

ABSTRACT

Title of Thesis: PARENTING STYLE AS A MODERATOR BETWEEN
MATERNAL TRAUMA SYMPTOMS AND CHILD
PSYCHOLOGICAL DISTRESS

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Current research suggests parents who experience symptoms of trauma transfer distress to their children. The purpose of this study was to understand the possible moderating effect of mothers' parenting style on this relationship. The level of maternal trauma, use of parenting styles, and child psychological distress was examined for a clinical sample ($n=113$) of mother and child dyads. Results indicated that mothers who experience high levels of trauma symptoms are more likely to parent using authoritarian or permissive behaviors. Mothers experiencing high levels of trauma symptoms who parent with a high use of authoritarian behaviors have children who experience more depression than those whose mothers use fewer authoritarian behaviors. However, mothers experiencing high levels of trauma symptoms who parent with a high use of permissive behaviors have children who experience less depression than those whose mothers use fewer permissive behaviors. The empirical and clinical implications of these findings are discussed.

PARENTING STYLE AS A MODERATOR BETWEEN MATERNAL TRAUMA
SYMPTOMS AND CHILD PSYCHOLOGICAL DISTRESS

by

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Table of Contents

Acknowledgements.....	ii
Table of Contents.....	ii
List of Tables and Figures.....	vi
Chapter I Introduction.....	1
Statement of the Problem.....	1
Chapter II Review of the Literature.....	5
Theoretical Foundations.....	5
Family Systems Theory.....	5
Stress and Coping Theory.....	5
Experience of Trauma.....	7
Definitions.....	7
Effect on Parents.....	10
Effect of Parental Trauma on Children.....	10
Impact of Trauma on Parenting Behaviors.....	15
Normative Parenting Behaviors.....	15
Parenting Behaviors Impacted by Traumatic Experience.....	19
Maternal Parenting Behaviors Impacted by Traumatic Experience.....	23
Literature Summary.....	26
Purpose.....	27
Hypotheses.....	27
First Research Question.....	27
Second Research Question.....	27

Third Research Question.....	28
Exploratory Question	28
Chapter III Methodology	29
Sample.....	29
Procedure	30
Measures	32
Demographics Questionnaire.....	32
The Trauma Symptom Inventory.....	32
The Parenting Practices Questionnaire	33
The Beck Depression Inventory.....	34
Variables	35
Independent Variable	35
Moderator Variable.....	36
Dependent Variables.....	36
Chapter IV Results	37
Primary Analysis.....	38
Hypothesis 1.....	38
Hypothesis 2.....	38
Hypothesis 3.....	39
Exploratory Question	41
Additional Analyses.....	42
TSI Subscales.....	42
Chapter V Discussion	44

Summary of the Results	45
Discussion of Findings.....	46
Limitations of the Study.....	55
Implications for Further Research	56
Implications for Clinical Application	58
Conclusion	60
Appendix A: Demographic Questionnaire.....	61
Appendix B: Trauma Symptom Inventory (Center for Healthy Families Version)	64
Appendix C: Parenting Practices Questionnaire.....	66
Appendix D: Beck Depression Inventory	68
References.....	71

List of Tables and Figures

Table 1: Characteristics of Normative Parenting Styles	16
Table 2: Mother Trauma (TSI) and Authoritative (PPQ Subscale) Regression	39
Table 3: Mother Trauma (TSI) and Authoritarian (PPQ Subscale) Regression	40
Table 4: Mother Trauma (TSI) and Permissive (PPQ Subscale) Regression	40
Table 5: Children’s Depression (BDI) Scores	41
Figure 1: Parenting Styles along Dimensions of Warmth and Control	54

Chapter I Introduction

Statement of the Problem

According to systems theory, stressors that impact one member of a family will impact every other member (Nichols & Schwartz, 2007). Stress and trauma have impacted families throughout history, yet the effects of stress and trauma on families are still considered a recent field of study (Catherall, 2004). In light of the increasing numbers of military service members who return to their families from deployment and suffer from psychological problems—often exhibiting posttraumatic stress disorder symptoms—it is important to understand the pathways through which children might be protected from parental experiences of trauma.

Children are often negatively affected when one or both parents exhibit symptoms of trauma (Matsakis, 2004). This transfer of distressing symptoms is referred to as secondary trauma and it can be exacerbated when the relationship with the traumatized person is one of dependence, as is the relationship between child and parent (Catherall, 2004). Secondary trauma in children is common when parents exhibit depression, anxiety, and stress responses to mental illness and trauma (Lombardo & Motta, 2008). Other negative child outcomes from parental trauma include problems with attachment, lower school performance, poor social functioning, and a higher incidence of being diagnosed with child disorders such as conduct disorder or attention deficit hyperactivity disorder (Rossman, 1999).

Many factors might moderate or protect against the impact of parental trauma, including the mental health of the other parent, the stability of the spousal relationship, and the support of the family's community (Garbarino, Bradshaw, & Kostelny, 2005).

One factor that may be particularly important to consider is the type of child rearing practices employed by parents. The majority of empirical evidence suggests that trauma-related stress negatively impacts family functioning and may undermine effective parenting strategies and styles (Lombardo & Motta, 2008). Parenting under trauma-related stress can produce parental behaviors such as insensitivity, low responsiveness, harshness, negativity, and low warmth. These behaviors are linked to high levels of child anxiety and unhappiness, as well as high rates of anger and defiance (Berk, 2005). However, it has also been found that some parents may respond to trauma-related stress by responding to children with nurturing, caring, and consistent parenting strategies that model successful coping, and by relying on social and community support (Garbarino, Bradshaw, & Kostelny, 2005). These parenting strategies are linked with high levels of child adjustment and well-being (Berk, 2005).

The potential impact of parenting style when parents experience trauma can be better understood by examining the influence of parenting style in general. In families not experiencing trauma, parenting style has been linked to variations in child outcomes for truancy, anxiety, and emotional problems (Berk, 2005). In her seminal work on parent's interaction with their preschoolers, Diana Baumrind (1971) revealed three prototypical parenting styles: authoritative, authoritarian, and permissive. Her findings, and those of others who extended her work, consistently find that authoritative parenting is the most effective parenting strategy as it involves high levels of parental acceptance and involvement, adaptive control techniques, and appropriate autonomy granting to children (Berk, 2005). Parents who employ the authoritarian style are low in acceptance and involvement, high in coercive control, and low in autonomy granting. Permissive

parents are high in acceptance, overindulgent and overinvolved, low in control, and engage in developmentally inappropriate autonomy granting to children.

Parents foster child competence through their parenting style, discipline strategies, and specific parenting behaviors (Berk, 2005). Authoritative parents, who are secure in the standards they hold for their children, provide a model of confident decision making and self-controlled behavior. In addition, their reasonable expectations of a child's behavior foster higher compliance and a greater sense of fair consequences. Authoritative parenting styles have also been linked to high levels of child resilience, or protecting the child from negative impacts of family stress or hardship (Pettit, Bates, & Dodge, 1997). Therefore, it is possible that children might be protected from the negative impact of parental trauma when parents employ healthy parenting strategies, such as those typical of the authoritative style.

Although significant efforts have been made to study the impacts of both maternal and paternal parenting styles, most of the parenting research specifically describes the parenting behaviors of mothers (Adamsons & Buehler, 2007). Mothers are often selected for studies that investigate the impacts of parenting on child outcomes because they are the primary caregivers in a family (Cornell & Frick, 2007). Typically, mothers spend more time with their young children than fathers, provide more of the children's day to day needs and discipline, and are primarily engaged in fostering the emotional and psychological development of their children (Beck, 2005). These normative tasks of motherhood are often compromised when mothers experience distressing symptoms of trauma (Lombardo & Motta, 2008).

Thus, the present study considers several questions regarding the relationship between maternal experience of trauma, parenting style, and child outcomes. First, do children report higher levels of psychological distress when their mother reports the experience of trauma symptoms? Second, are mothers who experience symptoms of trauma more likely to adopt a particular parenting style? Third, are children protected from the transfer of distress when their mother experiences trauma symptoms and yet parents in an authoritative style? As the answers to these questions are uncertain, there is a need for clear research to investigate the moderating effect of parenting style on child outcomes when mothers experience trauma symptoms. Therefore, this study focused exclusively on this potential relationship and its implications for intervention.

Chapter II Review of the Literature

Theoretical Foundations

Family systems theory. The most basic assumption of the current research—that experiences of one family member impact every other family member—is grounded in family systems theory (Nichols & Schwartz, 2007.) A family system is more than the sum of its members and every system is a subset of larger (e.g. communities) and smaller (e.g. spouses or siblings) systems. In other words, human behavior is understood in the context of interpersonal relationships and exchanges and the bi-directional effects of parents and children create a constantly changing set of actions and reactions. Relevant to the current study, it is assumed that when one member of a family system is stressed or changed, every other member of that system will also be impacted by the stress or change. Although family systems theory broadly grounds the current research, stress and coping theory more specifically introduces the expected impacts of parental trauma on children.

Stress and coping theory. The terms “stress” and “trauma” are often used interchangeably in the literature (Catherall, 2004). One of the most prominent and well supported theories of stress was conceptualized by Richard Lazarus in his seminal book published in 1966. In a divergence from his colleagues, Lazarus (1966) considered stress to be a primarily psychological problem that “results in intense and distressing experience and appears to be of tremendous influence in behavior” (p. 2). His theory of stress and coping privileges the role of cognitive appraisals in determining one’s reaction to a stressful experience.

When faced with a stressful situation, a person will evaluate its personal significance in terms of its impact on personal goals, motives, and beliefs. This process is known as primary appraisal. Primary appraisals are further categorized into four types: harm/loss, threat, challenge, and benign. Harm/loss appraisals are those that refer to an actual injury or damage, such as an experience of mugging or violence. Threat appraisals refer to a signal of danger or the anticipation of harm or loss, for example walking alone in a dark alley. Challenge appraisals are those that refer to an opportunity for personal growth or mastery, such as the minutes leading up to an athletic event or race. Benign appraisals do not signal harm or the threat of harm and no further action is taken by an individual. Harm and threat appraisals are associated with negative cognitive and emotional responses, while challenge appraisals are associated with positive responses. Lazarus (1966) emphasizes the concept of awareness with regards to appraisals, such that differing levels of awareness might influence the perception of stimulus details and the properties that make a stimulus threatening, the contingencies or constraints involved with coping with the stimulus, and the emotional reaction itself.

In addition to primary appraisals that assess the stimulus, individuals also evaluate secondary appraisals that involve an assessment of control and selection of coping strategies. Different stress appraisals lead to different coping responses. Lazarus (1966) suggests two main coping responses: those intended to reduce threat by resolving the stressful experience (direct-action tendencies, or problem-focused) and those intended to reduce threat by regulating unpleasant emotions that arise during the experience (defensive reappraisal, or emotion-focused). Examples of problem-focused coping strategies include actions that strengthen resources against harm, attack, planning, and

prioritizing. Examples of emotion-focused coping strategies include avoidance, inaction, and anxiety.

In general, Lazarus (1966) argues that the strength of the stress response and the quality of the coping response depend on the cognitive activity of appraisal. The two independent dimensions (threat and coping) are always reflected or observed in the same reaction. Thus, a person who reacts with depression may be just as threatened as a person who reacts with anger. Similarly, a person who responds with an attack as opposed to an avoidant reaction may be no less distressed.

Theories of stress and coping, including the one previously described by Lazarus, are often employed to understand the effects of trauma (and stress) on individuals and families. However, stress and trauma are often operationalized differently: appraisals and responses versus diagnostic criteria of Post Traumatic Stress Disorder. Further, the terms tend to be differentially preferred by social science researchers (stress) and clinical researchers (trauma). Thus, an additional review of the literature specifically regarding trauma is warranted.

