The Effects of Childhood Sexual Abuse on Parenting

Erin Ann Williams

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THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON PARENTING

by

Erin A. Williams

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

THE EFFECTS OF CHILDHOOD SEXUAL ABUSE ON PARENTING

By

Erin A. Williams

Adviser: Professor Cathy Spatz Widom

Childhood sexual abuse (CSA) is a pervasive problem that has been the focus of substantial empirical research. While negative outcomes such as psychiatric diagnoses or health problems have been well documented, the literature regarding the effects of CSA on parenting is sparse and has produced conflicting results. Moreover, the existing research on CSA’s effect on later parenting has several methodological limitations (e.g., retrospective data) and has failed to find any consistent explanatory mechanisms/pathways for which CSA is most likely to impede parental success. The present study examined whether a history of CSA leads to negative parental outcomes (i.e., how they handle conflict and whether victims of CSA engage in physical abuse or neglect of their children) using a prospective cohort design with 70 court-substantiated cases of CSA and a matched control group (n = 70). Current parenting behaviors as well as potential explanatory mechanisms/pathways, such as family-of-origin effects and psychiatric diagnoses, were assessed via self-report and standardized measures. Results of this study failed to find differences between the CSA and matched control groups in terms of current reported parenting behavior. Additionally, while CSA was associated with significantly higher rates of family-of-origin problems, those variables did not influence current parenting. Overall, this study failed to find a direct relationship between
a history of CSA and negative parenting practices (i.e., how they handle conflict, physical abuse, neglect), or an indirect relationship via additional pathways through family-of-origin effects or psychological distress. The results of this study suggest that parenting may not be as negatively affected by CSA as previously believed.
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The Effects of Childhood Sexual Abuse on Parenting

Introduction

Childhood sexual abuse (CSA) is a pervasive problem that is estimated to have been experienced by one in four adult women and one in six adult men (Center for Disease Control and Prevention, 2005). In 2012, 9.3% of the substantiated victims of childhood maltreatment, as investigated by Child Protective Services (CPS), were sexual abuse cases. That translates into approximately 62,936 children confirmed to be victims of CSA (NCANDS; U.S. Department of Health and Human Services, Children’s Bureau, 2013). That is a slight increase from the 2008 reports that indicated that 9.1% of the children referred were found to have CSA (NCANDS; U.S. Department of Health and Human Services, Children’s Bureau, 2010); however, it is consistent with the 2005 reports of 9.3% (NCANDS; U.S. Department of Health and Human Services, Children’s Bureau, 2007) and suggests the numbers have remained relatively stable.

Given the persistent nature of CSA, many studies have examined both its immediate and long-term effects. In particular, CSA has been linked to depression (Perez-Fuentes et al., 2013; Rhode et al., 2008), post-traumatic stress disorder (Bleiberg, 2000; Courtois, 2000; Perez-Fuentes et al., 2013, Widom, 1999), anxiety (Chou, 2012; Kendler et al., 2000), eating disorders (Brewerton, 2007; Chou, 2012; Treuer, Koperdak, Rozsa, & Furedi, 2005), somatization disorders (Spitzer et al., 2008; Zink, Klesges, Stevens, & Decker, 2009), suicide attempts (Perez-Fuentes et al., 2013), and substance use (Bailey, 2008; Zink et al., 2009). In addition to psychopathology, recent studies have focused on how CSA interferes with interpersonal relationships (Godbout, Sabourin,
& Lussier, 2009; Kernhof, Kaufhold, & Grabhorn, 2008) and have begun to examine how it may have an impact on parenting.

While some studies have indicated that CSA negatively affects parenting in areas such as discipline (Banyard, 1997; Ruscio, 2001), perceptions of parental competence (Bailey, DeOliveira, Wolfe, Evans, and Hartwick, 2012; Ehrensaft, Knous-Westfall, Cohen, Chen, 2014; Roberts, O’Conner, Dunn, Golding, & The ALPAC Study team 2004), levels of parental stress (Douglas, 2000), and general parenting behaviors (Cohen, 1995; Ehrensaft et al., 2014), others have failed to find an impact on parenting (Alexander, Teti, & Anderson, 2000; Fitzgerald, Shipman, Jackson, McMahon, & Hanley, 2005; Oates, Tebutt, Swanston, Lynch, & O’Toole, 1998; Renner, Whitney, & Easton, 2013). Moreover, some research has suggested that CSA indirectly affects parenting through other childhood adversities or adult psychiatric disorders (Barrett, 2010; Seltmann & Wright, 2013). Despite the recent interest in CSA’s effect on parenting, no consistent pathway or mechanism explaining the association has been discovered (Seltmann & Wright, 2013; Ehrensaft et al., 2014). There continues to be a need for research to identify the most salient factors affecting parenting in CSA survivors. This dissertation attempts to resolve some of the conflicting evidence by assessing the direct impact of CSA on parenting while addressing the role of potential pathways or mechanisms that have been suggested in previous literature. This paper begins with a description of the prevalence of CSA and how it is influenced by the definition of critical terms, followed by a brief review of the existing literature, and a discussion of methodological limitations.
Prevalence and Definitions of CSA

As definitions of CSA greatly vary from one study to the next, prevalence is difficult to assess. In comparison to the official reports of known cases, such as those reported in NCANDS, studies using self-report data for CSA often yield a higher prevalence and wide ranges of estimates. For example, Douglas and Finkelhor (2005) reviewed studies that examined CSA and reported that approximately 9-32% of females and 5-10% of males had described at least one incident of CSA in their childhood. Barth, Bermetz, Heim, Trelle, and Tonia (2013) attempted to clarify prevalence through a systematic literature review and meta-analysis of 55 studies from 24 countries; however, they found that the extreme heterogeneity of the studies led to vast differences. Specifically, according to that review, 8-31% of females and 3-17% of males had experienced CSA. Pereda, Guilera, Forns, and Gomez-Benito (2009) found similar results in their meta-analysis of 65 journal articles where they focused specifically on the broad ranges between countries. In particular, male rates of CSA ranged from 0.4% to 27% and women were 0.9% to 37.8%. Finally, a meta-analysis of 331 global studies conducted by Stoltenborgh, van IJzendoorn, Eusier, and Bakermans-Kranenburg (2011) highlighted the vast differences between official and self-reports of CSA. Findings from that study revealed that self-report studies predicted prevalence of CSA to be 30 times higher than those based on official reports. Specifically, self-report studies found CSA to be present in 127 of 1000 children, while official reports found 4 cases of CSA per 1000 children. The considerable difference in prevalence rates based on source of information is problematic and often believed to occur due to the lack of a uniform definition of CSA.
Although definitions of CSA vary in the literature, two basic features are typically included. The first feature represents any type of sexual act with a child that can involve either contact (touching a child’s genitals or having a child touch the perpetrators’ genitals) or non-contact (exhibitionism). The second feature represents a sexual act where there is a significant age difference between the child and the adult, the perpetrator is in the caretaker role, or the perpetrator uses any type of force to achieve the sexual act (Finkelhor, 1994). While these two basic features are often core elements within the definitions of CSA, studies are not consistent as the criteria included is usually at the author’s discretion. For example, based on the design of the study (e.g., retrospective self-report or court substantiated cases), the definition may change to fit the study. The most expansive studies include any kind of sexual act even when there is no contact, such as exhibitionism (Finkelhor, 1979), whereas others are more restrictive including only penetrative contact (Senn, Carey, & Vanable, 2008). The remaining definitions are somewhere in the middle, requiring some contact, such as kissing or fondling (Senn et al., 2008).

In terms of age, the definition of CSA typically includes any sexual abuse performed on a child or adolescent under the age of 18 (Bensley, Van Eenwyk, & Simmons, 2000; Hillis, Anda, Felitti, & Marchbanks, 2001); however, a review of the literature indicates that several variations have been used. For example, some studies have capped the age of abuse at age 17 (Paul, Catania, Pollack, & Stall, 2001; Walser & Kern, 1996), age 16 (Bartoi & Kinder, 1998; Kalichman, Gore-Felton, Benotsch, Cage, & Rompa, 2004), age 15 (Jinich et al., 1998, Mayall & Gold, 1995), age 14 (Merrill, Guimond, Thomsen, & Milner, 2003), age 13 (Carballo-Dieguez & Dolezal, 1995;
DiLorio, Hartwell, & Hansen, 2002), and age 11 (Widom, 1989a). Furthermore, some studies have focused on the age difference between the victim and the perpetrator (e.g., age discrepancy definition of CSA), opposed to the age of the victim.

The “age discrepancy” definition of CSA requires a minimum age difference between the victim and the perpetrator to qualify as CSA. However, this again can be problematic as there is no standard minimum number of years required. Moreover, the minimum number of years between the victim’s age and the perpetrator’s age may vary depending on whether the victim is a child or an adolescent (Briere, 1992; Briere, Elliott, Harris, & Cotman, 1995). For example, while a four-year age difference may be sufficient to determine abuse of a prepubescent child, a six-year minimum age difference may be required for a post pubescent child.

Finally, the definitions of CSA vary based on whether it is necessary to involve the use of threat or force. Some studies define CSA as any act involving force, regardless of the age difference between the victim and the perpetrator; while others do not require force as long the minimum age difference is met (Briere 1992; Briere et al, 1995; Wyatt, 1985, Wyatt, Lawrence, Vodounon, & Mickey, 1992). In summary, there is an obvious lack of uniformity in regard to the definition of CSA, which likely contributes to numerous problems with interpretation of research findings, comparison of results among the studies, and estimation of the prevalence of CSA.

**Effects of Childhood Sexual Abuse on Parenting**

While the failure to agree on a uniform definition of CSA is an obvious limitation in the literature, understanding the impact of CSA on factors such as parenting continues to be an important research endeavor. As interest in the impact of CSA on parenting
increases, studies have begun to address specific areas that may be influenced. In particular, studies have looked at parental behaviors (e.g., parental skills, discipline styles, role reversal) and perceptions of parental competence.

**Parental behaviors.** Cohen (1995) conducted one of the first empirical studies on CSA’s effect on parenting through examination of seven specific parental skills (role support, role image, objectivity, expectations, rapport, communication, and limit setting). Participants included 26 women seeking therapy services for abuse histories, and 28 professionals recruited from a lecture on CSA, who served as controls, for a total of 54 individuals. Information was assessed via self-report measures with an additional structured clinical interview for those with abuse histories. The results indicated that the mothers who reported a history of CSA had significantly lower scores on all seven variables, with particularly large differences in role support and communication.

Ehrensaft et al. (2014) also hypothesized that a history of CSA would have a significant impact on parenting skills, such that it would lead to decreased positive practices (e.g., satisfaction, availability) and increased maladaptive practices (e.g., discipline). Data for the study was gathered from 396 mothers through a series of interviews that examined history of childhood abuse, parenting practices, conduct disorder, and adult psychiatric disorders. The results from the study confirmed the authors’ hypothesis that a history of CSA did in fact lead to lower levels of availability and time for their children, as well as higher levels of perceived ineffectiveness. Also, a history of CSA marginally predicted parental satisfaction; however, there was no relationship with CSA and discipline styles.
While Ehrensaft et al. (2014) failed to find an association between a history of CSA and discipline styles, previous studies have indicated such a relationship. For example, Banyard (1997) found that mothers with a history of CSA were more likely to use physical strategies for handling conflicts with their own children compared to a control group. Moreover, Spieker et al. (1996) found that a history of CSA greatly increased the mother’s likelihood of contact with Child Protective Services (CPS) such that approximately 15.4% of women with no history of CSA reported CPS contact, 38.5% with CSA of brief duration reported CPS contact, and 83.3% with chronic CSA reported CPS contact.

In contrast to increased risk for more harsh discipline, some studies have found that individuals with a history of CSA are more permissive in their parenting. These studies have hypothesized that permissive parenting may be the result of avoidance of parental authority due to feelings of powerlessness as children (Ruscio, 2001), lack of confidence in parenting leading to feelings of inability to be effective parents (Cole, Woogler, Power, & Smith, 1992), or lack of energy to be effective parents due to dealing with one’s own emotional problems resulting from CSA (DiLillo & Damashek, 2003).

Ruscio (2001) used Baumrind’s typology of parenting including authoritative, permissive, and authoritarian to examine parenting styles among mothers with a history of CSA. In addition to CSA, the study included mothers with a history of alcoholic parents in the home to differentiate the role of CSA versus other dysfunctional family attributes, such as having an alcoholic parent. Overall, the study had 35 participants with a history of CSA and 10 participants with a history of alcoholic parents. After controlling for physical abuse, socioeconomic status (SES), and family-of-origin dysfunction, the
results indicated that mothers with a history of CSA or an alcoholic home utilized more permissive parenting. The author noted a unique combination of high permissive and low authoritarian parenting with CSA survivors in particular.

