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## **Sequelae of childhood sexual abuse and chronic headache pain in women**

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SEQUELAE OF CHILDHOOD SEXUAL ABUSE  
AND CHRONIC HEADACHE PAIN  
IN WOMEN

A Thesis

by

KATHY L. THEISS

Submitted to the Graduate School of the  
University of Texas-Pan American  
In partial fulfillment of the requirements for the degree of

MASTER OF ARTS

July 2010

Major Subject: Psychology



SEQUELAE OF CHILDHOOD SEXUAL ABUSE  
AND CHRONIC HEADACHEPAIN .  
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July 2010



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## ABSTRACT

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For many years the association of headache with CSA has been postulated and results have been similar across studies indicating a robust connection. Chronic headache is one of the most common causes of visits to physicians and contributes to decreased quality of life for those who suffer with them. Although CSA is detrimental to both men and women, evidence supports that women are more likely to suffer from chronic somatic headache pain than men. Therefore, it is hypothesized that chronic headache is significantly more common among women with a history of childhood sexual abuse when compared to women who have not suffered CSA.





## DEDICATION

I would like to dedicate this paper to my family. First and foremost I would like to sincerely thank my daughter Melody who has been so very patient with me and for the many hours she has given me in the pursuit of furthering my education. She has been my inspiration and my rock. To Caroline and Scot, my parents, who have helped me raise my daughter and supported me financially. Without them, returning to school would not have been possible. Also, I would like to thank my siblings Gayle, Kevin, Heather and Patricia who have not only helped me balance my childcare needs, but have also been my tireless support team who kept me motivated when I didn't think I could do it anymore.



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## CHAPTER I

### INTRODUCTION

Childhood sexual abuse (CSA) is a serious public health concern because the damage has a far-reaching ripple effect medically, socially and economically. There is a powerful relationship between our emotional experiences as children and our physical and mental health as adults (Felitti, V.J., 2002). In fact, studies support the notion that even half a century later the adverse effects one experiences in childhood do not just go away but fester to build a crescendo of disease and maladjustment in adulthood (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss & Marks, 1998; Felitti, 2002; Anda, 2008). According to The Adverse Childhood Experiences (ACE) Study, a decade-long and ongoing study designed to examine the childhood origins of many of our leading health and social problems, the list of ailments associated with early childhood trauma touch every area of public concern including organic disease (ischemic heart disease, cancer, chronic lung disease, skeletal fractures, STDs, liver disease), mental health (depressive disorder, anxiety, hallucinations, panic reactions, sleep disturbances, memory disturbances, poor anger control, domestic violence, suicide), poor physical health (smoking, alcohol and drug abuse, promiscuity, obesity, multiple somatic symptoms, poor preventative medicine practices), sexual health (early age at first intercourse, sexual dissatisfaction, teen pregnancy) and social problems are implicated in being outcomes of adverse childhood experiences (Anda, 2008).

The etiology of these health concerns are largely invisible to health care providers because the original problem is concealed by time. The presenting symptom most seen by medical doctors is chronic pain, specifically headache (Abbass, Lovas & Purdy, 2008). Somatic symptoms account for over 50% of all outpatient visits, or an estimated 400 million clinic visits in the US alone each year (Kroenke, 2003). It is important for health care providers to be informed of these associations so they can ask the questions necessary to help these patients root out the cancer causing their problem rather than treating the symptoms.

### **Childhood Sexual Abuse**

Childhood sexual abuse has been defined as unwanted sexual contact performed by an individual who is at least five years older than the victim and having occurred with the victim before the age of 13. This can include a wide range of behaviors including fondling, touching, exposure, penetration and rape (Goldberg, Pachas, & Keith., 1999). It is estimated that CSA occurs in 25% of the female population and 16% of the male population, respectively (Dong, Anda, Dube, Giles & Felitti, 2003; Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005; Lesserman, 2005; Goldberg & Goldstein, 2000; Tietjen, Brandes, Peterlin, Eloff, Dafer, Stein, Drexler, Martin, Hutchinson, Aurora, Reober, Herial, Utley, White & Khuder, 2009). Studies have shown that 34% of CSA victims described the perpetrator as someone who lived in their home (Dong, Anda, Dube, Giles & Felitti, 2003), and shockingly 39.1% have reported parents as sexual abusers (Goldberg & Goldstein, 2000). According to the Attorney General, 90% of child victims know their offender, with almost half of the offenders being a family member. In the majority of cases, abusers gain access to their victims through deception and enticement, seldom

using force. Abuse typically occurs within a long-term, ongoing relationship between the offender and victim and escalates over time. Most child sexual abusers offend against children whom they know and with whom they have established a relationship. It is no wonder that CSA is frequently associated with long-term significant psychiatric sequelae and markedly elevated rates of major depression among other health problems including chronic pain.