Experience of Trauma

Definitions. Individuals' experience of trauma presents in varied symptomology, which may be clinically recognized through the diagnostic criteria of Post Traumatic Stress Disorder (PTSD) (DSM-IV-TR, 2000). PTSD symptoms are clustered around three categories: re-experiencing, hyperarousal, and avoidance. PTSD can occur at any age, including childhood. Criteria for diagnosis include having been exposed to a traumatic event (criterion 1A) and responding to that event with intense fear, helplessness, or horror (criterion 2A). The characteristic symptoms resulting from the

exposure to the traumatic event include persistent reexperiencing (criterion B), persistent avoidance of stimuli associated with the event and numbing of general responsiveness (criterion C), and persistent symptoms of increased arousal that were not present before the trauma (criterion D). These symptoms cause significant distress (criterion F) that last for more than one month (criterion E).

Becker-Blease and Freyd (2005) posit a two dimensional model of trauma in an effort to move beyond the one dimensional model of the DSM. In addition to the terror or fear inducing properties of traumatic events, the authors consider social betrayal to be the second dimension of a traumatic event. The model's two scales, social-betrayal and terror/fear inducing, range from high to low. Events that are low on both scales are generally not traumatic. Events that are high on both scales, such as sadistic abuse by a caregiver or holocaust, are extremely traumatic. Events that are low on terror/fear inducing but high in social betrayal, such as some sexual or emotional abuse, and events that are low on social betrayal but high on terror/fear inducing, such as hurricanes or some auto accidents, are significantly traumatic. However, the authors also advocate for an even more complex model of trauma that considers dimensions of loss, secret keeping, shame, and isolation. They argue that the experience of trauma is gendered, individualized, and based on the type of traumatic event experienced. These different factors call for a more complex definition of trauma that reflects the multiplicity of trauma experience.

Initial reactions to trauma may include heightened distress, sleep disturbance, irritability, poor concentration, and somatic complaints such as headaches, pains, and fatigue (Kiser & Black, 2005). However, population prevalence studies demonstrate a

disproportionate risk between trauma exposure and the development of PTSD (see Seedat, 2001, for a review). While trauma exposure rates vary in the general population between 40% and 80% depending on the definition of trauma used, the prevalence of PTSD in exposed individuals is only 8%. This discrepancy may be due to genetic, environmental, or intergenerational transfer factors that increase one's liability to develop PTSD. For example, a history of depression in first-degree relatives has been linked to increased vulnerability to the development of PTSD (DSM-IV-TR, 2004). These findings suggest that the development of PTSD symptomology is more complex than simply exposure to a traumatic event.

Indeed, multiple pathways to adult mental health problems have been established. For example, links have been established between an experience of trauma in childhood, less protective adult resources, and psychological distress in adulthood (Banyard, Williams, Saunders, & Fitzgerald, 2008). In a longitudinal study of adult women referred for family violence ($n=283$), Banyard and colleagues (2008) found that women who reported adult trauma symptoms were likely to have been exposed to childhood family violence and to currently be in a violent interpersonal relationship.

These findings are consistent with findings that adults who experience greater numbers of traumatic events also report high levels of psychological suffering (Turner & Lloyd, 1995). Using a 20-item checklist of major life traumas (eight questions about events that may have happened before adulthood and twelve questions about events that may have happened any time in the respondent's life), the authors found a negative cumulative effect of multiple traumas on increased mental health risk. Specifically, results suggest that the more traumatic events an individual experiences during a lifetime,

the more at risk that person becomes for major depressive disorder and substance abuse/dependence disorders.

Effect on parents. Few studies explicitly investigate the impact of trauma on a person who is also a parent; most related studies investigate its impact on parenting behaviors specifically or family functioning generally. However, it has been suggested that reactions to traumatic events often intensify when the individual experiencing them is also parenting one or more children. For example, women exposed to terror during pregnancy described extreme insecurities regarding their children (Kaitz, Levy, Ebstein, Faraone, & Mankuta, 2009). During in-depth interviews in Israel, the authors found that almost all of the women spoke of a constant fear for their children's safety—especially when the women experienced losses of family members or were injured themselves.

Walker (2007) argues that it is parents' unresolved loss that prevents them from becoming "safe havens" for their children (p. 79). The cognitive and emotional disorganization present after the experience of trauma may interfere with parents' ability to interact with their child in a consistent and understandable manner. Furthermore, the association of traumatic experience with increased risk for depressive and substance abuse disorders suggests that parents who experience traumatic events are also at risk for further mental health problems (Turner & Lloyd, 1994).

Effect of parental trauma on children. A large body of literature documents the detrimental effects of trauma exposure on children's development (see Gewirtz, Forgatch, & Wieling, 2008, for a review). For example, researchers have consistently shown that a child's experience of trauma is related to increased internalizing problems (i.e., withdrawal, anxiety), externalizing problems (i.e., behavioral outbursts, aggression), and

somatic complaints. However, it is also likely that children of parents with high levels of stress, mental illness, or trauma will be affected through the intergenerational transmission of symptoms. Intergenerational transmission of trauma is defined as “the shown impact of trauma experienced by one family member on another family member of a younger generation, regardless of whether the younger family member was directly exposed to the traumatic event” (Kaitz, et al., 2009, pp. 160). Although symptoms of direct and transmitted trauma may not be identical, the consequences are negative and include stress, distress, and dysfunction.

The literature on the etiological factors in the development of fear and anxiety disorders in children describes three main pathways of transmission (Beidel & Turner, 2005). The first, direct conditioning, is the personal experience of a traumatic or fear-inducing stimulus. Direct conditioning is strongly linked to the development of specific phobias or fears. The second and third pathways, observational learning and information transfer, establish the processes of intergenerational transmission. Fears that develop through the vicarious experience of others are a result of behavior modeling. Children who observe someone acting fearfully model that fear response when in a similar situation. Observational learning is so powerful that children have been found to acquire fears from their parents even when parents attempt to hide their emotional responses. Information transfer regards the more concrete, verbal exchanges of conversation (as opposed to nonverbal cues, which would be gathered through observational learning). The reasons why parents direct their children to avoid potential dangers are clear; however, when caution is generalized to less dangerous objects or situations, children may develop abnormal or unnecessary fears. Therefore, children become vulnerable to

the stress reactions of their parents through the information transfer of direct conversation and the modeling of observed parental behaviors. This transmission of symptoms from parents to children has been termed 'secondary trauma' (Catherall, 2004).

In a study of the effect of secondary trauma in children of parents with mental illness, Lombardo and Motta (2008) investigated whether comorbid posttraumatic stress disorder (PTSD) with parental mental illness increased negative outcomes for children. Three groups of parent-child dyads were recruited from outpatient clinical and nonclinical populations where the parent had mental illness and PTSD ($n=20$), where the parent had only mental illness ($n=27$), and where the parents were considered non-mentally ill ($n=26$). In all three groups, participants were majority mothers and majority White. Results show that group differences exist in parent depressive symptoms between the three groups. A Tukey HSD revealed that children with parents who had mental illness and PTSD had significantly higher secondary trauma scores than the children with non-ill parents, but were not significantly higher than children with parents who had only mental illness. Therefore, children of parents with mental illness with and without comorbid PTSD had higher depression and anxiety symptoms than children of non-ill parents. This finding supports a spread effect of symptoms from mentally ill parents to their children, but calls into question the direct effect of PTSD on childhood depression and anxiety.

The intergenerational effect of parental trauma on children may also result in the transfer of negative world views (Abrams, 1999). These world views are transmitted by the telling of family stories or by parents teaching their children the lessons they have learned from their traumatic experiences. Children, for example, who grow up 'knowing'

that the world is a dangerous place may experience difficulty trusting others or may develop a generalized sense of anxiety about new experiences. When the parental traumatic event is secret yet present in the milieu of the family, a child's development of feelings of safety may be disturbed.

Children of tortured refugee parents and untortured refugee parents were studied for differences in child adjustment (see Rydelius & Daud, 2008, for a review). Swedish intact, two-parent families who recently immigrated from Iraq and Lebanon after experiences of torture ($n=15$) and a comparison group of the same ethnic heritage ($n=15$) were recruited. The comparison families may have been exposed to violence in their countries of origin, but were not exposed to torture. Both parents and children completed a range of psychological assessments. Traumatized parents scored higher than the comparison group on scales of posttraumatic stress disorder, depression, anxiety, and somatic complaints. Children of traumatized parents reported signs of insecure parental attachment, poor sociality with peers, and symptoms of depression, anxiety, and somatic complaints. These results suggest that children of parents who experienced a highly traumatic event fare worse than comparison children of parents who experienced stressful events.

A study by Rossman (1999) found similar negative outcomes for children whose parents were exposed to high levels of violence. In his study, 500 children aged 4-13 years old and their mothers were interviewed and completed questionnaires. Families were recruited for study participation through community schools and agencies, including battered women's shelters. Children were recruited into one of four groups: a nonabusive, nonviolence community group; a nonabusive but maritally aggressive

community group; a nonabusive but maritally violent shelter group; and a child abusive and maritally violent shelter group. Results indicate that group differences exist between children in each exposure group. For nonexposed children, greater family stress was the only significant predictor of trauma symptoms and was significantly related to lower SES. For nonabused children who were exposed to marital violence, parental aggression was significantly related to trauma symptoms and lower SES. For abused children, higher SES was linked to greater trauma symptoms. This study had several limitations. First, reports of children's behavior problems relied solely on maternal report and may be subject to social desirability bias. Furthermore, the Child Behavior Checklist trauma symptom subscale was used to analyze children's trauma reactions. The Child Behavior Checklist is most often used in the literature as a global assessment of child functioning and is not as useful for indexing trauma symptoms as other measures. Considering these limitations, the findings still further the understanding of risk factors for children of parents who have been exposed to trauma or abuse.

Most evidence suggests that the intergenerational transmission of symptoms and world views creates negative outcomes for children of parents who experience trauma. Furthermore, these negative outcomes are consistent whether the child witnessed the parental traumatic experience or not. For example, nonwitnessed violent events experienced by a parent were as distressing for children as witnessed violent events experienced by community members (Dulmus & Wodarski, 2000). In addition, these authors found that children whose parents were victims of community violence exhibited higher levels of distress symptoms than children whose parents were not victimized in the same violent community. It is probable that children who are exposed to a parental

traumatic event may experience a compounding of distress symptoms, stemming from both their witnessing the event and the transmission of parental symptoms after the event. However, it remains unclear whether witnessed or nonwitnessed parental traumatic events are more psychologically distressing for children.

Impact of Trauma on Parenting Behaviors

Normative parenting behaviors. It is worthwhile to review the vast literature on typologies of normative parenting before investigating the impact of trauma on parenting behaviors. Variations in parenting styles have been an interesting and valuable source of research for those interested in child development and family functioning. Diana Baumrind's (1971) parenting style typology has been extensively researched and accepted in the parenting literature; additionally, several standardized questionnaires employ her terms and operational definitions for assessing parenting style. Her parenting typology includes three distinct parenting styles: authoritative, authoritarian, and permissive. Authoritative parenting behaviors are those that balance love and affection towards children and firm discipline. Authoritarian parenting behaviors are those that require strict adherence to a set of absolute behavioral standards. Permissive parenting behaviors are those that place few restrictions on child behavior. See Table 1 for more details regarding the differences between the three parenting styles (Baumrind, 1971; Berk, 2005).

Table 1

Characteristics of Normative Parenting Styles

Feature	Parenting Style		
	Authoritative	Authoritarian	Permissive
Acceptance and Involvement	Warm; attentive, sensitive to needs	Harsh; rejecting; degrading; controlling	Highly warm; inattentive; overindulgent;
Control	Reasonable demands for maturity; explains reasons for the rules	Demands obedience by yelling, criticizing, commanding	Few or no rules or demands
Autonomy Granting	Permits child decision making when appropriate; values child point of view	Rarely is child point of view valued; little give-and-take for rule making	Permits child to have control over decisions and actions before appropriate

The authoritative parenting style has consistently been linked to positive child outcomes (Berk, 2005). Warm and involved parents who are fair and reasonable in decision making generate compliance and self-control in their children. They also foster high self-esteem and cognitive and social maturity by appropriately demanding the child take responsibility for their own behavior. Several studies highlight the varied benefits of

authoritative parenting. Steinberg (2001) reports that adolescents who experience authoritative parenting achieve more in school, report less depression and anxiety, report more self-esteem and self-reliance, and engage in fewer antisocial or delinquent behaviors. In an earlier study, Gray and Steinberg (1999) “unpacked” the components of authoritative parenting to determine which dimensions contribute to the success of children in authoritative homes. They found that, due to the emotional context that balances firmness and warmth, the authoritative dimensions of parental acceptance and involvement and parental psychological autonomy granting were most highly related to adolescents’ development of positive psychosocial functioning. These studies provide clear evidence that compared to children of authoritarian or permissive parents, children of authoritative parents fare better on a variety of important developmental targets.

