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The Occurrence of Child Maltreatment and Revictimization Among Hispanic Women

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THE OCCURRENCE OF CHILD MALTREATMENT AND REVICTIMIZATION AMONG HISPANIC WOMEN

A Thesis

by

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THE OCCURRENCE OF CHILD MALTREATMENT

AND REVICTIMIZATION AMONG

HISPANIC WOMEN

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ABSTRACT

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The current study examines the prevalence rates of child multi-type maltreatment and adult revictimization among Hispanic women who have witnessed domestic violence and/or experienced sexual abuse or physical abuse as children. A sample of two hundred-forty-three undergraduate, Hispanic, female students completed measures of events occurring in childhood and adulthood, sexual experiences, substance use, acculturation status, and family characteristics. The results indicate that experiencing multiple forms of child abuse is fairly common, especially for women who report a history of child abuse. The results also suggest that experience of abuse as a child is significantly associated with experiencing physical or sexual assault in adulthood. Other risk factors that can influence the occurrence of multi-type maltreatment and adult revictimization are also discussed.

DEDICATION

The completion of my master studies and thesis would not have been possible without the love and encouragement of God, my family, and friends. My mother, Rosalva Escorza, my father, Isaac Escorza, and particularly my fiancé, Efren J. Salinas, provided me with much support and motivation throughout this grueling, yet incredibly rewarding process. Thank you all for your endless patience, understanding, and love. I would also like to dedicate this work to the survivors of child maltreatment in the Rio Grande Valley. Their stories and experiences have inspired me in countless ways.

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CHAPTER I

INTRODUCTION

Child maltreatment can increase the risk of violence later in life, or revictimization. Revictimization was originally observed in studies of child sexual abuse (Maker, Kemmelmeier, & Peterson, 2001) in which researchers found that women who were sexually molested as children were extremely vulnerable to sexual assault in adolescence and/or adulthood. For example, Urquiza & Goodlin-Jones (1994) found that 65% of their female participants who reported being raped as an adult had also experienced sexual abuse as a child. Numerous studies have found revictimization to also be prevalent among survivors of other types of child maltreatment, such as physical abuse, neglect, and witnessing familial violence (Barnes, Noll, Putname, & Trickett, 2009; Briere & Elliot, 2003; Fargo, 2009; Fergusson, Horwood, & Lynskey, 1997; Hetzel & McCanne, 2005; Krahè et al., 1999; Messman-Moore & Brown, 2006; Messman-Moore & Garrigus, 2007; Schaaf & McCanne, 1998; Tice et al., 2001; Urquiza & Goodlin-Jones, 1994).

Most victimization studies tend to focus on single types of child maltreatment, mainly sexual abuse (Widom et al., 2008). However, more and more researchers are discovering that child victims usually experience more than one form of maltreatment. The terms “multi-type maltreatment” and “poly-victimization” have been initiated to indicate the experience of two or more types of abuse in childhood (Arata et al., 2007; Finkelhor, Ormrod, & Turner, 2007). Some researchers have found multiple maltreatment rates ranging from 30-64% in samples of

victimized children (Finkelhor, Ormrod, & Turner, 2007; Gustafsson, Gustafsson, & Svedin, 2009; Higgins & McGabe, 2000). Further investigation of multi-type maltreatment is warranted.

Additionally, the majority of the participants included in victimization studies have been White, non-Hispanic individuals. The few studies that have included minorities, specifically African Americans and Hispanics (also referred to as Latino/as), as participants have yielded conflicting results in terms of the maltreatment rates in childhood and revictimization rates in adolescent or adulthood. Inclusion of Hispanics in sample populations is crucial to the overall understanding, prevention, and treatment of child abuse.

CHAPTER II

LITERATURE REVIEW

Definition and Prevalence of Child Abuse

Although estimates vary widely, child abuse and child exposure to domestic violence is disturbingly prevalent in the United States. According to the U.S. Department of Health & Human Services, 3.3 million children across the U.S. were subjects of child maltreatment reports and investigations in 2007. Approximately 25% of those children were in fact found to have been abused; that is, about 794,000 U.S. children were victims of maltreatment (U.S. Department of Health and Human Services, 2009). Even though these official statistics reveal high rates, the reality of the matter is that many instances of child victimization go unreported (Zielinski, 2009).

Several retrospective studies which have used community, college, or clinical samples have found prevalence rates of childhood maltreatment that range from 21-37% in the general population (Briere & Elliot, 2001; Edwards et al. 2003; Wolfe et al., 2001). Studies specifically investigating childhood sexual abuse in strictly female populations have reported prevalence rates that range from 33% to 50% (Urquiza & Goodlin-Jones, 1994). Arata et al. (2005) found that 50% of their sample reported experiencing at least one form of child abuse (i.e., emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse). In regard to exposure to domestic violence, more than two thirds of Lewis et al. (2006)'s sample had frequently witnessed violence among caregivers. Evidence shows that child maltreatment and child exposure to domestic violence are still major problems in today's society.

For the purposes of this study, the term child maltreatment is defined as any occurrence of sexual abuse, physical abuse, and/or exposure to domestic violence during the ages of 0 to 18. Sexual and physical abuse are classified as abuse experienced before the age of 18, and sexual and physical assault are defined as experienced after the age of 17 (Kimberling et al., 2007). Exposure to domestic violence is described as witnessing caregivers hit each other, throw objects at each other, or using weapons against each other.

Effects of Child Abuse Including Revictimization

The victims of childhood maltreatment suffer a wide range of both short-term and long-term negative sequelae. Common short-term effects observed in survivors of child abuse are dissociative symptoms, severe distress, inappropriate sexual behavior, hostility, feelings of worthlessness, hopelessness, and loneliness, promiscuity, and somatic pre-occupation (Arata, et al., 2007; Briere & Elliot, 2003; Krahè et al., 1999; Ney, Fung, and Wickett, 1994; Wind & Silvern, 1992). The long-term consequences of experiencing maltreatment as a child include post-traumatic stress disorder (PTSD), depression, anxiety, anger, substance abuse, poor physical health, sexual disturbances, low self-esteem, eating disorders, interpersonal problems, financial difficulties, unstable employment, self harm, and suicidality (Barnes et al., 2009; Briere & Jordan, 2009; Bryant & Range, 1997; Boxer & Terranova, 2008; Coid et al., 2001; Gladstone et al., 2004; Hetzel & McCanne, 2005; Messman-Moore & Garrigus, 2007; Roodman & Clum, 2001; Schaaf & McCanne, 1998; Shin, Edwards, Heeren, & Anodeo, 2009; Tice et al., 2001; Zielinski, 2009).