Similar to permissive parenting, some research has questioned whether a history of CSA leads to role reversal between mothers and their children. Sroufe, Jacobvitz, Mangelsdorf, DeAngelo, and Ward (1985) examined role reversal in mothers with a history of CSA and found that they exhibited a seductive role-reversal with their sons and increased hostility towards their daughters. Burkett (1991) looked at the interactions between mothers and daughters and found that those with a history of CSA treated their daughters more as friends and confidantes and relied on them more heavily for emotional support compared to the mothers with no CSA. Burkett (1991) hypothesized that CSA survivors may use their children to meet their own needs for emotional support and companionship. Alexander et al. (2000) assessed potential role reversal among a sample of 90 women. Of the 90 participants, 19 reported having been sexually abused as a child, with CSA being defined as any unwanted sexual touching by someone at least five years older or if any use of force or threat was used. The results indicated that women with a history of CSA, who were dissatisfied with their current intimate relationship, were significantly more likely to display role reversal with their children in comparison to those with a history of CSA who were satisfied in the current relationship and those without a history of CSA who were dissatisfied with their current relationship. Furthermore, role reversal when dissatisfied with their current relationship was not seen when examining participants with histories of physical abuse or parental alcoholism, suggesting that this is unique to CSA.
Perceptions of parental competence. Perception of parental competence has received a lot of attention recently as researchers have questioned whether CSA survivors report a more negative perception of their own parenting abilities and parental self-efficacy (Fitzgerald et al., 2005; Schuetze & Eiden, 2005). This is particularly noteworthy because the level of confidence and perceptions of parenting roles have been shown to influence the way parents interact with and respond to their children (Johnston & Mash, 1989; Mash & Johnson, 1983). Specifically, lower perceptions of parenting abilities can result in higher levels of frustration, stress, and lowered parental satisfaction, which could all negatively impact the parent-child relationship (Fitzgerald et al., 2005).

Burkett (1991) examined mothers with and without a history of CSA and found that the non-CSA mothers had a more balanced view of parenting, while those with a history of CSA focused on extremes of really good parenting areas versus really bad parenting areas. Additional studies have found that a history of CSA is related to lower confidence in parenting (Cole, Woolger, Power, & Smith, 1992), less positivity in their relationship with their child (Roberts et al., 2004), lower satisfaction with self as a parent (Banyard, 1997), increased rates of parental stress (Douglas, 2000), and perceived ineffectiveness (Ehrensaft et al., 2014).

In contrast to those studies, Renner, Whitney, and Easton (2013) failed to find a relationship between CSA and perceptions of parenting competence, parental satisfaction, or parental stress. Specifically, Renner et al. (2013) found that of the 264 mothers assessed in their study, those with a history of CSA reported the ability to effectively parent and engage in satisfactory relationships with their children without any decreased perceptions of their abilities or increased levels of stress. Alexander et al. (2000) also
found that a history of CSA was not significantly related to increased levels of parental stress.

In addition to recognizing whether CSA affects perception of parenting, it is important to determine whether these perceptions accurately reflect parental abilities. To help clarify the relationship between perception and actual behavior, Fitzgerald et al. (2005) examined mothers’ perceptions of their parenting skills followed by behavioral observation of them with their children. The results indicated that mothers with a history of CSA in this study reported less self-efficacy as parents than mothers with no abuse history; however, no such differences were found in the behavioral observation. Specifically, mothers with a history of CSA showed no differences in maternal support, assistance, confidence, or child’s affection in comparison to the other mothers. This is an interesting finding that suggests that these mothers’ self-reports may not accurately reflect their actual abilities. While the behavioral observation was brief, this was one of the first studies to use an objective task to measure parenting behaviors against perceptions opposed to relying solely on self-report of the mothers.

Bailey et al. (2012) examined potential differences between 93 mothers’ perception of parenting skills and observed interactions with their children. Consistent with previous research, the mothers with a history of CSA endorsed lower levels of parental competency but their observed interactions were not consistent with their self-reports and did not show any deficient behaviors. Interestingly, while a history of CSA did not appear to effect parental abilities as observed by the researchers, a history of neglect or emotional maltreatment did make a difference in that these mothers showed more hostility towards their children.
These studies illustrate that while CSA likely influences parenting its exact relationship to parenting is unknown and requires further clarification. One possible reason for the lack of consistent findings is that the specific pathways or mechanisms by which CSA impedes parental success vary. Below I will review studies that have attempted to determine the specific ways in which CSA influences parenting.

**Explanatory Mechanisms: Psychological Distress and Family-of-Origin Effects**

**Psychological distress.** As researchers strive to identify possible mechanisms for how CSA affects parenting, one area that has been examined is the role of psychological distress. Specifically, researchers have speculated that CSA indirectly affects parenting through its impact on psychological distress such as depression, post-traumatic stress disorder (PTSD), and maternal anger, which in turn, then affect parenting (Banyard, Williams, & Siegel, 2003; Benedict, Paine, Paine, Brandt, & Stallings, 1999; Neumann, Houskamp, Pollock, & Briere, 1996; Widom, 1999). The rationale for this is based on previous literature that has shown a clear association between CSA and various psychiatric diagnoses (Perez-Fuentes et al., 2013; Chou, 2012), as well as between psychiatric diagnoses and parenting problems (Weissman et al., 2006). In the next section, I will briefly discuss psychological issues that have been linked to CSA (i.e., depression, PTSD, anger), and review studies that have examined whether those problems influence the parenting of CSA survivors.

**Depression.** Several studies have shown that parental depression has negative effects on parenting, including inconsistent discipline, lower levels of responsiveness, decreased emotional availability, and hostility (Carter, Garrity-Rokous, Chazan-Cohen, Little & Briggs-Gowan, 2001; Cummings & Davies, 1994; Downey & Coyne, 1990;
Lovejoy, Graczyk, O’Hare, & Neumann, 2000). Depression has also been related to feelings of decreased confidence in parenting abilities and unrealistic expectations regarding how their children should behave (Dumas & Serketich, 1994; Forehand, McCombs, & Brody, 1987; Schuetze & Zeskind, 2001). Maternal depression has been linked with poor mother-child interactions (Field, 1992; Stein et al., 1992), problematic developmental outcomes for children including behavioral problems (Campbell & Cohn, 1995; Philips & O’Hara, 1991, Williams & Carmichael, 1985), and increased rates of insecure attachments in the children (Teti, Gelfan, Nessinger, & Isabella, 1995). These findings, combined with the knowledge that CSA often precedes depression (Benedict et al., 1999; Neumann et al., 1996), suggest that depression may mediate the relationship between CSA and parenting problems.

Zuravin and Fontanella (1999) conducted one of the first empirical studies that looked at potential mediators between CSA and subsequent parenting, with particular focus on maternal depression. Their study used both clinical interviews and self-report measures to gather information about perceived parental competency, abusive parental behaviors, depression, and history of CSA among 516 mothers. Results from this study revealed that a history of CSA was significantly associated with decreased perceived parental competency and use of severe violence to handle conflict, irrespective of whether depression was present.

Similarly, Collin-Vezina, Cyr, Pauze, and McDuff (2005) failed to find that depression mediated the relationship between CSA and later parenting. Their study examined the current depressive symptomology of 93 mothers, half of whom reported a history of CSA. All of the participants had children that were involved in Youth
Protection Services due to neglect, physical abuse, sexual abuse, or because parents turned over authority to those services. Despite the children’s current issues, results from this study showed that neither maternal CSA nor depression predicted any of the parenting practices examined, including the use of positive reinforcement, lack of monitoring or supervision of child, inconsistent discipline, or use of corporal punishment. Therefore, the results of this study were consistent with the findings of Zuravin and Fontanella (1999).

Schuetze and Eiden (2005) hypothesized that depression, as well as current partner violence, would mediate the relationship between CSA and various parental factors such as discipline, stress, and perceived competency. Their study consisted of 263 women, of whom 107 (40%) reported a history of CSA. The results revealed that mothers with a history of CSA were found to have higher rates of depression and partner violence that in turn mediated the relationship between CSA and parenting. Specifically, while there was a significant association between CSA and both negative parental perceptions and more punitive discipline styles, those relationships dissipated when depression and partner violence were examined at the same time.

Barrett (2010) also looked at the possible influence of adult psychopathology (i.e., depressive symptoms) and other childhood factors (i.e., childhood physical abuse (CPA) and witnessing domestic violence) on parenting among women with history of CSA. The participants in the study consisted of 483 women who were given self-report measures to assess adult functioning (i.e., depressive symptoms, intimate partner violence, SES) and parenting issues (i.e., parenting stress, parental warmth, discipline). The results revealed that women with a history of CSA reported higher levels of depressive symptomology.
and intimate partner violence compared to those without a history of CSA. Interestingly, while CSA was significantly associated with parental warmth, psychological aggression, and corporal punishment, two of those variables were mediated by intimate partner violence. Specifically, a lifetime history of intimate partner violence mediated the relationship between CSA and parental warmth, while recent intimate partner violence (within 12 months) mediated the relationship between CSA and psychological aggression. When depressive symptomology was added to the analysis, intimate partner violence was no longer significantly associated with parental warmth, suggesting that depression mediates the relationship between CSA and parental warmth. This was not true for psychological aggression, as intimate partner violence remained a significant mediator between CSA and psychological aggression despite the addition of depressive symptomology. In terms of corporal punishment, CSA had a direct effect, regardless of whether intimate partner violence or depressive symptomology was present; however, CSA’s impact became non-significant when history of CPA and witnessing domestic violence was added. Overall, the findings from this study suggest that CSA does not directly affect later parenting. Rather, these findings indicate that the relationship is mediated by other childhood adversities (i.e., CPA or witnessing domestic violence), or issues in adulthood such as intimate partner violence or depression symptomology.

Seltman and Wright (2013) also found depression to be a mediator between CSA and later parenting problems while investigating risk and protective factors for effective parenting. Participants in this study included 54 women who were given self-report measures to assess current parenting and depressive symptomology. The results indicated that depression mediated the relationship between CSA and later parenting,
especially in terms of attachment, limit setting, communication, and involvement. While current partner support was found to be a protective factor, this finding was only true if the participant experienced low levels of depressive symptomology. Specifically, the protective factor of partner support dissipated when the mother was experiencing high levels of depressive symptomology. Overall, this study provided more evidence that CSA indirectly affects later parenting via depression.

Banyard, Williams, and Siegel (2003) expanded the research on the role of maternal depression as a mediator between CSA and parenting by also examining the impact of multiple trauma exposure and the effects of possible protective factors. The study sought to determine not only the unique impact of child maltreatment on later parenting behaviors/perceptions, but also to examine how these traumatic events (i.e., CPA, CSA, and witnessing violence) combined together to increase problems with parenting. The authors hypothesized that multiple traumas would increase risk for maternal problems and that depression would act as a mediator between childhood maltreatment and parenting. Participants in this study included 152 mothers, of whom 109 (71.7%) had a history of CSA. Results indicated that while adult sexual assault, CPA, and adult intimate partner violence were all associated with later parenting problems, CSA or witnessing violence as a child showed no such relationship. When the authors combined traumas to determine whether multiple traumas led to a greater impact on poor parenting outcomes, a significant relationship was found. Specifically, the more trauma exposure one endured, the greater the likelihood for decreased parental satisfaction, more neglectful behaviors, higher risks of protective service involvement, and more physical discipline used. Since CSA alone did not have an effect on any of the parental outcomes,
depression could not be examined as a mediator between CSA and later parenting. However, the authors found that maternal depression mediated the relationship between multiple traumas and parenting satisfaction but not the other three parenting outcomes. Contrary to previous research, the results of this study failed to find a relationship between CSA and later parenting problems. Furthermore, results from this study indicated that traumas in adulthood significantly impacted poor parenting outcomes more so than the childhood traumas.

**Post-traumatic stress disorder (PTSD).** PTSD is one of the most studied sequelae among CSA survivors (Neumann, Houskamp, Pollock, & Briere, 1996; Snider, 2007; Widom, 1999) with development of PTSD seen as one of the most prevalent risks for CSA survivors (Bremmer, Vermetten, & Kelley, 2007; Ginzburg et al. 2009; Kolko et al. 2010). For example, Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) found that sexually abused individuals tended to have the highest rates of PTSD compared to victims of other types of traumas, including combat and physical abuse. Several other studies with sexually abused children have found increased rates of PTSD (McLeer, Deblinger, Atkins, Foa, & Ralphe, 1988), even when compared with children who experienced physical abuse (Deblinger, McLeer, Atkins, Ralphe, & Foa, 1989).