Authoritative parenting is also important for the development of prosocial behavior and conscience development in behaviorally uninhibited children (Cornell & Frick, 2007). Antisocial youth have been identified as showing high levels of callous and unemotional traits, a property that differentiates them from their less severely aggressive antisocial peers. These behaviorally uninhibited youth are at risk for intense thrill seeking behaviors, less sensitive to threat of punishment or consequence, and less reactive to threatening stimuli. In an effort to identify mediators on the negative outcomes of antisocial youth, Cornell and Frick (2007) assessed parents of antisocial children ($n=87$) for their parenting styles and their child’s temperament. Results indicate that behaviorally uninhibited children who experienced authoritative parenting were rated higher on empathy and guilt, two variables that counter callous and unemotional characteristics in antisocial youth. The type of consistent and firm parenting provided by

the authoritative style may effectively protect at-risk antisocial youth from more negative outcomes.

Although research is mixed regarding the role of ethnic group differences in parenting styles, it is important to recognize potential cultural differences in the outcomes of parenting attitudes and behaviors. For example, group differences were observed in a study of cultural variation in parenting perceptions between Caucasian, African-American, Hispanic, and Asian-American parents (Julian, McKenry, & McKelvey, 1994). The authors controlled for socioeconomic status in order to isolate the effect of culture on parenting variations. Results showed that ethnic parents, compared to Caucasian parents, tended to emphasize self-control and doing well in school. Other results suggested that Hispanic fathers placed importance on obedience and getting along well with others, while African-American mothers placed greater importance on temper-control and independence. The authors suggest that ethnic parents hold parenting attitudes that reflect greater strictness, control, and social desirability in order to help their children cope with a harsh and usually prejudiced society. Thus, authoritarian parenting behaviors, marked by strictness and control, may be beneficial for children in stressed, ethnic minority families. The authors conclude that benefits of certain parenting behaviors over others are culturally based and that desirable parenting behaviors should not be normed on Caucasian families only.

However, other research has shown that child outcomes due to parenting style are more culturally complex than mere group differences. In her study of Singapore youth, Ang (2006) found that adolescents of parents perceived to be authoritative were more confident in their abilities at school and better adjusted socially. Specifically,

adolescents' perceptions of their father's parenting style were more influential than perceptions of mother's parenting styles. This gendered finding, not identified in Western samples, is explained by the cultural norm of Eastern fathers exerting more influence on family dynamics than mothers. Despite this cultural variation, these findings further the relation between authoritative parenting and better child outcomes in non-Western populations.

Other authors argue that research suggesting cultural differences in parenting practices should caution against concluding that the differences stem solely from cultural or ethnic group affiliation (Varela, Vernberg, Sanchez-Sosa, Riveros, Mitchell, & Mashunkashey, 2004). In their study, parents of Mexican-descent reported greater use of authoritarian parenting behaviors than Mexican or Caucasian-non-Hispanic parents. These results suggest that ethnic minority status, rather than affiliation to Mexican culture, contributes to a greater use of authoritarian parenting style for Mexican-descent families living in the United States. Similar to conclusions drawn by Julian and colleagues (1994), Verela and colleagues (2004) argue that ethnic families employ strict and controlling parenting behaviors as an adaptive response to their minority status.

Indeed, the role of race and culture on normative parenting behaviors is complex and worth further investigation. What is clear from the parenting style literature is that different parenting styles contribute to different outcomes for children. These outcomes may be further altered when parents change or adapt their parenting behaviors due to the experience of trauma.

Parenting behaviors impacted by traumatic experience. The occurrence of traumatic events in parents' lives has a significant effect on their ability to provide

emotional support, leadership, and a sense of family togetherness (Lohan & Murphy, 2007). Low levels of family cohesion and emotional expression have been linked to negative family outcomes, such as low marital satisfaction and high potential for child abuse (Mollerstrom, Patchner, & Milner, 1992). Furthermore, the experience of traumatic events in the workplace has been shown to affect parents' perceptions of family functioning and the use of personal coping skills (Shakespeare-Finch, Smith, & Obst, 2002).

In addition to impacting family functioning, the negative cognitive and emotional symptoms of trauma may alter parent's use of particular parenting strategies. Depression, one of the dominant clusters of symptoms resulting from traumatic experience, has complex negative impacts on parenting (Cummings, DeArth-Pendley, Schudlick, & Smith, 2000). On the one hand, depressed parents tend to be more lax in behavioral standards and ineffective in child management techniques than non-depressed parents. On the other hand, when depressed parents are not yielding to their child's demands, they are more likely to engage in direct and forceful control strategies such as emotional outbursts or quick-tempered decisions, and they are less likely to end a disagreement with a compromise. This mix of permissive and authoritarian parenting behaviors may stem from depressed parents' lack of energy and depressed mood.

Not all of the negative impacts of traumatic experience on parenting are due to the comorbid experience of depression. Kiser and Black (2005) conducted a meta-analysis of the clinical and research literatures focusing on the connections between chronic traumatic exposure and family processes, specifically focusing on low-income, urban families. To summarize, parenting under high stress is associated with negative parenting

behaviors, such as insensitivity, reactivity, irritability, harshness, lack of responsiveness, and withdrawal. Additionally, those traumatized parents living in poor, urban communities tend to report high levels of PTSD symptoms. All three clusters of PTSD symptomology (as defined by the DSM), are related to a parent's limited ability to effectively interact with their children. Rumination or preoccupation with the traumatic event decreases a parent's ability to respond sensitively to children's needs. Re-experiencing and hyperarousal symptoms are related to parenting behaviors of overprotection, intense need for behavioral control, and negative reactivity. The avoidance and emotional numbing symptoms prevent parents from providing warmth, support, and nurturance. Many families react to intense stress with chaos, disorganization, and instability. These harsh conditions are often associated with lack of parental leadership and poor delineation of family roles.

In contrast, Kiser and Black (2005) also reported findings from studies in which families experiencing high levels of trauma bonded together around adversity. Parents in these families established regular schedules for accomplishing household tasks and, although often extreme, developed an autocratic management style to promote the safety and wellbeing of all family members. The authors also note that after some parents realize their children are negatively affected by their trauma related symptoms, they rely more heavily on social supports in order to provide an altered calm, supportive presence. For many families, strong spiritual or religious beliefs help parents make sense of chronic adversity. Strong ties to religious organizations also provide an invaluable network of social and community support on which to rely for help.

Several individual studies best highlight these findings that parents' experience of a traumatic event may not always be linked to negative parenting behaviors. Mowder, Guttman, Rubinson, and Sossin (2006) studied parenting role perceptions and behaviors before and after the 9/11 terrorist attacks in New York City. The participants included 99 parents who worked at universities near Ground Zero. The sample was 73% female yet racially diverse. Perceptions and frequency of parenting behaviors was measured retrospectively for before 9/11 (T1) and in the aftermath of the attack (T2), and currently at the time of the interview, which was two years after the attack (T3). Post hoc pairwise comparisons revealed that mean ratings increased significantly between T1 and T2 on bonding, sensitivity, and general welfare and that mean ratings decreased significantly on discipline. Between T2 and T3, sensitivity continued to be rated as high importance, while all other parenting behaviors returned to pre-attack levels. This study confirms that experience of a traumatic event alters parenting behaviors and perceptions, and that these alterations are not always negative.

Parents who have been exposed to trauma in their work environment have been found to employ more varied coping strategies than workers in a non-traumatic environment (Shakespeare-Finch, Smith, & Obst, 2002). In this study, male ambulance workers ($n=39$) were compared with a control group of shift-workers ($n=32$) on variables of family functioning and coping resources. All study men were married and had at least one dependent child. Results suggested that both groups of men utilized social support as well as personal coping resources to increase positive family functioning. However, differences emerged in the pattern of utilization: ambulance workers who utilized social support, engaged in self-care, and employed healthy cognitive strategies had low levels of

family conflict and high levels of family intimacy. For the control group, only social support was significantly correlated with low levels of family conflict and high levels of family intimacy. Thus, the ambulance workers demonstrated a more varied repertoire of personal coping skills to aid in family cohesion and adjustment than workers not exposed to traumatic events in the workplace. The authors suggest that the ambulance workers learn coping strategies to compartmentalize the stressful and traumatic experiences of their job to prevent them from affecting their family at home. Although parents may be repeatedly exposed to traumatic events, it is possible for them to learn to employ healthy coping strategies to effectively deal with the negative experience of trauma.

Parenting after trauma is a highly complex and challenging undertaking (Appleyard & Osofsky, 2003). In general, studies indicate that the greater the impairment of parent and functioning following traumatic experience, the greater the negative impact on children's development. Yet studies also indicate that the successful use of healthy coping strategies and the reliance on formal and informal social supports enables parents to effectively handle their traumatic symptoms and continue to provide for their child's needs.

Maternal parenting behaviors impacted by traumatic experience. As the current study is focused exclusively on the effects of maternal parenting style under conditions of trauma, a more specific examination of the literature on mothers is required. In order to further understand the impact of maternal experience of trauma on family functioning, Lohan and Murphy (2007) studied bereaved mothers (married, $n=61$; single, $n=25$) who had recently lost a child to a violent death, but who still had at least one child living with her in the home. The mothers were longitudinally studied over three time

points, baseline (2-7 months postdeath, 6 months after baseline, and 18 months after baseline). At each time point, mothers were administered the Family Adaptability and Cohesion Evaluation Scales (FACES III) assessment, which consists of adaptability and cohesion subscales. Results showed no significant differences in adaptability and cohesion subscale scores at any of the time points between married and unmarried mothers, suggesting that marital status alone is not a sole predictor of post-trauma family functioning over time. However, through the use of participant case examples, the authors showed the complexity of personal experience of trauma and its impact on family cohesion and adaptability over time. Although the relations were not statistically significant, in general, the authors conclude that regardless of marital status, the maternal experience of a traumatic event has clinically significant effects on family functioning and that these effects may vary over time.

Kaitz and colleagues (2009) describe the highly negative impacts of experiencing trauma on parenting practices using data collected from interviews with Israeli women. The authors conclude that mothers who are affectively disturbed by trauma or who are highly symptomatic of posttraumatic stress are unable to provide sensitive guidance, regulation, or fun during encounters with their children. They explain these parenting challenges with evidence from the literature concerning maternal depression and anxiety. In particular, mothers' interactions with their children are disrupted by the traumatic experience such that depressed mothers are unable to accurately appraise and respond to their children's needs. This disconnect may result in a permissive parenting style, one in which the mother is unaware of her child's needs and does not make appropriate demands for control or provide appropriate levels of warmth. The withdrawn stance typical of the

permissive parenting style may be useful for mothers, as it could protect traumatized mothers from further distressing emotional arousal. However, Kaitz and colleagues (2009) also conclude that some mothers respond to trauma by exaggerating their responsiveness to children, resulting in an overly controlling manner of interaction. These parenting behaviors align with the authoritarian style. This overprotective stance typical of the authoritarian parenting style may also be useful for mothers, as their hyper-vigilance to avoid traumatic stimuli also protects their children and contributes to the perceived safety of the family. These findings, and those by Cummings and colleagues (2000), suggest that the distressing and disorganized experience of traumatic symptoms may similarly disorganize parenting behaviors, resulting in an inconsistent mix of permissive and authoritarian styles.

