Published in final edited form as:

J Child Sex Abus. 2016 January ; 25(1): 110–125. doi:10.1080/10538712.2015.1078867.

Posttraumatic Stress and Depression in the Nonoffending Caregivers of Sexually Abused Children: Associations with Parenting Practices

Lisa Jobe-Shields¹, Carole C. Swiecicki^{2,1}, Darci R. Fritz³, Jessica S. Stinnette³, and Rochelle F. Hanson¹

¹National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, SC

²Dee Norton Lowcountry Children's Center, Charleston, SC

³Children's Hospital of the King's Daughters, Norfolk, VA

Abstract

Caregiver mental health is a known correlate of parenting practices, and recent research indicated that parental depression following childhood sexual abuse disclosure is associated with concurrent parenting difficulties. The present study extended this line of research by investigating posttraumatic stress symptoms and depression in a sample of caregivers ($N=96$) of children who experienced sexual abuse recruited from a Children's Advocacy Center, as well as parenting practices reported by both caregivers and their children (Mean age = 10.79 years, $SD = 3.29$; 79% female). Twenty four percent of caregivers met criteria for presumptive clinical depression, clinically significant posttraumatic stress, or both. Results indicated elevated caregiver-reported inconsistent parenting in the context of clinically significant distress across symptom groups; children reported particularly elevated inconsistent parenting for caregivers with posttraumatic stress only. Caregiver depression was associated with low self-reported positive parenting and caregiver involvement, in addition to self-reported inconsistencies. Directions for future research are offered to further elucidate the relationships between caregiver mental health and parenting practices following childhood sexual abuse.

Keywords

Childhood sexual abuse; parenting; caregiver mental health; caregiver depression; posttraumatic stress

Childhood sexual abuse (CSA) is associated with a range of negative emotional and behavioral outcomes, such as posttraumatic stress (PTS), behavior problems, and depression,

Correspondence concerning this article should be addressed to Lisa Jobe-Shields, Medical University of South Carolina, National Crime Victims Research and Treatment Center, 67 President St., Charleston, SC 29425. ; Email: lisajobeshields@gmail.com
Lisa Jobe-Shields, National Crime Victims Research and Treatment Center, Medical University of South Carolina; Carole C. Swiecicki, Dee Norton Lowcountry Children's Center; Darci R. Fritz, Children's Hospital of the King's Daughters; Jessica S. Stinnette, Children's Hospital of the King's Daughters; Rochelle F. Hanson, National Crime Victims Research and Treatment Center, Medical University of South Carolina.

as well as academic and social difficulties (Putnam, 2003). Childhood sexual abuse also has an emotional impact on non-offending caregivers, who may experience emotional reactions including depression, guilt, shame, and fear (Holt, Cohen, Mannarino, & Jensen, 2014). Non-offending caregiver support and positive parenting behavior have been illuminated as crucial factors in recovery from CSA specifically (Merrill et. al, 2001; Cohen & Mannarino, 2000) and trauma more generally. Yet it is also well-established that when caregivers are distressed or depressed, such as is often documented among caregivers of child victims of CSA, parenting can be negatively impacted. Emotional security theory posits that when parenting is compromised, due to parental distress (e.g., parental depression) or interparental conflict, children may not develop the sense of felt security and safety required for healthy emotional development, and thus, resiliency to stressful life events (Cummings & Davies, 1994). As CSA would be understood to potentially undermine a child's felt security, as well as cause distress to caregivers, emotional security theory guided our investigation into parental distress and parenting behavior in the aftermath of CSA.

When caregivers and children both experience distress in the aftermath of CSA, there may be multiple challenges related to recovery; such as those related to the needs of the caregiver and the child as individuals, as well as the caregiver's specific responsibilities in the parenting role following CSA. New responsibilities include provision of emotional support and ensuring protection following abuse disclosure and navigation of legal, social, and service/mental health systems. Further, CSA may cause direct economic, social, or geographical changes for the family to navigate, such as instances when the perpetrator lived in the home or provided economic support. Additionally, new parenting challenges may arise if children are experiencing emotional and/or behavioral distress in the aftermath of CSA. A caregiver's ability to successfully attend to these novel challenges and provide emotional support to the victimized child is crucial to the recovery process following CSA, even more than abuse-related factors (Tremblay, Herbert, & Piche, 1999).