Despite the substantial literature on the relationship between CSA and PTSD, research on how that association may influence later parenting is scarce. While studies have found PTSD to have a negative impact on parental satisfaction among Veterans (Berz, Taft, Watkins, & Monson, 2008; Samper, Taft, King, & King, 2004), no reviews of research have been conducted with CSA survivors. Ammerman, Putnam, Stevens, Chard, and Van Ginkel (2012) attempted to clarify PTSD’s potential role on later
parenting through examination of the differences between depressed mothers with and without comorbid PTSD/PTSD symptom severity. However, while the authors stated that the majority of the traumas reportedly experienced by the women in the PTSD group were CSA (31.4%) or sexual assault as an adult (22.9%), this study did not specifically focus on how PTSD affected parenting of CSA survivors. Nonetheless, the study found that mothers who had a comorbid diagnosis of PTSD/PTSD symptom severity and Major Depressive Disorder (MDD) were found to experience more impairment in both maternal social and emotional functioning, as well as various issues with parenting compared to those with only MDD. Also, those with comorbid PTSD expressed decreased perceived social support compared to those with only MDD. This study highlights the impact that PTSD may have on parenting of CSA survivors; however, it is evident that more research needs to be done in order to fully understand the relationship.

**Maternal anger.** Maternal anger is another psychological issue that has been examined as a potential mediator between CSA and parenting. DiLillo, Tremblay, and Peterson (2000) examined anger as a potential mediator after reviewing research that suggested CSA survivors might have more difficulty coping with childrearing. Specifically, studies have suggested that women with a history of CSA may have more difficulty coping with the emotional demands of raising children and therefore may display more anger or frustration. Furthermore, anger regulation has been noted as a common difficulty among survivors of CSA (Briere, 1992; Briere & Runtz, 1998; Courtois, 1988; Donaldson & Gardner, 1985; Scott & Day, 1996). The participants in their study included 290 women who completed a clinical interview and self-report measures. Individuals who reported a history of CSA reported significantly more
attitudes and behaviors associated with abusive parenting and higher levels of psychological distress, including anger, compared to those who did not report CSA. Consistent with the authors’ hypothesis, anger mediated the relationship between CSA and later parenting problems, even after controlling for confounding CPA. Overall, while studies have begun to briefly examine the role of depression, PTSD, and anger on parenting of CSA survivors, conflicting results have been found with the need for further clarification.

Family of origin effects. Some scholars have argued that it is difficult to tease apart the effect of CSA on parenting from the effect of general dysfunctional family dynamics (Alexander and Lupfer, 1987; Harter, Alexander & Neimeyer, 1988). For this reason, Alexander (1992) encouraged the examination of family of origin effects, which has been defined as conflicts in the household, anger, level of supportiveness, structure, and control (Moos & Moos, 1994) and other forms of abuse, neglect, or rejection (Gold, 2000). That notion appears especially important considering that some research has found that family environment is a stronger predictor of long-term problems compared to the CSA itself. For example, Friedrich, Beilke, and Urquiza (1987) examined behavior problems among individuals with a history of CSA and found that characteristics of their family (decreased cohesion, conflict) were more predictive of future problems than any of the abuse variables (severity, duration, etc). Gold (2000) developed a “contextual theory” about family of origin effects, which specified the role that a dysfunctional family environment plays in the development and maintenance of psychopathology for CSA survivors, independent of the specific abuse characteristics. According to this theory, CSA survivors’ family of origin would be expected to have a greater degree of
dysfunctional family characteristics, regardless of whether CSA was intrafamilial or extrafamilial (Gold, Hyman, Andres-Hyman, 2004), compared to non-CSA survivors.

Gold’s rationale was rooted in the belief that aside from the abuse, individuals experiencing CSA tend to have more neglect, rejection, and inability to learn basic living skills such as coping, social, and instrumental skills. Furthermore, he proposed that these dysfunctional family characteristics might precede the actual abuse, thereby, contributing to the onset of the abuse (Gold, 2000). While Gold (2000) argued that family of origin plays a role, he did not believe that it is solely to blame for problems in CSA victims. Rather, he believed the combination of the family environment and the abuse adds to the problems and psychopathology experienced by the victims (Gold, 2000). While several studies have found evidence that family of origin environments of CSA victims are associated with higher rates of dysfunction compared to non-CSA families (Alexander & Lupfer, 1987; Alexander & Schaeffer, 1994; Long & Jackson, 1994; Ray, Jackson, & Townsley, 1991; Williamson, Borduin, & Howe, 1991; Yama, Tovey, & Fogas, 1993), limited research has examined how family of origin effects may perpetuate later parenting problems.

Zuravin and Fontanella (1999) found some evidence that family of origin effects facilitate later parenting problems during their study on CSAs effect on parenting. Specifically, their study noted that there was no longer a significant difference in parenting outcomes between CSA and non-CSA mothers after they controlled for family of origin effects (i.e. verbal abuse, physical abuse, physical neglect, emotional support). Moreover, their results indicated that three of the family of origin variables made a significant difference on parenting including: physical neglect, perceived parental support
and physical abuse. Specifically, physical neglect increased poor parenting outcomes, whereas physical abuse decreased these negative outcomes. Not surprising, individuals with perceived parental support as children also had lower levels of poor parental outcomes. Taken together, this study was an important first look at how additional factors such as family of origin effects may impact future parenting more than the actual CSA itself and again reinforce the need for further work on family of origin variables.

Barrett (2009) expanded upon the earlier research by Zuravin and Fontanella (1999) and also found that other childhood adversities influenced the impact of parenting more so than CSA. Specifically, while examining the effects of CSA on parenting of 483 mothers who were receiving welfare, Barrett (2009) found that CSA led to decreased parental warmth and increased psychological aggression and use of corporal punishment; however, those relationships dissipated when other childhood adversities were included in the model. Interestingly, other childhood problems such as physical abuse, perceived neglect, witnessed domestic violence, lived away from at least one parent, and childhood poverty were also found to significantly effect parenting, but the relationship did not disappear when these other childhood adversities were included in the model. Barrett’s study highlighted the importance of further research to determine the role of additional childhood hardships experienced by victims of CSA on their later parenting.

Unfortunately, aside from Zuravin and Fontanella (1999) and Barrett (2009), few studies have directly assessed the impact of family of origin effects on parenting. One area that has been discussed is the role of intergenerational transmission of abuse. However, compared to the number of studies focusing on the intergenerational transmission of physical abuse, little research has examined the transmission of CSA
from one generation to the next (DiLillo & Damashek, 2004). Research has focused on whether survivors of CSA surround themselves with individuals who are more likely to be sexual abusers (DiLillo & Damashek, 2004).

Oates, Tebbutt, Swanston, Lynch, and O’Toole (1998) examined the relationship between the risk of CSA for children whose mothers had a history of CSA compared to those with no maternal history of CSA. The results indicated that 34% of the mothers of sexually abused children reported a history of CSA compared to 12% of the mothers of the children in the control group. Similarly, McCloskey and Bailey (2000) found that a history of maternal CSA placed children at 3.6 times greater risk for CSA than children of mothers who did not report experiencing CSA. Zuravin et al. (1996) also examined the transmission of abuse and found that the severity of the abuse itself often influenced the risk of transmission: that is, a history of CSA involving intercourse increased the risk transmission of maltreatment, whereas CSA with molestation did not.

Taken together, studies on family of origin effects have suggested that individuals with a history of CSA may have experienced a more problematic childhood in regards to more household problems (i.e., increased conflict, less cohesion, less encouragement, less involvement from the parents), as well as being at an increased risk for other childhood adversities (i.e., CPA, witnessing violence, neglect, etc). Furthermore, studies on intergenerational transmission of CSA also suggest that parents with a history of CSA may be at higher risk for having their own child suffer from CSA compared to those without abuse history. As such, it appears necessary to examine how those factors may also effect later parenting compared to CSA alone.
Methodological Limitations

While the above studies have attempted to clarify the relationship between CSA and parenting, several methodological limitations were noted and need to be addressed in future research. Specifically, a review of this literature reveals problems with study designs, characteristics of and strategies for recruiting of participants, and failing to address extenuating factors such as SES and other current stressful life events (i.e., CPS involvement, welfare, recent domestic violence). Before addressing the limitations, it is necessary to revisit a major concern with the studies -- the lack of a consistent definition of CSA. Since there is no universal definition of CSA, studies vary in how it is defined; therefore, it is difficult to compare the findings and draw firm conclusions. Specifically, since many of the studies do not require cases to be substantiated, the determination of CSA is based on how the author(s) operationalizes it, which can lead to discrepancies across studies and the interpretation of the person in the study. Another problem is that definitions vary in terms of the age of the children included (Senn et al., 2008), use of force (Briere 1992, Briere, et al., 1995; Wyatt, 1985; Wyatt et al., 1992), and sexual act committed (Senn et al., 2008). Furthermore, the questions used to assess CSA were often confusing and may not have been understood by all the participants. In particular, several of the studies were not clear regarding their time frames for the abuse or what they considered to be abuse.

Another problem in the literature on CSA and parenting is the use of retrospective data compared to prospective data. Retrospective data has been an area of concern for several years and has often been found to depend on what the person has been told about their childhood as opposed to actual memories (Radke-Yarrow, Campbell, and Burton,
1970). Furthermore, when people are asked to report on events that occurred in the past, they may rationalize the meaning of past events based on their current situation, which may alter their representation of what actually occurred (White, Widom, & Chen 2007; Widom, 1989a). Henry, Moffitt, Caspi, Langley, and Silva (1994) examined the correlations between prospective and retrospective measures and found little agreement when examining issues surrounding individuals’ psychological processes and family issues. Retrospective self-report data may also not allow individuals to assess all the possible factors or circumstances that were occurring at the time of the abuse, which may have an impact on later functioning. Furthermore, social desirability may affect how an individual reports retrospective information. Specifically, individuals who are involved with child protective service agencies, as many of the participants in the above studies were, may recognize the negative connotation associated with it and, therefore, may reconstruct their own childhood history to help explain their current situation/behavior (Widom, 1989a). Also, some individuals may wish to protect their family and subsequently underreport any potential abuse that occurred in their childhood. Overall, retrospective studies can lead to both underreporting and over reporting of problems, symptoms, histories, etc.

The selection and type of participants chosen for these studies was also a concern and a potential serious limitation to the generalizability of the results. First, several of the participants were self-selected into the studies and drop out and attrition rates were rarely reported. Self-selection is important to address because individuals who volunteer for these types of studies may not represent the overall population of CSA survivors and therefore may bias results. Next, the mothers were often chosen during stressful times in
their lives such as immediately following childbirth, which without follow-up may have presented an inaccurate account of their actual functioning. Furthermore, several of the participants were chosen from larger studies that were addressing specific areas, such as domestic violence and therefore, may not be generalizable to broader samples. Additionally, several of the studies used women from low SES backgrounds, which again affects the generalizability of the results. Finally, the lack of male participants in the studies is a serious omission. While the literature on male survivors of CSA is increasing, research pertaining to their prevalence rates and sequelae are still in the early stages and therefore not fully understood. Due to the lack of studies on male victims of CSA, it is difficult to compare potential gender differences in the consequences of CSA (Young, Hartford, Kinder, Savell, 2007). Specifically, while many studies have noted that a history of CSA can have damaging mental health effects on both males and females, other studies have found them to differ in the sequelae (Young et al., 2007; MacMillan et al., 2001; Rind & Tromovitch, 1997). Specifically, some studies have argued that female CSA survivors often exhibit more internalizing disorders (i.e. depression, anxiety), while males exhibit more externalizing disorders (i.e. substance use, antisocial behaviors) (MacMillan et al., 2001). As such, it appears necessary to understand whether CSA affects parenting differently based on gender of the victim.

Finally, existing studies appeared to focus on a few isolated aspects of parenting and failed to consider extenuating circumstances, such as additional family problems during the time of abuse and psychological distress. While a few studies did address these other variables, some confusion still exists on their actual contribution to parenting. For example, while depression was shown to mediate the relationship between CSA and
parenting (Schuetze & Eiden, 2005), this relationship disappeared when family of origin effects were included in the analysis (Zuravin & Fontanella, 1999). Interestingly, another study found depression mediated the relationship between multiple traumas and later parenting, with the traumas often being family of origin effects (i.e. childhood physical abuse) (Banyard et al., 2003). Due to the contradictory nature of the findings, research is needed to identify the factors affecting parenting in CSA survivors and, hopefully, lead to improved treatments. In addition to the problems noted above, Breckenridge (2006) conducted a thematic analysis of the articles on CSA and parenting and noted faulty assumptions about mothers and a lack of consensus among researchers on the impact of CSA. Furthermore, Breckenridge (2006) pointed out that many of the research questions were narrowly focused and designed to elicit negative parenting outcomes while disregarding any positive parenting that may be evident.

