiffen, Thompson & Aube, 2001). Results suggest that survivors were more likely to report interpersonal problems (such as feeling either overly controlling or exorbitantly distant) in comparison with the other participants who did not have a sexual abuse history. This study suggests that because of the early childhood traumatic experience, girls seem to experience more difficulty understanding social boundaries and/or healthy emotional intimacy that can come along with a loving relationship or friendship. Yet while the results suggest that survivors are at increased risk for reporting interpersonal problems, it is uncertain whether or not problematic interpersonal relationships are the cause of depressive episodes. Furthermore, it is

unclear whether or not positive interpersonal relationships can lead to greater resilience in women who have a history of sexual abuse.

As psychologists and psychologists in training, we are constantly reminded of the power and influence (both positive and negative) that support networks can have on an individual. In the case of survivors who have had difficulty with interpersonal relationships, perhaps they will be less likely to use support systems, trust in them, or even have people who they can say that they would be close enough to talk to.

Stress

It is not uncommon for an adult female survivor of childhood sexual abuse to suffer from stress. In this section two kinds of stress will be reviewed: post-traumatic stress and parenting stress. First, post-traumatic stress will be explored in order to conceptualize how stress can affect an individual following a trauma. Parenting stress will then be discussed to provide a frame for understanding how previous stress can impact the parent-child system.

Post-Traumatic Stress. Perhaps the most widely reviewed sequelae of childhood sexual abuse is Post-Traumatic Stress. Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) examined effects of different types of large-scale traumas (such as being in combat, receiving or being exposed to physical and/or sexual abuse, etc.). The authors asserted that out of all types of traumas, the experience of a sexual assault will most often lead to post-traumatic stress disorder (PTSD). Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) noted that 45% of the women who reported having experienced a rape met criteria for PTSD, in comparison to the 38% rate of PTSD among men who had experienced combat.

Studies confirm that on clinical evaluation a large proportion of sexually abused children meet diagnostic criteria for Post Traumatic Stress Disorder (PTSD). For example, McLeer et al. (1988) examined 31 children with histories of sexual abuse who were currently involved in outpatient treatment. The child and parent(s) were given a structured interview developed by the researchers as well as several standardized instruments assessing self-esteem, anxiety, depression, and behavior difficulties. The determination of a PTSD diagnosis was made by comparing interview data to the DSM-III criteria for PTSD. Forty-eight percent of the sample met full diagnostic criteria for PTSD. These results point to the astounding frequency of cases and potency of symptoms that plague some survivors. As we begin to think about how all of these symptoms may look in one's daily life, and think about the survivor who has been able to form a meaningful relationship and is prepared to become a mother (a stressful time in and of itself), it is not difficult to imagine how some of these feelings and symptoms may become exacerbated and feel much more complex.

To illustrate this point further, Deblinger et al. (1989) examined the charts of children admitted to an inpatient psychiatric hospital. Of the 155 charts reviewed, 29 (18.71%) had a reported history of sexual abuse. These 29 were matched with children who had a history of physical abuse and children who had no history of abuse. A checklist of PTSD symptoms, developed by the researchers through comparison with DSM-III, was used in the chart review to determine the presence of PTSD. Of the three groups, the sexually abused group had the highest proportion (26%) of children with PTSD. A comparison was also made between the three groups and the three PTSD symptom categories listed in the DSM-III (i.e., intrusion, avoidance, and hyper-arousal).

Of particular interest, the sexually abused group exhibited more intrusive symptoms than both the other groups combined. Again, this study affirms the potential for powerful symptoms and incredible discomfort in the survivor's life.

Koverola et al. (1990) assessed 48 children referred by Child Protective Services because of suspected sexual abuse. These researchers used several standardized instruments administered to the parents and children to assess self-esteem behavior problems and depression. The children were interviewed to determine the severity of abuse, and they were given a medical examination to obtain physical evidence of the sexual abuse. A diagnosis of PTSD was determined from responses to selected items on the Child Behavior Checklist, Child Behavior Survey, Child Depression Inventory, and a structured interview. The researchers found that fifty percent of the sample met full DSM-III-R diagnostic criteria for PTSD.

In addition to the more traditionally defined DSM-IV diagnosis of PTSD, it is now well known that survivors may experience Complex Post-Traumatic Stress (Field, 2001). In this case, women may actually develop guilt, shame, and embarrassment following the traumatic incident(s). In this case, a woman may actually tell herself, "I should have never been in that situation at that time... I did this to myself."

Studies have also been done which examine the high rate of comorbidity of symptoms and disorders in survivors of childhood sexual abuse. McLeer et al. (1998) examined 80 non-clinically referred sexually abused children. The assessment was carried out during the thirty to sixty day period after disclosure and termination of abuse. The non-clinically referred sexually abused group was compared with clinical and non-clinical groups of non-abused children matched by age, race and socioeconomic status.

Structured diagnostic interviews, caregiver ratings and self-reports of anxiety and depression were used for the assessment of psychopathology. While PTSD was diagnosed in only one child across the non-abused groups, 29 of the sexually abused children (36%) had PTSD. PTSD was often co-morbid with other disorders including separation anxiety disorder, major depression, dysthymia and behavioral disruptive disorders. Thus, while in this exploration different symptoms are reviewed individually, it must be remembered that a survivor can experience many of these symptoms and disorders as they age into adulthood.

In sum, the gamut of psychological consequences one may have can significantly affect productivity, concentration, feeling of self-esteem or self-efficacy, and one's ability to go through a "normal" day without being plagued by symptoms. Particularly if a woman is pregnant, these symptoms could markedly change the way she feels about her body, anticipates the coming of the child, takes care of herself (and the child), attends to somatic signals (to eat, stay hydrated, rest), and bonds with the baby prenatally. Likewise, if a survivor experiences these symptoms when with her child, this may effect the dyadic relationship extraordinarily. Everything from the mother's play, to the ways in which she bonds, responds, teaches, observes, and even takes interest in her child could be changed by the abuse experience.

Parenting Stress. Abidin (1992) defines parenting stress as a parent's reaction to an event which can impact the parent-child dyad, or the larger family system. His definition is inclusive of both negative and positive life events, and as such, parenting stress can both service and hinder one's parenting capacity and competence. Additionally, Abidin (1995) notes that parenting stress is the difference between the

demands associated with the parenting role and the perceived availability of resources for dealing with those demands.

In the case of an adult female survivor of childhood sexual abuse, parenting stress could actually support a parent's growth and development in the parental role. For example, once a survivor identifies that she is pregnant, perhaps the parenting stress will facilitate a decision to seek psychological services (if she had symptoms which she does not want to get in the way of her pregnancy and parenting) or even parenting classes (if she was a young mother or a mother who did not have a positive model for mothering when she was growing up). Conversely, parenting stress could also lead to a more dysfunctional style of parenting if a survivor is not committed to the child.

In one study conducted by Leahy, Pretty, and Tenenbaum (2003), qualitative observations were made about childhood sexual abuse survivors. One of the participants in the study was experiencing symptoms of stress, and told the interviewer, "It's hard to believe because everyone knows how strong I am, you know. Things like this don't happen to me. It made me realize, I have no idea how to protect myself, no idea. And then like, all my life, I have been able to protect other people but I cannot protect myself." Such effects are all too common in survivors, as many wonder, "Will I be able to protect my child if I could not even protect myself?"

Parenting stress has also been extensively explored to help researchers better understand how children with a disability affect a parents' stress level. In particular, parents of children with developmental disabilities, psychological, or neuropsychological difficulties have been shown to have elevated levels of parenting stress (Morgan, robinson, & Aldridge, 2002; Baxter, Cummins, & Yioliotis, 2002). Similarly, studies

have looked at parenting stress levels in parents of sexually abused children (Bronk, 2006).

Yet not as much is known about parenting stress when a mother herself had the abuse history. Research suggests that parenting stress is particularly problematic in mothers either with postpartum depression or who have had a history of depression (Misri, Reebye, Milis & Shah, 2006). In a study conducted by Gelfand, Teti, and Fox (1992), raters judged depressed mothers with higher levels of parenting stress to be less competent and less emotionally attuned and responsive to their babies. On the contrary, depressed mothers with lower levels of reported parenting stress were perceived by raters to be more competent, warm, and sensitive in their interactions with their infants. Thus, depression does not inevitably lead to decreased parenting stress; however, studies seem to indicate that comorbidity of symptoms is quite possible.

This research will help to address the issue of parenting stress in adult female survivors of childhood sexual abuse, and aims to add to the body of literature on the effects of trauma on parenting.

Sense of Competence

While it is clear that symptoms certainly can arise following the trauma of childhood sexual abuse, the question of how the trauma can shape one's sense of competence in a parenting role is yet to be explored. Literature conducted in this area has been sparse, and the studies which have been done focus on one's perceived parenting skills and abilities. Literature on parenting skills and abilities will be presented, followed by a theoretical exploration which addresses the distinct differences between skills/abilities and perceived competence.

Cole et al. (1992) conducted a study which looked at perceived parenting skill in incest survivors, and found that incest survivors felt less skills than did a group who did not experience a history of incest or other form of sexual abuse. The incest survivors reported feeling less organized and consistent as compared to the control group.

Cohen (1995) used the Parenting Skills Inventory (PSI; Nash & Morrison, 1984) to assess parenting skills and abilities. The author reported that mothers with an abuse history reported poor parenting on several domains of the PSI: role support, role image, objectivity, expectations, rapport, communication, and limit settings. This study was limited in that the survivors were recruited from a treatment clinic, whereas the control group was recruited from the general community.

Yet while parenting skills/abilities and parenting competence are related variables, it is important to recognize that they have distinct differences in definition. Further, because the variables are not interchangeable, it is important for research to begin looking at perceived parenting competence as separate from perceived parenting skills or abilities.

Thus, in order to begin an exploration of parenting competence, it is important to recognize what kinds of thoughts and feelings allow a person to experience themselves as competent. In this text, competence will be defined according to the Parenting Sense of Competence Scale (Gibaud-Wallston &Wandersman, 1978), as feeling effective and satisfied in ones role.

Feeling satisfaction, having self-esteem, and being at ease with one's responsibilities is part in parcel of being an effective parent. Yet survivors have a history

which may complicate their ability to feel completely satisfied, self-assured, or competent, as many blame themselves for their sustained abuse (Blume, 1990).

Particularly for a child who may have had feelings of powerlessness, low self-esteem, or feelings of inadequacy before the trauma occurred, asserting control by being able to provide herself with a concrete (albeit erroneous) reason why something happened to her appears to be a justifiable defense mechanism. In the face of feeling powerless and inadequate, many of us may tend to embrace something within ourselves to negate the feelings of helplessness. However, because the defense mechanism they would cling to is a distorted one, a cycle of other problems would likely arise. For example, the child may choose not to tell another person about the abuse because they are scared that others would also perceive them as bad. Further, it would follow that a child may also feel more vulnerable to repeated abuse if more people were to consider her "bad." And, as we have reviewed, a good prognosis (in terms of reporting depressive symptoms or symptoms of post-traumatic stress) can be compromised when the disclosure occurs long after the abuse has taken place.

As adults, many survivors may continue to hold themselves responsible because they were passive or silent, and went several years without telling anyone about the abuse ("If it was such a bad thing, I would have told someone. But, I didn't. I just wasn't that big of a deal… and anyway, I was the one who went over his house to begin with. I deserved it.") Or, perhaps the child may excuse the abuser because he or she was drunk, sick, or sexually frustrated (Jehu, 1989), and again feel the guilt and shame around somehow being a catalyst for the traumatic event. Thus, survivors often assume not only that they did something "bad" but also that they are "bad."

Blume (1990) described how shame towards oneself may in some way be preferable for the child, as to assume that he or she is bad may be easier than to acknowledge that a loved and trusted abuser is bad and hurtful. Perhaps the survivor's family member committed the sexual assault, and thus they are left to make sense of how a loved one could possible commit such a crime. In order to cope, the survivor is left to blame themselves, as it is easier than to blame someone who is supposed to provide unconditional, healthy love and support.

Regardless of the self-talk that a child or adult uses, the aforementioned theoretically-based data points to one commonality—feelings of guilt, shame, and low-self esteem are likely to occur in survivors of childhood sexual abuse. Whether one believes that she was the cause, or that she could have prevented it if she were stronger, feelings of having and indelible reminder of weakness, worthlessness, responsibility, and blame are common. These feelings do not evaporate when a survivor becomes pregnant, and may in fact complicate the survivor's feelings of competency and ability in a parenting role.

Family Functioning

As a the child survivor grows and reaches the age where one would normally form intimate friendships, partnerships, or even find spouses, the after-affects of the previously discussed symptoms and characteristics can affect one's ability to find connection or enter into an intimate relationship. The literature in this area details some of the possible consequences of the trauma.

Siegel and Romig (1988) suggest that a survivor may trust too easily (a phenomenon previously reviewed, relating to the inability to negotiate boundaries), or

they may fear intimacy and thus may become too dominating in relationship in order to feel a sense of power and control over how far the relationship progresses.

Other studies have shown that a survivor may use hostility to protect themselves from rejection by rejecting others first (Gordy, 1983). As Wheeler and Walton (1987) described, survivors may crave intimacy and dependency but need to control the relationship in order to feel safe in it. Westerlund (1983) hypothesized that survivors can also keep significant others at enough of a distance so that they are less vulnerable to getting hurt. Thus, entering a relationship—whether it is an intimate sexual relationship or a parent-child relationship—can involve a great deal of stress and uncertainty.

Specifically, many studies noted that survivors are at increased risk for further sexual abuse, promiscuity, early (young) pregnancy, and inappropriate masturbatory acts (Alexander & Lupfer, 1987; AlterReid et al., 1986; Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; Brown & Anderson, 1991; Gelinas, 1983; Jackson et al., 1990; Jennings & Armsworth, 1992; Ogata et al., 1990; Simons & Whitbeck, 1991).

In a report by Simons and Whitbeck (1991), early childhood sexual abuse also seemed to be a frequent part of the background of women who ran away from home to enter a life of prostitution. It could by hypothesized that, because the women were made to feel during their childhood as if their only asset was their sexuality, their development proceeded accordingly. Their self-esteem and feelings of self-worth were derailed and they began to define themselves according to the traumatic event. Thus, using sex in an inappropriate way actually may become a way (albeit unhealthy or maladaptive) of embracing their feelings of worth. Further, literature on self-injurious behavior often mentions the presence of a history of childhood sexual abuse (van der Kolk, Perry, &

Herman, 1991) and thus one could think of a survivor as using prostitution as another means of injuring herself. Other studies concurred with the notion that phases of promiscuity are not uncommon. One study indicated that as many as seventy-five percent of prostitutes report sexual abuse in their histories (Faria & Beholavek, 1984).

Alternatively, there are many women who are not able to embrace their sexual self at all following a childhood sexual assault. Rather than engaging in unsafe, frequent casual sex, some women are unable to find pleasure or cravings at all by sex. Such women are thought to have separated from their sexuality because of the trauma—distancing their sexual desires and intimate thoughts—and consequently feel disconnected from their sexual selves. This severance often leaves a survivor feeling appalled by their femininity, unhappy with their body, and consequently, unworthy of finding love or feeling love in a positive way.

Oppenheimer, Howells, Palmer, and Chaloner's (1985) study of 78 female patients in an eating disorder clinic, two thirds of whom had been victims of childhood sexual abuse, indicated that the women's eating disorders were related to feelings of inferiority or disgust about their femininity and sexuality.

For those who are not promiscuous, but who do attempt to have sexual intercourse as part of an intimate relationship, there are also some reported predicaments involving one's sexuality and/or sexual experiences. Some studies report that survivors can experience flashbacks to the abuse incidents during sexual relations, which can manifest as fear, anger, or crying during sex. Brickman (1984) offered that survivors may even experience a sense of numbness or deadness, often dissociating from their bodies to tolerate the abuse experiences.