A recent study by Santa-Sosa and colleagues (Santa-Sosa, Steer, Deblinger, & Runyon, 2013) compared the self-reported and child-reported parenting practices of depressed and non-depressed non-offending biological mothers following CSA. They found 22% of mothers had presumptive clinical depression (using a Beck Depression Inventory-II cut-point of 25), similar to the 26% rate found in a similar sample by Mannarino and colleagues (Mannarino, Cohen, Deblinger, & Steer, 2007). On the Alabama Parenting Questionnaire (APQ), both mothers and children reported higher levels of inconsistent discipline in the context of presumptive clinical depression. Mothers, but not children, also reported higher levels of poor monitoring in the context of presumptive clinical depression. Other subscales (maternal involvement, positive parenting, and corporal punishment) did not differ between groups for mother or child reported parenting. Findings from this study led the authors to conclude that additional research is needed regarding the relation of parenting practices in non-offending caregivers to other sequelae following CSA, such as CSA-specific distress. The present study contributes to the literature by attempting to replicate the findings of Santa-Sosa et al. (2013) and expanding this line of research to include caregiver symptoms of PTS as well as symptoms of depression in relation to parenting practices in a sample of nonoffending caregivers of children who experienced CSA.

Traumatic Stress Reactions in Non-offending Caregivers Following CSA

Learning about their child's CSA can elicit a range of initial emotional and behavioral reactions from non-offending caregivers, including shock, anger, and disbelief/denial, as well as varying levels of expressed support and protection towards the child (Palmer, Brown, Rae-Grant, & Loughlin, 1999; Bolen & Lamb, 2004). Additionally, rates of posttraumatic stress disorder (PTSD) and levels of PTS symptoms (i.e., reflecting both clinical and subclinical levels of symptoms) related to the child's abuse, such as re-experiencing symptoms, physiological hyperarousal, and behavioral, emotional, and cognitive avoidance, have been found to be elevated in non-offending caregivers following their child's CSA disclosure (Timmons-Mitchell, Chandler-Holtz, & Semper, 1996). Levels of PTS were further elevated in caregivers who reported a history of their own CSA (Timmons-Mitchell et al., 1996).

Parenting in the Context of Caregiver Posttraumatic Stress and Depression

There is emerging evidence that the combined impact of depression and PTS on parenting is more detrimental than either condition alone (Ammerman, Putnam, Chard, Stevens, & Van Ginkel, 2012). Yet, to date, few studies have examined this interplay, so we look to the current literature regarding the relation of parenting to each condition independently. A large and impressive literature substantiates the risk for parenting difficulties in the context of maternal depression, including diminished warmth, disengagement, hostility, and controlling behaviors (for review, see Goodman, 2007; Lovejoy, Graczyk, O'Hare, & Neuman, 2000). Relatedly, studies have investigated the PTS-parenting link in a range of populations, as caregivers can experience trauma as children (e.g., CSA, physical abuse) or adults (e.g., adult sexual assault, combat exposure). Also, when children experience trauma, caregivers are often directly (e.g., domestic violence; disaster; car accident) or indirectly (e.g., learning of a child's life-threatening diagnosis) affected. More specifically, cross-sectional studies have indicated that PTS, assessed as both continuous symptom levels or diagnosable PTSD, places caregivers at risk for harsh and hostile parenting behaviors; withdrawal and disengagement, as well as over-involvement and intrusiveness, in the parenting role; and parenting stress and decreased satisfaction (Davies, Slade, Wright, & Stewart, 2008; Field, Muong, & Sochanvimean, 2013; Forcada-Guex, Borghini, Pierrehumbert, Ansermet, & Muller-Nix, 2011; Schechter et al., 2008; Schechter et al., 2005; Zerach, Greene, Ein-Dor, & Solomon, 2012). Although this literature continues to build, there are inconsistent findings—such as those indicating that caregivers with PTS are at elevated risk for engaging in harsh physical punishment (Leen-Feldner, Feldner, Bunaciu, & Blumenthal, 2011), and others reporting decreased risk (Cohen, Hien, & Batchelder, 2008). The majority of this work has focused primarily on caregivers with PTSD or PTS symptoms related to combat trauma, war exposure, or interpersonal violence histories such as childhood abuse (during the caregiver's childhood) or domestic violence. Thus, although the link between PTS symptoms and parenting has been established, it remains unclear whether caregiver PTS symptoms are related to specific parenting challenges in the aftermath of CSA. The present study builds on this literature by investigating caregiver symptoms of both depression and PTS after CSA disclosure in relation to parenting behavior. Information gained may be important in the design and implementation of service options for non-offending caregivers related to their

own mental health, their parenting, or their support and engagement in their child's treatment and recovery from CSA and CSA-related emotional or behavioral problems.

The Present Study

Given the need to better understand the individual and combined impact of both caregiver PTS and depression symptoms on parenting practices, the present study had two aims: (1) to describe rates of clinical depression and clinically significant levels of PTS in a sample of non-offending caregivers following CSA; and (2) to compare self-reported and child-reported parenting practices (positive parenting, poor monitoring, corporal punishment, inconsistent parenting, and caregiver involvement) between four groups of caregivers: those with clinically significant levels of PTS (PTS only), those with clinical depression (depression only), those with both (combined), and those with neither (no condition).