### **Health Consequences**

There is no question that the occurrence of CSA has far reaching consequences in many aspects of the victim's health and quality of life, studies suggest that possibly compounding this problem, exposure to extreme stress in childhood can promote long-term changes in the physical structure of the brain (Kaufman & Charney, 2001). Breakthroughs in neurobiological studies show that childhood trauma disrupts neurodevelopment and can have lasting effects on brain structure and function (Anda, 2008). CSA has been associated with volume loss in the hippocampus, corpus callosum and prefrontal cortex (Tomoda, Navalta, Polcari, Sadato & Teicher, 2009). The hippocampus plays an important role in long term memory. If the trauma experienced has been severe or prolonged, the stress hormones produced may inhibit or even damage the hippocampus, therefore the conscious memory of a person's life may be fractured or incomplete (Carter, 1998). The corpus callosum is a thick band of axons which connect the brain cells in one hemisphere to the cells in the other hemisphere. Reduced size of the corpus callosum has been associated with diminished communication between the cortical hemispheres (Teicher, Andersen, Polcari, Anderson, Navalta & Kim, 2003). These two systems also bring information to the prefrontal cortex which is involved in emotion regulation. Arrested

development in this area early in life is damaging because cells in the prefrontal lobe where the processing of emotion takes place, do not mature fully until adulthood (Carter, 1998). There is also evidence to support an altered symmetry in frontal lobes and reduced neuronal density in the anterior cingulate (Tomoda et al., 2009). The anterior cingulate cortex is an area primarily associated with emotion and attention and is also indicated in conscious pain. Conscious pain refers to the body's warning system to communicate to the body telling it to stop doing whatever is causing it strain (Carter, 1998). Some studies have shown dysregulation in the hypothalamic-pituitary-adrenocortical axis and overstimulation of the autonomic activation systems among those with sexual abuse history in response to stress which may increase the probability of developing a chronic pain condition (Lesserman, 2005; Dong et al., 2003; Tietjen, Brandes, Peterlin, Eloff, Dafer, Stein, Drexler, Martin, Hutchinson, Aurora, Recober, Herial, Utley, White, & Khuder, 2009). These areas of the brain are also integral in the function of memory, emotional regulation, and pain perception (Lesserman, 2005). These marked differences in brain development are found primarily in children who were exposed to abuse younger than the age of 13 indicating that there is a critical developmental window in which early life stress impedes neurobiological function (Tomoda et al., 2009, Teicher et al., 2003; Heim & Nemeroff, 2001).

Other studies comply with this line of thought suggesting that early childhood stress induces hyperproductivity of corticotrophin-releasing factor systems resulting in increased stress responsiveness (Kaufman & Charney, 2001; Heim & Nemeroff, 2001). Corticotropin-releasing factor is believed to have a major role in regulating stress and mediation of emotions in the average person. Excessive exposure to glucocorticoids may be damaging because of unpleasant effects on the central nervous system and physical organs (Lesserman, 2005).

There is also evidence to support that there is a gender difference in how CSA can shape the young brain. Findings indicate that sexual abuse in girls is associated with a smaller corpus callosum, while a smaller corpus callosum size in boys is associated with neglect (Teicher et al., 2003). There are also differences with respect to hormonal influences on development which could yield significant results on the neurobiological signs of CSA.

It is not clear exactly how these findings affect health and behavior in the long term but it is hypothesized that these neurobiological alterations may not simply reflect damage, but may serve some adaptive purpose (Tomoda et al., 2009). High levels of stress hormones create an alternative pathway of development which causes the brain to organize along a specific pathway selected to facilitate survival in a world of deprivation and strife (Teicher et al., 2003).

Unfortunately, this pathway is associated with an increase risk of serious medical and psychiatric disorders as well as a potential for an overall inability to cope in more harmonious times.

Several studies have identified associations between victims of CSA and adult health-risk behaviors including smoking, alcohol abuse, driving while intoxicated, avoidance of routine health care, sedentary lifestyle and high-risk sexual encounters. (Bensley, Van Eevwys & Simmons, 2000; Walker, Gelfand, Katon, Koss, Von Korff, Bernstein & Russo, 1999)

The insidious effects of these toxic childhood experiences can also be manifested in unexplained chronic pain. It is reported that psychological stress increases sensitivity to pain (Hwang, Kim, Kim, Kim, Park & Kim, 2008). Other factors associated with somatic pain include depression, posttraumatic stress disorder (PTSD) and sexual trauma (Haskell, Papas, Heapy, Reid & Kerns, 2008).



## **Somatic Headache Pain**

Pain is a symptom that links mind and body (Kendall-Tackett, 2001). The concept that "the body remembers" is very interesting because it captures the idea that when emotional distress cannot be expressed verbally, the body may express it through physical symptoms (Romans & Cohen, 2008). Problems identifying and feeling emotions is strongly associated with recurrent headache (Abbass, et al., 2008). Headache sufferers have been shown to have difficulty regulating anger (Abass et al., 2008; Venable, Carlson & Wilson, 2001). It is believed that when feelings are intensely uncomfortable and therefore deemed unacceptable, a defense mechanism is initiated to suppress this feeling of stress or anxiety. This is likely a coping strategy that is used when an abused child has feelings of love (as the love one feels for a parent or family member) mixed with rage and guilt. Thus, a pattern of turning these feelings inward begins and the person becomes prone to somatic complaints (Abbass et al., 2008).

It is in this area where male and female difference in coping with CSA becomes seemingly divisive. In a study that examined gender differences among those with a history of CSA found that females were more likely to internalize behaviors suppressing unwanted feelings while males were more likely to exhibit externalizing behaviors like delinquency or heavy drinking (Dube et al., 2005; Chandy, Blum & Resnick, 1996). Other studies have supported this idea associating male CSA with increased risk for engaging in more physical behavior as mentioned above rather than somatic symptoms like their female counterparts (Lesserman, 2005). In other words, males are more likely to act out and self-medicate. Contradicting these findings, another study found that gender was not a statistically significant predictor for sexual abuse after adjusting for pain taking a further step to theorize the odds of being in the pain group

are lower for women than for men (Goldberg & Goldstein, 2000). However, more evidence is documented that the major risk factors for the development of chronic headache pain are females with a history of depression and CSA (Tietjen et al., 2009; Teicher et al., Haskell et al., 2008).