However, other factors, such as relational support, may buffer mothers from the overwhelming experience of trauma symptoms and may promote a more healthy style of coping and parenting. Lyons, Henly, and Schuerman (2005) conducted a study examining the role of informal support among maltreating families receiving child welfare services. Using a majority ethnic-minority sample, the authors surveyed mothers ($n=826$) about financial strain, experience of traumatic life events, depression, positive and negative parenting behaviors, use of formal services, and informal supports, which included instrumental (i.e., money), emotional (i.e., conversation), and informational (i.e., advice), from specific sources (partners, fathers and mothers, brothers and sisters, and friends). Seventy-one percent of the mothers reported the use of at least one positive and at least one negative parenting behavior, although 31% reported losing control while punishing a child. Results suggest that parenting behaviors could be positively

influenced if higher levels of support lessen mothers' exposure to financial strain or negative life events, or reduce their depressive symptoms. Interestingly, depression had no significant effect on the positive parenting behaviors of mothers who also had high levels of informal support. The study suggests that with high levels of support, mothers may be able to parent through their distressing symptoms to reduce the likelihood that their children will be negatively affected by secondary trauma.

Literature Summary

Stress and trauma negatively impact individuals' ability to function and is often clinically recognized by the diagnosis of PTSD. Parental experience of trauma symptoms is often transferred to their children, which may negatively affect their psychological health and behavioral outcomes. An examination of parenting style typology reveals that different parenting strategies have different outcomes for children, and that these outcomes may be impacted by ethnic group. Most evidence is clear that parental experience of trauma, particularly that of mothers, can affect the expression of essential characteristics of parenting and that parenting under distressing psychological symptoms often results in direct negative impacts on children. However, it is uncertain whether or not mothers who experience highly stressful events are able to continue to parent effectively in the face of traumatic symptoms. The symptoms of trauma, such as depression or PTSD, may influence parenting style, and thus affect the transfer of psychological distress from mother to child. It remains unclear whether parenting style may exacerbate or reduce children's expression of secondary trauma or psychological distress when mothers experience trauma.

Purpose

The purpose of this study is to examine the impact of the symptoms resulting from parental experience of trauma on child psychological distress and functioning. Specifically, this research investigates links between maternal symptoms of trauma and child psychological distress. Interaction effects are investigated regarding how the effect of maternal trauma symptoms on child psychological distress might be moderated by the type of parenting practices employed by the mothers.

Hypotheses

The present study was designed to examine the relation between maternal experience of trauma symptoms and child report of psychological distress symptoms, as well as to investigate the moderating effects of parenting style. The following are the research questions that guide the study, and the specific hypotheses tested.

First research question. In a clinical sample, do children report higher levels of psychological distress when their mother reports the experience of trauma symptoms?

1. It is hypothesized that there is a positive relationship between mother's level of trauma symptoms and their children's report of psychological distress.

Second research question. Are mothers who experience symptoms of trauma more likely to adopt a particular parenting style?

2. It is hypothesized that mothers who report more symptoms of trauma are less likely to report authoritative parenting behaviors than mothers who report fewer symptoms of trauma.

3. It is hypothesized that mothers who report more symptoms of trauma are more likely to report either authoritarian or permissive parenting behaviors than mothers who report fewer symptoms of trauma.

Third research question. Are children protected from the transfer of distress when their mother experiences trauma symptoms and yet parents in an authoritative style?

4. It is predicted that the type of parenting strategies employed moderates the effect of maternal trauma symptoms on child symptoms of psychological distress.

Exploratory question. If sample size permits investigation, does race/ethnicity of the mother correlate with maternal trauma symptoms, parenting behaviors, or child psychological distress?

Chapter III Methodology

Sample

The data for this study were collected from 113 families seeking mental health therapy at the Center for Healthy Families (CHF), a therapist training facility located in the Department of Family Science at the University of Maryland. These families sought treatment between 2001 and 2008. The Center for Healthy Families clinic provides individual, couple, and family therapy services to a diverse population of clients in the surrounding communities of Washington, DC. The clinic offers services based on a sliding fee scale to accommodate those clients of lower socioeconomic status. Families who utilize CHF services are from a culturally diverse community population, and there is a higher representation of low-income and non-insured families than in the general public. The community clinic setting is equipped to respond to various types of relational problems and provides culturally sensitive practice and treatment methods. Before therapy may begin, family members must sign a confidentiality form that provides consent for their assessment questionnaires to be used in clinic research.

Families were selected for participation in the present study based on several requirements. First, the therapy treatment unit was a family, which included one mother and at least one child between the ages of 12 and 18 (82 mothers attended therapy without partners, 31 mothers attended therapy with their partners). Second, only data from mothers and the child(ren) who fully completed the assessment battery of questionnaires were used. Only data from mothers was used to examine the parental component of each research question due to insufficient numbers of fathers present in

therapy. If more than one child in the appropriate age group was present for therapy, selection of the child participant alternated between the oldest and youngest child present.

Mothers' ($n=113$) mean age was 40.6 years old, with ages ranging from 29 to 54 years old. Sixty-two mothers self-identified as African American (54.9%), 2 as Asian/Pacific Islander (1.8%), 12 as Hispanic (10.6%), 25 as White (22.1%), and 12 as Other/multiracial (10.6%). The majority of mothers were married and living with their partners ($n=31$). Other mothers were currently married, separated, but not divorced ($n=23$), divorced ($n=19$), living together with their partners but not married ($n=15$), dating but not living together ($n=3$), separated but never married ($n=1$), single ($n=16$), or widower ($n=2$). Three mothers did not report their relationship status. Mothers had between 1 and 6 children living at home with them, with an average of 2.3 children. Thirty mothers reported having at least one child not living in their home. Many mothers held advanced graduate degrees ($n=38$); others had completed at least some high school education ($n=25$), some college education ($n=39$), or had completed trade school ($n=6$). Mothers' income ranged from \$0 to \$160,000, and the mean income was \$34,244.

There were 113 children, 65 females (57.5%) and 48 males (42.5%), whose ages ranged from 12 to 18 years old, with a mean age of 14.7 years old. Sixty-six children self-identified as African American (58.4%), 1 as Asian/Pacific Islander (.9%), 8 as Hispanic (7.1%), 20 as White (17.7%), and 18 as Other/multiracial (15.9%).

Procedure

As previously stated, the participants in this study were clients of the Center for Healthy Families. Families may become aware of the clinic through various means, including active outreach by the clinic, flyers placed in schools and community centers,

referrals by other mental health agencies in the community, referrals from the court system or Child Protective Services, or word of mouth. Each family in the study initiated therapy services by first calling the CHF and completing an intake interview over the telephone. The intake worker gathered information such as the presenting problem, demographic information, and family structure. Once the intake was completed and filed, the family was assigned to a therapist intern, who was a graduate student in the master's Couple and Family Therapy Program at the University of Maryland. The assigned therapist contacted the family by telephone and explained that the first session would involve extensive paperwork assessments and that this initial session would be free of charge.

During the first session, all present family members are required to sign an informed consent agreement. CHF policy requires that all adults and children between the ages of 12 and 18 complete the entire questionnaire battery, which assesses variables such as depression, trauma symptoms, relationship styles, issues of family conflict, family and social support, drug and alcohol use, relationship distress, partner violence, and parenting practices. All assessments are stripped of identifying information to ensure client confidentiality. Once completed, the assessments are coded and entered as clinic data into a large SPSS dataset. For the purposes of this study, the data selected included only those clients seeking family therapy with one mother and at least one child between the ages of 12 and 18. In addition, only data from the demographics questionnaire, Trauma Symptom Inventory, Parenting Practices Questionnaire, and Beck Depression Inventory was used. These measures are described in greater detail below.

Measures

Demographic Questionnaire. The Family/Individual Information & Instructions questionnaire, a demographic questionnaire developed for new clients at the Center for Healthy Families was provided at the first therapy session. Forced-choice items include relationship status, occupation, current employment status, race/ethnicity, obtained level of education, religious preference, and importance of religion in daily life. These items are answered by selecting one of several options provided on the questionnaire. Open-ended items include age, yearly gross income, country of origin, number of people in household, number of children who live at home, current legal involvement, and four spaces to list the concerns and problems for which the family is seeking help. These items are answered by writing the appropriate answer in a blank space provided on the questionnaire.

The Trauma Symptom Inventory. In order to measure a parent's experience of trauma symptoms, the Trauma Symptom Inventory (TSI-A; Briere, 1995) was used. The TSI was created for use in clinical settings to assess the experience and severity of trauma-related symptoms. The original 100 item TSI has 13 subscales, three validity scales, and ten clinical scales. Due to the extensive battery of assessments required of new clients, the Center for Healthy Families' clinical administration shortened the TSI to 42 items and five clinical scales. For the purposes of this study, the CHF abbreviated version was used. The avoidant and intrusive experiences of trauma are represented by the intrusive experiences, defensive avoidance, and the dissociation subscales. The mood states associated with trauma are captured in the anger irritability and the anxious arousal subscales. These five scales correspond to the five DSM-IV diagnostic criteria for PTSD

(A, traumatic experience; B, intrusive experiences; C, defensive avoidance; D, anxious arousal; E, lasts longer than one month; F, significant distress). The TSI outcome data have been normed to the general population (men and women, 18 years and older), university, clinical, and Navy recruit samples. Race accounted for only 2% to 3% of the variance on the TSI scales; therefore, Briere (1995) recommends that the TSI clinical scales not be adjusted for race.

The TSI-A begins with instructions to answer each question based on how often in the past six months trauma symptoms were experienced. The participant answers on a Likert-type scale that ranges from 0 “Never” to 3 “Often”. The raw scores for each subscale are totaled, converted to T scores, and then compared to normative T scores. Higher total raw and T scores generally indicate greater degrees of symptomology, with a total T score above 65 being clinically significant (Briere, 1995). The five clinical subscales used on the CHF abbreviated version are internally consistent (mean alpha coefficients range from .84 to .87) and have sufficient convergent and predictive validity (predicting PTSD status in over 90% of the cases). Also, the TSI has high incremental validity, meaning its scores predicted the “victimization variance” beyond what was accounted for by other trauma symptom measures (Briere, 1995, p.43).

The Parenting Practices Questionnaire. In order to measure a parent’s use of various parenting behaviors, the Parenting Practices Questionnaire (PPQ; Coolahan, 1997) was used. The PPQ was constructed to measure parenting styles through an assessment of parenting behaviors. There are 62 items on the PPQ, which cluster on three parenting styles: authoritarian, authoritative, and permissive. The authoritative parenting scale consists of 27 items that measure dimensions of warmth,

reasoning/induction, good natured/easy going, and democratic participation (questions 1, 3, 5, 7, 9, 12, 14, 16, 18, 21, 22, 25, 27, 29, 31, 33, 35, 39, 42, 46, 48, 51, 53, 55, 60, 62). The authoritarian parenting scale consists of 20 items along four dimensions of verbal hostility, corporal punishment, nonreasoning/punitive, and directiveness (questions 2, 6, 10, 13, 17, 19, 23, 26, 28, 32, 37, 40, 43, 44, 47, 50, 54, 56, 59, 61). Finally, the permissive parenting scale consists of 15 items that emphasize lack of follow through, ignoring misbehavior, and lack of parenting self-confidence (questions 4, 8, 11, 15, 20, 24r, 30, 34, 36, 38r, 41, 45, 49, 52r, 57). Normative data exists on outcome data for the PPQ from a representative sample of pre-kindergarten Head Start parents (89% female; mean age 30 years).

The PPQ begins with instructions for the participant to select the response that best indicates how often certain parenting behaviors are performed. The participant answers on a Likert-type scale that ranges from 1 “Never,” to 3 “About half the time,” to 5 “Always.” The parenting style scales are not mutually exclusive; answers to items on each subscale are summed, generating three scores for each participant. The three parenting style scales are internally consistent, with Cronbach alphas of .87, .74, and .77 for the authoritative, authoritarian, and permissive parenting scales respectively (Coolahan, 1997). The PPQ has also been shown to have good construct validity, with 93% of items loading on only one of the three dimensions.