One long-term consequence of maltreatment that has recently received much support amongst researchers and clinical professionals is revictimization in adolescence and/or adulthood. Revictimization was originally observed in studies of child sexual abuse (Maker,

Kemmelmeier, & Peterson, 2001). In such studies, researchers found that women who were sexually molested as children were extremely vulnerable to sexual assault later on in life (Copeland, 1997). For example, women who were abused as children were found to be at risk for severe forms of sexual victimization in adulthood, such as attempted or completed rape (Krahé et al. 1999). Urquiza & Goodlin-Jones (1994) found that 65% of the female participants who reported being raped as an adult had also experienced sexual abuse as a child. In a meta-analysis of studies investigating the rate of revictimization, Roodman and Clum (2001) obtained an effect size of 0.59 indicating a marked relationship between child sexual abuse and revictimization.

Revictimization has now been applied to other forms of childhood abuse, such as physical abuse and neglect, and has received much support (Widom, Czaja, & Dutton, 2008). More and more studies have found the subsequent occurrence of victimization in adulthood, known as revictimization, to be prevalent among survivors of different types of child maltreatment (Barnes, Noll, Putname, & Trickett, 2009; Briere & Elliot, 2001; Fargo, 2009; Fergusson, Horwood, & Lynskey, 1997; Hetzel & McCanne, 2005; Krahè et al., 1999; Messman-Moore & Brown, 2006; Messman-Moore & Garrigus, 2007; Schaaf & McCanne, 1998; Tice et al., 2001; Urquiza & Goodlin-Jones, 1994). Widom, Czaja, and Dutton (2008) concluded that sexual abuse, physical abuse, neglect, and combinations of these forms of abuse were *all* associated with a high risk of revictimization in adulthood. Briere & Elliot (2001) found revictimization rates of 32% and 40% for victimized men and women, respectively. According to Kimberling et al. (2007), women who experienced physical or sexual abuse during their childhood were 5.8 times more likely to be physically or sexually assaulted in adulthood

than women who did not experience childhood abuse. Revictimization has now been recognized as a prevalent phenomenon.

Several recent studies have found that specific types of maltreatment experienced in childhood increase the chance of experiencing a particular type(s) of assault in adulthood. For example, childhood sexual abuse has been specifically associated with sexual assault in adulthood. Several researchers have found child sexual abuse to also be associated with physical assault in adulthood (Barnes et al., 2009). Physical abuse in childhood has been linked to an increase in the likelihood of experiencing physical assault in adulthood as well as sexual assault (Coid et al., 2001; Hetzel & McCanne, 2005; Kimerling et al., 2009; Wind & Silvern, 1992; Wolf et al., 2001). It is often the case that the assault experiences in adulthood occur within intimate relationships. While studying risk factors involved in intimate partner violence, Daigneault, Hébert, and McDuff (2009) found that female victims of childhood sexual abuse were to two to five times more likely to be physically, psychologically, and sexually abused by their intimate partners.

Why Does Revictimization Occur?

Several hypotheses have been postulated in regard to how the survivors of child maltreatment become victimized again. One hypothesis of revictimization involves repetition compulsion, a tendency to repeat one's behavior or reaction to a traumatic event. Repetition compulsion was first described by Sigmund Freud and was believed to occur universally in individuals suffering from "traumatic neurosis," an abnormal state of mind that is characterized by various disturbances due to an emotional or traumatic event. According to Freud, the unconscious mind is motivated to repeat one's experience in order to give the event significant meaning, i.e. to master the upsetting event or situation (Freud, 1920/1955). Chu (1992) asserts

that victims unintentionally and unconsciously re-experience the abusive experience, including their own personal feelings and sensations, in attempt to control the situation and change the outcome. Victims of child maltreatment may re-live the violent experience by returning to an abusive partner or engaging in potentially harmful behavior, such as becoming sexually involved with multiple different partners. Chewing-korpach (1993) postulates that when victims are in social situations they may send potential perpetrators unintentional messages of interest through nonverbal behavior, and consequently place themselves in a situation where victimization is more likely to occur. In most cases, the individual is victimized again. This theory of repetition compulsion has not received much empirical support.

A more evidence based theory of the mechanism of revictimization involves symptoms of Post-Traumatic Stress Disorder (PTSD) which are frequently experienced by survivors of child maltreatment. The most common symptoms of PSTD include intense fear, recurrent flashbacks, increased arousal, and avoidance of stimuli associated with the traumatic event. Some of these symptoms can be experienced immediately after an abusive experience, delayed for months or years after the abusive event has occurred, or they can be continuously experienced throughout a victim's life. According to the PTSD model, the experience of such symptoms, including dissociation, may affect the survivor's risk perception and information-processing so as to prevent the individual from perceiving cues of potentially dangerous situations and consequently increasing the individual's risk of revictimization (Chu, 1992; DePrince, 2005; Messman-Moore, Ward, & Brown, 2009; Risser, Hitzel-Riggin, Thomsen, & McCanne, 2006). This theory has received some empirical support as several studies have found that revictimized individuals report more symptoms of PTSD compared to individuals who have not experienced

revictimization or people who have not suffered from child abuse or neglect (Arata, 2000; Dietrich, 2007; Filipas & Ullman, 2006).

Maladaptive coping styles have also been thought to contribute to the mechanism of revictimization. Researchers have hypothesized that victims engage in self-destructive behaviors, such as using alcohol or illegal substances or frequently engaging in sexual activity with several different partners, in order to cope with the unpleasant thoughts, emotions, and feelings associated with the experience of child maltreatment. Such behaviors are negatively reinforced as the victim may experience reduced negative affect for a period of time. However, once the unpleasant memories or feelings resurface, the individual is likely to continue the risky behavior as a means to feel better. Engaging in such risky behavior consequently makes one susceptible to additional victimizations (Arata, 2000; Filipas & Ullman, 2006; Orcutt, Cooper, & Garcia, 2005). Messman-Moore, Ward, & Brown (2009) postulate that women who are very sexually active and/or use alcohol and other substances are more likely to be revictimized for various reasons. Women who engage in alcohol and/or substance use may have impaired problem-solving skills and poor self-protective behavior once they are intoxicated. They can possibly be perceived by men as sexually available as well. Sexually active women may be at increased risk of revictimization because they are more likely to encounter an aggressive sexual partner and be thought of as an appropriate target for sexual coercion. Child sexual abuse and other forms of maltreatment have been associated with engaging in sexual activity with several sexual partners, in addition to alcohol use and substance abuse (Arata, 2000; Kolko, Moser, & Weldy, 1990; Mullen, et al., 1996; Sappington, 2000; Shin, Edwards, Heeren, & Amodeo, 2009; Thornberry, Henry, Ireland, & Smith, 2010).