Consequently, the most common cause of visits to physicians is headache pain (Moschiano, D'Amico, Schieroni & Bussone, 2003; Hwang et al., 2008 Golding, 1999). Somatization, anxiety, depression and personality disorders are common features of many patients with chronic headache (Tietjen et al., 2009).

Chronic headache (CH) includes primarily headaches that occur daily or nearly daily and have endured for many months, even years (Verri, Cecchini, Galli, Granella, Sandrini and Nappi, 1998). Other studies have identified individuals from low frequency (0-4 days per month), to intermediate (5-9 days per month), and critical frequency (10-14 days per month) as also having chronic headache pain (Silberstein, Diener, Lipton, Goadsby, Dodick, Bussone, Freitag, Schwalen, Ascher, Morein, Greenberg, Biondi & Hulihan, 2008). It is important to mention that the majority of chronic headache begins with episodic or tension type headache and evolves into a chronic form over the years (Cevoli, Sancisi, Pierangeli, Grimaldi, Zanigni, Nicodemo, Cortelli & Montagna, 2006).

Headaches are significantly more common among those with a history of sexual assault than among those without (Golding, 1999) and this association is proven true even in countries very different from Western countries (Yücel, Özyalcin, Sertel, Çamlıca, Ketenci & Talu, 2002; Guitera, Muñoz, Castillo & Pascual, 2002). People who suffer from somatic headache pain rarely suffer from headache alone, associated is long list of comorbid conditions that accompany headache pain.

Those who have suffered headache pain for six months or longer have been indicated as being at risk for major depressive episode (Maeno, Inoue, Yamada & Maeno, Sato, 2007; Maizels & Burchette, 2004; Maizels & Houle, 2007). Headache sufferers have an increased occurrence of PTSD as compared to the general population (Peterlin, Tietjen, Meng, Lidicker & Bigal, 2007) also, those with dissociative identity disorder have shown to have a high prevalence of both sexual abuse and headache (Yucel et al., 2002; Golding, 1999). Other psychiatric disorders associated with chronic headache are generalized anxiety disorder, bipolar disease, panic disorder, simple phobia, social phobia, obsessive-compulsive disorder, dysthymia and somatoform disorders (Moschiano et al., 2003; Verri et al., 1998; Golding, 1999). Interestingly, the most robust association between CSA, chronic headache and depression was when abuse first occurred in the patient by the age of 12 (Tietjen et al., 2009).

It is worth mentioning that chronic headache is not the only chronic pain symptom associated with CSA. Sexual abuse has also been found to be associated with other pain syndromes including gastrointestinal disorders, fibromyalgia, back and myofascial pain (Haskell et al., 2008). It is hypothesized that sequelae presents itself years after the initial trauma. This gives evidence that the mind and body should not be thought of or treated as separate entities but as one in the same. Patients who are suffering frequent or daily headache and have a history of childhood sexual abuse merit prophylaxis.

## CHAPTER II

### METHOD

Students were recruited from introductory and advanced undergraduate courses in psychology. The sample on which this thesis is based consisted of 332 females whose mean age was 23.5 (standard deviation of 6.5) median age was 21 and mode of 20. In all cases the subjects received extra credit points for participation.

#### **Questionnaire**

The questions that were used to test the hypotheses of this study were embedded in a larger research project addressing multiple issues related to the experience of childhood sexual abuse. The primary independent variable is defined as the belief in having been sexually abused before the age of 13 which is derived from the responses to two questions (#1 and #2 below).

The questions for the independent and dependent variables of this thesis were specifically:

1. I believe that I was sexually abused before age 6. (independent variable)
2. I believe that I was sexually abused between the ages of 6 and 12. (independent variable)
20. Have you had headaches for the past six months or more? (dependent variable)
21. If yes, how long ago did your headaches begin? (dependent variable)

22. If you have had headaches for the past six months or more, how do they affect your ability to function? (dependent variable)

23. If you have headaches, are most of your headaches mild, moderate, or severe? (dependent variable)

24. Which statement best describes the frequency of your headaches? (dependent variable)

25. How many days per year do you miss school or work because of a headache? (dependent variable)

26. I am taking medication for headaches, rarely, occasionally, frequently, daily. (dependent variable)

### **Procedure**

Subjects were recruited by visiting their classes and reading a generic invitation to participate in a study involving the completion of a questionnaire that would address personal and sensitive issues. They were told that extra credit would be offered by the instructor and the details of the extra credit would be described by him or her. If interested, students were asked to sign on an appointment sheet which revealed the day, time, and room number to which they should report.

Five classrooms were used to administer the questionnaire. No more than eight subjects were schedule per room per time period in order to minimize the number of students in the room at one time. Subjects were asked to spread out so that no other subject could view the answers they provided. This part of the procedure ensured that subjects would perceive a maximum of

privacy in completing the questionnaire. The person administering the questionnaire was a research assistant who was not involved in any research derived from the questionnaire.