Consistent with previous research, we hypothesized the following: (1) caregivers with presumptive depression would exhibit higher levels of inconsistent parenting than caregivers with no distress; (2) caregivers with depression only would exhibit lower levels of positive parenting when compared to caregivers with no distress; and (3) caregivers with PTS would show similar levels of inconsistent parenting to depressed caregivers, and the group with comorbid PTS and depression would exhibit the most problematic levels of inconsistent parenting. Given the mixed literature regarding increased risk for physical and harsh punishment, we did not form a priori hypotheses regarding the corporal punishment subscale.

Method

Participants included children ($N = 96$) ages 6–17 and their caregivers who were referred by multidisciplinary partners (e.g., child protective services, law enforcement, military family advocacy program) for a clinical assessment at a hospital-based Children's Advocacy Center (CAC). Children were included in the study if their caregivers reported that the child had experienced sexual abuse, as reported on the UCLA PTSD Reaction Index (described below). The term 'caregiver' refers to biological/adoptive parents, stepparents, legal guardians and other custodial guardians (e.g. children living with a relative) who are responsible for the care of the child (Stauffer & Deblinger, 1996). Exclusion criteria included children and caregivers with diagnosed, untreated schizophrenia or other psychotic disorders, or behavior deemed dangerous to themselves or others (e.g., suicidality, homicidality, severe conduct disorder) due to the need for immediate, intensive specialized care. Additionally, caregivers who were suspected or found to have sexually abused a child were not eligible for the study. Although these exclusionary criteria were set, no caregivers of children were excluded from the study for these reasons during the enrollment period. Caregivers and children were not included in the study if they did not complete all of the measures. The study had approval from the program's affiliated Institutional Review Board and Hospital Research Committee.

Participants

Child participants ranged in age from 6 to 17 years ($M = 10.79$, $SD = 3.29$). A majority of the sample (79%) was female. Participants identified their racial background as African American (51%), White (50%), American Indian (5%), Asian (3%), and Native Hawaiian (2%). A total of 10% of the sample also identified their ethnic background as Hispanic/Latino (9.6%). Rates sum to more than 100% due to some participants endorsing more than one racial/ethnic group. Caregivers included biological/adoptive parents, stepparents, legal guardians and other custodial guardians (such as aunts and grandparents).

Procedure

Trained evaluators conducted a clinical assessment, which is the standard clinical protocol for this center, with all participants. Caregivers provided informed consent, and children age eight and older provided assent, to participate in the study. Caregivers completed a measure of their child's trauma exposure, as well as self-report measures of depression, PTSD symptoms related to their child's sexual abuse, and parenting behaviors. Children also reported on caregiver parenting practices. Measures were administered in a combination of formats, including interviews (with children under age 10, or those who expressed difficulty demonstrating comprehension of the first few items read) and self-report forms (read aloud to most child participants under age 13).

Measures

Child trauma history—Child trauma history was assessed using the UCLA PTSD Reaction Index Trauma Screen (UCLA PTSD RI; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998), a self-report questionnaire that includes 13 initial items to assess exposure to traumatic events. Participants answered “yes”/“no” to each of the items, which are written in behaviorally-specific terms.

Caregiver depression—Caregivers' depressive symptoms were measured using the Depression subscale of the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), a standardized measure of psychopathology. The BSI is comprised of 53 items that are rated on a 5-point scale ranging from “Not at All” to “Extremely.” Scores above 2 standard deviations of the established mean on the BSI-Depression Scale (Derogatis & Melisaratos, 1983) were considered indicative of presumable clinical depression for the current study. The BSI-Depression showed high internal consistency in this sample (Cronbach's $\alpha = .86$).

Caregiver PTS—Caregivers' PTSD symptoms were measured using the Posttraumatic Stress Disorder Symptom Scale – Self Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993) which consists of 17 items rated on a 4-point scale, ranging from “Not At All” to “Almost Always” (5 or more times a week/very much). Caregivers completed the PSS-SR answering about their distress related to their child's reported sexual abuse. For the current study, scores above the established cutoff of 28 (Coffey, Dansky, Falsetti, Saladin, Brady, 1998) were considered indicative of clinically significant PTSD symptoms. Internal consistency for the PSS-SR was high (Cronbach's $\alpha = .90$).

Parenting—Caregiver parenting behaviors were assessed using the Alabama Parenting Questionnaire (APQ; Shelton, Frick, & Wootton, 1996), a 42-item measure that has both caregiver- and child-report forms. The APQ generates five subscale scores, including positive parenting, poor monitoring, corporal punishment, inconsistent parenting, caregiver involvement, and other parenting behaviors, with items rated on a 5-point scale ranging from “Never” to “Always.” Internal reliability for the included subscales of the caregiver-report APQ ranged from a low of .56 (Corporal Punishment) to a high of .81 (Positive Parenting). Consistency in child-reported APQ subscales ranged from .54 (Inconsistent Discipline) to .83 (Positive Parenting).

