A TWO ARTICLE EXAMINATION OF THE IMPACT OF CHILDHOOD ABUSE ON PARENTING ATTITUDES AND BEHAVIORS IN ADULTHOOD

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Dedication

This dissertation is dedicated to all the caregivers out there who are doing their best to be a good enough parent. The ones who are making mistakes, working two jobs, yelling at their kids, and then snuggling them and reading them stories as they send them off to sleep at night. Being a parent is the hardest job you will ever have, and there is absolutely no training for it – other than how you were parented - and sometimes that training is just not good. My dedication to parents, children, and families goes deep because of my personal background and trauma history, which is why I feel so deeply for parents who have experienced trauma. It is exceptionally difficult to parent a child knowing all of the bad things that can happen while allowing them the freedoms of childhood. Along with this comes keeping your emotions in check and doing everything you can to keep your children safe – it's a very difficult balance.

I would also like to dedicate this paper to my grandmother Amber Elizabeth Cross who was one of my greatest inspirations and one of the most amazing humans. She left us at age 98 in 2020 and was not here to see my journey toward my doctorate, although she was a significant supporter of it. It is because of her that our family has a long line of strong women, and it is also the reason I am able to advocate for others in the way that I do. This paper is for you Mamoo, I love you and I know you are watching from above.

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The field of social work is immense; however, my passion has always been on children and families. My inspiration in this area has come from greats such as Christine Courtois, Maya Angelou, Brene Brown and many others. There is one quote that I try to apply in every area of work and life, and it is one that comes from Ms. Angelou – “Do the best you can until you know better. Then, when you know better, do better.”

ABSTRACT

A TWO ARTICLE EXAMINATION OF THE INTERSECTION OF CHILD ABUSE ON PARENTING ATTITUDES AND BEHAVIORS IN ADULTHOOD

Background: There are multiple factors that limit one's ability to parent effectively, such as caregiver alcohol and drug misuse, intimate partner violence, financial insecurity, inadequate housing, and caregiver disability. Parental trauma has been identified as a central risk factor for child abuse, which has serious and longstanding consequences for children, families, and society. Many questions remain unanswered in the literature about how best to support parents who have experienced abuse as children in being effective parents themselves. Specifically, the connection between childhood abuse and subsequent parenting attitudes and behaviors, as well as any moderating factors that influence one's ability to parent effectively following the experience of childhood abuse, have not been sufficiently explored.

Objective: To determine if people who report having experienced childhood abuse will endorse more negative parenting attitudes and less effective parenting behaviors in adulthood compared to individuals who do not report a history of abuse. The two specific questions this project aims to examine are: Study 1- Do people who report having experienced childhood abuse report significantly more negative parenting attitudes than individuals who did not report a history of abuse, and does attendance in therapy following childhood abuse moderate this relationship?; and Study 2- Do people who report having experienced childhood abuse report significantly less effective parenting behaviors than individuals who did not report a history of abuse, controlling for household income, and does educational attainment moderate this relationship?

Methods: This correlational, cross-sectional study utilized an anonymous survey at a single time point. Using non-probability sampling, the author sampled 131 participants. Participants were predominantly white (75.6% Caucasian, with 15.3% missing reported racial data) ages 25 to 75 (M=40.86, SD=9.39) and identified as caregivers to a single child or multiple children aged two years or older. Participants completed four validated survey measures electronically. The first was the Dimensions of Discipline Inventory, Part A, which assessed demographic information. Next, the participants were asked about their abuse history via the Adverse Childhood Experiences (ACE's) questionnaire. If the participant answered affirmative to any of the questions in the ACE's questionnaire, they were prompted to answer a dichotomous yes/no question about whether they received therapy related to their childhood abuse. Participants also completed the Alabama Parenting Questionnaire and the Parenting Sense of Competence Questionnaire.

Results: In Study 1, it was demonstrated that higher ACE's scores were associated with lower results related to parenting attitudes (B=-2.51, p=0.002). Attendance in therapy following childhood abuse did not moderate this relationship (F(5, 47)=1.59, p=0.18). Conversely, in Study 2 the relationship between reported abuse in childhood and parenting behaviors was not significant (B=0.68, p=0.26). This was observed when controlling for income, and caregiver educational attainment did not moderate this relationship (F(8, 79)=1.39, p=0.21).

Discussion: In this sample, caregiver reports of childhood abuse were associated with decreased parenting attitudes but not associated with negative parenting behaviors. These studies illuminate aspects of parenting that may and may not be associated with adverse experiences in childhood. There are further opportunities for research in this area with a broader sample.

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Introduction

Child abuse can have a lasting impact on a person both physically and psychologically. There are numerous risk factors that have been associated with surviving childhood abuse, including inadequate housing, reduced access to social supports, increased drug and alcohol use and limited financial means (Centers for Disease Control, n.d.). Unresolved trauma may complicate the relationship between parents who have had Adverse Childhood Experiences (ACE's) and their children, contributing to a reduced capacity for stress and frustration tolerance, challenging closeness and bonding (Iyengar et al., 2014). Intergenerational trauma, which has been increasingly recognized, also may have important long term negative outcomes.

Those with a history of trauma are more likely to have life experiences that they deem uncontrollable and unpredictable and may be more prone to emotional dysregulation. They may experience hypervigilance, anxiety, and negative cognitions, which may also then lead to insensitive or harsh parenting practices (Muzik et al., 2015). More research is needed to understand the full impact that childhood abuse may have on future parenting practices and attitudes.

Risk Factors that Contribute to Child Abuse

According to the United States Department of Health and Human Services (2021), there are several risk factors that may increase the likelihood of childhood maltreatment. These risk factors include caregiver alcohol abuse, domestic violence, drug abuse, financial problems, inadequate housing, public assistance, and caregiver disability. While not included in the Health and Human Services report, intergenerational trauma, the passing down of abuse and/or trauma that is experienced in childhood, as adults, may also be an important factor (Montgomery et al., 2018). The factors noted above may influence daily living skills and abilities, and many of them are themselves exacerbated by a caregiver's experience of abuse and/or trauma. Understanding the connection between abuse in childhood and how it impacts one across the lifespan is vital to understanding how one will parent in the future.

Intergenerational Trauma

Intergenerational trauma is the passing down of trauma from generation to generation, whether done consciously or not, and it does not always include abuse. It is defined by the American Psychological Association (2022) as

> A phenomenon in which the descendants of a person who has experienced a terrifying event show adverse emotional and behavioral reactions to the event that are similar to those of the person himself or herself (APA Dictionary of Psychology, 2022, para.1).

A cycle of violence that is perpetuated from parent to child, in the intergenerational pattern following childhood abuse, is documented to occur roughly 30% of the time (Scott & Copping, 2008). Although not all children who are abused will go on to repeat the cycle, many may be at increased risk for experiencing parenting challenges at some point in their parenting journey.

More research is needed to understand the impact of intergenerational trauma and how best to educate and support parents and keep children safe.

Adverse Childhood Experiences

ACE's are "potentially traumatic events that occur in childhood" (Centers for Disease Control, n.d.) prior to the age of maturity (18). Some examples of ACE's include experiencing violence in the home, being sexually, physically, or emotionally abused by a parent or caregiver, having a family member die by suicide, having a family member or parent go to jail, and witnessing abuse or violence in the home. ACE's are common, with roughly 60% of adults reporting having experienced at least one type of ACE prior to turning 18. The more ACE's one experiences, the greater the risk conferred. People with four or more ACE's tend to have more long-term challenges than those with two or less (Webster, 2022), confirming the importance of reducing childhood abuse.

ACE's are particularly damaging during the early years and may cause long-term changes to the developing brain, contributing to mental and physical health problems later in life (Woods-Jaeger et al., 2018). Abuse in childhood alters the chemistry in the brain, causing neurodevelopmental changes which can lead to deficits in relationships, attachment, and parenting (DiGregorio, 2012). These deficits may impact parenting abilities later in life and reduce the ability of the parent to regulate their emotions, leading them to be unable and/or unaware of how to respond appropriately to their children.