**Purpose of the Present Study**

As the review above suggests, there is some empirical evidence that CSA effects later parenting, however, the findings have varied across studies for a variety of reasons. Furthermore, knowledge of mechanisms by which CSA has an impact on later parenting is lacking. To contribute to the literature and to fill some of these gaps, the purpose of this dissertation is to examine the association between CSA and later parenting, while attempting to overcome many of the methodological limitations associated with earlier work. This study will examine how adults with documented histories of CSA handle conflict within their household and whether they display more physical abuse and/or neglect towards their children. Additionally, this study will examine whether this relationship persists, despite controlling for explanatory pathways, such as family-of-
origin effects, or parental psychiatric disorders (i.e., depression, anxiety, anti-social personality disorder, etc.) or hostility. This research uses data from an existing study that has a number of methodological advantages over prior research: (a) an unambiguous definition of childhood sexual abuse, (b) a prospective design, and (c) a control group matched as closely as possible for age, sex, race, and social class background. In addition, this study will broaden the literature by examining CSA’s effect on later parenting of fathers as well as mothers. Overall, this dissertation seeks to expand current knowledge of the impact of CSA on parenting and, hopefully, these findings will have implications for the development of clinical interventions that may be useful when working to help individuals with histories of abuse to achieve better parent-child relationships.

**Hypotheses**

1. Individuals with a documented history of CSA will differ significantly in their parenting compared to a matched control group in terms of how they handle conflict. Specifically, individuals with a history of CSA will report more negative behaviors when handling conflicts within their current household (i.e., verbal abuse, physical abuse), compared to the matched controls with no documented histories of CSA.

2. Individuals with a documented history of CSA will differ significantly in their parenting compared to a matched control group. Specifically, they will be more likely to report maltreatment (i.e., hitting, unable to provide financial support, leaving child at home unattended, or failure to provide food or medical attention), compared to the matched controls with no documented histories of CSA.
3. Individuals who experienced CSA will have higher rates of family of origin problems (i.e., higher rates of conflict within the home and higher rates of family problems), compared to the matched control group. The relationship between CSA and poor parenting outcomes will disappear or be substantially reduced, when control for family-of-origin effects.

4. Individuals who experienced CSA will exhibit higher rates of psychiatric disorders (i.e. major depression, dysthymia, generalized anxiety, post-traumatic stress disorder, antisocial personality, and substance use) and hostility compared to the matched control group. The relationship between CSA and poor parenting outcomes will disappear or be substantially reduced, when controlling for psychiatric disorders and hostility.

5. There will be an interaction between CSA and lifetime psychiatric diagnosis on parenting. Specifically, individuals with a history of CSA and any of the psychiatric disorders studied here (i.e., major depression, generalized anxiety, post-traumatic stress disorder, antisocial personality, and substance use) will report more hitting or neglectful behavior towards their children than those with a history of CSA and no diagnosis and those without CSA and psychiatric disorder.
Method

Design and Participants

The data utilized in these analyses are from a research project based on a cohort design study (Leventhal, 1982; Schulsinger, Mednick, & Knop, 1981) in which abused and neglected children were matched with non-abused and non-neglected children and followed prospectively into young adulthood. The prospective nature of this study allows some issues of causality to be examined and helps to disentangle the effects of childhood victimization from other potentially confounding effects. Because of the matching procedure, the subjects are assumed to differ only in the risk factor: that is, having experienced childhood sexual or physical abuse or neglect. Since it is not possible to randomly assign subjects to groups, the assumption of equivalency for the groups is an approximation. The control group may also differ from the abused and neglected individuals on other variables associated with abuse or neglect. (For complete details of the study design and subject selection criteria, see Widom, 1989b).

The rationale for identifying the abused and neglected group was that their cases were serious enough to come to the attention of the authorities. Only court-substantiated cases of child abuse and neglect were included here. Cases were drawn from the records of county juvenile and adult criminal courts in a metropolitan area in the Midwest during the years 1967 through 1971. To avoid potential problems with ambiguity in the direction of causality, and to ensure that the temporal sequence was clear (that is, child abuse or neglect led to subsequent outcomes), abuse and neglect cases were restricted to

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1 Portions of the description of the design and methods involved in this work are used with permission of Dr. Cathy Spatz Widom, the Principal Investigator on the grants supporting this work.
those in which children were less than 11 years of age at the time of the abuse or neglect incident. Thus, these are cases of childhood abuse and/or neglect.

This dissertation focuses only on individuals with a documented history of CSA. Sexual abuse charges varied from felony sexual assault to more specific charges of fondling or touching in an obscene manner, sodomy, incest, and rape.

A control group was established with children who were matched on age, sex, race, and approximate family social class during the time period of the study (1967 through 1971). Children who were under school age at the time of the abuse and/or neglect were matched with children of the same sex, race, date of birth (+/- 1 week), and hospital of birth through the use of county birth record information. For children of school age, records of more than 100 elementary schools for the same time period were used to find matches with children of the same sex, race, date of birth (+/- 6 months), class in elementary school during the years 1967 through 1971, and home address, preferably within a five-block radius of the abused or neglected child. Overall, there were matches for 74% of the abused and neglected children. This dissertation will utilize those members of the control group who are matched on demographic characteristics with the CSA group (more details will follow).

In the first phase of this research, a large group of children who were abused and/or neglected were followed up through an examination of official juvenile and criminal records and compared with a matched control group of children (Widom, 1989b). The second phase of the research involved the tracing, locating, and interviewing the abused/neglected individuals and matched controls (approximately 22
years later). The follow-up was designed to document long-term consequences of childhood victimization across a number of outcomes (cognitive and intellectual, emotional, psychiatric, social and interpersonal, occupational, and general health). Two-hour follow-up interviews were conducted between 1989 and 1995 and included a series of structured and semi-structured questionnaires and rating scales. The National Institute of Mental Health Diagnostic Interview Schedule revised (DIS-III-R), which corresponds to DSM-III-R diagnoses (Robins, Helzer, Cottler, & Goldring, 1989), was used to gather information regarding psychiatric diagnoses including: alcohol abuse and dependence, drug abuse and dependence, antisocial personality disorder, generalized anxiety, post-traumatic stress, and major depression. The DIS-III-R is a fully structured interview schedule designed for use by lay interviewers. Computer programs for scoring the DIS-III-R were used to compute DSM-III-R diagnoses.

Of the original sample of 153 subjects with court-substantiated cases of CSA, 134 were located (88%) and 96 interviewed (72%). Of the 153 cases, 125 involved sexual abuse only, whereas the other cases (n = 28) involved physical abuse and/or neglect in addition to the sexual abuse. Of the people not interviewed, 3 were deceased (prior to interview), 28 relocated and could not participate, 19 were not found, and 7 refused to participate. Although 96 participants with CSA were interviewed, this analysis will only examine those who reported having at least one child. While examining only those participants with children is restrictive, a previous study using this same sample indicated that there were no significant differences between individuals with a history of CSA and

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2 This research was supported in parts by grants from the National Institute of Justice (86-IJ-CX-0033 and 89-IJ-CX-0007) and National Institute of Mental Health (MH49467 and MH58386).
controls in rates of childlessness (Miller, 2010). Only White, non-Hispanic and Black, non-Hispanic participants are included in these analyses, because of the small number of participants in the CSA sample who are of Hispanic origin or other ethnicity \((n = 4)\).

Finally, these analyses are based on only those controls that are exact demographic matches to the individuals within the CSA sample as opposed to the entire set of controls from the original sample \((n = 520)\). Thus, the final sample is 70 individuals with documented histories of CSA and 70 demographically matched controls.

Approximately 86% of the sample is female and two thirds are White, non-Hispanic (67%). The mean age of the sample at the time of the interview was 29.7. There were no differences between the CSA group and controls in terms of gender, race/ethnicity, or age.

**Procedure**

Participants completed the interviews in their homes or another quiet environment that was appropriate for the interview, if preferred. The interviewers were blind to the purpose of the study and to the inclusion of an abused and/or neglected group. Participants were also blind to the purpose of the study and were told that they had been selected to participate as part of a large group of individuals who grew up in the late 1960s and early 1970s in that area of the country. Institutional Review Board approvals were obtained for the procedures involved in this study at each wave of the study across several academic institutions, and participants gave written, informed consent. For individuals with limited reading ability, the consent form was presented and explained verbally.
Measures

**Childhood sexual abuse.** Childhood sexual abuse was assessed through a review of official records processed during the years 1967–1971 and was limited to cases of children age 11 and younger. The sexual abuse cases came from both family court and adult criminal court. All of the cases were reviewed and those that involved a victim who was 11 years old or younger were selected for this study. Sexual abuse cases had charges ranging from felony sexual assault to more specific charges of fondling or touching in an obscene manner, sodomy, incest, and rape.

**Parenting.** Parents, as defined in this study, were individuals who reported having at least one biological child. Information regarding parenting was obtained through self-report. During the 1989-1995 interviews, participants were asked about the number and ages of their children, and whether they currently lived with them or whether they lived in an alternate setting such as with relatives, an institution, foster care, etc.

**Parent self-reports of maltreatment.** Maltreatment, as defined in this study, is a dichotomous variable (0 = no abuse/neglect, 1 = abuse/neglect) assessed by asking the participants whether they had ever hit or neglected their child. Parents’ reports of their own abusive or neglectful behavior toward their children were obtained from responses to the National Institute of Mental Health (NIMH) Diagnostic Interview Schedule - Revised (DIS-III-R: Robins et al., 1989). The DIS-III-R is a structured interview that provides computer-generated psychiatric assessments based on DSM-III-R criteria (Robins et al., 1989). The interviews were conducted in person by highly trained individuals who were experienced in the administration of the DIS, as well as supervised by the survey company and project staff. To assess parents’ reports of abuse/neglect, questions from the
antisocial personality disorder (ASPD) module of the DIS-III-R were used. Specifically, for physical abuse, participants were asked: “Have you ever spanked or hit any child, hard enough so that he or she had bruises or had to stay in bed or see a doctor?” For neglect, four questions were used: (1) “Has there ever been a period when you did not provide the financial support to your children you were supposed to?”; (2) “Have you sometimes left young children under six years old at home alone while you were out shopping or doing anything else?”; (3) “Have there been times when someone else fed a child (of yours/you were caring for) because you didn’t cook or have food in the house, or has someone kept your children overnight because no one was taking caring of him at home?”; and (4) “Has a nurse, or social worker or teacher ever said that any child (of yours/you were caring for) wasn’t being given enough to eat or wasn’t being kept clean enough or wasn’t getting medical care when it was needed?” If a participant responded yes to any of the above questions, they were given a score of 1 that indicated a self-report of maltreatment. For the purposes of this dissertation, the last two neglect questions (3 and 4) were combined into one variable (Failed to Provide Food or Medical Attention), because of similar substance and very low frequencies of endorsement. These final items in the parent self-report of maltreatment measure were labeled: Hit Child Hard, Did Not Financially Support, Left Child Under 6 years Alone, and Failed to Provide Food or Medical Attention. In addition, a general “any child maltreatment” variable was created that indicated whether the participant had reported yes to any of the individual questions about abuse/neglect.

**Parent reports of handling conflict.** Handling conflict, as defined in this study, is a continuous variable, assessed by information obtained from the participants in
response to a series of questions from the Conflicts Tactics Scale (CTS; Straus, 1973) about their current household. For this measure, participants were asked “in your own family or household, when you disagree or get annoyed with another person, how do you handle problems: During the last year (past 12 months), how often did you…?” For example, the participants were asked how often did they: “discuss an issue calmly,” “get information to back up your side of things,” sulk and/or refuse to talk about it,” “do or say something spiteful,” “push, grab, or shove someone,” “throw, smash, hit, or kick something,” or “beat someone up.” Scoring for this measure is based on the frequency with which participants engaged in these behaviors, with the following response options: 0 = never, 1 = once, 2 = twice, 3 = sometimes, 4 = frequently, and 5 = Most of the time. The various questions were then put into the following five subscales based on the nature of their content: Reasoning, Verbal Aggression, Minor Violence, Severe Violence, and Very Severe Violence. The subscales scores were computed by calculating the sum of participants’ responses to various questions. The Reasoning subscale was computed by calculating the sum of the participant’s responses to how often they discussed an issue calmly, got information to back up your side of things, and settled things to resolve a conflict. The verbal aggression subscale was computed by calculating the sum of the participant’s responses to how often they often insulted/swear, sulked, stomped, cried, made spiteful statements, or threatened to resolve the conflict. The Minor Violence subscale was computed by calculating the sum of participant’s responses to how often they threw something, threw something at someone, shoved someone, or spanked someone to resolve the conflict. The Severe Violence subscale was computer by calculating the sum of the participant’s responses to how often they kicked, hit or
attempted to hit, beat, burned, threatened with a weapon, or used a weapon to resolve the conflict. The Very Severe Violence subscale was computed by calculating the sum of participant’s responses to whether they ever kicked, used their fist, beat, burned, threatened with a weapon or used a weapon to resolve the conflict. It is important to note that this measure does not specifically refer to how the participant handles conflict with their children; rather it refers to how the participant handles conflict within the home. Therefore, the participant may be referring to conflict with any person who lives in the household (i.e., significant others, children, etc.).