Data Analysis

Assessment data were entered into SPSS databases, which were merged for these analyses, using SPSS v22. Study hypotheses were examined with a series of ANOVAs. Because previous research indicates that child age and gender may be related to parenting behaviors among caregivers of children who experienced sexual abuse (Santa-Sosa et al., 2013), correlational analyses were conducted examining the relationship among child age, gender, and APQ subscales. When relevant, demographic variables with significant relations with outcome variables were included as covariates.

Results

Descriptive Statistics

Caregivers reported that youth had experienced an average of two traumatic events (range 1–7; see Table 1). Caregivers reported experiencing an average of 7.84 PTS symptoms (criteria B, C, and D summed; $SD = 4.58$, range 0–16), and obtained an overall Total PTS mean score of 14.34 ($SD = 10.66$), with a total of 14% ($n = 13$) obtaining scores in the clinically significant range. Participants earned an average BSI-Depression score of 0.64 ($SD = .76$), with a total of 17% ($n = 16$) falling in the clinically significant range. Rates of caregiver membership in the four distress groups (PTS only, depression only, combined, no condition), in addition to mean scores on the APQ subscales, are displayed in Table 2.

APQ Involvement

For caregiver report, there was a statistically significant difference between groups ($F(3, 92) = 4.31, p < .01$). Post-hoc tests indicated that caregivers with depression only had lower scores than caregivers in the no condition group. The three clinical groups were not significantly different from one another. The overall model for child report of involvement was not statistically significant.

APQ Positive Parenting

Age was included as a covariate in models for positive parenting based on preliminary analyses. Results for caregiver report indicated a statistically significant difference between symptom groups ($F(3, 91) = 3.78, p = .01$). Post-hoc testing revealed that the depression only group had lower scores than the no condition or combined groups. Caregivers with only depression or PTS were not significantly different from one another. Regarding child reported positive parenting, no significant group effect was identified, although age emerged

as a significant predictor of child-reported positive parenting. Younger children reported higher levels of positive parenting.

APQ Poor Monitoring

Age was also included as a covariate for the model for poor monitoring (caregiver report), and overall ANCOVA results indicated that higher scores on poor monitoring were related to increased child age. There were no significant differences based on the caregiver distress groups. Since gender was related to child reported poor monitoring, it was included as a covariate. No significant group effects were identified in child reported poor monitoring.

APQ Inconsistent Discipline

For caregiver report, a statistically significant difference across caregiver distress groups emerged ($F(3,92) = 3.97, p = .01$). Post-hoc tests indicated that caregivers with depression only or PTS only had higher scores than caregivers in the no condition group. The combined group did not differ from any groups. For child-reported inconsistent discipline, a statistically significant difference among caregiver distress groups also emerged ($F=4.55, p<.01$). Caregivers in the PTS only group had higher scores than those with no distress or in the depression only group. There was no significant difference between the PTS only and combined groups, nor among the combined group and the other groups.

APQ Corporal Punishment

The overall model for caregiver reported corporal punishment was not statistically significant. For child reported corporal punishment, age and gender were included as covariates, with the overall model only significant for age. No group differences emerged across the caregiver distress groups.

Discussion

The present study aimed to investigate the associations between caregiver depression and PTS and parenting behavior. This investigation builds on existing literature in two ways. First, this investigation extended a recent investigation of differences in parenting behavior in caregivers with and without clinical depression following CSA (Santa-Sosa et al., 2013). One of the recommendations stemming from this prior investigation was to examine other CSA-related mental health reactions in caregivers, such as PTS symptoms related to the child's CSA. Second, the current study adds to the growing literature examining relations between PTS symptoms in caregivers and general parenting behavior by investigating these links in the context of CSA disclosure specifically.

Caregivers' CSA-related Distress

A total of 24% of our sample fell into one of the caregiver distress categories: 10% fell into the depression only group, 7% in the PTS only group, and 6% in the combined group. These findings are consistent with Santa-Sosa and colleagues' recommendations for researchers to consider other types of comorbid conditions when considering depression following CSA. Santa-Sosa and colleagues (2013) characterized 22% of their sample of non-offending mothers as experiencing clinically significant depression (presumptive depression), slightly

higher than the 17% of the current sample which fell into the depression only or combined groups of the present study.