It is also important to note that ACEs compound. Parents with multiple ACEs are at risk for myriad issues such as mental health and substance use, lack of social supports, and limited

educational attainment (Woods-Jaeger et al., 2018) – potential barriers to positive parenting. Panisch and colleagues (2019) note that parents with a history of ACEs have a higher likelihood of having children with developmental delays in toddlerhood, behavioral concerns in school during later years, and mental health challenges across the lifespan-- making positive parenting more challenging. Evidence shows that those with four or more ACEs are at greater risk for low parental resilience and low social connectivity, further lowering positive parenting attitudes (Felitti, et al., 1998)

Unresolved Trauma

Parents who have experienced trauma are more likely to have children that experience trauma (Fitzgerald et al. 2020). When parents have been subjected to trauma in their youth, and it goes unresolved, it has been suggested that they are far more likely to pass this trauma along to their children (Walker, 2007), whether consciously or subconsciously. It is hypothesized that unresolved trauma may impair a mother's ability to respond appropriately to her child's needs, increasing the risk of insecure attachment. Attachment is necessary for appropriate and healthy development. Trauma that is unresolved may then interfere with a caregiver's expectation and perception of their child as well as their ability to respond appropriately, resulting in another generation of attachment disruption (Iyengar et al., 2014).

Unresolved trauma is associated with differences in the brain as well. Iyengar and colleagues (2014) noted that people with unresolved trauma show a reduced activation in the amygdala, the part of the brain that helps with emotional processing. When this amygdala function is lowered, there is a limited ability to self-regulate and handle emotional dysregulation. Walker (2007) notes that within attachment theory itself, it is stated that "it is not the trauma per

se that is important in terms of parenting ability but whether there has been any resolution of the experience" (p. 79). He continues to describe "earned autonomy" (p. 79) which allows the parent to heal childhood wounds and stop the transmission of intergenerational trauma, stating

> A traumatic childhood history, in itself, is not predictive of maltreatment of children; what is predictive is if the adult has not been able to resolve their feelings about these experiences (Walker, 2007, p. 79).

There are several correlations between unresolved trauma and developmental concerns such as disorganized attachment, re-enactment of unresolved trauma, choosing partners that resemble abusers, perpetuating the same abuse that was perpetuated on them, developing "primitive" (Walker, 2007, p. 79) defenses and maternal dissociation, all factors that influence ones parenting attitudes and behaviors. Walker describes these unresolved traumas as "hidden files" (p. 81) that are only accessed through images and feelings. These memories are "strongly somatic, sensory, emotional, and inherently non-verbal" (p. 82) and are often triggered by trauma in adulthood or re-evoked by the birth of a child, or other child developments through the lifespan. As a child grows through different ages and stages, a parent may be triggered into different memories via somatic sensations, causing them to revert to the above-mentioned primitive responses.

Insightfulness is another construct that has been examined among mothers who have experienced childhood trauma and shown to be related to parenting. Koren-Karie and Getzler-Yosef (2019) examined the long-term impact of trauma on parenting among survivors of childhood sexual abuse compared to parents with no reported trauma history. Further, they compared those who had a known history of abuse and had undergone treatment for trauma with

those who also had a reported history of abuse yet had not received treatment. Results indicated that mothers who were sexually abused in childhood exhibited less insight toward their children than mothers without this history. They also observed that resolution of trauma impacted mother's insightfulness. Specifically, mothers who had participated in treatment following childhood sexual abuse exhibited significantly greater insightfulness following treatment for trauma. Evidence shows that resolving trauma is helpful in stopping the intergenerational transmission of trauma (Walker, 2007). Barriers remain in seeking mental health treatment, creating challenges for many in resolving childhood traumas (Taylor & Kuo, 2019).

The present study examined the association between self-reported experiences of childhood abuse and parenting attitudes. It was hypothesized that people who report having experienced childhood abuse would report significantly more negative parenting attitudes than individuals who did not report a history of abuse. Further, the author hypothesized that attendance in therapy following childhood abuse would moderate this relationship.

Methods

This study utilized a correlational, cross-sectional design with non-probability sampling.

Participants: The author sampled 131 participants. The study was open to adults aged 18 and older who were caregivers of one or more children aged two and older. There were no specific limitations as to what defined "parents" for this study, simply that you were a parent or caregiver to a child under the age of majority (18).

Procedures: An anonymous electronic survey in Qualtrics was utilized, comprised of three distinct validated measures as well as a single dichotomous yes/no question about therapy attendance. The survey was distributed through a variety of means such as email, social media,

and listservs as well as posted flyers in public areas with a quick response code (or QR code) for potential respondents to scan in order to access the survey via smart phone. Informed consent was obtained at the beginning of the survey by asking the participant to select "next" after reviewing the informed consent information page on the first page of the survey. Participants were given the option to proceed or not at this stage, affirming a voluntary process. As an incentive, participants were given the option to provide an email address to be entered into a lottery for a chance to win one of two $50 gift cards.

The proposal was reviewed by the University of Pennsylvania Institutional Review Board and determined to meet criteria for exemption.

Measures: The *Dimensions of Discipline Inventory* ([DDI] Straus & Fauchier, 2007; Van Leeuwen et al., 2012) is comprised of five sections: Part A – demographic information on the parents; Part B - demographic information on the child, as well as misbehavior by the child; Part C – Discipline behaviors used with a specific child; Part, D – mode of implementation, and context of the discipline; and Part E – cognitive appraisal. Each form included in the DDI has identical or parallel items available for the following purposes: Parent-Report, Child-Report, and Adult-Recall [memory] Report (Straus & Fauchier, 2007). The questionnaire in total contains 26 items and takes approximately 10-20 minutes to complete in full. It is permissible to utilize only specific sections of the instrument as each section is scored independently and not cumulatively. For this study, only Form P Part A, determining parental demographics, was utilized. Form P, Part A of the questionnaire is a fill-in-the-blank and multiple-choice format and serves as the primary demographic measure for the study.

The DDI has been evaluated in terms of internal consistency as well as test-retest reliability. The internal consistency, measured by Cronbach's alpha, is approximately .8 for both mothers and fathers (Fauchier & Straus, 2010). According to Fauchier and Straus (2010), the test-retest reliability is high for both the factor scores and scale scores with intraclass correlations ranging from r = .82 to .90. They also note that there are correlations with other similar measures and show evidence of convergent validity. Overall, the DDI is a reliable instrument with acceptable stability and high temporal consistency.

The *Adverse Childhood Experiences (ACEs) Survey* was the primary measure of childhood abuse for this study. In this questionnaire, each question is rated as yes or no and a total score of affirmative responses is computed. The ACEs assessment tool is considered a "reliable, valid and economic screen for retrospective assessment of adverse childhood experiences" (Wingfield et al., 2010, abstract,). It has adequate internal consistency (Cronbach's α = .88; Murphy et al., 2014.). The survey is comprised of 10 items that assess three domains. The first domain is abuse, which includes emotional, physical, and sexual abuse. The second domain covers household challenges and includes: Was your mother treated violently? Was there substance abuse in the house? Was there mental illness in the home? Were your parents separated or divorced? Was a household member incarcerated? The final domain is neglect, which queries about experiences of emotional neglect and physical neglect. The original ACE's study demonstrated that associations between childhood trauma and negative outcomes in adulthood were directly associated with higher ACE scores. (Department of Health and Human Services, n.d).

Previous therapy was assessed using a dichotomous yes/no question that stated, “Did you receive therapy or other treatment (support group, or other mental health services) to help you process and overcome challenges associated with your childhood abuse?” This was only asked of participants who endorsed one or more experiences of maltreatment on the ACE’s questionnaire.

The *Parenting Sense of Competence Questionnaire* is a 17-item questionnaire that measures a parent’s sense of self-efficacy and overall parenting confidence by assessing parenting self-esteem across two subscales: Efficacy and Satisfaction (Gibaud-Wallston et al., 1978; Gibaud-Wallston et al., 1989). Items are rated using a 1-6 Likert scale format where 1 = Strongly Disagree and 6 = Strongly Agree. Nine items are reverse coded. When scoring this measure, a higher score indicates a higher sense of parenting competency. This was the primary measure of parenting attitudes in the present study.