Another proposed hypothesis of the mechanism of revictimization is known as the resource loss model. According to this model, the experience of any trauma is always associated with a loss of material or psychological resources. In the case of child maltreatment, material resources may include a home, family, or schooling, while psychological resources can include self-esteem, social support, and a sense of security (Cloitre, Cohen, & Koenen, 2006). A sample of survivors of childhood sexual abuse reported that the most difficult losses they have experienced are a loss of trust, self-love, and self-identity (Bourdon and Cook, 1993; Murthi & Espelage, 2005). The model of resource loss postulates that the resources a child loses after experiencing abuse or neglect can markedly contribute to his/her vulnerability to later victimization, especially if there is no attempt to recover any of the lost resources (Cloitre, Cohen, Koenen, 2006; Mason, Ullman, Long, Long, & Starzynski, 2009). The lost resources may not influence the individual's vulnerability directly, but rather in a more indirect manner, such as affecting the manner in which the individual copes with traumatic events. Several investigations regarding resiliency factors of victims of abuse and assault have found that women who were victimized in childhood were less likely to be revictimized if they engaged in a coping style that did not involve self-blame and used social support available to them (Filipas & Ullman, 2006; Walsh, Blaustein, Knight, Spinazzola, van der Kolk, 2007).

Lastly, revictimization is believed to be significantly influenced by a victim's childhood attachments. According to the interpersonal schema approach, the attachments or relationships an individual forms during childhood are transformed into mental representations called schemas, so as to help the individual organize and simplify future social interactions or relationships. It is hypothesized that the schemas a child develops of his primary relationships are projected onto future relationships. Such expectancies may allow for revictimization to

occur. If the attachments a child develops are characterized by trust and respect, he or she will expect his/her relationships in adulthood to be characterized by similar traits. In the case of parental relationships characterized by abuse, an expectancy of hostility and mistrust is created during childhood and projected onto interpersonal relationships in adulthood. The interpersonal schema approach to revictimization has received some support from researchers and mental health professionals. Cloitre, Cohen, & Scarvalone (2002) found that women who were sexually abused as children and revictimized as adults expected more hostile and less friendly responses and behaviors from significant others than women who were never victimized.

Multi-type Maltreatment

Previous victimization research has mainly focused on only single forms of child maltreatment, primarily sexual abuse. However, researchers have recently discovered that many victims of maltreatment have experienced more than one type of abuse (Arata et al., 2005; Briere & Jordan, 2009; Bryant & Range, 1997; Clemmons et al., 2003; Edwards et al., 2003; Finkelhor, Orrmrod, and Turner, 2007; Follette et al., 1996; Higgins & McCabe, 2000; Higgins & McCabe, 2001; Larrivée, Tourigny, and Bouchard, 2007; Shin, Edwards, Heeren, and Amodeo, 2009; Teicher et al. 2006). In their study of the effects of multiple types of maltreatment in an adolescent sample, Arata et al. (2007) discovered that single occurrences of abuse were fairly uncommon. Ney et al. (1994) found that 95% of their sample who reported experiencing abuse in their lifetime had actually experienced more than one type of abuse. Finkelhor, Ormrod, and Turner (2007) identified a mean of 3.7 total victimizations in children from which they sampled. The term multi-type maltreatment (Higgins & McCabe, 2000) has been coined to refer to the co-occurrence of one or more types of maltreatment, such as sexual abuse, physical abuse, psychological abuse, emotional abuse, and neglect. According to Higgins & McCabe (2000) and

Arata et al. (2005), multi-type maltreatment is a crucial aspect of the nature and impact of child maltreatment that deserves consideration in future studies and in the prevention and treatment of child maltreatment.

Particular types of abuse have been found to be associated with other forms of child maltreatment. For example, several studies have found that sexual abuse is frequently accompanied by physical abuse (Arata et al., 2005; Carey, Walker, Rossouw, Seedat, Stein, 2008; Gladstone et al, 2004, Herrenkohl & Herrenkohl, 2007; Higgins & McCabe, 2001; Maker, Kemmelmeier, & Peterson, 2001; Schaaf & McCanne, 1998; Wind & Silvern, 1992). Physical abuse has been associated with psychological abuse and/or emotional abuse. (Arata et al., 2005; Briere & Jordon, 2009; Higgins & McCabe, 2001; Larrivée, Tourigny, and Bouchard, 2007; Lewis et al., 2006). Exposure to domestic violence in childhood has also been linked to the experience of child physical abuse and/or sexual abuse (Edleson, 2004; Gladstone et al, 2004; Maker, Kemmelmeier, & Peterson, 2001).

Specific risk factors for multi-type maltreatment have been identified. These risk factors include environmental characteristics, familial characteristics, and individual characteristics of children. Many researchers have found that the parents of children who are victims of more than one form of maltreatment tend to be single parents, who are very distressed, less educated, likely to use alcohol and other drugs regularly, lack social support, have financial problems, experience conflict with significant others, and have poor mental health (Finkelhor, Ormrod, & Turner, 2007; Gladstone et al, 2004; Larrivée, Tourigny, & Bouchard, 2007; Maker, Kemmelmeier, & Peterson, 2001; Mullen, et al., 1996; Wolfe et al., 2001). The home environments of abused children tend to be marked by the presence of a step-parent, less family adaptability, economic hardships, low family cohesion, and frequent parental conflict (Finkelhor, Ormrod, & Turner,

2007; Higgins & McCabe, 2000). Children who have been deprived of inter-parental relationships and other significant friendships and those who experienced a generalization of self-blame are more vulnerable to multiple forms of maltreatment (Finkelhor, Ormrod, & Turner, 2007; Mullen et al., 1996).

Only a few studies have been conducted to primarily investigate the effects of multi-type abuse compared to single types of abuse. However, evidence suggests that those who have experienced more than one type of maltreatment suffer from more adjustment problems and symptoms of trauma compared to individuals who only experience one form of abuse (Higgins & McCabe, 2000; Mullen, et al., 1996; Schaaf & McCanne, 1998; Wind & Silvern, 1992). It is also believed that the symptoms victims of multi-type maltreatment experience are more severe (Finkelhor, Ormrod, & Turner, 2007). Such evidence supports a cumulative/additive model of trauma, which concludes that the experience of several types of abuse is associated with a worse outcome (Arata et al., 2007; Boxer & Terranova, 2008; Higgins & McCabe, 2001). That is, more severe symptoms and lower levels of functioning are likely to be experienced by those who encounter more types of child abuse. Children who experience multi-type abuse are also more vulnerable to revictimization later on in life compared to children who experience only one form abuse (Fargo, 2009). Schaaf & McCanne (1998) found that risk of adult victimization doubled when childhood sexual and physical abuse had both occurred. These findings illustrate the necessity of further investigation into the multi-type maltreatment of children.