Inconsistent Parenting

Also consistent with Santa-Sosa et al.'s findings (2013), the results of the current study indicate that caregivers with presumptive clinical depression report more inconsistent discipline than their non-clinically depressed counterparts. Similarly, those with clinically significant levels of PTS also reported higher levels of inconsistent discipline than those without distress (and similar to the inconsistency reported by depressed caregivers). Those with comorbid depression/PTS also reported elevated levels of inconsistent discipline; however, their self-reported discipline inconsistencies were not as high as those caregivers with depression or PTS alone and did not differ significantly from other groups. This is inconsistent with findings of research with mothers with PTS and/or depression related to interpersonal violence, which indicated that having both conditions had the most problematic impact on parenting in a study of mother-infant dyads (Ammerman et al., 2012). Inconsistent discipline was the only subscale that evidenced statistically significant differences when considering child report. Interestingly, children reported the highest levels of inconsistent discipline for the PTS only group. Thus, it is possible that although caregivers with depression or PTS recognize that they parent in an inconsistent manner, but parents with PTS may not recognize the extent to which their parenting is inconsistent. Additionally, symptoms which are unique to PTS may impact child-perceived parenting differently. For example, caregivers with clinically significant PTS would expect to be at times preoccupied with re-experiencing symptoms, "on edge" or hyperaroused, or experiencing numbness. Thus, although their parenting would be observed by children as inconsistent, they might not be aware of these inconsistencies. Similarly, as we assessed PTS symptoms specifically related to the child's CSA, it is possible that the child and child-related cues serve as trauma reminders for caregivers which would be expected to trigger avoidance, further complicating parenting in the aftermath of CSA. Although driving factors are important to consider and investigate further, the results of the present study highlight that caregivers who are traumatically distressed following CSA also struggle with consistency in their parenting. This is of clinical interest as consistent parenting practices are implicated not only as a general resilience factor for child development, but also as a factor in developing emotional security, and thus healthy emotional functioning during childhood (Davies & Cummings, 1994).

Other Parenting Behaviors

The present study also found that non-offending caregivers with depression reported less caregiver involvement and positive parenting. This is not consistent with Santa-Sosa et al.'s (2013) findings. It could be presumed that within Santa-Sosa's sample, some mothers were experiencing PTS and depression as well. Thus, by considering these groups separately in the present study, the link between depression and positive involvement/parenting emerged. Caregivers experiencing only symptoms of depression may be particularly vulnerable to parenting difficulties such as decreased playing, complimenting, praising, talking about positive topics, and engaging in fun activities with their children.

Interestingly, caregivers with PTS and comorbid depression/PTS reported generally high levels of involvement and positive parenting (on average) contrary to our hypotheses. Prior research indicates a link between PTS and withdrawal in parenting interactions, as well as intrusiveness in parent-child interactions (Forcada-Guex et al., 2011; Davies et al., 2008; Schechter et al., 2005; Schechter et al., 2008). Similarly, parenting behaviors, such as over involvement and role-reversal, have been found to correlate with parental symptoms of PTS (Field et al., 2013; Zerach et al., 2012). Thus, caregivers with PTS may be “over-engaging” in what could be construed as problematic parenting behaviors following CSA, but which might have reflected as high levels of positive parenting from their own viewpoint. Child reporters, on the other hand, did not report caregivers with PTS or comorbid depression/PTS as displaying high levels of positive parenting or involvement. Future research is necessary to disentangle over-engaged parenting from general self-report bias (i.e., reporting parenting in an overly positive manner) in the reports of caregivers.

A second hypothesis relates to our assessment of PTS symptoms related to a child’s disclosure of CSA. Although this assessment did measure caregiver distress and reactivity to the CSA disclosure, it is unclear to what extent such reactions parallel the syndrome of PTSD. Primary considerations include whether or not a child’s disclosure of CSA could be considered an A1 event, and whether at least one month had passed since CSA disclosure. Thus, it is possible that caregivers who reported high levels of distress regarding CSA disclosure were in fact displaying a typical and perhaps protective, reaction to the disclosure, indicating resiliency rather than PTS. Relatedly, for some caregivers, high levels of distress related to the CSA may be related to high levels of guilt or self-blame, which could translate into “compensatory” parenting behaviors (e.g., attempting to be overly involved or positive; avoidance of behavioral correction; over-indulging children) which may or not be problematic.

Additionally, the present findings suggest that poor caregiver monitoring increases, rather than decreases, with child age. This may be a function of the items on the poor monitoring subscale, which are more common to occur with teenagers (e.g., not knowing your child’s friends) than school-age children. Furthermore, in contrast to prior research, the current results did not demonstrate a significant difference in poor monitoring behaviors between caregivers with and without presumptive clinical depression. It is possible that differences between our sample and the sample in the Santa-Sosa (2013) study may account for this discrepancy as our sample was slightly younger overall which may have contributed to wide variability in monitoring needs of the children.

Conclusions, Limitations, and Future Directions

There is a significant literature supporting the integral role of the caregiving and family context in recovery and resilience following CSA. The present study adds to this literature by identifying linkages between specific aspects of caregiver mental health following CSA and specific aspects of parenting. Thus, researchers would do well to continue to characterize challenges in the caregiving context, including caregiver mental health and parenting practices, and investigate further caregiver PTS, depression, and parenting as they relate to child outcomes. Clinically, we offer the following suggestions for consideration.