As subjects appeared for questionnaire completion, they were handed an informed consent handout that they could keep for reference. At no time during the questionnaire was any form collected that had the student's name on it. Informed consent stated UTPA Institutional Review Board for the Protection of Human Subjects (IRB), and contact information was given if the student felt like they felt the need to discuss any portion of the questionnaire. Students were asked to take a seat distant from anyone else already seated in the room. They were asked to complete the questionnaire only if they felt the information in the consent form was acceptable. They were reminded to not provide their names anywhere on the questionnaire. During the completion of the questionnaire subjects were prompted twice to choose either continuation or termination of participation. Each questionnaire had a number on each page with an index card revealing the same number. Subjects were asked to remove the index card and report to a different (designated) classroom where they would have their hands copied. Completed questionnaires were inserted into a box at the front of the room in which they completed them.

Subjects then reported to a second classroom in which they were asked to place their hands, palm side down on the glass face of an HP Officejet 6210 Printer after which a research assistant activated the copy function of the printer. When the copy was completed, subjects were told to place their name on a sign-up sheet (identifying their instructor) through which extra credit information would be provided.

## **Data Analysis**

Responses to questions #1 and #2 were used to generate an additional variable addressing whether or not the subject believes having been abused before the age of 13. This dichotomous variable [abused before age 13 (CSA+) or not abused before age 13 (CSA-)] serve as the primary independent variable in this study.

CSA+ and CSA- subjects will be compared using cross-tabulations and chi squared analyses for all dependent variables.

## CHAPTER III

### RESULTS

The hypotheses were tested using cross tabulations of the independent variable, CSA before age 13, with the dependent variables all of which were some aspect of headache disorder. The cross tabulations were subjected to Chi-Squared statistics to reveal whether or not there was a disproportionate frequency of headache pathology in subjects reporting histories of CSA when compared to those who report no histories of CSA.

The primary comparison of headache reported in the past six months between CSA+ and CSA- subjects revealed a statistically significant difference. Table 1 presents the frequency and percentage data and Chi Squared analysis. As can be seen in Table 1, CSA+ subjects were significantly more likely (59.3% vs 42.5%) to report headache in the past six months than CSA- subjects. These data are illustrated in Figure 1.

Only one other dependent variable revealed a difference between CSA+ and CSA- subjects. CSA+ subjects were significantly more likely to report moderate to severe headaches as revealed in Table 2 ( $p = 0.008$ ). This disproportionate frequency in headache intensity is illustrated in Figure 2.

Table 3 lists all other dependent variables and the frequencies/percentages reported by CSA+ and CSA- subjects. None of these differences were found to be statistically significant.



Table 1. Headache Reported During the Past Six Months by Subjects With and Without Childhood Sexual Abuse

	CSA+	CSA-
Headache 6 Months	32 (59.3%)	114 (42.5%)
No Headache	22 (40.7%)	154 (57.5%)

( $\chi^2 = 5.07$ ,  $df = 1$ ,  $p = 0.02$ )