As reported by Gibaud-Wallston and colleagues (1978) the original study reported alpha coefficients of .82 and .70 for the Satisfaction and Efficacy subscales respectively. These results were replicated in a subsequent study that found $\alpha = .75$ for the Satisfaction scale and .79 for the Efficacy scale (Gibaud-Wallston et al, 1989). The test-retest correlations after six weeks range from $r = .46$ to .82 for the scales and Total score.

Minor wording changes were made to the original Parenting Sense of Competence Scale to incorporate more inclusive phrasing and terminology. For example, on number’s 5, 6, 13, 14, 15 and 17 instead of using the word “mother,” the word “caregiver” was used to be more inclusive to all caregivers.

Data analyses: Descriptive statistics were used to describe the demographic characteristics of the sample. Means, standard deviations, minimums, and maximums were

calculated for all continuous variables including age and Parenting Sense of Competence score. Frequencies were examined for all categorical variables including race and child abuse history (ACE's).

To test the relationship between a history of child abuse and parenting attitudes, multiple regression analysis was conducted with Parenting Sense of Competence score (i.e., Parenting Attitudes) as the dependent variable (DV) and ACEs Scores and Therapy (i.e., attendance in therapy following childhood abuse, reported as yes/no) entered as independent variables (IV). To test therapy attendance as a moderator of the relationship between child abuse and parenting attitudes, a One-way Analysis of Variance (ANOVA) was conducted with Parenting Sense of Competence score as the DV among ACEs groups (defined as 1, 2-3 or 4-5 ACEs experienced) plus therapy attendance (yes/no), yielding a total of 6 groups.

Results

A total of 131 adults participated in the study, including 10 (7.6%) individuals who identified as males, 104 (79.4%) females and 17 (13.0%) participants who did not disclose their gender. The mean age of the sample was 40.86 (*SD*=9.39) years; participants ranged in age from 25 to 75 years old. Racially, the participants were homogenous with 99 (75.6%) identifying as Caucasian, five (3.8%) as Hispanic, four (3.1%) as more than one race, two (1.5%) as Asian, and one (0.08%) as African American. More than one third of the participants (n = 46, 35.1%) reported they had completed a post-graduate degree and 57 (43.5%) attended some or completed college or technical school. See Table 1.1 for additional detail.

Table 1.1 *Demographic Characteristics (N =131)*

Variable		n	%
Gender	Male	10	7.6
	Female	104	79.4
	Missing	17	13.0
Race	Asian	2	1.5
	African American/Black	1	0.8
	Caucasian/White	99	75.6
	Hispanic/Latino(a)	5	3.8
	More than one race	4	3.1
	Missing	20	15.3
Age Category	20's	7	5.3
	30's	48	36.6
	40's	43	32.8
	50's	9	6.9
	60's	2	1.5
	70's and above	3	2.3
	Missing	19	14.5
Highest Level of Education Completed	Grade school	1	0.8
	Some high school	1	0.8
	Completed high school	1	0.8
	Some college or technical school	30	22.9
	Completed 4-year college or university	27	20.6
	Some post-graduate education	6	4.6

Completed a post-graduate degree (MA, MSW, PHD)	46	35.1
Missing	19	14.5

As seen in Table 1.2, 80 participants (61.1%) reported living with a partner who is their child's parent and 77 participants (58.8%) reported having one or two of their children living in their home at least part of the time. Only 10 (7.6%) participants had none of their children living with them, while another 10 (7.6%) reported having four to six of their children living with them. Regarding household income, 61 (46.6%) respondents reported a household income of $100,000 annually or more, and another 12 (9.2%) reported income in the $80-99,000 per year range.

Table 1.2 *Household Characteristics (N = 131)*

Variable		n	%
Household Income	$20,000-$29,999	4	3.1
	$30,000-$39,000	4	3.1
	$40,000-$49,999	8	6.1
	$50,000-$59,999	11	8.4
	$60,000-$79,999	11	8.4
	$80,000-$99,999	12	9.2
	$100,000 and over	61	46.6
	Missing	20	15.3
Living Arrangement	Single Parent	19	14.5

	Living with a partner who is your child's parent	80	61.1
	Living with a partner who is NOT your child's parent	10	7.6
	Other living arrangement	7	5.3
	Missing	15	11.5
Number of children under 18 living in the home	Zero	10	7.6
	One	31	23.7
	Two	46	35.1
	Three	12	9.2
	Four	3	2.3
	Five	5	2.3
	Six	2	1.5
	Missing	22	16.8

One hundred six participants completed the ACEs assessment, 77 of whom confirmed having experienced at least one ACE before the age of majority. These participants were subsequently asked if they had received therapy related to their childhood adverse events. Sixty four participants answered the question related to therapy. Of those who responded, 35 (54.7%) reported they did attend therapy related to their childhood experiences and 29 (45.3%) reported that they did not attend therapy.

The average PSCS score was 61.93 (*SD*=6.06) and the average number of adverse childhood experiences ranged from 0-9, with mean number of 3.23 (*SD*=2.66) ACEs reported. The most commonly experienced ACE was having had a parent or adult who swore at, insulted, put them down, or humiliated them or acted in a way that made them afraid they might be physically hurt (38.9%). The next most common was having had a household member who was depressed, mentally ill, or had attempted suicide (38.2%), followed by having had someone they lived with who was a problem drinker or alcoholic, or used street drugs (35.1%), and/or having had a parent or adult who pushed, grabbed, slapped, or threw something at them or hit them so hard that they had marks or were injured (29.8%). See Table 1.3 for additional detail.

Table 1.3 *Adverse Childhood Experiences (N =106)*

Variable	n	%
Participants endorsing ≥ 1 ACE	77	58.8
ACEs Endorsed		
A parent or adult swore at you, insulted you, put you down, or humiliated you or acted in a way that made you afraid you might be physically hurt	51	38.9
A parent or adult pushed, grabbed, slapped, or threw something at you or hit you so hard that you had marks or were injured	39	29.8
A parent or adult touched or fondled you or had you touch their body in a sexual way or attempted or actually had oral, anal or vaginal intercourse with you	18	13.7
You often felt that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other	42	32.1

You often felt like you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it	16	12.2
Your parents or other adult caregivers were often pushed, grabbed, slapped, or had something thrown at them or were sometimes or often kicked, bitten, hit with a fist, or hit with something else or were ever repeatedly hit over at least a few minutes or threatened with a gun or knife	25	19.1
Someone you lived with was a problem drinker or alcoholic, or used street drugs	46	35.1
A household member was depressed, mentally ill, or had attempted suicide	50	38.2
A household member went to prison	10	7.6

As shown in Table 1.4, the combination of independent variables in the first model (i.e., ACEs Score and Therapy Attendance) explained 17% of the variance in parenting attitudes [R^2=0.17*, F*(2, 52)= 5.24*, p*=0.01]**.** The number of ACEs endorsed significantly predicted changes in parenting attitudes, with a 2 ½ -point decrease in parenting attitudes with every additional ACE (*B*= -2.51, *p*=0.002). Having received treatment for child abuse did not significantly predict differences in parenting attitudes (*B*= -1.06, *p*=0.54). This supports the hypothesis that higher ACEs scores would predict lower parenting attitude scores.

Table 1.4 *Multiple Regression Analysis of ACE's and Therapy Attendance on Parental Attitudes*

	B	SE	B	t-value	p-value

(constant)	69.04	2.49		27.74	<.001
ACEs Score	-2.51	0.78	-0.42	-3.22	0.002
Therapy	-1.06	1.70	-0.08	-0.62	0.54
R2=0.17; *F*(2,52) =5.24, *p*=0.01					

As shown in Table 1.5, there was no significant difference in mean parenting attitude scores between those who had received therapy and those who had not received therapy at any level of ACE [*F*(5, 47)=1.59, *p*=0.18]. Therefore, the hypothesis that therapy attendance would moderate the relationship between ACEs and parenting attitudes was not supported.