Thus, whether one uses her body promiscuously, feels as if her body is flawed and imperfect (as in the case of a survivor with disordered eating), or even if one is not able to achieve sexual satisfaction because of tormenting memories of the abuse, there is one certainty—there can be many long-term sequelae of childhood sexual abuse. Because sex, one's sexuality, and the ability to become intimate or have an intimate moment can be important to one's overall sense of happiness and pleasure, not being able to feel comfortable with one's sexuality is a major problem. On the converse, being too promiscuous has massive consequence—sexually transmitted diseases, unwanted pregnancy, and considerable psychological and physiological troubles.

The Emotional Experiences of Pregnancy. Having just discussed the barriers that many women have to experiencing sexual gratification and sexual intimacy, one could further extrapolate how difficult it may be for some to make a decision to become a mother. If symptoms are present when a survivor becomes pregnant, there is a chance for their nature and frequency to fluctuate (Benedict, Paine, Paine, Brandt, & Stallings, 1999). Thompson (1990) notes that even for a woman without a history of childhood sexual abuse, pregnancy is a time characterized as a time of stress requiring new or improved coping skills. For the most optimal, physically and psychologically healthy woman, pregnancy can be a time of heightened stress, increased feelings of vulnerability, and perhaps even self-doubt or self- questioning behaviors (for example, "Am I really cut out to do this?" or "I cannot possibly be ready to take on a child—I'm not sure that I even know how to be a mother!")

O'Brien-Abel (2005) addressed the impact of childhood sexual abuse on pregnancy, labor, and birth. Specifically, the author focused on how childhood sexual

abuse survivor's fears about invasive tests and procedures, choice of caregiver, disclosure of abuse, and issues of control played out over the course of the pregnancy process. The author discovered that mothers with a history of childhood sexual abuse are more likely to have increased distress over their birth experience. Further, female survivors were more apt to have breast-feeding complications, fears about their infant, and trust issues within their family (even if one never had experienced feelings of mistrust before). It was concluded that the pregnancy and birthing process could actually trigger past abuse memories, which had the possibility of in turn eliciting characteristics of mood disorders, and/or posttraumatic stress disorder in the mother.

Seng, Low, Sparbel, and Killion (2004) conducted a qualitative study after observing that many nurses and midwives did not have an awareness of how sexual abuse affects a woman's pregnancy and delivery experience, and further, how such a traumatic experience could complicate one's pregnancy. The authors interviewed 15 women at various points during their pregnancy, and concluded that participants' interviews included re-experiencing of previous trauma, avoidance and numbing of feelings, and the physiologic hyperarousal typically associated with post-traumatic stress disorder, as well as psychological symptoms such as somatization and dissociation (Seng, Low, Sparbel, & Killion, 2004).

Grimstad and Schei (1998) assessed whether survivors of sexual abuse were more likely to deliver low birth weight infants. Eighty-two women who had delivered a low birth weight infant and 91 women who had delivered a normal birth weight infant were asked about their childhood sexual abuse history. Fourteen percent of the women interviewed reported a history of sexual abuse. As previously stated, a statistically

significant relationship was not found between birthing a low-birth weight infant and having had experienced childhood sexual abuse. However, Grimstad and Schei (1998) reported that more women with a history of child sexual abuse were smokers during pregnancy (56% versus 31%) compared with non-abused women. Abused women reported lower age at first menstruation and at first intercourse experience. Nonscheduled contacts with the antenatal care clinic and discomfort during pregnancy were more frequent among abused women when controlled for low birth weight.

Accordingly, once a survivor does become pregnant, there are studies which suggest that some may continue to participate in behaviors that are both dangerous for one's self and for the baby (such as smoking). There are also studies which reveal how the symptoms reported in the first section of this literature review impact one's pregnancy (physiologically and psychologically) and how this may, in turn, set the tone for the parenting process.

Impact of childhood sexual abuse on parenting

Having reviewed the potential long-term sequelae of sexual abuse, it becomes clear that the aforementioned symptoms may have an impact on how one adjusts and functions into a parenting role. Herman (1981) suggested that women with a history of childhood sexual abuse have a stronger desire to avoid motherhood, perhaps because of the exacerbated symptoms previously reviewed. Further, Burkett (1991) and Banyard (1997) offer that because a survivor can have lower self-esteem she may be less likely to feel competent to become a parent.

As Cohen (1995) summarizes,

Accumulated clinical observations of mothers who were victims of incest and

> sexual abuse point to several areas of difficulties in their maternal role. Gelinas observed that those mothers find it difficult to provide an organizing dally structure for their children, and to sustain a reasonable balance of discipline and affection (Gelinas, 1983). Herman reports that these mothers show an inability to derive satisfaction from the maternal role and relates it to their unrealistic standards and expectations (Herman, 1981). A heightened sense of responsibility, hypervigilance, and inability to use support systems was observed as well (Cohen, 1987). Clinicians suggest that these difficulties may tax the mother emotionally, thus hinder her ability to cope with the "normal" demands of her children (p. 1424).

When a survivor becomes a mother, all of the symptoms that were reviewed do not simply disappear. Rather, they carry on. Particularly if the survivor had a difficult time conceiving or a difficult pregnancy, these symptoms (the sequelae of the abuse and other life events) may affect how one parents their child and understands their maternal role.

In one study, 419 mothers from a clinical sample (identified as "high-risk" because of a history of sexual abuse) and their children ages six and seven years old were examined, with the hope of assessing the effects of early childhood sexual abuse on maternal mental health and parenting behaviors (Dubowitz et al., 2001). Results of this study demonstrated that mothers victimized during both childhood and adulthood had poorer outcomes than mothers victimized during either childhood or adulthood. The women who were abuse exhibited more depressive symptoms and harsher parenting. Dubowitz et al. (2001) went further to note that that there was an association between a

mother's history of childhood sexual abuse and negative views of themselves. The authors also found that survivors were more likely to use physical punishment as a means of discipline for their children (2001) when compared to mothers who were not abused as children. Thus, this study concurred with Cohen's (1995) assessment of the impact of childhood sexual abuse sequelae on parenting practices and attitudes.

Boyer & Fineman (1992) did a pilot studies with 88 women aged eighteen and younger who were participating in adolescent parenting programs. Sixty-eight percent of the participants experienced some type of sexual abuse. This study gave evidence that supported the idea that young women that have experienced sexual abuse in adolescents are more likely to become mothers at an earlier age. From this study, it is possible to see a different angle to this problem. If female survivors are likely to become parents at an earlier age, perhaps their youth alone leads them to be less knowledgeable of parenting practices. Further, the shorter duration between the exposure to the traumatic event(s) and the conception/birth of their child would leave a woman with less time to actually cope and work through the events of her childhood. This would make a woman more likely to still have psychological and physiological sequelae from the trauma, and in turn, to approach parenting while carrying varying degrees of problematic symptoms.

Results from the Avon Longitudinal Study of Parents and Children (Roberts, O'Connor, Dunn, & Golding, 2004), a study in which 8,292 families completed self-report data on prior sexual assault history, life course variables, socioeconomic variables, psychological well-being, relationship quality, parent-child relationship quality, and children's adjustment, suggest that

> Prior child sexual abuse was associated with a range of outcomes in adulthood, including current membership of a nontraditional family type (single mother and stepfather) poorer psychological well-being, teenage pregnancy, parenting behaviors, and adjustment problems in the victim's later offspring. The relationship of child sexual abuse with aspects of the parent-child relationship in later life and with the offspring's adjustment difficulties were mediated in part by mother's mental health (p. 526).

Taking into consideration information that was put forth earlier about the potential for mental health issues to arise in childhood sexual abuse survivors, it becomes clear that parenting behaviors and the parent-child relationship can certainly be affected if psychological services were not utilized after the abuse, during adulthood, or even during one's pregnancy.

Despite this information, it is troublesome that most all of the studies done in this general area use convenient samples of women from a clinical population—the general population of women with a sexual abuse history are not necessarily represented in the predominant amount of studies. To take this one step farther, there are also few studies which seek to identify helpful recommendations for mothers who are experiencing sequelae of childhood sexual abuse. Research has indicated that one important precursor to infant – mother attachment security is the mother's own recollection of childhood attachment experiences (Hutch-Bocks, Levendosky, Bogat, & Eye, 2004). Not only does the mothers' recollection determine the experience her child will have, but rather, the study went further to discuss possible correlations between social support, demographic risk, and mothers' experiences of domestic violence, on infant attachment. Hutch-Bocks

et al. (2004) went further to state that prior studies have indicated that mothers' representation of childhood attachment experiences influence the way they see themselves as mothers. Thus, helping a mother during this critical time may not only have lasting, positive implications for her own mental health—it may also help her child to foster a more secure attachment as well.

Conclusion

While there is a large body of research documenting the possible emotional consequences of childhood sexual abuse, there is a much smaller base of literature which addresses the impact of childhood sexual abuse on maternal attitudes, perceptions, and behaviors. Since pregnancy and the transition to parenting can be a stressful life change for most all people without a history of childhood sexual abuse, one would think that women who have a history of childhood trauma may experience the process in a uniquely different way. Hence, the need to look very closely at women with a history of childhood sexual abuse during this delicate transition period is important.

The research which has been done in this area provides a foundation for better understanding the possible consequences of childhood sexual abuse. In such a way, the specific literature reviewed provides support for all hypotheses set forth in this research. However, there are definite differences between the existing body of research and that which is being examined in this research study.

Specifically, for those research studies which have attempted to look at this population, few have sampled from the general population of women who have histories of sexual abuse; rather, most studies have used clinical populations from residential treatment centers or outpatient treatment centers. One must wonder if the results

obtained by looking at the clinical populations can generalize to the non-clinical population. In this study, women were recruited from a non-clinical population.

Additionally, while studies have explored women's perceptions of parenting skills and/or abilities, this variable is subtly different from parenting competence. This study will look at parenting competence in particular, and will be able to better assess a survivor's sense of competence more broadly than her skills and abilities. In particular, competence is evaluated on 2 different dimensions: parenting satisfaction and parenting efficacy. In particular, the scale used in this study takes into account whether parenting is found to be rewarding, if a mother perceives herself as being a good model, doing a good job, and if she is genuinely interested in her role as a mother. Thus, this study looks at competence as something larger than one's particular skill set and abilities.

Similarly, this research study will look at family functioning more comprehensively than has been done in the past. Instead of looking at immediate family availability (whether or not two parents are present in a household, parental warmth, etc.), family functioning will include looking at how well a family problem solves and communicates, whether or not they spend time together, express affection, and whether or not there are individual members which are alone or feel one their own. In such a way this study will look at the immediate support group more holistically.

Hence, this research study hopes to extend the existing body of literature in order to better understand how the sequelae of sexual abuse in childhood can affect a mother's attitudes, perceptions, and behaviors in a non-clinical population. This study will seek to understand more about this problem, and will also hypothesize some means of helpful intervention which could be practically applied in a clinical setting.

CHAPTER III

METHODOLOGY

This chapter will discuss the methodology used in the present study, along with descriptions of the participants, instrumentation, and the power analyses used for the research questions. The present study employed archival data from n=265 participants contained within the 85th dataset of the National Data Archive on Child Abuse and Neglect (NDACAN), Family Life Development Center, Cornell University in Ithaca, NY. Instruments used in the respective research questions include Center for Epidemiologic Studies Depression Scale (CES-D; Ensel, 1986), Parenting Stress Index (PSI; Abidin, 1979, 1982), Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978), and the Family APGAR Scale (Smilkstein, 1978). Each participant, regardless of her abuse status, received the same scales.

Participants

Archival data from the National Data Archive on Child Abuse and Neglect (Dataset 85: Parenting Among Women Sexually Abused in Childhood, 1998) was used in this study. The Family Life Development Center at Cornell University collected prior medical records from an undisclosed source in order to locate participants and categorize them as abuse or non-abused. All potential participants were sent out a letter which described the intentions of the study and ensured confidentiality if one did choose to participate. The letter also introduced the research team, described how their names were obtained, discussed the parameters of participation (a 75-90 minute interview, followed up with a battery of assessments), and explained that participation would be rewarded with a $25.00 stipend.

The participants (n=357) were interviewed at 28 to 32 weeks gestation. Approximately two to four years after the birth of their child, 74% of the original sample (n=265) were re-interviewed to better understand parenting outcomes. Because the focus of this study is on the effects of childhood sexual abuse on maternal attitudes, perceptions, and behaviors, data from the second phase of the study will be used.

Participants were all female (n=265) and ranged in age from 20 to 44 years, with an average age of 27.0 years (SD=5.47). Of the total sample, 40% (n=107) indicated they had been abused, while 60% (n=158) did not have a history of abuse. African-American women comprised 71% of the sample (n=188). A substantial proportion of participants (n=101, 38.1%) attained 12 years of education (senior level of high school), with 4.2% (n=11), 8.7% (n=23), 2.6% (n=7), and 8.3% (n=22) attending one, two, three or four years of college, respectively. Fourteen percent (n=37) attended graduate school, 3.4% (n=9) pursued post-high school vocational training, and 15.8% (n=42) had not yet graduated high school at the time of study. Among participants who were no longer in high school, a significantly larger number (χ^2=222.89, $p < 0.001$) earned a diploma (75.8%, n=201) than earned a graduate equivalent degree (GED; 5.3% (n=14)).

Measures

Center for Epidemiologic Studies Depression Scale (CES-D; Ensel, 1986). The Center for Epidemiologic Studies Depression Scale (CES-D) consists of twenty items which measure depressive symptomotology. Participants are asked to rate their response to each of the twenty items according to whether or not they have experienced the feelings mentioned, "Rarely or none of the time," (recorded as a 0 point response) "Some or a little of the time," (recorded as a 1 point response) "Occasionally or a moderate

amount of the time," (recorded as a 2 point response) or "Most or all of the time" (recorded as a 3 point response). A score of greater than or equal to 22 indicates probable Major Depression; 15-21 indicates mild to moderate depression; and, a score of less than 15 does not indicate depression. The internal consistency of this scale has been shown to be .85 with the general population, and .90 with a clinical population (Radloff, 1977).

Parenting Stress Index (PSI; Abidin, 1979, 1982). The Parenting Stress Index (PSI) is a 120-item self-report scale which measures stress factors in parent-child interactions. The scale was developed to help recognize the risk of maltreatment or poor parenting, and further, to gauge parental perceptions of their child (Abidin, 1979, 1982). Parents are asked to endorse items according to whether or not they strongly agree (scored as a 1 point response), agree (scored as a 2 point response), are "not sure" of how to respond (scored as a 3 point response), disagree (scored as a 4 point response), or strongly disagree (scored as a 5 point response) with the stimulus statement. All raw scores are then added to obtain a Total Stress Score. In addition to calculating the total stress score, individual cluster scores also need to be consulted. Specifically, the PSI is divided into two domains (the child domain and the parent domain) which are further broken down into the following subscales:

Child Domain	**Parent Domain**
Distractibility/Hyperactivity	Competence
Adaptability	Isolation
Reinforces Parent	Attachment
Demandingness	Health
Mood	Role Restriction
Acceptability	Depression
	Spouse subscales

Domain and total scores are converted to percentile scores, with scores falling within the 15th and 80th percentile being considered to be within the normal range.

The PSI can be administered to parents who have children less than one month old, thus making early intervention possible for highly stressed parents (Abidin, 1995). The overall PSI score has been thought to be predictive of physical abuse and neglect, in addition to "poor parenting." The PSI has shown a high degree of internal consistency, with the coefficients for the domains cited above ranging from .70 to .84. Test-retest reliability is also significant at the $p<.01$ level. Further, the PSI has been found to have good validity (Abidin, 1995).