Research on Abuse of Hispanic Children

In most victimization studies, the majority of participants included have been White, Non-Hispanic individuals. Recent studies have begun including African-American participants, but very few have incorporated Hispanics as research participants (Huston, Parra, Prihoda, &

Foulds; 1995; Ullman & Filipas, 2005; Urquiza & Goodlin-Jones, 1994; Widom, Czaja, & Dutton, 2008). The small number of studies that have included Hispanics in their sample populations have found conflicting results in terms of the prevalence rates of child maltreatment, multi-type maltreatment, and revictimization among Hispanics. The U.S. Department of Health and Human Services (2009) determined that Hispanic children made up approximately one-fifth of all children abused in the United States in the year 2007 whereas African-American children made up 22% and White children were the majority (46%). Freisthler, Bruce, and Needell (2007), on the other hand, found Hispanic children to be less likely to experience child maltreatment than African-American children but more likely than White children. Schaaf & McCanne (1998) concluded that there was no significant difference in the types of abusive experiences in childhood experienced by their participants based solely on the participants' race or ethnicity. However, Newcomb, Munoz, and Vargas Carmona (2009) found that Latina adolescents had the highest prevalence rates of CSA compared to European American adolescents. The results of revictimization studies that have included Hispanics are just as contradictory. The prevalence of rape among female college students has been found to be equivalent across ethnicities in some studies (Kalof, 2000), but in others, rape in adulthood was found to significantly vary by ethnicity with Latinas reporting less occurrences of rape than African American or White women (Urquiza & Goodlin-Jones, 1994).

Several researchers studying child maltreatment amongst Hispanics have hypothesized that immigration status and acculturation can affect the prevalence rates of both child maltreatment and revictimization. The risk of child abuse is thought to be higher amongst immigrant families because of the loss of friends and family, isolation, language barrier, and tremendous stress associated with moving to a host country (Dettlaff, Earner, & Phillips, 2009).

With regard to revictimization, acculturation can play a significant role because the psychological adjustment of Hispanic individuals may be influenced by the degree to which they identify with the Anglo-American culture (Clemmons et al., 2003).

It is estimated that as of July 2008, 46.9 million people of Hispanic origin live in the United States. According to the U.S. Census Bureau, Hispanics are also the fastest-growing minority group and their population is expected to continue increasing in size (U.S. Census Bureau, 2009). As the Hispanic population in the U.S. continues to grow, the need to identify the occurrences of child maltreatment and its particular effects on the Hispanic population is warranted.

Statement of Purpose

Unlike previous studies investigating the victimization experiences of women, the present investigation will address the deficiency of research with Hispanic participants by primarily including Hispanic females as sample participants. In order to expand the current body of knowledge of child maltreatment and its effects, the primary purpose of this study is to identify the prevalence rates of childhood multi-type maltreatment and revictimization among Hispanic women. Risk factors for child maltreatment and hypothesized mediating factors of revictimization, such as risk-taking behaviors and acculturation status, will be examined as well. The following hypotheses will be tested in the current study:

1. Multiple forms of child abuse are fairly common amongst Hispanic females.
2. Childhood abuse is associated with experiencing assault in adulthood.
3. Maternal criminal arrest, mental instability, and alcohol use are correlated with the maltreatment of children.

4. Revictimization is associated with participant acculturation, substance use, and a large number of consensual sexual partners.

CHAPTER III

METHOD

Participants

A total of 243 female undergraduate students participated in this study. The dynamics of multi-type maltreatment and revictimization are potentially different for women and men. Thus, the current study was designed to focus solely on women with the maltreatment and revictimization of men beyond its scope. Participants were recruited from psychology and political science courses at the University of Texas- Pan American. The mean age was 22.9 (*s*=5.9) and the age of the participants ranged from 18 to 59 years of age. 70.4% (*n*=171) of participants reported being single, 21.8% (*n*=53) were reported as married, and 3.7% (*n*=9) were divorced. Of the 243 participants, 91.7% (*n*=222) were self-identified as Hispanic, 1.7% (*n*=4) as European-American, and .8% (*n*=2) as belonging to another minority group (See Table 1). These percentages of participants' ethnicity do not add up to 100% as 5.8% (*n*=15) participants did not specify their heritage.

Procedure

All procedures were approved by the University of Texas-Pan American Institutional Review Board prior to data collection. Initial contact with participants was made through in-class recruiting in which the investigator (E. Escorza) or a professor (F. Ernst) visited several undergraduate classes to inform the students of the objective and procedure of the study. A sign-up sheet was handed out so that those students who were interested in participating could select a

time outside of their regular class time where they could complete the measures that were part of the study. All measures were administered to participants in a small group setting. Participants were first given an informed consent form to read before completing any measures. Written consent was not obtained in order to secure the participants' anonymity and confidentiality. Participants were also notified beforehand that a resource sheet about abuse and assault was available and could be obtained by requesting it from a proctor. All participants were offered extra credit in exchange for their participation. This study was conducted in accordance with the ethical guidelines of the American Psychological Association.

Table 1

Participant Demographics

Demographics	Percentage	*n*
Ethnicity		
European-American	1.7%	4
Hispanic	91.7%	222
Other Minority	0.8%	2
Marital Status		
Single	70.4%	171
Married	21.8%	53
Divorced	3.7%	9
Other	1.2%	3

Measures

Life Experiences Survey

Sexual abuse, physical abuse, and exposure to domestic violence during childhood were assessed by the Life Experiences Survey (LES). This self-report measure also assessed physical and sexual assault after the age of 17, alcohol and substance use, number of consensual sexual partners, and characteristics of participants' mothers. It was developed by the investigator in addition to other graduate students and Psychology professors from the University of Texas – Pan American. The Life Experiences Survey was also used in several other research studies; consequently, it covered different topics related to participant demographics, child and adult life experiences, sexual activity and preferences, intimate relationships, physical health, and mental health. However, only the items related to participant demographics, childhood experiences, events in adulthood, intimate relationships, sexual activity, and information about participants' mothers were used in this paper.

The total number of items included in the LES was 87 (see Appendix A); however, only 24 were relevant to the current study (See Table 2). The experience of child sexual abuse, child physical abuse, adult sexual assault, and adult physical assault were determined by responses to items regarding whether or not the participant believed she had experienced the specified event between the ages of 0-18 (for child abuse) or after the age of 17 (for experiences of assault). Possible responses to these items were "Yes" or "No." This approach to assessing childhood sexual and physical abuse and assault in adulthood was adapted from Finkelhor's (1979) sexual victimization survey.

Exposure to domestic violence was assessed by the question "Did you ever see your caregivers hitting, throwing objects at each other, or using weapons against each other?" Items

of the LES that measured alcohol and substance use were "Have you ever tried alcohol?" and "Other than alcohol, have you ever used other substances for recreational purposes?" Possible responses to these items were also in Yes/No format. If participants answered "Yes" to items assessing alcohol and substance use, they were asked additional questions regarding the age at which they started using and the frequency of their use. In order to measure sexual promiscuity, participants were asked "How many consensual sexual partners have you had in your lifetime?" In responding to this item, participants were expected to write in their answer on the line provided. The characteristics of participants' mothers were assessed by asking the participants "Did your mother ever experience mental or emotional problems?" "…Drinking problems?" and "…Or was arrested for a crime?" Possible responses to these items were either "Yes" or "No."