Table 1.5 *One-way Analysis of Variance of Parental Attitudes among Therapy/ACEs Groups*

	Mean	SD	SE	Min	Max	N
Therapy 1 ACE	66.14	6.12	2.31	57	73	7
Therapy 2-3 ACEs	61.20	6.66	1.49	46	73	20
Therapy 4-5 ACEs	57.60	4.51	2.02	51	62	5
No Therapy 1 ACE	63	9.90	7.00	56	70	2
No Therapy 2-3 ACEs	63.27	5.89	1.52	52	74	15
No Therapy 4-5 ACEs	58	7.17	3.58	51	66	4
Total	61.92	6.51	0.90	46	74	53
	Sum of Squares	df	Mean of Square	F-value	p-value	
Between Groups	319.51	5	63.9	1.59	0.18	
Within Groups	1886.19	47	40.13			
Total	2205.70	52				

Discussion

This study examined the relationship between childhood abuse and parenting attitudes in adulthood. It was hypothesized that experiencing adverse events in childhood would be associated with more negative attitudes toward parenting in adulthood. Consistent with the hypothesis, results demonstrated that those with two or more reported ACE's endorsed more negative parenting attitudes in adulthood than caregivers who did not indicate a history of abuse. This finding is important because it adds to the research on the impact of childhood trauma and how it relates to parenting, which may help guide intervention development for parents who have experienced trauma.

The main finding --that ACE's scores were associated with parenting attitudes-- is consistent with the broader literature demonstrating that childhood abuse has multiple negative consequences. Specifically, in our sample, higher ACE's scores were associated with lower parenting attitudes. These findings add to the literature on the sequalae of trauma by elucidating how childhood experiences of trauma may impact the larger family unit, most immediately the children of those who have experienced childhood maltreatment. Future studies that examine caregiver awareness of their parenting attitudes and how those may be impacted by their own experiences as children would be interesting.

Attendance in therapy did not moderate the relationship between ACE's and parenting attitudes, contrary to hypotheses. This was surprising because prior studies have indicated that resolving trauma increases insightfulness in mothers and reduces the occurrence of intergenerational trauma. A limitation of this study was the reliance on a single item to assess therapy attendance. A single dichotomous question may have been insufficient for understanding

participants' experience with mental health services. Future studies would benefit from more rigorous querying about the timing and content of therapy. Qualitative research may help further elucidate how therapy after trauma impacts future parenting.

The present study, which adds to our understanding of how adverse childhood experiences may relate to parenting attitudes, is not without limitations. Limitations include a lack of a diverse sample. Future studies that include a broader representation of racial, ethnic, and socioeconomic backgrounds and educational experiences are needed. Additionally, utilizing a mixed methods approach where, in addition to quantitative data, the stories of the participants can be heard, would add valuable depth and context and give a fuller picture of how childhood trauma truly impacts parenting in adulthood.

Conclusion

The purpose of this study was to elucidate the relationship between adverse childhood experiences and their impact on parenting attitudes in adulthood. It is important to understand the factors that are associated with positive parenting attitudes because that can inform the development of strategies that will address and reduce barriers to positive parenting practices among survivors of childhood abuse. Adaptations to treatments and programs may be needed to increase inclusivity and expand ways to reach and engage families. A long-term goal of this line of research is to inform the development of strategies that will support trauma survivors in breaking the cycle and devastation of intergenerational trauma and increase positive parenting. Whether or not one has received therapy following childhood trauma, and how treatment may impact future parenting, are factors that warrant further study.

Article Two: The intersection of Adverse Childhood Experiences (ACE's) and parenting behaviors

Introduction

Child abuse is common and does not discriminate based on race, educational background, or socioeconomic status. There are noted risk factors leading to child abuse, including inadequate housing, limited access to supports, caregiver drug and alcohol use and limited financial means (Centers for Disease Control, n.d.). The ramifications of child abuse may manifest physically, psychologically, or behaviorally, and may be short-term or long-lasting. There are also important societal impacts. The economic impact of child abuse has been estimated at nearly 100 million dollars in hospitalizations alone (Peterson et al., 2015; Rovi et al., 2004).

Trauma impacts brain development by altering the chemistry in the brain which impacts relationships and responses to others over time (DeGregorio, 2012). This is important in understanding how trauma impacts children from a young age and carries through to adulthood. When one experiences trauma, they are more likely to see life as unpredictable and/or uncontrollable and may be more prone to emotional dysregulation. Many people who have endured abuse in childhood experience hypervigilance, anxiety, and negative thought patterns, which are thought to lead to intense or harsh parenting practices in adulthood (Muzik et al., 2015).

Child Abuse Statistics

The most recent data compiled by the United States Department of Health and Human Services in 2021 reported that there were 4.0 million child abuse referrals made nationwide. Two million of these reports were screened out, meaning they did not meet criteria for investigation.

This equates to 2.0 million investigations, or referrals, alleging maltreatment of children – an increase of 9.4 percent from the 2017 reporting period. The percentages of victim's genders among substantiated abuse reports are nearly equal (47.5% boys and 52.2% girls). In terms of race, victims were identified as either White, Hispanic, or African American at 42.8%, 24.0% and 21.5% respectively. According to the report by the U.S. Department of Health and Human Services (2021), the most prevalent form of child abuse is neglect (76.0% of reports). Second to neglect is physical abuse (16.0%) followed by sexual abuse (10.1%). The remaining 3.6% of reported cases are classified as "other" which includes several subcategories. It is important to note that many cases of reported abuse lack sufficient evidence and/or information to proceed with an investigation which results in dismissal of cases that may be valid, thus these numbers are likely an underestimate of actual child abuse occurrences.

Economic Burden of Child Abuse

Child abuse is a major public health burden. The total cost of the nearly 580,000 fatal and non-fatal child maltreatment cases that occurred in the United States in 2008 is estimated at $124,000,000,000 (Fang et al., 2012). Hospitals experience considerable resource and financial burdens associated with child abuse. Rovi and colleagues (2004) demonstrated that children who have been identified as abused stay in hospitals longer and typically have more significant injuries and worse outcomes. They are also nine times more likely to expire during their time in the hospital when compared to children hospitalized for other reasons. The financial cost to hospitals, as of 1999, was close to $92 million for less than 5000 children (Rovi et al., 2004). These children were more likely to have multiple diagnoses, more complex medical needs, and longer stays in the hospital due to the above, increasing cost overall. Peterson and colleagues

(2015) strengthen the argument with their research on pediatric abusive head trauma in which their findings showed the cost of hospitalization for pediatric abusive head trauma alone resulted in expenditures of over $69 million over a five-year period.

Importance of Addressing Childhood Abuse

Addressing child abuse and its impact on parenting behaviors is essential in stabilizing our society and equalizing the playing field for those who have been historically disenfranchised and/or mistreated. Child abuse can have a lasting impact, both physically and psychologically, and thus effective intervention is needed. Those with a history of trauma are more likely to have life experiences that they deem uncontrollable and unpredictable and may be more prone to emotional dysregulation. This tends to lead to hypervigilance, anxiety, and negative cognitions, which may also then lead to insensitive or harsh parenting practices (Muzik et al., 2015). By addressing the impact of child abuse on parenting we may be able to interrupt the cycle of abuse and call attention and focus to areas of growth for parents.

The Impact of Child Abuse on Behavior

Research suggests that parents with a history of childhood abuse are more likely to default to angry behaviors because they are a "secondary response to parental trauma reactions" (Montgomery et al., 2018, p. 242). Montgomery and colleagues (2018, p.249), continue by stating that "anger is likely to be a central feature of posttraumatic responses because it is a core component of the survival response in traumatic situations." Individuals with post-traumatic stress disorder may also have a lower threshold for stressful situations and may perceive them inappropriately, leading to a response that does not match the situation. In their systematic review, Greene and colleagues (2020) found that parents who reported experiencing physical

abuse in childhood were at increased risk for engaging in abusive or neglectful parenting. Parenting behaviors have a significant impact on the relationship in the parent/child dyad and have an impact on the day-to-day emotional regulation and behaviors of both the parents and the children (Muzik et al., 2015).