First, a focus on consistency in parenting may be warranted when completing parenting intervention, or conjoint therapies that include a parenting component, with the caregivers of children who have been sexually abused. Caregivers may have skills to implement suggested parenting practices, but may have difficulty implementing these strategies under times of stress. Thus, teaching caregivers their own stress management techniques (e.g., deep breathing, mindfulness) may allow them to increase consistency in their parenting. Regarding concern for decreased positive parenting and involvement for caregivers with depression, although this is intuitively consistent with our understanding of depression as a syndrome (e.g., symptoms of withdrawal, anhedonia), clinicians would do well to explicitly tie these parenting behaviors to concerns of caregiver depression and tailor treatment accordingly (e.g., clearly including in the parenting component of trauma focused cognitive behavioral therapy; TF-CBT). Techniques such as behavioral activation within the family context, such as explicitly planning, scheduling, and monitoring mood states in conjunction with positive activities may deserve clinical attention. Direct care workers and others involved in the care of children who have been sexually abused would do well to educate families on these linkages and provide family-based intervention and appropriate referrals when necessary to support the development and maintenance of healing caregiving contexts in families following CSA.

The results of the present study should be interpreted in the context of several limitations. First, our clinical groups were small, as we chose conservative cut-points to indicate clinically significant levels of distress. Second, as some symptoms of PTS are not event-specific, it is unclear to what extent some caregivers were experiencing symptoms of PTS related to other life events. Given the intergenerational links between traumatic stress and abuse, it is likely that many caregivers had experienced trauma, and even CSA themselves, and future research should assess traumatic event exposure and symptomatology accordingly. While a strength of this investigation is the fact that these measures were all part of a standard clinical service interview in a real-world context, the study is limited by the clinical nature of the data (i.e., participants were reporting in the context of seeking or being referred to clinical services) as well as the low level of demographic information available for analysis. Although we had demographic information available for the child participants, we did not have such information available for caregivers, such as family structure or caregiver age. Relatedly, although we had child and caregiver report of parenting behaviors, the study is overall limited by the use of self-report measures which could be biased in a number of ways. For example, caregivers may have limited insight into their emotional states and/or parenting behaviors, or may have felt it was necessary to present their mental health or parenting in an overly positive light. Finally, results should be interpreted in the context of the variation (from low to high) in reliability of the APQ subscales. Although the APQ has been used with families in the aftermath of sexual abuse in prior studies (Santa-Sosa et al., 2013), the variations in reliability may have impacted the results, which deserve replication. Reliability as well as results could have been impacted by the wide age range included in the present study.

Future research could clarify these findings in a number of ways. First, research could include the assessment of caregivers' trauma histories prior to their child's CSA disclosure and PTS symptoms associated with other traumatic events. Additionally, this pattern of

results highlights the importance of nuanced parenting assessment when investigating the parenting behaviors of caregivers with mental health conditions. For example, although caregivers with depression appear to be at risk for engaging in decreased monitoring; the relation between parental PTS and monitoring appears less clear. Further, as inconsistent parenting continues to gain support as a key area of difficulty for caregivers with mental health conditions, research that extends and validates parenting assessments to capture these nuanced difficulties, for example, in short term longitudinal studies (e.g., daily diary studies) or other increasingly ecologically valid studies (e.g., home observation studies), is warranted. Finally, future research should further consider how specific aspects of caregiver mental health and parenting following CSA relate to child functioning following CSA disclosure. As our investigation regarding the caregiver mental health and parenting behaviors was guided by emotional security theory, an investigation of the full emotional security model, including assessment of emotional security in the child, would shed light on potential mediators in the relations between caregiver mental health/parenting and child outcomes in the context of CSA disclosure (Davies & Cummings, 1994).

Acknowledgments

Preparation of the manuscript by Dr. Jobe-Shields was supported by National Institute of Mental Health Training Grant T32 MH18869-26. The views in this article do not necessarily represent those of the agency supporting this research.

References

- Ammerman RT, Putnam FW, Chard KM, Stevens J, Van Ginkel JB. PTSD in depressed mothers in home visitation. *Psychological Trauma: Theory, Research, Practice, and Policy*. 2012; 4(2):186–195. DOI: 10.1037/a0023062
- Bolen RM, Lamb JL. Ambivalence of nonoffending guardians after child sexual abuse disclosure. *Journal of Interpersonal Violence*. 2004; 19(2):185–211. DOI: 10.1177/0886260503260324 [PubMed: 15006001]
- Coffey SF, Dansky BS, Falsetti SA, Saladin ME, Brady KT. Screening for PTSD in a substance abuse sample: Psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. *Journal of Traumatic Stress*. 1998; 11:393–399. DOI: 10.1023/A:1024467507565 [PubMed: 9565924]
- Cohen LR, Hien DA, Batchelder S. The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreatment*. 2008; 13(1):27–38. DOI: 10.1177/1077559507310045 [PubMed: 18174346]
- Cohen JA, Mannarino AP. Predictors of treatment outcome in sexually abused children. *Child Abuse and Neglect*. 2000; 24(7):983–994. DOI: 10.1016/S0145-2134(00)00153-8 [PubMed: 10905421]
- Cummings, EM.; Davies, PT. *Children and marital conflict: The impact of family dispute and resolution*. New York: Guilford Press; 1994.
- Davies P, Cummings EM. Marital conflict and child adjustment: An emotional security theory. *Psychological Bulletin*. 1994; 116:387–411. DOI: 10.1037/0033-2909.116.3.387 [PubMed: 7809306]
- Davies J, Slade P, Wright I, Stewart P. Posttraumatic stress symptoms following childbirth and mothers' perceptions of their infants. *Infant Mental Health Journal*. 2008; 29(6):537–554. DOI: 10.1002/imhj.20197
- Derogatis LR, Melisaratos N. The brief symptom inventory: An introductory report. *Psychological Medicine*. 1983; 13(03):595–605. DOI: 10.1017/S0033291700048017 [PubMed: 6622612]