Acculturation Rating Scale for Mexican Americans-2nd Edition (ARSMA-II: Cuellar, Arnold, & Maldonado, 1995)

The ARSMA-II is a brief self-report questionnaire that measures acculturation through cultural behaviors such as language use, ethnic identity, and specific ethnic behaviors. It contains two subscales that measure the degree of orientation towards Mexican and Anglo culture. These two subscales are called the Mexican Orientation Scale (MOS) and Anglo Orientation Scale (AOS), respectively. The MOS contains a total of 17 items that include statements such as "I enjoy speaking Spanish," "My friends are of Mexican origin," and "I like to identify myself as Mexican American." The AOS contains 13 items. Examples of AOS items include "I associate with Anglos," "I enjoy English language TV," and "My friends now are of Anglo origin." Responses to the items on the ARSMA-II consist of five Likert-type statements that range from (1) Not at all to (5) Almost Always/Extremely Often. Both subscales have been found to have good internal consistency (Cronbach α=0.88 for the MOS; Cronbach α= 0.83 for

the AOS). The MOS score is subtracted from the AOS score to obtain an overall/total acculturation score.

Table 2

Items of Life Experiences Survey Used in Current Study

Item
Demographics
Race/Ethnicity
Age
State and Country of Birth
Are you bi-lingual?
What is your "first" language?
What is your "second" language?
Marital status
Life Experiences
Have you tried alcohol?
If so, at what age did you begin using?
In the past month, how often have you had 5 alcoholic beverages (4 if you are female) in one night?
In the past year, how often have you had 5 alcoholic beverages (4 if you are female) in one night?
Other than alcohol, have you ever used other substances for recreational purposes?
If "Yes," at what age did you begin using?
How many consensual sexual partners have you had in your lifetime?
Child Sexual Abuse
I believe that I was sexually abused before age 6
I believe that I was sexually abused between ages 6 and 12.
I believe that I was sexually abused between ages 12 and 18
Child Physical Abuse
I believe that I was physically abused as a child
Exposure to Domestic Violence
Did you ever see your caregivers hitting, throwing objects at each other, or using weapons against each other?
Information about Participants' Mothers
Did your mother ever experience mental or emotional problems?
Did your mother ever experience drinking problems?

Was your mother ever arrested for a crime?
Adult Physical Assault
I was physically assaulted after the age of 17.
Adult Sexual Assault
I was sexually assaulted after the age of 17.

CHAPTER IV

RESULTS

Child Abuse & Multi-type Maltreatment

Due to skipped questions, the sample size of each variable varied from 243 (complete sample) to 198. Approximately 39% (*n*=86) of sample participants reported that they had experienced some form of maltreatment as a child and 14% (*n*=32) experienced multiple forms of child maltreatment (i.e. sexual abuse, physical abuse, and exposure to domestic violence). Of those reporting a history of child abuse, 63% (*n*=54) of participants reported experiencing only one form of abuse, 30% (*n*=26) experienced two types of maltreatment, and 7% (*n*=6) reported experiencing three types (see Figure 1). Within the group of women who were victimized as children, about 34% of them (*n*=29) experienced physical abuse, 57% (*n*=49) experienced sexual abuse, and 53% (*n*=46) were exposed to domestic violence (See Table 3). As a result of some participants experiencing more than one form of maltreatment, the total percentage of reports of child maltreatment exceeds 100%.

Revictimization Rates

Of those participants who reported experiencing assault after the age of 17, approximately 73% (*n*=19) were physically assaulted and 58% (*n*=15) were sexually assaulted. These percentages of reported assault exceed 100% as some participants reported experiencing both types of assault. Participants' responses to the LES items assessing physical and sexual assault in adulthood first had to be combined into one composite score of ADULTHOOD

ASSAULT. Possible scores of this variable ranged from 0-2. Participants that answered "Yes" to both questions of assault were assigned a total score of 2, while participants who answered

Figure 1. Percentages of Single and Multiple Forms of Child Abuse Reported in Participants with a History of Child Abuse (*n*=86)

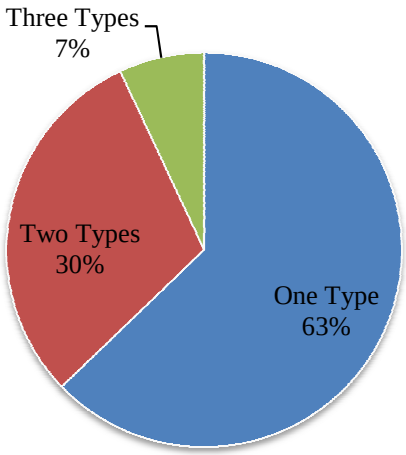


Table 3

Forms of Childhood Abuse Reported by Participants with History of Abuse

Child Maltreatment	Percentage	N
Sexual Abuse	56.9%	49
Physical Abuse	33.7%	29
Exposure to Domestic Violence	53.4%	46

"No" to both items were given a score of 0. All cases were then sorted by the variable of ADULTHOOD ASSAULT. The REVICTIMIZATION variable was computed manually by the identification of every participant who had a score of 1 or more on both the child maltreatment and adult assault variables. Possible scores of REVICTIMIZATION ranged from 0 to 1. Those participants who had a child maltreatment score of 0 and an adulthood assault score of 0 were

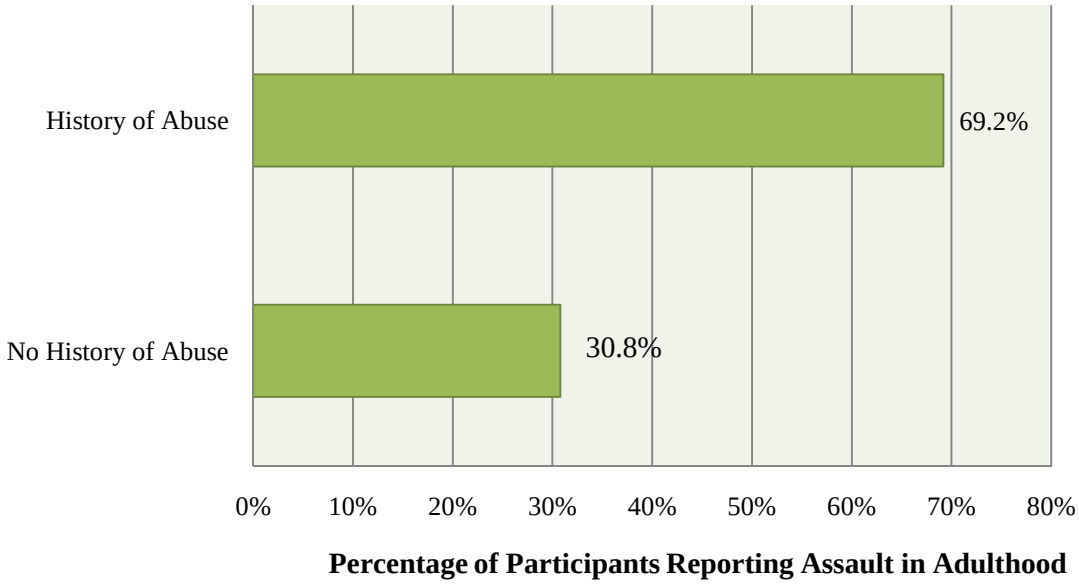
assigned a revictimization score of 0. Participants who had an adulthood assault score of 1 or 2 but had a child abuse score of 0 were also assigned a revictimization score 0. Participants who had a child maltreatment score of 1, 2, or 3 *and* a score of 1 or 2 on ADULTHOOD ASSAULT were assigned a revictimization score of 1.