The PSI has also been found useful with diverse populations. As the publishers of the PSI note,

> The PSI has been empirically validated to predict observed parenting behavior, and children's current and future behavioral and emotional adjustment, not only in a variety of U.S. populations but in a variety of international populations. The transcultural research has involved populations as diverse as Chinese, Portuguese, French Canadian, Italian, Korean, etc. These studies demonstrated comparable statistical characteristics to those reported in the PSI Manual, suggesting that the PSI is a robust diagnostic measure that maintains its validity with diverse non-English-speaking cultures. This ability to effectively survive translation and demonstrate its usefulness as a diagnostic tool with non-English-speaking populations suggests that it is likely to maintain its validity with a variety of different U.S. populations (Psychological Assessment Resources, 2005, "Validation with Diverse Populations" section).

Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston &Wandersman, 1978). Perceived Parenting Competence is measured using a seventeen item self-report questionnaire, which measures two dimension of "competence": parenting satisfaction (comprised of responses to nine items) and parenting efficacy (comprised of responses to eight items). Broadly defined, competence encompasses whether a parent feels skilled and capable of dealing with caretaking difficulties, the emotional aspects of parenting, and the degree to which a parent feels frustrated, anxious, and poorly motivated in the parenting role (Gibaud-Wallston & Wandersman, 1978).

Parents are asked to provide ratings for each of the seventeen questions according to a four point Likert scale ranging from "strongly disagree" (awarded with a 1 point response) to "strongly agree" (awarded with a 4 point response). The raw scores are then tallied and converted to scaled scores, which are sorted according to the gender of the parent. Scores falling within the 15^{th} to 85^{th} percentile are considered to be within the normal limits.

Reliability and validity have been documented in several research projects (Cutrona & Troutman, 1986; Gibaud-Eallston & Wandersman, 1978). Further, Johnston and Mash (1989) reported internal consistency scores of .79 for the satisfaction domain, and .76 for the efficacy domain. Test-retest correlations reported by Gibaud-Eallston & Wandersman (1978) over a six week interval ranged from .46 to .82.

Family APGAR (Smilkstein, 1978). APGAR is an acronym for adaptability, partnership, growth, affection, and resolve. The Family APGAR is a screening tool which uses a five item, three choice scale ("Almost always," "Some of the time," and "Hardly ever") to examine each of the aforementioned areas of functioning. A parent

taking the Family APGAR would endorse each of the five items on the three choice scale. Endorsing "almost always" would be counted as a 2-point response, "some of the time" as a 1-point, and "hardly ever" as 0 points. Scores are then tallied. A score between 7 and 10 would suggest a highly functional family, 4-6 suggesting a moderately dysfunctional family, and 0-3 suggesting a severely dysfunctional family. Thus, the lower the score achieved, the better likelihood of higher family functioning. Internal consistency on the Family APGAR has been reported between .80 and .90, and test-retest reliability after a two week span was reported as .82 (Sawin & Harrigan, 1994).

Power Analysis

In order to ensure that a sufficient number of participants were available to test study hypotheses a power analysis conducted. Within this sample a customary alpha of 0.05, power of 0.95, and moderate effect size of 0.50 were used as parameters in the estimation of the number of subjects required to avoid Type II error. Power analysis conducted using G*Power (Faul & Buchner, 1992) and the Cohen conventions for effect size (Cohen, 1988), revealed that 176 participants would be required to test the null hypotheses. The collected sample of 265 participants, therefore, was ample for the present study.

Analysis of the Data

Hypothesis I: There will be a statistically significant rise in levels of depressive symptoms in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Hypothesis I was examined with an analysis of covariance (ANCOVA) model with history of sexual abuse (abuse+ versus abuse-) entered as the independent variable,

depression scores entered as the dependent variable and mother's age entered as the covariate.

Hypothesis II: There will be a statistically significant rise in levels of parenting stress in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Hypothesis II was examined with an analysis of covariance (ANCOVA) model with history of sexual abuse (abuse+ versus abuse-) entered as the independent variable, parenting stress scores entered as the dependent variable and mother's age entered as the covariate. An individual ANCOVA model was used for each of the 13 individual PSI subscales.

Hypothesis III: There will be a statistically significant decrease in levels of perceived parenting competence in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Hypothesis III was examined with an analysis of covariance (ANCOVA) model with history of sexual abuse (abuse+ versus abuse-) entered as the independent variable, parenting sense of competence aggregate score entered as the dependent variable and mother's age entered as the covariate.

Hypothesis IV: There will be a statistically significant decrease in levels of perceived family functioning in women who have a history of childhood sexual abuse as compared to women who do not have a history of abuse.

Hypothesis IV was examined with a cross-tabulation with Chi-square procedure to determine if there were significant differences in cell frequency counts between

women with and without sexual abuse history on individual domains of the Family APGAR scale.

CHAPTER IV

Results

Sample Characteristics

As previously reviewed, the present study employed archived data from n=265 participants contained within the 85th dataset of the National Data Archive on Child Abuse and Neglect (NDACAN), Family Life Development Center, Cornell University in Ithaca, NY. Sample demographic characteristics are presented in Table 2. Participants were all female and ranged in age from 20 to 44 years, with an average age of 27.0 years (SD=5.47). A substantial proportion of participants (n=101, 38.1%) attained 12 years of education (senior level of high school), with 4.2% (n=11), 8.7% (n=23), 2.6% (n=7), and 8.3% (n=22) attending one, two, three or four years of college, respectively. Fourteen percent (n=37) attended graduate school, 3.4% (n=9) pursued post-high school vocational training, and 15.8% (n=42) had not yet graduated high school at the time of study. Among participants who were no longer in high school, a significantly larger number (χ^2=222.89, p< 0.001) earned a diploma (75.8%, n=201) than earned a graduate equivalent degree (GED; 5.3% (n=14)).

Table 2. Sample Demographic Characteristics (N=265)

	f (%)	*M* (*SD*)	Range
Age (years)		27.0 (5.47)	20-44
Highest Education Completed			
10th grade	12 (4.5)		
11th grade	30 (11.3)		
12th grade	101 (38.1)		
1 year post high school	11 (4.2)		
2 years post high school	23 (8.7)		
3 years post high school	7 (2.6)		
4 years post high school	22 (8.3)		
Graduate School	37 (14.0)		
Vocational Degree/Certification	9 (3.4)		
High School Graduation Type	1 (3.4)		
Diploma	201 (75.8)		
GED	14 (5.3)		

Note. GED = Graduate Equivalency Diploma

Statistical Analysis

Descriptive and Inferential Statistics. In order to examine study hypotheses, descriptive statistics for dependent variables were calculated in the form of means and standard deviations. One-way analyses of co-variance (ANCOVA) were conducted to examine for mean differences between participants who did and did not report a personal history of sexual abuse on primary study variables. For these analyses, a series of independent ANCOVAS with study outcome variables entered as the dependent variable, history or no history of sexual abuse entered as the independent variable, and age entered as a covariate were computed. Birth date was included to control for a potential confound related to the participant's life experiences, maturity level, and potential educational opportunities.

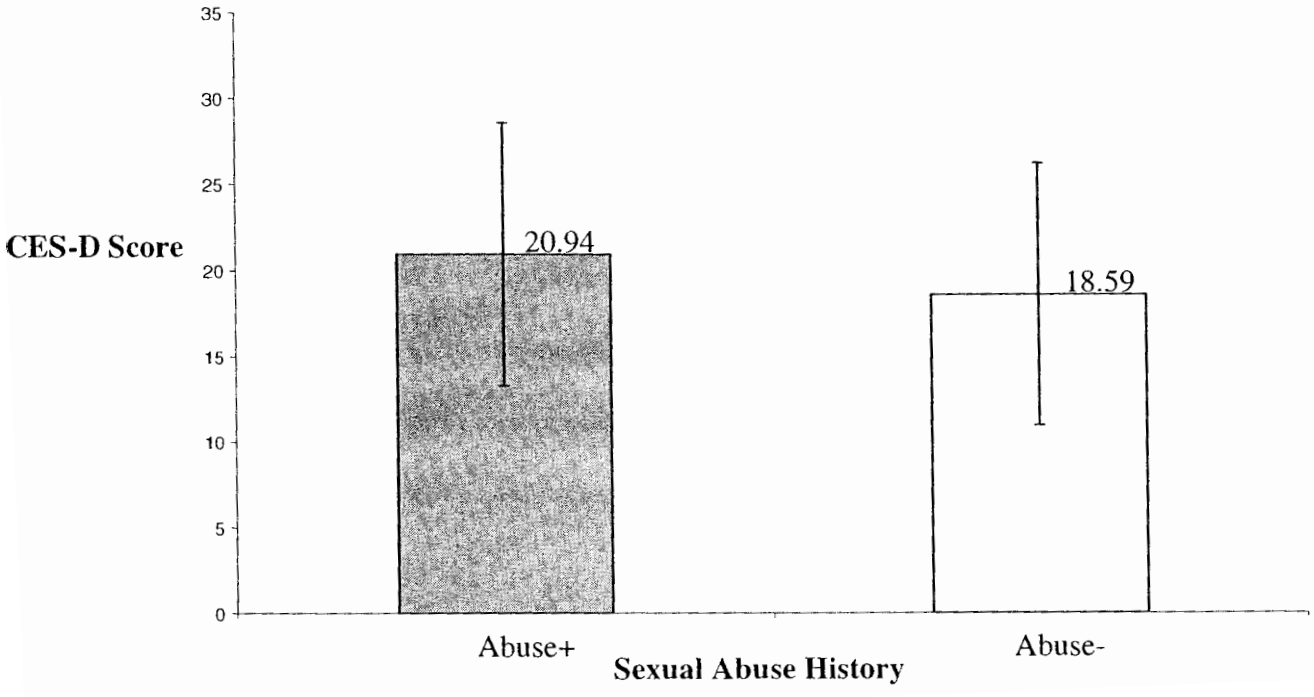
For factors in which dependent variables were comprised of nominal level data, frequency counts were generated. Non-parametric chi-square analyses were conducted to compare observed and expected cell frequencies as a parameter of statistical significance. In order to compare sexually abused and non-sexually abused participants on discriminant dependent variables, cross-tabulation and chi-square analyses were conducted. Standardized residuals were calculated for each cell and a customary residual of ≥ 2 was deemed statistically significant.

These statistical analyses are based on a sufficient sample size and employ solid inferential comparisons that are among the most rigorous available given the nature of the data provided.

Hypothesis I

The first hypothesis attempted to determine if there was a statistically significant difference in self-reported depressive symptoms between women with and without a history of childhood sexual abuse. The Center for Epidemiological Studies – Depression Scale (CES-D) was employed to assess depression. Mean scores and standard deviations for each study group were calculated and compared using ANCOVA, with mother's date of birth entered as a covariate. As seen in Figure 2, participants with a history of sexual abuse (M=20.94, SD=7.64) reported significantly higher levels of depression than participants without a history of sexual abuse (M=18.59, SD=7.08; $F(1, 260)$=8.14, p=0.01).

Figure 2. Mean CES-D Total Depression Scores Aggregated by Group



Hypothesis II

The second study hypothesis examined levels of parenting stress between women with and without a personal sexual abuse history. It was believed that women with history significant for abuse would have significantly greater levels of parenting stress than women without an abuse history. Parenting stress was assessed with the Parenting Stress Index. Parenting stress was measured among the 13 independent indices that were calculated by summing across relevant items. Mean scores and standard deviations for each domain were calculated for participants with and without abuse history and are displayed in Table 3. Analyses of covariance were used to examine group mean differences for each scale index.

The results reveal no identifiable pattern of differences between women who were and were not sexually abused. Significant group differences were observed only for the Isolation and Depression PSI indices, where women with a sexual abuse history unexpectedly reported less isolation and less depression than women who were not sexually abused. No other significant group differences were observed.

Table 3. Mean Family PSI Index Scores by Sexual Abuse Status (*N*=265)

Demographic	Total Sample (*n*=265)	Abuse+ (*n*=107)	Abuse- (*n*=158)	*F*	*p*
Distractibility/Hyperactivity	27.3 (4.4)	26.8 (4.4)	27.7 (4.4)	3.22	0.07
Adaptability	36.2 (4.9)	35.7 (4.9)	36.5 (4.9)	2.90	0.09
Reinforces Parent	19.5 (2.4)	19.8 (2.4)	19.4 (2.3)	1.31	0.25
Demandingness	28.7 (3.89)	28.2 (3.8)	29.0 (4.0)	3.50	0.06
Mood	19.0 (2.5)	19.2 (2.4)	18.9 (2.5)	0.91	0.34
Acceptability	29.1 (3.7)	28.8 (3.7)	29.3 (3.7)	1.60	0.21
Competence	30.3 (3.9)	30.1 (4.0)	30.5 (3.8)	0.73	0.40
Isolation	21.1 (3.2)	20.5 (3.4)	21.6 (3.0)	7.10	0.01
Attachment	23.8 (2.7)	23.6 (2.6)	24.0 (2.7)	1.53	0.22
Health	16.0 (2.7)	15.6 (2.7)	16.3 (2.7)	3.10	0.08
Role Restriction	23.3 (4.7)	22.8 (4.7)	23.6 (4.7)	2.40	0.13
Depression	34.3 (5.1)	33.2 (4.9)	35.1 (5.1)	9.20	0.01
Spouse	23.3 (5.5)	22.6 (5.2)	24.0 (5.6)	3.0	0.09

Notes. Values are means (*SD*). Larger scores indicate less agreement with the item (less parenting distress).

Hypothesis III

In the third study hypothesis, it was posited that perception of parenting competence would be higher among women who were not sexually abused than women who were abused. In order to test this hypothesis, the Parenting Sense of Competence

Scale was employed. Individual item responses for this scale range from strongly agree to strongly disagree with 8 of the 17 items requiring reverse scoring. Responses for appropriate items were recoded in order to have all items scored in the same direction, with lower scores representing greater parent competence. Individual items were then summed into one total variable. Means and standard deviation scores for this aggregate variable were calculated for both study groups and compared with ANCOVA. The results are displayed in Table 4. The results indicate that women who were sexually abused reported significantly better parenting competence (M=36.7, SD=3.4) than women who were not abused (M=38.0, SD=3.8; $F(2, 260)$=8.34, p=0.004).

Table 4. Mean Parenting Competence Scores by Sexual Abuse Status (N=265)

Demographic	Total Sample (n=265)	Abuse+ (n=107)	Abuse- (n=158)	F	p
Parenting Competence	37.4 (3.6)	36.7 (3.4)	38.0 (3.8)	8.34	0.004

Hypothesis IV

Hypothesis IV posited that there would be significant differences in family functioning between women who were sexually abused and women who were not sexually abused. In order to examine this hypothesis, frequency counts were generated for each of the 5 items of the family APGAR subscale and were aggregated by sexual abuse history. The results are displayed in Table 5. Cross-tabulation with chi-square procedures were conducted to determine if there were significant differences in cell frequency counts between women with and without sexual abuse history. The results did not reveal significant differences between the two sub-groups of women.