- Foa EB, Riggs DS, Dancu CV, Rothbaum BO. Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*. 1993; 6(4):459–473. DOI: 10.1002/jts.2490060405
- Field NP, Muong S, Sochanvimean V. Parental styles in the intergenerational transmission of trauma stemming from the Khmer rouge regime in Cambodia. *American Journal of Orthopsychiatry*. 2013; 83(4):483–494. DOI: 10.1111/ajop.12057 [PubMed: 24164520]
- Forcada-Guex M, Borghini A, Pierrehumbert B, Ansermet F, Muller-Nix C. Prematurity, maternal posttraumatic stress and consequences on the mother-infant relationship. *Early Human Development*. 2011; 87:21–26. DOI: 10.1016/j.earlhumdev.2010.09.006 [PubMed: 20951514]
- Goodman SH. Depression in mothers. *Clinical Psychology*. 2007; 3:107–135. DOI: 10.1146/annurev.clinpsy.3.022806.091401
- Holt T, Cohen J, Mannarino A, Jensen TK. Parental emotional response to children's trauma. *Journal of Aggression, Maltreatment, and Trauma*. 2014; 23:1057–1071. DOI: 10.1080/10926771.2014.953717
- Leen-Feldner EW, Feldner MT, Bunaciu L, Blumenthal H. Associations between parental posttraumatic stress disorder and both offspring internalizing problems and parental aggression within the National Comorbidity Survey-Replication. *Journal of Anxiety Disorders*. 2011; 25:169–175. DOI: 10.1016/j.janxdis.2010.08.017 [PubMed: 20880666]
- Lovejoy MC, Graczyk PA, O'Hare E, Neuman G. *Clinical Psychology Review*. 2000; 20(5):561–592. DOI: 10.1016/S0272-7358(98)00100-7 [PubMed: 10860167]
- Mannarino AP, Cohen JA, Deblinger E, Steer R. Self-reported depression in mothers of children who have experienced sexual abuse. *Journal of Psychopathology and Behavioral Assessment*. 2007; 29(3):203–210. DOI: 10.1007/s10862-006-9036-7
- Merrill LL, Thomsen CJ, Sinclair BB, Gold SR, Milner JS. Predicting the impact of child sexual abuse on women: The role of abuse severity, parental support, and coping strategies. *Journal of Consulting and Clinical Psychology*. 2001; 69(6):992–1007. DOI: 10.1037/0022-006X.69.6.992 [PubMed: 11777126]
- Palmer SE, Brown RA, Rae-Grant NI, Loughlin MJ. Responding to children's disclosure of familial abuse: What survivors tell us. *Child Welfare*. 1999; 78:259–282. URL: www.cwla.org/child-welfare-journal/. [PubMed: 10418117]
- Putnam FW. Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2003; 42(3):269–278. DOI: 10.1097/00004583-200303000-00006 [PubMed: 12595779]
- Pynoos, R.; Rodriguez, N.; Steinberg, A.; Stuber, M.; Frederick, C. The UCLA PTSD reaction index for DSM IV (Revision 1). Los Angeles: UCLA Trauma Psychiatry Program; 1998.
- Santa-Sosa EJ, Steer RA, Deblinger E, Runyon MK. Depression and parenting by nonoffending mothers of children who experienced sexual abuse. *Journal of Child Sexual Abuse*. 2013; 22(8): 915–930. DOI: 10.1080/10538712.2013.841309 [PubMed: 24283543]
- Schechter DS, Coates SW, Kaminer T, Coots T, Zeanah CH, Davies M, ... Myers MM. Distorted maternal mental representations and atypical behavior in a clinical sample of violence-exposed mothers and their toddlers. *Journal of Trauma & Dissociation*. 2008; 9(2):127–147. DOI: 10.1080/15299730802045666
- Schechter DS, Coots T, Zeanah CH, Davies M, Coates SW, Trabka KA, ... Myers MM. Maternal mental representations of the child in an inner-city clinical sample: violence-related posttraumatic stress and reflective functioning. *Attachment & Human Development*. 2005; 7(3):313–331. DOI: 10.1090/1461673500246011 [PubMed: 16210242]
- Shelton KK, Frick PJ, Wootton J. The assessment of parenting practices in families of elementary school-aged children. *Journal of Clinical Child Psychology*. 1996; 25:317–327. DOI: 10.1207/s15374424jccp2503_8
- Stauffer LB, Deblinger E. Cognitive behavioral groups for nonoffending mothers and their young sexually abused children: A preliminary treatment outcome study. *Child Maltreatment*. 1996; 1:65–76. DOI: 10.1177/1077559596001001007