**Psychiatric diagnoses.** Psychopathology, as defined in this study, was assessed based on responses to the NIMH DIS-III-R. For the purposes of this dissertation, the following diagnoses were included: major depressive disorder (MDD), dysthymia, post-traumatic stress disorder (PTSD), generalized anxiety disorder (GAD), antisocial personality disorder (ASPD), and alcohol and drug abuse/dependence, as these have been most often implicated in the CSA literature (Banyard et al., 2003; DiLillo et al., 2000; Lev-Wiesel et al., 2009; Schuetze & Eiden, 2005; Zuravin & Fontanella, 1999). Based on responses to those questions, dichotomous variables were calculated with 0 = no lifetime diagnosis and 1 = lifetime diagnosis. Lifetime measures, rather than current, were used, because the latter measures are highly responsive to immediate life circumstances and so can mask long term but fluctuating mental health consequences associated with childhood experiences. In addition, reliance on current outcome measures would eliminate persons who suffered from adverse psychological consequences in the past, but were not ongoing at the time of the interview. The use of lifetime measures, however, raises issues of cause and effect. Although the assumption is that the occurrence of
symptoms follows, rather than precedes, CSA, the reliance on lifetime diagnoses of mental health means these data cannot be used to untangle the causal sequences between states of mental health and various stressors over the life course.

**Levels of hostility.** Hostility was assessed using the six-item hostility subscale of the Symptom Checklist (SCL-90; Derogatis, 1977). For this scale, the participants were asked to rate the frequency in which they experienced the following hostile feelings/behaviors over the past year: (1) easily annoyed, (2) temper outbursts, (3) urge to injure someone, (4) urge to break things, (5) got into arguments, and (6) shout or throw things. The responses were obtained through a 5 point Likert scale with the following responses: 1 = never, 2 = rarely, 3 = occasionally, 4 = frequently, 5 = Always-Almost Always. The mean of the responses from these six items were then computed and placed into one item of hostility.

**Family of origin effects.** Family of origin effects, as defined in this study, is a continuous variable, assessed by information obtained from the participants in response to a series of questions from the Conflicts Tactics Scale (CTS; Straus, 1973) about their childhood household. Specifically, participants were also asked how conflicts were resolved in their household “when they were growing up” by rating a list of things that their parents or the people in their family might have done when they had a disagreement with the participant when they were growing up, up until the time the participants finished elementary school. Specifically, the participants rated how often their parents or family members did various behaviors during an argument such as: “discuss an issue calmly,” “stomp out of the room or house,” “slap or spank you,” “hit you or try to hit you with something,” “do or say something to spite you,” and “threaten you with a knife or
The various questions were then put into the following five subscales based on the nature of the content: Reasoning, Verbal Aggression, Minor Violence, Severe Violence, and Very Severe Violence. Scoring for this measure was based on the frequency with which participants engaged in these behaviors, with the following response options: 0 = never, 1 = once, 2 = twice, 3 = sometimes, 4 = frequently, and 5 = Most of the time. The Reasoning subscale was computed by calculating the sum of the participant’s responses to how often their parent’s family discussed an issue calmly, got information to back up your side of things, and settled things to resolve a conflict. The verbal aggression subscale was computed by calculating the sum of the participant’s responses to how often their family insulted/swore, sulked, stomped, cried, made spiteful statements, or threatened to resolve the conflict. The Minor Violence subscale was computed by calculating the sum of participant’s responses to how often their family threw something, threw something at someone, shoved someone, or spanked someone to resolve the conflict. The Severe Violence subscale was computed by calculating the sum of the participant’s responses to how often their family kicked, hit or attempted to hit, beat, burned, threatened with a weapon, or used a weapon to resolve the conflict. The Very Severe Violence subscale was computed by calculating the sum of participant’s responses to how often their family ever kicked, used their fist, beat, burned, threatened with a weapon or used a weapon to resolve the conflict.

**Family problems.** During the 1989-1995 interviews, participants were asked several questions about their families, including whether their parents had a history of divorce, drug or alcohol abuse, legal or employment problems, or had died. Each
question was coded as a dichotomous variable with 0 = no family problem and 1 = family problem.

**Analysis**

Chi square analyses, multivariate analyses of variance (MANOVAs), and logistic regressions were conducted using SPSS 21 to assess differences between the CSA and matched control groups in terms of parenting behavior. Analyses also examined differences between CSA and matched controls on family-origin effects and lifetime psychiatric diagnoses. A power analysis was conducted using G*Power (Faul, Erdfelder, Lang, & Buchner, 2007), setting the parameters at alpha < .05 and a medium effect size of .20. Results showed that 127 participants were needed for the MANOVA analysis; therefore, with a sample size of 140, the study was adequately powered. As the logistic regression required 198, it was underpowered for a medium effect size.

MANOVAs were used with continuous variables to determine whether the CSA group differed from the matched control group on how conflict was handled in their current household, as well as their household when they were children, as measured by the CTS. Chi square analysis and logistic regressions were used with dichotomous variables to examine whether there were differences in the two groups in regard to any self-reports of maltreatment towards their children and lifetime diagnoses of psychiatric disorders (i.e., MDD, GAD, PTSD, ASPD, and alcohol and drug abuse or dependence). Finally, a one-way analysis of variance (ANOVA) was computed to determine whether there were differences in hostility levels between the CSA and control group. Because of the matching of demographic characteristics of the CSA and control group participants to determine the sample for this study, both groups are similar in terms of age, sex, and race.
Also, the CSA and matched control group did not differ in terms of current SES. However, the CSA and matched control group did differ significantly in terms of level of education, with the CSA group reporting lower levels of education than the matched controls, $\chi^2 (1, N = 140) = 6.59, p = .01$. Therefore, education was controlled in subsequent analyses (see Table 1).
Results

Childhood Sexual Abuse and Parenting: Self-Reports of Handling Conflict

The first hypothesis predicted that individuals with a documented history of CSA would differ in their parenting and how they handle conflict compared to the matched controls. To examine this hypothesis, a MANOVA was conducted with history of abuse (CSA vs. controls) as the independent variable and scores on the five sub-scales of the Conflict Tactics Scale (i.e., Reasoning, Verbal Aggression, Minor Violence, Severe Violence, Very Severe Violence) as the dependent variables (see Table 2).

The results of the one-way MANOVA revealed marginal significance for the main effect of history of CSA, Wilks’ λ = .927, F (5, 132) = 2.08, p = .07, partial eta squared = .07. There was also a marginally significant effect on the Very Severe Violence subscale; however, it was in the opposite direction of the hypothesis. Specifically, the analysis revealed that there was a trend for individuals in the matched control group to report the use of severe forms of violence (i.e., kick, hit, burn, threaten with weapon, etc.) to handle conflict in their current households (M = .29, SD = .89) at higher rates than the CSA group (M = .14, SD = .43); F (1, 136) = 3.09, p = .08, partial eta square = .02. There were no significant differences between the two groups on the other four CTS subscales. Notably, analysis of the CTS subscales also revealed that while the CSA group reported higher means on reasoning, verbal aggression, and minor violence, the matched controls reported higher scores on severe violence and very severe violence. Therefore, the results of this analysis did not provide support for the first hypothesis (see Table 2).
Childhood Sexual Abuse and Parenting: Self-Reports of Maltreatment

The second hypothesis predicted that individuals with a documented history of CSA would be more likely to report hitting or neglectful behavior toward their children compared to matched controls. Chi square analysis revealed that there was no significant relationship between CSA and any of the maltreatment variables (see Table 3).

Furthermore, the results of the logistic regression indicated that CSA did not predict any of these self-reported behaviors of maltreatment, controlling for level of education. That is, a history of CSA did not predict higher rates of reports of hitting their children, failing to provide financial support, leaving them unattended, or neglecting them in terms of food or medical care (See Table 4).

Childhood Sexual Abuse and Potential Explanatory Pathways: Family of Origin Problems

In terms of family of origin problems, it was hypothesized that individuals who experienced CSA would report higher rates of conflict within their childhood homes compared to matched controls. To examine this hypothesis, a MANOVA was conducted with history of CSA as the independent variable and scores on five subscales of the CTS (i.e., Reasoning, Verbal Aggression, Minor Violence, Severe Violence, Very Severe Violence) regarding how conflict was handled in the participants’ homes when they were children as dependent variables (see Table 5). A one-way MANOVA revealed a significant main effect for CSA, Wilks’ $\lambda = .888$, $F(5, 131) = 3.30$, $p < .01$, partial eta squared $= .11$, showing that individuals with a history of CSA reported higher rates of family of origin problems based on CTS scores than matched controls, providing support for hypothesis 3. Further examination of the CTS subscales showed that individuals with
A history of CSA reported higher rates of household conflict compared to the controls on three of the five subscales. On the Verbal Aggression subscale, individuals with histories of CSA reported higher rates of conflict in their childhood homes that involved using insults, swearing, and making threats (M = 4.10, SD = 1.83) as compared to controls (M = 3.39, SD = 1.88); F (1, 135) = 5.77, p = .02, partial eta square = .04. Similarly, on the Severe Violence subscale, those who experienced CSA reported that conflicts in their childhood homes was solved by engaging in severe behaviors (i.e., kick, hit, etc.) (M = 1.57, SD = 1.78) at higher rates than controls (M = .79, SD = 1.15); F (1, 135) = 8.56, p = .00, partial eta square = .06. Finally, on the Very Severe Violence subscale, CSA victims reported that conflicts in their childhood homes was solved by using several severe forms of behavior (i.e., kick, hit, burn, threaten with weapon, etc.) (M = 1.03, SD = 1.42) at higher rates than controls (M = .39, SD = .76); F (1, 135) = 9.99, p = .00, partial eta square = .07 (See Table 5).

As the majority of studies that have examined family of origin effects among CSA survivors have focused solely on females (Gold, Hyman & Andres-Hyman, 2004; Ray et al., 1991; Zuravin & Fontanella, 1999), additional analyses were conducted using only women in the current sample. Among women only, individuals with histories of CSA reported more family of origin violence on the three subscales (Verbal Aggression, Severe Violence, and Very Severe Violence), compared to controls. Interestingly, one additional CTS subscale emerged as significant. Specifically, on the Minor Violence subscale, women with a history of CSA reported that conflicts in their childhood homes were solved via throwing, shoving, or spanking someone at significantly higher rates (M
= 2.46, SD = 1.28) as compared to controls (M = 1.87, SD = 1.36); F (1, 116) = 5.20, p = .02, partial eta square = .04.

Notably, while examination of women only in the study found that the CSA group differed from matched controls on an additional CTS subscale compared to when looking at both genders in the model, the analysis did not reveal gender differences on family of origin effects. Specifically, results of an additional MANOVA revealed no main effect for gender, Wilks’ λ = .976, F (5, 132) = .64, p = .67, partial eta squared = .02. Furthermore, examination of the CSA group alone failed to find any significant differences between male and female participants, Wilks’ λ = .868, F (5, 62) = 1.88, p = .11, partial eta squared = .13.

While this study found a significant association between a history of CSA and family-of-origin problems, an analysis determining whether that relationship would lead to a substantial reduction in effects of CSA on parenting could not be conducted because CSA was not found to be significantly related to parenting problems. Nonetheless, a post-hoc analysis was conducted to determine whether family-of-origin issues were associated with later parenting problems for any of the participants in the current study, irrespective of a history of CSA, in order to further clarify the role of additional childhood adversities. Thus, further analyses compared whether individuals who reported history of family-of-origin problems differed in their reports of any maltreatment (i.e., physical abuse/neglect) compared to those who did not report family-of-origin problems. These results showed that those who endorsed higher rates of severe violence (OR = 0.05, 95% CI 0.00-0.842, p = .04) and very severe violence (OR = 38.90, 95% CI = 1.26-120.85, p = .04) within their childhood homes (family-of-origin) were more likely to report that they hit their child.
In addition to examining family-of-origin effects in regard to level of conflict within the participant’s childhood home, analyses were conducted to determine if there were any differences among their parents in regards to certain family characteristics. Chi-square analyses revealed that individuals with histories of CSA did not differ in the extent to which their parents had problems with arrest, unemployment, divorce, or death, compared to controls (See Table 6).