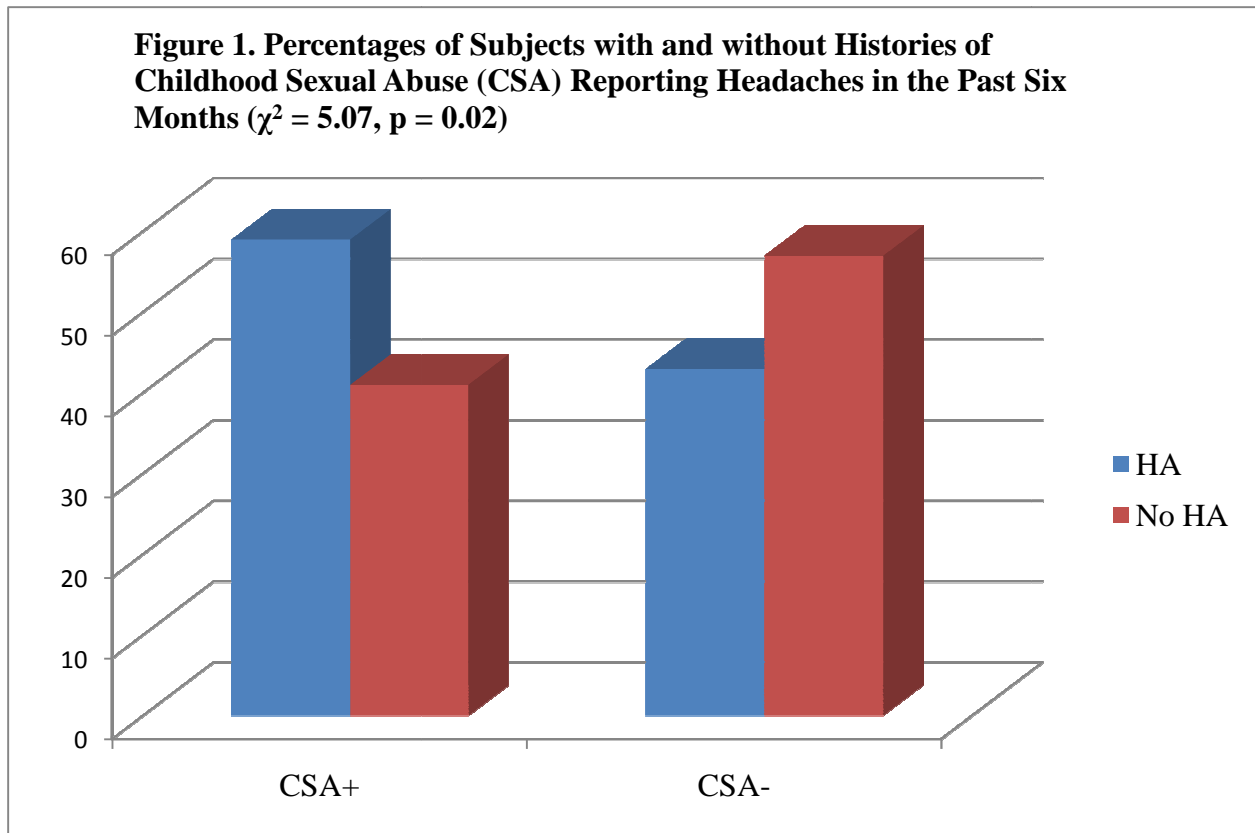


Table 2. Comparing Severe to Moderate Headache to Mild Headache in Subjects With and Without Childhood Sexual Abuse

	CSA+	CSA-
Severe to Moderate	25 (80.64%)	68 (59.65%)
Mild	6 (19.35%)	46 (40.35%)

( $\chi^2 = 10.50$ ,  $df = 1$ ,  $p = 0.0012$ )

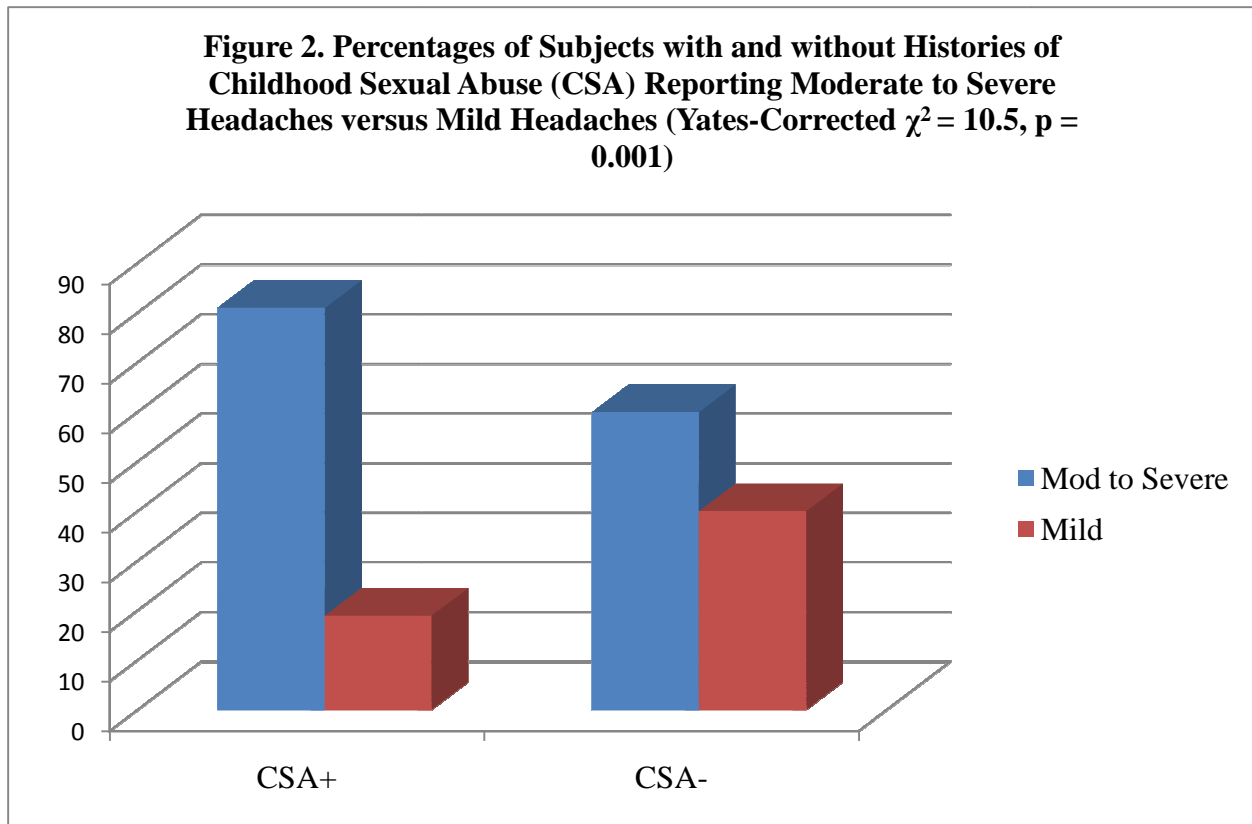


Table 3. Other Comparisons Made Not Showing Statistical Significance

Medical Diagnosis

	CSA+	CSA-
Migraine Headache	3 (11.5%)	29 (27.9%)
Tension Headache	6 (23.1%)	19 (18.3%)
Both	4 (15.4%)	15(14.4%)
Other	13 (50.0%)	41 (39.4%)

( $\chi^2 = 3.08$ ,  $df = 3$ ,  $P = .379$ )