The Beck Depression Inventory. In order to measure a child’s report of distressing psychological symptoms, the Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) was used. The BDI was designed to measure severity of depression. It was based on the clinical observations of depression psychiatric patients

and non-depressed psychiatric patients (Beck, Steer, & Garbin, 1988). The BDI consists of 21 items that describe the symptoms and attitudes typically expressed by depressed individuals. It is proven as a reliable measure, with good internal consistency (mean coefficient alpha = .86) and stability (correlation coefficients between .48 and .86). The BDI also has excellent content, concurrent, discriminate, construct, and factorial validity (Beck, Steer, & Garbin, 1988). Scores on the BDI are related to suicidal ideation, alcoholism, and adjustment disorders, and they discriminate from anxiety disorders.

The BDI begins with instructions for the participant to rate his or her feelings in the past week. Each response is reported on a Likert-type scale that ranges from 0 to 3, where higher scores indicate more severe depression. Responses to the 21 items are summed for a total BDI score. The total score indicates level of depression: scores less than 10 indicate none to minimal depression, scores 10-18 indicate mild to moderate depression, score 19-29 indicate moderate to severe depression, and scores 30-63 indicate severe depression. Scores above 15 are considered clinically significant (Beck, 1996). Although the BDI was developed for use on adult populations, it is accurate in detecting depression among adolescents ages 13 to 18 (Sitarenios & Kovacs, 1999). A child version, most often used in samples of children younger than 13, also exists. Because both adults and children between the ages of 12 and 18 complete the entire Center for Healthy Families assessment battery, the “adult” version of the BDI is used.

Variables

Independent variable. For the present study, all three research questions use the independent variable of maternal trauma symptoms. Adult trauma-related stress reactions include cognitive and emotional distress that is usually displayed through

unhealthy behaviors, such as the experience of nightmares, flashbacks, worry, irritability, absent-mindedness and anxiety (Kiser & Black, 2005). Maternal trauma symptoms are determined by total score on the TSI explained above.

Moderator variable. For the third research question (Are children protected from the transfer of distress when their mothers experience trauma symptoms and yet parent in an authoritative style?), parenting style is used as a moderator variable. Parenting style is operationally defined by the cluster of parenting behaviors and strategies most often employed by a parent, as reported on the PPQ. According to Diana Baumrind (1971), parenting strategies cluster in to three main styles, authoritative, authoritarian, and permissive.

Dependent variables. The dependent variable used to measure the first research question is the child's level of psychological distress symptoms, operationally defined by the report of depressive symptoms on the BDI. For the second research question the dependent variable is parenting style. Parenting style is operationally defined as described previously. For the third research question, regarding the moderating effect of parenting style on the association between mother level of trauma symptoms and child outcomes, the dependant variable is child symptoms of psychological distress, operationally defined by the report of depressive symptoms on the BDI.

Chapter IV Results

The present study was designed to examine the relation between maternal trauma symptoms and child psychological distress, as well as the moderating effect of parenting behaviors. The following are the research questions that guided the study, and the specific hypotheses that were tested:

1. In a clinical sample, do children report higher levels of psychological distress when their mother reports the experience of trauma symptoms?

It was hypothesized that there will be a positive relationship between mothers' level of trauma symptoms and their children's report of psychological distress.

2. Are mothers who experience symptoms of trauma more likely to use a particular parenting style?
 - a. It was hypothesized that mothers who report more symptoms of trauma will be less likely to report authoritative parenting behaviors than mothers who report fewer symptoms of trauma.
 - b. It was hypothesized that mothers who report more symptoms of trauma will be more likely to report either authoritarian or permissive parenting behaviors than mothers who report fewer symptoms of trauma.

3. Are children protected from the transfer of distress when their mother experiences trauma symptoms and yet parents in an authoritative style?

It was hypothesized that the type of parenting strategies employed will moderate the effect of maternal trauma symptoms on child symptoms of psychological distress.

4. If sample size permits investigation, does race/ethnicity of the mother correlate with maternal trauma symptoms or parenting behaviors?

Primary Analysis

Hypothesis 1. For the first question regarding the relation between mother's level of trauma symptoms and her child's level of psychological distress, a Pearson correlation was conducted. The independent variable tested was the mother's level of trauma symptoms and the dependent variable was the child's level of depression.

Contrary to the stated hypothesis, the results indicated no significant relationship between mother's level of trauma and child's level of depression, $r(111) = .08, p = .38$.

Hypothesis 2. Three Pearson correlations were conducted to test the relations between mother's level of trauma symptoms and her use of parenting behaviors, one for the use of authoritative parenting behaviors (hypothesis 2a), and the other two for the use of authoritarian and permissive parenting behaviors (hypothesis 2b). For all three correlations, the independent variable was mother's level of trauma and the dependent variables were level of authoritative, authoritarian, and permissive parenting behaviors.

Mother's level of trauma symptoms and her level of authoritative parenting behaviors (hypothesis 2a) were not significantly correlated, $r(111) = -.07, p = .50$.

However, mother's level of trauma symptoms and her level of authoritarian, $r(111) = .25, p < .01$, and permissive, $r(111) = .45, p < .01$, parenting behaviors (hypothesis 2b) were significantly positively correlated. In accordance with the stated hypothesis, the results indicated that mothers who experience higher levels of trauma symptoms are more likely to use authoritarian and permissive parenting behaviors than mothers who experience lower levels of trauma symptoms.

Hypothesis 3. Three step-wise multiple regressions, one for each parenting style, were conducted to test the moderating effect of maternal level of trauma and parenting behaviors on child psychological distress. For each regression, an interaction variable was created by multiplying mother’s level of trauma symptoms with her respective level of parenting behaviors on authoritative parenting, authoritarian parenting, and permissive parenting scores. The level of child depression was the dependent variable. Maternal level of trauma was entered first and each interaction variable was entered second. As can be seen in Tables 2, 3, and 4, there was no moderating effect for authoritative parenting. However, a significant moderating effect was found for both authoritarian parenting and permissive parenting.

Table 2

Mother Trauma (TSI) and Authoritative (PPQ Subscale) Regression

Variable	Standardized		
	Beta	t	Sig.
Trauma	.08	0.21	.83
Trauma x Authoritative	.01	0.02	.98

Table 3

Mother Trauma (TSI) and Authoritarian (PPQ Subscale) Regression

Variable	Standardized		
	Coefficient		
	Beta	t	Sig.
Trauma	-.40	-1.72	.09*
Trauma x Authoritarian	.53	0.53	.03*

* $p < .01$

Table 4

Mother Trauma (TSI) and Permissive (PPQ Subscale) Regression

Variable	Standardized		
	Coefficient		
	Beta	t	Sig.
Trauma	.49	2.12	.04*
Trauma x Permissive	-.45	-1.92	.06*

* $p < .01$

In order to understand the direction of the moderating effects, children's depression means were examined under conditions of high and low maternal trauma and the parenting style of interest. For these analyses, the level of trauma symptoms was divided in two categories based on a median split between "low scores" (a score of 0-39) and "high scores" (a score of 40-121). The level of authoritarian and permissive parenting behaviors were also divided in two categories based on a median split between "low scores" (a score of 25-43 authoritarian; a score of 19-31 permissive) and "high

scores” (a score of 44-82 authoritarian; a score of 32-62 permissive). As can be seen in Table 5, under conditions of low maternal trauma, using authoritative or permissive parenting strategies does not appear to affect child depression. The effect does seem to be evident, however, under conditions of high trauma. Mothers experiencing high levels of trauma symptoms who parent with a high use of authoritarian behaviors have children who experience more depression than those whose mothers who use low levels of authoritarian behaviors. However, mothers experiencing high levels of trauma symptoms who parent with a high use of permissive behaviors have children who experience less depression than those whose mothers use low levels of permissive behaviors. The means of these analyses are presented in Table 5.

Table 5

Children’s Depression (BDI) Scores

	Low	High	Low	High
	Authoritarian	Authoritarian	Permissive	Permissive
Low Maternal Trauma	10.90	10.18	10.83	10.19
High Maternal Trauma	9.34	13.30	14.86	9.62

Exploratory question. In order to test the exploratory question of the relation between mother’s race/ethnicity and her level of trauma symptoms or parenting behaviors, four one-way ANOVAs were conducted. Due to limitations of sample size, only mothers who self-identified as African American ($n=62$) or White ($n=25$) were used in these analyses. The independent variable for all tests was mother’s race/ethnicity and the dependent variable for each of the four tests was maternal level of trauma symptoms,

and maternal level of authoritative parenting behaviors, authoritarian parenting behaviors, and permissive parenting behaviors, respectively. The results indicated no significant difference in the level of trauma symptoms experienced by African American and White mothers, $F(1, 86) = 2.15, p = .15$. The results also indicated no significant difference between racial/ethnic groups in the use of authoritative parenting behaviors, $F(1, 86) = .62, p = .43$, or permissive parenting behaviors, $F(1, 86) = 1.3, p = .26$. However, results did indicate a significant difference between African American and White mothers in the use of authoritarian parenting behaviors, $F(1, 86) = 7.58, p < .01$. The means indicate that African American mothers report more authoritarian parenting behaviors ($M=47.90, SD=12.8$) than White mothers ($M=40.24, SD=8.30$).

Additional Analyses

After reviewing the findings for the proposed analyses, further analyses were conducted to explore an additional question. This question focused on the relation between mother's level of trauma symptoms and level of child psychological distress. According to Briere (1995), TSI scores greater than 65 indicate clinically significant levels of traumatic symptoms. The mean TSI score of the present sample was only 42.72 ($SD=29.00$). Thus, even though the first analysis showed no significance between maternal level of trauma symptoms and child depression, it was decided to conduct additional correlations using each of the trauma subscales on the TSI.

TSI subscales. As previously stated, the original 100 item TSI has 13 subscales, three validity scales, and ten clinical scales (Briere, 1995). Due to the extensive battery of assessments required of new clients, the Center for Healthy Families' clinical administration shortened the TSI to 42 items and five clinical scales. The five clinical

subscales used in these additional analyses were Intrusive Experiences, Defensive Avoidance, Anger Irritability, Dissociation, and Anxious Arousal.

When the total level of trauma symptoms variable was replaced with each of the five subscale scores as the independent variable, the findings were again not significant for any of the subscales. Only the Pearson correlation between the Intrusive Experiences subscale and child level of depression approached significance, $r(111) = .17, p = .08$.

Chapter V Discussion

The purpose of this study was to investigate the impact of symptoms resulting from maternal experience of trauma on parenting styles and child psychological distress. Previous research shows a strong transfer of distress from traumatized parents to their children, regardless of whether or not the child witnessed the traumatic event (Dulmus & Wodarski, 2000; Matsakis, 2004). Furthermore, mothers who experience intense symptoms of trauma may not be able to parent as effectively as mothers who are not traumatized (Kaitz, et al., 2009). Yet this relationship has been challenged by other research which suggests that although parenting may be affected by the experience of trauma, those effects may not always be negative (Mowder, et al., 2006). It has also been suggested that the use of parenting styles varies by ethnicity and that for different groups of children parenting styles are related to different outcomes (Julian, Mckenry, & McKelvey, 1994).

Therefore, the current research project aimed to disentangle the relationship between maternal experience of trauma and its effect on children, as well as the impact of parenting styles under conditions of stress. It was hypothesized that this study would replicate findings of previous research that suggested a transfer of distressing symptoms from mothers who experience high levels of trauma symptoms to their children. Based on Baumrind's (1971) parenting typology, it was further hypothesized that mothers who experience high levels of trauma symptoms will be more likely to use both authoritarian and permissive parenting strategies, rather than authoritative parenting strategies. Finally, it was important to examine the possible moderating effect of parenting style under conditions of high and low trauma symptoms on child psychological distress in

order to determine if mothers could alter the effects of secondary trauma by using particular parenting behaviors. As exploratory analyses, the relations between maternal race/ethnicity and maternal trauma symptoms, parenting behaviors, and child psychological distress were examined.