A Fisher's exact test of significance was conducted to compare the proportion of participants reporting assault in adulthood and child maltreatment to those who also experienced adulthood assault but did not report abuse in childhood. A Fisher's exact test was thought to be more appropriate than a t-test or chi-square since two categorical variables were to be compared, each variable had only one degree of freedom, and the cell potential value was less than ten. Sixty-nine percent (n=18) of participants with a history of child maltreatment reported experiencing assault whereas 31% (n=8) of participants with no history of abuse reported adult assault (see Figure 2). Results confirmed that women who experienced maltreatment in childhood were significantly more likely to have experienced assault as adults (i.e., revictimization) than those who did not experience child maltreatment (p<.01, one-sided Fisher's exact test).

Risk Factors of Child Maltreatment

Participants' responses to items of childhood physical abuse, sexual abuse, and exposure to domestic violence were combined into one composite CHILD MALTREATMENT score so that the experience of each type of abuse was assigned one point. Possible scores ranged from 0-3. Participants who responded "Yes" to all of the LES items assessing child maltreatment were assigned a score of 3 and those who responded "No" to all three items were assigned a score of 0.

Figure 2. Victimization in Adulthood Reported by Abused and Non-abused Participants



In order to assess maternal characteristics of participants' mothers, such as mental/emotional problems, alcohol problems, and criminal arrest, as potential risk factors of child abuse, a composite score of MATERNAL RISK FACTORS was also created by merging participants' responses to items measuring such characteristics. Possible scores ranged 0-3. Participants who answered "No" to all of these items were assigned a score of 0; those who answered "Yes" to all three questions were given a score of 3. A two-tailed Pearson product-moment correlation coefficient was subsequently computed to assess the relationship between MATERNAL RISK FACTORS and the reported occurrence of child abuse.

A positive correlation between maternal risk factors and the participant's experience of child maltreatment was observed (r=0.41, p<.01). That is, the occurrence of child abuse is correlated with the presence of maternal emotional problems, drinking problems, and criminality. Table 4 shows the frequencies of the characteristics of participants' mothers among those reporting a history of child maltreatment and no history of child abuse.

Table 4

Participant Report of Maternal Risk Factors Separated by History of Abuse in Childhood

Presence of Maternal Risk Factors	No History of Abuse	History of Abuse
Mental/Emotional Problems	20.6% (*n*=28)	51.8% (*n*=44)
Alcohol Problems	2.2% (*n*=3)	8.3% (*n*=7)
Arrested for Crime	0.7% (*n*=1)	5.9% (*n*=5)
No Risk Factors Reported	76.5% (*n*=104)	34% (n=29)

Risk Factors of Revictimization

Of the 236 participants who responded to the LES item assessing number of consensual partners, approximately 19% (*n*=45) reported never having engaged in sexual activity, 20% (*n*=48) disclosed having only one consensual sexual partner, 15% (*n*=36) had two partners, and 45% (*n*=107) had three or more partners. The mean number of sexual partners reported by participants was 3.84 (*SD* = 6.95; range 0 to 80). The distribution of the number of consensual partners is highly skewed as a small number of the participants reported having a large number of partners. Consequently, the mean is higher than the median (*mdn*=2.0).

In regard to substance use, approximately 88% (*n*=210) of the sample reported having tried alcohol and 29% (*n*=70) admitted to trying other substances for recreational purposes. Of that same group of participants who have used alcohol, 14% (*n*=30) reported having 4 or more alcoholic beverages only once in the past month, 12% (*n*=27) had 4 or more alcoholic beverages on two occasions in the past month, and 12% (*n*=26) had 4 or more alcoholic beverages three or more times in the past month (See Table 5).

Table 5

Risk Factors of Revictimization Reported by Participants

Risky Behaviors	Mean	SD	Percentage	N
Alcohol & Substance Use Amongst Total Sample (*n*=240)				
Tried Alcohol			87.5%	210
Age at which began Using Alcohol	16.9	2.53		210
Tried Other Substances			29.2%	70
Age at which began Using Substances	16.9	3.87		70
Of those Reporting Alcohol Use (*n*=210)				
Had 4+ drinks in past month			39.5%	83
Had 4+ drinks in past year			60.5%	127
Consensual Sexual Partners Amongst Total Sample (*n*=236)				
None			19.1%	45
One			20.3%	48
Two			15.3%	36
Three or More			45.3%	107

In order to measure the association between behavioral risk factors of revictimization and the actual occurrence of revictimization, a composite variable of SUBSTANCE USE was created by summing participants' positive responses to the two items of the LES that assessed alcohol and substance use (i.e. "Have you ever tried alcohol?" and "Other than alcohol, have you ever used other substances for recreational purposes?"). Scores of SUBSTANCE USE ranged from 0-2. Participants that said "No" to both questions were given a score of 0, participants who said "Yes" to one item were given a score of 1, and participants who said "Yes" to both items were given a score of 2. The relationship between SUBSTANCE USE and REVICTIMIZATION was assessed by the computation of a two-tailed Pearson-product correlation coefficient. A positive correlation was identified between participants' risky substance behavior and their report of

revictimization [r=0.18, p<0.01]. This correlation coefficient indicates that revictimization in adulthood is related to alcohol and substance use.

A second potential risk factor of revictimization is having a large number of sexual partners. A two-tailed Pearson-product correlation coefficient was conducted to assess the relationship between REVICTIMIZATION and number of reported consensual sexual partners. Before the correlation coefficient was calculated, the data of one participant was removed because her report of 80 consensual sexual partners notably affected the entire sample's mean number of sexual partners. With the exclusion of the participant's response, the mean number of sexual partners was 3.52 (SD=4.86, range 0-35, mdn=2). A positive correlation coefficient was obtained, r=0.14, p<.05, s, which indicates that revictimization is related to having a large number of sexual partners.

The relationship between acculturation and REVICTIMIZATION was also measured through the computation of several two-tailed Pearson-moment correlation coefficients. Since the ARSMA-II provides three acculturation scores (i.e., Mexican acculturation score, Anglo acculturation score, and total acculturation score), three different correlation coefficients were calculated to assess the relationship between each acculturation score and REVICTIMIZATION. As expected, revictimization and Anglo acculturation score were significantly positively related, r=.15, p<.05. However, revictimization was not significantly related to the Mexican acculturation score (r= -.02, p<.05, ns) nor was the total acculturation score (r=.07, p<.05, ns). Results indicate that orientation toward the Anglo culture is related to revictimization whereas participants' total acculturation score and orientation toward Mexican culture are not.