- Timmons-Mitchell J, Chandler-Holtz D, Semper WE. Post-traumatic stress symptoms in mothers following children's report of sexual abuse: An exploratory study. *American Journal of Orthopsychiatry*. 1996; 66(3):463–467. DOI: 10.1037/h0080196 [PubMed: 8827269]
- Tremblay C, Hébert M, Piché C. Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect*. 1999; 23(9):929–945. DOI: 10.1016/S0145-2134(99)00056-3 [PubMed: 10505906]
- Zerach G, Greene T, Ein-Dor T, Solomon Z. The relationship between posttraumatic stress disorder symptoms and paternal parenting of adult children among ex-prisoners of war: a longitudinal study. *Journal of Family Psychology*. 2012; 26(2):274–284. DOI: 10.1037/a0027159 [PubMed: 22309816]

Biographies

Lisa Jobe-Shields, Ph.D. is a postdoctoral research fellow at the National Crime Victims Research and Treatment Center at the Medical University of South Carolina.

Carole C. Swiecicki, Ph.D. is the Executive Director of The Dee Norton Lowcountry Children's Center, a licensed psychologist, and a Clinical Assistant Professor at the Medical University of South Carolina in the Department of Psychiatry and Behavioral Sciences.

Darci Fritz, M.S. is a project coordinator at the Children's Hospital of the King's Daughters in Norfolk, VA. Jessica Stinnette is a Research Assistant and evaluator at the Children's Hospital of the King's Daughters Child Abuse Program in Norfolk, VA.

Rochelle F. Hanson, Ph.D. is a Professor and director of the Child and Family Clinic at the National Crime Victims Research and Treatment Center at the Medical University of South Carolina.

Table 1

Traumatic events experienced by child participants (caregiver report)

Trauma Type	% Endorsed
Sexual abuse	100%
Witnessing family violence	26%
Physical abuse	18%
Traumatic illness/bereavement	16%
Medical trauma	12%
Physical assault at school	8%
Accident (e.g., bike, car)	8%
Natural disaster	7%
Witnessing community violence	6%
Seeing a dead body	1%

Table 2

Mean APQ Scores by Subscale and Distress Group

Scale	Overall Sample		No distress		BSI-Depression		2SD		PTS Total		Both BSI-Depression Total 28		2SD and PTS		F value	Partial Eta Squared
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD		
<i>Caregivers</i>																
	(N=96)		(n=73)		(n=10)			(n=7)		(n=6)						
APQ Involvement	38.29	6.14	39.27	5.98	32.3	5.36	37.57	3.82	37.17	6.52	4.31**	0.12				
APQ Positive Parenting	25.95	3.25	26.29	3.22	23.5	3.17	24.86	3.39	27.17	1.47	5.08**	0.18				
APQ Poor Monitoring	13.84	4.14	14.05	4.47	13.3	3.53	13.43	2.57	12.67	2.07	4.60**	0.17				
APQ Inconsistent Discipline	12.41	3.64	11.74	3.43	15.0	4.19	14.71	2.43	13.5	3.89	3.97 (p=.01)	0.11				
APQ Corporal Punishment	4.29	1.40	4.21	1.24	4.7	1.95	4.43	1.13	4.5	2.51	2.42	0.1				
<i>Children</i>																
	(N=95)		(n=73)		(n=9)			(n=7)		(n=6)						
APQ Caregiver Involvement	33.26	8.14	32.95	8.28	33.70	7.92	34.43	5.86	35.00	10.56	0.18	0.01				
APQ Positive Parenting	22.42	5.54	22.1	5.48	22.5	5.52	24.71	5.74	23.5	6.77	2.56*	0.1				
APQ Poor Monitoring	18.11	6.07	18.1	6.62	18.33	3.04	16.71	3.9	19.5	4.89	1.4	0.06				
APQ Inconsistent Discipline	12.67	4.20	12.04	4.08	12.7	3.27	17.57	4.39	14.5	3.21	4.55**	0.13				
APQ Corporal Punishment	5.32	2.74	5.47	2.92	5.78	2.44	4.14	1.57	4.17	1.33	3.49**	0.16				

Note.

* $p < .05$.** $p < .01$.