When Reported Headaches Began

	CSA+	CSA-
Weeks Ago	1 (3.85%)	19 (17.3%)
Months Ago	10 (38.5%)	41 (37.3%)
Years Ago	15 (57.7%)	50 (45.5%)

( $\chi^2 = 3.24$ ,  $df = 2$ ,  $p = .197$ )

### Headaches Affecting Ability to Function

	CSA+	CSA-
Too few to cause concern	8 (26.7%)	51 (46.4%)
Frequently but is ignored	12 (40.0%)	40 (36.4%)
Frequently and interferes	10 (33.3%)	18 (16/4%)
Interferes on a daily basis	0 (0.00%)	1 (.91%)

( $\chi^2 = 5.92$ ,  $df=2$ ,  $p = .115$ )

### Frequency of Headaches

	CSA+	CSA-
Once a month	7 (22.6%)	32 (28.6%)
More than 5 monthly	0 (0.00%)	10 (8.9%)
Once a week	14 (45.1%)	29 (25.9%)
More than once a week	7 (22.6%)	23 (20.5%)
Once a day	2 (6.45%)	12 (10.7%)
More than once daily	1 (3.2%)	6 (5.4%)

( $\chi^2 = 6.81$ ,  $df = 5$ ,  $p = .24$ )

## Frequency of Medication Taken to Ease Headache Pain

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	CSA+	CSA-
Rarely	9 (31.0%)	55 (50.0%)
Occasionally	15 (51.73%)	40 (36.37%)
Frequently	3 (10.35%)	13 (11.82%)
Daily	2 (6.9%)	2 (1.82%)

---

( $\chi^2 = 6.47$ ,  $df=6$ ,  $p = .37$ )

## Discussion

The hypothesis for this study was to show that there is an association with women who report CSA as having a higher prevalence of headache pain. The results of the current study extend prior research in this area by demonstrating there is a robust association among women who report CSA+ as having a higher risk of headache pain. It is theorized that CSA before the age of 13, or by the age of 12, carries the greatest risk for adverse brain development because this is when the brain has the most plasticity.

Of the 332 female subjects that opted to complete the survey, seven subjects opted not to answer questions regarding CSA and 54 confirmed that they believed to have been sexually assaulted by the age of 12. This gave the result of 20% of the subject group reporting having experienced CSA in their childhood which is slightly lower than what was reported by the ACE Study (Anda et al., 2008). Of the 20% who were CSA+, 59% confirmed that they have had headache pain for the past six months or more.

The substance of the independent variable was based on a self-selected, closed ended postal questionnaire. This makes it difficult for a researcher to gather information that is rich in depth and detail. When a researcher is not present during the questionnaire, it is difficult to know whether or not a respondent has understood a question properly. Finally, questionnaires, like many evaluation methods occur after the event, so participants may forget important issues.

On a final note, the point should be made that the vast majority of those who have suffered CSA are asymptomatic as adults. The occurrence of CSA merely presents an increased risk factor for headache pain.

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## APPENDIX A



## APPENDIX B

APPENDIX B

QUESTIONNAIRE

**THANK YOU VERY MUCH FOR ASSISTING OUR RESEARCH PROGRAM BY AGREEING TO COMPLETE THIS BRIEF QUESTIONNAIRE**

PLEASE REMEMBER THAT YOUR PARTICIPATION IS VOLUNTARY AND THAT YOU SHOULD FEEL FREE TO WITHDRAW FROM ANSWERING AT ANY TIME WITHOUT PENALTY. **DO NOT PUT YOUR NAME ANYWHERE ON THIS QUESTIONNAIRE!**

THIS DEMOGRAPHICS PAGE AND A COVER SHEET ARE PROVIDED TO KEEP YOUR ANSWERS PRIVATE. NO ONE ELSE WILL HAVE ACCESS TO THIS QUESTIONNAIRE EXCEPT THE PERSONS DOING THIS RESEARCH. THE INFORMATION YOU PROVIDE WILL BE PUT ONTO A COMPUTER DATABASE BY DR. ERNST OR A RESEARCH ASSISTANT AND THE QUESTIONNAIRES WILL BE IMMEDIATELY DESTROYED BY SHREDDING.

Please provide this information and answer the questions which follow ONLY IF YOU ARE COMFORTABLE DOING SO AND ONLY IF YOU WANT TO.

Please **circle** your preferred answer when given more than one option to choose from.

AGE \_\_\_\_ SEX \_\_\_\_ CLASS STANDING: *Freshman Sophomore Junior Senior*

RACE/ETHNICITY (Circle One): *Mexican-American European-American Asian-American*

*African-American Other Hispanic/Latino \_\_\_\_\_ Other \_\_\_\_\_*

State and Country of Birth \_\_\_\_\_ I am *right left* handed.

Are you Bi-Lingual? Yes No What is your "first language"? \_\_\_\_\_

What is your "second language"? \_\_\_\_\_

Age of your *mother* when you were born \_\_\_\_ Age of your *father* when you were born \_\_\_\_

Please **circle** the highest level of education attained by your mother.

*Some grade school Completed grade school Some high school Completed high school*

*High school + additional training Some college Completed college*

*Some graduate school Graduate degree Doctorate*

Please circle the highest level of education attained by your father.