Summary of the Results

The findings for the first hypothesis, as reported in greater detail in the previous chapter, indicate that contrary to previous research (Catherall, 2004; Lombardo & Motta, 2008; Rydelius & Daud, 2008) no relationship was found between maternal experience of trauma and child psychological distress. Additional analyses using subscale scores of maternal trauma symptoms also did not yield significant effects on child psychological distress.

The second hypothesis, regarding the relation between maternal trauma symptoms and parenting styles, was partially supported. The current research found no relation between mother's level of trauma symptoms and use of authoritative parenting behaviors. However, a significant positive relationship between mother's level of trauma symptoms and use of authoritarian and permissive parenting behaviors was found. These findings support previous research that suggests the symptoms of trauma, such as lack of energy and a depressed or irritable mood, correspond to characteristics of authoritarian and permissive parenting behaviors (Kaitz, et al., 2009; Cummings, et al., 2000).

The third hypothesis regarding the moderating effect of parenting style on the relationship between maternal symptoms of trauma and child psychological distress was also partially supported. No relation was found for authoritative parenting behaviors, contrary to the hypothesis that children might be protected from the transfer of distress

when mothers under conditions of trauma parent in authoritative ways. Yet findings did indicate significant results for authoritarian and permissive parenting behaviors under conditions of high trauma. Mothers experiencing high levels of trauma symptoms who parent with a high use of authoritarian behaviors have children who experience more depression than those whose mothers use low levels of authoritarian behaviors.

However, mothers experiencing high levels of trauma symptoms who parent with a high use of permissive behaviors have children who experience less depression than those whose mothers use low levels of permissive behaviors.

Results from the exploratory analyses suggest racial/ethnic differences in parenting behaviors. The findings indicate that African American mothers are more likely to use authoritarian parenting behaviors than White mothers. This relation is supported by previous research that suggests minority parents hold parenting attitudes that reflect greater strictness and control in order to help their children cope with a harsh and usually prejudiced society (Julian, McKenry, & McKelvey, 1994; Varela, et al., 2004). No significant results were found for other exploratory questions, such as the relation between maternal race/ethnicity and maternal trauma symptoms.

Discussion of Findings

The current study both aligns with and differs from previous research on the complex relationships between maternal trauma, parenting behaviors, and child psychological distress. One of the most interesting differences in the findings of this study is that it did not replicate findings of secondary trauma in children of mothers who experience high levels of trauma symptoms. One possible explanation for this finding is that the majority of sample children did not report clinically significant levels of

depression. The group mean depression score was 11.13 and the standard deviation was 9.90. Moderate to severe levels of depression on the BDI are indicated by scores between 19 and 29 (Beck, 1996). The majority of mothers of the current sample also did not have significantly high levels of trauma symptoms. The group mean trauma score was 42.72 and the standard deviation was 29.00. Higher raw scores on the TSI indicate higher experience of trauma symptoms (the highest raw score possible on the abbreviated version used in this study is 126). While there was some variability in these scores, they still over all were quite low. The low level and low variability in depression scores of the current sample combined with the low level of maternal trauma scores may have weakened the relation between maternal symptoms of trauma and child distress.

Additionally, the use of an older child/adolescent sample rather than younger children may have influenced these results. Much of the literature that documents secondary trauma in children uses samples of children younger than age 12. The current sample, due to the data available, included only children between the ages of 12 and 18. It is possible that older children and adolescents are better protected from their parent's trauma symptoms than younger children, due to their more developed coping skills and support systems, such as peers or other significant adults such as a teachers or school counselors. Younger children who are more likely than adolescents to spend time interacting with and be dependent on parents may be more likely to experience a transfer of distressing symptoms. Older children also have more developed cognitive skills than younger children, which allow them to better reason and understand their parent's trauma in a way that may further protect them from a transfer of distress. It is also possible that older children who are negatively impacted by their parent's trauma symptoms respond in

other ways. For example, older children may respond with anger or anti-social behaviors such as substance abuse, rather than with symptoms of depression or anxiety. Therefore, it is possible that with a younger child sample, the relation between maternal symptoms of trauma and child psychological distress would be replicated.

Similar to previous research, the current study supported the link between the experience of trauma and the use of authoritarian and permissive parenting behaviors. Mothers in the current study were more likely to use authoritarian or permissive parenting behaviors when they also experienced high levels of trauma symptoms. Furthermore, mothers' use of authoritarian and use of permissive parenting behaviors were highly correlated. In a secondary analysis, authoritarian behaviors and permissive behaviors were significantly positively related, $r(111) = .35, p < .01$, such that mothers who reported high levels of authoritarian behaviors were also likely to report high levels of permissive behaviors. Previous research supports the relation that stressed mothers are more likely than non-stressed mothers to be generally lenient in their behavioral standards for their children and yet also engage in harsh tactics for control (Cummings, et al., 2000; Kaitz, et al., 2009). The combination of internalizing trauma symptoms, such as depression and emotional numbing, and externalizing trauma symptoms, such as hyper-arousal and aggression, may lead mothers to tend towards the withdrawn behaviors of permissive parenting and the hyper-vigilant behaviors of authoritarian parenting. This conclusion is supported by stress and coping theory. The theory distinguishes between problem-focused coping strategies, which tend to be externalizing and reactively control the stressful experience, and emotion-focused coping strategies, which tend to be

internalizing and describe the emotional response to the stressful experience (Lazarus, 1966).

However, it seems that in this study while maternal trauma per se does not seem to impact child psychological distress, how mothers parent through their traumatic symptoms does have an impact. Based on previous research, it is not surprising that highly stressed mothers tend to use both authoritarian and permissive parenting behaviors—what is surprising is that the use of authoritarian versus permissive parenting behaviors has inverse effects on child depression.

The impacts on child psychological distress from mothers who use authoritarian parenting under conditions of high trauma were in the expected direction. In the current study, mothers who experienced high levels of trauma symptoms and who used high levels of authoritarian parenting behaviors had children who experienced higher levels of depression. Parents who experience high levels of trauma symptoms are likely to parent with authoritarian-like behaviors (Cummings, et al., 2000; Kaitz, et al., 2009). Some authors suggest that the authoritarian behaviors of traumatized parents stem from their tendency to go to exaggerated lengths to protect their children from the kinds of traumatic experiences they themselves encountered (Kaitz, et al., 2009). For example, when a mother perceives her child to engage in a situation deemed dangerous, she will harshly reprimand her child without warning to protect them.

Authoritarian parenting is characterized by high levels of criticism and coercive control and by low levels of warmth and acceptance (Baumrind, 1971). Authoritarian parents appear cold and rejecting to their children and are more likely to respond harshly with yelling and punishments. The parenting literature suggests that children of

authoritarian parents tend to be unhappy and respond with hostility when frustrated (Berk, 2005). In general, this type of authoritarian behavioral control may lead to infantilizing children and restricting their development of autonomy and confident decision making.

In line with both the parenting and trauma literatures, the results of the current study suggest that the combination of maternal trauma symptoms and the use of authoritarian parenting behaviors are related to an increase in a child's level of psychological distress. However, an inverse result was found for the effect of permissive parenting behaviors on the relationship between maternal trauma symptoms and child psychological distress. Contrary to both hypotheses and previous research, the current study found that children reported lower levels of depression when their mother used higher levels of permissive parenting behaviors under conditions of high trauma.

Previous research has linked the internalizing symptoms of trauma, such as depressive or avoidant behaviors, with permissive parenting behaviors, such as lax standards and inattention (Cummings, et al., 2000). Indeed, the permissive parenting style is generally characterized as overly warm and indulgent, yet inattentive and undemanding (Berk, 2005). Parenting studies have shown that children of permissive parents tend to be impulsive and disobedient. These children also perform poorly on school achievement, are overly demanding of adults, and display more antisocial behaviors than children whose parents set firm limits. Yet the findings of the current study suggest that for mothers under conditions of high trauma, using permissive parenting behaviors is linked to *less* distress for children. While this finding may seem counterintuitive, it may be that it is the overly warm and connected characteristics of

permissive parenting, and not the inattentive and lenient characteristics, that make a difference for children of parents who have experienced trauma.

The literature on the impacts of combat-related trauma on military families may broaden the understanding of this finding. It is important to acknowledge, however, that the vast majority of studies on the effects of military stress describe the traditional military family in which the father is the service member. Similar to the civilian workplace, the numbers of women in the military has grown significantly (Kelley, Herzog-Simmer, & Harris, 1994). However, strikingly few studies focus on the unique stressors that military service poses for mothers. Therefore, it is acknowledged that although the findings of the current study are applicable to mother's experience, important insight about the effects of trauma on parenting can be gained from military fathers' experience.

In a study by Ruscio, Weathers, King, and King (2002), male Vietnam veterans were administered a combination of structured interviews and self-report questionnaires to assess their level of post-traumatic stress psychopathology and current relationship quality with their children. Correlational analyses indicated that the post-traumatic stress symptom of emotional numbing was most highly associated with fathers' poor relationship quality with their children. The authors surmise that the disinterest and detachment that characterize the experience of emotional numbing impact a combat veteran father's ability to seek out and engage in quality interactions with their children. In a related study, Samper, Taft, King and King (2004) found that male Vietnam veterans who experienced the post-traumatic stress symptoms of avoidance and emotional numbing also reported low levels of over-all parenting satisfaction. In this study,

parenting satisfaction was measured by a self-report assessment of parent-child relationship quality, their perception of how well their children were “turning out” and level of problems the children exhibited. The authors of both studies conclude that it is the emotional unavailability of these fathers that corresponds to poor relationship quality.

Both the trauma literature in general and the trauma literature specifically concerning military families describe a withdrawn parenting style more aligned with the uninvolved parent. Uninvolved parents are those who are so overwhelmed by their own emotional experience that they are unable to respond to the needs of their children (Berk, 2005). This type of parental disengagement is often called neglect and results in poor emotion regulation and school performance in children. But it is important to recognize that a description of an emotionally unavailable, inattentive, and detached parent is not the image of a permissive parent. Permissive parenting, as used in the parenting literature, is characterized by high levels of parental emotional involvement and warmth and low levels of behavioral control.

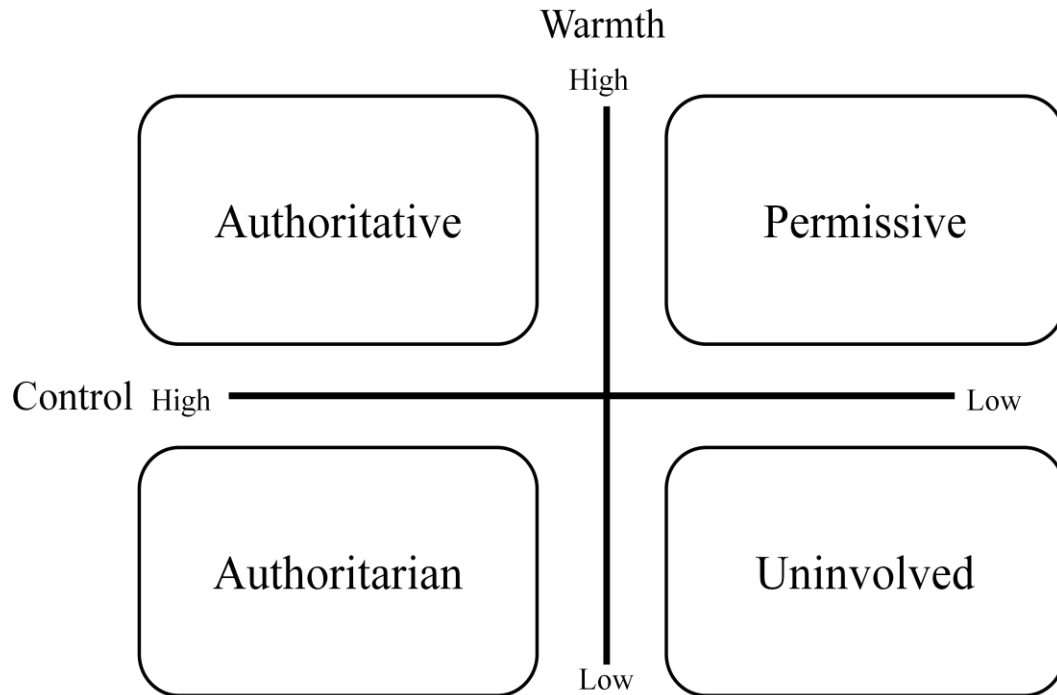
Both the authoritarian and uninvolved parenting styles are characterized by extremely low levels of positive emotional engagement yet are on opposite ends of the spectrum of behavioral control, and both styles have been found under conditions of high maternal trauma to negatively impact children, both in the current study and in previous research. Perhaps, then, the difference in the effect on child distress for authoritarian parenting versus permissive parenting under conditions of high trauma is not due to the level of behavioral control exerted by mothers, but by their level of warmth and emotional engagement with their children. That is, if parents experiencing higher symptoms of trauma are able to maintain a warm emotional connection to their children,

regardless of their level of behavioral control, the children may fare better. Research on authoritative parenting further supports this possibility.