Household Income, Socioeconomic Status (SES) and Educational Attainment

Lower socioeconomic status (SES) is associated with increased children's mental health problems and decreased parental emotional well-being. Research has shown that children and adolescents who grow up in affluent families are more likely to avoid problematic behaviors such as aggressiveness and opposition, as well as depression and anxiety, when compared to their lower SES counterparts (Boe et al., 2014). Additionally, 25% of low-income mothers of young children are diagnosed with Major Depressive Disorder, which is an independent risk factor for ineffective parenting practices (Michl-Petzing et al., 2019).

Previous research has not sufficiently explored differences between lower and higher household income parents with regards to parenting behaviors. More research should be done across household incomes to determine if this is a predictor of parenting behaviors overall. We do know, however, that lower SES is associated with parental and child mental health challenges (Boe et al., 2014) which impacts parenting behaviors in the long run. Because there are documented health disparities related to SES (Centers for Disease Control and Prevention, n.d.), it is plausible that household income may impact parenting behaviors as well. Higher educational levels have been hypothesized to improve attitudes toward mental health treatment (Gonzales et al. 2011) and associated with higher utilization of mental health services (Steele, 2007), but more research is needed to understand the impact of education on parenting behaviors.

This research seeks to understand the self-reported parenting behaviors of parents who have experienced childhood abuse compared to parents who did not experience a history of abuse, controlling for household income given that this is known to be independently associated with parenting behaviors. It was hypothesized that higher ACE scores would predict lower parenting behavior scores. It was further hypothesized that education would moderate the relationship between ACEs and parenting behaviors.

Methods

This study utilized a correlational, cross-sectional design with non-probability sampling.

Participants: The author sampled 131 participants. The study was open to adults 18 years of age and older who were parents of one or more children two years of age and older. There were no specific limitations as to what defined "parents" for this study, simply that you were a parent or caregiver to a "child" under the age of 18.

Procedures: An anonymous electronic survey in Qualtrics was utilized, comprised of three distinct validated measures. The survey was distributed through a variety of means. Electronic surveys included email, social media, and listservs. Some posted flyers in public areas offered a quick response code (or QR code) to scan where the participant could access the survey via smart phone. A voluntary process was affirmed and informed consent was obtained by asking the participant to select "next" after reviewing the informed consent content on the first page of the survey if the participant wished to proceed. As an incentive, participants were given the option to provide an email address to be entered into a lottery for a chance to win one of two $50 gift cards.

The proposal was reviewed by the University of Pennsylvania Institutional Review Board and determined to meet criteria for exemption.

*Measures***:** The *Dimensions of Discipline Inventory* (DDI; Straus & Fauchier, 2007; Van Leeuwen et al., 2012) encompasses five sections: Part A – demographic information on the parents; Part B - demographic information on the child, including misbehavior by the child; Part C – Discipline behaviors used with a specific child; Part, D – Mode of implementation, and context of the discipline; and Part E – Cognitive appraisal (Straus & Fauchier, 2007). Each form included in the DDI has identical or parallel items available for the following purposes: Parent-Report, Child-Report, and Adult-Recall [memory] Report (Straus & Fauchier, 2007). The questionnaire in total consists of 26 items and takes roughly 10-20 minutes to complete in full. It is allowable to utilize only specific sections of the instrument as each section is scored separately and not cumulatively. For this study, only Form P Part A, determining parental demographics, was utilized. This portion of the questionnaire is a fill-in-the-blank and multiple-choice format and serves as the primary demographic measure for the study.

The DDI questionnaire has been evaluated in terms of internal consistency as well as test-retest reliability. The internal consistency, measured by Cronbach's alpha, is approximately .8 for both mothers and fathers (Fauchier & Straus, 2010). The test-retest reliability is high for both the factor scores and scale scores with intraclass correlations ranging from $r = .82$ to .90 (Fauchier & Straus, 2010). Fauchier and Straus (2010) note that the correlations of the DDI with other similar measures show evidence of convergent validity. Overall, the DDI is a reliable instrument with acceptable stability and high temporal consistency.

The *Adverse Childhood Experiences (ACE's) Survey* was the primary measure of childhood abuse for this study. In this questionnaire, each question is rated as yes or no and a total score of affirmative responses is computed. The ACEs assessment tool is considered a "reliable, valid and economic screen for retrospective assessment of adverse childhood experiences" (Wingfield et al., 2010). It has adequate internal consistency (Cronbach's $\alpha = .88$; Murphy et al., 2014.). The survey is comprised of ten items that assess three domains. First is the domain of abuse, which includes emotional, physical, and sexual abuse. Second is the domain of household challenges and includes: Was your mother treated violently? Was there substance abuse in the house? Was there mental illness in the home? Were your parents separated or divorced? Was a household member incarcerated? Neglect is the final domain, which inquires about experiences of emotional neglect and physical neglect. The original ACE's study demonstrated that associations between childhood trauma and negative outcomes in adulthood were directly associated with higher ACE scores. (Department of Health and Human Services, n.d).

The *Alabama Parenting Questionnaire* (APQ; Frick, 1991) was the primary tool used to measure parenting behaviors for this study. It is a self-report survey that includes 42 items evaluating parenting practices across five domains (Essau et al. 2006) including: parental involvement, positive parenting, poor monitoring/supervision, inconsistent discipline, and corporal punishment. Each item is scored using a 5-point frequency scale from 1 = never to 5 = always.

The APQ has acceptable levels of reliability, with Cronbach's alpha > .70 for all subscales except inconsistent discipline, which was demonstrated to be .54 and .62 for fathers

and mothers respectively. Construct validity of the APQ has been demonstrated. Child conduct problems and aggressive and antisocial behaviors have been found to be negatively correlated with parental involvement and positive parenting. The strongest area of parenting that correlated with conduct problems and aggressive behaviors was the use of corporal punishment by parents (Essau et al., 2006).

Data analyses: Descriptive statistics were used to describe the demographic characteristics of the sample. Means, standard deviations, minimums, and maximums were calculated for all continuous variables including age and APQ score. Frequencies were examined for all categorical variables including race and child abuse history (ACE's).

To test the relationship between parenting behaviors and a history of child abuse, multiple regression analysis was conducted with Alabama Parenting Questionnaire total scores as the dependent variable (DV) and ACEs scores and Income (i.e., household income) entered as independent variables (IV). Income was controlled for given that it has been associated with risk for child maltreatment in the literature. To test educational attainment as a moderator of the relationship between child abuse (i.e., ACEs score) and parenting behaviors (APQ total score), a One-way Analysis of Variance (ANOVA) was conducted with APQ score as the DV among ACEs groups (defined as 1, 2-3 or 4-5 ACEs experienced) plus education group (i.e., Grade School + Some High School + Completed High School = 1; Some College or Technical School + Completed 4-year College or University = 2; and Some Post-graduate Education + Completed Post Graduate Degree (MA, MD, PhD, etc.) = 3), yielding a total of 9 groups.

Results

A total of 131 caregivers participated in the study, including 10 (7.6%) self-reported males, 104 (79.4%) self-reported females and 17 (13.0%) participants who did not disclose their gender. The mean age of the sample was 40.86 (*SD*=9.39) years and ranged in age from 25 years of age to 75. Racially, the participants were homogenous with 99 (75.6%) self-identifying as Caucasian, 5 (3.8%) as Hispanic, 4 (3.1%) as more than one race, 2 (1.5%) as Asian, and one (.08%) as African American. More than one third of the participants, 46 (35.1%) completed a post-graduate degree, with another 57 (43.5%) having attended some or completed college or technical school. See table 2.1 for additional detail.