**Childhood Sexual Abuse and Potential Explanatory Pathways: Psychiatric Disorders and Hostility**

The fourth hypothesis was that a history of CSA would predict higher rates of lifetime psychiatric diagnoses than in matched controls. These analyses revealed a marginally significant difference between CSA and lifetime diagnosis of PTSD, $\chi^2 (1, N = 138) = 3.71, p = .06$; however, no other differences were significant (see Table 7). Furthermore, that marginally significant difference was reduced with the introduction of education in the logistic regression (OR = 1.88, 95% CI - .89-3.93, $p = .09$). The logistic regressions revealed no other significant effects for lifetime psychiatric diagnoses. Although CSA did not significantly predict these psychiatric diagnoses, it is noteworthy that the results were in the expected direction, except for MDD and Drug Abuse/Dependence diagnoses. Specifically, while not significant, individuals in the CSA group reported higher levels of Alcohol Abuse/Dependence, GAD, Dysthymia, PTSD, and ASPD than the matched controls (see Table 8).

Finally, a one-way ANOVA was conducted to determine whether the CSA and control groups differed in terms of hostility. The results indicated that the CSA and control groups did not differ on hostility level $F (1,137) = .415, p = .52$, partial eta
squared = .003. Thus, contrary to the hypothesis, a history of CSA was not associated with higher scores on hostility.

**Interaction between Childhood Sexual Abuse and Lifetime Psychiatric Diagnosis As a Predictor of Self-Reports of Child Maltreatment**

Logistic regression analyses were conducted to examine the fifth hypothesis that predicted that there would be an interaction between CSA and lifetime psychiatric diagnoses, such that those who have a history of CSA and a diagnosis will be more likely to report maltreatment against their children (i.e., hitting or neglectful behaviors) than those with a history of CSA and no diagnosis and those without CSA and psychiatric disorder. These results revealed a significant interaction between CSA and GAD (OR = .04, 95% CI = .00-1.01, p = .05). Specifically, the odds of maltreatment are the lowest when there is no CSA or GAD; however, when both CSA and GAD are present, the odds of maltreatment are highest. The results revealed no other significant interactions between CSA and lifetime psychiatric diagnosis predicting any self-reported maltreatment. It is interesting to note that having a lifetime diagnosis of GAD (OR = 16.85, 95% CI = 1.58-179.76, p = .02) or MDD (OR = 4.97, 95% CI = 1.39-17.82, p = .01) predicted self-reports of any maltreatment (see Table 9).
Discussion

This study examined whether a history of childhood sexual abuse influences aspects of later parenting using a prospective cohort design. Prior to this research, the majority of studies that examined this topic only utilized retrospective self-reports of childhood sexual abuse, whereas this dissertation studied documented cases of childhood sexual abuse and followed these individuals into young adulthood when they were assessed. That process allowed this study to avoid the use of self-selected, specialized populations and eliminated potential confounding influences of other factors such as current SES. The use of court substantiated cases of CSA also helped to eliminate problems with the definition of CSA or inaccurate childhood memories in regard to sexual abuse.

Contrary to the first two hypotheses, the results from this study did not show more parenting problems among individuals with histories of CSA compared to those without such histories. That is, when comparing individuals with a history of CSA and matched controls, there were no significant differences in terms of how they handled conflict within their homes or whether they reported engaging in any physical or neglectful behaviors towards their children. Notably, this finding was consistent for both males and females in the CSA group. While these results were contrary to the hypotheses, the findings were not completely surprising given the conflicting nature of the existing literature. In particular, some studies have found that CSA survivors are more punitive and have more frequent contact with CPS (Banyard, 1997; Spieker et al., 1996; Zuravin & Fontanella, 1999), whereas others have reported that CSA was associated with more permissive patterns of discipline (Ruscio, 2001), and still others have found that CSA
alone had no impact on discipline (Ehrensaft et al., 2014). Interestingly, the studies that found significant differences in punitive parenting styles of CSA survivors often used specialized populations (i.e., primarily African American participants, low-income, involvement in CPS or Family Aid) and retrospective self-report data to obtain information on history of CSA (Banyard, 1997; Ruscio, 2001; Zuravin & Fontanella, 1999), which may have decreased generalizability of their findings to overall CSA population. In comparison, studies that did not find an association between CSA and discipline used participants with documented cases of CSA opposed to relying solely on self-report, suggesting their results might be more accurate in regard to the overall effects of CSA (Banyard et al., 2003; Ehrensaft et al., 2014). As the current study used a prospective, longitudinal design to examine discipline styles and a group of court substantiated sexual abuse cases, these results provide further evidence that CSA alone may not lead to increased risk for more neglect, physical discipline, or conflictual households. Also, while the CSA and match control groups did not differ significantly on the outcomes assessed here, in contrast to expectations, the controls reported the use of severe and very severe violence at higher rates than the CSA group. However, these results should be interpreted with caution due to the low prevalence of responses endorsing these outcomes and the small sample size. Additionally, since the CSA group differed significantly from the matched controls in regard to education, it was subsequently controlled for, and actually found to be significantly associated with severe and very severe violence. This finding is consistent with research by Boe et al. (2014) who found lower maternal education led to more negative discipline. Due to that observed relationship, future research should consider education when examining
maltreatment patterns among CSA survivors to assess whether education impacts that relationship.

In addition to methodological explanations for the lack of significant differences between the two groups, it is important to review the role resiliency factors may have played in these findings. One individual characteristic that has been to lead to higher rates of resiliency among those with a history of maltreatment is gender. Specifically, DuMont, Widom, and Czaja (2007) examined resiliency among individuals with a history of CSA, childhood physical abuse, and neglect and found that females were twice as likely to be resilient in adolescence and young adulthood compared to males. As the sample in the current study was predominantly females, it is possible that the resilience identified by others may have played a role in the findings here and particularly the lack of parental problems in the CSA group. It is also possible that the tendency of girls and women to be more resilient may be related to more supportive responses from those around them following disclosure of the abuse or, less stigmatization of CSA among females than males (DuMont et al., 2007; Rutter, 1987). That belief appears particularly salient for this study, as all of the CSA cases were court-substantiated.

The fact that these cases came to the attention of the court may have some relevance to resilience as well. For example, it is more likely that the court case resulted in the termination of abuse, decreasing potential long-term negative consequences (Paine & Hansen, 2002). This is consistent with the work of Himelein and McElrath (1996) who found that women with a history of CSA who were willing to disclose and discuss the abuse were found to have better emotional adjustment later in life. As the participants in the current study were 11 years of age or younger at the time of the substantiated
abuse, it is possible that early court intervention helped to eliminate any additional abuse and led to decrease in long term effects, including maltreatment of their own children. While future research should continue to explore potential resiliency factors, it may be that early disclosure and belief in victims’ claims of abuse plays a role in consequences of CSA, including parenting problems.

**Family-of-origin effects**

Given that these results showed that having a history of CSA did not influence self-reported parenting (physical discipline, neglect, or how conflict is handled within the home), it was not appropriate to examine whether family-of-origin effects substantially reduced those relationships. Consideration of the characteristics of this CSA sample may provide some insight into the lack of differences in parenting between the CSA and matched control groups. In particular, while this study did not exclude court substantiated CSA participants who also had documented physical abuse or neglect, the majority of individuals examined were believed to have only suffered from CSA. That is noteworthy when one considers the research that addresses the role of other childhood adversities on parenting compared to CSA alone. Specifically, as CSA affects victims in a very personal way, many have argued that it is difficult to identify symptoms directly linked to CSA (Alexander, 1995; Banyard, 1997; Finkelhor, 1990) or to tease apart the effect that CSA has on parenting versus other childhood factors, particularly dysfunctional family dynamics (Alexander and Lupfer, 1987; Harter, Alexander, & Neimeyer, 1988). Moreover, studies have shown that individuals who experience CSA in conjunction with other forms of childhood adversity may differ in their parenting compared to those who only experience CSA (Dubowitz et al., 2001; Zuravin &
Fonatanella, 1999). As such, some have questioned whether previous research highlighting the impact of CSA on parenting may have been erroneously inflated if other childhood issues were not considered. In particular, some have proposed that studies that have found CSA negatively affected parenting may not have thoroughly reviewed whether other childhood adversities were present in those participants and possibly what influenced the parenting opposed to CSA alone (Barrett, 2009; Bailey et al., 2012).

However, analyses to determine whether CSA interacted with family-of-origin effects to lead to later parenting problems also did not find that the combination of those childhood adversities lead to increased risk for parenting problems with this sample.

Interestingly, this study failed to find a significant difference between the CSA and matched control groups in terms of problems among their parents during their childhood (i.e., parents arrested, received welfare, alcohol or drug use, etc). This is noteworthy when considering other research that has used the complete set of this dataset (i.e., childhood physical and sexual abuse and neglect cases) found that the maltreatment group differed significantly from the matched control group on these same parental characteristics. For example, Widom, Czaja, and Paris (2009) found that individuals who experienced childhood abuse or neglect were significantly more likely to have parents that were arrested, received welfare, or engaged in alcohol or drug use. This finding again suggests that the CSA sample used here may not have suffered as many other forms of adversity as individuals with histories of physical abuse and neglect. Taken together, the lack of current parental differences between the CSA and matched control groups combined with the fact that the majority of participants in the CSA group did not have other documented adversities (i.e., physical abuse or neglect) or differ significantly from
matched control group in terms of parental problems may add credence to the view that additional childhood adversities are more likely to affect later parenting than CSA alone. This finding is consistent with Barrett (2009) who found that CSA no longer significantly impacted parenting in terms of parental warmth, psychological aggression, or corporal punishment after controlling for other childhood adversities. Furthermore, Barrett (2009) found that physical abuse and the perception that one was neglected as a child significantly affected parenting on at least one dimension of parenting, regardless of whether CSA was present.

While the CSA and matched control groups were similar in regards to any reported problems among their parents when they were children, the two groups (CSA and controls) differed significantly in regard to how they reported that conflict was handled within their childhood homes. Specifically, individuals with a history of CSA reported that conflict within their childhood homes was solved via negative/maladaptive behaviors, such as verbal aggression and violence, at significantly higher rates than those in the matched control group. This finding is consistent with previous research indicating that CSA survivors’ childhood homes are likely to be more dysfunctional (Gold, 2000; Gold, Hyman, Andres-Hyman, 2004) and, therefore, the possible cause of later parenting problems.

As described earlier, a post-hoc analysis was conducted to determine whether family-of-origin problems were associated with later parenting problems for the participants in the current study, regardless of a history of CSA. Those results indicated that there was only one significant association between family-of-origin problems and current parenting problems and this was for one item, hitting. In particular, those who
endorsed higher rates of severe and very severe violence within their childhood homes were more likely to report that they have hit their child. Those results suggest that while individuals with histories of CSA were more likely to report that they grew up in conflictual homes compared to the matched controls, the current findings indicated that family-of-origin issues did not significantly influence parenting on the majority of areas examined except for hitting. Furthermore, while that one finding (e.g., hitting) may lend minimal support to the notion that a conflictual childhood home may influence later parenting problems, the use of self-report to obtain that result may have influenced the findings. For example, studies have shown that self-reports can be particularly problematic in regard to child abuse data (DeGarmo, Reid, & Knutson, 2006) as there is often a social desirability factor that may prevent parents from accurately identifying their behaviors due to fear of negative repercussions (Bennet, Sullivan, & Lewis, 2006). Therefore, it is possible that those who admitted to engaging in such behaviors reported that they too experienced that type of discipline in order to excuse their own behavior on some level. Furthermore, some have questioned whether a history of maltreatment compromises an individual’s ability to accurately reflect upon their own interpersonal behavior, such as parenting (Bailey, Moran, & Pederson, 2007).

In order to assess the potential influence of self-reports, another post-hoc analysis was conducted to compare self-reports of CSA with documented cases of CSA. In the first interview, all participants were asked whether they had experienced any type of sexual abuse as a child. As expected, the CSA group differed significantly from the matched control group on self-reports of CSA; however, the CSA group did not universally report being abused as a child. A within group analysis of the CSA group was
conducted to determine whether those who self-reported CSA were also more likely to self-report more conflictual childhood household with physical violence on the Conflict Tactics Scale than those with histories of CSA who did not self-report CSA. Interestingly, that analysis revealed that of the individuals in the CSA group, those who self-reported sexual abuse differed significantly from those who did not on four of the five subscales of the Conflict Tactics Scale. Moreover, in the matched control group, those who self-reported any type of childhood sexual abuse also differed significantly from those who did not self-report on the same four variables. Notably, these differences were greater than the between group analysis of CSA and matched control group, which only differed on three on the four scales. Taken together, these analyses suggest that the willingness to self-report childhood sexual abuse is more indicative of reported childhood physical abuse/conflict within childhood home than the CSA itself.