Authoritative parenting, often associated with positive child outcomes, is characterized by high levels of acceptance and involvement, reasonable behavioral control, and high psychological autonomy granting (Berk, 2005). Gray and Steinberg (1999) hypothesized that the three dimensions of authoritative parenting would differently affect adolescent outcomes of behavior problems, psychosocial development, internal distress, and academic competence. Most relevant to the current discussion, the study found that adolescents reported less psychological distress when they perceived their parent to be high on dimensions of acceptance-involvement and psychological autonomy granting. Parental behavioral control was unrelated to adolescent internal distress once the other two aspects of authoritative parenting were accounted for. These results suggest that when it comes to internal distress, warm and involved parenting that allows adolescents their own decision making may be more important than parental levels of behavioral control. As illustrated in Figure 1, although the authoritative and permissive parenting styles differ in their levels and type of behavioral control, the warm and emotionally connected characteristics of authoritative parenting are shared by the permissive parenting style. Although the current study did not find significant results for the effects of authoritative parenting on child psychological distress under conditions of high maternal trauma, perhaps it was this warmth dimension of authoritative parenting that fueled that hypothesis.

Figure 1

Parenting Styles along Dimensions of Warmth and Control



Authoritarian and permissive parents differ not only in their level of behavior control, but also in their level of warmth and emotional attention. As the findings from the current study suggest, highly stressed mothers who do not set firm rules of behavior and yet are able to emotionally connect with their children may protect their children from symptoms of depression. This specific permissive mix of high emotional closeness and low negative reactivity may help prevent parents from overtly displaying their distress to their children and thereby reducing the likelihood of secondary trauma. Alternatively, authoritarian mothers who employ the opposite mix of low emotional closeness and high negative reactivity increase the likelihood that their children will experience symptoms of secondary trauma. Mothers in the current study who are overly controlling and harsh in their standards and who do not display high levels of warmth or

affection have children who suffer from more symptoms of depression. Therefore, perhaps under conditions of high trauma it is not the use of the permissive or authoritarian parenting style in general but the narrower dimension of parental warmth and acceptance that influences the level of secondary trauma and psychological distress in children.

Limitations of the Study

When reviewing the findings of this study, several limitations should be considered. One limitation concerns the potential for a social desirability bias on the parenting questionnaire. For example, mothers may be more likely to endorse socially desirable behaviors such as “I show sympathy when my children are hurt or frustrated” that appear on the authoritative subscale, than to endorse those behaviors not typically approved by society, such as “I shove my children when they are disobedient” or “I allow my children to annoy someone else”, which appear on the authoritarian and permissive subscales respectively. The majority of mothers reported high use of authoritative parenting versus the other two styles (as indicated by the group means on each parenting style subscale), which may suggest a social desirability bias in responses and distort their actual use of authoritarian or permissive parenting behaviors.

A second limitation stems from the study population in general. It is possible that the use of a convenience clinical sample affected the means of the sample or the relation of the variables. Although the clinic serves an ethnically and socioeconomically diverse population, the sample may not be representative of the larger population. Additionally, the sample composition limited analyses of parenting behaviors to those of only mothers. Furthermore, participants in the current study completed the assessment questionnaires as

their first step to receiving therapy services for their family. The therapy setting in which the assessments were completed may have influenced the responses of both mothers and children. For example, it is possible that adolescents who did not want to attend therapy with their families may have inaccurately reported their level of depression.

Finally, interpretations of the findings need to be made in the correlational context of the study design. It may be that the parents in the study were consistently authoritarian or permissive before the onset of traumatic symptoms. The correlational results also cannot identify the specific mechanisms of the transfer of distress from mothers to their children under authoritarian parenting conditions, or the mechanisms of protection from mothers to their children under permissive parenting conditions. For these reasons and others, causal conclusions cannot be made from the data.

Implications for Further Research

Future research should strive to account for the limitations of this study, particularly in the composition of the sample and need for longitudinal data that may provide causal relations. Additionally, future research that is not reliant on a secondary dataset should also increase the number of variables in the study. Several other factors are likely to influence the impact of maternal trauma symptoms on child psychological distress and on parenting style, such as use of coping strategies, level of social and community support, quality of marital satisfaction, and the parenting strategies of other caregivers. Furthermore, it is important to gather additional information regarding the nature of the traumatic experience itself, such as the type of trauma experienced and when it occurred. Results may indicate differences between the cumulative effects of lifetime traumas such as child abuse or adult traumas such as rape or the witnessing of a

violent event. A more qualitative assessment of maternal parenting and trauma symptoms, as well as of child psychological distress, would likely provide a more complete understanding of the interactions between the variables.

The findings of the current study strongly support the need for further study of the effects of parental trauma symptoms and parenting style on child psychological distress. Based on previous research, secondary trauma in children is likely when parents experience intense levels of trauma symptoms. Yet this relation may be different for adolescents, due to their more developed cognitive, emotional, and coping skills and increased amount of time spent away from their parents. Future studies should seek to more clearly understand the potential for secondary trauma in adolescents. Additionally, the results of the current study replicated previous research that found that African American mothers are more likely than White mothers to use authoritarian parenting behaviors. Studies suggest that for certain groups, the authoritarian parenting style is less detrimental to child outcomes (Julian, McKenry, & McKelvey, 1994). Although results did not indicate other significant differences between African American and White mothers, future research should further investigate the effects of trauma on parenting style between different racial/ethnic groups of families.

Furthermore, the current findings support the fact that parenting is a multidimensional construct and that different aspects of parenting may be more critical for child outcomes under conditions of high trauma. It is important for future research to better understand which specific permissive parenting behaviors are potentially protective under conditions of high maternal trauma. What is the impact of permissive parenting under conditions of high trauma that changes outcomes for children in ways that are

different from conditions of low trauma? What constellation of parental acceptance, autonomy granting, and behavioral control is plausible for parents who experience severe trauma symptoms? Which parenting dimensions have positive outcomes for children when their parents' emotional and energy resources are compromised by their trauma symptoms?

The answers to these questions may further identify ways that children may be protected from the transfer of distressing symptoms when mothers experience high levels of trauma and yet parent in a certain style. In particular, future research should consider the implications of the current findings for military mothers. As briefly discussed previously, the number of women in the military is growing steadily (Kelley, Herzog-Simmer, & Harris, 1994). Yet research specifically on the impacts of maternal deployment, combat exposure, and reintegration is lacking. Due to the increasing numbers of mothers, as well as fathers, who are serving in the current military conflicts in the middle east, future research should investigate the impacts of military-induced stress and trauma on parents and the effects of the ways in which parents are able to parent through their traumatic symptoms to reduce the likelihood of secondary child psychological distress.

Implications for Clinical Application

The findings of this study generally support the clinical use of a systems theory perspective. Systems-oriented clinicians believe that stressors which impact one member of the family will impact every other member (Nichols & Schwartz, 2007). Couple and Family Therapists are trained to conduct systemic psychotherapy in both their orientation, which refers to theories of problem formation and resolution, and the therapy context,

which refers to the interpersonal structure of therapy. Other mental health clinicians, such as psychologists or school counselors, may benefit from training in a systems orientation. Relations appear to be complex between a mother's experiences of trauma, her use of parenting behaviors, and the interaction of maternal trauma and parenting on her child's mental health. Clinicians who understand these types of effects from multiple symptoms on multiple systems may be better equipped to diagnose and treat mothers and children under stress.

Due to limitations of this study previously discussed, it may be important for clinicians who work with mothers experiencing trauma symptoms to conduct assessments both via self-administered questionnaires and clinical interviews. Personal experience of trauma is nuanced, as is its impact on parenting behaviors, and may be best assessed with a comprehensive assessment format (Briere & Scott, 2006). Building on the cognitive theories of stress and coping posited by Lazarus and discussed in the literature review of this paper, treatment of stress should be based on a multilevel, multiprocess orientation. By focusing on multiple levels of analysis, clinicians using a comprehensive model may facilitate a more meaningful dialogue with their clients about the nature of their stressful experiences and how those experiences impact different aspects of their life, including their parenting behaviors.

After a thorough assessment of trauma, clinicians may use the technique of psychoeducation to help mothers adapt their parenting to use behaviors that reduce the transfer of distress to their children. For example, clinicians may coach mothers to parent through their trauma symptoms in the warm and emotionally engaged style of permissive parenting, rather than the harsh and cold style of authoritarian parenting, to reduce the

transfer of traumatic distress to their children. Research suggests that it is difficult for parents who experience high levels of trauma symptoms to parent using authoritative behaviors and that it is more likely they will use authoritarian or permissive parenting styles (Catherall, 2004; Kaitz, et al., 2009; Cummings, et al., 2000). According to the findings of this study, the use of authoritarian and permissive parenting styles under conditions of high trauma may have different effects on child mental health outcomes. Thus, through psychoeducation and coaching, highly stressed parents may learn to use parenting behaviors that contribute to healthier outcomes for their children.

Conclusion

Although this study did not replicate the finding that mothers who experience high levels of trauma symptoms transfer their distress to their children, it did find interesting effects of maternal trauma and parenting style on levels of child depression. Most research on parenting styles indicates that authoritative parenting produces the best outcomes for children (Berk, 2005). However, it may be that for parents under conditions of high trauma, the acceptance and autonomy granting dimensions of parenting are more important than the behavioral control dimension to protect children from the effects of secondary trauma. The present study found that permissive parenting, marked by high levels of parental warmth and low levels of behavioral control, was the style found to be related to less child psychological distress. Future research may build on the findings of this study to further explore how children of traumatized parents may be protected from the negative experience of secondary trauma.

Appendix A: Demographic Questionnaire



FAMILY/INDIVIDUAL INFORMATION & INSTRUCTIONS

This is the first in a series of questionnaires you are being asked to complete that will contribute to the knowledge about individual and family therapy. In order for our research to measure progress over time we will periodically re-administer questionnaires. Please answer the questions at a relatively fast pace, usually the first response that comes to mind is the best one. **There are no right or wrong answers.**

4. Date: _____

1. Case #: _____

2. Therapist's(s') Code: _____

3. _____

The following information is gathered from each family member separately.