Table 5. Family APGAR Scale Scores by Sexual Abuse Status (N=265)

Demographic	Total Sample (n=265)	Abuse+ (n=107)	Abuse- (n=158)	X^2	p
Satisfied with Family Help				4.94	0.09
Almost Always	182 (68.7)	66 (61.7)	116 (73.4)		
Sometimes	68 (25.7)	32 (29.9)	36 (22.8)		
Hardly Ever	15 (5.7)	9 (8.4)	6 (3.8)		
Discussion & Problem Solving				1.98	0.37
Almost Always	131 (49.4)	48 (44.9)	83 (53.5)		
Sometimes	108 (40.8)	46 (43.0)	62 (39.2)		
Hardly Ever	26 (9.8)	13 (12.1)	13 (8.2)		
Family Accepts Wishes				2.82	0.24
Almost Always	157 (59.2)	58 (54.2)	99 (62.7)		
Sometimes	90 (34.0)	39 (36.4)	51 (32.3)		
Hardly Ever	18 (6.8)	10 (9.3)	8 (5.1)		
Family Expresses Affection				3.61	0.17
Almost Always	158 (59.6)	60 (56.1)	98 (62.0)		
Sometimes	83 (31.3)	33 (308)	50 (31.6)		
Almost Always	24 (9.1)	60 (56.1)	98 (62.0)		
Family & I Spend Time Together				1.94	0.38
Almost Always	143 (54.2)	52 (49.1)	91 (57.6)		
Sometimes	95 (36.0)	43 (40.6)	52 (32.9)		
Hardly Ever	26 (9.8)	11 (10.4)	15 (9.5)		

Notes. Values are frequency (%).

In order to further examine this hypothesis items from the Family APGAR scale were treated as continuous variables ranging from a low score of 1(good family functioning) to a high score of 3 (poor family functioning). Mean scores were generated for women with and without family functioning and are displayed in Table 6. Analysis of covariance (ANCOVA) was used to examine these mean values while controlling for participant date of birth. As seen in Table 6, ANCOVA revealed significant group differences only for the item regarding participation satisfaction with family help, where women with a history of sexual abuse were found to be significantly more satisfied with family help than women without abuse history (p=0.01). Mean scores for the remaining Family APGAR items did not differ significantly.

Table 6. Mean Family APGAR Scale Scores by Sexual Abuse Status (N=265)

Demographic	Total Sample (n=265)	Abuse+ (n=107)	Abuse- (n=158)	F	p
Satisfied with Family Help	1.37 (0.59)	1.47 (0.65)	1.30 (0.54)	6.06	0.01
Discussion & Problem Solving	1.60 (0.66)	1.67 (0.68)	1.56 (0.64)	2.70	0.10
Family Accepts Wishes	1.48 (0.62)	1.55 (0.66)	1.42 (0.59)	3.26	0.07
Family Expresses Affection	1.49 (0.66)	1.57 (0.72)	1.44 (0.61)	2.70	0.10
Family & I Spend Time Together	1.56 (0.67)	1.61 (0.67)	1.52 (0.67)	1.71	0.19

Notes. Values are means (*SD*). Smaller scores indicate greater agreement with the item (greater family functioning).

Chapter V

Discussion

This study attempted to better understand the impact of childhood sexual abuse on a woman's attitudes, perceptions, and behaviors as she transitioned to motherhood. Depressive symptoms, parenting stress, perceived parenting competence, and perceived family functioning were examined in women who had a history of childhood sexual abuse and in their non-abused counterparts. Existing literature in these areas supported the notion that women with a history of childhood sexual abuse may have increased depressive symptoms, increased parenting stress, a decreased sense of parenting competence, and a decreased sense of family functioning.

Summary and Rationale of Study

Previous research which looked at depression in adult female survivors guided this investigation, and provided impetus for a more thorough examination on the impact of childhood sexual abuse on maternal attitudes, perceptions, and behaviors. It was hypothesized that survivors would have increased levels of depression when compared to non-abused counterparts, and that perhaps the increased depressive symptoms would affect a woman's parenting stress, sense of competence, and sense of the family's functional level. Additionally, Herman (1981) suggested that women with a history of childhood sexual abuse have a stronger desire to avoid motherhood, perhaps because of the exacerbated symptoms previously reviewed. Further, Burkett (1991) and Banyard (1997) suggest that a survivor typically has lower self-esteem and is less likely to see herself as a competent and strong person, and that she is less likely to feel competent to

become a parent. Thus, it was expected that findings from this study would support previous research in this area.

Discussion of the Results

It was found that women with a history of childhood sexual abuse do have increased levels of depressive symptoms as measured by the CES-D. However, despite significant findings the differences were very minor. Further, the results did not reveal an identifiable pattern of differences between women who were and were not sexually abused with regards to parenting stress. In fact, as previously shown, significant group differences were observed only for the Isolation and Depression PSI indices, where women with a sexual abuse history unexpectedly reported less isolation and less depression than women who were not sexually abused. This finding raises two important points: (1) the results from the PSI were contradictory to the results from the CES-D; (2) survivors were experiencing less isolation than their non-abused counterparts. I will review each point in further detail.

As for why the PSI results were contradictory to the results from the CES-D, a possible explanation for such difference can be the fact that the PSI measures depression in a much more limited way than the CES-D. To be more specific, the CES-D is a screening tool which assesses the frequency and duration of specific symptoms which are commonly associated with depression. The tool is solely used to measure depression (and to track recovery from depression following treatment), and thus it has much more detailed, comprehensive questions which help to detect particular symptoms of depression. The PSI, on the other hand, is a measure which primarily focuses on the magnitude of stress in the parent-child dyad, and thus it assesses depression in a more

limited, incomplete manner. On the PSI, only certain characteristic symptoms of depression are evaluated as way to better understand if depression could be a possible source of stress in the parent-child system.

The second finding which suggests that survivors are experiencing less isolation than their non-abused counterparts indicates that the women in this study seem to be well connected in their community and/or family, and that they may not see the charge of parenting and child rearing to be something that falls on their shoulders alone. I believe that this finding highly correlates with the other findings (namely, survivors experience of increased competence) as she does not feel secluded or abandoned in the parenting process.

Most notably, results indicate that women who were sexually abused reported significantly better parenting competence (M=36.7, SD=3.4) than women who were not abused (M=38.0, SD=3.8; $F(2, 260)$=8.34, p=0.004). These findings should be looked at critically and explored carefully, as this research could help identify factors which lead to greater resilience, feelings of self-efficacy, and one's overall sense of capability in a parenting role. The survivors could have been participants in a psychotherapy or counseling regimen, or perhaps other factors (such as having a strong support network or role model) led them to develop such a strong sense of competence and mastery around parenting. Or, it is possible that the survivors did not have a heightened sense of self-awareness or insight and thus could not report competencies (or lack thereof) in an accurate way.

Lastly, there were significant differences in family functioning between women who were sexually abused and women who were not sexually abused where women with

a history of sexual abuse were found to be significantly more satisfied with family help than women without abuse history (p=0.01). It is difficult to speculate as to why this may be, however, it is possible that if a survivor experienced her home life as negative or unsupportive growing up she may be more keenly aware to the love and support of a partner, significant other, or child as an adult. Another possible explanation for such finding could be that the women in this study were likely not living in isolation (as most live below the poverty line and may live in homes with other family members) and thus feel very helped and supported by family members in the parenting of their child. Furthermore, if the women are not experiencing themselves as isolated and are more collectivistic in nature, perhaps they experience and use their community as family ("it takes a village to raise a child.")

Limitations

This study was completed using a predominantly African-American population (71%). Because the sample was not diverse, results may not be able to be generalized to a larger, diverse population. Additionally, 40% of the sample had reported an income of below $15,000.00 per year, while approximately 33% reported an income of less than $30,000.00 per year. Thus, the sample was comprised of women who are living below the poverty line, and women in a low socio-economic bracket. Resources are quite limited for this group and thus finding access to free or low-cost health care and/or mental health treatment would be difficult. Additionally, because some women may have been living in shelters, multiple-family homes, or with relatives, it is difficult to discern if the mothers were primary caregivers to their children. If, in fact, the women and their

children were living with family, perhaps another family took on the role of primary caregiver. This would inevitably affect the ability to generalize the results of this study.

Furthermore, demographic information did not discern women who had experienced intrafamilial sexual abuse (versus extrafamilial sexual abuse) or the amount of force used in the act of abuse. In Trickett, Reiffman, Horowitz, and Putnam's (1997) review of sexual abuse severity factors (e.g., penetration, duration, frequency, presence of force or violence, relationship to perpetrator, and age at onset of abuse), the characteristics most consistently associated with later adjustment problems were longer duration of abuse, presence of force or violence, and father (or father figure) as the perpetrator. Without knowing about the severity factors or the perpetrator it is difficult to generalize the results of this study into a larger frame of reference.

Lastly, because of the care that the Family Life Development Center at Cornell University takes to protect those whose information was used in the National Data Archive on Child Abuse and Neglect, the center is not at liberty to disclose whether they recruited locally or nationally to obtain participants for their sample.

Implications for Future Research

These findings indicate the need for future research to discover factors that lead to increased resilience in women/mothers with an abuse history. Specifically, for those women with a history of childhood sexual abuse who did not experience symptoms of depression, parenting stress, or feelings of inadequacy around parenting competence or family functioning, it would be interesting to understand what kind of protective factors (factors which helped lead to greater resilience and which mitigate potential consequences) aided how a survivor managed the trauma.

It would be highly contentious to over-generalize these results and suggest that having a history of childhood sexual abuse does not necessarily imply a history of trauma; however, it would be fitting to use these results to better help researchers, clinicians, and survivors to better understand ways in which others have successfully alleviated traumatic sequela.

Wright, Fopma-Loy and Fischer (2005) conducted a study with 79 mothers with a history of CSA who had a child living at home with them. Participants completed four measures, three of the four used in this study (Center for Epidemiologic Studies—Depression Scale, Parenting Stress Index, Parenting Competence Scale, and a measure of marital satisfaction). They also collected information related to the CSA experience, coping strategy (avoidance, seeking social support, and problem solving), child characteristics, and spousal/partner support. Findings stated that:

> Mothers showed discrepancies in how adequately they functioned across domains. While severity of the CSA experience was only weakly associated with outcome, use of avoidant coping emerged as a significant risk factor and was strongly and consistently associated with negative outcome across domains. Spousal/partner support was a strong protective factor and buffered the relationship between depressive symptoms and parenting competence. Difficult child characteristics were significantly associated with mothers' perceptions of physical health and parenting competence" (p. 1173).

Thus, there is preliminary data to suggest that resilience is related to spousal or partner assistance and support. Just as in my study, there appears to be a correlation between a lack of isolation in survivors (staying connected to a family or support system) and

feelings of increased competence, decreased depressive symptoms, and feeling a sense of efficacy in a parenting role.

Further research can aid in better understanding what dimensions of partner support truly help the "buffer" between emotional symptoms and owning a sense of parenting competence.

Implications for Future Practice

Given the findings from this and other research studies, it seems clear that childhood sexual abuse can have negative consequences. However, since many studies which have been done use convenience samples from clinical populations, results from these studies cannot be generalized to a non-clinical population. Similarly, studies which identify resilience patterns in women with a history of childhood sexual abuse are not conclusive. Therefore, future research should look to identifying patterns of resilience which can help to inform intervention. Additionally, resilience patterns can help clinicians and administrators to establish preventative measures which survivors can receive for themselves and for their children.

There have been attempts over the past ten years to improve treatment protocols for dealing with trauma. In fact, the United States government allocated in excess of 1.37 million dollars to the Federal Emergency Management Agency (FEMA) to help mental health professionals and researchers improve treatment procedures for dealing with trauma, as well as to help survivors cope with trauma of all kinds—political, physical, emotional, and sexual (White, 2001). Despite this allocation to FEMA and the efforts of many mental health professionals, statistics show that the United States loses millions of

dollars in revenue due to problems in coping with a variety of traumatic events (Hillman, 2002).

Beyond monetary loss, it is most worrisome that survivors may not be receiving consistent, empirically supported treatment with proven positive outcomes and lasting effects. In a post-September 11, 2001 society, one would expect that refining crisis and trauma work would be at the forefront of many research agendas. Yet, in 2002 the American Psychological Association's Division 12 (Task force on Education and Training) acknowledged that most training procedures for trauma counseling (including their own) are "woefully inadequate" (Hillman, 2002).

Palmer, Brown, Rae-Grant, and Loughlin (2001) studied survivors of childhood sexual abuse, hoping to learn more about the participant's willingness and intent to seek out and use professional help, and further, to evaluate how trainings for clinicians and other mental health service providers could benefit how we approach clinical work with survivors. Interestingly, survivors reported difficulty finding professionals who had specific knowledge and/or sensitivity to their needs, and additionally, found long-term treatment to be hard to find (Palmer et al., 2001). While they did identify traditional psychotherapy as useful the clients did sense a lack of true awareness or experience in dealing with survivors. These conclusions again point to the critical nature of training mental health providers on the most effective methods of working with survivors.

In order to be able to improve training for trauma counseling, it is critical that a more intense initiative begins to find empirically supported treatment methods for working with trauma survivors, and to more critically analyze the literature which is currently dictating how we work with such patients.

One of the consistently validated, effective, and empirically (qualitatively and quantitatively) supported method of working with/treating adult female survivors of childhood sexual abuse is group therapy (Alexander et al., 2001). Yet in the present day and age of managed care, a non-behavioral approach is sometimes not looked upon with grace or much consideration.

Yalom (2005) described group therapy as one that decreases a victim's sense of isolation by helping a survivor to explore different styles of relating to others, and which helps one to explore and experiment with more adaptive behaviors and attitudes. Yalom (2005) specifically describes a group format for adult female survivors of childhood sexual abuse as one that focuses on the helping a survivor to find hope and interpersonal connection through learning about relationships and group cohesiveness. Thus, the need for a group environment—one in which a safe atmosphere can be instilled and employed—can help to begin to rebuild a survivor's sense of relationships, trust, hopefulness, and connection.

Herman (1992) also affirms that allowing survivors to reconnect with others in a safe space that allows for a spectrum of emotional experiences is essential to the healing process for people who are dealing with all kinds of trauma. More specifically, as Morgan and Cummings (1999) suggest, the empowerment model of group therapy emphasizes the idea that "childhood sexual abuse trauma occurred within relationships and that healing cannot occur in isolation. Within healing relationships with other survivors, women can realize that they are not alone and they can examine societal and political factors that contribute to the prevalence of sexual abuse" (p.28).

Similarly, in a study conducted by Vaa, Egner, and Sexton (2002), highly symptomatic survivors reported to be significantly less symptomatic on scales of depression, anxiety, and posttraumatic stress after the cessation of group therapy during a long-term follow-up evaluation. Unlike strict behavioral theory and/or behavioral techniques, this model supports the idea of healing in connection, growth and empowerment through mutuality, shared experiences, and common understandings. Group therapy enables survivors to experientially work through issues—sometimes issues which are larger than the one act of trauma—in a way that will always be a model for effective coping, connection, cohesion, and healing through adaptive relationships.

Alexander et al. (1991) showed that survivors who attended group therapy had decreased symptoms of posttraumatic stress responses, maladjustment, self-blame, anger, and depression. The aforementioned study used a battery of questionnaires, depression and posttraumatic stress scales, and interviews by the therapist to uncover symptoms pre and post group therapy, and to in turn, explore the process of change for adult female survivors of childhood sexual abuse using group therapy. In short, the study showed that survivors had a statistically significant decrease on all scales and self-report measures (including the therapist interview and analysis) after the group therapy sessions concluded, and after an unspecified time in which a follow-up was conducted, versus a control group which received individual psychotherapy.

The findings of these studies are consistent with results from studies which try to understand the needs of survivors, as well as the roles of group leaders who work with this population. One of the hallmark studies conducted in such area was done by Draucker (1999), who studied the psychotherapeutic needs of female survivors of sexual

abuse. Draucker (1999) suggests that while the participants' needs seem to be influenced by the pervasiveness of violence in their lives, "with regards to professional services, the participants were most concerned about the quality of the therapeutic relationship and advised clinicians to appreciate the strengths and resources women bring to their own recovery" (p.21). It is at this intersection that we can understand the integration of Feminist Therapy (and Feminist Group Therapy) when working with such population.