*Some grade school*      *Completed grade school*      *Some high school*      *Completed high school*  
*High school + additional training*      *Some college*      *Completed college*

*Some graduate school*      *Graduate degree*      *Doctorate*  
MARITAL STATUS \_\_\_\_\_ NUMBER OF CHILDREN \_\_\_\_\_

NUMBER OF OLDER SISTERS \_\_\_\_\_ NUMBER OF YOUNGER SISTERS \_\_\_\_\_

NUMBER OF OLDER BROTHERS \_\_\_\_\_ NUMBER OF YOUNGER BROTHERS \_\_\_\_\_

RELIGIOUS PREFERENCE \_\_\_\_\_

If you were a participant in a research project, how would you feel about being asked personal questions for research?

*Very Uncomfortable*      *Uncomfortable*      *Comfortable*      *Very Comfortable*

How would you feel about answering questions about aspects of your sexual behavior?

*Very Uncomfortable*      *Uncomfortable*      *Comfortable*      *Very Comfortable*

How would you feel about being asked if you have experienced sexual abuse as a child?

*Very Uncomfortable*      *Uncomfortable*      *Comfortable*      *Very Comfortable*

How would you feel about answering questions concerning details of childhood sexual abuse without naming the person who did the abuse?

*Very Uncomfortable*      *Uncomfortable*      *Comfortable*      *Very Comfortable*

Have you ever tried alcohol?    *Yes*    *No*    If so, at what age did you begin using? \_\_\_\_\_

*In the past month*, how often have you had 5 alcoholic beverages (4 if you are female) in one night?  
\_\_\_\_\_

*In the past year*, how often have you had 5 alcoholic beverages (4 if you are female) in one night? \_\_\_\_\_

Other than alcohol, have you ever used other substances for recreational purposes?    *Yes*    *No*

If "Yes," at what age did you begin using? \_\_\_\_\_

\*\*\*\*\*      **PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY**      \*\*\*\*\*  
**IF YOU ARE COMFORTABLE DOING SO AND ONLY IF YOU ARE SURE YOU WANT TO.**

(Select one of these options):    **I elect to continue** \_\_\_\_\_    **I prefer to not continue** \_\_\_\_\_

- 1. I believe that I was sexually abused before age 6.      *Yes*      *No*
- 2. I believe that I was sexually abused between ages 6 and 12.      *Yes*      *No*
- 3. I believe that I was sexually abused between ages 12 and 18.      *Yes*      *No*

4a. Were criminal authorities notified? *Yes No* 4b. Was legal action taken? *Yes No*

5. If "Yes" to any of # 1 through # 3, was the person a...? (Check as many as apply):

*Stranger*  *Friend or acquaintance*  *Relative*  *Parent or caregiver*  *Step-parent*

6. If "Yes" to any of #1 through #3, how often did this occur?

*Once*  *Twice*  *3 times*  *4 times*  *5 times*  *More than 5 times*

7. If "Yes" to any of # 1 through # 3, please circle any of the following people you have **talked** to about these experiences.

*Family Doctor*      *Psychologist*      *Husband*      *Parent*      *Uncle/Aunt*  
*Psychiatrist*      *Social Worker*      *Counselor*      *Sibling*      *Friend*      *Teacher*

Other \_\_\_\_\_ (Please specify)

8. Which of these people did you talk to FIRST? \_\_\_\_\_

9. If "Yes" to any of #1 through #3, please estimate the **percentage** (0% to 100%) of "adjustment to" or "recovery from" the effects of the experience(s) you feel **at this time in your life**. \_\_\_\_\_%

10. I believe that I was *physically* abused as a child. *Yes or No*

If "Yes," how often?  *Once*  *Twice*  *3 times*  *4 times*  *5 times*  *More than 5 times*

11. How many caregivers did you have between the time you were born and age 17? \_\_\_\_\_

12. Did you ever see your caregivers hitting, throwing objects at each other, or using weapons against each other? *Yes No*

13. Did your mother ever experience mental or emotional problems? *Yes No*

drinking problems? *Yes No*

or was arrested for a crime? *Yes No*

14. Were you often left alone at home when an adult or responsible babysitter should have been there? *Yes*

*No*

15. I was physically assaulted **after** the age of 17. *Yes No*

If "Yes," how often?  *Once*  *Twice*  *3 times*  *4 times*  *5 times*  *More than 5 times*

16. I was sexually assaulted **after** the age of 17. *Yes No*

If "Yes," how often?  *Once*  *Twice*  *3 times*  *4 times*  *5 times*  *More than 5 times*



**REMINDER: PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY  
IF YOU ARE COMFORTABLE DOING SO AND ONLY IF YOU ARE SURE YOU WANT TO.**

(Select one of these options): I elect to continue \_\_\_\_\_ I prefer to not continue \_\_\_\_\_

Please circle, check, or fill in the correct answer as it applies to you...

17. Have you ever been diagnosed with Attention Deficit Disorder (ADD or ADHD)? Yes No

If yes, at what age? \_\_\_\_\_ If yes, are you currently taking medication for this? Yes No

18. As a child, did you experience problems with bed-wetting? Yes No

19. Are you currently taking prescriptive medication for depression? Yes No

If yes, which medication(s) are you taking?

---

If yes, do you experience any adverse side effects from the medication? Yes/No

If yes, what side effects do you experience?