As the majority of studies that have linked CSA and additional childhood adversities to parenting problems have been based on self-reports, the current study suggests that relying on self-reports as the sole data may be problematic and once again reinforces the importance of obtaining documented or court substantiated evidence of such abuse. Furthermore, continued research into the combination of CSA with other traumas endured during both childhood and adulthood may clarify current knowledge of CSA’s influence on parenting. Specifically, Banyard et al. (2003) found that while CSA alone did not negatively impact parenting, it became influential when combined with other traumas, suggesting it may be part of an accumulation effect.
Psychiatric Disorders and Levels of Hostility

In addition to family-of-origin effects, this study also assessed whether CSA was significantly associated with psychiatric disorders and hostility and whether these factors might serve as potential explanatory mechanisms between CSA and later parenting problems. Prior research has reported an association between a history of CSA and psychiatric diagnoses and anger regulation (Bailey, 2008; Bleiberg, 2000; Briere, 1992; Briere & Runtz, 1998; Brewerton, 2007; Courtois, 2000; Hill et al., 2000; Kendler et al., 2000; Scott & Day, 1996; Spitzer et al., 2008; Treuer et al., 2005), and thus, it seemed reasonable to hypothesize these characteristics may impact the relationship between CSA and later parenting problems. However, studies addressing this issue have reported conflicting results regarding the extent to which psychiatric illnesses and anger play a role in parenting (Ammerman et al., 2012; Banyard et al., 2003; Lev-Wiesel et al., 2009; Schuetze & Eiden, 2005; Zuravin & Fontanella, 1999).

In contrast to previous research, this study did not find CSA to be significantly related to any of the psychiatric disorders studied here. While there was a marginally significant relationship between CSA and PTSD, that relationship dissipated when the analysis controlled for education. It should be noted, however, that the findings with regard to psychiatric disorders were in the expected direction for all expect MDD and Drug Abuse/Dependence diagnoses. Surprisingly, individuals with histories of CSA had lower levels of MDD compared to the matched control group. Although not a significant difference, this finding was unanticipated given the past research that has repeatedly shown an association between CSA and depression when looking at both clinical (Gibb, Chelminski, & Zimmerman, 2007) and community (Teicher, Samson, Polcari, &
Anderson, 2009; Wyatt et al., 2004) samples, as well as cross-sectional (Kendler, Kuhn, & Prescott, 2004) and longitudinal (Fergusson, Lynskey, & Horwood, 1996; Schilling, Aseltine, & Gore, 2007) studies. However, those studies relied upon participants’ self-report to determine history of CSA and the majority of them focused on a female sample. Furthermore, other studies have failed to find a significant association between CSA and depression (Widom, DuMont, Czaja, 2007) or have found that the level of depression varies based on the type and severity of CSA (Hulme & Agrawal, 2004).

Widom et al. (2007) was the first prospective study examining the risk of depression among substantiated cases of abuse and found that while those with a history of CSA reported higher levels of depression symptoms, there was not a significant difference between individuals with histories of CSA and the matched control group in regards to current or lifetime diagnoses. Interestingly, while this dissertation also found no significant difference between CSA and matched control groups in terms of MDD, the direction differed, as the control group was found to have higher levels of depression compared to the CSA group. As the only difference between the two studies’ participants was whether they had a biological child under the age of 18 at the time of the data collection, one could surmise that something about parenting may act as a protective factor against MDD. Interestingly, although a significant difference was not found, the results showed that the CSA group reported higher levels of dysthymia compared to matched controls. That finding suggests that while parents with history of CSA tend to experience low-levels of depressive symptomology at higher rates than matched controls, the more severe symptoms needed for MDD diagnoses were not evident.
While the CSA group did not differ significantly in terms of self-reports of any maltreatment against their children or lifetime diagnoses compared to matched controls, there was a significant interaction between CSA and GAD on any maltreatment. Specifically, the results revealed that individuals had the highest rate of engaging in any maltreatment against their children if they had both a history of CSA and lifetime diagnosis of GAD. While studies on GAD’s influence on the relationship between CSA and parenting are sparse, Ehrensaft et al. (2014) recently found that GAD mediated the relationship between CSA and amount of time spent with their children. The significant interaction from this study provides further evidence for a possible relationship between CSA and GAD on parenting and the need for more research on that area.

Overall, this study utilized a prospective, longitudinal design to study the effects of CSA on parenting with particular focus on how they handle conflict or if they engage in physical abuse/neglect. Because of the design of this study, it was possible to eliminate several previous methodological limitations (i.e., use of self-selected, specialized populations) through the use of documented cases of CSA with matched control groups. This study failed to find a direct relationship between a history of CSA and negative parenting practices (i.e., how they handle conflict, physical abuse, neglect), or an indirect relationship via additional pathways such as family-of-origin effects or psychological distress. These findings extend previous knowledge about the consequences of CSA, and suggest that additional aspects of parenting may need to be assessed.
Strengths and Limitations

This study had several strengths that allowed it to extend the current knowledge on CSA and later parenting. Most notably, this dissertation’s prospective longitudinal design eliminated previous issues of relying upon cross sectional studies that only provided a snapshot of CSA’s effect. Also, this study used court-substantiated cases of CSA, which helped ameliorate problems associated with lack of uniform definition and retrospective memory of previous abuse. Additionally, while past studies have mostly used low-income, minority participants, this study had both Caucasian and African Americans and there was no significant difference between CSA and matched controls in regards to SES. Although there was no difference in SES between the two groups, it is important to note that the whole sample was heavily weighted towards the lower end of SES spectrum and thus, these findings cannot be generalized to sexually abused children who come from middle and upper-class families. Finally, this study included fathers as well as mothers, which had been neglected in previous research. As previous studies have almost exclusively focused on the link between CSA and parenting of mothers, these findings suggest that individuals with history of CSA do not differ in their parenting regardless of their gender. Clearly, these findings are preliminary as the number of male participants was low (n = 10); however, these findings are provocative and warrant further investigation.

Despite the strengths, this study also had many limitations that must be acknowledged. First, the use of court-substantiated cases of CSA limits the generalizability of the results because these cases represent only those cases that came to the attention of the court and may reflect more severe forms of abuse. Second, the study
considered these individuals who experienced CSA as one group and did not distinguish between children who had experienced different types of CSA (e.g. penetration vs. fondling). Third, the parenting measures available were limited and therefore may not have captured the construct of parenting as accurately as possible. That is, while this dissertation was able to examine some issues in parenting, such as hitting and neglectful behaviors and how participants handled conflict within their current households, it was not possible to investigate other aspects that have been examined in prior research, such as specific parenting behaviors (i.e., rapport, communication, availability, satisfaction, etc.) and perceptions of parenting. Fourth, information on current parenting and family-of-origin effects were based on self-report measures that may have biased the results. While self-report measures can provide valuable information, because this information is based solely on participants’ account of events, it may not be an accurate depiction. Additionally, since the questions addressed in the parenting measures are sensitive in nature and probe into whether the participants have engaged in any negative behaviors toward their children, the possibility of social desirability must be taken into account.

Also, this study did not collect information on possible childhood interventions (i.e. therapy) that may have led to decreased psychiatric diagnoses or parenting issues later in life. Finally, the small sample size and low number of reported problems by any of the participants, especially on self-report maltreatment variables, clearly influenced some results; therefore additional analyses with larger samples and more questions assessing parenting issues would be beneficial.

**Clinical Implications**
Several clinical implications can be derived from these results. First, the findings from this study suggest that individuals with a history of CSA were not more likely to report increased rates of physical abuse/neglect of their own children in terms of physical abuse or neglect. Although the sample size of the current CSA group was somewhat small, similar findings have been reported in other research (Banyard et al., 2003; Ehrensaft et al., 2014). Therefore, it may be appropriate to consider more seriously the notion that a history of CSA may not directly increase risk for maltreatment of one’s own children. While this study did not find that family-of-origin effects or psychiatric diagnoses predicted later parenting problems, the results showed a significant interaction between CSA and lifetime diagnosis of GAD. As similar findings have suggested that GAD mediates the relationship between CSA and later parenting (Ehrensaft et al., 2014), therapeutic interventions aimed at decreasing anxiety may be appropriate and lead to reduction in offspring maltreatment among individuals with histories of CSA.

Additionally, as the current CSA sample showed resiliency in terms of later parenting issues, this study reinforces the results of previous research that disclosure or early intervention may be effective in terms of reducing problems later in life. While this study did not directly study resiliency, the fact that the cases were brought to the attention of the courts by the time the children were 11 years of age or younger, suggests that continued clinical work on early detection and disclosure may help reduce negative long term effects.

**Future Directions**

This dissertation provided an unusual prospective examination of the relationship between CSA and later parenting and, the findings suggest a number of directions for
further research. First, in terms of gathering information on current parenting, as well as family-of-origin effects, future studies would benefit by obtaining Child Protective Services’ records and other collateral information on participants, rather than relying solely upon self-report data. Second, studies should broaden the areas of parenting assessed to clarify specific aspects that may be impacted by CSA. This appears especially important in order to define what areas of clinical interventions can be used with these parents. As such, collecting data via observational methods, as well as through parenting measures, would be beneficial. Furthermore, as previous studies have indicated that CSA may influence perceptions of parenting more than actual parenting abilities, observational methods may help clarify that issue. Third, while this study did not find that males or females with histories of CSA differed in terms of parenting, the sample was small, so future studies should strive to determine if these results would be replicated with more participants. Fourth, since education was found to influence the relationship between CSA and PTSD, as well as have a significant relationship with current parenting variables (i.e., use of severe and very severe violence to handle conflict), future studies need to control for its impact. Particularly, since many previous studies that have found CSA to negatively impact parenting utilized participants from low-income backgrounds, it is possible that those participants had lower levels of education, which may have influenced the findings. Fifth, as some studies have found that individuals who appear to be resilient earlier in their lives may succumb at later points in their lives (DuMont et al., 2007), it would be beneficial to examine any problematic parental issues among individuals older than the current sample, who were primarily in their mid to late 20s. Specifically, it would be worthwhile to re-examine these individuals as they and their children age.
Finally, future studies should address the impact of current adult problems, such as intimate partner violence, as other researchers have found that additional adversities are likely to interfere with a person’s ability to parent.
Table 1

*Background Characteristics for Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls*

<table>
<thead>
<tr>
<th></th>
<th>Childhood Sexual Abuse (N = 70)</th>
<th>Matched Controls (N = 70)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Females</td>
<td>60</td>
<td>85.70</td>
<td>60</td>
</tr>
<tr>
<td>White, non-Hispanic</td>
<td>47</td>
<td>67.10</td>
<td>46</td>
</tr>
<tr>
<td>12+ years Education</td>
<td>33</td>
<td>47.10</td>
<td>48</td>
</tr>
<tr>
<td>Current Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-25</td>
<td>5</td>
<td>7.10</td>
<td>4</td>
</tr>
<tr>
<td>26-30</td>
<td>31</td>
<td>44.30</td>
<td>31</td>
</tr>
<tr>
<td>31-35</td>
<td>30</td>
<td>42.90</td>
<td>33</td>
</tr>
<tr>
<td>36-40</td>
<td>4</td>
<td>5.70</td>
<td>2</td>
</tr>
<tr>
<td>Current SES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled/Menial</td>
<td>38</td>
<td>54.30</td>
<td>31</td>
</tr>
<tr>
<td>Skilled/Small Business</td>
<td>8</td>
<td>11.40</td>
<td>4</td>
</tr>
<tr>
<td>Clerical/Sales</td>
<td>15</td>
<td>21.40</td>
<td>19</td>
</tr>
<tr>
<td>Technical/ Administrative Executive</td>
<td>9</td>
<td>12.90</td>
<td>13</td>
</tr>
</tbody>
</table>

*Note.*  
*p = significance*  
*p < .05*
Table 2

Descriptive Statistics for Conflict Tactic Scale (CTS) Subscales for Current Household Functioning in Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th>Variable</th>
<th>CTS-Current Household Functioning</th>
<th>Childhood Sexual Abuse</th>
<th>Matched Controls</th>
<th>df</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasoning</td>
<td></td>
<td>M: 2.38, SD: 0.62</td>
<td>M: 2.33, SD: 0.68</td>
<td>1.00</td>
<td>.22</td>
<td>.64</td>
</tr>
<tr>
<td>Verbal aggression</td>
<td></td>
<td>M: 3.87, SD: 1.80</td>
<td>M: 3.80, SD: 1.60</td>
<td>1.00</td>
<td>.00</td>
<td>.96</td>
</tr>
<tr>
<td>Minor violence</td>
<td></td>
<td>M: 1.67, SD: 1.29</td>
<td>M: 1.33, SD: 1.28</td>
<td>1.00</td>
<td>1.34</td>
<td>.25</td>
</tr>
<tr>
<td>Severe violence</td>
<td></td>
<td>M: 0.33, SD: 0.70</td>
<td>M: 0.50, SD: 1.18</td>
<td>1.00</td>
<td>2.42</td>
<td>.12</td>
</tr>
<tr>
<td>Very severe violence</td>
<td></td>
<td>M: 0.14, SD: 0.43</td>
<td>M: 0.29, SD: 0.89</td>
<td>1.00</td>
<td>3.09</td>
<td>.08</td>
</tr>
</tbody>
</table>