Name: (Print)

Address:

_____ ZIP _____

E-mail address: _____

Phone Numbers: (h) _____ (w) _____

(cell) _____ (fax) _____

5. Gender: M F

6. SSN _____ - _____ - _____

7. Age (in years): _____

8. You are coming for: a.) Family _____ b.) Couple _____ c.) Individual _____ therapy.

9. **Relationship Status** _____

1. Currently married, living together

2. Currently married, separated, but not divorced

3. Divorced, legal action completed

4. Living together, not married

5. Separated, not married

6. Dating, not living together

7. Single

8. Widowed/ Widower

9. Domestic partnership

10. **Years Together:** _____

1. What is your **occupation?** _____

1. Clerical sales, bookkeeper, secretary

2. Executive, large business owner

3. Homemaker

4. None – child not able to be employed

5. Owner, manager of small business

6. Professional - Associates or Bachelors degree

7. Professional – master or doctoral degree

8. Skilled worker/craftsman

9. Service worker – barber, cook, beautician

10. Semi-skilled worker – machine operator

11. Unskilled Worker

12. Student

12. What is your **current employment status?** _____

1. Employed full time

2. Employed part time

3. Homemaker, not employed outside home

4. Student

5. Disabled, not employed

6. Unemployed

7. Retired

13. Personal **yearly gross income**: \$ _____
(before taxes or any deductions)

14. **Race**: _____

1. Native American
2. African American
3. Asian/Pacific Islander
4. Hispanic
5. White
6. Other (specify) _____

15. What is **your country of origin**? _____

What was **your parent's country of origin**? 16. _____ (father's) 17. _____ (mother's)

How many years have you lived in the USA? _____

18. Highest Level of **Education** Completed: _____

1. Some high school	6. Some graduate education
2. High school diploma	7. Masters degree
3. Some college	8. Doctoral degree
4. Associate degree	9. Trade school
5. Bachelors degree	

19. Number of **people in your Household**: _____ 20..Number of **children** who **live at home** with you: ____
21..Number of children who **do not live** with you: ____

Names and Phone Numbers of **Contact People** in case of emergency (minimum 2):

22. What is your **religious** preference? _____

1. Mainline Protestant (e.g., Episcopal, Lutheran, Methodist, Presbyterian, Unitarian)
2. Conservative Protestant (e.g., Adventist, Baptist, Pentecostal)
3. Roman Catholic
4. Jewish
5. Other (e.g., Buddhist, Mormon, Hindu)
Please Specify _____
6. No affiliation with any formal religion

23. How often do you **participate in organized activities** of a church or religious group? _____

1. several times per week	5. several times a year
2. once a week	6. once or twice a year
3. several times a month	7. rarely or never
4. once a month	

24. How **important is religion or spirituality** to you in your daily life? _____

1. Very important	2. Important	3. Somewhat important	4. Not very important	5. Not important at all
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25. **Medications**: _____ Yes _____ No. If yes, please list the names, purpose, and quantity of the **medication(s)** you are currently taking. Also list the name and phone number of the medicating physician(s) and your primary care physician:

Medications:

Primary Care Physician:

Phone:

Psychiatrist? Yes/No Name & Phone, if yes.

Phone:

Legal Involvement:

26. Have you ever been involved with the police/legal authorities? Yes/No (circle)

If yes, please explain:

27. Have formal, legal procedures (e.g., ex-parte orders, protection orders, criminal charges, juvenile offenses) been brought against you? Yes/No (circle) If yes, please explain:

28. If formal procedures were brought, what were the results (e.g., eviction, restraining orders)? _____

29. Many of the questions refer to your "family." It will be important for us to know what individuals you consider to be your family. Please list below the names and relationships of the people you will be including in your responses to questions about your family. Circle yourself in this list.

(Number listed in family) _____.

Name

Relationship

List the concerns and problems for which you are seeking help. Indicate which is the most important by circling it. For each problem listed, note the degree of severity by checking (✓) the appropriate column.

	1 – Mild	2. Moderate	3 -Somewhat Severe	4. Severe
30.				
32.				
34.				
36.				

38. The most important concern (circled item) is # _____.

Appendix B: Trauma Symptom Inventory (shortened by Center for Healthy Families)



TSI-A

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

Instructions: The items that follow describe a number of things that may or may not have happened to you. Read each one carefully, and then indicate on the answer sheet how often it has happened in the last **6 months** by circling the correct number. Circling a 0 means it hasn't happened at all in the last 6 months. Circling a 3 means it has happened often in the last **6 months**. Circling a 1 or 2 means it has happened in the last 6 months, but has not happened often.

Never **Often**
 0 1 2 3

Please answer each item as honestly as you can. **Be sure to answer every item.**

*In the last **6 months**, how often have you experienced:*

		Never			Often
1/1.	Nightmares or bad dreams	0	1	2	3
2/2.	Trying to forget about a bad time in your life	0	1	2	3
3/3.	Irritability	0	1	2	3
4/4.	Stopping yourself from thinking about the past	0	1	2	3
5/8.	Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
6/10.	Feeling like you were outside your body	0	1	2	3
7/12.	Sudden disturbing memories when you were not expecting them	0	1	2	3
8/15.	Becoming angry for little or no reason	0	1	2	3
9/20.	Your mind going blank	0	1	2	3
10/22.	Periods of trembling or shaking	0	1	2	3
11/23.	Pushing painful memories out of your mind	0	1	2	3
12/26.	Feeling like you were watching yourself from far away	0	1	2	3
13/27.	Feeling tense or "on edge"	0	1	2	3
14/29.	Not feeling like your real self	0	1	2	3
15/31.	Worrying about things	0	1	2	3
16/34.	Being easily annoyed by other people	0	1	2	3
17/35.	Starting arguments or picking fights to get your anger out	0	1	2	3
18/37.	Getting angry when you didn't want to	0	1	2	3
19/38.	Not being able to feel your emotions	0	1	2	3
20/41.	Feeling jumpy	0	1	2	3
21/42.	Absent-mindedness	0	1	2	3

22/45.	Yelling or telling people off when you felt you shouldn't have	0	1	2	3
23/51.	High anxiety	0	1	2	3
24/54.	Nervousness	0	1	2	3
25/57.	Feeling mad or angry inside	0	1	2	3
26/59.	Staying away from certain people or places because they reminded you of something	0	1	2	3
27/62.	Suddenly remembering something upsetting from your past	0	1	2	3
28/63.	Wanting to hit someone or something	0	1	2	3
29/66.	Suddenly being reminded of something bad	0	1	2	3
30/67.	Trying to block out certain memories	0	1	2	3
31/70.	Violent dreams	0	1	2	3
32/72.	Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
33/74.	Frightening or upsetting thoughts popping into your mind	0	1	2	3
34/83.	Not letting yourself feel bad about the past	0	1	2	3
35/84.	Feeling like things weren't real	0	1	2	3
36/85.	Feeling like you were in a dream	0	1	2	3
37/87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
38/88.	Daydreaming	0	1	2	3
39/89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
40/91.	Being startled or frightened by sudden noises	0	1	2	3
41/93.	Trouble controlling your temper	0	1	2	3
42/97.	Feeling afraid you might die or be injured	0	1	2	3

Appendix C: Parenting Practices Questionnaire



PPQ

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Directions: This questionnaire is about your parenting practices. Think about what you usually do as a parent in the raising of your child or children and select the response that best indicates how often you usually do the following things: (If you have one child, respond as you usually do to that child in general.)

1. Never 2. Once in a while 3. About half of the time 4. Very often 5. Always

- ___ 1. I encourage my children to talk about their troubles.
- ___ 2. I guide my children by punishment more than by reason.
- ___ 3. I know the names of my children's friends.
- ___ 4. I find it difficult to discipline my children.
- ___ 5. I give praise when my children are good.
- ___ 6. I spank when my children are disobedient.
- ___ 7. I joke and play with my children.
- ___ 8. I don't scold or criticize even when my children act against my wishes.
- ___ 9. I show sympathy when my children are hurt or frustrated.
- ___ 10. I punish by taking privileges away from my children with little if any explanation.
- ___ 11. I spoil my children.
- ___ 12. I give comfort and understanding when my children are upset.
- ___ 13. I yell or shout when my children misbehave.
- ___ 14. I am easy going and relaxed with my children.
- ___ 15. I allow my children to annoy someone else.
- ___ 16. I tell my children my expectations regarding behavior before they engage in an activity.
- ___ 17. I scold and criticize to make my children improve.
- ___ 18. I show patience with my children.
- ___ 19. I grab my children when they are disobedient.

- ___ 20. I state punishments to my children, but I do not actually do them.
- ___ 21. I am responsive to my children's feelings or needs.
- ___ 22. I allow my children to help make family rules.
- ___ 23. I argue with my children.
- ___ 24. I appear confident about my parenting abilities.
- ___ 25. I give my children reasons why rules should be obeyed.
- ___ 26. I appear to be more concerned with my own feelings than with my children's feelings.

- ___ 27. I tell my children that we appreciate what they try to accomplish.
- ___ 28. I punish by putting my children off somewhere alone with little if any explanation.
- ___ 29. I help my children to understand the effects of behavior by encouraging them to talk about the consequences of their own actions.
- ___ 30. I am afraid that disciplining my children for misbehavior will cause them not to like me.
- ___ 31. I take my children's desires into account before asking them to do something.
- ___ 32. I explode in anger towards my children.
- ___ 33. I am aware of problems or concerns about my children in school.
- ___ 34. I threaten my children with punishment more often than I actually give it.
- ___ 35. I express affection by hugging, kissing, and holding my children.
- ___ 36. I ignore my children's misbehavior.
- ___ 37. I use physical punishment as a way of disciplining my children.
- ___ 38. I carry out discipline after my children misbehave.
- ___ 39. I apologize to my children when making a mistake in parenting.
- ___ 40. I tell my children what to do.
- ___ 41. I give into my children when they cause a commotion about something.
- ___ 42. I talk it over and reason with my children when they misbehave.
- ___ 43. I slap my children when they misbehave.
- ___ 44. I disagree with my children.
- ___ 45. I allow my children to interrupt others.
- ___ 46. I have warm and intimate times together with my children.
- ___ 47. When two children are fighting, I discipline the children first and ask questions later.
- ___ 48. I encourage my children to freely express themselves.
- ___ 49. I bribe my children with rewards to get them to do what I want.
- ___ 50. I scold or criticize when my children's behavior doesn't meet my expectations.
- ___ 51. I show respect for my children's opinions by encouraging them to express them.
- ___ 52. I set strict well-established rules for my children.
- ___ 53. I explain to my children how I feel about their good and bad behavior.
- ___ 54. I use threats as punishment with little or no justification.
- ___ 55. I take into account my children's preferences in making plans for the family.
- ___ 56. When my children ask why they have to conform, I state: "Because I said so" or, "I am your parent and I want you to."
- ___ 57. I appear unsure about how to solve my children's misbehavior.
- ___ 58. I explain the consequences of my children's behavior.
- ___ 59. I demand that my children do things.
- ___ 60. When my children misbehave, I channel their behavior into a more acceptable activity.
- ___ 61. I shove my children when they are disobedient.
- ___ 62. I emphasize the reasons for rules.

Appendix D: Beck Depression Inventory



BDI

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code _____

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY!** Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all the time.

6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. 0 I don't feel I am worse than anybody else.
 - 1 I am disappointed in myself.
 - 2 I am disgusted with myself.
 - 3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
 - 1 I am critical of myself for my weaknesses or mistakes.
 - 2 I blame myself all the time for my faults.
 - 3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
 - 1 I have thoughts of killing myself, but I would not carry them out.
 - 2 I would like to kill myself.
 - 3 I would kill myself if I had the chance.

10. 0 I don't cry any more than usual.
 - 1 I cry more than I used to.
 - 2 I cry all the time now.
 - 3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated now than I have ever been.
 - 1 I get annoyed or irritated more easily than I used to.
 - 2 I feel irritated all the time now.
 - 3 I don't get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
 - 1 I am less interested in other people than I used to be.
 - 2 I have lost most of my interest in other people.
 - 3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
 - 1 I put off making decisions more than I used to.
 - 2 I have greater difficulty in making decision than before.
 - 3 I can't make decisions at all anymore.

14. 0 I don't feel I look any worse than I used to.
 - 1 I am worried that I am looking old or unattractive.
 - 2 I feel that there are permanent changes in my appearance that make me look unattractive.
 - 3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired more doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.
I am purposely trying to lose weight. Yes ___ No ___
20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches, pains, an upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

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