CHAPTER V

CONCLUSION

Overall, the data indicate that more than one third of the Hispanic, female sample reported experiencing maltreatment as children and 14% of participants experienced two or more forms of child abuse. As hypothesized, multi-type maltreatment is fairly common in this Hispanic sample. These findings are comparable to the prevalence rates of single and multi-type child maltreatment found by other investigations, as well as some studies that included Hispanics as participants (Clemmons et al., 2003; Gladstone et al., 2004; Higgins & McCabe, 2000; Messman-Moore & Garrigus, 2007; Schaaf & McCanne, 1998). For example, 25% of Arata et al.'s (2005) primarily Caucasian sample reported having experienced two or more forms of maltreatment during childhood. Hetzel and McCanne (2005) also found that 8.1% of their ethnically diverse sample of childhood victims reported experiencing both sexual and physical abuse. Although only a small number of victimization studies have included members of minority groups as participants, child multi-type maltreatment appears to be common across ethnicities (Arata, et al., 2007; Finkelhor et al., 2007; Lewis et al., 2006).

The occurrence of child abuse was found to be more prevalent among participants who reported that their mothers had mental/emotional problems, drinking problems, or that their mothers were arrested for a crime. However, the frequencies of these maternal characteristics amongst the participants' mothers must be taken into consideration. As seen on Table 4, there is a large discrepancy between the frequencies of the three maternal characteristics. In particular,

the occurrence of mental or emotional problems was reported more often by participants than drinking problems or arrests. Consequently, any conclusions regarding maternal alcohol abuse or arrests as risk factors of child maltreatment based solely on the correlation coefficient calculated in this study would be premature. However, other studies have identified that parental alcoholism is associated with the occurrence of child maltreatment (Harris, 2008; Johnson, 2001; Shin, et al., 2009).

The results of this study also indicate that experience of victimization in childhood is significantly associated with experiencing assault in adulthood, also known as revictimization. These findings are consistent with the results of previous studies investigating both single and multiple forms of child maltreatment (Coid et al., 2001; Fergusson, Horwood, & Lynskey, 1997; Krahè, et al., 1999; Messman-Moore & Garrigus, 2007; Roodman & Clum, 2001; Schumm, Hobfoll, & Keogh, 2004; Walsh et al., 2007) and the few investigations that have included Hispanics in their sample population (Kimerling et al., 2007). The current study supports the conclusion that revictimization is prevalent among victims of single and multiple types of child maltreatment, particularly physical abuse, sexual abuse, and witnessing domestic violence.

As predicted, revictimization was found to be related to the use of risky behaviors such as the use of alcohol and/or other recreational substances and having numerous consensual sexual partners. However, the correlation coefficients of the relationship between substance use and revictimization and number of sexual partners and revictimization are quite small (r=0.18, p=.01; r=0.14, p=.05, respectively). Although the relationship between these variables is statistically significant, other factors, such as an individual's personality in addition to substance use and sexual activity, may collectively influence the risk of revictimization. Alcohol use, substance use, and sexual activity have all been found to increase a child abuse survivor's

vulnerability to victimization in adulthood (Fergusson, Horwood, & Lynskey, 1997; Krahè, et al., 1999; Messman-Moore, Ward, & Brown, 2009). Although not directly assessed in the current study, use of risky behaviors has been shown to be common amongst survivors of child abuse and has also been considered to be a possible coping mechanism for experience of a traumatic event or for the symptoms/consequences of child maltreatment that are commonly experienced by such victims (Orcutt, Cooper, & Garcia, 2005). These coping mechanisms and other factors, such as the experience of PTSD symptoms, can possibly mediate the relationship between the use of risky behaviors and revictimization (Deliramich & Gray, 2008; Risser et al, 2006).

Contrary to expectation, total acculturation and orientation towards Mexican culture was not associated revictimization; although, orientation towards Anglo culture did seem to be somewhat related to revictimization. However, this finding must be interpreted with caution as the relationship between revictimization and orientation towards Anglo culture is negligible (r=.15, p<.05). Clemmons et al. (2002) also failed to establish a relationship between acculturation and victimization. Immigration status, rather than level of acculturation, has been thought to be more strongly associated with child maltreatment, but results of such studies have been incongruent. It is likely that stress associated with the immigration to another country, such as low socioeconomic status, acculturative stress, and lack of social support, may mediate the potential relationship between immigration status and child abuse and/or revictimization. Dettlaff, Earner, & Phillips' (2009) findings indicate that children of immigrants were more likely to experience sexual abuse than children of native parents, but no significant difference was found between the overall number of substantiated reports of child abuse among immigrant and native-born families.

The present study had several limitations. First, convenience sampling was used in recruiting participants; that is, the participants included in our study volunteered to participate and were not randomly chosen. Thus, the extent to which the results of the current study are applicable to the general Hispanic population is greatly reduced. Second, our study used only retrospective self-reports of child maltreatment and adult assault. Participants were simply asked if they were victimized as either children or adults. As a result, some inaccuracies in the participants' reports of abusive experiences may be present as such reports greatly depend on the accuracy of the participants' memory and their willingness to report the events. It is possible that some events were forgotten despite the severity of the event(s) or that participants were uncomfortable in recalling or sharing their traumatic experiences.

Third, childhood maltreatment and assault in adulthood were measured by asking the participants if they believed they had experienced such events. It is likely that the belief of what constitutes abuse or assault varies from person to person. Child sexual abuse was found to be more commonly experienced by participants than child physical abuse despite the findings of other studies that indicate physical maltreatment is more common (Blankertz, Cnaan, & Freedman, 1993; Kimerling et al., 2007; MacMillan, Jamieson, & Walsh, 2003; U.S. Dept of Health and Human Services, 1996; Walsh, MacMillan, & Jamieson, 2002). It is possible that the participants involved in the present investigation have a more restrictive definition of physical abuse than sexual abuse.

The age of the participants involved in the present study is yet another limitation. The participants involved in the current study are of fairly young age and have possibly not encountered as many life experiences (i.e., assault, consensual sexual partners) as individuals older in age. The use of older participants might considerably alter the findings of this study.

Lastly, only three types of child maltreatment were assessed in the present study, specifically physical abuse, sexual abuse, and witnessing domestic violence. If additional forms of maltreatment, such as emotional abuse and neglect, had been assessed, the prevalence rates of child abuse, multi-type maltreatment, and revictimization amongst the current Hispanic sample might have been significantly different from the rates obtained in the current study.

Despite the limitations, the findings contribute to the current body of knowledge which shows that multi-type maltreatment and revictimization are phenomena that affect many victims of child maltreatment, including Hispanic women. The results from this study also identified maternal mental/emotional problems and victims' risky behavior as important risk factors of child abuse and revictimization in adulthood, respectively. Other individual, familial, and environmental factors that were not assessed in the current study, such as characteristics of participants' personality and the presence of a stepparent, may also contribute to the risk of child maltreatment and possibly later victimization. Since victimization studies involving minorities, specifically Hispanic Americans, are scarce and the consequences of child maltreatment are so well-known, further research on child maltreatment and revictimization is warranted. Future investigations should use the risk factors identified in the current study and other potential risk factors in an effort to enhance our understanding of child maltreatment and revictimization.