---

20. Have you had headaches for the past six months or more? Yes No

If yes, has a doctor diagnosed them as: *tension (muscle contraction) headaches?*

*or* *migraine (vascular) headaches?*

*or* *both?*

*or* *other*

---

21. If Yes, how long ago did your headaches begin? \_\_\_\_\_Weeks ago \_\_\_\_\_Months ago \_\_\_\_\_Years ago

22. If you have had headaches for the past six months or more, how do they affect your ability to function?

*I have too few to cause me concern*

*I have them frequently, but I can ignore them*

*My headaches frequently interfere with my ability to function*

*My headaches interfere with my ability to function on a daily basis*

23. If you have headaches, are most of your headaches? \_\_\_\_\_Mild \_\_\_\_\_Moderate \_\_\_\_\_Severe

24. Which statement best describes the frequency of your headaches? \_\_\_\_\_one each day \_\_\_\_\_more than one daily

\_\_\_\_\_one each week \_\_\_\_\_more than one weekly \_\_\_\_\_one per month \_\_\_\_\_more than 4-5 per month

25. How many *days per year* do you miss school or work because of a headache? \_\_\_\_\_

26. I am taking medication for headaches... *rarely* *occasionally* *frequently* *daily*

The medication(s) I take for headache  
is/are \_\_\_\_\_

27. Are you currently in an intimate relationship? *Yes* *No*

28. If yes, how long have you been in your current relationship? \_\_\_\_\_

29. What is the longest period of time you have been in a continuous intimate relationship?  
\_\_\_\_\_

30. How easy or difficult do you find talking about sex to your partner or boyfriend/girlfriend?

*No difficulty at all* *Difficult on **some** topics but not others* *Difficult on **most** topics* *Difficult on **all** topics*

31. How many consensual sexual partners have you had in your lifetime? \_\_\_\_\_

32. During your current or previous romantic relationships, how often have you “cheated” on your partner by having sex with another person?

*Never* *Once* *Occasionally* *Often*

33. Approximately **how many** X-rated videos or films have you viewed in the past year? \_\_\_\_\_

What percentage (%) were viewed...

[*alone*\_\_\_\_%] [*with a female*\_\_\_\_%] [*with a male*\_\_\_\_%] [*with a group*\_\_\_\_%]?

34. On average, how many **hours per week** do you spend visiting internet porn sites or viewing pornographic media on your computer? \_\_\_\_\_

What percentage (%) were viewed...

[*alone*\_\_\_\_%] [*with a female*\_\_\_\_%] [*with a male*\_\_\_\_%] [*with a group*\_\_\_\_%]?

35. Does it ever sexually arouse you to think about being raped ? *Yes* *No*

36. Does it ever sexually arouse you to think about raping someone ? *Yes* *No*

37. How would you describe your sexual orientation/preference?

*Exclusively Heterosexual* *Occasionally Bi-Sexual* *Regularly Bi-Sexual* *Exclusively Gay or Lesbian*

38. I consider myself exclusively homosexual (gay or lesbian) but occasionally I have sex with the opposite sex.

*Yes* *No* *Not Applicable, I do not consider myself exclusively homosexual*

39. I am exclusively heterosexual but I *have thought about* being with someone of the same sex.

*Never* *Occasionally* *Often* *Always*



Please note that *NONE* of the activities described in the following questions are illegal or considered “abnormal” if performed alone or with another consenting adult...

**Please indicate the frequency with which you have performed the following sexual activities:**

“Threesome”:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
“Foursome”:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Group Sex (more than 4):	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Swinging: (trading sexual partners with one couple)	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Fetish:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Bondage (“Receiver”)	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Bondage (“Giver”)	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
(Non-Bondage) S & M:					
S:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
M:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Auto-Erotic Asphyxiation: (Strangling to enhance orgasm)		<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>
Bestiality: (Sexual Contact with an animal)		<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>
Sex involving urine:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Sex involving feces:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Cross-Dressing:	<i>Never</i>	<i>Once</i>	<i>Occasionally</i>	<i>Often</i>	
Have you ever considered a sex-change?		<i>Yes</i>	<i>No</i>		

**A resource sheet about sexual abuse & assault and physical abuse & assault is available. If you would like one, please let the Proctor know.**

## BIOGRAPHICAL SKETCH

Kathy L. Theiss was born on May 4, 1971 in Harlingen, Texas as Kathy Lynn Campbell. Theiss graduated from Raymondville High School in Raymondville, Texas in 1989. After high school, Theiss received her bachelor's degree in Education at the University of Texas at Brownsville in 1999.

Theiss began teaching school in Raymondville in the Special Education Department. Theiss later taught in the computer dyslexia lab in Brownsville, Texas. Theiss received further training in the Scottish Rite, Gifted and Talented and Success For All (SFA) programs. Theiss was awarded Exemplary Teacher from Los Fresnos ISD for three years in a row and was invited by the Texas Education Association to assist in evaluating and proofreading the Texas Assessment of Knowledge and Skills Test (TAKS) in 2003-2004. Theiss served as Secretary for the Harlingen Parent Teacher Association (PTA) where she taught elementary school for four years.

At the end of the 2006-2007 school year Theiss left teaching to pursue a Master's degree in at The University of Texas Pan American. In the summer of 2010, Theiss earned a degree in Experimental Psychology with Emphasis in Applied Behavior Analysis.

Theiss currently lives in Harlingen, Texas where she lives with her daughter Melody. All correspondence should be sent to 15691 Odom Road, Harlingen, Texas 78552.