Note. M = Mean; SD = Standard Deviation; df = degrees of freedom; F ratios were generated from Wilks’ Lambda; p = significance

Findings based on multivariate analysis of variance (MANOVA)
<table>
<thead>
<tr>
<th>Self-Reports of Maltreatment Against Children</th>
<th>Total Sample (N = 140)</th>
<th>Childhood Sexual Abuse (N = 70)</th>
<th>Matched Controls (N = 70)</th>
<th>Chi Square</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hit Child Hard</td>
<td>7.10</td>
<td>7.10</td>
<td>7.10</td>
<td>.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Did not Financially Support Children</td>
<td>11.50</td>
<td>12.90</td>
<td>10.10</td>
<td>.61</td>
<td>.74</td>
</tr>
<tr>
<td>Left Children Under 6 years old alone</td>
<td>1.50</td>
<td>1.40</td>
<td>1.50</td>
<td>.00</td>
<td>.99</td>
</tr>
<tr>
<td>Failed to Provide Food or Medical Attention</td>
<td>3.60</td>
<td>5.70</td>
<td>1.40</td>
<td>1.82</td>
<td>.17</td>
</tr>
<tr>
<td>Any Self-Reported Maltreatment</td>
<td>20.70</td>
<td>22.90</td>
<td>18.60</td>
<td>.39</td>
<td>.53</td>
</tr>
</tbody>
</table>

*Note: p = significance*
Table 4

Summary of Logistic Regressions Predicting Self-Reports of Maltreatment Against Children In Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th></th>
<th>Hit Child Hard</th>
<th>Did Not Financially Support Children</th>
<th>Left Children Under 6 years Alone</th>
<th>Failed to Provide Food or Medical Attention</th>
<th>Any Self-Reported Maltreatment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>p</td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>CSA</td>
<td>1.00</td>
<td>.28 - 3.62</td>
<td>1.00</td>
<td>1.00</td>
<td>.28 - 3.62</td>
</tr>
<tr>
<td>CSA</td>
<td>1.02</td>
<td>.27 - 3.81</td>
<td>.98</td>
<td>1.16</td>
<td>.46 - 3.90</td>
</tr>
<tr>
<td>Education</td>
<td>1.11</td>
<td>.29 - 4.24</td>
<td>.88</td>
<td>1.01</td>
<td>.34 - 2.96</td>
</tr>
</tbody>
</table>

Note. OR = odds ratio; CI = Confidence Interval; p = significance
Table 5

Descriptive Statistics for Conflict Tactic Scale (CTS) Subscales for Childhood Household Functioning in Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th>Variable</th>
<th>CTS-Childhood Household Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Childhood Sexual Abuse</td>
</tr>
<tr>
<td></td>
<td>M  SD</td>
</tr>
<tr>
<td>Reasoning</td>
<td>1.82  0.88</td>
</tr>
<tr>
<td>Verbal aggression</td>
<td>4.10  1.83</td>
</tr>
<tr>
<td>Minor violence</td>
<td>2.38  1.28</td>
</tr>
<tr>
<td>Severe violence</td>
<td>1.57  1.78</td>
</tr>
<tr>
<td>Very severe violence</td>
<td>1.03  1.42</td>
</tr>
</tbody>
</table>

Note. M = Mean; SD = Standard Deviation; df = degrees of freedom; F ratios were generated from Wilks’ Lambda; p = significance
Findings based on multivariate analysis of variance (MANOVA)
*p<.05  **p<.01
Table 6
Prevalence of Problems among the Parents of Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th>Reports of Parent Problems</th>
<th>Total Sample (N = 140) %</th>
<th>Childhood Sexual Abuse (N = 70) %</th>
<th>Matched Controls (N = 70) %</th>
<th>Chi Square</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Either parent ever arrested</td>
<td>59.10</td>
<td>62.50</td>
<td>55.90</td>
<td>.51</td>
<td>.47</td>
</tr>
<tr>
<td>Either parent out of work (6+months)</td>
<td>30.20</td>
<td>31.30</td>
<td>29.30</td>
<td>.05</td>
<td>.83</td>
</tr>
<tr>
<td>Natural parents divorced</td>
<td>46.80</td>
<td>49.30</td>
<td>44.30</td>
<td>4.11</td>
<td>.13</td>
</tr>
<tr>
<td>Natural /Adoptive parents death</td>
<td>30.00</td>
<td>35.70</td>
<td>24.30</td>
<td>2.71</td>
<td>.26</td>
</tr>
<tr>
<td>Either parent had alcohol/drug problem</td>
<td>55.00</td>
<td>54.30</td>
<td>55.70</td>
<td>.37</td>
<td>.83</td>
</tr>
</tbody>
</table>

*Note. p = significance*
Table 7

Prevalence of Lifetime Psychiatric Diagnoses in Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th>Lifetime Psychiatric Diagnosis</th>
<th>Total Sample (N = 140) %</th>
<th>Childhood Sexual Abuse (N = 70) %</th>
<th>Matched Controls (N = 70) %</th>
<th>Chi Square</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Abuse and/or Dependence</td>
<td>47.90</td>
<td>54.30</td>
<td>41.40</td>
<td>2.32</td>
<td>.13</td>
</tr>
<tr>
<td>Drug Abuse and/or Dependence</td>
<td>32.40</td>
<td>31.40</td>
<td>33.30</td>
<td>.06</td>
<td>.81</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>24.30</td>
<td>22.90</td>
<td>25.70</td>
<td>.16</td>
<td>.69</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td>7.10</td>
<td>8.60</td>
<td>5.70</td>
<td>.43</td>
<td>.51</td>
</tr>
<tr>
<td>Dysthymia</td>
<td>14.30</td>
<td>15.70</td>
<td>12.90</td>
<td>.23</td>
<td>.63</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>33.30</td>
<td>41.20</td>
<td>25.70</td>
<td>3.71</td>
<td>.06</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td>12.90</td>
<td>15.70</td>
<td>10.00</td>
<td>1.02</td>
<td>.31</td>
</tr>
</tbody>
</table>

Note. \( p \) = significance
Table 8

Summary of Logistic Regressions Predicting Lifetime Psychiatric Diagnoses in Individuals with a History of Childhood Sexual Abuse (CSA) and Matched Controls

<table>
<thead>
<tr>
<th>Lifetime Psychiatric Disorders</th>
<th>Alcohol Abuse and/or Dependence</th>
<th>Drug Abuse and/or Dependence</th>
<th>Major Depressive Disorder</th>
<th>Generalized Anxiety Disorder</th>
<th>Dysthymia</th>
<th>Post-Traumatic Stress Disorder</th>
<th>Antisocial Personality Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA</td>
<td>OR 1.68 (95% CI 0.86 - 3.28) p 1.31</td>
<td>OR 0.92 (95% CI 0.45 - 1.87) p 0.81</td>
<td>OR 0.68 (95% CI 0.40 - 1.86) p 0.69</td>
<td>OR 1.55 (95% CI 0.42 - 5.74) p 0.51</td>
<td>OR 1.26 (95% CI 0.49 - 3.27) p 0.63</td>
<td>OR 2.02 (95% CI 0.98 - 4.16) p 0.06</td>
<td>OR 1.68 (95% CI 0.61 - 4.62) p 0.32</td>
</tr>
<tr>
<td>CSA</td>
<td>OR 1.53 (95% CI 0.77 - 3.01) p 0.23</td>
<td>OR 0.81 (95% CI 0.39 - 1.69) p 0.58</td>
<td>OR 0.96 (95% CI 0.43 - 2.12) p 0.91</td>
<td>OR 1.61 (95% CI 0.42 - 6.17) p 0.49</td>
<td>OR 1.18 (95% CI 0.44 - 3.12) p 0.75</td>
<td>OR 1.88 (95% CI 0.89 - 3.93) p 0.09</td>
<td>OR 1.34 (95% CI 0.47 - 3.80) p 0.59</td>
</tr>
<tr>
<td>Education</td>
<td>OR 0.62 (95% CI 0.31 - 1.25) p 0.18</td>
<td>OR 0.57 (95% CI 0.27 - 1.19) p 0.13</td>
<td>OR 1.71 (95% CI 0.75 - 3.94) p 0.21</td>
<td>OR 1.22 (95% CI 0.32 - 4.68) p 0.77</td>
<td>OR 0.72 (95% CI 0.27 - 1.89) p 0.49</td>
<td>OR 0.69 (95% CI 0.34 - 1.46) p 0.34</td>
<td>OR 0.33 (95% CI 0.12 - 0.97) p 0.04</td>
</tr>
</tbody>
</table>

Note: OR = odds ratio; CI = Confidence Interval; p = significance
*p<.05.
### Table 9

**Summary of Logistic Regressions: Interaction of Childhood Sexual Abuse (CSA) and Lifetime Psychiatric Diagnoses Predicting Any Self-Report of Maltreatment**

<table>
<thead>
<tr>
<th></th>
<th>Any Self-Reports of Maltreatment</th>
<th>OR</th>
<th>95% CI</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA</td>
<td></td>
<td>1.34</td>
<td>.39 - 4.65</td>
<td>.64</td>
</tr>
<tr>
<td>Alcohol Abuse and/or Dependence</td>
<td></td>
<td>1.86</td>
<td>.55 - 6.25</td>
<td>.32</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>.97</td>
<td>.41 - 2.29</td>
<td>.94</td>
</tr>
<tr>
<td>CSA*Alcohol Abuse and/or Dependence</td>
<td></td>
<td>.83</td>
<td>.15 - 4.44</td>
<td>.83</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>.98</td>
<td>.29 - 3.33</td>
<td>.97</td>
</tr>
<tr>
<td>Drug Abuse and/or Dependence</td>
<td></td>
<td>2.96</td>
<td>.86 - 10.24</td>
<td>.09</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>1.15</td>
<td>.47 - 2.84</td>
<td>.76</td>
</tr>
<tr>
<td>CSA*Drug Abuse</td>
<td></td>
<td>2.02</td>
<td>.36 - 11.29</td>
<td>.43</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>1.43</td>
<td>.46 - 4.46</td>
<td>.53</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td></td>
<td>4.97</td>
<td>1.39 - 17.82</td>
<td>.01</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>.76</td>
<td>.31 - 1.86</td>
<td>.55</td>
</tr>
<tr>
<td>CSA*Major Depressive Disorder</td>
<td></td>
<td>.83</td>
<td>.14 - 4.88</td>
<td>.84</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>1.72</td>
<td>.69 - 4.28</td>
<td>.24</td>
</tr>
<tr>
<td>Generalized Anxiety Disorder</td>
<td></td>
<td>16.85</td>
<td>1.58 - 179.76</td>
<td>.02*</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>1.01</td>
<td>.42 - 2.43</td>
<td>.98</td>
</tr>
<tr>
<td>CSA*Generalized Anxiety Disorder</td>
<td></td>
<td>.04</td>
<td>.00 - 1.01</td>
<td>.05</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>.81</td>
<td>.30 - 2.16</td>
<td>.67</td>
</tr>
<tr>
<td>Dysthymia</td>
<td></td>
<td>1.29</td>
<td>.23 - 7.09</td>
<td>.77</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>.94</td>
<td>.38 - 2.29</td>
<td>.88</td>
</tr>
<tr>
<td>CSA*Dysthymia</td>
<td></td>
<td>7.56</td>
<td>.82 - 69.52</td>
<td>.07</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>.62</td>
<td>.17 - 2.24</td>
<td>.46</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td></td>
<td>2.12</td>
<td>.59 - 7.60</td>
<td>.25</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>1.07</td>
<td>.43 - 2.63</td>
<td>.89</td>
</tr>
<tr>
<td>CSA*Post-Traumatic Stress Disorder</td>
<td></td>
<td>3.21</td>
<td>.53 - 19.61</td>
<td>.21</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td>1.12</td>
<td>.42 - 2.98</td>
<td>.82</td>
</tr>
<tr>
<td>Antisocial Personality Disorder</td>
<td></td>
<td>4.19</td>
<td>.79 - 22.21</td>
<td>.09</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td>1.20</td>
<td>.48 - 2.98</td>
<td>.70</td>
</tr>
<tr>
<td>CSA*Antisocial Personality Disorder</td>
<td></td>
<td>1.47</td>
<td>.17 - 12.47</td>
<td>.73</td>
</tr>
</tbody>
</table>

Note. OR = odds ratio; CI = Confidence Interval; p = significance

*p<.05.
References


Washington University, St. Louis, MO.