For the intents and purposes of this analysis, one can define Feminist Therapy according to Feminist Therapy pioneers Laura Brown and Mary Brabeck's (1997) classification. The major tenants include: (Tenets 1& 2) Social transformation toward development of feminist consciousness; (Tenet 3) Develop out of experience; (Tenet 4 & 5) Examine power imbalance in gender and diversity; (Tenet 6) Authorize voices of the oppressed; (Tenet 7) Expand notions of identity and multiple subjectivities; (Tenet 8) Reformulate understanding of psychological distress from feminist theory. Feminist group therapy incorporates mutual empowerment and empathy, is sensitive to issues of power and interpersonal dynamics, social hierarchies that may affect women (particularly women survivors) and the healing power of the therapeutic dyad when both therapist and client strive to work from disconnection to connection (Baker Miller & Stiver, 1997).

There are many who endorse Feminist Therapy, and Feminist Group Therapy, as the sole method of dealing with adult female survivors of sexual abuse. Enns (1990) suggests that a feminist group therapists' knowledge of power issues, respect for the relational component of therapy, ethical decision-making, understanding of cultural diversity and oppression, and views on the egalitarian client-therapist relationship are among the many factors which make the feminist modality of group therapy most

effective in dealing with sexual abuse survivors. Of course it could be argued that other forms of group therapy prioritize the relationship of therapist and client (or therapist and group), but Feminist Therapy (and Feminist Therapy in a Group Therapy setting) uniquely understands the therapeutic relationship with adult female survivors of childhood sexual abuse and encourages collaboration, cohesiveness, and the redefinition of self in relation to others in a way that is empowering, healing, and unlike anything done in a strict behavioral model.

Specifically, studies have began to understand work with survivors as moving from using strategies of disconnection to connection—using defenses, techniques which allow us to dissociate from the problem, and escape relationships (disconnection) to a relationship that allows us to honor the reasons why we disconnect, but ultimately helps us to reform connections and understanding (Baker Miller & Stiver, 1993; Baker Miller & Stiver, 1997). As Jean Baker Miller and Irene Stiver (1993) discuss the paradox of connections and disconnections (known in other theoretical models as "tears" and "repairs") is at the core of the process of therapy with such clients. The authors go on to note that when the therapist can continue to be an empathic presence during both the connections and disconnections she can have a deep understanding of how frightening and disquieting it is for people to express their need and want for connection while at the same time giving up and letting go their strategies for staying out of connection.

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Appendix A

REC 01

TIME BEGAN ..... |_|_|:|_|_| 31

SECTION A: SOCIO-DEMOGRAPHIC

A1. I would like to begin with some background questions about you and your family. What is your date of birth?

DOB ..... |_|_| |_|_| |_|_| 35
MM DD YY

A2. Are you currently attending school or taking vocational training? 41

NO 0
YES ..... (SPECIFY) 1

SPECIFY: _____

A3. What is the highest grade or year of regular school that you have completed? 42

GRADE 00 01 02 03 04 05 06
07 08 09 10 11 12
COLLEGE 13 14 15 16
GRADUATE SCHOOL 17
VOCATIONAL DEGREE BEYOND HIGH SCHOOL ... (SPECIFY) 18

SPECIFY: _____

A4. Do you have a high school diploma or did you pass a high school equivalency or GED test? 44

DIPLOMA 1
GED 2
NEITHER 3

A5. How would you describe the place where you live now? IF NECESSARY, USE ANSWER CATEGORIES TO PROBE. 45

APARTMENT IN A HOUSE OR GARDEN APARTMENT (1-4 STORIES) 01
HIGH RISE APARTMENT (MORE THAN FOUR FLOORS) 02
ROWHOUSE OR DUPLEX 03
DETACHED SINGLE FAMILY HOUSE 04
SHELTER ..... (SKIP TO A8) 05
TRAILER 06
OTHER ..... (SPECIFY) 07

SPECIFY: _____

A6. Do you or someone in your household own your (house/apartment/trailer) or is it rented? 47

OWNED ..... (SKIP TO A8) 1
RENTED 2
OTHER ..... (SPECIFY) 3
DK 8

SPECIFY: _____

A7. Is this home in public or subsidized housing? IF YES, PROBE FOR PUBLIC, SUBSIDIZED OR SECTION 8. 48

NO 0
YES, PUBLIC 1
YES, SUBSIDIZED 2
YES, SECTION 8 3
DK 8
NA 9

REC 01

A8. Are there any problems in the home with (READ CATEGORIES)?

	NO	YES	
a. lack of space or privacy	0	1	49
b. lack of security from break-ins	0	1	50
c. crime in the neighborhood	0	1	51
d. other (SPECIFY)	0	1	52

SPECIFY: _____

A9. In the last two years, how many different places have you lived? These places include houses and apartments of your own, homes of friends and relatives where you stayed and shelters, or other places.

OF PLACES ..... ⌊_⌋⌊_⌋ 53

A10. Was there a time in the last two years when you had nowhere to sleep?

NO 0 55
YES 1

A11. Was there a time in the last two years when you stayed in a shelter of any kind?

NO ..... (SKIP TO SECTION B) 0 56
YES 1

A12. What kind of shelter was it? READ CATEGORIES. CODE ALL THAT APPLY.

Homeless/transient 1 57
Battered women 2
Substance abuse facility 3
Other ..... (SPECIFY) 4

SPECIFY: _____

REC 01

SECTION B: FAMILY/HOUSEHOLD & SOCIAL CONTACTS

IF R IS CURRENTLY LIVING IN A SHELTER ASK ABOUT THE LAST REGULAR HOUSEHOLD WHERE R LIVED.

B1. Now I am going to ask you some questions about your relationships with friends and relatives. How many people live in your household including yourself?

OF PEOPLE ..... ☐☐ 58
LIVES ALONE . (SKIP TO B3) 99

B2. Would you tell me who lives in your household besides yourself, starting with the oldest and going to the youngest. I'd like to know their first name, relationship to you, age and sex. The names are just to help us keep track of which person we are discussing in the rest of the questions. RECORD FIRST NAME, RELATIONSHIP, AGE AND SEX BELOW.

	FIRST NAME	RELATIONSHIP	AGE	SEX M	SEX F	
1.	_____	_____ ☐☐	☐☐	1	2	60
2.	_____	_____ ☐☐	☐☐	1	2	65
3.	_____	_____ ☐☐	☐☐	1	2	70
4.	_____	_____ ☐☐	☐☐	1	2	75
5.	_____	_____ ☐☐	☐☐	1	2	80
6.	_____	_____ ☐☐	☐☐	1	2	85
7.	_____	_____ ☐☐	☐☐	1	2	90 END 01
8.	_____	_____ ☐☐	☐☐	1	2	07
9.	_____	_____ ☐☐	☐☐	1	2	12
10.	_____	_____ ☐☐	☐☐	1	2	17

IF MORE THAN 10, RECORD AT BOTTOM OF PAGE OR INSIDE THE COVER.

PROBE: I have listed (READ RELATIONSHIPS). Have I missed any babies or small children? Is there anyone else who usually lives here but is away temporarily, for instance at school, a job, or in the hospital? ADD TO CHART.

REC 02

FAMILY APGAR QUESTIONNAIRE

B3. For the next statements, please tell me whether you are almost always, some of the time, or hardly ever satisfied with your family including those members who are not living in the household. READ STATEMENTS AND HAND R CARD A.

	ALMOST ALWAYS	SOME OF THE TIME	HARDLY EVER	
a. I am satisfied with the help that I receive from my family when something is troubling me	1	2	3	22
b. I am satisfied with the way my family discusses items of common interest and shares problem solving with me	1	2	3	23
c. I find that my family accepts my wishes to take on new activities or make changes in my life-style	1	2	3	24
d. I am satisfied with the way my family expresses affection and responds to my feelings such as anger, sorrow, and love	1	2	3	25
e. I am satisfied with the amount of time my family and I spend together	1	2	3	26

B4. When a problem arises, would you say that (READ STATEMENTS)? HAND R CARD A.

	ALMOST ALWAYS	SOME OF THE TIME	HARDLY EVER	
a. Each person in the family is on his or her own to solve the problem	1	2	3	27
b. We try to help each other come up with a way to deal with the problem	1	2	3	28
c. In general, on a day-to-day basis, the members of your family look out for each other	1	2	3	29

B5. The next few questions are about friends and social activities. About how many families in your neighborhood are you well enough acquainted with that you visit each other in your homes?

OF FAMILIES ..... ⌊__⌋ 30

B6. About how many **close** friends do you have--people you feel at ease with and can talk to about what is on your mind? You may include relatives.

OF CLOSE FRIENDS ..... ⌊__⌋ 32
OVER 95 95

REC 02

B7. Over a year's time, about how often would you say you get together with friends or relatives, like going out together or visiting in each other's homes? Would you say (READ CATEGORIES)?

Every day 01
Several days a week 02
About once a week 03
2 or 3 times a month 04
About once a month 05
5 to 10 times a year 06
Less than 5 times a year 07

34

B8. During the **past month**, about how often have you had friends over to your home? Do **not** count relatives. Would you say (READ CATEGORIES)?

Every day 1
Several days a week 2
About once a week 3
2 or 3 times in the past month 4
Once in the past month 5
Not at all in the past month 6

36

B9. About how often have you visited with friends at **their** homes in the **past month**? Do **not** count relatives. Would you say (READ CATEGORIES)?

Every day 1
Several days a week 2
About once a week 3
2 or 3 times in the past month 4
Once in the past month 5
Not at all in the past month 6

37

B10. About how often were you on the telephone with close friends or relatives during the **past month**? Would you say (READ CATEGORIES)?

Every day 1
Several days a week 2
About once a week 3
2 or 3 times in the past month 4
Once in the past month 5
Not at all in the past month 6

38

B11. How often do you attend church or worship services? READ CATEGORIES.

Never 1
Almost never 2
Several times a year 3
Once or twice a month 4
Every week or more 5

39

B12. About how many voluntary groups or organizations do you belong to--like church groups, clubs or lodges, parent groups, etc.? (Voluntary means because you want to).

GROUPS/ORGANIZATIONS . . . . . ⌊__⌋
NONE . . . . (SKIP TO SECTION C) 00

40

B13. How active are you in the affairs of these groups or clubs you belong to? Would you say that you are very active and attend most meetings, fairly active and attend fairly often, or not very active, that is you belong but hardly ever go? (If you belong to a great many, just count those you feel closest to).

VERY ACTIVE, ATTEND MOST MEETINGS 1
FAIRLY ACTIVE, ATTEND FAIRLY OFTEN 2
NOT VERY ACTIVE, BELONG BUT HARDLY EVER GO 3
VARIES, DEPENDS ON CLUB 4

42

REC 02

SECTION C: CONFLICT TACTICS SCALE

C1. No matter how well a family gets along, there are times when they disagree on major decisions, get annoyed about something or just have spats or fights because they're in a bad mood or tired. They also use different ways of trying to settle their differences. I'm going to read a list of some things that you and your family might have done when you had a dispute during the **last year**. For each item I read, tell me **how often anyone in your family over 12 years old might have done the following to you during the last year.** FOR QUESTIONS j THROUGH o, IF THE RESPONDENT ANSWERS ONCE OR MORE TIMES TO THE QUESTIONS ASK THE RELATIONSHIP OF THE PERSON THAT COMMITTED THE ACT. READ CATEGORIES AND HAND R CARD B.

	Never	Once	Twice	3-5 Times	6-10 Times	11-20 Times	20+ Times	
a. Insulted or swore at you	0	1	2	3	4	5	6	43
b. Sulked and/or refused to talk about it	0	1	2	3	4	5	6	44
c. Stomped out of the room, house or yard	0	1	2	3	4	5	6	45
d. Did or said something to spite you . . .	0	1	2	3	4	5	6	46
e. Threatened to hit or throw something at you	0	1	2	3	4	5	6	47
f. Threw, smashed, hit or kicked something other than you	0	1	2	3	4	5	6	48
g. Threw something at you	0	1	2	3	4	5	6	49
h. Pushed, grabbed, or shoved you	0	1	2	3	4	5	6	50
i. Slapped you	0	1	2	3	4	5	6	51
j. Kicked, bit or hit you with their fist . .	0	1	2	3	4	5	6	52
ASK WHO DID IT	REL _____						☐☐	53
k. Hit or tried to hit you with something	0	1	2	3	4	5	6	55
ASK WHO DID IT	REL _____						☐☐	56
l. Beat you up	0	1	2	3	4	5	6	58
ASK WHO DID IT	REL _____						☐☐	59
m. Choked you	0	1	2	3	4	5	6	61
ASK WHO DID IT	REL _____						☐☐	62

	Never	Once	Twice	3-5 Times	6-10 Times	11-20 Times	20+ Times	
n. Threatened you with a knife or gun	0	1	2	3	4	5	6	REC 02 64
ASK WHO DID IT	REL							65
o. Used a knife or gun	0	1	2	3	4	5	6	67
ASK WHO DID IT	REL							68

IF RESPONDENT ANSWERS ONCE OR MORE TO ANY QUESTIONS j - o, PLEASE ASK C2.
OTHERS GO TO C3.

C2. Were you ever injured badly enough that you had to see a doctor or go to the hospital?

NO 0
YES 1
DK 8
NA 9

70

C3. Now I am going to read this list again. This time I want you to tell me some of the things that you might have done to a family member during a dispute during the **last year. For each item I read tell me how often you might have done the following to someone in your family during the last year.** READ CATEGORIES AND HAND R CARD B.

	Never	Once	Twice	3-5 Times	6-10 Times	11-20 Times	20+ Times	
a. Insulted or swore at someone	0	1	2	3	4	5	6	71
b. Sulked and/or refused to talk about it	0	1	2	3	4	5	6	72
c. Stomped out of the room, house or yard	0	1	2	3	4	5	6	73
d. Did or said something to spite someone	0	1	2	3	4	5	6	74
e. Threatened to hit or throw something at someone	0	1	2	3	4	5	6	75
f. Threw, smashed, hit or kicked something other than someone	0	1	2	3	4	5	6	76
g. Threw something at someone	0	1	2	3	4	5	6	77
h. Pushed, grabbed, or shoved someone	0	1	2	3	4	5	6	78
i. Slapped someone	0	1	2	3	4	5	6	79
j. Kicked, bit or hit someone with your fist	0	1	2	3	4	5	6	80
k. Hit or tried to hit someone with something	0	1	2	3	4	5	6	81
l. Beat someone up	0	1	2	3	4	5	6	82

	Never	Once	Twice	3-5 Times	6-10 Times	11-20 Times	20+ Times	REC 02
m. Choked someone	0	1	2	3	4	5	6	83
n. Threatened someone with a knife or gun	0	1	2	3	4	5	6	84
o. Used a knife or gun	0	1	2	3	4	5	6	85

REC 02

SECTION D: RELATIONSHIPS

D1. Right now are you (READ OPTIONS)?

Married and living with your spouse 1
Married and your partner is temporarily away 2
Separated or divorced . (SKIP TO D3) . . 3
Not married but living with a partner . . . . . (SKIP TO D6) . . 4
Widowed . . . . . (SKIP TO D3) . . 5
Never married . . . . . (SKIP TO D3) . . 6

86

D2. How long have you been married?

YEARS . . . . . (SKIP TO D10) . . . . . ⌊_⌋⌊_⌋
(IF LESS THAN 1 YR, CODE 00)

87

D3. Do you have a regular partner or a fiance who is not living with you?

NO . . . . . (SKIP TO D7) 0
YES 1

89

D4. How often do you see this person? READ OPTIONS.