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APPENDIX A

APPENDIX A

LIFE EXPERIENCES SURVEY

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

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

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

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

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

AGE_____ SEX _____ CLASS STANDING: *Freshman* *Sophomore* *Junior* *Senior*

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

African-American *Other Hispanic/Latino*_____ Other_____

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

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

What is your "second language"? _____

Age of your *mother* when you were born_____ Age of your *father* when you were born_____

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

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

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

Some graduate school *Graduate degree* *Doctorate*

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

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

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

Some graduate school *Graduate degree* *Doctorate*

MARITAL STATUS_____ NUMBER OF CHILDREN_____

NUMBER OF OLDER SISTERS _____ NUMBER OF YOUNGER SISTERS _____

NUMBER OF OLDER BROTHERS _____ NUMBER OF YOUNGER BROTHERS _____

RELIGIOUS PREFERENCE_____

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

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

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

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

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

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

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

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

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

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

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

Other than alcohol, have you ever used other substances for recreational purposes? *Yes* *No*
If "Yes," at what age did you begin using? _____

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

(Select one of these options): I elect to continue _____ I prefer to not continue_____

1. I believe that I was sexually abused before age 6. *Yes* *No*

2. I believe that I was sexually abused between ages 6 and 12. *Yes* *No*

3. I believe that I was sexually abused between ages 12 and 18. *Yes* *No*

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

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

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

6. If "Yes" to any of #1 through #3, how often did this occur?
☐ *Once* ☐ *Twice* ☐ *3 times* ☐ *4 times* ☐ *5 times* ☐ *More than 5 times*

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

Family Doctor *Psychologist* *Husband* *Parent* *Uncle/Aunt*

Psychiatrist *Social Worker* *Counselor* *Sibling* *Friend* *Teacher*

Other_____ (Please specify)

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

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

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

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

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

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

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

drinking problems? *Yes* *No*

or was arrested for a crime? *Yes* *No*

14. Were you often left alone at home when an adult or responsible babysitter should have been there? *Yes* *No*

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

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

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

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

REMINDER: PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU ARE COMFORTABLE DOING SO AND ONLY IF YOU ARE SURE YOU WANT TO.
(Select one of these options): I elect to continue _____ I prefer to not continue_____

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

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

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

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

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

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

_____

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

If yes, what side effects do you experience?

_____

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

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

or *migraine (vascular) headaches)?*

or *both?*

or *other* _____

21. If Yes, how long ago did your headaches begin? _____Weeks ago _____Months ago _____Years ago

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

☐ *I have too few to cause me concern*

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

☐ *My headaches frequently interfere with my ability to function*

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

23. If you have headaches, are most of your headaches? _____Mild _____Moderate _____Severe

24. Which statement best describes the frequency of your headaches? _____one each day _____more than one daily

_____one each week _____more than one weekly ____one per month _____ more than 4-5 per month

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

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

The medication(s) I take for headache is/are_____

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

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

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

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

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

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

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

Never Once Occasionally Often

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

What percentage (%) were viewed…

[*alone*_____%] [*with a female*_____%] [with a *male*_____%] [with a *group*_____%]?

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

What percentage (%) were viewed…

[*alone*_____%] [*with a female*_____%] [with a *male*_____%] [with a *group*_____%]?

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

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

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

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

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

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

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

Never Occasionally Often Always

40. If you indicated you were sexually abused as a child, how much do you believe your sexual orientation is related to the experience of having been sexually abused?

0% 5% 10% 25% 50% 75% 100%

41. How many times, on average, do you masturbate per month? _____

42. Which of these terms describes your **typical** ability to achieve orgasm by masturbation?

_____ I have never been able to achieve orgasm this way _____ It is difficult for me to achieve orgasm

_____ It is easy for me to achieve orgasm _____ Not Applicable, I do not masturbate

43. Which of these terms describes your **typical** ability to achieve orgasm with a partner?

_____ I have never been able to achieve orgasm this way _____ It is difficult for me to achieve orgasm

_____ It is easy for me to achieve orgasm _____ Not Applicable, I have not had sex with anyone

44. How would you rate the amount of your usual sexual desire?

Very Low *Low* *Average* *High* *Very High* *Out of Control*

45. How much, if any, do you worry about your level of sexual desire?

None *A Little* *Average* *A Lot*

46. How would you rate the amount of your usual sexual activity?

Very Low *Low* *Average* *High* *Very High* *Out of Control*

47. How much, if any, do you worry about your level of sexual activity?

None *A Little* *Average* *A Lot*

Please note that NONE of the activities described in the following questions are illegal or considered "abnormal" if performed alone or with another consenting adult…

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

"Threesome":	*Never*	*Once*	*Occasionally*	*Often*
"Foursome":	*Never*	*Once*	*Occasionally*	*Often*
Group Sex (more than 4):	*Never*	*Once*	*Occasionally*	*Often*
Swinging: (trading sexual partners with one couple)	*Never*	*Once*	*Occasionally*	*Often*
Fetish:	*Never*	*Once*	*Occasionally*	*Often*
Bondage ("Receiver")	*Never*	*Once*	*Occasionally*	*Often*
Bondage ("Giver")	*Never*	*Once*	*Occasionally*	*Often*
(Non-Bondage) S & M:				
S:	*Never*	*Once*	*Occasionally*	*Often*
M:	*Never*	*Once*	*Occasionally*	*Often*
Auto-Erotic Asphyxiation: (Strangling to enhance orgasm)	*Never*	*Once*	*Occasionally*	*Often*
Bestiality: (Sexual Contact with an animal)	*Never*	*Once*	*Occasionally*	*Often*
Sex involving urine:	*Never*	*Once*	*Occasionally*	*Often*
Sex involving feces:	*Never*	*Once*	*Occasionally*	*Often*

Cross-Dressing: *Never* *Once* *Occasionally* *Often*

Have you ever considered a sex-change? *Yes* *No*

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

BIOGRAPHICAL SKETCH

Eleni Isis Escorza was born and raised in Brownsville, Texas. Eleni attended Homer Hanna High School, and throughout her high school career, she planned on becoming a medical doctor as she was enrolled in a magnet program at her high school that emphasized natural and medical sciences. She pursued the study of psychology and chemistry at Baylor University and also concentrated on pre-med studies. She graduated from Baylor University in 2007 and soon after began working at a local mental health agency located in her hometown.

After working in the mental health field for a few years, Eleni decided to pursue a career in the field of psychology and entered the Clinical Psychology Master's program at University of Texas – Pan American after discovering a new passion of hers consisting of mental health and psychopathology. While completing the requirements for a Master's degree, she conducted the research investigation presented here. She graduated with a Master of Arts in August 2010. Eleni hopes to continue conducting research involving child abuse while also working with victimized children in addition to those suffering from behavioral problems and mental disorders.