Table 2.1 *Demographic Characteristics (N =131)*

Variable		n	%
Gender	Male	10	7.6
	Female	104	79.4
	Missing	17	13.0
Race	Asian	2	1.5
	African American/Black	1	0.8
	Caucasian/White	99	75.6
	Hispanic/Latino(a)	5	3.8
	More than one race	4	3.1
	Missing	20	15.3
Age Category	20’s	7	5.3
	30’s	48	36.6
	40’s	43	32.8
	50’s	9	6.9
	60’s	2	1.5
	70’s and above	3	2.3

	Missing	19	14.5
Highest Level of Education Completed	Grade school	1	0.8
	Some high school	1	0.8
	Completed high school	1	0.8
	Some college or technical school	30	22.9
	Completed 4-year college or university	27	20.6
	Some post-graduate education	6	4.6
	Completed a post-graduate degree (MA, MSW, PHD)	46	35.1
	Missing	19	14.5

As seen in Table 2.2, 80 participants (61.1%) reported living with a partner who is the parent of their child and 77 participants (58.8%) reported having one or two of their children living with them at least part of the time. Only 10 (7.6%) participants had no children living with them, while another 10 (7.6%) reported having four to six of their children living with them in their home. Regarding household income, 61 (46.6%) respondents reported an annual household income of $100,000 or more, and another 12 (9.2%) reported an annual income in the $80-99,000 range.

Table 2.2 *Household Characteristics (N =131)*

Variable	n	%

Household Income	$20,000-$29,999	4	3.1
	$30,000-$39,000	4	3.1
	$40,000-$49,999	8	6.1
	$50,000-$59,999	11	8.4
	$60,000-$79,999	11	8.4
	$80,000-$99,999	12	9.2
	$100,000 and over	61	46.6
	Missing	20	15.3
Living Arrangement	Single Parent	19	14.5
	Living with a partner who is your child's parent	80	61.1
	Living with a partner who is NOT your child's parent	10	7.6
	Other living arrangement	7	5.3
	Missing	15	11.5
Number of children under 18 living in the home	Zero	10	7.6
	One	31	23.7
	Two	46	35.1
	Three	12	9.2
	Four	3	2.3
	Five	3	2.3
	Six	2	1.5
	Missing	22	16.8

One hundred six participants completed the ACEs assessment, with 77 (58.8%) of those individuals reporting having experienced at least one ACE before adulthood. The average number of adverse childhood experiences ranged from 0-9, with an average of 3.23 (*SD*=2.66) ACEs reported. The most frequently reported ACE was having had a parent or adult who swore at, insulted, put them down, or humiliated them or acted in a way that made them afraid they might be physically hurt (38.9%). The next most frequently reported was having had a household member who was depressed, mentally ill, or had attempted suicide (38.2%), followed by having had someone they lived with who was a problem drinker or alcoholic, or used street drugs (35.1%), and/or having had a parent or adult who pushed, grabbed, slapped, or threw something at them or hit them so hard that they had marks or were injured (29.8%). See Table 2.3 for additional detail.

Table 2.3 *Adverse Childhood Experiences (N =106)*

Variable	n	%
Participants endorsing ≥ 1 ACE	77	58.8
ACEs Endorsed		
A parent or adult swore at you, insulted you, put you down, or humiliated you or acted in a way that made you afraid you might be physically hurt	51	38.9
A parent or adult pushed, grabbed, slapped, or threw something at you or hit you so hard that you had marks or were injured	39	29.8
A parent or adult touched or fondled you or had you touch their body in a sexual way or attempted or actually had oral, anal or vaginal intercourse with you	18	13.7
You often felt that no one in your family loved you or thought you were important or special or your family didn't look out for each other, feel close to each other, or support each other	42	32.1

You often felt like you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you or your parents were too drunk or high to take care of you or take you to the doctor if you needed it	16	12.2
Your parents or other adult caregivers were often pushed, grabbed, slapped, or had something thrown at them or were sometimes or often kicked, bitten, hit with a fist, or hit with something else or were ever repeatedly hit over at least a few minutes or threatened with a gun or knife	25	19.1
Someone you lived with was a problem drinker or alcoholic, or used street drugs	46	35.1
A household member was depressed, mentally ill, or had attempted suicide	50	38.2
A household member went to prison	10	7.6

The average APQ score was 117.52 (*SD*=8.53). As shown in Table 2.4, the combination of independent variables in the regression model (i.e., ACE score and Income) explained 2% of the variance in parenting behavior (i.e., APQ total score) and was not significant *[R^2=0.02, F (2, 85)= 0.75, p=0.48]*. The number of ACEs did not significantly predict changes in parenting behavior when controlling for income (B= -0.68, p=0.26). This does not support the hypothesis that higher ACE scores would predict less effective parenting behaviors (i.e., lower parenting behavior scores on the APQ).

Table 2.4 *Multiple Regression Analysis of ACEs and Income on Parenting Behavior*

Variables	B	SE	B	*t*-value	*p*-value
(constant)	117.32	5.48		21.40	<.001
ACEs Score	-0.68	0.60	-0.12	-1.14	0.26
Income	0.13	0.53	0.03	0.25	0.80

R2=0.02; *F*(2, 85)=0.75, *p*=0.48

As shown in Table 2.5, there was no significant difference in average parenting behavior scores by education at any level of ACEs [*F*(8, 79)=1.39, *p*=0.21]. This does not uphold the hypothesis that education would moderate the relationship between ACEs and parenting behaviors.

Table 2.5 *One-way Analysis of Variance of Parental Behavior among Education/ACEs Groups*

Variable	Mean	SD	SE	Minimum	Maximum	N
EduGroup 1, 0 ACEs	110			110	110	1
EduGroup 2, 0 ACEs	119.54	9.23	2.56	105	135	13
EduGroup 3, 0 ACEs	120.14	5.69	1.24	111	132	21
EduGroup 2, 1 ACE	112.71	4.46	1.69	108	120	7
EduGroup 3, 1 ACE	108.00			108	108	1
EduGroup 2, 2-3 ACEs	118.20	6.86	1.53	107	133	20
EduGroup 3, 2-3 ACEs	115.00	10.01	2.58	102	132	15
EduGroup 2, 4-5 ACEs	121.00	16.43	7.35	102	139	5
EduGroup 3 4-5 ACEs	112.80	9.88	4.42	96	122	5
Total	117.52	8.53	0.91	96	139	88
	Sum of Squares	df	Mean Square	F-value	p-value	
Between Groups	782.72	8	97.84	1.39	0.21	
Within Groups	5553.23	79	70.29			
Total	6335.96	87				

Discussion

This study examined the relationship between child abuse and parenting behaviors in adulthood. It was hypothesized that if one endured adverse experiences in childhood they would

be more likely to report engaging in negative parenting behaviors as adult caregivers. Inconsistent with the hypothesis, results demonstrated that there was not a significant association between self-reported parenting behaviors and adverse childhood experiences. This finding is important, because it counters prior research which has shown that childhood abuse impacts brain development (DeGregorio, 2012) as well as mental and physical health. When mental and physical health are compromised, parenting warmth and sensitivity can be weakened (Centers for Disease Control, n.d.) leading to reduced parenting capacity. Given the inconsistency in findings between this study and the broader literature, further research is needed, particularly with diverse and low-income samples.

Education level did not moderate the relationship between ACEs and parenting behaviors. This was unexpected because prior research has suggested that parents with higher educational attainment utilize mental and physical health services more often (Steele et al., 2007) and those with lower educational attainment experience more barriers accessing care. It is important to note that this sample was predominantly Caucasian, higher SES, and highly educated. A sample with more diverse education histories may have allowed for greater ability to detect differences among education groups. Future studies may also benefit from collecting additional demographic details, such as characteristics of the caregiver's family of origin (e.g., how the participant grew up, if it differs from their current situation, and their current SES). Qualitative inquiry could also add valuable depth to the data.