Every day 1
A few times each week 2
A few times each month 3
Once a week 4
Once a month 5
Not at all . . . (SKIP TO D7) 6

90

D5. How long have you been involved in this relationship?

MONTHS . . . . (SKIP TO D10) . . . ⌊_⌋⌊_⌋⌊_⌋

91

D6. How long have the two of you been living together?

MONTHS . . . . (SKIP TO D10) . . . ⌊_⌋⌊_⌋⌊_⌋

94
END 02

D7. Are you currently going out or dating (READ OPTIONS)?

Once a week or more 1
Once a month or more 2
Less than once/month 3
Not at all . . . . . (SKIP TO SECTION E) . . 4

07

D8. How many different people are you dating?

OF PEOPLE . . (SKIP TO §E) . . . . ⌊_⌋⌊_⌋⌊_⌋
1 PERSON ONLY 001

08

D9. How long have you been dating this person?

MONTHS . . . . . ⌊_⌋⌊_⌋⌊_⌋

11

IF D9 IS LESS THAN 3 MONTHS, SKIP TO SECTION E.

D10. Does your (partner/spouse/boyfriend) work, either full- or part-time?

NO 0
YES 1
NA 9

14

I do not have a reference for this scale —

REC 03

D11. The next set of questions are about your relationship with your (partner/spouse/boyfriend). Tell me if you strongly disagree, disagree, agree or strongly agree with the statements I am going to read you. READ STATEMENTS AND HAND R CARD C.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	NA	
a. My partner is someone I can count on for financial support if I need it	1	2	3	4	9	15
b. My partner is someone that I can talk with about things that are important to me	1	2	3	4	9	16
c. My partner is someone who is affectionate toward me	1	2	3	4	9	17
d. My partner is someone who helps me to care for my child(ren)	1	2	3	4	9	18
e. My partner is someone who understands how I am feeling	1	2	3	4	9	19
f. My partner is someone who talks with me and spends time with me	1	2	3	4	9	20
g. My partner is someone whom I can count on	1	2	3	4	9	21
h. My partner is someone who does things with me	1	2	3	4	9	22

D12. How often would you say that you and your partner agree about discipline to use in raising your child(ren). Would you say (READ CATEGORIES)?

Almost always 1
More than half the time 2
About half the time 3
Less than half the time 4
Almost never 5

23

D13. How often would you say that you and your partner agree about any other issues related to raising your child(ren) e.g. child care, activities, bedtimes, etc. Would you say (READ CATEGORIES)?

Almost always 1
More than half the time 2
About half the time 3
Less than half the time 4
Almost never 5

24

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SECTION E: CHILDREN

The next questions are related to your children. Please refresh my memory. REC 03

E1. How many children have you given birth to altogether, not counting babies who were stillborn?

OF CHILDREN ..... ⌊_⌋⌊_⌋ 25

CHILD 1

E2. Now I'd like to ask you a few questions about each of your children. READ STATEMENTS.

a. What is your oldest (next oldest, etc.) child's birth date?

BIRTHDATE ..... ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ 27
MM DD YY

b. What is the (oldest/next) child's first name?

FIRST NAME: _____

c. Is (CHILD) a boy or a girl?

BOY 1 33
GIRL 2

d. How much did (s/he) weigh at birth?

WEIGHT ..... ⌊_⌋⌊_⌋ ⌊_⌋⌊_⌋ 34
LBS OZ

E3. Where does (CHILD) usually live?

WITH SUBJECT ..... (SKIP TO E6) ... 01 38
WITH OTHER PARENT ..... (SKIP TO E4) ... 02
OTHER RELATIVES ..... (SKIP TO E4) ... 03
IN FOSTER CARE ..... (SKIP TO E4) ... 04
WITH ADOPTIVE PARENTS ..... (SKIP TO E4) ... 05
INSTITUTION ..... (SKIP TO E4) ... 06
AWAY AT SCHOOL ..... (SKIP TO E6) ... 07
DECEASED ..... (ASK E3A & E3B) ... 08
OTHER ..... (SPECIFY & SKIP TO E4) ... 09

SPECIFY: _____

a. How old was (CHILD) when he/she died?

AGE DIED ..... ⌊_⌋⌊_⌋ 40

b. Did (CHILD) die from an illness or injury?

ILLNESS 1 42
INJURY 2
OTHER ..... (SPECIFY) ... 3

SPECIFY: _____

GO TO NEXT CHILD/E4

E4. Do you contribute money or things like clothes on a regular basis for (CHILD)'s support?

NO 0 43
YES 1

E5. How often do you see (CHILD)? Would you say (READ CATEGORIES)?

Every day 01 44
2-4 times a week 02
2-4 times a month 03
Once a month 04
6-8 times a year 05
2-4 times a year 06
Once a year or less 07
Never 08

GO TO E6

REC 03

CHILD 2

BIRTHDATE ..... ⌊_⌊_⌋ ⌊_⌊_⌋ ⌊_⌊_⌋ 46
MM DD YY

FIRST NAME: _____

BOY 1 52
GIRL 2

WEIGHT ..... ⌊_⌊_⌋ ⌊_⌊_⌋ 53
LBS OZ

WITH SUBJECT ..... (SKIP TO E6) ... 01 57
WITH OTHER PARENT ..... (SKIP TO E4) ... 02
OTHER RELATIVES ..... (SKIP TO E4) ... 03
IN FOSTER CARE ..... (SKIP TO E4) ... 04
WITH ADOPTIVE PARENTS ..... (SKIP TO E4) ... 05
INSTITUTION ..... (SKIP TO E4) ... 06
AWAY AT SCHOOL ..... (SKIP TO E6) ... 07
DECEASED ..... (ASK E3A & E3B) ... 08
OTHER ..... (SPECIFY & SKIP TO E4) ... 09

SPECIFY: _____

AGE DIED ..... ⌊_⌊_⌋ 59

ILLNESS 1 61
INJURY 2
OTHER ..... (SPECIFY) ... 3

SPECIFY: _____

GO TO NEXT CHILD/E11

NO 0 62
YES 1

Every day 01 63
2-4 times a week 02
2-4 times a month 03
Once a month 04
6-8 times a year 05
2-4 times a year 06
Once a year or less 07
Never 08

GO TO F6

CHILD 3

BIRTHDATE ..... ⌊_⌊_⌋ ⌊_⌊_⌋ ⌊_⌊_⌋ 65
MM DD YY

FIRST NAME: _____

BOY 1 71
GIRL 2

WEIGHT ..... ⌊_⌊_⌋ ⌊_⌊_⌋ 72
LBS OZ

WITH SUBJECT ..... (SKIP TO E6) ... 01 76
WITH OTHER PARENT ..... (SKIP TO E4) ... 02
OTHER RELATIVES ..... (SKIP TO E4) ... 03
IN FOSTER CARE ..... (SKIP TO E4) ... 04
WITH ADOPTIVE PARENTS ..... (SKIP TO E4) ... 05
INSTITUTION ..... (SKIP TO E4) ... 06
AWAY AT SCHOOL ..... (SKIP TO E6) ... 07
DECEASED ..... (ASK E3A & E3B) ... 08
OTHER ..... (SPECIFY & SKIP TO E4) ... 09

SPECIFY: _____

AGE DIED ..... ⌊_⌊_⌋ 78

ILLNESS 1 80
INJURY 2
OTHER ..... (SPECIFY) ... 3

SPECIFY: _____

GO TO NEXT CHILD/E11

NO 0 81
YES 1

Every day 01 82
2-4 times a week 02
2-4 times a month 03
Once a month 04
6-8 times a year 05
2-4 times a year 06
Once a year or less 07
Never 08

GO TO F6

		CHILD 1	REC 03
E6.	Does (CHILD) go to school or daycare outside the home?	NO . . . . . 0 YES 1	84
E7.	Who is the one person primarily responsible for caring for (CHILD) every day? IF MORE THAN ONE NAMED, GET THE ONE MOST RESPONSIBLE ON A DAY-TO-DAY BASIS.	CHILD'S MOTHER . . . . . (GO TO E8) . . . 01 CHILD'S FATHER . . . . . 02 MOTHER'S PARTNER (NOT DAD) . . . . . 03 FATHER'S PARTNER (NOT MOM) . . . . . 04 CHILD'S GRANDMOTHER . . . . . 05 OTHER RELATIVE . . . . . 06 OTHER . . . . . (SPECIFY) . . . 07 SPECIFY: _____	85
	a. How satisfied are you with the care (PROVIDER) gives to (CHILD)? Would you say (READ CATEGORIES)?	Very dissatisfied . . . . . 1 Dissatisfied . . . . . 2 Satisfied . . . . . 3 Very satisfied 4	87
E8.	Does (CHILD) have any physical, emotional, or mental conditions that require (READ CATEGORIES)?		
	a. frequent attention or treatment from a doctor or other health professional	NO . . . . . 0 YES 1	88
	b. regular use of any medicine or drug other than vitamins	NO . . . . . 0 YES 1	89
	c. use of any special equipment, such as a hearing aid, a brace, crutches, a wheelchair, special shoes, a helmet, etc.	NO . . . . . 0 YES 1	90
E9.	About how long has it been since (CHILD) had a routine physical examination, that is, not for a particular illness but for a general check-up?	LESS THAN 1 YEAR . . . . . 1 1 YEAR, LESS THAN 2 YEARS . . . . . 2 2 YEARS, LESS THAN 5 YEARS . . . . . 3 NEVER 4	91
E10.	Sometimes, for one reason or another, some children are particularly difficult. Would you describe (CHILD) as "difficult"?	NO . . . . . 0 YES 1	92
		GO TO NEXT CHILD/E11	END 03

CHILD 2		
NO	0	07
YES	1	
CHILD'S MOTHER (GO TO E8)	01	08
CHILD'S FATHER	02	
MOTHER'S PARTNER (NOT DAD)	03	
FATHER'S PARTNER (NOT MOM)	04	
CHILD'S GRANDMOTHER	05	
OTHER RELATIVE	06	
OTHER (SPECIFY)	07	
SPECIFY: _____		
Very dissatisfied	1	10
Dissatisfied	2	
Satisfied	3	
Very satisfied	4	
NO	0	11
YES	1	
NO	0	12
YES	1	
NO	0	13
YES	1	
LESS THAN 1 YEAR	1	14
1 YEAR, LESS THAN 2 YEARS	2	
2 YEARS, LESS THAN 5 YEARS	3	
NEVER	4	
NO	0	15
YES	1	

GO TO NEXT CHILD/E11

CHILD 3		REC 04
NO	0	16
YES	1	
CHILD'S MOTHER (GO TO E8)	01	17
CHILD'S FATHER	02	
MOTHER'S PARTNER (NOT DAD)	03	
FATHER'S PARTNER (NOT MOM)	04	
CHILD'S GRANDMOTHER	05	
OTHER RELATIVE	06	
OTHER (SPECIFY)	07	
SPECIFY: _____		
Very dissatisfied	1	19
Dissatisfied	2	
Satisfied	3	
Very satisfied	4	
NO	0	20
YES	1	
NO	0	21
YES	1	
NO	0	22
YES	1	
LESS THAN 1 YEAR	1	23
1 YEAR, LESS THAN 2 YEARS	2	
2 YEARS, LESS THAN 5 YEARS	3	
NEVER	4	
NO	0	24
YES	1	

GO TO E11

I do not have a reference for this scale — not used or analyzed —

REC 04

E11. Now I am going to read you a list of statements that describe some of the feelings and behaviors of children. For each statement, tell me whether the behavior or feeling is "not true," "somewhat or sometimes true," or "very true or often true" for (OLDEST CHILD) either **now or at sometime during the past six months.** READ STATEMENTS AND HAND R CARD D.

		NOT TRUE	SOME TRUE	OFTEN TRUE	
a.	Actively explores new places	0	1	2	25
b.	Has angry moods	0	1	2	26
c.	Asserts independence; may say, "Let me do it."	0	1	2	27
d.	Can't be disciplined or controlled	0	1	2	28
e.	Can't sit still or is restless	0	1	2	29
f.	Can't stand waiting, wants everything now	0	1	2	30
g.	Clings to adults or too dependent	0	1	2	31
h.	Complies with requests	0	1	2	32
i.	Constantly seeks help	0	1	2	33
j.	Cries or fusses a lot	0	1	2	34
k.	Dawdles; too slow when getting dressed, eating, going somewhere	0	1	2	35
l.	Is defiant	0	1	2	36
m.	Demands must be met immediately	0	1	2	37
n.	Destructive with toys, books, pets	0	1	2	38
o.	Is disobedient	0	1	2	39
p.	Does what (he/she) is told	0	1	2	40
q.	Is easily frustrated	0	1	2	41
r.	Easily becomes jealous	0	1	2	42
s.	Gets along well with new playmates	0	1	2	43
t.	Gets into everything	0	1	2	44
u.	Gets too upset when separated from me	0	1	2	45
v.	Hits or bites others	0	1	2	46
w.	Inquisitive; seeks explanations from others	0	1	2	47
x.	Is irritable	0	1	2	48
y.	Keeps with a task until it is completed	0	1	2	49
z.	Likes to be alone	0	1	2	50

	NOT TRUE	SOME TRUE	OFTEN TRUE	REC 04
aa. Likes to take part in outgoing activities	0	1	2	51
bb. Is outgoing when meeting new adults	0	1	2	52
cc. Punishment doesn't change (his/her) behavior	0	1	2	53
dd. Seeks out adults with whom to play	0	1	2	54
ee. Shares toys, foods, etc. with other children	0	1	2	55
ff. Is shy or timid	0	1	2	56
gg. Squirms or struggles when picked up or held	0	1	2	57
hh. Is stubborn or strong-willed	0	1	2	58
ii. Shows sudden changes in mood or feelings	0	1	2	59
jj. Sulks or pouts	0	1	2	60
kk. Takes the first step in play with others	0	1	2	61
ll. Teases or argues with siblings or other children	0	1	2	62
mm. Throws temper tantrums or has a hot temper	0	1	2	63
nn. Is uncooperative	0	1	2	64
oo. Whines	0	1	2	65
pp. Will play with one toy for a long time	0	1	2	66

SECTION F: ABIDIN PARENTING STRESS INDEX (PSI) Must be purchased

REC 04

ADMINISTER THE PARENTING STRESS INDEX (PSI). HAND R CARD E. READ QUESTIONS TO R FROM MASTER PSI BOOKLET AND RECORD ANSWERS BELOW.

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE	
PSI-1.	1	2	3	4	5	67
PSI-2.	1	2	3	4	5	68
PSI-3.	1	2	3	4	5	69
PSI-4.	1	2	3	4	5	70
PSI-5.	1	2	3	4	5	71
PSI-6.	1	2	3	4	5	72
PSI-7.	1	2	3	4	5	73
PSI-8.	1	2	3	4	5	74
PSI-9.	1	2	3	4	5	75
PSI-10.	1	2	3	4	5	76
PSI-11.	1	2	3	4	5	77
PSI-12.	1	2	3	4	5	78
PSI-13.	1	2	3	4	5	79
PSI-14.	1	2	3	4	5	80
PSI-15.	1	2	[redacted]	4	5	81
PSI-16.	1	2	3	4	5	82
PSI-17.	1	2	3	4	5	83
PSI-18.	1	2	3	4	5	84
PSI-19.	1	2	3	4	5	85
PSI-20.	1	2	3	4	5	86
PSI-21.	1	2	3	4	5	87
PSI-22.	1	2	3	4	5	88
PSI-23.	1	2	3	4	5	89
PSI-24.	1	2	3	4	5	90
PSI-25.	1	2	3	4	5	91
PSI-26.	1	2	3	4	5	92
PSI-27.	1	2	3	4	5	93
PSI-28.	1	2	3	4	5	94
PSI-29.	1	2	3	4	5	95
PSI-30.	1	2	3	4	5	96
PSI-31.	1	2	3	4	5	97
PSI-32.	1	2	3	4	5	98

END 04

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE		REC #
PSI-33.	1	2	3	4	5		07
PSI-34.	1	2	3	4	5		08
PSI-35.	1	2	3	4	5		09
PSI-36.	1	2	3	4	5		10
PSI-37.	1	2	3	4	5		11
PSI-38.	1	2	3	4	5		12
PSI-39.	1	2	3	4	5		13
PSI-40.	1	2	[redacted]	4	5		14
PSI-41.	1	2	3	4	5		15
PSI-42.	1	2	3	4	5		16
PSI-43.	1	2	3	4	5		17
PSI-44.	1	2	3	4	5		18
PSI-45.	1	2	3	4	5		19
PSI-46.	1	2	3	4	5		20
PSI-47.	1	2	3	4	5		21
PSI-48.	1	2	3	4	5		22
PSI-49.	1	2	3	4	5		23
PSI-50.	1	2	3	4	5		24
PSI-51.	1	2	3	4	5		25
PSI-52.	1	2	3	4	5		26
PSI-53.	1	2	3	4	5		27
PSI-54.	1	2	3	4	5		28
PSI-55.	1	2	3	4	5	9	29
PSI-56.	1	2	3	4	5		30
PSI-57.	1	2	3	4	5		31
PSI-58.	1	2	3	4	5		32
PSI-59.	[redacted]						
PSI-60.	1	2	3	4	5		33
PSI-61.	1	2	3	4	5		34
PSI-62.	1	2	3	4	5		35
PSI-63.	1	2	3	4	5		36
PSI-64.	1	2	3	4	5		37
PSI-65.	1	2	3	4	5		38
PSI-66.	1	2	3	4	5		39

	STRONGLY AGREE	AGREE	NOT SURE	DISAGREE	STRONGLY DISAGREE	REC 05
PSI-67.	1	2	3	4	5	40
PSI-68.	1	2	3	4	5	41
PSI-69.	1	2	3	4	5	42
PSI-70.	1	2	3	4	5	43
PSI-71.	1	2	3	4	5	44
PSI-72.	1	2	3	4	5	45
PSI-73.	1	2	3	4	5	46
PSI-74.	1	2	3	4	5	47
PSI-75.	1	2	3	4	5	48
PSI-76.	1	2	3	4	5	49
PSI-77.	1	2	3	4	5	50
PSI-78.	1	2	3	4	5	51
PSI-79.	1	2	3	4	5	52
PSI-80.	1	2	3	4	5	53
PSI-81.	1	2	3	4	5	54
PSI-82.	1	2	3	4	5	55
PSI-83.	1	2	3	4	5	56
PSI-84.	1	2	3	4	5	57
PSI-85.	1	2	3	4	5	58
PSI-86.	1	2	3	4	5	59
PSI-87.	1	2	3	4	5	60
PSI-88.	1	2	3	4	5	61
PSI-89.	1	2	3	4	5	62
PSI-90.	1	2	3	4	5	63
PSI-91.	1	2	3	4	5	64
PSI-92.	1	2	3	4	5	65
PSI-93.	1	2	3	4	5	66
PSI-94.	1	2	3	4	5	67
PSI-95.	1	2	3	4	5	68
PSI-96.	1	2	3	4	5	69
PSI-97.	1	2	3	4	5	70
PSI-98.	1	2	3	4	5	71
PSI-99.	1	2	3	4	5	72
PSI-100.	1	2	3	4	5	73
PSI-101.	1	2	[redacted]	4	5	74

REC 05

F1. During the last **six months**, how much responsibility did your (spouse/partner [in house]/child's father) have for (READ STATEMENTS).

	NONE	LITTLE	SOME	A LOT	TOTAL	
a. supervising/caring for (CHILD)? Would you say none, a little, some, a lot or total responsibility?	0 (SKIP TO §G)	1	2	3	4	75
b. disciplining (CHILD)? Would you say none, a little, some, a lot or total responsibility?	0 (SKIP TO F2B)	1	2	3	4	76

F2. How comfortable are you with the way your (partner/child's father/spouse) (READ CATEGORIES).

	VERY UNCOM	SOME UNCOM	SOME COM	VERY COM	
a. disciplines (CHILD)? Would you say very uncomfortable, somewhat uncomfortable, somewhat comfortable or very comfortable?	0	1	2	3	77
b. supervises/cares for (CHILD)? Would you say very uncomfortable, somewhat uncomfortable, somewhat comfortable or very comfortable?	0	1	2	3	78

Qns - from different Scales - only a few individual qns. used.

REC 05

SECTION G: PARENTING BELIEFS AND FEELINGS

G1. Parents differ tremendously with regard to their parenting behaviors and their beliefs about how to raise children. Please tell me how strongly you agree with the following statements. HAND R CARD C.

		STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	
SIMON	a. When children do something wrong, the best thing to do is to try to reason with them about why they shouldn't act that way	1	2	3	4	79
SIMON	b. Parents must often yell at or scold their children harshly in order to teach them proper behavior	1	2	3	4	80
BAVOL EK-EMP/ A & B	c. Children who feel secure often grow up expecting too much	1	2	3	4	81
BAVOL EK-PUN/B	d. Children seldom learn good behavior through the use of physical punishment	1	2	3	4	82
BAVOL EK-EMP/ A & B	e. Parents who pay attention to their children's feelings and moods often spoil their children	1	2	3	4	83
BAVOL EK-PUN/ A & B	f. Children should always be spanked when they misbehave	1	2	3	4	84
SIMON	g. Parents should try to use punishments involving restrictions, such as making the child stay in his/her room, sit on the steps, sit in the corner, etc. rather than physical punishments like spanking	1	2	3	4	85
BAVOL EK-EMP/ A & B	h. Children who are given too much love by their parents will grow up to be stubborn and spoiled	1	2	3	4	86
BAVOL EK-EMP/ A & B	i. Parents who encourage their children to talk with them only end up listening to complaints	1	2	3	4	87
SIMON	j. Parents shouldn't hit their kids when disciplining them	1	2	3	4	88
BAVOL EK-EMP/ A & B	k. Children will quit crying faster if they are ignored	1	2	3	4	89
SIMON	l. The best way to get kids to behave well is to give them lots of praise and attention when they do something right	1	2	3	4	90

		STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	
BAVOI EK-EMP/ A & B	m. Children whose feelings and needs are ignored by their parents will often grow up to be more independent	1	2	3	4	REC 05 91
BAVOI EK-EMP/ A & B	n. Parents **will not** spoil their children by picking them up and comforting them when they cry	1	2	3	4	92

G2. At one time or another, all kids misbehave, do things that could be harmful, are wrong, that their mother doesn't like, or just plain get on their mother's nerves. Examples of misbehavior include hitting someone, having a temper tantrum, whining, talking or arguing back, throwing things, lying, etc. Parents have many different ways of dealing with these problems. Below are some statements that describe some of the different ways parents handle such problems with their kids. As I read each statement, tell me **how frequently** during the last **three months,** you used any of the following methods. HAND R CARD F. INTERVIEWER NOTE: FOR CHILDREN WHO DO NOT CURRENTLY LIVE AT HOME BUT DID AT SOME TIME DURING THE LAST YEAR, ASK FOR THE LAST THREE MONTHS BEFORE THE CHILD(REN) LEFT HOME.

		NOT AT ALL	NOT FREQUENTLY	FREQUENTLY	VERY FREQUENTLY	
NL	a. When (your child/any of your children) misbehaved, how frequently did you wait until later to do something about the behavior	0	1	2	3	93
TALK	b. Before you did anything about a problem caused by (your child/any of your children), how frequently did you give him or her several reminders or warnings that you were going to do something unless she/he stopped	0	1	2	3	94
OVER	c. When you were upset or under stress, how frequently did you pick on or nag at your (child/children)	0	1	2	3	95
TALK	d. When you told (your child/any of your children) not to do something, how frequently did you repeat it over and over again	0	1	2	3	96
NL	e. When (your child/any of your children) pestered you or got on your nerves, how frequently did you ignore him/her	0	1	2	3	97 END 05

		NOT AT ALL	NOT FREQUENTLY	FREQUENTLY	VERY FREQUENTLY	
OVER	f. When (your child/any of your children) misbehaved, how frequently did you get into a long argument with him/her/them	0	1	2	3	REC 06 07
LAX TALK	g. When (your child/any of your children) misbehaved, how often did you threaten to do things that you knew you wouldn't actually do	0	1	2	3	08
LAX	h. How frequently did you let your (child/children) do whatever (he/she/they) wanted	0	1	2	3	09
TALK OVER	i. When (your child/any of your children) misbehaved, how frequently did you give him/her/them a long lecture	0	1	2	3	10
OVER	j. When (your child/any of your children) misbehaved, how frequently did you raise your voice and yell at him/her/them	0	1	2	3	11
TALK	k. If saying no didn't work right away, how frequently did you keep talking and try to get through to the child	0	1	2	3	12
LAX	l. When you wanted (your child/any of your children) to stop doing something, how frequently did you coax or beg the child to stop	0	1	2	3	13
NL ADAPT ED	m. When (your child/any of your children) was/were out of your sight or away from the house, how frequently did you know what he/she was doing or where she/he was	0	1	2	3	14
OVER	n. After there was a problem with (your child/any of your children), how frequently did you hold a grudge against the child	0	1	2	3	15

		NOT AT ALL	NOT FREQUENTLY	FREQUENTLY	VERY FREQUENTLY	
LAX	o. When you went out someplace with your (child/children), how frequently did you let (him/her/them) get away with a lot more than when you were at home	0	1	2	3	REC 06 16
LAX	p. When (your child/any of your children) did something you didn't like, how frequently did you ignore it or just let it go	0	1	2	3	17
OVER	q. When there was a problem with (your child/any of your children), how frequently did you let things build up to the point where you did something that you didn't mean to do	0	1	2	3	18
OVER	r. When your (child/any of your children) misbehaved, how frequently did you spank, slap, grab or hit him/her	0	1	2	3	19
LAX	s. When (your child/any of your children) didn't do what you asked, how frequently did you let it go or end up doing it yourself	0	1	2	3	20
LAX	t. When you warned or threatened (your child/any of your children) to stop misbehaving, how frequently did they do what you said	0	1	2	3	21
LAX	u. If saying "no" didn't work when (your child/any of your children) was/were misbehaving, how frequently did you offer your child something nice so he/she would behave	0	1	2	3	22
OVER	v. When (your child/any of your children) misbehaved, how frequently did you get so frustrated or angry that the child could see you were upset	0	1	2	3	23
TALK	w. When (your child/any of your children) misbehaved, how frequently did you make him/her tell you why he/she did it	0	1	2	3	24

		NOT AT ALL	NOT FREQUENTLY	FREQUENTLY	VERY FREQUENTLY	
LAX	x. If (your child/any of your children) misbehaved and then acted sorry, how frequently did you let the misbehavior go without punishment	0	1	2	3	REC 06 25
OVER	y. When (your child/any of your children) misbehaved, how frequently did you curse at or use bad language toward the child	0	1	2	3	26
LAX	z. When you said (your child/any of your children) couldn't do something, how frequently did you let him/her do it anyway	0	1	2	3	27
EXTRA -BANK	aa. When (your child/any of your children) wouldn't do what you wanted, how frequently did you nag at him/her about his/her behavior	0	1	2	3	28
OVER	bb. When (your child/any of your children) did something you didn't like, how frequently did you insult him/her, say mean things, or call him/her names .	0	1	2	3	29
TALK	cc. If (your child/any of your children) talked back or complained when you handled a problem, how frequently did you give him/her a lecture about not complaining	0	1	2	3	30
LAX	dd. If (your child/any of your children) got upset when you said "no", how frequently did you back down and give in to the child	0	1	2	3	31
EXTRA - SIMON	ee. When (your child/any of your children) misbehaved, how frequently did you hit him/her with an object like a broom, belt, paddle, or extension cord	0	1	2	3	32
EXTRA -BANK	ff. To get (your child/any of your children) to stop misbehaving, how frequently did you try to make him/her/them feel guilty about what he/she/they had done	0	1	2	3	33

		NOT AT ALL	NOT FREQUENTLY	FREQUENTLY	VERY FREQUENTLY	
EXTRA - SIMON	gg. When (your child/any of your children) misbehaved, how frequently would you lock him/her/them out of the house	0	1	2	3	REC 06 34
EXTRA -BANK	hh. To get (your child/any of your children) to do what you wanted, how frequently did you nag at (him/her/them) . .	0	1	2	3	35
NL	ii. When you had to handle a problem with (your child/one of your children), how frequently did you tell the child you were sorry about what you had to do	0	1	2	3	36

REC 06

SECTION H: PARENTING SENSE OF COMPETENCE (PSOC)

H1. Now I would like to ask you some general questions about how you feel about being a parent. Please tell me if you strongly disagree, disagree, agree or strongly agree with the following statements. HAND R CARD C.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	
a. The problems of taking care of a child are easy to solve	1	2	3	4	37
b. Even though being a parent could be rewarding, it is difficult now	1	2	3	4	38
c. I go to bed feeling like I have not gotten a whole lot done	1	2	3	4	39
d. Sometimes when I'm supposed to be in control, I feel like the one being controlled	1	2	3	4	40
e. My parents were better prepared at being good parents than I am	1	2	3	4	41
f. I would make a fine model for a new parent	1	2	3	4	42
g. Any problems associated with being a parent are easily solved	1	2	3	4	43
h. One problem with being a parent is not knowing whether you are doing a good job	1	2	3	4	44
i. Sometimes I (feel/felt) like I (am/was) not getting anything done	1	2	3	4	45
j. If anyone can find the answer to what is troubling my child(ren), I can	1	2	3	4	46
k. I (do/did) a good job of caring for my child(ren)	1	2	3	4	47
l. I am more interested in other things than being a parent	1	2	3	4	48
m. Considering how long I've been a mother I know what I'm doing	1	2	3	4	49
n. I would be a better parent if parenting were more interesting	1	2	3	4	50
o. I have all the skills to be a good parent	1	2	3	4	51
p. Being a parent makes me tense and nervous	1	2	3	4	52
q. Being a good parent is rewarding	1	2	3	4	53

REC 06

SECTION I: MATERNAL HEALTH/FEELINGS Mastery Scale (Pearlin)

I1. Please tell me how strongly you agree or disagree with the following statements about yourself. HAND R CARD C. READ STATEMENTS.

		STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE	
a.	There is really no way I can solve some of the problems I have	1	2	3	4	54
b.	Sometimes I feel that I'm being pushed around in life	1	2	3	4	55
c.	I have little control over the things that happen to me	1	2	3	4	56
d.	Sometimes I feel I protect my child/children too much	1	2	3	4	57
e.	I can do just about anything I really set my mind to	1	2	3	4	58
f.	I often feel helpless in dealing with the problems of life	1	2	3	4	59
g.	What happens to me in the future mostly depends on me	1	2	3	4	60
h.	There is little I can do to change many of the important things in my life	1	2	3	4	61
i.	There is little I can do to save my child/children from harm	1	2	3	4	62

I2. Now I would like to find out a little bit about how you have been feeling during the **past week**. Please tell me which of the following best describes how often you felt or behaved this way during the past week. READ STATEMENTS AND HAND R CARD G.