The present study, which adds to our understanding of how adverse childhood experiences may relate to parenting behaviors, is not without limitations. Limitations include a lack of a diverse sample and a reliance on a survey at a single time point. Future efforts to

represent a broad range of racial, socioeconomic, gender and educational backgrounds would be beneficial to this line of research. Additionally, parenting behaviors were self-reported by caregivers. While the survey was anonymous, lack of insight or social desirability bias may have impacted responding. Studies that use observational paradigms to assess parenting behaviors may increase confidence in the results.

Conclusion

The purpose of this study was to elucidate the relationship between adverse childhood experiences and their impact on parenting behaviors in adulthood. It is important to understand the factors that are associated with positive parenting behaviors because by doing so it can inform the development of strategies that will address and reduce barriers to positive parenting practices among survivors of childhood abuse. In order to achieve these goals, however, additional data must be compiled due to gaps in the current literature. More research is needed in particular with families of lower SES backgrounds and with diverse education histories. There may also need to be different approaches to the research itself to ensure appropriate strategies are utilized. For example, more qualitative, mixed method, and observational studies are needed to fully understand the impact of childhood abuse on parenting behaviors. The ultimate goal of this line of research is to develop strategies and programs to help parents engage in positive parenting practices, regardless of their financial means and educational backgrounds.

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Appendix A: Measures

Dimensions of Discipline Inventory- part A Form P (demographics)

1. Are you (circle a number to answer):
    1. Single parent
    2. Living with a partner who is your child's parent
    3. Living with a partner who is not your child's parent
    4. Other living arrangement _____

2. Your sex:
    1. Male
    2. Female
    3. How old were you at your last birthday: _____ years old.
    4. How many of your children or stepchildren who are under 18 are living with you for part or all of every week? _____

5. Please list the ages of the children or stepchildren under 18 who are living in your house for at least part of every week.
    Girls: _____/_____/_____/_____/_____
    Boys: _____/_____/_____/_____/_____
6. Please circle a number in each column for how much education you and your partner finished:

YOU	PARTNER	
1	1	Grade School
2	2	Some high school
3	3	Completed high school
4	4	Some college or technical school
5	5	Completed 4-year college or university
6	6	Some post-graduate education
7	7	Completed a post-graduate degree (M.A., M.D., Ph.D., etc.)

7. About how much was your total household income before taxes for the previous year:
    1. $0-$2,999
    2. $3,000-$7,999
    3. $8,000-$12,999

4. $13,000-$19,999
5. $20,000-$29,999
6. $30,000-$39,999
7. $40,000-$49,999
8. $50,000-$59,999
9. $60,000-$79,999
10. $80-000-$99,999
11. $100,000 and over

8. How many people (include both adults and children and stepchildren) lived on this income? _____
9. In what kind of home do you live?
    1. Apartment, condo, or co-op owned by myself or partner
    2. Rented apartment or condo
    3. Trailer on property owned by myself or partner
    4. Trailer on property owned by another family member or friend living on the same property
    5. Trailer in a trailer park or other rented property
    6. Rented house
    7. House owned by myself or partner
    8. Home owned by another member of your household (for example, a family member living with you)
    9. Other _____

10. Your racial/ethnic identification:
    1. Asian
    2. African American/Black
    3. Caucasian/White
    4. Native American/Pacific Islander
    5. Hispanic/Latino(a)
    6. Other
    7. More than one race

Adverse Childhood Experiences Assessment

Alabama Parenting Questionnaire

	Never	Almost Never	Sometimes	Often	Always
1. You have a friendly talk with your child.	1	2	3	4	5
2. You let your child know when he/she is doing a good job with something	1	2	3	4	5
3. You threaten to punish your child and then do not actually punish him/her	1	2	3	4	5
4. You volunteer to help with special activities that your child is involved in (such as sports, boy/girl scouts, church youth groups)	1	2	3	4	5
5. You reward or give something extra to your child for obeying you or behaving well	1	2	3	4	5
6. Your child fails to leave you a note or to let you know where he/she is going	1	2	3	4	5
7. You play games or do other fun things with your child	1	2	3	4	5
8. Your child talks you out of punishing him/her after he/she has done something wrong	1	2	3	4	5
9. You ask your child about his/her day at school	1	2	3	4	5
10. Your child stays out in the evening past the time he/she is supposed to be home	1	2	3	4	5
11. You help your child with his/her homework	1	2	3	4	5
12. You feel that getting your child to obey you is more trouble than it is worth	1	2	3	4	5
13. You compliment your child when he/she does something well	1	2	3	4	5
14. You ask your child what his/her plans are for the coming day	1	2	3	4	5
15. You drive your child to a special activity	1	2	3	4	5
16. You praise your child if he/she behaves well	1	2	3	4	5
17. Your child is out with friends you do not know	1	2	3	4	5
18. You hug or kiss your child when he/she has done something well	1	2	3	4	5
19. Your child goes out without a set time to be home	1	2	3	4	5
20. You talk to your child about his/her friends	1	2	3	4	5
21. Your child is out after dark without an adult	1	2	3	4	5

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

☐ Yes ☐ No If Yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

☐ Yes ☐ No If Yes, enter 1 _____

10. Did a household member go to prison?

☐ Yes ☐ No If Yes, enter 1 _____

	Never	Almost Never	Sometimes	Often	Always
22. You let your child out of a punishment early (e.g., lift restrictions earlier than you originally said)	1	2	3	4	5
23. Your child helps plan family activities	1	2	3	4	5
24. You get so busy that you forget where your child is and what he/she is doing	1	2	3	4	5
25. Your child is not punished when he/she has done something wrong	1	2	3	4	5
26. You attend PTA meetings, parent/teacher conference, or other meetings at your child's school	1	2	3	4	5
27. You tell your child that you like it when he/she helps out around the house	1	2	3	4	5
28. You don't check that your child comes home at the time he/she is supposed to	1	2	3	4	5
29. You don't tell your child where you are going	1	2	3	4	5
30. Your child comes home from school more than an hour past the time you expect him/her	1	2	3	4	5
31. The punishment you give your child depends on your mood	1	2	3	4	5
32. Your child is at home without adult supervision	1	2	3	4	5
33. You spank your child with your hand when he/she has done something wrong	1	2	3	4	5
34. You ignore your child when he/she is misbehaving	1	2	3	4	5
35. You slap your child when he/she has done something wrong	1	2	3	4	5
36. You take away privileges or money from your child as a punishment	1	2	3	4	5
37. You send your child to his/her room as a punishment	1	2	3	4	5
38. You hit your child with a belt, switch, or other object when he/she has done something wrong.	1	2	3	4	5
39. You yell or scream at your child when he/she has done something wrong	1	2	3	4	5
40. You calmly explain to your child why his/her behavior was wrong when he/she misbehaves	1	2	3	4	5
41. You use time out (make him/her sit or stand in a corner) as a punishment	1	2	3	4	5
42. You give your child extra chores as a punishment	1	2	3	4	5

Parenting Sense of Competence Scale

Please rate the extent to which you agree or disagree with each of the following statements.

Strongly Disagree	Somewhat Disagree	Disagree	Agree	Somewhat Agree	Strongly Agree
1	2	3	4	5	6

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired. 1 2 3 4 5 6

2. Even though being a parent could be rewarding, I am frustrated now while my child is at his / her present age. 1 2 3 4 5 6

3. I go to bed the same way I wake up in the morning, feeling I have not accomplished a whole lot. 1 2 3 4 5 6

4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated. 1 2 3 4 5 6

5. My mother was better prepared to be a good mother than I am. 1 2 3 4 5 6

6. I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent. 1 2 3 4 5 6

7. Being a parent is manageable, and any problems are easily solved. 1 2 3 4 5 6

8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one. 1 2 3 4 5 6

9. Sometimes I feel like I'm not getting anything done. 1 2 3 4 5

10. I meet by own personal expectations for expertise in caring for my child. 1 2 3 4 5 6

11. If anyone can find the answer to what is troubling my child, I am the one. 1 2 3 4 5 6

12. My talents and interests are in other areas, not being a parent. 1 2 3 4 5 6

13. Considering how long I've been a mother; I feel thoroughly familiar with this role. 1 2 3 4 5 6

14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent. 1 2 3 4 5 6

15. I honestly believe I have all the skills necessary to be a good mother to my child. 1 2 3 4 5 6

16. Being a parent makes me tense and anxious. 1 2 3 4 5 6

17. Being a good mother is a reward in itself. 1 2 3 4 5 6

Appendix B: Recruitment Letters

Sample Initial Email:

Jae Kierstin Carreira MSW, LSW
DSW Student
University of Pennsylvania
Philadelphia, PA
School of Social Policy and Practice

Michael Jordan
Access Services
500 Office Center Drive, Suite 100
Fort Washington, PA 19034-3234

Dear Mr. Jordan,

My name is Kierstin Carreira and I am a doctoral student at the University of Pennsylvania within the School of Social Policy and Practice. **I am conducting my dissertation research under the mentorship of Dr. Courtney Benjamin Wolk on parenting attitudes and behaviors in adulthood following childhood abuse.** I have a particular interest in understanding what factors lead to positive parenting attitudes and behaviors following childhood abuse, such as attending therapy and educational attainment.

I need your help disseminating this survey. The survey includes demographic questions, a brief assessment of adverse childhood experiences, a parenting practice questionnaire, and a parenting confidence survey. The survey will be available electronically and will take approximately 10-15 minutes to complete. Participants who complete the survey may choose to enter a lottery to possibly receive a gift card as a token of gratitude for their participation.

I would be grateful if you would disseminate the survey widely to your organization. **For ease, I have attached a flyer with a direct link to the survey.** Would you kindly share this within your network?

If you have questions or would like me to come to your office or to do a virtual presentation of the research project, please feel free to contact me at jkcarr@upenn.edu or 484-857-9411. Thank you, and I look forward to working with you.

Sincerely,
Kierstin Carreira

Jae Kierstin Carreira MSW, LSW
DSW Student

Sample Follow-Up Email:

University of Pennsylvania
Philadelphia, PA
School of Social Policy and Practice

Michael Jordan
Access Services
500 Office Center Drive, Suite 100
Fort Washington, PA 19034-3234

Dear Mr. Jordan,

My name is Kierstin Carreira and I am a doctoral student at the University of Pennsylvania within the School of Social Policy and Practice. **I am studying parenting attitudes and behaviors in adulthood following childhood abuse.** About three weeks ago I sent you a letter outlining the details of my research project and asked for your help distributing my survey. I would like to find a time to discuss whether you would be willing to distribute my survey within your organization.

Feel free to reach out to me at 484-857-9411 (call or text) or via email at jkcarr@upenn.edu to set up a time to chat. Thank you,

Kierstin Carreira

Jae Kierstin Carreira MSW, LSW
DSW Student

Appendix C: Advertising Flyer

We are looking for parents aged 20 and older!

for a

Parenting

Research Study

with the

University of Pennsylvania

School of Social Policy and Practice

Philadelphia, PA

Photo by Ketut Subiyanto from Pexels 1

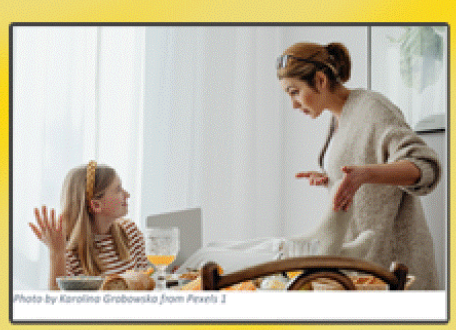

Photo by Karolina Grabowska from Pexels 1

Photo by cottonbro from Pexels 1

Scan here to take the survey now!

Survey should take 10-15 minutes only!

We are conducting a study of parenting attitudes and behaviors and how early experiences may impact parenting. Participants will complete a brief, one-time survey, and will have the opportunity to be entered into a lottery for the chance to win a gift card (see below). Scan the QR code above or visit https://upenn.co1.qualtrics.com/jfe/form/SV_8wXu7pXGnEhABoi.

Gift cards of $50 will be awarded via raffle at two times during the study, November, 2022 and March, 2023. Completed participation and email address required for entry.

Questions can be directed to Kierstin via text or phone call at 484-857-9411 or via email at jkcarr@upenn.edu

Appendix D: Consent Script

Research Study

You are being invited to participate in a research study. Your participation is voluntary, and you should only participate if you completely understand what the study requires and what the risks of participation are.

This research study is being conducted to elucidate the relationship between childhood abuse and parenting attitudes and behaviors among those who did and did not receive treatment for their trauma and among differing educational levels of parents, controlling for race and household income.

If you agree to join the study, you will be asked to complete the following research procedures: An electronic survey comprised of four different measures. These measures include a demographic questionnaire, a childhood experience questionnaire, a parenting attitude questionnaire, and a parenting confidence questionnaire.

You are being asked to join this study because as a caregiver, whom is at least 20 years old, and has at least one child you will be able to offer valuable information regarding parenting. This study values a diverse sample group, which is why the researcher is searching for caregivers of all types, including all genders and sexual orientations, all races and ethnicities, and immigration and marital statuses. This study is asking for participants to be English-Speaking caregivers (although, they do not have to be native English-speakers), and we are asking that for the sake of the survey, that caregivers focus on the children in the home who do NOT have significant special needs. Children with special needs have unique parenting needs and these do not relate to the data being collected in this survey.

Participation

Your participation will last for approximately 10-15 minutes, one time only. This survey can be completed at the time and location of the your choosing. The alternative to participating in this survey is to not participate. There is no penalty if you choose not to join the research study. You have the right to drop out of the research study at any time during your participation. There is no penalty or loss of benefits to which you are otherwise entitled if you decide to do so.

Benefits

You will not benefit directly from completing the survey. Your potential benefits include having the opportunity to participate in an incentive drawing at the conclusion of the study. You will also be contributing to generalizable knowledge about the impact of childhood abuse on parenting practices. In the future, this may help other people to stop the cycle of intergenerational passing down of maladaptive parenting patterns.

Two raffle drawings will take place during the study. Monetary gift cards in the form of Visa, Master Card, or American Express will be raffled in amounts of two $50 gift cards (one per

drawing) available for each drawing. You must have completed the entire survey in order to be eligible for the incentive lottery.

Risks

The risks involved in this research are 1) discomfort from recall of memories from negative childhood experiences while completing the survey 2) possible identification via email address.

Measures have been established to help with risk 1 wherein resources will be listed at the end of the survey to help with difficult feelings. Local and national crisis lines will be listed as will therapeutic organizations and web-based telehealth services.

Risk 2 is guarded against by not making public any of your information as well as not utilizing email addresses for coding or data analysis. The only purpose of the email address is for the secondary survey that will enter you into the raffle drawing; therefore, it will not be utilized in a way that could be disseminated accidentally as it pertains to the research. Additionally, gift cards will be disseminated electronically to limit the amount of personal information obtained and retained.

Personal Information

Your personal information may be given out if required by law. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used. The Institutional Review Board (IRB) at the University of Pennsylvania will have access to your records.

The only personal information that will be collected (on a voluntary basis) is your email address if you select to enter the raffle. This information is not used or connected in any way to the research data, it is only used to enter you into a drawing for the gratitude gift cards via a secondary survey.

Your information will be de-identified. De-identified means that all identifiers have been removed. The information could be stored and shared for future research in this de-identified fashion. The information may be shared with other researchers within Penn, or other research institutions. It would not be possible for future researchers to identify you as we would not share any identifiable information about you with future researchers. This can be done without again seeking your consent in the future, as permitted by law. The future use of your information only applies to the information collected on this study.

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator Courtney Wolk, (215-746-6099), or the primary researcher Kierstin Carreira, (610-997-0927). If a member of the research team cannot be reached or you want to

talk to someone other than those working on the study, you may contact the Office of Regulatory Affairs with any question, concerns or complaints at the University of Pennsylvania by calling (215) 898-2614.