CES-D ↓

		Rarely or none of the time (less than 1 day a week)	Some or a little of the time (1-2 days a week)	Occasionally or a moderate amount of time (3-4 days a week)	Most or all of the time (5-7 days a week)	
a.	I was bothered by things that usually don't bother me. Would you say (READ CATEGORIES)?	1	2	3	4	63
b.	I did not feel like eating; my appetite was poor	1	2	3	4	64
c.	I felt that I could not shake off the blues even with help from my family or friends	1	2	3	4	65

		Rarely or none of the time (less than 1 day a week)	Some or a little of the time (1-2 days a week)	Occasionally or a moderate amount of time (3-4 days a week)	Most or all of the time (5-7 days a week)	
d.	I felt that I was just as good as other people	1	2	3	4	REC 06 66
e.	I had trouble keeping my mind on what I was doing	1	2	3	4	67
f.	I felt depressed	1	2	3	4	68
g.	I felt that everything I did was an effort	1	2	3	4	69
h.	I felt hopeful about the future	1	2	3	4	70
i.	I thought my life had been a failure	1	2	3	4	71
j.	I felt fearful	1	2	3	4	72
k.	My sleep was restless	1	2	3	4	73
l.	I was happy	1	2	3	4	74
m.	I talked less than usual	1	2	3	4	75
n.	I felt lonely	1	2	3	4	76
o.	People were unfriendly	1	2	3	4	77
p.	I enjoyed life	1	2	3	4	78
q.	I had crying spells	1	2	3	4	79
r.	I felt sad	1	2	3	4	80
s.	I felt that people disliked me	1	2	3	4	81
t.	I could not get "going"	1	2	3	4	82

I3. At the present time, would you say your physical health is excellent, very good, good, fair or poor? 83

EXCELLENT 1
VERY GOOD 2
GOOD 3
FAIR 4
POOR 5

I4. During the last 3 months, were there any times when you were kept from your work, school or usual activities for at least one whole day because of an injury or because you weren't feeling well? 84

NO ..... (SKIP TO I6) 0
YES 1

I5. On any of these days, were you kept from your usual activities because of (READ CATEGORIES)? REC 06

		NO	YES	
a.	an accident or injury	0	1	85
b.	an illness or physical condition	0	1	86
c.	an emotional problem or trouble with your nerves	0	1	87

I6. Now I am going to ask you about some things that might have occurred during the **past year** that might have made you feel stressed or upset. Please tell me how much of a hassle the following things were for you. HAND R CARD H.

Hassles scale

To what extent (READ STATEMENTS)?

		Very Much	Some-what	Not Much	Not At All	
a.	were worries about food, shelter, health care, and transportation a hassle for you during the past year, would you say (READ CATEGORIES)	1	2	3	4	88
b.	were money worries like paying bills a hassle for you during the past year	1	2	3	4	89
c.	were problems related to family a hassle for you during the past year	1	2	3	4	90
d.	was having to move, either recently or in the future a hassle for you during the past year	1	2	3	4	91
e.	was a recent loss of a loved one a hassle for you during the past year	1	2	3	4	92
f.	was pregnancy a hassle for you during the past year	1	2	3	4	93
g.	was sexual assault or sexual harassment a hassle for you during the past year	1	2	3	4	94
h.	were problems with alcohol or drugs a hassle for you during the past year	1	2	3	4	95
i.	were work problems a hassle for you during the past year	1	2	3	4	96
j.	were problems with your friends a hassle for you during the past year	1	2	3	4	97
k.	was feeling generally "overloaded" a hassle for you during the past year	1	2	3	4	98
l.	was physical violence or emotional abuse a hassle for you during the past year	1	2	3	4	99 END 06

REC 07

SECTION J: SUBSTANCE USE

TOBACCO USE

J1. The next questions are about tobacco and alcohol use. Have you ever smoked cigarettes, cigars, or pipe tobacco?

NO ..... (SKIP TO J5) 0
YES ..... 1 — 07

J2. Do you smoke cigarettes, cigars, or pipe tobacco now?

NO 0
YES ..... (SKIP TO J4) ..... 1 — 08

J3. About how long has it been since you last smoked fairly regularly? LESS THAN ONE MONTH CODE 000.

MONTHS ..... ⌊_⌊_⌊_⌋ — 09

J4. On average, how many cigarettes (do/did) you usually smoke per day? Cigars? Pipes?

OF CIGARETTES ..... ⌊_⌊_⌋ — 12
OF CIGARS ..... ⌊_⌊_⌋ — 14
OF PIPES ..... ⌊_⌊_⌋ — 16

ALCOHOL USE

J5. Next I'd like to ask you some questions about drinking alcoholic beverages, including beer ,wine, and liquor. Have you ever had a drink of an alcoholic beverage?

NO ..... (SKIP TO J13) 0
YES 1
RF ..... (SKIP TO J13) ..... 7 — 18

J6. When was the most recent time you had anything to drink?

IN PAST 7 DAYS 1
IN PAST 30 DAYS 2
MORE THAN 30 DAYS BUT IN PAST YEAR .. 3
MORE THAN A YEAR AGO ..... 4 — 19

J7. When you (drink/drank), what (do/did) you usually drink, beer, wine, or liquor? CODE ALL THAT APPLY.

BEER ..... 1 — 20
WINE ..... 2 — 21
LIQUOR ..... 3 — 22

J8. On the days that you (drink/drank), how many drinks (do/did) you have on an average day? DRINK = A CAN OF BEER, A GLASS OF WINE, A SHOT GLASS OF LIQUOR.

OF DRINKS ..... ⌊_⌊_⌋ — 23

J9. Have you ever gone on binges or benders where you kept drinking for a couple of days or more without sobering up?

NO ..... (SKIP TO J11) 0
YES ..... 1 — 25

J10. When was the **last time** you went on a binge or bender?

LAST 2 WEEKS 1
2 WEEKS - 1 MONTH 2
1 MONTH - 6 MONTHS 3
6 MONTHS - 1 YEAR 4
LAST 12 MONTHS 5
+1 YEAR AGO ..... 6 — 26

J11. Have you ever tried to get any counselling or other kinds of services related to alcohol use?

NO 0
YES ..... 1 — 27

J12. To the best of your knowledge, have any of your friends or relatives ever gone on a binge or bender during which they did not sober up for a couple of days or have a period of two weeks when every day they were drinking 5 or more bottles of beer, glasses of wine or drinks of any kind?

NO 0
YES ..... (ASK A) 1

REC 07 28

A. If yes, who? RECORD RELATIONSHIP.

RELATIONSHIP: _____ 29

DRUGS

J13. Now I will ask some questions about drug use. Please remember that all the information you give will be strictly confidential. In the last six months, have you used any of the drugs on this list to get high, or for other effects when not prescribed by a doctor.

Have you used (SUBSTANCE) in the past six months?	YES (ASK A)	NO (GO TO NEXT SUB)	A. During the past six months, have you regularly used (SUBSTANCE) once a week or more? YES	NO	
a. marijuana, hashish, THC	1	0	1	0	31
b. inhalants such as glue, gasoline, paint thinner, nitrous oxide, amyl nitrate	1	0	1	0	33
c. hallucinogens or psychedelics such as PCP, Angel dust, LSD, DMT, mescaline, peyote, STP	1	0	1	0	35
d. crack or rock	1	0	1	0	37
e. cocaine or powder	1	0	1	0	39
f. heroin	1	0	1	0	41
g. heroin and cocaine together at the same time also known as a speedball	1	0	1	0	43
h. street or illegal Methadone	1	0	1	0	45
i. other narcotics or opiates such as opium, morphine, codeine, Demerol, Dilaudid, Talwin	1	0	1	0	47
j. downers or depressants, that is, sedatives, barbiturates, and tranquilizers such as Qualludes, Nembutal, Seconal, Quinal, Valium, Librium	1	0	1	0	49
k. uppers or speed such as amphetamines, methamphetamines also benedrine, dexedrine, Preludin, Ritalin	1	0	1	0	51

IF RESPONDENT HAS ANSWERED NO OR NEVER REGULARLY TO ALL DRUGS IN J13, GO TO SECTION K. OTHERWISE, ASK J14 - J22. REC 07

J14.	Have you ever used any of these drugs enough so that you felt like you needed it or were dependent on it?	NO ..... 0 YES 1	53
J15.	Have you ever tried to cut down on any drugs, but found you couldn't do it?	NO ..... 0 YES 1	54
J16.	Have you ever had withdrawal symptoms -- that is, have you felt sick because you stopped or cut down on any of these drugs?	NO ..... 0 YES 1	55
J17.	Have you ever gone to an emergency room as a result of using any of these drugs?	NO ..... 0 YES 1	56
J18.	Were you ever admitted as an inpatient to a hospital because of using any of these drugs?	NO ..... 0 YES 1	57
J19.	Have any of these drugs caused you considerable problems with your family, friends, on the job, at school or with the police?	NO ..... 0 YES 1	58
J20.	Have you had any emotional or psychological problems from using drugs -- such as feeling crazy or paranoid or depressed or uninterested in things?	NO ..... 0 YES 1	59
J21.	Have you sought professional help for substance use within the last year?	NO ..... 0 YES 1	60
J22.	Do you plan to seek professional help for substance use?	NO ..... 0 YES 1	61

SECTION K: PERCEPTIONS OF CHILD ABUSE AND NEGLECT

As you know, child abuse and neglect are important problems in this country. The following questions are to find out what people think about child abuse.

K1. In your opinion, how would you define child abuse i.e. What do you think child abuse is?

A. In your opinion, what is child neglect?

K2. In your opinion, what are the differences between child abuse and normal discipline of children?

These questions were made up by the Investigators developed? for another study

REC 07

K3. I would now like to ask you what you think could be some of the causes of child abuse or neglect. I am going to read you a list. Please tell me how likely you think each factor is a **cause** of child abuse or neglect. HAND R CARD I.

Do you think that (READ CAUSE) is very likely, likely, somewhat likely, or not at all likely to be a cause of child abuse or neglect?	VERY LIKELY	LIKELY	SOMEWHAT LIKELY	NOT AT ALL LIKELY	
a. family stress	1	2	3	4	62
b. a parent who was abused as a child	1	2	3	4	63
c. a child who has a difficult temperament	1	2	3	4	64
d. a parent with low self esteem	1	2	3	4	65
e. violence in family or partner abuse	1	2	3	4	66
f. a parent's lack of knowledge about child development	1	2	3	4	67
g. a parent's low education level	1	2	3	4	68
h. a parent with a mental illness	1	2	3	4	69
i. a child's health or disability	1	2	3	4	70
j. a child who has a developmental delay	1	2	3	4	71
k. a family with financial problems	1	2	3	4	72
l. a parent's temperament	1	2	3	4	73
m. wrong discipline practices	1	2	3	4	74
n. a child who does poorly in school	1	2	3	4	75
o. a parent who is mentally retarded	1	2	3	4	76
p. poor housing	1	2	3	4	77
q. a parent's alcohol use	1	2	3	4	78
r. a parent's unemployment	1	2	3	4	79
s. a child who has a learning problem	1	2	3	4	80
t. a parent's cultural upbringing	1	2	3	4	81
u. the neighborhood environment	1	2	3	4	82
v. a parent who abuses drugs	1	2	3	4	83
w. a child's behavior	1	2	3	4	84
x. a child who is slow to learn	1	2	3	4	85
y. family conflict	1	2	3	4	86
z. immaturity of parents	1	2	3	4	87

REC 07

K4. Is there anything else that you can think of that could cause child abuse? NO ..... 0 YES ..... (SPECIFY) 1 88

SPECIFY: _____

K5. Now I would like to ask you what you think could help to prevent child abuse. Tell me how likely you think each service will **prevent** child abuse or neglect. HAND R CARD I.

For example, do you think that (READ STATEMENTS) is very likely, likely, somewhat likely, or not at all likely to prevent child abuse or neglect?

	VERY LIKELY	LIKELY	SOMEWHAT LIKELY	NOT AT ALL LIKELY	
a. teaching parents about child development	1	2	3	4	89
b. Respite Care or having someone care for kids to give parents a break	1	2	3	4	90
c. day care	1	2	3	4	91
d. Head Start	1	2	3	4	92
e. special education for child	1	2	3	4	93
f. self esteem classes for parents	1	2	3	4	94
g. individual counseling for parents	1	2	3	4	95
h. family support programs	1	2	3	4	96
i. community education about child abuse	1	2	3	4	97 END 07
j. GED and other educational opportunities for parents	1	2	3	4	07
k. family counseling	1	2	3	4	08
l. teaching parents about ways to discipline their children	1	2	3	4	09
m. visiting parents in their homes	1	2	3	4	10
n. programs to keep families together	1	2	3	4	11
o. counseling for children	1	2	3	4	12
p. better employment opportunities for parents	1	2	3	4	13
q. substance abuse counseling for parents	1	2	3	4	14
r. foster care	1	2	3	4	15
s. stress management for parents	1	2	3	4	16
t. financial assistance programs	1	2	3	4	17
u. better housing	1	2	3	4	18

REC 08
19

K6. Is there anything else that you can think of that could prevent child abuse?

NO 0
YES ..... (SPECIFY) 1

SPECIFY: _____

REC 08

SECTION L: EMPLOYMENT AND SERVICES USED

We will finish this interview with a few questions about your employment and income.

L1. What were you doing **most** of last week? READ CATEGORIES. IF ON VACATION ASK ABOUT THE WEEK BEFORE. CODE ONLY ONE. 20

- Working ..... (SKIP TO L3) ... 01
- Laid off/with a job, but not at work ..... (SKIP TO L3) ... 02
- Looking for work 03
- Keeping house 04
- Unable to work 05
- School 06
- Something else ..... (SPECIFY) ... 07

SPECIFY: _____

L2. Were you employed anytime in the past two years? 22

- NO ..... (SKIP TO L4) 0
- YES 1

L3. What were your jobs in the past 2 years? Please start with your most recent job.

JOB #1: _____

JOB #2: _____

JOB #3: _____

L4. Did you or your family receive any of the following services within the last year? READ CATEGORIES.

	NO	YES	
a. Supplemental Security Income (SSI or SSDI)	0	1	23
b. Unemployment compensation	0	1	24
c. Alimony	0	1	25
d. Child support	0	1	26
e. Aid to families with dependent children (AFDC)	0	1	27
f. Food stamps	0	1	28
g. WIC	0	1	29
h. Substance abuse counseling	0	1	30
i. Substance abuse detoxification	0	1	31
j. Mental health services	0	1	32
k. Housing assistance	0	1	33
l. Child protective services	0	1	34
m. Social work services	0	1	35

REC 08

L5. To get a picture of people's financial situation, we need to know the general range of income of all families we interview. Now think about your household's total income from all sources, before taxes, including wages, salaries, welfare, and any other income. About how much did your family receive in the last 12 months? Please stop me when I reach your income level. HAND R CARD J AND READ CATEGORIES. 36

Less than $2,500	01
Less than $5,000	02
Less than $7,500	03
Less than $9,000	04
Less than $15,000	05
Less than $20,000	06
Less than $25,000	07
Less than $30,000	08
$30,000 or more	09
REFUSED	97

TIME END ..... |__|__|:|__|__| 38

Thank you very much for your time. We appreciate your help with this survey and in appreciation for your time, please accept this money order for $25.

OBTAIN ADDRESS INFORMATION AND FUTURE CONTACT INFORMATION. ENTER THIS ON THE FACE SHEET.

COMPLETE INTERVIEWER OBSERVATIONS DURING FIELD EDIT.

REC 08

SECTION M: INTERVIEWER OBSERVATIONS

M1. How cooperative was the respondent? 42

Very cooperative 1
Fairly cooperative 2
Not too cooperative 3
Openly hostile 4

M2. Was the interview done without anyone else present (that you could tell)? 43

NO . . . . . (SPECIFY) 0
YES 1

SPECIFY: _____

M3. Do you have any reason to believe R was not honest with you regarding drug use? 44

NO 0
YES . . . . . (SPECIFY) 1

SPECIFY: _____

END 08

ADDITIONAL COMMENTS: