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A

MENTAL REPRESENTATIONS OF ATTACHMENT AND CAREGIVING IN WOMEN SEXUALLY ABUSED DURING CHILDHOOD: LINKS TO THE INTERGENERATIONAL TRANSMISSION OF TRAUMA?

by

Natalie K. Fisher

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

2000

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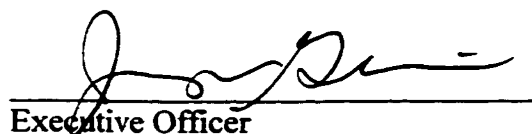
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Abstract

MENTAL REPRESENTATIONS OF ATTACHMENT AND CAREGIVING IN WOMEN SEXUALLY ABUSED DURING CHILDHOOD: LINKS TO THE INTERGENERATIONAL TRANSMISSION OF TRAUMA?

by

Natalie K. Fisher

Advisor: Arietta Slade, Ph.D.

Recent empirical studies indicate that children of survivors of childhood sexual abuse are at greater risk of being sexually abused than are children whose mothers have never been abused. Using attachment theory as a foundation, this study explored the relationships between mental representations of attachment and caregiving among women sexually abused during childhood to better understand individual differences in the intergenerational transmission of trauma. The study also looked at how the resolution of trauma and use of dissociative defenses can impact those representations so as to influence variables believed to be related to a child's risk of second-generation sexual abuse.

This was an exploratory, qualitative study that examined whether attachment theory could offer any new perspectives on the intergenerational transmission of trauma between women sexually abused during childhood and their children. Ten women who were sexually abused during childhood by a significant caregiver responded to the Adult Attachment Interview (AAI) and Experiences of Caregiving Interview (CI) in order to examine mental representations of attachment and caregiving. The Traumatic Antecedents Interview (TAI) and Dissociative

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Experiences Scale (DES) were also administered to look at overall exposure to trauma and current use of dissociative processes.

Several findings from this study were noteworthy and indicate the need for further investigation. First, mental representations of attachment in this study were related to age at onset of the sexual abuse. Women in this sample who were Unresolved with respect to trauma were more likely to have been sexually abused beginning around age 3, while those who displayed organized mental representations of attachment were more likely to be older when the abuse began. Second, a relation was noted between overall exposure to trauma and mental representation of caregiving; however, a lack of correspondence was found between mental representations of past attachments and representations of current caregiving relationships. This suggests that, when in an ongoing relationship, trauma and its associated affects can be evoked and may influence parenting. Use of attachment theory in the interpretation of the findings from this study showed the relevance of using this theoretical framework to help understand individual differences in the intergenerational transmission of trauma.

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… It takes all the running you can do, to keep in the same place

- Lewis Carroll, Through the Looking Glass (1946, p.216)

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INTRODUCTION

Over the past twenty years, the literature on second-generation childhood sexual abuse has consisted mostly of clinical case studies and anecdotes (Brown, 1979; Finkelhor & Baron, 1986; Rosenfeld, Nadelson & Krieger, 1980). Recently, empirical studies have begun to document that children of survivors of childhood sexual abuse may be up to three times more likely to be sexually abused than children whose mothers have never been abused (Finkelhor, Moore, Hamby, & Straus, 1997; Goodwin, McCarthy & DiVasto, 1981; Oates, Tebbutt, Swanston, Lynch & O'Toole, 1998). To date, however, few studies have examined why this type of intergenerational transmission of trauma occurs.

Several theories have been used to help explain the frequency with which general trauma comes to be transmitted across generations and attempts have been made to apply these theories to the population of sexual abuse survivors. For example, Freud's theory of repetition compulsion (1920) has been used to help understand why sexual abuse victims repeat their traumatic experiences or repeat scenarios from their own experiences that may promulgate abuse in their children. Family systems theory proposes that individuals have the propensity to reproduce patterns of behavior congruent with the family system they knew as a child (Egeland, Jacobvitz & Sroufe, 1988; Person & Klar, 1994; Stoll, 1993). Yet, many children of survivors of sexual abuse are never abused. Each of the above theories does little to explain resiliency in children and parents. The goal of this study is to use attachment theory as a way to better understand individual differences in the intergenerational

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transmission of trauma among survivors of sexual abuse.

The intergenerational transmission of physical abuse has been well documented and researchers in this area have used various theoretical foundations to help explain why the cycles of abuse persist in some families (Curtis, 1963; Galdston, 1965; George, 1996; Green, Gaines & Sandgrun, 1974; Kempe & Kempe, 1978; Zeanah & Zeanah, 1989). Although attachment theory has been used extensively as a foundation from which to understand the intergenerational transmission of physical abuse (Bowlby, 1984; Egeland, et al., 1988; George, 1996; Schneider-Rosen, Braunwald, Carlson & Cicchetti, 1985; Zeanah & Zeanah, 1989) until very recently it has not been applied to studies in childhood sexual abuse. Previous research in the area of childhood sexual abuse has often been conducted without a theoretical framework from which to interpret the findings. This has often led to varied and somewhat inconsistent results, particularly when the long-term effects of this experience have been studied. Use of attachment theory has aided researchers in the field of physical abuse better understand (1) the meaning that has been attributed to the traumatic experience; (2) individual differences in the organization and processing of information; (3) defensive processes; and (4) evaluations and attributions of both the parent's and the individual's behavior (George, 1996). "It is clear that the patterns of how we are attached to and intimately relate with others constitute precisely the area of difficulty in child abuse" (Zeanah & Zeanah, 1989, p.178). It is possible that attachment theory can make the same contributions to the study of childhood sexual abuse since mental representations of attachment and caregiving

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may help explain individual differences in the intergenerational transmission of this trauma.

Since John Bowlby first proposed attachment theory as a way to understand how actual childhood experiences with significant caregivers help form who we are as adults, researchers have used this theory as a basis for understanding the continuity and intergenerational transmission of relationships. Attachment theorists believe that young children develop internal working models, or more specifically, a set of rules that provide a framework for understanding the sense of self in relation to the world, based upon their parent's actual behaviors towards them (Bowlby, 1969/1982, 1973, 1980; Bretherton, 1985). This occurs through the parent's responses to the child when the child's attachment behavioral system has been activated. When parents respond promptly and consistently to the child's needs, the child comes to see herself as loved and worthy of this attention. Conversely, when parents are inconsistent or disorganized in providing nurturance to their child, the child comes to see herself as undeserving and unworthy (Belsky & Cassidy, 1994; Bretherton, 1985; Main, Kaplan & Cassidy, 1985). Because these models are based upon moments that most often occur during times of intense, negative affect, the internal working model comes to "...represent both a cognitive template of relationships and a strategy of affect regulation" (Alexander, Anderson, Brand, Schaeffer, Grelling & Kretz, 1998, p.46).

Internal working models of attachment are thought to be with an individual throughout her life, and come to be transmitted intergenerationally, from parent to child. While it is widely believed that working models of self, other, and self-with-other can be revised and adapted throughout life, especially with the experience of

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positive relationships, a trauma occurring early in life for which there is little or no conscious memory for the events makes this difficult. Instead, the traumatic memory may come to be represented in some type of a cognitive schema that is incomprehensible to the individual, thereby deeming it impossible to revise one's mental representation (Bretherton, 1995).

The corollary to the child's attachment behavioral system is the caregiving system in the parent. Parents develop a system of caregiving based upon their own working model of attachment. Since internal working models of attachment include both representations of self and other, the parent's representations of the other guide their interactions with their own child (George, 1996).

Of great importance, though not often highlighted in the attachment literature, is that both the parental and infant attachment systems are dependent upon the continual and active monitoring and accurate assessment of the environment (Solomon & George, 1998). While this type of monitoring often occurs simultaneously, each system can, at times, be dependent upon the other as a backup. What happens, however, if a traumatic experience in the mother's past hinders her ability to accurately and/or actively assess and monitor her child's environment? Alexander (1992) proposed that a disturbance in attachment in any or all family members is likely to be associated with a diminished capacity to meet a child's needs in appropriate ways, to monitor the child's environment to ensure safety and protection, and/or to seek help to stop abuse. Attachment theory may therefore be able to elucidate how aberrant patterns of parenting, combined with an inability to tolerate intense affects, can be transmitted across generations thereby increasing the

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likelihood of the sexual victimization of the next generation (Sroufe, 1986).

Dissociation, commonly understood as a constriction of affect and memory, is one possible symptom that can occur after experiencing a traumatic event. Although dissociative experiences run along a continuum and vary in severity and duration, all can leave a parent at least momentarily, but possibly for extended periods of time, unavailable to her child. Current research has found that survivors of childhood sexual abuse are more likely to suffer from dissociative experiences than are their non-abused counterparts (Davies & Frawley, 1994).

Mary Main and her colleagues (Main, DeMoss, & Hesse, 1991/1994; Main & Goldwyn, 1984; Main & Hesse, 1992) have hypothesized that unresolved past traumas have a direct impact upon parenting behaviors. If a parent is unable to deal with intense negative affect or she is prone to moments of dissociation when her child displays attachment behaviors, she may be unable to regulate her own affects and/or those of her child's. A parent who experiences dissociation may be unable to actively monitor and assess the environment during dissociative periods and as a result, her ability to protect her child in dangerous situations may be compromised.

During dissociative moments it is not only possible that a mother might be unable to actively scan her own, as well as her child's, environment to ensure their safety, but her behaviors may actually come to be perceived by her child as frightened and/or frightening (Main & Hesse, 1990, 1992). Children of parents who display frightening and unpredictable (i.e. dissociative) behaviors not only learn to inhibit their negative affects, but they may come to display disorganized or disoriented behaviors when their own attachment system becomes highly activated. This often

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results in the child believing that they are the cause of their parent's distress and/or unworthy of their love (Main & Hesse, 1990).

What makes some women more resilient and perhaps less likely to transmit their trauma onto their own children, while other women remain unable to prevent this from happening with their child? Using attachment theory as a foundation, this study explored the relationships between mental representations of attachment and caregiving behaviors among women sexually abused during childhood. The study also looked at how the resolution of trauma and use of dissociative defenses may impact those representations so as to influence the intergenerational transmission of trauma. This was a qualitative study that examined whether attachment theory can offer any new perspectives on the intergenerational transmission of trauma between women sexually abused during childhood and their children.

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REVIEW OF THE LITERATURE

ATTACHMENT THEORY

From infancy, children are dependent upon caring adults for their survival. As first developed by John Bowlby, attachment theorists posit the existence of a biologically based bond, or behavioral system, between a child and her caregiver. This bond adaptively functions to ensure the child will be adequately cared for and protected from danger (Ainsworth, 1982; Alexander, et al., 1998; Bowlby, 1969/1982; George & Solomon, 1999; Solomon & George, 1998). In the child, this system is called the "attachment behavioral system" and the reciprocal system in the parent is known as the "caregiving system". The attachment relationship has long been thought to be complementary; the attached person seeks security while the attachment figure provides it.

The attachment behavioral system and the caregiving system are thought to be only two of the many behavioral systems in mammals. Other systems include those for eating, sleeping and exploration. All behavioral systems are comprised of behaviors that are coordinated to achieve a specific goal and all have an adaptive function. For example, the goal of the attachment behavioral system is proximity to a caregiver, while the goal of the caregiving system is protection of the young from danger. Both have the assurance of survival of the infant as their adaptive function. All behavioral systems are seen as "goal-corrected", meaning that behaviors used to achieve a specific goal are flexible and are dependant upon the circumstances and the individual's development (Bowlby, 1969/1982).

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The attachment behavioral system in the infant is comprised of a set of "attachment behaviors" that have the predictable outcome of increasing proximity of the child to the "attachment figure". The "attachment figure" is thought to be any discriminated individual, although it is the mother who is most often viewed as the primary figure. Seen from an ethological standpoint, Bowlby hypothesized that proximity to the attachment figure provided the child with the advantage of survival because it increased the likelihood that she would be protected from predators by her attachment figure. With evolution, attachment behaviors have come to contain not only the biological function of protecting an individual from physical harm, but from psychological harm as well (Bretherton, 1985). Because of this biological function of protection, it is believed that children are particularly predisposed to seek the parent in times of emotional distress (Ainsworth, 1982; Belsky & Cassidy, 1994; Bowlby, 1969/82; Goldberg, 1991).

The attachment behavioral system becomes activated when the child experiences a sense of danger, whether real or imagined. Attachment behaviors, which during infancy include crying, seeking, crawling towards the parent, and smiling, are elicited to aid the child in seeking physical proximity to her caregiver. The attachment behavioral system becomes deactivated once the child attains physical contact with or a sense of security from the attachment figure. Attachment behaviors change over the course of time and with the child's development, but are thought to always assure not only the physical safety of the child but the child's perceived security, which in turn leads to the child's physical and emotional survival (Bowlby, 1977). However, it is not just the mother's physical presence to the child

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that is important, but the child's belief that the attachment figure will be available if needed (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1969/1982). Research has since shown that a mother's sensitive and prompt response to her infant's signals is the single most important predictor of an infant's attachment security (Ainsworth, et al., 1978).

The reciprocal system of the caregiver also has as its behavioral goal proximity to the child. At the emotional level this is thought to include felt safety or protection of the child. Theoretically, the caregiving system can be activated either by external or internal cues associated with situations that the caregiver perceives as dangerous, frightening, or stressful for the child. Once this system is activated, the caregiver can call upon her own repertoire of behaviors that include retrieval, maintaining proximity, following, calling, and looking to ensure the child's safety. The caregiving system becomes deactivated by physical or psychological proximity to the child, signs that the child is comforted, contented, or satisfied, or a change in the environment that signals that danger has passed (Solomon & George, 1998). Over time, the mother's behaviors are modified to acknowledge her child's new developmental capabilities. While the child's physical safety continues to be of great importance, as the child ages the mother may rely more on psychological proximity to assure the child's security.

Affect has been shown to play a central role in the regulation of behavioral systems. In the attachment behavioral system, affect functions both as a means to regulate the child's own behaviors and those of her parent's, as well as a way for the child to make sense of daily experiences. For example, the infant uses fear, anger and

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distress as a way to maintain and monitor her relationship with her parent. How the parent regulates the infant's negative affect is seen as a crucial component to the mother's caregiving (Kobak, 1987; Solomon & George, 1998). Affectivity in the parent can also have an impact upon caregiving behaviors. For example, pleasure can motivate a parent to prolong or repeat behaviors, fear can motivate a parent to overcome obstacles, and feelings of despair or being overwhelmed can cause a caregiver to relinquish the goal of protection (Solomon & George, 1998). In sum, affect both activates and regulates behavioral systems, which in turn, leads to the development and maintenance of one's model for attachment relationships.

Internal Working Models of Attachment

Unlike Freudian theory, which emphasized one's inner fantasy life as a way to explain child development and psychopathology, Bowlby based his theory of attachment on one's real experiences. Bowlby believed that through continual transactions with the world, the child comes to construct increasingly complex models of the world and significant people in it, including the self (Bretherton, 1985). It is the interactions between the caregivers and child that lead to the child's cognitive templates of relationships and affect regulation, or one's internal working model of attachment. The term "internal working model" is used to describe the individual's internal representation of the world, significant figures, the self, and the relations among them (Main, 1991). Internal working models are basically understood to be a set of rules that govern one's behaviors in interactions with others. The models are derived from experiences and interactions with the world and one's significant

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caregivers. The models are then used to appraise and guide behavior in new situations so that the child does not need to assess each new situation and her attachment figure's availability every time as though it were the first time. Craik, as quoted by Bretherton (1985) stated,

> If the organism carries a small-scale model of external reality and of its own possible actions within its head, it is able to try out various alternatives, conclude which is the best of them, react to future situations before they arise, utilize the knowledge of past events in dealing with the present and future, and in every way to react in a much fuller, safer and more competent manner to the emergencies which face it. (p.11)

The term internal working model implies that it is an active construction. As new information comes in, it is assimilated into existing models and these models are constantly revised over the course of early development. However, because it is thought that the internal working models of the attachment figure and self operate outside of conscious awareness, as an individual ages the models become relatively resistant to dramatic changes (Bowlby, 1977; Bretherton, 1985; Main, et al., 1985). Bowlby believed that as an adult, existing models of self-with-other would be used when any new bond with a significant other, such as a spouse or a therapist, was formed. While some researchers have documented relative stability in attachment behavior from 12 months to 6 years (Main, et al., 1985), others have found that life stresses can cause either beneficial or detrimental changes in attachment patterns (Egeland & Sroufe, 1981; Thompson, Lamb, & Estes, 1982; Vaughn, Egeland, Sroufe, & Waters, 1979).

Since internal working models of attachment are formed from generalized attachment-related experiences with the parent, one's sense of self and self-with-other

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are closely intertwined with one's parenting experiences. In other words, each side of the infant-parent relationship can only be understood with reference to the other (Bretherton, 1985; Main, et al., 1985). For example, if a caregiver displays rejection when the child displays behaviors asking for comfort during stressful situations, the child comes to develop an internal working model of the parent as rejecting and a model of the self as unworthy of such love and comfort. Conversely, if the parent responds to the child's cries for comfort in an effective and helpful manner, the child comes to develop an internal working model of the parent as loving and one of herself as worthy of such love and support.

Bowlby (1973) originally introduced the concept of multiple models of attachment as a way to account for an individual's incoherence regarding attachment. He hypothesized that an individual can create two or more working models of the same attachment figure which are contradictory or incompatible, in that both or several could not be true simultaneously. These models refer to the same aspect of reality, rather than to multiple models of different aspects of reality. In other words. one can have several models of relationships with significant caregivers, such as one for mother and a separate one for father, but an individual should have only one model for each parent. However, multiple models may occur when an individual is confronted with discrepant and inconsistent experiences with a caregiver (such as when an abusive parent is also caring) and they need to defensively exclude or dissociate one aspect of the relationship in order to make sense of the other aspects (Bowlby, 1973; Bretherton, 1985). Bowlby believed that defensive exclusion of attachment occurs when the attachment behavioral system is strongly activated but

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the attachment figure is unable to provide the child with a sense of security (Solomon & George, 1999). Under these extremely stressful conditions, the child can develop what Bowlby termed "segregated systems", which he defined as an extreme and potentially pathological form of exclusion that functions to separate information regarding attachment from consciousness (Solomon & George, 1999).

Thus, it is believed that individual differences in the functioning of the attachment behavioral system are tied to actual experiences with significant caregivers that have formed the individual's working model of self, other, and world. When a young child displays intense attachment behaviors that are either ignored or reprimanded by the attachment figure, the child can develop multiple models of attachment as a way to deactivate the attachment behavioral system. For this to occur, it is believed that the individual defends against or dissociates one model while the other model is in operation (Liotti, 1999).

Main (1991) believes that children under three are most vulnerable to developing multiple models since they lack the cognitive capacity to code and make sense of experiences that are contradictory. For example, young children are unable to engage in metacognition, or thinking about their own cognitive processes. One aspect of this, "dual-coding", or the ability to fit the same item into two different categories at the same time is necessary in order to make sense of contradictory or incompatible behavior by a parent. It is believed that by age 6 most children can do this, while three year-olds have yet to develop this ability. Rather, they have tremendous difficulty understanding that their mother can also be somebody else's sister, let alone that their mother can be the source of abuse and the source of care. It

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is also thought that the younger one is when these experiences occur the more likely they are to become solidified and therefore less likely to change. This is noteworthy since it can be hypothesized that individuals who are subjected to sexual abuse during early childhood are confronted with incompatible and inconsistent interactions with their abuser that become difficult to change over time. If this person is both an attachment figure, who the child turns to for comfort and support, and the source of alarm or hurt, this experience is likely to lead to the development of multiple internal working models of the relationship. In light of the present study looking at mental representations of attachment and caregiving among women sexually abused during childhood, this is theory is particularly interesting. Attachment theorists would hypothesize that through these internal working models of attachment, the patterning of the adult personality and future caregiving behaviors takes place (Ainsworth, 1967: Bowlby, 1973; Bretherton, 1985; Main, et al., 1985). How then do multiple models of attachment and segregated systems of attachment-related experiences, affects, and cognitions influence the intergenerational transmission of attachment and/or trauma?

The Intergenerational Transmission of Attachment

It has been hypothesized that internal working models of attachment are the most important mechanism through which early attachments influence new relationships (Ainsworth, 1991; Bowlby, 1977; Main et al., 1985). Recent studies indicate not only a high rate of concordance between an adult's "state of mind" with respect to attachment and the attachment status of their infant, but also that an adult's thoughts and emotions about relationships influence their own caregiving behaviors.

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These behaviors, in turn, influence their child's attachment status (George & Solomon, 1996; Goldberg, 1991; Main & Hesse, 1990; Slade, Aber, Belsky & Phelps, 1999; Van IJzendoorn & Bakersmann-Kranenburg, 1997). Internal working models provide an individual with information regarding how people will respond to her in social contexts based upon how her parents responded to her within the parenting context (Bretherton, 1985; Main, et al, 1985; Solomon & George, 1996). This can lead to a continuation of particular patterns of interacting and relating, however maladaptive, that were established early in childhood.

Intergenerational transmission of patterns of attachment has been demonstrated via concordances between infant attachment classification on the Strange Situation and parent classifications on the Adult Attachment Interview (AAI) (Ainsworth & Eichberg, 1991; Fonagy, Steele, Moran, Steele, & Higgitt, 1993; George, Kaplan & Main, 1984/1996; Main et al., 1985; Van IJzendoorn, 1992). The Strange Situation looks at how young children respond when faced with increasingly stressful separations from a significant caregiver over the course of 20 minutes. Based on their responses to their caregiver upon reunion, children are classified as Secure, Avoidant, Ambivalent, and/or Disorganized/Disoriented (Ainsworth et al., 1978; Ainsworth, Bell & Stayton, 1971; Main & Solomon, 1986, 1990). The AAI, on the other hand, is a semi-structured interview and classification system used to identify adult mental representations or "states of mind" with respect to attachment, as opposed to the adult's actual internal working models of attachment relationships. After careful review of the interview transcript, each adult is classified into one of four categories of adult attachment: Secure autonomous, Dismissing of attachment,

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Preoccupied by past attachments, or Unresolved with respect to trauma (Main & Goldwyn, 1985). (For more information about the AAI and the classification system, see section in Methods.) Each of these categories has since been shown to correlate with infant attachment behaviors.

Studies have shown that secure children most often have parents with Secure/autonomous states of mind with respect to attachment. On the AAI, these parents readily recall attachment experiences and can discuss them in a coherent way. They display a particular ease in discussing both positive and negative aspects of their feelings. When responding to their children's heightened attachment behaviors, these parents accurately read their cues and respond sensitively to their children's needs. They come to be perceived by their children as consistently available. Avoidant children most often have parents who are Dismissing of attachments and Ambivalent children most often have parents who are Preoccupied with attachment relationships. On the AAI, these parents have poorly integrated discussions of their early attachment experiences and show many contradictions and inconsistencies in their organization of recollections (Main, et al., 1985). In responding to their children, those who are Avoidant are perceived as being rejecting of their infant's attachment behaviors, while those who are Preoccupied are seen as responding to them in an inconsistent or insensitive way. These children perceive their parents as unavailable to them on a consistent basis (Slade & Aber, 1992).

In contrast to the above classifications, which show an organized strategy for dealing with the activation of the attachment behavioral system, children who are classified as Disorganized/Disoriented in their attachment behaviors lack a consistent

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and organized strategy. Instead, upon reunion with their parent during the Strange Situation, they are more likely to engage in contradictory or incompatible reunion strategies, such as approaching the parent with head averted, approaching then suddenly freezing, or rocking on their hands and knees without moving forward (Main & Solomon, 1990). These infants do not appear to have constructed consistent, predictable rules to guide cognition, affect, and behavior in attachment-related situations (Slade & Aber, 1992). Instead, disorganized/disoriented children seem to behave as if they have experienced a collapse of behavioral and attentional strategies (Main, 1995). Since identification of this classification, these children have also been found to have a parent with a history of unresolved trauma (Ainsworth & Eichberg, 1991; Main, et al., 1985).

The origin of the unresolved trauma of the parents in Main's original study was death of a significant caregiver (Main & Hesse, 1992). Since then, other researchers have shown that infant disorganized status can also be linked to parental experiences of abuse (Carlson, 1990; Ward & Carlson, 1995). While many parents who experience a trauma during childhood may also show inconsistencies in their descriptions of their attachment relationships, what distinguishes these individuals most is their tendency to break down during their retelling of traumatic events. Here, they may become irrational, illogical or be unable to stay on the topic. They display what Main has identified as lapses in the monitoring of reasoning or discourse during the discussions of the traumatic events (Main & Goldwyn, 1985/1994). Since not all adults who experienced loss or abuse receive this classification, it has been hypothesized that this category is related not to the actual experiencing of a trauma,

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but rather to the ability to consciously access the information regarding the trauma, as well as to the way the attachment-relevant information becomes organized around the traumatic experience (Main, 1991; Main, et al., 1985).

Main and Goldwyn (1985) have offered some suggestions as to how attachment relationships come to be transmitted intergenerationally. They hypothesized that the secure adult is able to perceive and understand infant signals without distortions, whereas the insecure adult has to ignore or alter some of the infant's signals because they threaten to destabilize the current mental organization of past experiences. Another hypothesis that has been generated is based on the belief that different states of mind with respect to attachments are associated with different childrearing practices. While the specific way still remains unclear, we do know that parental responsiveness to a child's signals is a major factor in the intergenerational transmission of attachment (Bretherton, 1985; Haft & Slade, 1989). How then does an unresolved trauma come to impact the attachment behavioral system and, ultimately, mental representations of attachment?

Unresolved Trauma: Its Relationship to Disorganized/Disoriented Attachment Classifications

The association between indices of disorganized mental states with respect to loss and the infant's disorganized attachment status was first noted by Main & Solomon (1990) as part of a follow-up study of Main's original Bay area sample. In this study, AAI transcripts were compared with the child's behavior toward the parent in the Strange Situation. The authors found a strong association between infant

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disorganized attachment status and lapses in the monitoring of reasoning or discourse on the part of the parent during discussions of potentially traumatic events. This finding was replicated by Ainsworth & Eichberg (1991) and elaborated on by showing that parents who had experienced a significant loss during childhood but did not show lapses in reasoning or discourse did not have infants judged to be disorganized on the Strange Situation. Main & Hesse (1992) have suggested that lapses in the monitoring of reasoning or discourse may represent either interference from normally dissociated memories or unusual absorption related to the memories triggered by discussions of traumatizing events. These lapses can indicate either a parallel but incompatible belief and memory system or a shift of state, whereby the individual has entered into a peculiar, compartmentalized state of mind involving a particular traumatic experience (Hesse, 1996).

Main and Hesse (1990, 1992) have generated one hypothesis to explain how unresolved trauma comes to impact the attachment behavioral system. They believe that parents of disorganized infants may experience some kind of constriction or dissociation at times when the parenting situation becomes too stressful, like when the child's attachment behavioral system becomes strongly activated or when the parent is confronted with affect that incites the memory of the traumatic event. The child in the company of this parent is then faced with a caregiver who may appear either frightened or frightening. Either stance can be traumatizing for the young child since the source of the behaviors is internal and therefore incomprehensible to the child. While the child wishes to flee from this frightening figure, she is left in an irresolvable paradox. Although fear activates the attachment system and the infant is

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compelled to seek proximity, proximity to this attachment figure increases the child's fear. The attachment figure has become both the source of the alarm and a haven of safety. Yet, since the child cannot terminate the activation of her attachment system by approaching the parent, avoiding or shifting attention away from the parent, or fleeing (Main, 1996; Solomon & George, 1999) a visible collapse of behavioral and attentional strategies may now be observed (Main & Hesse, 1990, 1992; Main & Morgan, 1996). As a way to make sense of what is occurring, the child may also come to believe that she is the source of the alarm.

Solomon & George (1999) and Lyons-Ruth, Bronfman & Atwood (1999) take this hypothesis one step further. These researchers believe that a key feature to the development of disorganization in the child is not whether the parent engages in frightened/ frightening behavior per se, but rather whether they attempt to repair the situation with their child afterwards. These researchers all agree that many parents engage in frightening behavior towards their children, often accidentally such as when a child is dropped. What distinguishes those parents whose children have an organized attachment system from those who are disorganized is the parent's ability to correct or repair their errors by terminating the child's attachment behavioral system once it has been strongly activated. Failure to terminate the attachment system is seen by Solomon and George (1999) as a type of abdication of the caregiving system.

When confronted with a parent who is frightened or frightening, the disorganized child is likely to view herself as both frightened and without recourse, which leads to the development of a segregated system. "Because...behavioral

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systems are inextricably tied to mental representation, these experiences should be reflected in the disorganized child's mental representation of *him- or herself* as vulnerable and helpless in the face of frightening events and the *attachment figure* as failing to provide protection and reassurance" (Solomon & George, 1999, p.16)

One key point to understanding the intergenerational transmission of attachment and trauma was suggested by Main (1995). Main believes that parents who are not themselves abusive toward their children, but who have been unable to resolve their own history of trauma may in fact traumatize their children by withdrawing from them or by entering into dissociative or trance-like states. It is believed that these parents suffer from partially dissociated experiences of trauma and the disorganization in their child is understood as a second-generation effect of the parent's experiences. These dissociative behaviors on the part of the parent can cause unresolvable conflicts for the child, which require her to construct an internal working model of the self and attachment figure that is multiple and incoherent (Liotti, 1992).

Since identification of the disorganized/disoriented category, 80% of maltreated infants and 15-20% of low-risk infants have been found to fit this classification (Carlson, Cicchetti, Barnett & Braunwald, 1989; Lyons-Ruth, Repacholi, McLeod & Silva, 1991; Spangler, Fremmer-Bombik & Grossman, 1996). As children develop, it is believed that a shift from disorganized attachment behavior to mental representations of attachment that are classified as controlling occurs. Follow-up studies of disorganized infants at age 6 do, in fact, show that these children are more likely to engage in controlling behaviors toward their parents following a

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one-hour separation. These controlling behaviors are seen as a way to maintain engagement with the parent on the parent's own terms by reorienting their own attachment behaviors away from seeking comfort and support from their caregiver (Main & Cassidy, 1988). Controlling behaviors have since been found to be divided into two types, punitive and role-inverting/caregiving (Main & Cassidy, 1988). When asked to play out family separations with dolls, researchers found that controlling/punitive children engaged in fearful, violent or catastrophic fantasies without positive solution, while those who were controlling/caregiving became inhibited, sitting frozen in silence (Solomon & George, 1991; Solomon, George & De Jong, 1995). Solomon and George (1999) also found that many of these disorganized children revealed evidence of segregated systems, showing a mixture of becoming flooded and constricted during these tasks. As will be discussed in the next section on trauma, these affects are similar to the flooding and constriction that many survivors of trauma report.

It has been hypothesized that disorganized children, given the opportunity to develop a sense of security with other supportive, loving figures and in the absence of intervening trauma, can grow up to become adults with organized mental representations of attachment. However, it is also believed that since parents of disorganized children are less attuned to their children's attachment cues, these children are more likely to be exposed to trauma and less likely to rely on their attachment figure to help resolve the experience (Lyons-Ruth, et al., 1999; Lyons-Ruth & Jacobvitz, 1999). It is therefore believed that disorganized children are at the greatest risk for developing psychopathology in later life.

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Liotti (1992) has hypothesized that should other traumas come to be experienced during the disorganized child's life, these individuals may be more likely to develop dissociative disorders. In fact, Main & Morgan (1996) have proposed that infant disorganization, lapses in the monitoring of reasoning and discourse, and dissociation have similar phenotypic resemblances. Liotti (1999) takes this argument one step further by showing how disorganized infants are unable to synthesize their overall interactions with a caregiver into a cohesive memory structure and that it is this same inability of the integrative functions of memory that characterizes pathological dissociation. (For a more detailed discussion on dissociation see section under 'Trauma'.)

Recent studies have provided some support for these hypotheses. Using the AAI, Main (1995) found that college students who were classified as Disorganized were more likely to show significantly elevated levels on a scale of absorption and dissociation, as compared to all other groups of insecure students. Coe, Daleenberg, Aransky & Reto (1995) similarly found that fearful attachment style in adulthood (which has been equated with earlier disorganization) is significantly related to a greater likelihood of dissociative experiences among a non-clinical sample. In a longitudinal study, E. Carlson (1998) found that infants classified as Disorganized scored higher on ratings of dissociative behavior during the elementary school years and overall psychopathology in adolescence. By age 17 ½, disorganization during infancy was positively correlated with significant scores on the Dissociative Experiences Scale (DES), a self-report measure of dissociation.

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In another longitudinal study, Ogawa, Sroufe, Weinfield, Carlson & Egeland (1997) compared scores on the DES for three groups of young adults previously classified during infancy. The first group consisted of those classified as Disorganized in infancy who had not experienced later trauma, the second group consisted of those young adults classified as Disorganized who had been subjected to later trauma, and the final group consisted of all others not previously classified as Disorganized. A significant elevation in DES scores was noted for those young adults who had experienced later trauma. In fact, these authors found that 78% of those classified as Disorganized during infancy later experienced some form of trauma, suggesting that their caregiving environments may have placed them at risk for further exposure to trauma or loss.

We now turn to an examination of the caregiving system to better understand how mental representations of attachment can impact the caregiving system. Fraiberg, Edelson & Shapiro's (1975) seminal paper on childrearing practices, together with recent research on the caregiving system, can help us to understand why some parents' traumatic experiences remain unresolved and therefore are prone to be transmitted to the next generation, while other parents who are resolved with respect to their traumatic histories are able to limit the potential for transmission to the next generation.

The Caregiving System

In every nursery there are ghosts

Fraiberg, Edelson & Shapiro, Ghosts in the Nursery,
1975 p.164

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It is generally believed that a parent's experiences as a child will greatly influence his or her own childrearing attitudes and practices (Ainsworth & Eichberg. 1991; Fraiberg, et al., 1975; Slade & Cohen 1996; Van IJzendoorn, 1992). Fraiberg, et al. (1975) labeled these past histories our 'ghosts'. Fraiberg and her colleagues hypothesized that memory for traumatic events and the affect associated with those experiences influence whether or not a parent will transmit their trauma onto the next generation. These authors believed that while some parents are able to keep their pasts buried and others learn to live side-by-side with their ghosts, other individuals end up allowing their ghosts to take hold of daily interactions, leaving the parent to repeat her conflicted past with her own child. Fraiberg and her colleagues, however. clearly believed that history was not destiny; experiences of loss and trauma do not mean that one is destined to repeat those experiences with one's own child. These authors, instead, believe that what differentiates those parents who repeat prior traumas from those who do not is the ability to remember one's past. "...The parent who cannot remember his childhood feelings of pain and anxiety ...will need to inflict his pain upon his child" (Fraiberg, et al., 1975, p. 182). These authors are also clear that memory alone is not enough; affect must not become isolated from the memories. They hypothesize that access to childhood pain is a powerful deterrent against repetition in parenting, while repression accompanied by the isolation of affect allows for identification with those who inflicted the original pain. In other words, repetition does not happen automatically but comes with an inability to remember and feel.

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Attachment theorists would concur with these views. It is believed that only a parent who is flexible and free to engage in thoughtful reflections about their own childhood memories, whether painful or loving, is able to parent her child in such a way so as to be available to her child as a secure base. Researchers now also understand not only the significant role the primary caregiver plays in shaping the quality of the relationship with her infant, but also that the actual caregiving experiences with the infant serve as a catalyst for the development of the caregiving system, including the development of representations that help guide that system (Aber, Belsky, Slade & Crnic, 1999; Solomon & George, 1996).

George and Solomon (1993, 1996; Solomon & George, 1996) have proposed, in accordance with Bowlby's original theory, that the caregiving representational system has its developmental roots in the construction of working models of self and other in the context of attachment relationships during childhood. Under normal circumstances, this model is viewed as distinct from the attachment behavioral system, with its own developmental trajectory. Each mother needs to ask and answer not only if they are able to care for their child, but also if they want to protect their child (Solomon & George, 1998). To the extent that the young adult has had positive or benign experiences with caregivers, these preliminary questions can be answered positively. However, individuals who have had experiences with caregivers that have been disappointing or traumatic will have a harder time answering these questions. The caregiving representational system is constantly developing but most probably goes through its most radical growth and change during the transition to parenthood. Solomon and George (1996) also believe that each parent must find the appropriate

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balance between caring for her young child and taking on her other roles, for example as wife, employee, and mother to her other children.

Several research teams have recently begun to study the caregiving system. Though each team has defined the concepts somewhat differently and approached their data from different perspectives, most have conceptualized and measured parents' mental representations of the caregiving relationship in similar ways (Aber, et al., 1999; George & Solomon, 1996; Slade, Aber, Belsky, & Phelps, 1999; Solomon & George, 1996; Zeanah, Benoit, Barton, Regan, Hirshberg & Lipsitt, 1993). Preliminary results indicate that all have recognized that parents' mental representations of caregiving impact their parenting behaviors.

Zeanah & Benoit (1995) developed the Working Model of the Child Interview (WMCI) as a means to assess parents' perceptions and subjective experiences of their infants and their relationships with them. In this system, parents' representations of the child are classified as Balanced, Disengaged or Distorted, ratings that are thought to be comparable to those developed by Main for the AAI. The authors found that a mother's WMCI classification is systematically related to her infant's concurrently assessed attachment classification at 12 months of age, between 69 and 73% of the time (Zeanah, et al., 1993; Zeanah & Benoit, 1995).

Slade and her colleagues have taken a slightly different approach to measuring parent's representations of their relationship with their child. They believe there exists three distinct dimensions of the mother's affective experience of parenting a young child: joy/pleasure, anger, and guilt and separation distress. In a study of 66 middle- and working-class families with toddlers, Slade, Aber, Belsky & Phelps

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(1999) found that mothers who represented their attachment history with their own parents in an autonomous way on the AAI displayed significantly more positive parenting during a home observation than mothers who did not have autonomous representations. However, the opposite was not found; representation of attachment history and negative mothering were not found to be significantly correlated. On the Parent Development Interview, Aber, Slade, Berger, Bresgi, & Kaplan (1984) found that maternal representations predicted mothering style. Mothers who evinced more joy/pleasure also engaged in more positive parenting behaviors, whereas mothers who revealed more anger engaged in less positive parenting and more negative parenting.

In another study by this same team of researchers, 125 working- and middle-class families were observed with their first-born male toddler at 15 and 28 months. Aber, et al. (1999) found that mothers who represented their relationship with their child in a more coherent manner at 15 months expressed less anger at 28 months, and mothers who expressed less anger at 15 months represented the relationship in a more coherent manner at 2 years. It was also noted that the more positive parenting a mother engaged in during this time period, the more the mother's representations of their children increased in terms of joy/pleasure and coherence. However, parenting hassles, both those associated with parenting as well as hassles one encounters in daily life, predicted an increase in parenting representations of anger during the toddler years.

Adapting the Parent Development Interview (Aber, et al., 1984), George & Solomon (1989, 1996) interviewed mothers to better understand how styles of information processing and defensive exclusion differentiated among parents' mental

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representations of caregiving and their child's attachment status. They have conducted studies with both infants and 6-year olds. Similar to the results of studies using the AAI, these researchers found that balanced and integrated thinking distinguished mothers of Secure children who are able to provide adequate protection when their child's attachment system becomes activated. Mothers of Avoidant children were noted to deactivate the caregiving system and reject their child's attachment needs, while mothers of Ambivalent children used cognitive disconnection, or uncertainty, as a way to defensively exclude attachment-related cues. Both Rejecting and Uncertain mothers were considered to be able to provide only limited protection to their children. Finally, mothers of Disorganized children displayed helpless behaviors and described themselves as being out of control and lacking effective strategies to handle their children. These mothers are believed to be the least able to provide protection to their children (George, 1996).

As previously discussed, unresolved traumas or experiences that cannot be fully acknowledged because of an inability to tolerate the associated affects can lead an individual to have moments of lapses in discourse or reasoning. Solomon & George (1999) found that during attachment interviews, mothers of Disorganized children often described themselves as helpless and without strategies to parent effectively. These mothers often made explicit statements related to two themes: 1) that they are out of control and unable to manage their child, the situation, or their own behavior and 2) that they experience exceptional closeness or merging between themselves and their child. These two stances of caregiving mirror those of constriction and flooding that was earlier seen in Disorganized children and has been

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associated with symptoms seen in survivors of trauma who suffer from Posttraumatic Stress Disorder, as will be reviewed in the next section.

Recently, studies have begun to look at Main & Hesse's hypothesis regarding frightened/frightening behavior on the part of the caregiver to better understand its relationship to attachment disorganization. As reviewed by Lyons-Ruth & Jacobvitz (1999), these studies have used observations of parent-infant interactions and systematically found that broadly defined maternal frightened/frightening behaviors are related to both infant disorganized attachment status and to parental unresolved states of mind. A subscale for maternal dissociated behavior more strongly predicted infant disorganized behavior than did the Dissociative Experiences Scale, a self-report of dissociation. Other studies reviewed by Lyons-Ruth & Jacobvitz (1999) found that mothers of disorganized infants displayed less affectionate behavior toward their children, displayed disruptions in maternal affective communication, and were less emotionally available than mothers of children with organized attachment strategies.

As one takes on the role of a parent, Solomon & George (1996) have suggested that a simultaneous shift should occur from a childhood perspective (being the one who is attached) to a caregiving perspective (being the one who is the caregiver). Now, in situations of danger and alarm, the caregiving system should be activated and the parent should organize her psychological and behavioral strategies to provide protection to her young child. If, however, the parent's own attachment behavioral system is activated during these times of alarm and danger, then she should turn to her own attachment figures for protection and not to her own children.

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These authors suggest that when in a state of helplessness, parents of Disorganized children are likely to abdicate the caregiving system thereby failing to provide care that will terminate the child's attachment system. This is an example of a multiple model, whereby the individual who needs to provide security to a child may instead seek protection from that child. It has thus been hypothesized that parents who are unresolved with respect to trauma are more likely to abdicate the caregiving system and are therefore less capable of providing protection when their child's attachment system is strongly activated. This can increase the child's risk of being exposed to trauma.

Fraiberg and her colleagues, together with attachment theorists, have helped to elucidate how unresolved traumas can influence parenting behaviors. We will now turn to the study of trauma to better understand what constitutes a traumatic experience, how individuals encode and remember traumatic events, and how these types of experiences during childhood can influence adult personality functioning.

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TRAUMA

It is only within the past hundred years that psychological reactions to trauma have been identified, linked and studied. Until the late nineteenth century, the medical community viewed symptoms developed after a stressful life event as a hereditary weakness of the nervous system. Breuer and Freud (1895) were among the first professionals to reject the long-standing belief that people were predisposed to symptomatic reactions. Instead, they proposed a theory that focused on the contribution of unconscious psychological processes to stress responses. Significantly, they were among the first to hypothesize that traumatization contributed to the formation of hysteria. As reported by Herman (1992), Pierre Janet was conducting similar studies with patients in France and found comparable results.

Freud and Janet both agreed that unbearable emotional reactions to traumatic events produced an altered state of consciousness. Both recognized that the somatic symptoms of hysteria really represented distressing events that had been banished from memory. These investigators also agreed that hysterical symptoms could be alleviated when the patient recovered and put into words the traumatic memories and the affects associated with them. Eventually, as Freud helped his patients remember and talk about early traumas, he began to hear about stories of childhood sexual abuse. In 1896, Freud wrote, "...at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience" (p.203). Yet a year later, perhaps out of fear of rejection by his colleagues and friends, Freud repudiated this theory of the traumatic origins of hysteria thereby causing the psychological study of trauma in Vienna to abruptly come to a halt. In contrast, Janet continued his work

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with hysterical patients and never abandoned his theory of the impact of trauma on their lives. However, his views soon fell out of favor and his work was forgotten for many years until after the end of the First World War, when soldiers returned from the war with symptoms of trauma. Only then did research again begin to focus on the psychological ramifications of trauma.

What remains critical today from both Freud and Janet's writings is the focus on the subjective element of traumatic experiences. The DSM-IV (1994) defines as traumatic any experience that an individual has witnessed or been confronted with in which there is feared or actual exposure to death or injury, accompanied by a consequent sense of terror, horror, and/or helplessness. Some elements of the stressful situation are so difficult for victims to cope with or integrate into their existing cognitive schemata that distortions of affective or cognitive functioning are inevitable (Spaccarelli, 1994). Several models by which traumatic life events have been studied and understood now exist; one based on a psychoanalytic model and the other on an information-processing model will be briefly reviewed below.

Within the psychoanalytic model, trauma is viewed as a state of being paralyzed and overwhelmed, with concomitant states of immobilization, withdrawal, possible depersonalization and evidence of disorganization (Krystal, 1988). Krystal believes this implies a loss of ego functions, which can lead to regression and psychopathology. The ego's capacity to provide a minimal sense of safety and integrative intactness has been abruptly overwhelmed (Cooper, 1986). Krystal posits this kind of regression can be followed by attempts at mastery through repetition, dreams, and/or neurotic, characterological, or psychosomatic syndromes. He also

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theorizes that, "in these patients we see a lifelong disturbance in affectivity" (Krystal, 1988, p.142).

Catastrophic psychic trauma occurs when the ego surrenders to what is experienced as an unavoidable danger, whether of external or internal origin. The psychic reality of this surrender then causes the individual to give up and abandon life-preserving activity (Krystal, 1988). Evaluation of the situation as one of inevitable danger and the surrender to it is believed to initiate the traumatic process. Krystal (1988) distinguishes between 'upsetting' and 'traumatic' events by focusing on the subjective reaction of the person in the situation. His view is that anxiety is a sign of preventable danger and therefore is in evidence during upsetting events, while total helplessness is the signal of unavoidable danger and therefore a sign of a traumatic event.

Psychoanalytic theorists believe that traumatic memories are not encoded like ordinary memories. As opposed to typical memories that are encoded in a verbal, linear narrative that is assimilated into an ongoing life story, traumatic memories end up having a frozen, wordless quality (Herman, 1992; Davies & Frawley, 1994). They lack verbal narrative and context. Instead, traumatic memories tend to be encoded in the form of vivid sensations and images. These memories are thought to resemble the everyday memories typical of very young children (Herman, 1992).

Recovery, according to this model, is the capacity to recall the trauma and the associated affect at will, while being equally capable of turning one's mind to other matters (Horowitz, 1976). Although Herman frames this slightly differently, she too underscores the basic tenet of recall. According to Herman (1992), there are several

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fundamental stages to recovery: the establishment of safety, the reconstruction of the trauma story, and finally the reconnection between the survivor and her community.

Another way to understand trauma comes from the cognitive/information-processing model of personality theory. This theory of trauma also assumes a subjective aspect to what is considered a traumatic experience. In this model, trauma is defined as an experience which cannot be assimilated into a person's schema of self-in-relation-to-the-world (Horowitz, 1986). Janoff-Bulman (1985, 1992) hypothesizes that every person has schema for three basic assumptions: the belief in personal invulnerability, the perception of the world as meaningful and comprehensible, and the view of themselves in a positive light. Much of a person's psychological trauma is due to victimizing events that shatter the very basic assumptions that these individuals hold about the operation of the world. Traumatic events cannot be readily assimilated into the victim's assumptive world. Instead, old assumptions are shattered, and this produces psychological upheaval. According to Janoff-Bulman (1992), serious life events are those that will eventually change cognitive maps of how the self interacts with the world. In other words, the victim's assumptions about the world, her safety in it, and her self-worth are put into question. When any one of an individual's basic assumptions is shattered, trauma is considered to have occurred.

In order for a person to recover from a traumatic experience, this model assumes a "completion tendency". In other words, the "...mind continues to process important new information until the situation or the models change, and reality and models reach accord" (Horowitz, 1979, p.246). Or in Piagetian terms, people

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assimilate and accommodate information until their world makes sense again (Piaget, 1968). Until a traumatic life event can be successfully integrated into the existing self-structure, elements of the event remain in memory as determinants of intrusive imagery or other stress syndrome symptoms (Wilson, Smith & Johnson, 1985). These memory contents are stored in an active form of coding and tend toward repeated mental representation; that is, they tend to be examined continuously. Excessively high inhibitory controls may interrupt the process of assimilation and accommodation (Horowitz, 1986).

Recovery in this model, therefore, is seen as the integration of this new information into long-term memory and inner schemata. When this occurs, repetitions and intrusions will cease (Horowitz, 1979). The event can now be remembered, the attendant feelings are neutralized, and the anxiety generated by the event is controlled (Hartman & Burgess, 1988).

Since this study focuses on childhood sexual abuse, a specific type of trauma experienced before the age of 18, it is necessary to understand how trauma in childhood differs from traumas experienced in adulthood. Unlike adults who are traumatized when their cognitive assumptions about the self and the world are disrupted, children's cognitive assumptions about the self and the world have either not yet developed or may not be solidified. Does trauma experienced before these assumptions take root have different effects from trauma that occurs in adulthood?

Childhood Trauma

Today, psychologists acknowledge that children can and do experience a great

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deal of anxiety about their safety in the world. However, it is believed that children inherently look to their caregivers, typically one or both of their parents, to protect them from real or imagined dangers. But what happens when these figures are not physically or psychologically available to the child?

Psychoanalytic psychiatrist Lenore Terr (1991) defines childhood trauma "...as the mental result of one sudden, external blow or a series of blows, rendering the young person temporarily helpless and breaking past ordinary coping and defensive operations" (p.11). In this definition, Terr includes both experiences that are marked by intense surprise as well as those marked by a prolonged and sickening anticipation, as is often the case in long-term sexual abuse. Terr believes that all childhood trauma is generated from the outside, and unlike adult trauma cannot be generated solely from within the child's own mind (1991).

Krystal (1988), however, might not agree with this view and delineates an important distinction between an external traumatic event experienced by a child and what he calls "infantile psychic trauma". He believes a state of infantile psychic trauma can develop if a parent fails to intervene when the infant's diffuse affect state threatens to overwhelm him or her. Krystal describes the infant thus traumatized as flooded with unregulated, somatic, global and primitive affects, which render him inconsolable. In adults, the result of infantile psychic trauma can be seen in the lifelong presence of dread and expectation of the return of the traumatic state, accompanied by impairment in affect tolerance and lifelong anhedonia. The important thing to note in this type of trauma is that the unregulated affect state, by itself, is believed to be the source of trauma.

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Children are thought to be vulnerable to trauma because of their limited prior experiences and their dependency on adults to keep them safe. Once an event is perceived as traumatic, internal changes in the child can take place. While researchers looking at the resilient child have found that outcomes vary enormously because of the many variables influencing children, research specifically looking at trauma experienced during childhood has found that it can have deleterious effects on various aspects of a child's functioning. For example, research studies have found trauma can have a negative impact on a child's cognition (memory, school performance, and learning), affect, interpersonal relations, impulse control and behavior, and vegetative functioning (Bowlby, 1973; Elmer, 1977; Terr, 1991). It is also believed that trauma often leads to the formation of psychiatric symptoms (Pynoos & Eth, 1985). In addition, delays in the development of the self and in the ability to get along with and understand others have been found (Fish-Murray, Koby, & van der Kolk, 1987; Horowitz, 1992). It has also been noted that traumatized children are more withdrawn and apathetic, but also may exhibit a hypervigilant quality with a frozen watchfulness (Fish-Murray, et al., 1987). This finding is interesting in light of the research reviewed earlier on disorganized children who display flooding alternating with constriction during doll play of family reunions.

Information-processing theorists believe children may develop what is called a "trauma schema" after experiencing an overwhelming life event. That is, they learn to associate certain behaviors, experiences, or events with the initial trauma and they may come to over-generalize their reactions to other, non-traumatic situations. In

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later life, the early trauma schemas can be reactivated by non-traumatic events and the individual may be traumatized again (Horowitz, 1992).

The susceptibility of an individual child to psychic trauma is a function of several factors, including genetic, constitutional and personality makeup, past life experiences, state of mind, and the content and intensity of the event (Egeland, Carlson & Sroufe, 1993; Pynoos & Eth, 1985). It is thought that the most powerful influence in overcoming the psychological impact of a traumatic event is the availability of a caregiver who can be blindly trusted (Egeland, et al., 1993; van der Kolk, 1987).

It has also been shown that the developmental stage at which the child experienced the traumatic event is significantly related to the overall impact of that trauma. If the child is under four years of age at the time of a traumatic life event, the child will commonly react with anxious attachment behavior, which includes clinging and uncontrollable crying. However, the young child may be unable to take solace from the attachment figure (Bowlby, 1977; Main, 1995; Main & Hesse, 1990, 1992).

Pynoos and Eth (1985) found significant differences in the reactions of children to traumatic events depending on their age. They found preschoolers to be more likely to appear withdrawn, subdued or mute and to engage in reenactments and play involving the traumatic themes. Preschoolers also may experience significant sleep disturbances. In contrast, school-age children were found to display cognitive constrictions, as well as lowered intellectual functioning. Children in this age group also showed a decline in school performance although it was not always related to lower intellectual functioning. Behavioral alterations were also evidenced, such as

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irritability and a vacillation between extreme aggressiveness and avoidance of conflict which, in turn, may cause peer relationships to suffer. School-age children were especially prone to developing psychosomatic complaints. Finally, traumas experienced during adolescence seemed to be coupled with a premature entrance into adulthood combined with a premature closure of identity formation. Acting-out behaviors in this age group included school truancy, precocious sexual activity, substance abuse, and delinquency.

Typically, memory storage is understood as an active mental process whereby events first need to be perceived or registered before they can have an impact on the individual. After an event is perceived, it is encoded and goes into a short-term memory bank. If the event is considered significant, the coded memory then goes into long-term memory. Traumatic memories are believed to be stored differently from other kinds of memories. Based on Piaget's theory of cognitive development (1968), it is believed that traumatic events are organized on a sensorimotor or iconic level, as opposed to a symbolic/linguistic level. The traumatic event is encoded as a "thing" representation as opposed to as a "word" representation (Person & Klar, 1994).

Although research on memory for traumatic events in childhood is a relatively understudied field, researchers have been able to learn that single episodes of trauma are more easily remembered than repeated episodes (Terr, 1991). Terr (1988) also found that age at time of trauma affects how the event is remembered. In a study of 20 children, who were 5-years old or younger when they experienced a traumatic event, the author found that by the time a child was 2 ½ to 3 years old most children

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have the capacity to lay down and later retrieve some memory of the event. Most children in this study had some sort of behavioral memory as evidenced through post-traumatic play, personality changes related to frequent reenactments, and trauma-specific fears. However, it is important to remember that behavioral memories do not require conscious awareness. In other words, one can have a dissociated memory for a traumatic event, although one's behaviors can show evidence of the trauma.

Horowitz (1976) hypothesizes that the processing of a stressful event is less difficult if the person affected perceives the event correctly, translates the perceptions meaningfully, and then relates the meaning to her own enduring attitude. The person then must decide on appropriate action, and revise memories, attitudes, and belief systems to fit a new developmental line. This process is least likely to occur among young children. If ideal processing cannot or does not take place, the thoughts, feelings and memories associated with the event occupy active memory storage and constantly push toward release. Since they can be overwhelming, they may be actively put away or denied. Hence, a cycle occurs in which intrusive and repetitive thoughts alternate with denial and reports of numbing. When traumatic events remain in active memory or become defended against through the use of denial, dissociation, or splitting, the DSM-IV would consider the individual to be experiencing Posttraumatic Stress Disorder (Hartman, & Burgess, 1988).

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) can occur when a person has been exposed to an overwhelming life event. There exist two primary symptoms of PTSD.

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The first symptom consists of the re-experiencing of the event through repetitive, intrusive recollections or recurrent dreams. The second symptom consists of numbing or reduced responsiveness to the outside world which is commonly evidenced by diminished interest in previously enjoyed activities, a feeling of detachment from others, and/or constricted affect (Horowitz, 1986; Janoff-Bulman, 1985). These two contradictory responses of intrusion and constriction establish an oscillating rhythm. Since neither the intrusive nor numbing symptoms allow for the integration of the traumatic event, the alternation between these two extreme states might be understood as an attempt to find a satisfactory balance between the two. But an appropriate balance is precisely what the traumatized person lacks (Herman, 1992).

Wilson, et al. (1985) conducted a study to determine which factors influenced the severity of PTSD among various survivor groups. The authors found two variables that were considered the most stressful and which led to the most severe symptoms; these were threat and loss. The greater the degree of life threat and the greater the degree of loss, the more difficult was the task of assimilating elements of the stress into the self-structure. The highest levels of PTSD symptoms were found among Vietnam Veterans; however, the next highest was found to be among victims of rape. Researchers who have studied the effects of childhood sexual abuse have found rates of PTSD ranging from 69% to 96% among clinical samples of adult survivors (Donaldson & Gardner, 1985; Rowan, Foy, Rodriguez & Ryan, 1994). Recently, it has also been shown that dissociation at the moment of the trauma is an

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important concomitant experience for the development of full-blown PTSD, although this process is still not well understood (van der Kolk, 1997b).

To date, theorists and clinicians have been unclear about what exactly occurs during each of the two extreme states of PTSD. One possibility is that during the phase in which the person experiences intrusive and repetitive thoughts about the trauma, the person is actually reenacting the trauma, hoping to make sense of the event and transform it into one with a successful outcome (van der Kolk, 1985). This phase is characterized by hypervigilence, whereby the subject constantly scans the environment for threatening cues. This is in contrast to the numbing and denial phase, where the person may actually be dissociating. During moments of dissociation, all thoughts and affects stirred up by the event are blocked from the individual's mind. An inner clouding of perceptions may occur, accompanied by a diminished awareness of bodily sensations (Horowitz, 1986). Some people can do this to such an extent that they no longer acknowledge that the traumatic event occurred. As Person & Klar state, "the pathology of memory associated with post-traumatic stress disorder is forked; on the one hand dissociation produces amnesia, on the other hand, the intrusion of memories and repetitive images of the trauma. Amnesia alternates with symbolic repetition" (1994, p.1074). As medical technology has improved, recent studies of the brain have been conducted which have identified the chemical reactions that occur when a person experiences PTSD.

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The Psychobiology of Posttraumatic Stress Disorder

The human response to trauma is relatively constant across traumatic stimuli; the central nervous system seems to react to any overwhelming, threatening and uncontrollable experience by activating the autonomic nervous system. This occurs as a preparation for the individual to meet external threats. When the autonomic system is activated, the person can assess their situation and create appropriate psychological distance in order to achieve a measured response. The degree of autonomic arousal determines the intensity of the emotional response.

Intense stress is also accompanied by the release of neurotransmitters, such as catecholamines and serotonin, and endogenous opioids. These hormones help the organism mobilize the energy required to deal with the stress. In a well functioning individual, stress produces rapid and pronounced hormonal responses. However, chronic and persistent stress inhibits the effectiveness of the stress response and induces desensitization (van der Kolk, 1997a, 1997b). In people suffering from PTSD, we know that biobehavioral changes to this normal stress reaction have occurred. It is thought that the persistence of intrusive and repetitive thoughts, by means of the process of kindling, sets up a chronically disordered pattern of arousal (van der Kolk, 1997a, 1997b). Over time, people with PTSD come to suffer from numbed responsiveness to the environment as a way to avoid stimuli that remind them of the trauma; however, they may also experience intermittent hyperarousal in response to mildly emotionally arousing stimuli.

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What has been unclear, until recently, is whether these reactions are due to neuronal changes in the brain or whether they are considered a generalized conditioned response. Recent research has shown that these two are inextricably intertwined as trauma affects people on multiple levels of biological functioning (van der Kolk, 1997b). If an individual experiences what he believes to be inescapable stress, we know that he will also experience a depletion in his norepinephrine (NE) and dopamine levels, which help initiate fight-or-flight behaviors. An experience of escapable stress, in contrast, does not lower NE levels, but may actually increase them. NE depletion can become a conditioned response; chronic recurrent depletion of NE in the central nervous system renders the NE receptors in the brain hypersensitive to subsequent NE stimulation in response to threat or other arousal. This may lead to long-term changes in the noradrenergic system, possibly at both output and receptor levels (van der Kolk & Greenberg, 1987).

It has also been proposed that simultaneous activation of catecholamines and glucocorticoids stimulates active coping behaviors, whereas increased arousal in the presence of low glucocorticoid levels provokes undifferentiated fight-or flight reactions. Acute stress is thought to increase glucocorticoid levels, whereas chronic stress results in decreased resting glucocorticoid levels and decreased glucocorticoid secretion in response to subsequent stress (van der Kolk, 1997b). Serotonin systems also appear to modulate NE responsiveness and arousal. Low serotonin in animals is related to an inability to modulate arousal, as exemplified by an exaggerated startle response and increased arousal in response to novel stimuli and pain.

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Other researchers have hypothesized that people with PTSD have abnormal psychobiological reactions both in response to specific reminders of the trauma and to intense, but neutral stimuli (Kardiner, 1941, as reported by van der Kolk & Greenberg, 1987; van der Kolk, 1997b). Traumatized individuals tend to have a poor tolerance for arousal. They tend to respond in an all or nothing way: either unmodulated anxiety or else social and emotional withdrawal. Their difficulties in modulating affect leads them to either barely respond to emotional stimulation or to react with an intensity appropriate to the original trauma.

Chronic physiological arousal and the resulting failure to regulate autonomic reactions to internal or external stimuli can affect a person's capacity to utilize emotions as signals. One function of emotions is to alert people to pay attention to what is happening so that they can take adaptive action. People who suffer from PTSD no longer use their emotions as a cue to pay attention to incoming information. Instead, they go immediately from stimulus to response without first trying to figure out the meaning of what is going on. This causes them to freeze or to overreact and intimidate others in response to minor provocation.

Two areas of the limbic system are involved in the processing of emotionally charged memories, the amygdala and the hippocampus. The amygdala is thought to evaluate the emotional meaning of incoming stimuli. The amygdala may also integrate internal representations of the external world in the form of memory images with emotional experiences associated with those memories. The hippocampal system is thought to record in memory the spatial and temporal dimensions of experience. It is especially involved in short-term memory, where it is held in place

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for a few moments before it is decided whether to store it in more permanent memory or to immediately forget it. Being able to learn from experience depends, in part, on smoothly functioning short-term memory processes. In animals, it has been shown that high-level stimulation of the amygdala interferes with hippocampal functioning (Ademac, 1991). This implies that intense emotions may inhibit the proper evaluation and categorization of experience (van der Kolk, 1997b).

It has been found that hyperarousal also occurs not only after a traumatizing incident, but also in response to disruptions in attachments to caregivers. Physiological disorganization has been found in infants separated from their caregivers. In the prolonged absence of the mother, the infant may suffer extremes of under- and over-arousal that are aversive and disorganizing (Field, 1985; Reite, Short. Seiler, et al., 1981; McKinney, 1985).

In sum, traumatic childhood experiences are believed to profoundly affect adult reactivity to external stimuli. Children who have been physically or sexually abused often overreact to subsequent situations and have trouble modulating anxiety and aggression, both against others and against themselves (van der Kolk & Greenberg, 1987). Long-lasting neurobiological abnormalities can also occur as a response to a significant disruption in attachment. Both types of neurobiological changes can be seen in the adult's tendency to swing between hyper- and hypoarousal to external and internal stimuli.

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Dissociation

Dissociation is viewed as a sign of breakdown of the integrative, meaning-making functions of consciousness and memory that would, under normal circumstances, become generated into a coherent sense of self (Liotti, 1999). It is also considered to be one side of the constellation of symptoms that are part of PTSD.

Writing in the late 1800s, Pierre Janet was among the first to discuss dissociation. According to Janet, the aim of the working mind was essentially to adapt to the environment and create order and meaning. This was achieved through the personal synthesis of meaning structures. At the highest level, this involved a generalized meaning of a sense of self. Dissociation was thought to be the failure of this synthesis, whereby the individual could no longer integrate experiences into generalized meanings (Liotti, 1999). Most importantly, Janet was among the first to recognize the critical association between pathological dissociation and trauma. He also understood that dissociation could be brought about not only by trauma, but also by strong emotions or severe illnesses (Liotti, 1999).

Unlike theorists today, Janet did not view dissociation as an active defense of the mind against the psychological consequences of the trauma, but rather as a direct consequence of the trauma. He saw that a consequence of trauma was the actual breakdown of adaptive mental processes that lead to the maintenance of an integrated sense of self. Memory for the traumatic event eventually assumes a subconscious status because it is unable to reach a fully conscious level of representation. "To become fully conscious of an event is synonymous with being able to tell the story of

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that event" (Liotti, 1999, p.293). Dissociation interferes with the ability to coherently retell the story of a traumatic event. This view corresponds both with the inability to attain personal synthesis and with Main's (1991, 1995) theory of lapses in the monitoring of discourse or reasoning that was reviewed earlier.

Although dissociation can affect cognitive, affective and behavioral functioning, its primary effect is the disruption of the organization of the self. Unlike repression, which is understood as a horizontal division between what is conscious and unconscious, dissociation involves a vertical splitting of the ego. While repression leads to forgetting, dissociation leads to severing. The result of dissociation is two or more self-states that are organized separately, function independently, and alternate in consciousness (Davies & Frawley, 1994).

After Janet's initial writings on dissociation, research in this area did not resume in earnest until the 1980s (Ross, 1996). By this time, however, dissociation had taken on a somewhat different definition based on work by Freud. In this view, dissociation came to be understood as a warding off of the memories and affects associated with an unresolved psychological trauma.

Dissociation has recently come to be understood as a phenomenon that lies along a continuum of increasing complexity, chronicity and severity. To the left side of the continuum is normal dissociation, such as daydreaming or absorption in a book. Next along the continuum are the progressively more pathological forms of dissociation, such as trance-like states and simple dissociative disorders, like dissociative amnesia disorder. On the far right is the most severe form of dissociation, Dissociative Identity Disorder (DID), which is believed to be the

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existence of distinct personality states in one individual (Ross, 1996). Current research on dissociation, however, suggests that a typological model may be more appropriate to understanding this phenomenon. This model postulates that there are two distinct types of dissociation, normal and pathological and that people differ in their threshold for dissociative experiences (Putnam, 1997). In other words, some individuals may have a genetic predisposition to dissociate under stress, while others will never dissociate, no matter how traumatized they are by an event.

Although dissociation can be related to biological processes, such as amnesia that might occur after a brain injury, it is most often seen as a response to traumatic life events. As reported by Putnam (1997), retrospective studies of patients with Dissociative Identity Disorder have almost unanimously found that 85-100% of cases reported a traumatic childhood. Several studies have also shown dissociation to be significantly correlated with severity of the trauma. In addition, studies comparing traumatized and non-traumatized samples have found the traumatized sample to obtain significantly higher scores on measures for dissociation than the non-traumatized samples (Putnam, 1997).

Davies and Frawley (1994) postulate that experiences ultimately come to be understood vis à vis the interactions between self and other during these events and that these are bound together and organized with respect to the intense affects associated with them. Dissociation, then, is seen not just as the splitting off of memories and affects, but also of the internalization of self and others during these events. Connections between one set of these mental contents and another can be severed. For example, dissociation can occur between memories of good and bad

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experiences with a significant caregiver, between certain events and their associated affects, between events and the meaning of those events, and between events and symbolic processes to encode them. Successful treatment of dissociation is then understood as the integration of all these aspects, not just the remembering of the memories and their associated emotions.

Varying degrees of dissociation have been found to play a significant role in the psychic organization of most patients who have suffered chronic sexual abuse in childhood, particularly when a significant caregiver has been involved (Davies & Frawley, 1994; Herman, 1992; Wilson, et al., 1985). We now turn to the literature on childhood sexual abuse to better understand the risk factors associated with being abused and the short- and long-term consequences of this particular type of childhood trauma.

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SEXUAL ABUSE

As he attempted to make sense of the material his patients brought into the treatment room, Freud observed that many who presented with symptoms of a hysterical illness reported incidents of childhood sexual abuse. This led Freud to propose that childhood seduction was the ultimate cause of all hysterical neurosis in women (Davies & Frawley, 1994; Freud, 1896). Within a year and a half, however, Freud shifted his thinking from acknowledging real events to focusing on unconscious fantasies. Thus, an entire era, both within the psychoanalytic community and in the population at large, was outlined by reports of early sexual abuse reframed as unconscious childhood wishes (Davies & Frawley, 1994).

However, even before Freud's original statements, childhood sexual abuse had long been a topic of controversy, surrounded by taboo, secrecy, and disbelief. Some authors have reported finding references to incest and sexual abuse dating back to biblical times (Rush, 1980). Yet, Freud's repudiation of the possibility of childhood sexual abuse among so many of his patients meant that this topic went back underground. It wasn't until the women's movement gained acceptance in the United States in the 1970's that the reality and extent of the problem truly came to light (Cosentino & Collins, 1996).

Prevalence studies have attempted to estimate the proportion of the population that has been sexually abused in the United States. These studies claim that between one-quarter to one-third of all women in the United States have had some kind of childhood sexual experience with an adult before the age of 18 (Cosentino & Collins, 1996; Finkelhor, Hotaling, Lewis & Smith, 1990). Studies have also found that

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between 16% and 43% of the women who report histories of childhood sexual abuse claim that these incidents involved a close relative (Cosentino & Collins, 1996; Goodwin, et al., 1981; Russell, 1983).

Yet, the literature on childhood sexual abuse is filled with inconsistent prevalence rates. One reason for this lack of consistency is that the definition of childhood sexual abuse has varied among studies. The definition that has come to be most accepted, and therefore will be used in this study, is broad in nature but speaks to the power differential between the victim and the perpetrator as a critical aspect of the abuse. Incestuous abuse is defined as any physical contact that an individual interprets as having been sexual in intent between herself, before the age of 18, and a family member at least 5 years her senior (Harter, Alexander, & Neimeyer, 1988). For the purposes of this study, 'family member' includes all individuals who are in a position of responsibility for caring for the child.

Although childhood sexual abuse is defined as the unwanted physical sexual contact between a child and an adult, it is believed that it may be most debilitating in terms of the emotional injury to the relationship between the child and the rest of her family. The dynamics of sexual abuse include both a power differential and some sort of implicit or explicit threat. The sexually abused child is being asked or forced to keep a secret from the rest of the family and the child carries some sort of stigma both inside and outside of the family setting. The damage to and potential loss of a relationship within the child's family and with significant caregivers is perhaps the most severe outcome. Therefore, the level of distress may be determined more by the meaning of the sexual incidents and disturbed relationship with the perpetrator and

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with the rest of her family than by the incidents themselves. It is also important to consider that besides the actual trauma, the victim of childhood sexual abuse experiences extended periods of apprehension, guilt, and fear between sexual contacts.

Risk Factors Associated With Childhood Sexual Abuse

Relying on samples from the general population, Finkelhor and Baron (1986) both asked people retrospectively about their own abuse experiences and conducted an extensive review of the literature. These researchers found that sexual abuse cuts across a diverse range of children and families. Significantly, they found no relationship between childhood sexual abuse and socioeconomic status of the family. They did, however, find that more cases of sexual abuse among lower SES families were identified and reported to welfare agencies by other professionals. These researchers also found few differences in rates for childhood sexual abuse for various ethnic groups. The only ethnic group that was found to have slightly higher rates of incidence was among Hispanic women. These findings were recently substantiated by a review of the literature conducted by Cosentino & Collins (1996).

Although few to no socioeconomic or ethnic differences have been found, Finkelhor and Baron (1986) were able to identify several risk factors for childhood sexual abuse. Girls were found to be at a higher risk than were boys. In both sexes, the authors found an increase in risk at about age 6, and then a second significant increase between ages 10-12 (Finkelhor & Baron, 1986). Sexual abuse victims were also found to be isolated from their peers, although their families were not necessarily

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more socially or geographically isolated than other families (Finkelhor & Baron, 1986). Again these findings were substantiated in Cosentino & Collin's review of the literature (1996).

Several studies have found higher vulnerability to sexual abuse among women who live without their natural mother or father at some time during childhood (Finkelhor, et al., 1997). Women who reported having been sexually abused were more likely to report a poor/distant relationship with their mother. These women also reported that the relationship between their parents was poor (Alexander, 1992; Finkelhor & Baron, 1986; Russell, 1986). However, Finkelhor and Baron are careful to note that it is unclear if this, in and of itself, is a risk factor to sexual abuse or if, instead, this is really an outcome of the abusive situation.

Overwhelmingly, studies are showing that particular family characteristics are significant predictors for the increased risk of all kinds of sexual abuse. These variables include absence of a biological parent, maternal unavailability, marital conflict, and family violence (Alexander, 1992; Alexander & Anderson, 1994; Finkelhor, 1990; Finkelhor & Baron, 1986; Russell, 1986). Several studies have also confirmed the significance of a stepfather in the home as increasing the likelihood of sexual abuse (Alexander, 1992; Finkelhor, 1990; Finkelhor & Baron, 1986).

Perhaps most significant, however, was a finding by Finkelhor, et al. (1997) that showed an increased risk of sexual abuse among children whose parent had a history of sexual abuse during childhood. In a national survey of 1,000 parents, parents were up to three times more likely to report their child was sexually abused if the parent also reported a history of childhood sexual abuse. These researchers also

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found several other risk factors that were related to the child's likelihood of being sexually abused; these included the child not living with both biological parents and the parent admitting to leaving the child home alone without adequate supervision. This is of particular interest since it can be hypothesized that a breakdown in the caregiving system of these women may occur and result in their not offering adequate protection to their children.

Effects of Childhood Sexual Abuse

Prior literature on the impact of childhood sexual abuse has been based predominantly on retrospective studies with adults. To compensate for this problem, Kendall-Tackett, Williams & Finkelhor (1993) reviewed 45 studies that had been conducted using children under the age of 18. They looked both at short-term outcomes, longitudinal studies, and children who were asymptomatic.

Amongst studies looking at short-term outcomes, the authors found that for almost every symptom examined, sexually abused children were more symptomatic than their nonabused counterparts. These symptoms included anxiety, fear, PTSD, depression, low self-esteem, somatic complaints, sexualized behavior, school problems and behavior problems. Other researchers identified factors that were positively associated with variations in these short-term symptoms. These included the victim having a supportive relationship with another adult or sibling and the number of characteristics of the victim's family which are indicative of a generally poorly functioning family. The number of types of sexual abuse, receipt of some kind of reward for the abuse, physical restraint during the abusive incident, an effort to

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escape, avoid, or resist the abuse, or passive submission by the victim to the abuse were all positively associated with symptomatic behaviors after the abuse. Other factors that contributed to short-term symptoms were the victim's fear of negative consequences to the self if the abuse was disclosed, the offender's denial that any abuse took place, and the type of and degree of relationship between victim and offender (Conte & Schuerman, 1987a, 1987b).

Kendall-Tackett, et al. (1993) found that symptoms abated in the majority of cases. However, about 10%-24% of children appeared to become more symptomatic over the course of about 18 months. The authors found significant differences among the types of symptoms that decreased in intensity versus those that showed an increase. For example, anxiety symptoms were likely to disappear, while symptoms of aggressiveness persisted or became worse. Sexual preoccupation also tended to increase over time.

Long-term consequences based on reports of adult survivors tend to be varied and contradictory, however most studies have found symptoms to cluster around feelings of self worth, affective states and social relationships (Harter & Burgess. 1988). Female adult survivors of sexual abuse have also been shown to display higher levels of dissociation than non-abused samples (Davies & Frawley, 1994).

In order to try to minimize the contradictory results that were appearing among various studies, Neumann, Houskamp, Pollack, & Briere (1996) conducted a meta-analysis of studies that looked at the relationship between childhood sexual abuse and psychological problems in adult women. These authors found a significant relationship between childhood sexual abuse and psychological distress and

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dysfunction in adult women. Holding constant methodology, sample variation, and measurement differences among the various studies, these researchers still found childhood sexual abuse to be a general risk factor for the development of later psychological disturbance in adult women. Of particular note is the finding that in adulthood these women were still attempting to cope with ongoing traumatic stress related to the abuse. Significantly, this often led to re-victimization.

While it is clear that childhood sexual abuse can have deleterious effects both in the short and long-term, several studies have shown that not all victims of sexual abuse have equally negative outcomes or are equally traumatized. As many as one third of all children who are sexually abused remain symptom free (Finkelhor, et al., 1990; Kendall-Tackett, et al., 1993). Kendall-Tackett, et al. (1993) offer several explanations for these findings, mostly related to methodological problems with the studies. The first possibility is that the studies did not include measures for all appropriate symptoms or the measures that were used were inappropriate. Another explanation is that when studied, these children had yet to manifest their symptoms. Finally, it is possible that asymptomatic children were truly less affected. These may be children who were abused for shorter periods of time, without force or penetration, by someone who was not a father figure, and/or they received the full support of a well-functioning family after disclosure (Finkelhor, 1990).

These findings suggest, perhaps, that the significant effects of abuse result more from the long-term relationships that precede the abuse and that continue after its termination, than from the abuse itself. Yet, it must also be remembered that sexual abuse does not occur in a vacuum, but instead often co-occurs with other types

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of abuse and neglect which have their own distinct effects (Alexander & Anderson, 1994). Therefore, it has been very difficult to tease apart the long-term consequences of the sexual abuse, per se, from factors related to family variables.

Family Systems and The Relationship to Outcome Among Sexual Abuse Victims

One explanation for the differential outcomes of child sexual abuse is that the families of the victims differ tremendously and that the type of family one is raised in has more impact on one's long-term outcome than on any particular incident of abuse. Traditional families are considered to be "open systems" in which there is a clear differentiation of roles and generational boundaries. These families continuously interact with their environment, thereby creating change within the current system. In contrast, incestuous families are considered to be "closed systems." These families are isolated from the environment and avoid a differentiation of roles and functions among individual members. The incestuous family may use the sexual abuse as another means to avoid the growth and change that is inherent when children and adolescents seek outside contacts.

Alexander & Schaeffer (1994) were among the first researchers to look at and classify the types of families in which sexual abuse occurs as a way to study whether differential constellations of abusive family structure have differential impact on the survivor. These researchers found three clusters of family types among survivors of childhood sexual abuse. Victims from families in Cluster 1 reported the least severe abuse, the least amount of family pathology, and little or no physical or verbal abuse from either mother or father, and reported they had observed very little marital

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violence. The survivors also exhibited fewer long-term effects. Victims from Cluster 2 families fell in between the two other clusters with regard to severity of abuse. There was more physical invasiveness and coercive methods by the perpetrator than those in Cluster 1, but these victims also reported fewer perpetrators throughout their childhood and an older age of onset than those in Cluster 3. However, the subjects in this group described a more conflictual family than those survivors from Cluster 1. Although mothers in this group did not tend to be physically abusive toward their children or their husbands, their husbands were moderately abusive both to the children and their wives. Women in this group exhibited approximately the same degrees of symptoms as women in the first group.

In contrast to the above two groups, survivors from Cluster 3 families experienced the most severe abuse and were raised in the most pathological families. These survivors reported that the sexual abuse usually began before the age of 4, they had significantly more perpetrators than victims from the other two groups (on average they had more than three perpetrators each), and the average duration of the abuse was twelve years. Significantly more conflict and control was evidenced in these families than families from the other two clusters. Cluster 3 families showed the most marital violence and both mothers and fathers were physically abusive toward the victim. Victims in Cluster 3 also responded affirmatively more often than victims in the other two clusters to questions about actual or threatened abandonment.

In fact, it was the experience of abandonment and neglect by their mothers that most distinguished Cluster 3 survivors from the other two groups. These children were characterized by growing up in terrorizing households. However, women in this

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group also reported that their fathers were less verbally abusive to them than they were to their mothers. In contrast to the other two groups, survivors from Cluster 3 families also reported more dissociation and other personality disorders. Interestingly, no matter which family cluster one grew up in, all of the subjects in this study had similar symptoms of PTSD, depression and current distress (Alexander & Schaeffer, 1994).

Current Research on Sexual Abuse Using Attachment Theory

Recently, researchers have begun to use attachment theory as a theoretical foundation for understanding the varied and sometimes inconsistent responses of individuals to the experience of childhood sexual abuse. In general, these researchers believe that internal working models of self-in-relationship-with-other can impact an individual's strategies for coping, which may influence later adult functioning. For example, Liem & Boudewyn (1999) propose that when individuals who have representational models of others as loving and supportive and of themselves as worthy of that love experience childhood sexual abuse, they can activate their attachment systems so that they can use their social supports in the service of coping. In contrast, individuals with representational models of others as unresponsive or hostile/rejecting and of themselves as unworthy of eliciting care and support from others may activate an ineffective use of their social support system when confronted with the experience of childhood sexual abuse.

In a secondary analysis of data, which had previously been collected from a college sample, Liem & Boudewyn (1999) found that childhood maltreatment and

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loss experiences had both a direct and mediational effect on adult self- and social functioning. Frequency of maltreatment and loss during early childhood consistently predicated later exposure to childhood sexual abuse. In turn, this led to higher levels of adult depression, lower levels of adult self-esteem, and greater frequency of maltreatment in adult relationships. These findings suggest that childhood sexual abuse is more likely to occur in the context of other childhood stressors. Using attachment theory to make sense of these findings, the authors propose that the experiences of loss and maltreatment may create a climate whereby the child is provided with inadequate supervision and/or becomes excessively dependent making her more vulnerable to sexual victimization.

Shapiro & Levendosky (1999) conducted a structural equation modeling analysis and found that attachment style can mediate the effects of childhood sexual abuse on coping and psychological distress. In a study of 80 college students, 26 who reported a history of childhood sexual abuse, these researchers found that childhood sexual abuse had a significant negative impact on the development or maintenance of a secure attachment style. The authors also found that childhood sexual abuse was positively related to 'maladaptive' coping strategies, such as avoidant and cognitive coping styles. Attachment style was found to be strongly associated with amount of psychological distress experienced. When confronted with interpersonal conflicts, those individuals with insecure attachments had the most difficulty. The findings show that the presence of an insecure attachment style together with the use of maladaptive coping strategies can increase the psychological distress of the victim and interpersonal difficulties during adolescence and possibly on into adulthood.

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In a study of 112 incest survivors, which looked at how attachment style and sexual abuse characteristics were related to the long-term effects of the abuse, Alexander (1993) found particular characteristics strongly predicted later outcomes. For example, early age of onset strongly predicted depression and intrusive thoughts in adulthood. To a lesser extent, this characteristic also predicted avoidance of or constriction surrounding the memories of the abuse. However, lack of a secure attachment more strongly predicted avoidance of memories of the abuse. In addition, basic personality structure was predicted by adult attachment style, such that insecure attachments more often predicted personality disorders.

In one of the first studies using the AAI with survivors of sexual abuse, Stalker & Davies (1995) found similar results with regard to personality disorder. About half the women in the study met criteria for two or more personality disorders. Interestingly, seven out of the eight women found to have a Borderline Personality Disorder were classified as Unresolved on the AAI. Perhaps most noteworthy was the distribution of AAI classifications among this sample of women, which had obtained from various clinic populations. Sixty percent of the women in this study were classified as Unresolved, while only 12.5% received a classification of Secure/Autonomous. However, when women were assigned to a second best-fitting classification, 67.5% were considered to be Preoccupied with attachment relationships.

Eger (1998) also used the AAI with survivors of childhood sexual abuse to look at the relationship between attachment classification and dissociation. Unlike Stalker & Davies, she did not use a clinical sample of women, although almost all of

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her subjects had participated in some type of psychotherapy. Her findings on the AAI are somewhat different than those of Stalker and Davies (1995). Of the ten women interviewed who had experienced childhood sexual abuse, four were found to be Unresolved, three were Secure/Autonomous, two were Dismissive and one was Preoccupied. Eger compared these women's classifications and scores on the DES with those of ten women who had not experienced sexual abuse and found that severity of sexual abuse was somewhat related to use of dissociation. In addition, use of dissociation was negatively related to security of attachment.

In general, these few studies, combined with the literature on trauma and sexual abuse, have shown that attachment theory can make a significant contribution to understanding the varied outcomes of the short- and long-term consequences of childhood sexual abuse. Insecure attachment not only predicts later difficulties in personality functioning, but may also predict greater likelihood of being subjected to traumatic experiences. However, none of these studies looked specifically at the long-term consequence on the next generation. To date, only a few studies have looked at how the experience of childhood sexual abuse impacts parenting, and with few exceptions, this has been done without the benefit of attachment theory as a theoretical foundation from which to understand the findings.

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CURRENT RESEARCH ON SEXUAL ABUSE AND PARENTING

Although research in this area is relatively new, the few studies conducted have shown that the experience of childhood sexual abuse does have a significant impact on parenting, particularly with respect to how survivors differ from controls in relating to their children.

Burkett (1985, 1991) compared a group of 20 women who had been sexually abused with a same size control group of women who had no childhood experiences of sexual or physical abuse. She found that mothers sexually abused during childhood tended to focus more on themselves and less on their children than the nonabused comparison group. These mothers also tended to provide fewer messages to their children that indicated understanding and affirmation. Mothers with a history of abuse also tended to use their child to meet their own emotional needs and described their children as demanding more of their attention than did control mothers. An interesting, complementary finding in this study was that the children of abused mothers were found to be more parent-focused than children in the comparison group. This finding seems to support the theory of a pattern of role reversal in families with a history of incest.

Interestingly, in this study the experimental group really looked like two separate groups. About half the mothers in the experimental group looked just like the control group, while the other half had such low scores on these measures that they "produced" the statistical difference between the two groups (Burkett, 1985). This speaks to the resiliency of some sexual abuse survivors and maybe to possible differences among mothers who cannot break the cycle of abuse.

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Cole, Woogler, Power & Smith (1992) studied both women with a history of incest and those who were children of alcoholic fathers but did not experience sexual abuse, since a correlation has been shown to exist between alcohol abuse and incest. A non-risk group of mothers was recruited from university classes whose fathers had no known history of problems. They found that women who were incest victims reported significantly less confidence and less sense of control as parents than the non-risk group, with the children of alcoholics falling somewhere in between. Additionally, the incest group reported significantly less support in the parental partnership with their spouses, and reported being less consistent and organized in their interactions with their children. The authors interpret these findings as corroborating the hypothesis that incest victims feel emotionally overwhelmed by the demands of parenting, and show particular difficulties engaging in childrearing practices that promote autonomy in their children.

Cohen (1987, 1995) has more recently supported the findings from this study, particularly with respect to parental feelings of support. Cohen administered the Parenting Skills Inventory to 26 mothers who were victims of childhood sexual abuse and found them to show a significant difference in seven areas of parenting skills as compared with a control group of 28 mothers who had no such abuse in their background. The study group was found to be less skillful in areas involving role-image, objectivity, expectations, rapport, communication, limit setting, and role-support. The largest differences were seen on communication, role-image and role-support. The author suggests this may be due to a hindrance of the survivor to trust others. These mothers also worried constantly about the potential abuse of their own

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children. This may inhibit the mother from enlisting support from others and in sharing childcare responsibilities, thus contributing to their feelings of being constantly overwhelmed.

In a large scale study of women involved with child protective services, Baynard (1997) found that even after controlling for factors associated with growing up in a dysfunctional family, the experience of sexual abuse still had a direct influence on parenting. The author found that the experience of childhood sexual abuse was associated with more negative views of the self in the role as parent and with the greater use of physical strategies in conflicts with children, even after accounting for differences in the quality of family-of-origin relationships.

Using the Experiences of Caregiving Interview, Kreklewetz & Piotrowski (1998) interviewed 16 mothers who were survivors of incest. All the women in the study had a daughter between the ages of 9 and 18 and were currently receiving counseling. The authors found that the women described themselves as very protective of their daughters. The mothers also believed their strategies to supervise their children were highly effective. However, the majority of women in this study talked about having been emotionally withdrawn or depressed at some point in the course of parenting. Since entering counseling, this had changed and they reported enjoying their role as a parent more. The women also saw themselves as more protective and effective as a parent. Yet strikingly, 50% of the women reported having a daughter whom had also been sexually abused. This finding is particularly significant in light of the literature on second-generation sexual abuse and speaks to the impact that counseling can have on the parenting process.

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In a qualitative study of mothers sexually abused during childhood, O'Brien (1998) found several themes indicative of the intergenerational transmission of trauma through parenting. Although these women were able to recognize and openly discuss how they wanted to parent, because they lacked models of appropriate functioning it was difficult for these women to implement changes in their parenting behaviors. Instead, these women often created a deficit model of parenting, whereby in an attempt to have their own needs met they often ignored or overlooked the needs of their child. O'Brien found that mothers who are incest survivors are often unsure of themselves and the normal developmental demands of their child. They often had unrealistic expectations of their child and attributed adult-like characteristics onto the child.

In a unique study informed by attachment theory, Lyons-Ruth & Block (1996) looked at parenting differences among women with varied childhood histories of abuse. This study was comprised of 45 mothers from both high-risk and community groups. The findings showed that sexual and physical abuse in childhood had different associations with current caregiver behavior. Mothers with a history of physical abuse displayed more hostile interactions with their young children on a videotaped observation. In contrast, mothers who had histories of sexual abuse tended to withdraw from their children during these interactions. Severity of sexual abuse was negatively related to maternal warmth and positively related to flatness of affect. Mothers with a history of sexual abuse also tended to increase their withdrawal as their infant increased its cries of distress.

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Lyons-Ruth & Block (1996) also found that sexual abuse survivors reported elevated trauma symptoms, while those who had been physically abused reported significantly lower levels of trauma-related symptoms. Mothers of Disorganized infants tended to have bimodal results on the reporting of symptoms; they either expressed few symptoms or they were polysymptomatic. This bimodal outcome is consistent with the literature on PTSD that shows numbing and flooding responses to commonly alternate among abuse survivors.

When infant attachment classifications were examined in relation to maternal trauma history, the authors found that the presence of abuse in the family was not related to infant security. However, abuse did have an important relation to the secondary (insecure) attachment strategies adopted by the infants. If an infant was insecure and her mother had experienced child abuse, the infant was more likely to display disorganized attachment strategies. In contrast, infants of mother who were not abused displayed predominantly organized avoidant strategies. It appears that the intergenerational effects of a parent's abuse can be as serious as the effects associated with experiencing violence directly.

Two other studies have used attachment theory to understand parenting among women sexually abused during childhood. These studies looked specifically at the intergenerational transmission of seductive/sexually inappropriate behaviors between mothers and their toddler-aged children (Sroufe, Jacobvitz, Mangelsdorf & Ward, 1985; Sroufe & Ward, 1980). These authors found that some mothers tended to use affection or sensuality as a means to control or manipulate their toddler-aged child. This could involve sensual teasing and promises of or requests for affection when

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done at times that were considered to be in direct opposition or unresponsive to the child's needs. Although their sample size was small, Sroufe & Ward (1980) found that 7 out of 11 mothers with a history of sexual abuse engaged in seductive or sexually inappropriate behavior with their male toddlers. Sroufe, et al. (1985) also found that a predominant number of women who engaged in seductive interactions with their toddlers had a history of childhood sexual abuse.

In sum, although research is now being conducted looking at the impact of sexual abuse on the next generation, few studies have used a viable theoretical model to help explain their findings. Attachment theory seems to be an appropriate model as it can elucidate how trauma may impact parenting, thereby transmitting aberrant patterns of attachment and caregiving from one generation to the next.

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SUMMARY OF THE LITERATURE REVIEW

Although few research studies on childhood sexual abuse have used attachment theory as a theoretical foundation from which to interpret their results, the literature reviewed indicates that it may be particularly useful in explaining second-generation sexual abuse. The construct of the internal working model helps us to understand how our patterns of relating to others constitutes the arena in which trauma may be transmitted from one generation to the next.

Although Freud ultimately chose to abandon his theory of childhood seduction, he was instrumental in the development of our current understanding that it is not the experience of a traumatic event, in and of itself, that constitutes trauma. Rather, it is the meaning that the individual places on the event and how it was experienced that is most relevant to whether an event is experienced as traumatic.

In light of the research on childhood trauma and dissociative processes, we can begin to understand how this particular type of a defense can impact attachment style in children and parenting behaviors in adults. These studies have helped explain how multiple models of attachment and segregated systems come to be formed and exist simultaneously. For example, a child may use dissociation as a way to defend against traumatic interactions with a parent, while maintaining a good, loving relationship with that same parent. Although the child develops a repertoire that seems contradictory, this allows for continued interaction with a caregiver who may be both a source of fright and a haven of safety (Horowitz, 1992; Main & Hesse, 1990, 1992).

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From the literature and research on childhood sexual abuse, it is clear that this is a traumatic experience that has long-standing effects, above and beyond those of being raised in a dysfunctional family. Women who are incest survivors show high rates of PTSD, dissociation and other psychiatric symptoms. Prolonged symptoms can also lead to a restriction in affect and changes in the chemical structure and neurobiology of the brain. Studies have also shown that survivors of childhood sexual abuse may experience parenting difficulties. Parenting is a stressful life event and under stressful conditions, people who have not resolved an earlier trauma may dissociate.

Current research has shown that children with a disorganized attachment style are, in fact, more likely to experience later traumas (Lyons-Ruth, et al., 1999; Lyons-Ruth & Jacobvitz, 1999; Ogawa, et al., 1997). A parent of a disorganized child is most likely to feel overwhelmed by parenting and lacks appropriate resources. She will most likely abdicate the caregiving system when she feels she has no other recourse. When the caregiving system is abdicated, this mother becomes less available to protect her child from potentially dangerous situations. It is also possible that a disorganized child, who has learned that she cannot rely on her parent for comfort and support, may not seek out an attachment figure during times when her behavioral system becomes strongly activated. She thus may put herself into potentially dangerous situations. Understanding the internal working models of attachment and caregiving among women sexually abused in childhood may help to elucidate why some families are more vulnerable to second-generation sexual abuse, while others remain resilient.

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Statement of the Problem

This is an exploratory, qualitative study that seeks to understand whether long-lasting traumatic reactions to childhood sexual abuse have consequences that go beyond the individual into the next generation. Specifically, it explores whether attachment theory and internal working models of attachment and caregiving can be used to better understand individual differences to childhood sexual abuse. Ten women who were sexually abused during childhood were interviewed about their childhood relationships with their parents, their experiences of sexual abuse and their current relationships with their children. In addition, a measure of dissociation was administered.

Attachment theory suggests that resolution of trauma is an important factor in influencing whether a mother is able to protect her own children from being abused. It is also thought that experiences of dissociation contribute to the intergenerational transmission of trauma. These two variables are thought to highly influence whether or not a mother is available to her child as a secure base and can offer the child necessary protection from danger when needed. Therefore, these variables: 1) mental representations of attachment and caregiving, 2) resolution of trauma, and 3) dissociation are studied in this qualitative investigation to better understand their impact on the intergenerational transmission of sexual abuse.

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METHOD

Subjects

This study examined the internal working models of attachment and caregiving, along with experiences of dissociation among ten women with a history of childhood sexual abuse. The women were recruited in one of two ways: 1) flyers were posted at several public universities in the New York City area or, 2) potential subjects were informed of the study and given flyers by professionals known to them at a New York City public hospital and at a small agency specializing in the evaluation and treatment of childhood sexual abuse. (See Appendix A for sample flyer.) In order to insure confidentiality, women were asked to call the researcher directly if they were interested in participating. Criteria for participation included having been sexually abused by a person at least five years their senior who was in a position to provide some form of care or protection towards them. All subjects were also required to have at least one child. This child needed to be at least three years of age and in their care. Because of the nature of the interview and the attention placed on language and discourse, English was the primary language of all the participants. Although initial attempts were made to recruit the same number of women who had a child who had been sexually abused as women whose child had never been sexually abused, this was not possible.

Since the interview involved discussion of potentially traumatic material, women who were suicidal or actively psychotic were excluded from the study. It was also thought that the stresses of being homeless would be so great as to impact one's parenting. Therefore, women who were currently homeless were also excluded from

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the study. Finally, women who were currently abusing alcohol or drugs were excluded from the study for similar reasons.

Of the women who participated in the study, seven were Hispanic and three were Black, either African-American or from a Caribbean Island. No Caucasian women volunteered to participate in this study. This is believed to be a reflection of the populations from which this sample was culled and in no way reflects the current statistics for ethnicity among survivors of childhood sexual abuse. Their ages ranged from 24 to 38, with a mean age of 30.7 (S.D. = 4.14). Eight of the women had either never been married or were currently separated or divorced. Two of the participants were currently living with a significant other but were not married.

Seven of the women had either taken or were currently taking college level classes on at least a part-time basis. Two women had completed college and one of those women was now pursuing graduate studies. One woman had not completed high school. Four women were employed full time, five were employed part-time and were attending college part-time, and one was not currently employed outside the home and was receiving financial assistance from the government. Nine of the participants had an annual income of less than $35, 000, with five of those women having annual incomes of less than $15,000. One woman reported her annual income to be somewhere in the range of $36,000-$50,000.

Four women had one child, five women had two children, and one woman had seven children. For women with more than one child, mothers were asked to identify one child who was at least 3 years of age to serve as the model from which to discuss her parenting. The children identified for the study ranged in age from 5 to

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15, with a mean age of 8.6 (S.D. = 3.2). Three women identified at least one of their children as also having been sexually abused based on the findings of an outside agency, such as protective services for children.

Nine of the participants were currently receiving or had previously been in some form of counseling or therapy. Two women stated their therapy lasted less than 6 months, while the other seven women had been in treatment for longer than 6 months. Of these, four had been in therapy for more than 2 years. One woman reported never having received any type of therapy.

Measures

The Brief Symptom Inventory

The Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982), is a 53-item, self-report measure of symptomatic distress. Each item on the BSI is rated on a five-point scale, ranging from "not at all" (0) to "extremely" (4). Participants are asked to circle the response that best describes how much a particular problem has distressed or bothered them during the past seven days, including the day of the test (Derogatis, 1993).

The BSI measures 9 primary symptom dimensions of distress. These dimensions include somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism (Derogatis, 1993). Two of these scales, depression and psychoticism, were used to screen for women who were currently suicidal or actively psychotic. Women who

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positively endorsed any item on either of these two scales were further queried about suicidal ideation and psychotic thinking.

There are two kinds of reliability scores on the BSI. Internal consistency measures the homogeneity of the items selected to represent each symptom construct. Internal consistency for psychoticism was 0.71 and for depression was 0.85 (Derogatis & Melisaratos, 1983). Test-retest reliability reflects the stability of the measurement across time. As longer periods of time elapse between test administrations there is a greater opportunity for change to occur. Test-retest reliability for depression was 0.84 and was 0.78 for psychoticism. Both of these scores are considered to be fairly stable across a two week time period (Derogatis & Melisaratos, 1983).

The BSI can also be scored for a Global Severity Index (GSI), which measures overall symptomatic distress. However, since recent studies have shown that both college students and women with a history of sexual abuse have elevated GSI scores (Bennett & Hughes, 1996) and that women with a dissociative disturbance can have elevated scores on the psychoticism scale (Allen, Coyne & Console, 1996) this measure was not formally scored.

The Adult Attachment Interview

The Adult Attachment Interview, (AAI) (George, Kaplan and Main, 1996), was chosen as a means to help each participant tell the story of their relationship with each of their parents as they were growing up and as it is seen by them today. (For a brief summary of the AAI, see Appendix B.) The AAI is comprised of a series of 15

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questions and usually takes between one to two hours to complete. The interview focuses upon the subject's descriptions and evaluations of their relationship to each parent during childhood and the subsequent effects upon the subject's development (George, et al., 1984/1996). The importance of this interview is not in whether the adult's memories of childhood relationships are accurate, but rather in her ability to produce and reflect upon memories related to attachment-related issues while simultaneously maintaining coherent discourse with the interviewer (Hesse, 1996).

This interview has been described as an attempt "to surprise the unconscious" (George, et al., 1984/1996) and inconsistencies and discrepancies between semantic and episodic memories are analyzed carefully. For example, a subject is asked for 5 words or phrases to describe her childhood relationship first with her mother and then with her father. After she provides each set of words or phrases, the interviewee is asked to provide specific memories to illustrate each adjective that was used to describe the relationship (George, et. al, 1984/1996). Adults are later asked about experiences of rejection and of loss and/or trauma. They are also queried about how they reacted at that time to the loss or trauma, how they thought the loss or trauma affected their adult personality, and how it may have affected their relationship with their own child.

The interview is transcribed verbatim and, following the application of several detailed scoring systems, the subject is assigned a single overall classification for his or her state of mind with respect to attachment. Subscale scores include the subject's experience of the parents as 1) loving, 2) rejecting, or 3) role-reversing, as well as scores for 4) coherency of the transcript, 5) idealization of the parent, 6) anger, 7)

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insistence upon lack of memory for childhood, and 8) lack of resolution of mourning/trauma (Main & Goldwyn, 1985/1994). Again, the classification system focuses upon discourse usage during the description and evaluation of the interviewee's relationship history rather than upon the history, per se. This scoring system assesses an adult's current state of mind with respect to his or her attachment relationships (Main & Goldwyn, 1985/1994).

Transcripts can be assigned to one of four categories, all of which correspond to infant attachment classifications. The overall rating system permits classification of each transcript as Secure (F), Dismissing (Ds), Preoccupied (E), and Unresolved/disorganized (U) with respect to state of mind about attachment relationships. A fifth category, Cannot Classify (CC), has recently also been developed. Like those in children, the first three classifications - Secure, Dismissing and Preoccupied - are considered to be organized internal models of attachment. Securely attached individuals display a coherent balance between autobiographical and semantic information. Individuals Dismissive of attachment relationships show a systematic rejection of negative autobiographical memory. Adults Preoccupied with past attachment experiences display enmeshment with negative autobiographical memory (Solomon & George, 1996).

The other two classifications, Unresolved and Cannot Classify, are considered to be a disoriented/disorganized strategies for handling internal working models of attachment. For the person who is classified as Unresolved, this disorganization occurs only during discussions of potentially traumatic events. Transcripts are placed into the Cannot Classify category when no single attentional strategy is prominent

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and/or there appears to be a collapse in one's discourse strategy at a global level, rather than only during specific discussions of loss and/or trauma (Hesse, 1996).

Since this is a sample of sexual abuse survivors, the Unresolved category is of particular interest because of the potential for a lack of resolution of trauma that these women are confronted with. Therefore, it will be elaborated upon here. According to Main & Goldwyn (1985/1994), an "Unresolved" rating would be given if, while discussing loss or abuse experiences the subject experiences a lapse in the monitoring of discourse or reasoning. The interviewee might indicate incompatible beliefs when discussing a traumatic topic or they may indicate a belief that they were somehow causal to the traumatic event's occurrence. For example, a subject may state during a discussion of the sexual abuse that they were dressed in such a way as to provoke their father's sexual advances.

The subject may also alter the form of discourse during a discussion of a traumatic event, which can include disoriented changes in speech or suddenly talking about the traumatic experience in an unrelated context. This can be seen when during discussions of traumatic events, the speaker suddenly becomes markedly incoherent where they were not before. This also includes odd associations, the inability to finish sentences, and when visual-sensory information intrudes during a portion of speech leading to markedly incoherent sentences.

Lack of resolution about a traumatic experience is also assessed by looking for the adult's efforts to dissociate memories from awareness, identifying interference from a partially dissociated memory, or through evidence of co-existing but incompatible and dissociated memories. An example of this is seen when an

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interviewee claims that every time she thinks about the sexual abuse, she attempts to manipulate it by pushing it to the back of her mind or allowing her mind to float away.

Lapses in the monitoring of discourse or reasoning may indicate parallel, but incompatible beliefs and memory systems for traumatic events that have become dissociated. These lapses can also be indicative of shifts in state of mind, whereby an individual enters into a compartmentalized state of mind involving a traumatic event. Both types of lapses may be suggestive of momentary but qualitative changes in the influence of memory upon consciousness (Hesse, 1996).

Other clinical indications of unresolved trauma are not taken into consideration in the scoring of the AAI, such as reports of lingering grief, expressions of continuing regret for experiences missed, or expressions of continuing hatred for the perpetrator. Unresolved subjects, when discussing non-traumatic events may otherwise fit into a second classification and this is given as an additional score.

The scoring system for the AAI is dependent upon two separate scales. The first scale looks at inferred parental behavior based upon the subject's descriptions of childhood experiences. The second component of this scoring system is based upon the judge's overall assessment of the individual's state of mind with respect to attachment. This part of the analysis of the interview is understood in terms of the concept of "cooperative discourse" as described by Main and Goldwyn (1985/1994), who drew upon the work of the linguistic philosopher Grice. Grice (as reported by George, et. al, 1984/1996) believed that in order for discourse to be rational, a speaker must adhere to an overriding Cooperative Principle. This principle consists of 4

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specific maxims: (1) Quality - "be truthful and have evidence for what you say", (2) Quantity - "be succinct yet complete", (3) Relation - "be relevant to the topic as presented", and (4) Manner - "be clear and orderly" (George, et. al, 1996, p.5).

The interview analysis tries to understand adherence to versus violation of each of these maxims. Each violation of a particular maxim is noted in several of the scoring systems, such as vague discourse which violates manner, repeated insistence upon lack of memory which violates quantity, and unsupported positive betrayal of parent which violates quality (George, et. al, 1984/1996). The rater also evaluates the transcript based on the subject's "coherence of presentation" by looking for contradictions, oscillations and incoherencies in episodic memories as compared to semantic memories. From all of these subscales, an overall attachment classification is given (Main, 1992).

Use of this interview to assess resolution of a trauma is critical since, to date, it is the only research method available that looks at cognitive and ideational disorganization/disorientation sequelae to trauma, as observed through an individual's discourse (Main & Hesse, 1992).

Published studies record reliability of the three dominant attachment classifications (Secure, Dismissing and Preoccupied) at 78-90% over the short-term (2 months). However, little research has been done on long-term reliability. Also, the Unresolved category has been found to be less stable than the other three categories. This is in part due to the nature of the construct itself. Resolution of traumatic events <u>does</u> change over time and positive life experiences, such as therapy, can play a major role in resolution of trauma. Attachment classifications using the

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AAI have been well discriminated from intelligence and memory (Bakersman-Kranenberg & Van IJzendoorn, 1993).

Traumatic Antecedents Interview

The Traumatic Antecedents Interview (TAI) (Herman and van der Kolk, 1990) is a two-part interview, which probes for experiences of trauma during childhood. The first part of this interview focuses on developing rapport with the subject while obtaining basic demographic information. This part was administered to each subject towards the beginning of the first interview session. The second part of the TAI was adapted so that it could be included in the AAI. This part asks subjects to describe their experiences involving major accidents or illnesses, separations from caretakers, family alcoholism and drug abuse, family discipline and conflict resolution, and early sexual experiences. (See Appendix B for the additional questions inserted into the AAI and Appendix C for demographic questions.)

This part of the interview was scored in accordance with Perry, Herman, & van der Kolk's (1992) rating criteria for gross abuse, gross neglect, separations/losses, and chaos in the home. Each domain takes into account the number of perpetrators and the extent of the abuse across three developmental periods. Each subject is then given a separate score for their experiences of abuse, neglect, loss/separations, and overall chaos.

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The Experiences of Caregiving Interview

Originally developed by Aber, et al. (1984) and later adapted by Solomon & George (1993), the Experiences of Caregiving Interview (CI) is an hour long, semi-structured interview that focuses upon the description and evaluation of a parent's statements about her relationship with her child. (See Appendix D.) Similar to the Adult Attachment Interview, it asks parents to use five adjectives to describe their relationship with their child and then to give specific, descriptive examples of those adjectives. This is done to compare semantic and episodic memory as a way to better understand a parent's mental representations of caregiving behaviors. Individuals are also asked to describe themselves as parents, their perceived similarities and differences with their child, and how they manage age-appropriate attachment-related and age-related issues, such as separations.

George and Solomon (1993, 1996) believe that every parent is faced with the fundamental question of how much and for how long she will provide care for a particular child. The answer to this question ultimately structures her caregiving strategy. While infants require a high level of protection, a gradual tapering off needs to occur as the child matures and can be responsible for her own protection. This strategy is considered by George and Solomon (1993) to be "flexible". However, the parent has two other alternatives; parenting at a distance, which may leave the young child in danger some of the time or keeping the child close, which requires great physical and psychological effort on the part of the parent. Each of these strategies has been correlated with one of Ainsworth's attachment behavioral strategies in the

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infant – Secure, Avoidant, and Ambivalent. The last strategy, Helplessness, correlates with Disorganization/disorientation (George & Solomon, 1989, 1993).

George and Solomon (1996, 1997) developed scales to assess each of these strategies using 32 mother/child dyads from a larger sample, looking at attachment in middle childhood. A system of four 7-point global rating scales, one for each classification group was developed. Since it was believed that the scales for Secure Base and Helplessness would be most significant in understanding how trauma transcends generations through an individual's parenting style, only these two scales were scored for the present study. They are reviewed in depth below.

The Secure Base scale looks for a flexible caregiving strategy as highlighted by the mother's descriptions of herself, the child, and the relationship as flexible and balanced (George & Solomon, 1993). Flexible integration is revealed during the course of the interviews in two ways. First, the mother may give positive evaluations of herself on three dimensions of caregiving, whereby she displays a willingness to respond to her child, an ability to accurately read her child's signals, and she views her caregiving strategies as effective (George & Solomon, 1997). She may also have positive evaluations of the child, such that she sees the child as accepting and deserving of her care, able to signal what is needed, and responsive to the care that her mother gives. In other words, the mother's statements about her relationship with her child show that she attempts to provide the child with a sense of security from real or imagined dangers without compromising either of their needs or sense of autonomy (George & Solomon, 1997). Secondly, flexible integration is shown in a lack of defensive processes such as deactivation, cognitive disconnection, and

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dysregulation. The scale is designed so that scores at or above the midpoint reflect a representation of caregiving that is secure, while scores below the midpoint reflect a representation that is not indicative of a secure base.

Helplessness, the scale predicted to be used in women with high rates of dissociation and/or who are Unresolved with respect to their own histories of trauma. is related to Disorganization/control. Mothers who score high on this domain feel helpless because they do not have any caregiving strategy that they believe to be adequate to protect either themselves or their child. Helplessness leads to the dysregulation of information-processing strategies. That is, these mothers exclude information from consciousness or are unable to use strategies to regulate the information appropriately. This leaves the mother open to being flooded by emotions aroused during the course of providing care for her child (George & Solomon, 1993). George and Solomon (1997) propose that a parent may develop segregated systems of caregiving in response to unresolved loss or trauma. Stressful situations in the course of parenting may unlock painful memories and experiences from the parent's segregated caregiving representation and this may leave the parent unable to regulate or deactivate the system. This can leave a parent feeling helpless and out of control. A mental representation of caregiving in which helplessness is emphasized consists of postulates that evaluate the self, the child, and the relationship as out of control. Statements from the mothers that indicate a sense of powerlessness, confusion, and ineffectiveness characterize these interviews. The mother may also indicate a lack of ability to control her own behavior and feeling as if she has no resources from which to draw. The parent may also evaluate the child as out of control. These mothers

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may appear to be struggling to gain control, but use strategies that are viewed as harsh or overly rigid in order to do so. A rating at or above the midpoint is indicative of a parent who is helpless and out of control, while a rating below the midpoint is indicative of a parent who is resourceful and not helpless (George & Solomon, 1997).

George & Solomon (1996) found significant concordance between rating of maternal representations of caregiving using the Caregiving Interview and the child's attachment based on the child's response to the first 5 minutes of reunion with mother after a 75-minute separation. There was a direct, significant correspondence between the highest rating on the maternal representational scale and the predicted child classification group, such that the highest rating for Secure Base were received by mothers with Secure children. Two assistants who were blind to all other information about the dyad rated each scale. Inter-rater reliability varied with the scale: Secure Base, .77; Rejection, .81; Uncertainty, .90; Helplessness, .85. They also found a concordance rate of 69% between adult attachment and mental representation of caregiving. Classification matches were found for 17 out of 22 cases classified as Secure, Dismissive or Preoccupied. However, women who were Unresolved were also rated as Helpless only 50% of the time.

The Dissociative Experiences Scale

The Dissociative Experiences Scale (DES) (Carlson & Putnam, 1992) is a paper and pencil measure which looks at types of dissociative experiences subjects may currently have. (See Appendix E.) It is a brief, self-report inventory of both normal and abnormal experiences and takes about 5-10 minutes to complete.

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Questions vary from the not unusual experience of driving/riding in a car and suddenly realizing that you don't remember what has happened for all or part of the trip, to the more unusual experience of finding evidence for having done something you can't remember doing.

Inter-rater reliability for the DES of absolute agreement is .96 and coefficient of relative agreement is .99. Validity has been established using students, patients with multiple personality disorder, and patients with Dissociative Disorder, not otherwise specified (alpha for total combined sample = .95) (Bernstein & Putnam. 1986). However, the authors have argued that this scale is not really valid on a normal population because people will score so low on the scale as to make differences negligible. Thus, it is only valid on groups with high rates of dissociation. The authors agree that individuals with histories of sexual abuse fall into this group (Carlson & Putnam, 1992).

Procedure

The majority of the participants contacted the principal investigator directly by telephone as posted on the flyers. One participant was given the flyer by a professional known to her at a public hospital. She agreed to allow the professional to give her phone number to the researcher, who then contacted her directly.

During the first telephone contact, a brief screening interview was conducted to review criteria for participation (see Appendix F). A total of 28 screenings were conducted. Disqualification from the study included: not having been sexually abused during childhood (1), not being female (2), not having any children (5), child

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was under age 3 (3), child was now an adult (2), did not meet qualifications for sexual abuse by a person in a position of caregiving (3), and evidence of thought disorder (1). The first ten subjects who met the study qualifications were invited to participate.

After a brief description of the study, confidentiality issues, requisite time commitment, and payment for time were reviewed. All women who called and qualified to participate in the study agreed to participate. After the women agreed to participate, an appointment was scheduled for the first interview. However, one woman did not show up for any of three scheduled appointments and was therefore dropped from the study.

At the start of the first session, the researcher briefly reviewed the contents of the study and the consent form (see Appendix G) with each subject verbally, highlighting the possible effects that participation in the study may have on them. For those women recruited from a public hospital, an additional consent form from the hospital was reviewed and signed (see Appendix H). All mothers were alerted to the fact that the material they would be talking about could be upsetting and they were informed of their right to terminate the interview at any time. Participants were also informed that talking about these issues might be helpful to both themselves and to the community at large. All subjects were then asked to read the consent form and sign two copies of it, one copy for the interviewer's files and the other to be taken home by the subject at the end of the session.

The Brief Symptom Inventory was the first measure administered so as to screen all potential participants for active psychosis and/or current suicidality. This

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questionnaire took less than 10 minutes to complete. Any items that were endorsed positively on the depression or psychoticism scale were reviewed with the potential subject to determine the severity of the distress. No participants were found to be actively psychotic and/or suicidal.

Next, subjects were asked to answer questions concerning demographic information, which was recorded by the interviewer on a demographic form. This usually took about 10-15 minutes and allowed the researcher and participant time to warm up and get to know each other. The AAI was then administered along with the incorporated trauma questions. This portion of the interview was audiotaped and later transcribed verbatim by either the researcher or a graduate student trained in the transcription of the AAI. Because of the addition of the trauma questions, this interview lasted between 2 – 2 ½ hours. At the end of this session, each participant was asked to draw in pencil, a picture of a person. This measure was meant solely as a non-verbal, non-intrusive activity by which each woman could disengage from the researcher and allow herself time to regroup after the long interview. At the end of this session participants were given an opportunity to ask any questions and talk about their experience of the interview. An appointment was then scheduled for the second interview.

During the second session, the Experiences of Caregiving Interview and the Dissociative Experiences Scale were administered. The first measure was administered verbally by the interviewer and was also tape-recorded. Again, these tapes were transcribed verbatim by either the researcher or graduate student. The second measure is a paper-and-pencil task and took participants about 10 – 15

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minutes to complete. This measure was also used to allow the subject time to distance themselves from the interviewer, although the researcher was available to answer any questions during this time, as well as to provide any support to the participant. At the end of this session, all subjects were paid $50.00.

A third, non-mandatory session was offered to all participants in order for them to review their experiences and share their reactions to the two interviews and other measures administered. No participant elected to schedule a third session. The researcher was also available during any of the interview sessions, or by telephone after the sessions, to provide referrals to counseling centers when necessary. A referral list of clinics and agencies in the New York City area that provide low-cost or free counseling to incest and abuse survivors was also made available to all study participants (see Appendix I). Several women took the referral list; however, no one asked the researcher for help in locating services.

Analysis of Data

The AAI was coded by an independent rater who had received prior training directly from Mary Main on the coding of the AAI transcripts and was judged reliable. This coder also had extensive experience coding interviews of women with histories of childhood trauma. Carol George, Ph.D. and a graduate student deemed reliable by Dr. George scored the scales for Secure Base and Helplessness on the CI. The TAI was scored by two clinical psychology graduate students trained on this measure by the principal investigator. Finally, the principal investigator scored the DES since this was a quantifiable number and did not require any clinical judgements

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to be made. All of the coders of the interviews were blind to the nature of the study.

All measures were formally scored and subjects were classified with respect to their mental representation of attachment. Mental representations of caregiving were also assessed, as well as prevalence of trauma and use of dissociative defenses. This data was analyzed and is described in the next section. In addition, the AAI and the CI were both examined qualitatively to look for common themes of attachment relationships and parenting experiences that these ten women discussed. Since this was a preliminary, qualitative study that sought to examine whether internal working models of attachment among trauma survivors could help explain how early-childhood relationships influence later parenting, a qualitative analysis of the data was warranted. The results of this analysis are also described in the next chapter.

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RESULTS

Part I: Understanding Their Past

Mental Representations of Attachment: Profile of AAI Classifications

Every subject in this study received an overall classification for mental representation of attachment based on the Adult Attachment Interview. Those women who were Unresolved with respect to trauma also received a secondary best-fitting classification. The results are shown below, in Table 1.

Table 1: Adult Attachment Interview Classifications

Subject's Name*	AAI Classification**
Jan	U/Ds2
Rosa	U/Ds2
Ana	F2
Belle	F4
Sue	F4b
Fran	Ds3
Diana	F4b
Lynn	U/CC/E3
Eve	U/F4b
Maria	U/Ds3

* All names have been changed in order to protect the identity of each participant.

** F = Secure; D = Dismissive; E = Preoccupied; U= Unresolved; CC = Cannot Classify

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Two findings from this data are particularly noteworthy. First, half of the women in this study (5) were classified as Unresolved with respect to trauma. The second finding of particular interest was the high number of women (4) who displayed a Secure mental representation of attachment. Only one woman was found to have an organized but Dismissive attachment strategy for relationships. These three classifications, Unresolved, Secure and Dismissive, are reviewed below and some examples of statements taken from the women's interviews are given to illustrate each attachment strategy.

To receive an overall classification of Unresolved, an individual most show evidence of disorganizing or disorienting thought processes during discussions of traumatic experiences. This was seen when lapses in the monitoring of reasoning or discourse occurred during discussions of separations, losses or abuse. Reports of extreme behavioral reactions were also taken as examples of a disorganizing or disorienting state. For example, the interviewee may have indicated a disbelief that the person actually died, they may have conveyed a sense of being causal in a death where no other evidence of causality was present, they may have displayed a disorientation with respect to time or space, or they engaged in psychologically confused statements or gave unusual attention to detail (Main & Goldwyn, 1985/1994). When speaking specifically about abusive experiences, lack of resolution of trauma was seen in lapses of the monitoring of reasoning and/or discourse through the denial of the abusive experience, by feeling as though they caused and/or deserved the abuse, or in disoriented or psychologically confused

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statements (Main & Goldwyn, 1985/1994).

The traumas and losses that these women discussed extended well beyond the realm of the trauma of sexual abuse. In sum, the majority of these women were subjected to physical abuse, neglect, separation from or loss of a significant caregiver, and an overall sense of chaos in their home. Some examples of statements from Unresolved transcripts follow; however, it is important to remember that one statement by itself is usually not enough to classify a participant as Unresolved. Rather, a series of lapses during discussions of traumatic events would qualify an individual for this classification.

One woman spoke about her reaction to her father several months after the sexual abuse occurred, when he goaded her about what had happened:

> I think when he said that to me, whatever love I had for him died right there. He was like the devil himself. And I wish he would die....I pray that he would just die, and die, and die over again. And uhm...

In the middle of this statement, the subject switched from past tense to present tense without any warning to the listener or any indication that she, herself, was aware of doing this. This statement also evidenced disorganization with respect to the monitoring of reasoning. Although her statement expressed a strong desire for her father to die and thus be out of her life, her repetition of this is a disorganizing stance since it is not possible for a person to, "die, and die, and die over again." Her ending of this statement, "and uhm...", was also suggestive of passivity of thought.

Another woman replied incoherently to a question about why she thought her parents behaved as they did when she was growing:

> Cause they didn't know. Yeah. My mother, I know my

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> mother told me when I went to see her, she said, you know, with you I didn't keep your secret although *Name1*, not *Name 1*. I get my sister and my daughter mixed up a lot. With uh, *Name 2*, she said she kept her hidden a little bit longer than with me. She didn't tell anyone...

This was in direct contrast to other parts of her interview when she was not discussing traumatic events and was able to maintain a coherent dialogue with the interviewer.

At other times during these interviews, the women classified as Unresolved spoke in whispers as they discussed their sexual abuse or they exhibited unusual attention to the details of a traumatic situation. Women who previously had answered questions either in normal tones or with brief responses were now noted to speak softly or talk about their abuse experience in great detail. A kind of absorption occurred, which took the speaker out of the immediate interview context. This was further evidence for lapses in the ability to monitor discourse.

Four women were classified as Secure in terms of their mental representation of attachment relationships. These women valued attachment relationships and were able to talk freely about their parents and their childhood. In contrast to the Unresolved women, these interviews did not show indications in the lapses of monitoring of discourse or reasoning during discussions of traumatic events. Instead. these interviews were most notably characterized by being coherent, reflective and thoughtful regarding attachment relationships. Several examples that follow illustrate some statements that would be part of a transcript scored Secure.

When asked to which parent she felt closest to as she was growing up, one woman responded that she felt closer to her dad, but in describing this she was also able to put her mother's behavior into perspective based on an adult understanding

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and appreciation for her mother's experiences:

> ...I guess 'cause [she] was just so emotionally distant. You know, not affectionate and stuff. So it was just hard for me to be closer to her....I don't think she meant to be cold but I don't think she really, well now I know because she didn't really know how to say, 'I love you' and be affectionate and all...'cause she didn't get that from her mother so she didn't really know how to do that.

One woman also talked about how her relationship with her previously unavailable mother had changed over time:

> ...Once we finally lived together for a while it was sort of unpredictable in a sense because there were times where she was really there, really loving...but then there were times where she would be angry, she just didn't want to bother. Then when I had gotten pregnant...just her showing me how there for me she really was, how she supported me all throughout school....Recently...I think we found...the common ground.

Finally, one woman was classified as Dismissive with respect to attachment. This interview was characterized by an ongoing attempt to limit discussion of how attachment relationships may have influenced her development. Fran expressed idealized views of her early childhood and described life before her father's death with an Ozzie and Harriet-like quality.

> We were the normal family, however, my father was a womanizer and I remember going with him to visit his girlfriends. But he was a good provider, he was always there, we never needed anything....On the weekends we did family things.

Although she did not fully dismiss her childhood experiences, she did not believe these experiences had significantly affected the development of her adult personality. In addition, when Fran was asked to give five adjectives that described her childhood relationship with her father, she had a very difficult time. "Five adjectives...that's hard 'cause I thought he was like so perfect." Here, rather than

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dealing with the various inconsistencies that were beginning to surface, she dismissed the particulars of her relationship with her father.

When asked about her relationship with her mother, Fran stated, "We've always had a good relationship." Yet, Fran later described her mother as very needy in terms of asking Fran for comfort and support. She also discussed an incident when her mother behaved in an extremely threatening way towards her because she had told her father something her mother had asked her to keep secret.

None of the women in this study were found to be primarily Enmeshed, or preoccupied by attachment relationships. In addition, no woman was given the primary classification of Cannot Classify, which would have been indicated if lapses in the monitoring of reasoning and discourse occurred throughout the transcript and not just during discussions of trauma.

Nine out of ten of the women in this study are either currently in therapy or had been in some form of treatment in the past. Table 2 shows the relationship between therapy and AAI classification. Having engaged in therapy did not appear to influence one's attachment classification.

Table 2: AAI Classification and Treatment History

	Therapy	**No Therapy**
Secure	4	0
Dismissive	1	0
Unresolved	4	1

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Women were also asked about length of time in treatment. The four women who were Unresolved with respect to trauma and who reported receiving some type of treatment stated they have been in therapy for somewhere between six months to two years. Two of these women also reported having been in a past treatment that lasted for more than two years. In contrast, two women judged to be Secure were not currently receiving treatment and their past therapy had lasted for less than six months. Another woman classified as Secure reported being in therapy for between six months to two years, while the fourth woman stated that she has been in treatment for more than two years. Attachment classification was therefore not related to length of time in therapy.

Experiences of Being Parented: Qualitative Analysis of the AAI

What follows are just a few examples of statements taken from the women's interviews that illustrate their experiences of being parented. These women often described their mothers as physically or emotionally distant or absent for extended periods of time. This was consistent with prior studies of women sexually abused during childhood (Alexander, 1992; Finkelhor & Baron, 1986; Russell, 1986). The mothers of six women in the study were perceived by their daughters to be physically or emotionally unavailable. Many had difficulty recalling memories of their mothers from when they were young, while others expressed having had a general sense that she was not there for them.

> She was just mom. It wasn't nothing close...it was just there....She was responsible in the sense that she made sure we had our medicals, she made sure we went to school, we had clothing, we were fed. But she was still distant. She didn't form that type of

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> relationship or bond where there was a lot of hugging, a lot of kissing type of reinforcements to try to guide a child.

Three women also reported that they were physically separated from their mothers for extended periods of time. These separations were often perceived as particularly difficult since there was often little preparation or discussion about them.

> I remember her telling me that I was going to go stay with my grandmother and I would tell her, 'No. I don't want to go over there'....She did stay for like a week...and then...she wasn't there the Monday when I woke up. And then she called me and told me, 'I left in the morning and you were sleeping and I didn't want to wake you up'....It was scary [even though] I was with family members...because I couldn't believe that she had just left...I think it made me kind of paranoid to think that anyone could just walk out of my life...I think I also felt angry 'cause she didn't even say goodbye to me.

One woman recalled her trip to a new country to be reunited with her mother after several years of separation. Since the age of 4 she had been living with her maternal grandparents and came to view them as her primary caregivers. The separation from them felt unbearable:

> ...As that plane took off it just felt like someone was ripping my heart out. You know, that's exactly what it felt like. And I threw up and I got physically ill on the plane. I don't think it was the plane ride, I just was really upset...and just trying to keep it together...'cause I'm on a plane, I'm five, I'm not with anybody...I came alone.

Several of the women had similar experiences with their fathers. Four women were separated from their father or father figure when their parents divorced or separated. For three of these women, the separation was the result of their mother's ability to end an abusive relationship. However, the result was that after the separation they often saw their father inconsistently or not at all. There was, therefore, a general sense that their fathers were also unavailable to them.

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The majority of the women in this study also reported that, as children, when their own attachment behavioral system was activated, for example during times of illness, injury, or when emotionally upset, there was a general feeling of a lack of protection or emotional responsiveness from their parents. They perceived their parents, both mother and father, to be rejecting of their needs for comfort and support. This was evidenced by their parents' minimizing of their attachment behaviors or by trying to increase their child's early independence. In particular, many of the participants could not recall being hugged or held by either of their parents when they were upset or hurt.

One woman remembered her parents' reaction when she fell and hurt herself, causing their day at the beach to end abruptly:

> I was running along the rocks and I saw a big crab so I ran in the opposite direction and slipped and fell and I opened up this whole thing in my arm...and we had to leave and...my parents were like getting very upset with me. [They said] that I'm always getting hurt and they just got to the beach. We had to pack everything up and go to the hospital and what the hell is wrong with me and why can't I stay still and that's good for me....I got stitches and all the way over there I heard it.

As a way to cope with the lack of nurturance from their parents, two participants reported that when they got hurt physically they didn't tell anybody and, instead, ignored the pain. This is illustrated in one woman's description of her first roller skating experience:

> ...I went out there and immediately I hurt myself. Someone ran over my arm. That didn't stop me. I skated the whole night with my arm. The next morning I realized I couldn't move my arm....I had a cast on my arm.

Because they were so rarely provided with support during stressful events,

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when these women were shown some type of parental comforting, they had vague memories and often tried to embellish them with more than what really occurred, as illustrated in the following examples:

> I think my mom hugged me when I didn't make valedictorian...yeah, I think she hugged me....So she hugged me over that. She knew I was looking forward to that.

One woman recalled getting beaten up by several girls at school and her mother's reaction when she returned home:

> When I came home my mother was furious and she told me to drop my bag and everything and she took me to the...ringleader's house and she give me a hug...[well] she didn't really give me a hug. She just was very compassionate.

These same parents, however, were often perceived as threatening to their children either for purposes of discipline or just jokingly. These threats created an atmosphere where the children understood that their attachment behaviors needed to be minimized.

> I used to tell my father everything that would go on from the morning until he came home. And one day my mother...decided she wanted to go to the beach with her friend....We were excited. We were going to play hooky that day and go to the beach. So the first thing my mother said [was], 'Don't tell your father because if you tell your father we are going to be in big trouble'....And that's the first thing I did when my father came home 'cause he had been calling all day and I says, 'Yeah, we went to the beach.' And my mother called me in the kitchen and she says, 'Stick your tongue out.' So I stuck my tongue out. She put it next to a board...and she had a meat cleaver in her hand and she says, 'You keep on telling your father the things that we do...I'm going to cut your tongue off.' Then after that I never said...[another word.] My father would come home, 'What did you guys do?' 'Oh nothing, the usual.'

This woman believed this threat is partly responsible for her inability to disclose the sexual abuse by her stepfather years later.

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Dissolution of age-appropriate boundaries and expectations were the norm in the majority of these families. This was often evidenced in the children being exposed to inappropriate stimuli for their age, or a total disregard for the need for privacy among household members as illustrated by the following example:

> I'd be at [my grandmother's] house and she'd just walk in on me. There was no lock on the bathroom door. And I'd be taking a shower and she'd push the curtain back, look at me and leave the bathroom....She would just come over and grab my breasts while I'm sitting at the kitchen table and other people are standing around...it was like nothing. They didn't [have] any reaction to it.

Several women remembered coming between their parents during scenes of domestic violence in order to offer some type of protection to their mothers. Sometimes their mothers inserted them into these situations in hopes that having a child present would provide some type of protection; other times they took it upon themselves to get involved. The realization that they needed to offer protection to their mother, as opposed to securing protection from her, was a form of role reversal that many acknowledged occurred starting at an early age:

> One time...I think it was in the middle of the night and he dragged her out of bed...and he was beating her. And I just...it was enough is enough and I remember like running into the kitchen and I got this knife and I was like, 'Don't hit her no more. Leave.' And my mother was so scared. She was like, '[Daughter] put the knife down.' And I was like, 'If you hit my mother one more time, I'm gonna stab you with this knife.' I was so serious...but it was just enough is enough.

Other women had memories of feeling as though they were more like a companion to one of their parents, rather than their child. They were sought out at times when their parents needed comfort and support. This other type of role reversal is illustrated in the following examples:

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> ...He would always have these conversations where he would talk to me in a way like I was his equal. Like he would tell me about his women friends, his relationships with women, his sexual relationships with women and what they did and...what was going on.
>
> My father would stay out a lot. And I think the only people that [my mother] had in her life were my brother and me. And that's the time she would get like the mushiest with us. She'd want to cuddle and hug us and hold us....She would say, 'Come on, come sleep with me....Get the pillows and come cuddle in the bed.' I used to be like, 'Oh, no, here we go'.

Several women also expressed that their mothers often had a great deal of difficulty when it came to age-appropriate separations, in part because these separations indicated to the parent that their child was growing up and therefore their role as a parent was changing. One woman talked about how difficult it was for her to separate from her mother when she turned school age. She reflected upon her mother's response to her separation anxiety, "I guess she welcomed it, she liked to feel needed."

Other women reported other types of role reversals, such as taking on parental responsibilities like cooking, cleaning and supervising their younger siblings because of their parents' unavailability. For some, their parents mandated these chores; others realized that there was no one else available to perform these necessary tasks. They therefore took them on in order to ensure as normal a life as possible for themselves and for their siblings:

> I used to clean the whole house [so] that when she came home and she saw the whole house she wasn't going to leave us no more....When we would have sibling rivalry, I was the one who had to correct my little brother, I was the one [because] there was vast irresponsibility when it came to our parents....It kind of seemed normal for your parents not to be around...so it didn't seem abnormal and I really adjusted very well to having to do the supervising and having to provide the food.

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Although all ten women in this study reported that they were parented in such as way as to leave them in tentative or vulnerable situations when their attachment behavioral system was aroused, all of them also spoke of a significant figure during their childhood who they viewed as loving. Because many of these women had multiple caregivers, it was often these alternate providers who gave them comfort and support when their parents were unavailable. These figures included grandparents, aunts and foster parents. Although many of these women spoke about their childhood with marked detachment, when they spoke of this special person they often became quite emotional. Notable was the fact that almost no woman expressed sadness or negative affect during the retelling of their childhood experiences, but several of the women cried during the discussions of their loving caregiver. It was these loving figures who were most responsible for providing them with a positive sense of life and feelings of self-worth.

Referring to her aunt, one woman recalled:

> She always took me to the museum, she did my hair, she always made me look very pretty. She was just...I loved [my aunt]. I remember her fixing me up in the second grade. I was at [school] and I had to wear this uniform. She had these butterfly socks. They were yellow and white and that was the first time I could get my hair straightened. And I had all these rubber bands...I just thought I was it. They said it wasn't proper dress code. I said, 'My aunt fixed me up.' I was very proud.

Another woman remembered a babysitter who took care of her during the day, starting from infancy. As she got older, she often went to the babysitter's house on weekends:

> She was really a nice woman. She would take care of me like her own grandchild and stuff. And she had a house...and I would go

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> to her. I loved going to her house. It was so nice and peaceful and quiet. She was so nice and giving and loving. And she would make me things and we would spend time together. She was really nice.

Four women viewed one or both of their biological parents as loving. They usually saw their parents from this light during more tranquil periods in their household, for example after their parents separated or before a stepparent moved in. One woman remembered how her relationship with her mother changed after her parents separated. Her father had been physically abusive toward the whole family:

> She was always taking me and my sister places, to the beach, to the park, museums....She was always doing stuff with us. Even if we didn't have money, we would do something for free....[I was] probably eight. It was...after the divorce. So it was just the three of us....It was great. 'Cause she didn't have to work. We had her all to ourselves.

Another woman had some vague memories of her father before he died, when she was four years old:

> I have a very few memories of him but what I remember of him is that he was very loving. He was artistic so he would do drawing with me and things like that. I remember he loved music and we sang together....I just remember a lot of love coming from him.

These experiences of love and support may in fact have contributed to the high number of Secure women in this group, as well as to the lack of women in the Enmeshed and Cannot Classify group. We now turn to the data derived from the TAI to look at whether differences in trauma influenced AAI classification. Do differences exist between women classified as Unresolved/disorganized and those classified as having an organized internal working model of attachment with respect to their traumatic childhood experiences?

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Experiences of Trauma: Data from the TAI

The results of the Traumatic Antecedents Interview are given in Table 3, below.

Table 3: Traumatic Antecedent Interview Data

Subject's Name	AAI*	TAI/ Sexual Abuse	TAI/ Physical Abuse	TAI/ Viol.	TAI/ Phys. & Emot. Neglect	TAI/ Separ. & Loss	TAI/ Chaos	Overall Trauma**
Jan	U/Ds2	6	1	1	0	2	3	High
Rosa	U/Ds2	3	1	1	2	4	3	High
Ana	F2	1	0	0	0	2	0	Low
Belle	F4	2	3	0	3	4	3	High
Sue	F4b	3	1	1	2	6	0	High
Fran	Ds3	2	3	0	0	3	0	Moderate
Diana	F4b	2	4	2	5	2	3	High
Lynn	U/CC/ E3	5	3	0	5	3	0	High
Eve	U/F4b	2	0	2	0	0	2	Moderate
Maria	U/Ds3	2	1	2	2	3	3	High

* F = Secure; D = Dismissive; E = Preoccupied; U= Unresolved; CC = Cannot Classify

** Assigned to a category based on the total score of all the subscales on the TAI. Less than 5 = Low; 5-10 = Moderate; Above 10 = High

What is immediately evident from looking at this data is the similarity among the participants in this study in terms of their exposure to various traumas during childhood. In addition to the sexual abuse, the majority of families in this study also

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exposed or subjected their children to physical abuse, domestic violence, physical and/or emotional neglect, separations and losses, and overall chaos. Upon initial inspection, no differences appear to exist between women who were Unresolved with respect to trauma and those who displayed organized mental representations of attachment. However, a closer look at each of these variables is warranted. The incidents and variables related to the sexual abuse are reviewed first, and then other traumas that were experienced will be discussed.

Examination of the sexual abuse scores on the TAI shows that seven of the ten participants received a score of 2 or 3. This indicates that they were sexually abused across multiple developmental stages of their life and/or there was more than one perpetrator of sexual abuse during a particular era. Two women had scores greater than three, indicating multiple perpetrators across several developmental periods. Only one woman had a score of 1. Again, based on only the data from the TAI, no differences appear to exist between those women who were Unresolved with respect to trauma and those who were Secure or Dismissive on the AAI.

Because trauma takes on different meanings for every individual depending on the circumstances, other variables surrounding the sexual abuse were reviewed to better understand their impact on overall traumatization. Table 4, on the next page, shows variables such as age at time abuse began, type of abuse, and relationship to perpetrator in order to better understand each woman's experience of the sexual abuse. A significant finding appears when one examines this data closely. Four out of five women who were classified as Unresolved on the AAI stated that their sexual

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Table 4: Summary of Sexual Abuse Information

Subject 's Name	AAI*	Age Started	Age Ended	Number of Perpetrators	Perpetrator's Relationship to Subject	Disclosed Abuse?	Severity of Sexual Abuse**
Jan	U/Ds2	6	9	4	Father and Friends	No	2
Rosa	U/Ds2	3/12	12/12	2	Grandmother/ Father	No	1/3
Ana	F2	8	9 ½	1	Uncle	No	1
Belle	F4	10	13	1	Mother's boyfriend	Yes	1
Sue	F4b	8	15	1	Father	Yes	3
Fran	Ds3	10	17	1	Stepfather	No	3
Diana	F4b	8	12	1	Stepfather	No	1
Lynn	U/CC/E 3	3	5	3	Family Friend/ Cousins	No	3/1
Eve	U/F4b	3	8	1	Older brother	No	1
Maria	U/Ds3	3	5	1	Mother's boyfriend	No	1

* F = Secure; D = Dismissive; E = Preoccupied; U= Unresolved; CC = Cannot Classify

** 1 = Fondling; 2 = Oral sex; 3 = Penetration

abuse began when they were about 3 years old. The fifth woman remembered the abuse beginning around age 6. None of the other women in the study reported such early occurrences of the sexual abuse. Instead, the four women classified as Secure and the one woman who was classified as Dismissive reported that their abuse began during latency age, somewhere between the ages of 8 and 10.

The relationship between AAI classification and age at onset of abuse is shown below, in Table 5.

Table 5: Relationship Between AAI Classification and Age When Abuse Began

	Preschool	School Age
Secure	0	4
Dismissive	0	1
Unresolved	4	1

With regard to the other variables studied, seven of the ten women reported being sexually abused by their father or a father figure (e.g. stepfather or mother's live-in boyfriend). The other three women reported being sexually abused by a male relative or family friend living in their home who, at the time, had some form of caregiving responsibility. Seven women reported only one perpetrator, while the other three stated that there were multiple perpetrators, either simultaneously or throughout various periods in their childhood.

Only two of the women reported disclosing the sexual abuse to their mother at

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some point while it was still occurring. For one, however, it took 7 years before she was able to do so. For both women, the sexual abuse stopped immediately after disclosure. The other 8 women reported telling no one about the abuse at the time because they felt as though they had no one to turn to or that no one would believe them. None of these variables seemed to differentiate between those viewed as organized versus those who were disorganized on the AAI. Only age at the time when the sexual abuse began seemed to play a significant role in resolution of trauma.

With respect to the other traumas experienced, eight women reported at least one parent or alternate caregiving figure was physically abusive towards them for at least some period of time during their childhood. Six women reported witnessing domestic violence in their home, usually between their primary caregivers although sometimes it included other family members, such as an older brother. Six women also reported experiencing physical and/or emotional neglect at the hands of one or both of their primary caregivers. This was evident in their parent not providing basic necessities for them, like food or shelter. It was also seen in their parents' lack of responsiveness towards them during times of stress or upset. The women in this study also seemed to have experienced a significant number of separations and losses. All but one of the participants in this study experienced at least two major losses or separations from significant caregivers and three women reported four or more significant losses or separations. Six women also discussed home environments that were best characterized by an overall sense of chaos. This included not having clear rules or forms of discipline, no regular schedules, and/or a general sense of ambiguity as to their parents' whereabouts on a day to day basis. Again, scores on the TAI did

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not seem to differentiate between those women classified as Unresolved and those who were Secure or Dismissive on the AAI.

In reviewing the scores of the TAI, it is important to remember that they do not reflect the number of incidents experienced, but rather whether there was the existence of any type of trauma during a given developmental time period. In other words, they represent the prevalence of trauma, and not the actual number of traumatic events. In order to highlight the prevalence of trauma, the scores on the TAI were collapsed so that each woman was assigned an overall classification for her experiences of trauma in childhood. One woman, Ana, received a combined score of less than 5 and was therefore classified as having experienced 'Low Trauma'. Two women, Fran and Eve, had a summed score of between 5 and 10 and were categorized as having experienced 'Moderate Trauma'. The final seven women had summed scores greater than 10 and were thought to have had experiences considered 'High Trauma'.

Table 6: Relationship Between AAI Classification and Prevalence of Trauma

	Low	Moderate	High
Secure	1		3
Dismissive		1	
Unresolved		1	4

Overall, exposure to Moderate to High levels of trauma did not appear related

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to AAI classification, as seen in Table 6. However, since only one woman received a Low score on trauma, no definitive statement can be made about the relationship between a low, but significant amount of trauma and mental representations of attachment. Rather, based on the data from this study it is only possible to state that exposure to a high level of trauma during childhood does not preclude an individual from being Secure with respect to attachment on the AAI.

Narrative Material Related to Trauma

All the women who participated in this study spoke openly and freely about their experiences of sexual abuse during childhood, as well as the other experiences of abuse and neglect. What follows are just a few examples of what these women said about these traumatic experiences.

With regard to the sexual abuse, almost all of the women who participated in this study gave very detailed accounts of their experiences. Many spoke about the sexual abuse early in the interview, without any question being asked specifically about it. Later in the interview, when participants were asked to talk about their experiences of childhood sexual abuse, most were able to do so without much prompting from the interviewer.

> He was my aunt's husband and it was when I was like about 8 but I didn't know what was going on. It was more like this is our secret....I just remember the first time I saw anything [I] was coming home and he was watching a porno film and he just told me to sit there and watch it with him. And then from then on gradually he just started touching me....[It continued until I was] like 9 ½ and when I think about it now I think the only reason why he did stop was because him and my aunt broke up and she asked him to move out.

> ...I don't know how old I was or when it started but he was the

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> one that I was sexually abused by...I think the earliest memory I have [is] around eight or something....Like there was always a premise, I would come get my allowance and then be there for a little while. He worked in an office...he would be there after hours when the offices were closed and he would tell me to come down and he would abuse me....I think I was scared of him not loving me or seeing me again if I didn't be with him. ...Then it would always be one of these things where like if you want something then we would have to do this....I was about 15...when I finally stopped it, had the courage to stop it.

When asked whether they ever told anyone about the sexual abuse before the age of 16, most subjects stated that they felt they did not have anyone to turn to. Although few reported that physical force was used during the abusive incidents, often there were both overt and covert threats of the withdrawal of love or the dissolution of the family. Many feared the repercussions of the perpetrator and worried how their mothers would react, as illustrated in the following example:

> He just used to tell me that I couldn't tell anyone and, 'You know how your mother gets when she's upset. You don't want to see her cry and you know how your family is...so don't tell anyone, it's just our secret.' I do know that he used to constantly tell me, 'We're not doing anything wrong'....then I remember telling him that I didn't want to do this anymore, that I wanted to stop 'cause it didn't feel good and then he came on again and told me, '...Do you want me to go tell your mother, you know how she gets...'

Whether chronic or sporadic, whether one or multiple perpetrators, 7 out of 10 women in this study viewed the sexual abuse as traumatic and life altering. When asked what childhood experience had the most serious and lasting effect on their life, most subjects talked about how the sexual abuse permeated all aspects of their lives and affected them in deleterious ways:

> I think the [sexual abuse] has affected me greatly. One sense is I think that it plays a lot in why I feel so lonely sometimes and I also hold things in whenever I'm upset, or anything like that I don't like talking about it. And I just hold it in till I just can't take it no more and I'll just start crying....I still feel like I can't [tell anyone when I'm

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upset] because someone might get angry at me.

> The sexual abuse [has been the most traumatic to me because]...I was robbed. It was like part of my life was taken away from me. And it took me almost 20 years to realize that, time just went and there's no way...[I can] ever replace that.

The other three women believed that their experiences of physical abuse, neglect and violence, which occurred in their home simultaneously with the sexual abuse, were more traumatic for them. As reviewed in the TAI data above, nine out of ten women in this study lived in families where there was a history of physical abuse, domestic violence, and physical and/or emotional neglect.

Often discussions of incidents of physical abuse came about spontaneously, most often while the participant was discussing her relationship with one or both parents or during discussions of other aspects of her childhood, such as issues related to discipline. A few examples of their experiences of physical abuse are highlighted below:

> ...I think I was like 10 or 11...and I think I was feeling jealous and...I was angry that the friend was there and I was just being really rude. We were having dinner and I was just making comments and being nasty to the friend. And [my mother] just grabbed me and took me in the room and was like throwing things at me and screaming....She was hitting me, she was smacking me.

Another woman recalled being hit by both her parents:

> I used to get hit on a regular basis...mostly by my stepfather. [He used to hit me with] a belt....[One] time we were in the bedroom and... [my mother] came in the room and she would say, 'Oh, you better go to sleep.' And [she] looked at me and slapped the shit out of me in my bed. And then I peed on the bed that night. I [think] I used to pee on the bed 'cause I was scared to get up and make noise so that she could come back and hit us.

Six women reported witnessing acts of domestic violence in their home as

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they were growing up. This created an atmosphere where the women became afraid of at least one of their parent's anger and were left to feel unprotected by the other parent.

> [My parents] would do a lot of yelling. If they were angry at each other my stepfather would hit my mother. So there was violence when they were angry.

> He was abusive towards her....He used to beat her. And I remember one time he just beat her and kicked her. And I got in it and he just kept pushing me to the side and kicking her....I must have been about 5, maybe younger....And he kept kicking her, stomping her really cause she was on the floor.

Six women reported some form of physical or emotional neglect. There were many reasons why their basic needs went unmet. These ranged from their parents' long work hours to their parents being emotionally unavailable to them because of their own problems.

> She was living her own life....I guess the best example would be, we do what we wanted to do really. My brothers and I, if it was too much for her, we got in her hair supposedly, she'd send us outside. She didn't want us around....She'd just send us outside and we used to roam about, do whatever we wanted. It got to a point where we joined gangs just to feel like we belonged in something.

Another woman was 10-years old when her father died. She remembered feeling emotionally neglected by her mother after that. Referring to herself and her younger sibling, she stated, "It's like when he died, we died....We didn't exist anymore....She provided us with the basics, you know the shoes, clothes and food, but we didn't exist."

Nine women reported experiencing at least one major loss or separation from a primary caregiver during their childhood but often there were multiple losses and/or separations. Three women reported the death of their father or other primary

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caregiver while they were young. One result of the death was that they often experienced a second loss, at least temporarily, when a separation occurred from their other parent. For example, one woman's father died when she was 4-years old. As a result of his death, she was sent to live with her grandparents while her mother relocated to a new country in order to look for work and establish a new life for herself. She was not reunited with her mother for several years. Another woman spent most of her days after school at her grandmother's house because of her mother's work schedule. Although she always returned home with her mother in the evenings, she viewed her grandmother as a primary caregiver. Her grandmother died when she was about 9-years old.

Three women were separated from their biological mothers for some time during their childhood, usually because of a conflict between their mother's work schedule and childcare arrangements. For example, one woman was separated from her mother and sent to live with her grandmother in another country when her mother needed to work at night and could not arrange for childcare. Another was separated from both her biological parents and sent to live with her paternal grandparents from age 1 to age 5, although she was unclear as to the reason for this. At age 5 she was returned to her biological parents, but a few years later her mother left the family for one year in order to attain a better job in a different city.

Six subjects reported an overall sense of chaos in their homes as they were growing up. Life was often unpredictable and there were few clear rules for behavior. The sense of uncertainty is illustrated in the following statement:

> ...If we were having fun, all of a sudden he would get annoyed. If we were laughing too loud he would curse us out....And there was a

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> flip side. If we thought we were gonna get hit because of something we did, he would let it go by. So, it was just kind of hard cause you didn't know.

Seven women reported that either one or both of their parents abused drugs and/or alcohol as they were growing up. Their drug and alcohol abuse also contributed to an overall sense of chaos as illustrated in the following example:

> I also remember when she was cooking a big pot of food that I didn't think she was coming back....On a couple of occasions...we came home from school and the marshals [were] removing our furniture from our home...and I ran to my grandmother's, got the money, ran back, paid the rent. [Another time] I remember when she didn't come home...for like four days....I must've been 12. I went to my grandmother's house to get food and came back....I just used to feel like coming home from school I didn't know what I was going to find. My home always seemed like it wasn't going to be there tomorrow.

Given the amount of trauma that these women were exposed to and that five of them were Unresolved with respect to trauma on the AAI, it is important to understand the role of dissociation as a defensive process. We now turn to look at the results of the DES to see whether differences exist between those women who have a dissociative disorder and those who do not in terms of their mental representations of attachment.

Dissociation and Traumatic Memory Loss: Data from the DES

The results of the Dissociative Experiences Scale are reported in Table 7, on the next page. Only two women, Lynn and Eve, had significant scores on the DES. These scores are indicative of the presence of a Dissociative Identity Disorder. Both these women conveyed a reliance on the use of dissociation as a defense by which they negotiate the world. Both of these women were also Unresolved with respect to

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trauma on the AAI and had experienced the onset of the sexual abuse around age 3.

The other eight women in this study did not have significant scores for dissociation on the DES.

Table 7: Dissociative Experiences Scale and Traumatic Memory Loss

Subject's Name	DES Score	Traumatic Memory Loss*
Jan	17.5	1
Rosa	03.2	0
Ana	13.2	0
Belle	07.9	1
Sue	02.1	0
Fran	04.6	1
Diana	17.9	1
Lynn	48.6**	1
Eve	54.0**	1
Maria	02.5	1

* 0 = No; 1 = Yes
** Scores of 30 or greater are considered significant for a Dissociative Disorder.

Prevalence of trauma did not seem to differentiate among women who had high DES scores and those who had non-significant scores.

Narrative Material Related to Dissociation

The findings on the DES, however, were not representative of the use of

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dissociation as discussed by these women during their interviews. Eight women in this study reported some form of traumatic memory loss. This was usually related to the events surrounding the sexual abuse, although not exclusively. Most did not remember the abuse until they were adults. For some, the memories were stimulated by dreams. For at least two women the memories returned during pregnancy. Yet traumatic memory loss was not necessarily related to DES score, as seen above in Table 5, although both women who had significant scores on the DES also expressed having experienced some form of traumatic memory loss.

The following statements are representative of some of their experiences of traumatic memory loss and the sudden recollection of the abuse:

> I blocked it out. I didn't remember. I was in the bathroom pregnant with my daughter and I saw it. I saw it. It was clear. And I was, I was shaking it out my head. What the hell is this? And it just came up and I just start seeing. And it just hit me. It just hit me.

> I remember it happening but I...don't remember it happening so often but I never remembered it at all until the other year....I remember having dreams that somebody was touching me. And then I was in my mother's house one time and I said, 'And you know, [my stepfather] used to touch me'...it just came out of my mouth like a blurted thing, without even me thinking.

In addition, as reviewed earlier, at least five women in this study who were classified as Unresolved were found to be engaging in lapses in the monitoring of discourse or reasoning during discussions of traumatic incidents or they used odd language when describing these events. The use of odd language and lapses are considered a form of dissociation, whereby the individual may be left holding two incompatible beliefs. They therefore may develop a segregated system of internal working models of attachment so that they can make sense of an abusive caregiver

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that they must rely on nevertheless for comfort and support.

At least two women in the study reported getting hurt during childhood, but ignored the pain and did not tell anybody about what had happened. Another woman reported engaging in acts of self-mutilation during adolescence. These experiences can also be seen as a form of dissociation.

Several women reported using dissociative defense mechanisms now, in their life as a parent. This seems to occur most frequently when they are confronted with stressful events regarding the parenting of their children. For example, when asked to talk about a particularly stressful event that had occurred between herself and her daughter, Belle stated, "I'm trying to remember one particular thing. I can't even remember. You know why? Because it so triggered me that I like...I blocked everything out....I blocked out the specific details."

In reference to her daughter, Diana stated, "...Her lying has made me angry on a regular basis and I have never dealt with those feelings....I have phased her out, blocked her out."

The next section focuses on how these women's traumatic experiences during childhood influenced their lives as they entered into new relationships as adults and as parents. How have these traumatic life experiences impacted them in terms of the challenges they now face raising children?

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Part II: Becoming A Parent

Mental Representations of Parenting: Data from the CI

The results of the CI are given below, in Table 8.

Table 8: Experiences of Caregiving Interview Scores and Child/Parent Variables

Subject's Name	CI/ Secure Base*	CI/ Helplessness**	Child's Age	Child's Sex	Single Parent?***	Child in Family Abused?***
Jan	2.0	6.0	9	F	1	0
Rosa	2.5	7.0	8	M	1	0
Ana	5.0	4.0	10	M	1	0
Belle	1.5	5.0	7	F	1	0
Sue	2.5	5.5	9	M	0	0
Fran	5.0	3.0	12	F	1	0
Diana	1.0	7.0	15	F	1	0
Lynn	3.0	7.0	6	F	1	1
Eve	6.0	5.0	5	M	1	1
Maria	3.0	6.0	5	F	1	1

* A score of 4 is considered at the midpoint. A rating below the midpoint is reflective of a parent who does not describe a secure base representation.

** A score of 4 is considered at the midpoint. A rating above the midpoint is reflective of a parent who is Helpless.

*** 0 = No; 1 = Yes

Several aspects of this data are noteworthy. The first important finding from this data is the overwhelmingly high scores on the scale for Helplessness among the majority of women in this study. Additionally, only three women in this study had

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scores on the scale for Secure Base whereby they could be said to be providing their child with an appropriate sense of safety and protection. Scores on the scales for Secure Base and Helplessness appeared to be unrelated to age or sex of the child and to whether the participant is a single parent or has a partner who shares in the caregiving responsibilities. These scores were also unrelated to whether their child had been sexually abused.

Table 9: Trauma and CI Scores

Subject's Name	Overall Trauma*	CI/ Secure Base**	CI/ Helplessness***
Jan	High	2.0	6.0
Rosa	High	2.5	7.0
Ana	Low	5.0	4.0
Belle	High	1.5	5.0
Sue	High	2.5	5.5
Fran	Moderate	5.0	3.0
Diana	High	1.0	7.0
Lynn	High	3.0	7.0
Eve	Moderate	6.0	5.0
Maria	High	3.0	6.0

* Assigned to a category based on the total score of all the subscales on the TAI. Less than 5 = Low; 5-10 = Moderate; Above 10 = High

** A score of 4 is considered at the midpoint. A rating below the midpoint is reflective of a parent who does not describe a secure base representation.

*** A score of 4 is considered at the midpoint. A rating above the midpoint is reflective of a parent who is Helpless.

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Another interesting finding was that mother's history of trauma appeared to be directly correlated with their score on the scales for Secure Base and Helplessness. This can be seen above, in Table 9. The lower the prevalence of trauma in one's childhood, the higher was their score on the scale for Secure Base. In addition, those who experienced higher rates of trauma had higher scores on the scale for Helplessness.

Table 10, on the next page, illustrates the relationship between adult mental representations of attachment and current mental representations of caregiving. Though a correlation was found between the CI and women who were Unresolved on the AAI, the same did not hold true for women who were Secure on the AAI. More specifically, a correlation was found between women who were Unresolved with respect to trauma and those who had high scores on the scale of Helplessness. This was true in all but one case. Yet, women judged Secure did not necessarily have a higher score on the Secure Base scale than women judged Dismissive or Unresolved. In fact, the woman who received the highest score on the Secure Base scale was actually classified as Unresolved with respect to trauma, although her secondary classification was Secure. This woman's child had also been sexually abused. This finding seems to indicate that the way a traumatized individual thinks about past attachment relationships does not necessarily translate into how they think about current relationships or into their actual parenting behaviors.

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Table 10: AAI Classification and CI Score

Subject's Name	AAI Classification*	CI/ Secure Base**	CI/ Helplessness***
Jan	U/Ds2	2.0	6.0
Rosa	U/Ds2	2.5	7.0
Ana	F2	5.0	4.0
Belle	F4	1.5	5.0
Sue	F4b	2.5	5.5
Fran	Ds3	5.0	3.0
Diana	F4b	1.0	7.0
Lynn	U/CC/E3	3.0	7.0
Eve	U/F4b	6.0	5.0
Maria	U/Ds3	3.0	6.0

* F = Secure; D = Dismissive; E = Preoccupied; U= Unresolved; CC = Cannot Classify

** A score of 4 is considered at the midpoint. A rating below the midpoint reflects a parent who does not describe a secure base representation.

*** A score of 4 is considered at the midpoint. A rating above the midpoint is reflective of a parent who is Helpless.

The next section describes narrative material taken from the CI in order to describe what the women said about their relationship with their child and about their experiences of parenting. After, narrative material is reviewed that describes their relationships now with other significant adults.

Narrative Material Related to Parenting

All of the women in this study have struggled in their role as a parent, at one

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time or another. When asked to describe themselves as a parent, their statements included positive aspects but for the most part seemed to convey feelings of being overwhelmed in this role. For example, when asked to describe herself as a parent, one woman said, "I have fun, [but it's] tiresome, lonely, pressured, burdensome, technical, [and] boring." Another replied, "I think it's challenging and hard. I question myself a lot as far as the way I try to discipline him...I just try to do the best I can."

While these sentiments are not atypical among many parents, these women believed that the difficulties they experience were due to their lack of appropriate role models for parenting. For example, one woman recalled her feelings about parenting when her daughter turned 10, the age she was when her stepfather entered her life and the sexual abuse began:

> I had her, okay and it really didn't hit me. I knew I was a mom. Okay, 'cause here I was going through the motions...the bathing, the feeding, dressing, going out, doing things together. But it basically hit me when she reached like 8, 9, 10 years old....I knew that I'd be a [good] parent till she hit 10...[After that] I was like, 'What do I do?' And when she turned 9, I was like, 'I have to do something because I know how to be a parent until the age of 10. After that, I don't know what's going to happen. So that's when I looked for help.

Most of the women in this study spoke specifically about wanting to raise their children differently from the way they had been raised. Many of them also spoke about wanting to provide their children with things they had not received during childhood. This included materialistic items, but centered mostly on issues of being available to their children and providing them with emotional support. Sometimes they were successful; other times they were not. This is illustrated in the following statements:

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> I want to be the sort of mother that my mother wasn't. I kid around with them. You know, that serves to turn the negative to positive. 'Cause I want them to be an asset to society. I don't want them to have to go through [what I went through]. And I would do anything to make sure that...happens.

One woman remembered how she had felt rejected by her father when he wouldn't show up for visits after her parents separated. After waiting hours for him, her mother would pretend that her father had just telephoned and explained to her that an emergency had prevented him from coming. Her ex-husband has also been inconsistent in her son's life:

> I just tell my son, 'Well your father knows where you are; he has the phone number, he has the address. And he doesn't choose to have a role in your life and I'm sorry and it's not your fault. But sometimes people don't know how to be parents.' Which is hard for me 'cause I know that...I'm the one that has to deal with his hurt feelings.

Most of the women in this study chose extremely positive adjectives when asked to describe their relationship with their child. Words they used included fun, close, patient, loving, compassionate, and caring. There were many examples of these sentiments in their interactions with their children, as illustrated by the following statements:

> Just recently she went to holiday camp...and just when she stepped off that bus and I saw her again...there was a lot of joy for me in just seeing her again....I just grabbed her and I gave her this big hug.

Another mother described her relationship with her son as 'flexible'. In support of this adjective she spoke about how she had to change her expectations of when he would do his homework based upon his needs:

> I used to like him to come home and do his homework right away. And I realized that he would do it, but he would be kind of

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> fussing....Like want to do it scribbly, purposefully. And he would give me a hard time with it. Where now I realize...I give him more choices. And he likes to relax and wind down first, then go to it. Which to me, I wanted the opposite, but I have to be flexible with him.

Yet overall, parenting has been a very stressful experience for most of these women. Although it is important to remember that nine out of ten of these women are single parents, which certainly compounds the stresses they feel, even the woman who has a partner helping to raise her children feels overwhelmed by the experience. Many expressed having few resources to turn to for help when things went awry. Most end up turning to their children's fathers or their own mothers for help, yet most also agreed that these figures were undependable and available inconsistently. Their difficulties and pain can be heard in the following statements:

> When she would cry a night and all day, sometimes I used to call my mother and tell her that I was gonna kill her. That I was gonna kill [my daughter]....I really thought this was gonna be a baby doll and I wasn't gonna hear a peep from her and it was the exact opposite....And being a mother I felt like I constantly got slapped in the face with something that I didn't know that I wasn't doing correctly...it was a very difficult time.

> I wrote in my journal that I wanted to kill her and I was really angry that she was up. And then like twenty minutes later it passed....The most difficulty is that...I'll get triggered and it's hard to not act out with it....Sometimes I think, 'How can I be there for you, I have to be there for myself?'

Many of these mothers worry about losing control with their children. When angry or upset, they are often unable to restrain themselves and end up responding to their children in a fit of rage. Sometimes, in order to prevent themselves from going over the edge they shut down, either by purposefully ignoring their child or simply by turning inward. These reactions are highlighted in the following responses:

> Mostly I'm a screamer...other times I just stay quiet 'cause I

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> know I'm gonna lose my temper. And I wait till we're alone mostly to talk to him....If I'm not screaming, I just shut up. I just won't talk.
>
> He used to throw these little temper tantrums and we...go to the supermarket and he throws a tantrum in the supermarket. And...it was just the whole stress of the day and everything...So I said, '...We're going to leave this store.' He continued to cry and tantrum and everything out in the street and I guess I just have reached my boiling point so I started hitting him. And I was beating him and...then I just caught myself, 'cause I mean I literally was really stating to hit him hard! And I just started crying....And we went in the house and I just cried and cried....I mean I was right at that edge. I mean, I caught myself but...I could've killed him.

Almost all of these mothers have relinquished caregiving behaviors at some point in time when they felt overwhelmed and distressed. These behaviors are related to the high scores on the Helplessness scale. When confronted by situations in which they felt unable to offer their child an appropriate amount of protection and security, they turned their children away by either bringing in other caregivers or by deactivating their own caregiving system. This is illustrated in the following examples, as these mothers described incidents when they became angry or upset:

> I [was] just totally disgusted with her. I was probably verbally abusive to them [both]...'I can't stand none of you all. You both get on my damn nerves. You don't follow instructions! I don't believe that you're doing this...Okay, you know what? You're gonna go stay at your grandmother's and you're gonna go to your father's, 'cause I don't need this shit'....When I'm overwhelmed and feeling like I'm going crazy she needs to go with her father. 'Cause then I'm not gonna like being a parent and I'm not gonna like parenting her.
>
> [One time] she came home with a spot on her butt. A red mark on her butt. And she was probably slapped very hard. She was telling me that it hurt. I told her, "Go to your bed.' I didn't want to hear it....[Another time] I caught her and her sister in an inappropriate act, they were fondling each other. I was about to go to church and when I saw it, I literally lost my mind....I took both of them down and flogged them....I didn't want to go to church anymore. I just wanted to stay home, put them to bed...and I wanted to just curl up.

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Other times, specifically when related to the possibility that their own child may have been sexually abused, these mothers abdicated their caregiving system because they believed they were left with no caregiving strategies to protect their child and/or themselves. This can be seen as evidence for a segregated system of caregiving. Where this parent was left unprotected as a child, she is now unable to protect her own child. Following are two examples that illustrate this.

When one mother worried that a male friend of hers may have sexually abused her daughter, she reported that she handled it by basically dismissing it:

> I just like kind of meditated it...and just reassured myself that she's safe....I think the only way I can really handle it is to give it to God and say that I don't control all of this and I can't protect her from everything. I can protect her to a certain extent...but it's not my responsibility to cushion her life.

This is considered an abdication of the caregiving system since she did not employ any strategies to ensure the safety of her child. Rather, she thought about it and decided that she could only leave it to God, since there was little she could do to protect her child.

Another mother reported that she initially ignored her child's statements about being abused because it meant that she had to also deal with her own past. Again, this is considered an abdication of the caregiving system since no evidence is given that this mother took any immediate action to protect her child:

> [At first] I sent her away because I didn't want to hear who did it. I went to bed...I turned my phone off. I didn't want to know. I didn't talk to nobody.

Many of the women in this study described their relationships with their children in a psychologically merged way. Several also expressed a blurring of age-

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appropriate boundaries and/or role reversals, whereby they relied on their child to provide them with protection and a sense of security. This was similar to their own experiences in childhood. The following are examples of merging:

> When she got her period, she was ten. I experienced all the symptoms. It was funny. I was nauseous. I had cramping. I was wondering what was wrong.

> When she left [for camp], it felt like a piece of me was ripped out and when she came back it felt like the piece was put back. It just felt like a part of me, like a limb was put back in my body.

Several women also described their children as a companion to them. Sometimes this was in the guise of having the child help with household chores. Many times, however, the children end up offering care and support to their mothers. Often it is as basic as helping their mother feel needed. The following examples illustrate this sentiment:

> Like if we miss the train [in the morning,] she immediately takes responsibility and apologizes for it.

> I need him to acknowledge me or always need me. I want him to sometimes say, 'Let's play. Let's do this' so I can feel needed and everything.

All of the mothers in this study spoke of their concerns for their children's safety, particularly around the issue of sexual abuse. Many worried constantly and saw the potential for sexual abuse everywhere. Some feared their child had been sexually abused at some point in time, although they could not state a specific reason for their concern.

> I'm very cautious [about] who I leave him with. I feel a lot of guilt having to leave him. I get overly scared. Sometimes I have an anxiety attack, like something's gonna happen to him. And that even though I know the signs of someone being molested or notice when little things change...I'm almost obsessed with preventing something

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> from happening....I'm always questioning him if anybody touched him. I'm always questioning my son and my son looks at me like, 'What's wrong with you?' But I have to ask.

Sometimes, because of their worries, they convey conflicting messages to their children, as illustrated in the following example:

> I sit down and I talk with her. I told her to tell [her father] to stop anything. [If] anybody does [anything] to you, tell them to stop. I say, 'If you want you can tell him, I'm gonna tell the police.' But then again, I get scared because I don't want her to alarm anybody. And then I'm afraid the person might get alarmed and might try to hurt her.

A few women reported having difficulty with intimacy and physical closeness with their children. At least two mothers worried about sexual feelings that may get aroused in them if they allowed too much physical contact between themselves and their child. Both of these women were classified as Secure on the AAI, but both had sustained very severe sexual abuse in the form of penetration by their father or stepfather. However, because the discussion of these feelings came up spontaneously with both these women, it is possible that other women in the study have experienced similar feelings but did not feel comfortable spontaneously discussing them. The following two statements illustrate these sentiments:

> As a little girl she always wanted to touch me before she went to sleep and that used to bother me so much. Or she wanted to sleep with me even after she had her own room. And that would just annoy me or irk me so bad. And I wouldn't say anything but I know that she could sense the tenseness and the distance between us.

> ...Sometimes I feel uncomfortable when he wants like hugs....I never felt this way before but now I'm starting to feel uncomfortable. I guess he's starting to get bigger and stuff, too. I'm just starting to feel uncomfortable hugging him and really being affectionate with him...Then it'll be times like, if I see [my son] without any clothes on, I just feel anxious....I was reading about incest, I was like, 'Will I feel those feelings?' And I don't even put

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myself in [that] situation [now].

Several mothers described turning to professionals for help with their children when things became too stressful or got out of hand. Some took their children to individual therapy; others participated with them in family therapy. While some say it was extremely helpful, others were disappointed by this experience.

One mother reported feeling confident as a mother only after taking her son to therapy:

> I guess [I felt confident] when I started taking him to therapy....In the beginning it was terrible. He would cry, he didn't want to be there. It's like he knew why he was there and I think I started feeling confident and just excited when I started seeing him engaging and started to change. Like even after a few weeks, I saw a big change.

Another, however, felt discouraged when therapy didn't work out for her and her daughter. She had hoped it would be a turning point in their already tumultuous relationship:

> I had just moved into the apartment and [the children's service agency] investigated and they said, 'No, we didn't find anything.' But she said, 'Being that there are some conflicts between you and your daughter, why don't I recommend counseling?' So I said, 'Okay'....And then we went to counseling and the doctor did her assessment and she asked me, 'So how long did they sentence you to?' And I said, 'Who?' She said, 'Oh, you know, this is a mandated counseling session. You were referred by ACS.' And I said, 'Well, they didn't sentence me to anything'....She said, 'well, there's nothing wrong with your daughter and if you don't want to bring her don't.'...And I feel that was a setback because...she didn't want to treat her....She was so discouraging....So I feel that was a setback because I feel that...may have been the road to recovery for our relationship.

An ancillary finding of this study is that most of these women expressed having some difficulty with adult relationships, both currently and in the past. The

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material that follows describes their relationships with significant others and peers as they moved into adulthood and had children. These findings are not particularly surprising given the high number of women who were disorganized with respect to their mental representations of attachment. These interactions with other adults affects their parenting and their ability to provide their child with a sense of safety and protection.

Relationships with Significant Others: Narrative Material

Most of the women in this study left home at a young age, often because it was the only way they could find to get away from the abusive environment they had grown up in. For a few, it was the outcome of disclosing the sexual abuse after years of silence; others were asked to leave their homes by their parents because of ongoing conflicts. A few were left to negotiate on their own, as their parents made attempts to get on with their own lives. The following examples highlight some of the experiences these women had as they struggled to find a place for themselves when they left their parent's home:

> I couldn't take it any more, what was happening to me sexually, the sexual abuse happening to me. And I finally broke down and told the gynecologist, who...got all these other people involved. And my mother was told. And she didn't believe me. She said I was lying. And a result of that, I had to move out....At first my aunt took me in [but] I didn't like it there too much and I asked a cousin if I could move in with her....I moved in with her for a few months and then when I finished high school I moved. I finished high school at 17 and I got my own apartment.

> The first time [I was on my own, my mother] had found a boyfriend, she went to live with him. She left the apartment to me and my brothers. I had my daughter, so I'd say I was about 15. Fifteen, sixteen and she left.

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In addition to leaving home early, all of the women in this study had their first child when they were in their teens or early twenties. If they were still living at home, this now created a new tension as they struggled to achieve a sense of independence and take on their new role as a parent. For those already living on their own, it was an opportunity to create a new life and family for themselves.

> I didn't move away from home until I was 20. That's when I had my son...I just had my son, I was uncomfortable. I just finished...like a semester of college....And it was just like my mother was really starting to get on my nerves. Like telling me how to raise him, to do this...it was just too much....So I was like this is her house, she pay the rent here, her name is on the lease, I got to go.

Yet, these women had a very difficult time in their new, intimate relationships. As teens and young adults, they often chose inappropriate partners and their relationships ended quickly. This was not surprising given their great desire to be loved and their poor skills at judging others. Only one woman is currently involved with the father of her children. This couple has been together for about 10 years. Two other women reported being involved in a significant relationship now, with someone other than their child's father. All three of these women were Secure on the AAI.

Seven women reported that their relationship with their partner was physically abusive. Interestingly, the women reported that they were just as likely to hit their partner, as he was to hit them. Once they recognized what was happening, most were able to end these relationships so as to stop the cycle of abuse.

> ...With my daughter's father...he was abusive. And he was a bully. And I refuse. And that's why I told him, 'Listen...we have a baby together so I think the best thing we do is go [our] separate ways...because I'm not going to let you get the best of me.' I said, 'I'll

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end up either in jail or dead.' So...that ended.

Three women also reported getting into physical fights now, as adults, with their peers. Getting into physical altercations seems to be the only way these women know how to express their anger and resolve problems that arise in close relationships. When asked about how they felt during or after these incidents, these women reported feelings of rage and an inability to control their actions. This is illustrated in the following two statements:

> I felt enraged, out of control...it doesn't feel good...yeah, I feel out of control and I felt like I didn't want to be that way but I couldn't help it....yeah, I guess it felt kind of natural in a way.

> ...I'm so quick to [be] very argumentative....To the point where I annoy the person for the person to hit me, just to give me a reason. I would not attack you first, but I would torment you...and I will go get at you....All I think about is kill, kill....And I have to cry. If [I] don't cry... I'm going to give in to it, so all I do is cry.

Almost all of the women reported that one of the effects of their childhood experiences is their current inability to trust people, particularly men.

> ...I would not accept anything from anybody. It's just lack of trust. I don't trust nobody. I have friends that I don't trust.

Yet, while they spoke about the difficulties they had in relying upon others for comfort and support, they simultaneously described experiences where they had trouble determining whether someone was trustworthy. The result of this was that they sometimes put themselves and their children into dangerous situations.

> ...Sometimes it takes me a long time to learn how to trust people whereas at the same time if you show me...if I get the feeling from the beginning that you're honest and so forth, I become very trusting and then in a sense I guess just very vulnerable....I think with men I'm more trusting than anything else....I become trustful of men more than I do of women, more quickly...I remember going out dancing...and meeting a guy at the club and it was just like, 'Oh, he's

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> so nice.' And the next day we went out on a date and he picked me up at my house and then I was like, 'Wait a minute, what the heck am I doing?' I invited this man over to my house. I don't even really know him.

These experiences have often affected both their perception of themselves as a parent and the caregiving behaviors they provide to their children. Three women in this study have engaged in relationships with men who ultimately sexually abused one of their children. Clearly, their difficulty in engaging in appropriate adult relationships had a direct impact on their child's safety.

In sum, the significant findings of this study show that age at the time when sexual abuse began can influence an individual's resolution of trauma. However, a lack of correspondence was found between adult mental representations of attachment and current mental representations of caregiving behaviors. Based on the data obtained from all the measures in this study, it is hypothesized that prevalence of trauma and the availability of a loving figure during childhood are the intervening variables that influence how one parents one's own children. In the next section, three hypotheses that have been generated from this data will be examined.

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Part III: The Intergenerational Transmission of Trauma

Table 11, below, is a summary of the variables that represent each participant's mental representation of attachment, mental representation of caregiving, prevalence of trauma, and use of dissociative defenses.

Table 11: Summary of Trauma, AAI, CI, and DES Scores

Subject's Name	Overall Trauma*	AAI**	Caregiving/ Secure Base***	Caregiving/ Helplessness ****	DES*****
Jan	High	U/Ds2	2.0	6.0	17.5
Rosa	High	U/Ds2	2.5	7.0	03.2
Ana	Low	F2	5.0	4.0	13.2
Belle	High	F4	1.5	5.0	07.9
Sue	High	F4b	2.5	5.5	02.1
Fran	Moderate	Ds3	5.0	3.0	04.6
Diana	High	F4b	1.0	7.0	17.9
Lynn	High	U/CC/E3	3.0	7.0	48.6
Eve	Moderate	U/F4b	6.0	5.0	54.0
Maria	High	U/Ds3	3.0	6.0	02.5

* Assigned to a category based on the total score of all the subscales on the TAI. Less than 5 = Low; 5-10 = Moderate; Above 10 = High

** F = Secure; D = Dismissive; E = Preoccupied; U= Unresolved; CC = Cannot Classify

*** A score of 4 is considered at the midpoint. A rating below the midpoint reflects a parent who does not describe a secure base representation.

** ** A score of 4 is considered at the midpoint. A rating above the midpoint is reflective of a parent who is Helpless.

***** Scores of 30 or greater are considered significant for a Dissociative Disorder.

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Three hypotheses about how trauma is transmitted from one generation to the next have been generated from this data. What follows are each of the hypotheses and a clinical case study illustrating how the dynamics between the variables of trauma, mental representations of attachment, and dissociation may be played out with the next generation through the caregiving system.

Hypothesis #1:

If in childhood one has a low prevalence of trauma combined with the availability of a loving figure, and no propensity toward dissociation or traumatic memory loss, it is then possible for this individual to have mental representations of attachment that are classified as Secure on the AAI. This individual should be able to develop a caregiving system whereby they are able to offer adequate protection and security to their child without displaying helplessness in terms of their caregiving behaviors.

A discussion of Ana's life will serve to highlight this hypothesis. Ana was born in a large, urban city in the Southwest, but spent most of her childhood going back and forth between her mother's house in the U.S. and her grandmother's house in another country. By the time she was a teenager, she believes she was bounced between these two households about 15 times. Separations were initially difficult for her, especially the first time when her mother left her with her grandmother without saying goodbye. However, by the second or third separation, she remembered thinking that it was okay because she had been there before.

What Ana remembers most about her mother is her not being there when she needed

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her:

> When I needed to talk, when I needed say girl talk, she wasn't there for me to talk with her....When I was here I remember...she worked the day shift [and] it was sort of okay because she was home in the evenings and we got to like spend some time together. But then there was the times where she was also working the night shift and I would stay home with my aunt, so it was like during the day she was sleeping, during the night she wasn't home. So it was still sort of like the same feeling, like she still wasn't there.

When asked to describe her relationship with her mother in childhood, Ana was able to present a balanced portrait. She stated that their relationship was, "distant, scary, sometimes happy, weird, and lonely." In talking about experiences that would exemplify each of these adjectives, Ana was able to talk about both difficult and loving times with her mother. She allowed herself to express her emotions freely and she was able to put many of these experiences into perspective, given her view of them now.

Ana's parents separated when she was still an infant and she saw her father infrequently as she was growing up. However, when she did visit with him, she recalled that it was usually "fun". When asked to talk about her relationship with him, Ana described it as, "Empty, angry, confused. That's it." Again, she was able to talk about that relationship freely without seeming either dismissive of the relationship or preoccupied with her anger towards him.

When asked about what would happen if she were sick or upset as a young child, Ana responded:

> When I was sick, I mean [my mother] did take care of me and made sure I had, but never any hugging or stuff like that. As far as emotional...after a while I just learned to just like keep things to myself and just never even said anything when I was upset. I would just go to my room and cry and then come out.

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Ana could not recall any time in her life when her mother was physically threatening toward her. She did, however, remember one time when her mother threatened to send her to live with her grandmother because she was misbehaving. There was no violence in her home as she was growing up and she felt that discipline was handled consistently and fairly. None of her caretakers had a drinking or a drug problem. Although a few close relatives died during childhood and young adulthood, again Ana again spoke freely about these experiences and was able to reflect openly about their effect on her life and her experiences with her own child.

When asked about other significant caregivers in her life, Ana spoke affectionately of her aunt:

> She was just very sweet, very understanding and very protective, yet not as much as my mother was….And just being able to talk to her about things that I couldn't [tell my mother]….I remember times where… [she and her husband] would get into arguments and she [never] changed her attitude toward us, towards the kids. Neither did he….She always had a smile on her face, food was always at the table…she basically puts everything into a joke….I think that's one of the reasons why I feel so close to her, just because she always put a smile on my face.

Her uncle who lived with her for a period of about a year-and-a-half and who was responsible for caring for her after school, began sexually abusing her from the age of 8 until age 9½. The abuse consisted of exposing her to sexually inappropriate material and fondling. She did not describe any type of dissociative behavior around the experience of being sexually abused nor did she express any traumatic memory loss for the events. Ana has never told her mother about the abuse. Before the age of 16, the only person she told about the abuse was a friend, who helped her to get into counseling. Yet, she stayed in treatment for only a short time:

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> I would say [I saw her] for about three months only. I remember missing like two sessions and I felt like well she should have called to see why I had missed them but she never did. And then after that I just stopped and I would say, 'Well, she doesn't really care or she would've called me if she did' and then I just stopped seeing her.

Ana was classified as having experienced Low amounts of trauma during her childhood. Her score on the DES was not significant. She received an AAI classification of Secure.

Ana now has one child who is 12-years old. She got pregnant at the age of 14 and felt her mother was very supportive when she chose to keep her baby. She and her son lived with her mother until she got married at age 24. That relationship ended quickly and she and her son now live alone, although Ana reported that she is currently involved in an intimate relationship with a man who she is considering marrying. However, she also reported having many conversations with her son about this relationship in hopes of helping him learn to accept this new person in his life.

When she described herself as a parent, Ana presented a balanced view:

> I think [parenting] is challenging and hard. I question myself a lot as far as the way I try to discipline him, as far as am I doing the right thing. I try to be his friend and let him know that we are friends, but there is a limit to the friendship where the parent comes in. I just try to do the best I can.

She described feeling a lot of joy when, "he comes home with good grades and he's like extremely proud to show them to me, he's very eager to show them to me." She was also able to talk about difficult times, such as when she's angry or upset with her son. Although she expressed some role reversal, like when she needed him to keep her company when she and her husband separated, overall she had relatively balanced and appropriate views of protecting him and providing him with a

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secure base. In turn, he often looks to her as a source of comfort and support. The following is an example of how she provides a sense of security for her son when he is upset:

> We went to see wrestling and it was a Christmas gift to him so he was really like, 'Wow!' I went out and I got him a tee shirt. He was trying really hard to make a sign to take with him and he just couldn't come up with a sing that was nice enough. And I said to him, 'Well you made that one, that one's okay." And he was going, 'No, I don't like this one. It looks crappy and everybody else is going to have better signs than me....I think like five minutes before we were supposed to leave I said, 'All right, let's do a sign'....So I turned on the computer...and I'm writing a sign...and I cut it up and I put it on a poster board....[Then] we cut out pictures of his favorite wrestler and taped them on and he was just like, 'Oh, this looks really cool.' When we got home [that night] he said, 'My mom was so cool.'

Ana received a score of 5.0 on the Secure Base scale and a 4.0 on the Helplessness scale.

Overall, Ana's experiences of Low trauma and a supportive, loving figure have allowed her to be open in her thinking about intimate relationships. She also did not describe using dissociative defense mechanisms, which has allowed her to process her experiences in a single, as opposed to segregated, system for attachment relationships. Although Ana did not spend much time in treatment, she was able to find other supportive relationships that have sustained her. While she does sometimes engage in role-reversals with her son and has occasionally looked to him to offer comfort and support, overall she has been able to maintain control in her role as a parent and offer him protection and a sense of security.

Hypothesis #2:

Given a high prevalence of trauma but with a loving figure that helped to

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develop one's sense of self-worth and esteem, and no propensity for dissociation or traumatic memory loss, this individual can develop mental representations of attachment that are Secure in terms of their AAI classification. However, when they are involved in intensely intimate relationships, like with their children, they may not be able to translate their thoughts about these relationships into behaviors that are necessary for providing protection and a secure base for their child. Their children come to view them as unavailable and end up turning away from them when they need protection and support.

A discussion of Sue's life will highlight the elements of this hypothesis. Sue was also born in the inner city of a state in the Northeast. During infancy and early childhood she lived with her grandmother while both her parents were in drug rehabilitation programs. Because her grandmother worked, she was cared for during the day by an older woman who she viewed as an incredibly warm and loving figure. At the age of seven, Sue moved in with both her mother and father, yet she continued to visit with her babysitter on weekends. She recalled:

> She was always hugging me and kissing me and telling me how much she loved me. All the time....We'd be running around, she'd be, 'Come give me a hug, come give me a kiss.' And she'd have, she was kind of a heavier woman and she would just, you just felt so comfortable and safe in her arms.

This arrangement lasted until Sue was an adolescent, when her parents separated. Sue then lived with her mother and her mother's boyfriend.

Her memories of her mother are of a person who was distant and cold:

> My mother, she worked a lot. So I remember her working a lot. I remember her working a lot but I don't really remember like a lot of memories with her....I don't remember her telling me she loved me or hugging me and that kind of thing. So that was like kind of

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> cold. I mean, I knew she loved me but...I don't think she was able to really show me.

Although Sue did not remember her mother being available as a secure base, she did have balanced memories of her and was able to speak about times when they had fun together. She was able to speak freely about both good and bad memories and related a sense of understanding about why her mother may have behaved as she did during Sue's childhood.

Sue was sexually abused by her father. The abuse began when she was about 8-years old and continued until she was 15. It included fondling and intercourse. However, when she chose words to describe her relationship with him, she was able to communicate a sense of balance in her current understanding of the relationship:

> I had a lot of fun times with him 'cause he was just...he would cook for me a lot and take me out to the park and stuff....We would always be going to the park and he cooked for me all the time and I cracked jokes....[But on the other hand], he was a promiser. He was always promising me things...and then when it was time to come through he couldn't come through....It was always something. That was just the nature of how he did things....I was [also] scared of him....I think I was scared of him not loving me or seeing me again, if I didn't be with him.

Sue often took on the role of spouse with her father. He would take her into his confidence and talk with her about her mother and the various other women he was dating.

When her parents lived together, Sue did not recall any violence in the home. However, that changed after her parents separated and her mother moved in with another man. This man was physically abusive towards her mother and Sue felt pressure to take on the role of protector of her mother. Once, during a fight between her mother and this man, Sue came between them with a knife and threatened to hurt

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him if he continued to hit her mother. After that incident, her mother ended the relationship.

Sue did not report any type of dissociative experiences around the sexual abuse nor did she recall ever having any memory loss for any kind of trauma.

She received a score of High Trauma because the sexual abuse spanned three developmental periods and because of the violence during adolescence. She also received a high score because of the many losses and separations she sustained during childhood. Her score on the DES was not significant. Sue was classified as Secure on the AAI.

Sue now has two children; a son, age 11 and a daughter, age 5. She lives with her partner who is the father of both her children. They have lived together since her son was an infant, although it was unclear how involved he is in the care of their children. She chose to speak about her relationship with her son for the second interview.

Sue described herself as a, "patient, loving, caring, sympathetic" parent. However, throughout the interview she had trouble describing her relationship with her son in a free and unencumbered manner. She also could not describe a time in the past week when they had really clicked. Sue was unable to convey a sense of supplying her son with a secure base. Although she seems to struggle to remain in control during trying situations with her son, her strategies seem brittle. She once described a time when she beat her son in the midst of his temper tantrum and she felt as if she was close to losing control. The following example is illustrative of Sue's current caregiving strategies when her son's attachment behavioral system becomes

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activated:

> I asked him to wash the dishes...then something went wrong and he was getting into some problem with the dishes...so I told him to come on, just do the dishes. And then he started crying....so then I said, '...I don't want to hear the crying, stop the crying.' Then I guess he musta just got really angry and he was like, 'You don't love me' and just ran out the house with no shoes on or anything....It really caught me off guard....At first I sat down. I say, 'You know what? I'm gonna let him just think about what he did and see if he ring the bell to come back,' 'cause my door is locked. Then I said, 'No let me go 'cause who knows where he could go or whatever could happen.' So I get dressed...and I come outside...I said, 'you running out in the street with no shoes on you make people think I'm in the house killing you or something....everybody in the street somebody'll call...a child service [agency] and...make a complaint....And they'll swear I done did something to you physically or hurt you in some kind of way and they will take you to'....I just had to walk away...by the time I came back he was calm and he was sitting there.

Sue also spoke freely and openly about her reticence to show her son affection. She said her uncomfortable feelings with being physically affectionate with him began after her daughter was born. The following example is typical of what happens between them now:

> Sometimes I feel uncomfortable when he wants hugs....We used to hug all the time before [my daughter] was born but now...I'm starting to feel uncomfortable....[Once] I was dancing...and we were outside with my friends and stuff and he likes to perform for people too. He loves to dance and everything. So...then I was dancing and then he like came up in front of me and he was like, you know, put his arms around me and I was like, '...come on move.' You know, that kind of thing. He was like, 'What? Don't you love me? You don't want to hug me?'...Afterwards I felt guilty about not hugging him...he needed to be reassured about that. He wanted me to hug him at that moment and I felt guilty about not doing it.

Sue received a score of 2.5 on the Secure Base scale and a score of 5.5 on the Helplessness scale. The incidents cited above are examples of how conflicted Sue feels both in terms of protecting her child from harm and in providing him with a

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sense of security. In both instances, her son's experience is that of uncertainty about whether his mother will be available to him for love or comfort. Instead, he has learned to turn away from this relationship, as illustrated by his leaving the apartment during the first incident described above.

In sum, although Sue is able to think about her past attachment relationships in an integrated and secure way, her thinking about these relationships does not seem to translate into an ability to act as a protector for her child and provider of a secure base during stressful times. Although there was no evidence for dissociation or traumatic memory loss, her high scores for trauma may, in fact, be negatively influencing her ability to parent securely without abdicating the caregiving system.

Hypothesis #3:

Given even just moderate levels of trauma, if an individual has poor or no loving figures during childhood and a propensity to dissociate or experience traumatic memory loss, these individuals may have a difficult time resolving their traumatic life experiences. As parents, they are unable to provide a secure base for their child and they remain helpless in terms of protecting their child. These individuals may, in fact, have a segregated system of attachment and caregiving. This, in turn, may put their child at greater risk for being sexually abused.

Eve's story highlights this hypothesis. Eve was born and raised in an inner city of California. She lived with her mother and two older siblings, the oldest of which was ten years her senior. She does not remember her parents ever living together and she recalled having only a few visits with her father as she grew up. She

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was unable to come up with any adjectives to describe her childhood relationship with him and she stated that she felt rejected by him as she was growing up.

In contrast, her memories of her mother are clear and unencumbered. She recalls her mother as someone who was always physically present, but who she viewed as stern and brusque:

> I just felt that sometimes she was very harsh with her words or with her manners. Like earliest I remember when we used to go to school…every morning she would brush my hair. And it was like by the time I went to school my hair was hurting because she was real rough….But she was always there for me and she was very supportive. But also she's very controlling at times. She likes things done her way….She has a narrow view of certain things. She's stubborn.

In her description of her relationship with her mother during childhood, Eve portrayed a balanced view and used words like, "comforting, safe, friction, pleasant, guilt." She was able to support each of these adjectives with examples that often contained her adult perspective on the event. While Eve described moments when her mother offered her comfort and support, she also spoke about how her mother made her feel guilty for having been born:

> While we were growing up…she would always say stuff like, 'If it wasn't because I had you two, I woulda been working'. She made it sound like we stopped her life, the second half, the two kids. The first ones she never complained, but the second two were like a mistake….Especially myself because I was supposed to be a twin, so she had gone to have an abortion and the other one died and she still stayed pregnant, so…I felt a lot of guilt 'cause I felt like I stopped her from moving on and she made it clear to me.

Eve's memories included being hit a lot as a child. She recalled being hit at least once a week by her mother with either a belt or a broom. She also remembered her mother being verbally abusive towards her. When asked what would happen when she got hurt physically, Eve could only recall times when her mother had hit

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her:

> I remember than I would never cry....Since I was so stubborn, she used to say willful, I didn't cry so she would hit me harder....I remember the feeling but I don't remember why....I know she had the belt and she hit and I was like refusing to be fearful. I was always the tough one. So that got me more in trouble than just being compliant....She would get mad and try to get me to succumb to her ways.

When Eve was upset as a child, she recalled slamming doors and throwing things around. Although she did have memories of sitting in her mother's lap and being held, she remembered those to be around happy times, and not when she was physically hurt or emotionally upset.

Eve stated that the violence in her home began when her oldest brother returned from the Navy with a severe drug habit. Eve was about 9-years old when the violence began and she recalled several fights that her brother got into with various household members. At least one of those fights involved the use of a knife. Eve remembered feeling a lot of anxiety during this time period. She recalled feeling unsafe, as if there was no one to protect her from what was occurring.

This same brother sexually abused Eve. During the retelling of these events, Eve recalled engaging in dissociative defenses during the abusive incidents. She also evidenced some disorganization in the retelling of this part of her life. This was seen in her inability to ascertain how long the abuse went on for and how old she and her brother were when the sexual abuse began. Eve first expressed with a sense of certainty that she was very young when the abuse occurred:

> I must've been very young, 'cause I even remember having a pacifier. I must've been like three, four, five...well I used to use a pacifier till I was like seven, after school. But I know it was, I didn't go to school yet so it must've been young.

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On the other hand, she was also certain that her brother, who is ten years her senior, was older than 13 when the sexual abuse was occurring. When this discrepancy was pointed out to her, she was able to reflect on it but she remained unable to consolidate her views on it. She also continued to maintain that the abuse happened only a few times:

> ...He would touch me in places were he wasn't supposed to. But I was young and I didn't understand it. And I used to always say, 'Well, if I pretend I'm sleeping, then eventually he'll get away from me.' And that's as far as it went....[Yet] I must've been older then, because I remember him being older. Maybe he was 16 or 17. Then again, I always remember it being that I was younger. Maybe, but I know I remember him being an, almost adult already. It wasn't like he was thirteen or anything like that. He must've been 16 plus.

Later, Eve recalled the abuse continuing when her brother returned from the Navy.

Eve expressed experiencing a traumatic memory loss for the events until she was an adult. She recalled:

> It's funny 'cause I didn't know about it until I think I was like twenty-something, which I didn't even know what triggered it. I really don't. But it was weird because all of a sudden I had a recollection but I kept denying it.

She has never told her mother about the sexual abuse. Rather, she believes that her mother will, "try to deny it or try to change my mind out of it and that'll make me very angry so I try not to bring it up".

Eve received a score of Moderate in relation to the prevalence of trauma during her childhood. She was assigned this score mostly because of the violence and chaos that ensued in her home when her brother returned from the service. Her score on the DES was significant for the use of severe dissociative defenses. She was classified as Unresolved with respect to trauma on the AAI, although she did attain a

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second-best fitting classification of Secure.

Eve had her first child when she was 18. She lived with her mother for the first few years of her son's life, but then moved out at age 24 because she found her mother too controlling. She later married and had a second son, who is eight years younger than her first. This marriage did not last long and she now lives by herself with her youngest son. Eve chose to speak about her relationship with her younger son during the CI.

When she described herself as a parent, Eve stated having two separate images; these are based on her role as a parent with each of her children:

> It's hard. I have like two perceptions. I guess because they're far apart in age. I do a lot of things differently now that I didn't know for [my other son] and also they're very complete different children....I think [now] I am a compassionate, understanding parent....I try to give my [younger son] more independence and more choices because before I didn't know the importance of choices for children. I expected him to do what I say and that's it....So I try to be more understanding, more open to parenting. I read a lot about parenting issues and stuff.

She described her current relationship with her younger son in a balanced and open way. The words she used to describe it included, "flexible, happy, confident, and sometimes difficult". For each of these adjectives she was able to supply examples of times when she and her son were together and it felt that way. When his own attachment behavioral system becomes activated, Eve described instances in the recent past where she is able to provide her son with a secure base. For example, she remembered his severe separation anxiety when he began school at age 2 ½. Eve reported that she would stay with him in the mornings for an extended time to help him settle in. At first, he attended for just half a day, but slowly Eve began extending

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his day. To ease this transition, she would often visit him during her lunch hour or leave work early. She recollected:

> I would say [it took] like eight months....'cause after six months he went through a period where he started to be aggressive with the children....For two months in the summer I would go in my lunch hour and I would leave work early and be with him for a while to help him....So if I would go, then he would be a little bit better.

However, Eve also spoke about times when she lost control as a parent and she abdicated the caregiving system. This seemed to be most prevalent during the period of time when she discovered that her older son was sexually abusing her younger son. Eve recalled when her son tried to disclose an incident of sexual abuse between himself and his older brother:

> One night I was gonna take him a bath. He didn't want me to touch him there. He says, 'Oh no. It hurts.' That's when I said, 'Why does it hurt?' He said then, he said it was my son, older son. He said '[My brother] bit me'. They really played a lot cause, you know kids. So I said, 'Maybe he was playing with you.' He said, 'Yeah, but he really bit me and it hurts.' So then I kind of found it funny but then I...put it in the back of my mind. The two days later I confronted my older son.

In response to how she handled that situation, Eve stated:

> At first I got very angry. I became, like I would slam the door. And I didn't even notice it was coming out in different ways. 'Cause I kept saying to myself, 'Okay, well I have to figure this out.' But I didn't really want to feel it, so it would come out [in other ways]. And at one point...during that time...my son had a videotape and I told [him], 'I told you not to watch it.' So I yanked it out. The videotape fell, the TV broke, everything broke. And I didn't mean to throw it but...[then] I realized there was a lot of rage that I was suppressing.

Eve also reported getting in physical fights now, as an adult. These incidents have occurred with both friends and with her husband. She has spent a short amount of time in jail because of her physical violence.

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Eve received a score of 6 on the CI scale for Secure Base. However, she also received a score of 5 on the Helplessness scale. These discrepant scores seem to be evidence for a segregated system of caregiving. It is also important to remember that both Eve and her son have been in therapy since shortly after his disclosure of sexual abuse. It is possible that the treatment has been extremely beneficial and has helped Eve to communicate a greater sense of security towards her son. It is unclear if she would have received such a high score on the Secure Base scale before she entered treatment.

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Summary of Significant Findings

In sum, the three clinical vignettes described above illustrate how pervasive the impact of trauma can be with respect to one's internal working models of attachment. When parental figures are either the direct source of the trauma or are not available to offer protection and a secure base, children can develop segregated systems of attachment. Their figure of safety comes to be seen as the source of alarm. In order to make sense of this quandary, they can develop traumatic memory loss or engage in dissociative defenses. However, not surprisingly the presence of a loving figure, even if it is other than a primary caregiver, who provides protection, support and a sense of self-worth seems to mitigate the effects of the trauma, no matter how prevalent it was. Therapy also seems to have an impact upon how some of these women view their childhood experiences and came to be resolved with respect to their past traumatic experiences.

However, a lack of correspondence existed between adult mental representation of past attachments and current mental representations of caregiving. Instead, mental representation of caregiving seemed most influenced by the prevalence of trauma in childhood. It appears that for women who have experienced significant trauma during childhood, how one thinks about past relationships and how one behaves when engaged in an intense, often stressful, and constantly changing relationship, like that of a parent and child, may in fact be two different concepts. This may be considered further evidence for the theory of segregated systems of attachment and caregiving in individuals with a history of trauma and/or disorganization. To date, it is unclear whether therapy can play a significant role in

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altering this outcome.

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DISCUSSION

Discussion of Main Findings

The present qualitative study examined mental representations of attachment and caregiving among a group of ten women sexually abused during childhood. In addition to the hope that this study would contribute to our knowledge of how sexual abuse impacts internal working models of attachment and caregiving, this study had also been undertaken to examine whether attachment theory could help explain individual differences in the intergenerational transmission of trauma. Because it is generally accepted that childhood sexual abuse often does not occur in isolation, the prevalence of trauma during childhood was assessed to better understand the impact of overall trauma, and of sexual abuse specifically, on adult attachment and caregiving status. Also, use of dissociative defenses was considered in relation to attachment. Since this was a small exploratory study, interpretation of its findings and their generalizability are understandably limited. However, the following findings are worthy of attention in that they expand our understanding of (1) the relationship between age at the time of a trauma and resolution of that trauma, (2) the relationship between trauma and the caregiving system and (3) the lack of correspondence between mental representations of attachment and caregiving among women who have experienced significant trauma during childhood. An ancillary finding related to interpersonal difficulties these women experience in adult intimate relationships also contributes to our understanding of the impact of childhood sexual abuse on adult functioning. Overall, these findings speak to the relevance of using

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attachment theory as a way to understand past sexual traumatization in mothers and its impact on the next generation.

In the present study, half the women were found to have disorganized/disoriented mental representations of attachment while the other half had organized strategies for representing attachment relationships. A major difference was found between women who had disorganized versus organized mental representations of attachment in terms of their age at the time the sexual abuse began. Four out of five women who were classified as Unresolved stated their abuse began around the age of 3. The fifth woman classified as Unresolved stated her experiences of sexual abuse began when she was 6-years old. The five women who displayed organized mental representations of attachment, whether they were classified as Secure or Dismissive, all stated their sexual abuse began sometime between age 8 and 10.

This finding was not surprising given that attachment theorists believe young children to be more likely than older children to develop multiple models of attachment given inconsistent and incompatible experiences with a caregiver. Main's (1991) paper on singular (coherent) versus multiple (incoherent) models of attachment offers an explanation of how understanding the distinction between appearance and reality is influenced by age and cognitive development, which in turn influences ones internal working models of attachment and self. To review, the concept of multiple models does not refer to different models of attachment based on separate aspects of reality, such as with multiple caregivers, but rather to implicitly contradictory models of the same aspect of reality, such as widely divergent

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experiences with the same caregiver. In other words, the young child who is abused by a caregiver is left to deal with the fact that their attachment figure is both "good", as in when they provide the child with comfort, and "bad", such as when they hurt the child.

While abuse has serious repercussions at all ages, an older child, such as one in latency age who has entered the formal stage of cognitive development, can engage in metacognition. Metacognition, the ability to engage in thoughts about one's own cognitive processes, can help an individual to make sense of differences between how things appear and how they are in reality. It is therefore believed that those women who experienced sexual abuse beginning around age 8-10 were at an advantage; they could come to an understanding that although the perpetrator of the abuse thought they were a person unworthy of love, other people valued them and thought they were good. In contrast, those women who experienced the abuse beginning at age 3 were unable to engage in dual coding at the time the abuse began and may have had difficulty altering their beliefs later, once their internal model of self and others became solidified.

Interestingly, four out of five women who had organized strategies were rated Secure on the AAI. This finding was surprising given that prior attachment studies with survivors of sexual abuse had not found such a high rate of attachment security among survivors of childhood sexual abuse. Instead, Shapiro & Levendosky (1999) found that childhood sexual abuse most likely leads to an insecure attachment style. Only 12.5% of a sample in an article by Stalker & Davies (1995) were classified as Secure on the AAI, while 60% were classified as Unresolved. Several factors may

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help to explain the high number of women classified as Secure in this study. These include the concept of resiliency, use of treatment by the survivor, sample bias, and issues related to scoring when the AAI is administered to survivors of abuse.

Egeland, et al. (1993) define the capacity to successfully adapt or function despite having endured chronic stress, prolonged or severe trauma, or a chaotic home environment as resiliency. These researchers believe that resiliency as a developmental outcome is determined by the interaction of various factors. These factors include genetic, biological, psychological and sociological, and all interact with environmental support. Given this view, resiliency is best understood not as a given trait but rather as a capacity that develops over time in the context of a supportive environment. In their study of factors that lead to resiliency, Egeland, et al. (1993) found that this capacity developed in environments where a loving figure was identified, although this individual did not necessarily have to be the primary caregiver.

The four women classified as Secure in the present study all reported having a loving figure during childhood to whom they could turn for comfort and support and who provided them with a view of themselves as worthy of love and attention. While the six other women also reported having a close, adult figure in their life at some point during childhood, when the transcripts were analyzed qualitatively differences in the consistency and the availability of the loving figure were noted. The women who were Secure described their loving figure as someone they could consistently rely upon during a particular period of their childhood, even if that period of time was brief. In contrast, the women classified as Unresolved did not appear to have the

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same kind of access to the individual they viewed as loving, even if the figure was a presence in their lives for extended periods of time. In other words, these findings suggest that having a consistent, supportive and loving figure in one's life, even for a brief period of time, may be more beneficial than having a frequently unavailable and/or inconsistent loving caregiver. Given the view by Egeland and his colleagues (1993) concerning the various factors necessary for the development of resiliency, it is also possible that the four women classified as Secure differed from the Unresolved group in terms of their genetic or biological endowment, which could account for additional differences in resiliency.

While this study found no apparent relationship between involvement in therapy and AAI status, it is possible that women who were classified as Secure with respect to their mental representations of attachment have had different treatment experiences than those classified as Unresolved. Although no data was collected about the type of treatment received or the training of their therapist, one could speculate that women classified as Secure had therapists who served as an auxiliary secure base and who promoted an environment where the woman felt safe and worthy of love and attention. A qualitative analysis of the interview transcripts showed this could be the case; three of the four women classified as Secure referenced their therapists often during the interviews and presented a positive view of their treatment experiences. This was not necessarily the case for those women who were Unresolved with respect to trauma. Instead, they rarely spoke about their experiences in treatment and several reported having switched therapists often.

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In addition to possible differences in treatment, differences were found in terms of relationship history with other adults between those women classified as Secure and those who were Unresolved on the AAI. Three of the four women classified as Secure are either currently living with a man or are involved in a significant long-term relationship with one. The fourth woman, while not currently involved in an intimate relationship, has several close friends that she relies upon and turns to during stressful times to provide her with comfort and support. None of the women in the disorganized group reported having such relationships. This was somewhat consistent with the findings from the study conducted by Shapiro and Levendosky (1999) which found that women with a history of childhood sexual abuse, who also relied upon an insecure attachment style, displayed difficulties in interpersonal relationships. Thus, it is possible that an intimate, intense adult relationship has provided the Secure women with the opportunity to avail themselves of another loving figure, one who makes them feel safe and worthy of love and attention, while those who are Unresolved have been unable to do so. Instead, their attachment style leaves them vulnerable to further interpersonal difficulties.

Attachment researchers have discussed the possibility that an individual could develop secure mental representations of attachment over time and have labeled this "Earned Security". These individuals are considered to have developed secure and organized mental representations of attachment despite difficult childhood experiences because of corrective relationships with a significant other, such as with a therapist or an adult partner. Since the Unresolved classification has been found to be the least robust of the AAI classification system, that is, most likely to change over

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time, it is possible that the four women who are Secure have only recently attained this status. This view would fit well with the theory that security of attachment can change over time, particularly when an individual has been provided with experiences of loving and supportive relationships, as these four women have with their therapists and significant partners.

Another possible reason for the high number of women classified as Secure in this study may be related to sample bias. Since participation in this study was voluntary and required that the subject call the researcher, attend two appointments, and discuss difficult subject matter, this group of women may have been particularly high functioning and motivated to tell a coherent story, as compared to other women who have been sexually abused. Also, since a majority of the women were recruited from flyers placed around college campuses, it could be argued that this group of women had a particularly high educational level and were more interested in engaging in discussions that required them to reflect on past relationships. However, this criticism is least valid since no differences were found between the Secure and Unresolved group in terms of educational levels.

To better understand the results of the AAI it is also important to consider its use among survivors of abuse. Although the AAI as a measure of mental representations of attachment has undergone thorough and systematic investigation with various low-risk, non-clinical populations, it is only within the past 5-10 years that researchers have begun to use this instrument with high-risk and clinical populations. In addition, as explained earlier, the Unresolved classification was first developed by Main and colleagues on a sample of individuals who had experienced

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only one form of trauma, a significant loss. These researchers have assumed that the same principles should hold true for other kinds of trauma. However, individuals with traumatic experiences due to abuse and/or neglect, as opposed to loss, have been the least studied using this measure. Also, few studies have been conducted looking at multiple traumas.

The current coding system most probably does not accurately reflect and capture lack of resolution of trauma from abuse. For example, in this small sample of sexual abuse survivors, seven women reported having experienced traumatic memory loss for the abuse. However, according to the scoring manual, this in and of itself does not lead to a classification of Unresolved. Yet, the AAI has no way to rate this type of an experience even though it is clearly understood as an attempt on the part of the individual to use dissociation as a way to minimize and disconnect from painful memories and affects. It is possible that more women would have been classified as disorganized with respect to mental representations of attachment if factors like this were appropriately accounted for in the AAI scoring system.

Other researchers have also found classification on the AAI to be particularly difficult when studying survivors of abuse. Lyons- Ruth and colleagues (Lyons-Ruth. et. al, 1999) have labeled many of the interviews that were administered to a group of women "at risk" for parenting difficulties who were also abused during childhood as "difficult-to-classify". What they have consistently found was that the internal working models of attachment among these women were not accurately reflected in the current AAI rating system. Rather, these researchers believe that the attachment strategies of survivors of abuse could be better described as clustering along a hostile-

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helpless dimension rather than the secure-unresolved continuum. These authors feel that the hostile versus helpless state of mind is related to infant disorganization and they have speculated that these two distinct parental stances may reflect alternate expressions of a relationship prototype, whereby the parent came to be seen as both victim and aggressor (Lyons-Ruth, et. al, 1999). Lyons-Ruth and her colleagues have since developed an alternate classification system that acknowledges hostile versus helpless states of mind on the AAI when looking at disorganization.

A qualitative analysis of the Adult Attachment Interviews in this study showed the women were as likely to display hostile behaviors, as they were to display helpless behaviors. Identification with the aggressor was most apparent when they spoke about relationships with other adults and their propensity to engage in physical altercations, while identification with the victim was seen in their adult relationships where they often became the victims of physical abuse. The adaptation of this behavioral stance was also apparent as the women discussed parenting behaviors on the CI. Almost all of the women in this study reported engaging in hostile and/or helpless behaviors when they became involved in stressful interactions with their own children. Either they displayed bullying and verbally abusive behaviors or they withdrew from their children, thereby abdicating the caregiving system. While adherence to behaviors on either end of this continuum can significantly impact caregiving behaviors, each is believed to have a different effect on the child. To better understand its impact on the next generation, it would therefore be important to identify where an individual stands along this continuum.

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The second group of noteworthy findings from this study involved the relationship between prevalence of trauma during childhood, adult mental representations of attachment and mental representations of caregiving. Although no relationship was found between trauma and AAI classification, a relationship was found between trauma and scores on the CI. In other words, women with high rates of trauma during childhood were as likely to be Secure on the AAI as they were to be Unresolved. Yet, women who experienced low to moderate rates of trauma were more likely to have higher scores on the scale for Secure Base and lower scores on the Helplessness scale of the CI, while those who had a high rate of trauma were more likely to have lower scores on the Secure Base and higher scores on the Helplessness scale. These findings can best be understood using prior research in the area of trauma and attachment theory.

The lack of correspondence between the TAI and AAI was somewhat surprising given that Shapiro & Levendosky's study (1999), which used structural equation modeling analyses on adolescents sexually abused during childhood, found that childhood sexual abuse had a direct effect on attachment style, independent of other forms of child abuse. However, findings from the TAI need to be interpreted cautiously since this measure is unable to capture the meaning of the trauma or context in which the trauma occurred, which can certainly impact resolution of the trauma and classification on the AAI. Instead, the TAI looks only at exposure to an external trauma and therefore is reliant upon a qualitative analysis of the data to better understand what meaning the trauma may have had for the survivor.

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In addition, the TAI does not take into account other kinds of traumas that may be experienced, such as the inability of a parent to respond to or modulate an infant's intense affect. As previously reviewed, when this occurs the infant is left in a state in which they can be easily overwhelmed by these intense emotions. This type of trauma takes place on an internal level. While both external and internal traumas can leave the individual with similar feelings of being overcome by affect, it is important to distinguish between these two distinct events. That the majority of women described their mothers as distant and unavailable to them throughout childhood may be viewed as evidence for the hypothesis that most of these women experienced trauma during infancy related to the unavailability of a figure to protect them from intense affect. The lack of a relationship between AAI classification and trauma may be related to these limitations.

The relationship that was found to exist between trauma and mental representations of caregiving has been supported by the research of Lyons-Ruth and Block (1996) who found that severity of trauma in mother's childhood was associated with misattuned caregiving behavior toward their infant at home. The literature on trauma and dissociation seems most able to aid our understanding of this finding.

It has been hypothesized that women who experience high levels of trauma during childhood may develop an unresponsiveness to their children as a form of a defensive process used to guard against the re-experiencing of affects associated with their earlier trauma (Lyons-Ruth & Block, 1996). The mother may need to deactivate her caregiving system in order to protect herself from overwhelming feelings of fear and/or anger and to protect her overall ability to function. However, this defensive

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process impinges on her parenting behaviors since it most probably occurs during times when her own child's attachment needs become highly activated. This leaves the child in the unenviable position of having to rely on a figure that is psychologically and/or physically unavailable to them. Since it is believed that women who experienced high levels of trauma during childhood are more likely to engage in this type of a dissociative defense, it was not surprising that these same women exhibited high levels of helplessness during stressful parenting situations.

The third finding, lack of correspondence between adult mental representations of attachment and scores on the scales for Secure Base and Helplessness on the CI, is particularly noteworthy. The lack of correspondence between these two measures was surprising given prior research that showed a relationship between an adult's working model of her own child and her representation of the relationship with her own parents (Slade & Aber, 1986; Zeanah, et al., 1991). More specifically, George & Solomon (1996) had found concordance between AAI classifications and CI scores. However, the first two studies did not involve mothers who were Unresolved with respect to trauma and George & Solomon have since been unable to replicate their findings (George, October 1999, personal communication).

One reason for this lack of correspondence may be related to the fact that how one thinks about past relationships is very different from how one thinks about ongoing relationships. According to Slade, et al., (Slade, Bernbach, Grienenberger, Levy & Locker, 1999) "in contrast to the AAI which evokes prior and relatively solidified representations..." the caregiving interview "...is presumed to tap into

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experiences that are live and immediate, and into representations that are still being constructed" (p.1). In other words, adult representations of attachment relationships may be on a separate track from mental representations of caregiving, particularly among women who have experienced significant traumas during childhood.

However, a second possibility for this lack of correspondence may be that AAI classification is simply a poor predictor of parenting behaviors. Although work has been done that correlates adult mental representations with child attachment, few studies have actually looked at whether mental representations of caregiving are also associated with AAI classification. Instead, as Lyons-Ruth, et al. (1999)propose, it may be more relevant to study other mechanisms that influence parenting, such as the hostile-helpless relational diathesis model. It would be interesting to note if a correspondence exists between the CI and AAI, when the AAI is scored using this continuum.

Other researchers have also developed alternate coding strategies for the AAI that may be more appropriate when studying the impact of abuse on caregiving. For example, Fonagy, Steele, Steele & Target (1997) have one system that looks at reflective functioning to better understand the psychological processes that underlie one's ability to mentalize. Mentalization is the ability to perceive and understand oneself and others in terms of mental states such as feelings, beliefs, intentions and desires. It also refers to the capacity to reflect about one's own and others' mental states. Fonagy and his colleagues (Fonagy, et al., 1991) have since demonstrated that high scores on reflective functioning are related to infant security. They believe this is because a parent's capacity to reflect on the intent of their child's behavior

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enhances the child's capacity for self-control and affect regulation (Fonagy, et. al, 1997). If this is actually the case, given the scores on the CI, one would predict that both the organized and the disorganized mothers in this study would demonstrate an equally poor ability to engage in reflection on their own mental states and/or those of their children. It would also seem to be the case that exposure to high levels of trauma would impact upon the ability to mentalize.

In addition, Slade, et al. (1999) have recently incorporated Fonagy's theories of reflective functioning into a new coding system for the Parent Development Interview, upon which the CI was based. It may be that coding the CI using this system would provide for better correspondence with adult internal working models of attachment or with adult reflective functioning about past relationships. Future studies should incorporate this scale into the AAI and CI coding system to see whether there is a clear correspondence between internal working models of attachment and caregiving.

Finally, a few other findings from this study were somewhat surprising and therefore warrant some discussion. First, no differences were found between AAI classification and use of dissociative defenses as measured by the DES. The lack of findings from the DES was only somewhat surprising given the mixed results of prior studies using this measure. However, given the prevalence of the use of dissociative defenses, such as lapses in the monitoring of reasoning or discourse on the AAI, this was slightly more surprising. A qualitative analysis of the AAI found that during discussions of traumatic events, most of the women in this study had moments when they exhibited memory loss, blamed themselves for the abuse, switched tenses from

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past to present without licensure, and engaged in verbal dyfluencies. This occurred whether or not they were classified as Unresolved. All of these are indicative of some type of dissociative process. Yet, only two women in the study were found to have significant scores on the DES, indicating the presence of a dissociative disorder. Both these women were also classified as Unresolved on the AAI. For the other eight women, however, no relationship was found between DES score, prevalence of trauma, and AAI classification.

One explanation for these findings is related to the small sample size. Administration among a larger group of women may have produced significant findings. However, it is also important to consider that while the DES has been used extensively with survivors of trauma and clearly seems able to identify individuals with a dissociative disorder, it is not sensitive enough to capture somewhat less severe, albeit chronic, use of dissociation. Of course, the presence of a dissociative disorder is understood to have a significant negative impact on parenting, but it is similarly believed that chronic use of dissociation could also negatively affect parenting abilities. The DES is not an appropriate measure to assess the use of dissociation as a defensive process.

Secondly, a small but interesting relationship was also noted for two women on the DES in terms of their child's sexual abuse status. The two women who had scores on the DES that were significant for a dissociative disorder and were Unresolved with respect to trauma had children who had recently been sexually abused. Although little can be said about this finding due to the small numbers of women in this study with significant scores on the DES, one might hypothesize that

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these mothers are less able to monitor their child's environment and thus leave their child more vulnerable to being victimized. This finding certainly warrants further study to better understand how dissociation combined with lack of resolution of a trauma can impact second-generation childhood sexual abuse.

Summary and Implications for Future Research

In sum, several findings from this study are noteworthy in that they point to important trends that can ultimately aid in the understanding of individual differences in the intergenerational transmission of trauma. First, a strong relationship between age at onset of trauma and resolution of that trauma was found. Second, although no relationship was found between prevalence of trauma and AAI classification, a relationship was found between exposure to high rates of trauma and mental representations of caregiving. This finding is of great significance in that it shows a direct link between the experience of trauma in one generation and its impact on parenting, which, in turn impacts the next generation. Finally, a lack of correspondence between AAI classification and CI scores was noted. This last finding may be indicative of the fact that adult mental representations of attachment are not necessarily on the same track as current mental representations of caregiving among women who have experienced significant trauma during childhood. This is an area that needs to be studied further to better understand how internal working models of past relationships influence current parenting behaviors. Overall, use of attachment theory in the interpretation of these results was not only relevant, but also

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crucial, in that it allowed for a new and deeper understanding of how trauma experienced in childhood can impact the next generation.

Although this was a qualitative study including only ten women, these noteworthy findings warrant future studies with larger samples. To improve interpretation of results, future studies should include a control group so that differences in attachment and caregiving can be identified in women who have experienced sexual abuse, other types of abuse, and no abuse.

It would also be valuable for future studies to include the children of these women in order to understand how mental representations of caregiving impacts upon their behaviors. Given the high scores on the Helplessness scale and low scores on the scale for Secure Base, current attachment theory would predict that many of these children would be disorganized with respect to their own attachment behaviors. In school-age children, this would be illustrated by behaviors that are indicative of either controlling-punitive or controlling/caregiving patterns of attachment. This is an important area to study in order to understand how mental representations of caregiving directly affect the child and whether adaptation of one side of this continuum over the other is more likely to lead the child to being exposed to other traumas, such as sexual abuse. It could be hypothesized that children who fall on the caregiving side of this continuum may be more likely to be abused, while those who fall on the controlling side of the continuum identify more with the aggressor and are therefore better able to protect themselves from abuse. If this could be accurately identified, preventative treatment could begin before any abuse occurred.

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An important question that was touched upon by this study is why some experiences of trauma become resolved while others do not. Prior writings in this area have often hypothesized that in the absence of a significant emotional experience, change is unlikely to occur. More specifically, attachment theorists would suggest that although a mother may consciously wish to parent her child differently than she had been parented, this is unlikely to occur unless she has also altered her underlying representational models of self and other (Ricks, 1985). This study showed that age at time of trauma also has a great impact upon the survivor's ability to make sense of their experiences in a coherent way. Although this finding was not new, the inclusion of attachment theory in its explanation aided the understanding of how multiple models of an attachment relationship can develop, which, in turn, can influence use of dissociative processes and later parenting.

Some attachment theorists might also hypothesize that resolution of trauma ultimately should rely upon two factors, the quality of the trauma and the quality of the on-going comfort and communication provided to the child within a loving attachment relationship (Lyons-Ruth, et. al, 1999). This study confirmed this view. Although all of the women in the study reported having a loving caregiver at some point during childhood, the consistent availability of the individual appeared to impact upon feelings of love and self-worth. Loving figures who were present consistently, even if only for a brief period of time, were found to have more impact than loving figures who may have been more available but were less consistent. Future research studies need to investigate this further to better understand the role of loving figures on resiliency.

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Finally, research studies need to be conducted using other measures of dissociation to better understand the impact that this type of a defensive process can have on parenting. In addition, larger numbers of women with dissociative disorders should be studied to better understand the impact of this disorder on their children. The small relationship that was found between women who are Unresolved and who also have a dissociative disorder and their child's history of sexual abuse is important and warrants further study to increase our understanding of second-generation sexual abuse.

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APPENDIX A

Volunteers Wanted

For A Study on Childhood Sexual Abuse and Parenting

I am looking for mothers
who are survivors of incest or childhood sexual abuse
willing to participate in
a doctoral research study on parenting.

2 interview sessions required
English must be your primary language

- Safe and confidential environment
- Referrals to private practitioners and clinics available
- You will receive $50.00 for your time

If interested, please contact Natalie Fisher at

(212) 866-5621

Research approved by the City University of New York, City College and NYU/Bellevue Hospital Medical Center

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APPENDIX B

SUMMARY OF THE ADULT ATTACHMENT INTERVIEW
(Excerpted from George, Kaplan & Main, 1996. With Questions Inserted from the Traumatic Antecedents Interview by Perry, Herman & van der Kolk, 1992)

1. **To begin, can you tell me a little bit about your family when you were little? For example, tell me about the members of your immediate family and where you lived.**

2. **Now I'd like you to try to describe your relationship with your parents as a young child, from as far back as you can remember.**

3/4. **Now I'd like you to choose five adjectives or phrases that describe your relationship with your mother/father during childhood. After we have all five, I'll ask you for a memory or an experience that led you to choose them.**

5. **To which parent did you feel the closest and why?**

6. **When you were upset as a child what would happen?**

7. **Describe the first time you remember being separated from your parents.**

8. **Did you ever feel rejected as a child? What did you do? Do you think your parents realized they were rejecting you?**

9. **Were your parents ever threatening to you in any way, maybe for discipline, or maybe just jokingly?**

    Some mothers remember some kind of physical abuse in their family as they were growing up. Did anything like this ever happen to you or in your family?

    How old were you at the time?
    Did it happen frequently?
    Do you feel this experience affects you now as an adult?
    Does it influence your approach to your own child?

    (If still unclear) Can you tell me about how discipline was handled in your home?
    How did it make you feel?
    Why do you think they did this?
    Did it ever get better or change in any way?

When did you first move away from home?
Get details regarding circumstances, including age.

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As a child, did you ever runaway?
If yes, how many times did they runaway? Age, circumstances, duration of each episode.

When you parents were angry, what would happen?

Was there ever any (other) violence in your home?
Probes: If yes, how often would you estimate it occurred. Who was it between?

Was there a gun in the house?
If yes, was it ever used against anyone?

Did anyone in your household ever receive medical attention as a result of violence at home?

How did it make you feel?
Did it ever get better?
Did you ever seek help to limit violence at home?
If yes, were efforts to get help successful?

Some of the other women in this study have told me that they too get involved in physical fights now, as adults. Since the age of 16, have you ever gotten involved in that type of a situation?
If yes, how many times has this happened?
Can you describe each incident and specify who was involved and your age at the time of occurrence.
How did it make you feel?

Did anyone in your family ever have a drinking and/or drug problem?
If yes, who? Describe the type of drinker/drug abuser.
What kind of effect did it have on everyday life in your home? What kinds of problems did it cause?
Did you ever seek help from anyone because of a family member's drinking/drug problem? If yes, what kind of help did you seek? Were efforts to get help successful?

How did you get your early sexual information?

I know that you came into this study because you are a survivor of childhood sexual abuse. Can you tell me more about that?

Probes: Have subject describe her age at the time of each incident, the age and her relationship to the perpetrator, how long the incident lasted, how often this occurred and the type of contact.
Was force or another means of coercion used?
Was the sexual contact a secret?
How did you react?

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Before the age of 16, did you ever tell anyone or try to get help because of these experiences?
If yes, were efforts to get help successful?

Since age 16, has anyone ever pressured or forced you into unwanted sexual contact?
Probes: If yes, for each incident have subject describe her age at the time, the age and relationship of the perpetrator, the duration and frequency of the incident and type of contact that occurred.

Use of force or another means of coercion?
Was the sexual contact a secret?
Did you ever tell anyone or try to get help because of this experience?
If yes, were efforts to get help successful?

10. **Overall, how do you think these experiences with your parents have affected your adult personality? Are there any aspects you feel were a setback to your development?**

11. **Why do you think your parents behaved as they did during your childhood?**

12. **Were there any other adults with whom you were close, like parents, as a child?**

13. **Did you experience the loss of a parent or other close loved one during childhood or as an adult?**

14. **Have there been many changes in your relationship with your parent(s) between childhood and adulthood?**

15. **What is your relationship with your parents like for you now?**

Of all the traumatic experiences you have discussed, which do you feel has had the most serious or lasting effect on your life?
How do you feel these experiences have affected you as an adult?
Do they influence your approach to your own child?

What do you think has been the most helpful in overcoming the traumatic effects of these events?

What advice would you give to others on the basis of your experiences?

Note: **Several questions and critical follow-up probes have been omitted from this summary. AAIs should not be conducted based on this modified protocol.**

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APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE
Questions Adapted From the Traumatic Antecedents Questionnaire
(By Herman & van der Kolk, 1990)

ID Number __________

Date ________________

Demographics

1) Age at last birthday _______

2) Marital status _______
   1. Single, never married
   2. Married
   3. Single, living with mate
   4. Separated
   5. Divorced
   6. Widowed

3) Present religious identification _______
   1. Catholic
   2. Protestant
   3. Jewish
   4. Other
   5. None

4) Role of religion in current life _______
   1. Minor
   2. Major, positive
   3. Major, negative

5) Religion of upbringing _______
   1. Catholic
   2. Protestant
   3. Jewish
   4. Other
   5. None

6) Role of religion in upbringing _______
   1. Minor
   2. Major, positive
   3. Major, negative

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7) Ethnic/racial background ______

1. Caucasian
2. Black, northern city
3. Black, southern city
4. Black, islands
5. Latino (country of origin________________)
6. Asian
7. Other

8) Education ______

1. < 12th grade (years completed_________)
2. Completed high school
3. H. S. + other training
4. Some college (years completed_________)
5. Completed college
6. Some postgraduate education________________
7. Completed postgraduate degree______________

9) Occupation ____

10) Current Employment ______

1. Full-time student
2. Employed full-time
3. Employed part-time
4. Homemaker
5. Unemployed
6. Disabled
7. Retired
8. Other________________

11) Estimate of current household income per year ______

1. under 10,000
2. 10,000-15,000
3. 16,000-25,000
4. 26,000-35,000
5. 36,000-50,000
6. 50,000-75,000
7. more than 75,000

12) Number of people in household ______

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For each member or household record:

First name	Age	Sex	Relationship to subject
________	___	___	____________
________	___	___	____________
________	___	___	____________
________	___	___	____________
________	___	___	____________

13) Number of children ________
(Include those not currently living with subject)

14) People subject relies on for practical help

First Name	Age	Sex	Relationship to subject
________	___	___	____________
________	___	___	____________
________	___	___	____________
________	___	___	____________

15) People subject relies on for emotional support

First Name	Age	Sex	Relationship to subject
________	___	___	____________
________	___	___	____________
________	___	___	____________
________	___	___	____________

16) Health self-rating ________

1. excellent
2. good
3. fair
4. poor

17) Number of days sick in past year ________

18) Cigarettes (score packs/day) ________

19) Alcohol consumption per week ________

20) Days drinking per week ________

21) Type of drink ________

1. beer
2. wine/wine cooler
3. vodka/gin
4. whiskey/scotch
5. other ____________

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22) Was there a time in your life when you thought you had a drinking problem? _______

0. no
1. yes

If yes, dates and circumstances_______________________________________

____

____

23) Prescription medications _______________________________________

24) Length of time used _______

25) Was there a time in your life when you thought taking these medications was causing a problem for you? _______

0. no
1. yes

If yes, dates and circumstances ___________________________________

26) Have you ever taken illegal drugs on a regular basis? _______

0. no
1. yes

27) When did you most recently take illegal drugs? _______

1. This year
2. One year ago
3. Between 1-5 years ago
4. Between 5-10 years ago
5. More than 10 years ago

28) Which ones? _______

1. marijuana
2. heroin/other narcotic
3. barbiturates
4. other sleeping pills, like Quaaludes
5. amphetamines
6. cocaine
7. LSD/other hallucinogens
8. Other

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29) Was there a time in your life when you thought taking these drugs were causing a problem for you? ______

0. no
1. yes

If yes, quantity, dates, circumstances____________________________
____
____

30) Major illnesses: Current: ________________________________
Past: ____

31) Major accidents or injuries ________________________________
____
(Include self-inflicted injuries and suicide attempts)

32) Hospitalizations a) Medical – How many times, at what ages, for how long?
____
____

b) Psychiatric – How many times, at what ages, for how long? ______________
____
____

33) Pregnancies – Number and outcome ______________________________

34) Are you currently in therapy? ______

1. yes
2. No

If yes, for how long? ______

1. less than 6 months
2. more than 6 months, less than 2 years
3. more than 2 years

35) Have you ever been in therapy? ______

1. yes
2. no

If yes, for how long? ______

1. less than 6 months
2. more than 6 months, less than 2 years consistently
3. more than 2 years
4. off and on, for an extended period of time

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Family of Origin Demographics

36) Birthplace___________________________________

37) Where did you spend most of your childhood (until age 16)? _______________

38) Number of moves before age 16 _____________________

39) Persons in childhood household (0=absent; # = how many)

1. Mother _______
2. Father _______
3. Siblings (number ______) _______
4. Stepmother _______
5. Stepfather _______
6. Stepsiblings (number _______) _______
7. Half siblings (number ______) _______
8. Grandmother (M or P) _______
9. Grandfather (M or P) _______
10. Other ________________ _______

40) Birth order: # __________ of ___________ siblings

41) Father's occupation ___________________________

42) Father's highest level of education _______

1. < 12th grade (years completed_________)
2. Completed high school
3. H. S. + other training
4. Some college (years completed_________)
5. Completed college
6. Some postgraduate education_______________
7. Completed postgraduate degree_____________

43) Mother's occupation __________________________

44) Mother's highest level of education _______
(Use numbers from above)

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APPENDIX D

EXPERIENCES OF CAREGIVING INTERVIEW

Adapted by Judith Solomon and Carol George from "The Parent Development Interview" Aber, L., Slade, A., Berger, B., Bresgi, I. & Kaplan, M. (1985).

I'd like to get a much better understanding of what it is like to be (child's) parent, so I'm going to be asking you a lot of questions about your relationship with (child).

I. To begin with, could you tell me a bit about your family. Tell me who is in it and the ages of your children.

II. Let's focus first on what it feels like to be (child's) mother/father.

Could you begin by describing yourself as a parent?

What gives you the most joy in being (child's) parent?

Can you think of an example with (child) when you've felt joy?

What gives you the most pain or difficulty in being (child's) parent?

Can you think of an example with (child) that's been painful or difficult?
(Probe what the parent decides to describe.)
How did you handle the situation?
How did you handle your feelings?

Do you ever feel really needy as (child's) parent?

Needy can be defined as "you need something as an individual." Do not define unless parent is stuck. If a parent spontaneously offers a definition while trying to clarify "needy," go with that definition.

Tell me about a situation that made you feel that way.
How do you handle your needy feelings?

Do you ever feel angry as (child's) parent?

The purpose of this question is to discover situations with the child that make the parent feel angry. Some parents claim they are never angry with the child, deferring to explanations that the something in the context (e.g. Work, spouse) makes them angry. Pursue this, but then go back and ask, "Do you ever feel irritated with (child)?

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Tell me about a recent time when you felt angry/irritate with (child)?
How do you handle your angry feelings?

Do you ever feel really guilty as (child's) parent?

Can you think of an example when you've felt guilty about something concerning (child)?
How do you handle your guilty feelings?

When you worry about (child), what do you find yourself worrying most about?

Can you think of an example when you worry about child?
How do you handle your worry?

When do you feel confident as (child's) parent?

Can you tell me about a time when you felt confident?

III. Let's focus now on your relationship with (child). Take a moment and think about when you and (child) are together. I'd like you to choose five descriptive words that reflect your relationship with (child). I'd really like you to describe how it feels when you are together, so think about times when you and (child) are together as you choose your words. After you think of the words, I'd like you to tell me why you chose them. You may have talked a little bit about this already, but why don't you try and pull it all together in 5 words.

For each word, "Can you think of an example that illustrates _________?"

Can you describe a time in the last week when you and (child) really clicked? (When you got along really well together.)

Can you tell me about (the incident)?
How did you feel?

Now describe a time in the last week when you and (child) really weren't clicking.

Can you tell me more about the incident?
How did it feel?

Have there been any experiences that you feel were a setback in your relationship with (child)?

Could you explain how (experience) was a setback in your relationship?

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Parents often notice similarities between themselves and their children. How do you think (child) is like you?

How do you think these similarities have influenced your relationship with (child)?

How do you think (child) is unlike you?

How do you think these dissimilarities have influenced your relationship with (child)?

IV. Now I'd like to talk about routine separations, such as when you leave (child) with a babysitter he/she knows.

How do you think (child) feels about these separations?
What are these separations like for you?

Now could you describe the kind of separation (child) might experience as somewhat more stressful than a routine separation?

How does he/she react to these separations?
What are these separations like for you?

(If no previous separations of a week or more, then ask) **Would you consider being away from (child) for a week or two?**

How do you think he/she would react to this kind of separation?
What do you think this separation would be like for you?

(If child has started daycare, nursery school, or kindergarten) **Could you tell me what it was like for you when (child) started day care/nursery school/kindergarten?**

How did you feel?
How do you think (child) felt?

What would you hope (child) might have learned from his/her experiences with you as his/her parent?

Thank you.

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APPENDIX E

DISSOCIATIVE EXPERIENCES SCALE

Carlson & Putnam, 1992

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you **are not** under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

Example:

0% (Never) 10 20 30 40 50 60 70 80 90 100 (always)

Date ______________ Age _______ ID# __________ Sex: M F

1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle the number to show what percentage of the time this happens to you.
   0% 10 20 30 40 50 60 70 80 90 100%

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8. Some people are told that they sometimes do not recognize friends or family members. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

19. Some people find that they sometimes are able to ignore pain. Circle the number to show what percentage of the time this happens to you.
0% 10 20 30 40 50 60 70 80 90 100%

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20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

22. Some people find that in one situation they may act so differently compared with another situation that they fell almost as if they were two different people. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that things (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

25. Some people find evidence that they have done things that they do not remember doing. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

26. Some people sometimes find writing, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle the number to show what percentage of the time this happens to you.
    0% 10 20 30 40 50 60 70 80 90 100%

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APPENDIX F

INITIAL TELEPHONE SCREENING INTERVIEW

Name: ______________________

Date of Birth: ________________

Phone Number: _______________ Home
_______________ Work

1. I am a graduate student in clinical psychology and I am conducting a doctoral research study. I am hoping to learn about how the experiences of childhood sexual abuse affects parenting. I wonder if this would be a good time for me to ask you some questions?

2. Do you currently have children? _______
   If yes, continue
   If no, end now

3. How old are your children? _________
   If less than 3 years old, end now.
   If older than 3, continue.

4. You've obviously seen the flyers and now understand the nature of the study. Since you've responded to the flyer, can I assume you were sexually abused during your childhood? _________
   If yes, continue
   If no, end now

5. Age at time of sexual abuse ________
   If under age 16, continue
   If over age 16, end now.

6. Without going into any detail now, can you just tell me your relationship to the person who abused you? ______________________
   If significant caregiver, continue
   If not significant caregiver, reject for study

7. Have you ever been treated or hospitalized for psychiatric problems?
   If yes, what was your diagnosis? _____________________
   If psychotic, reject now.

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Are you currently or have you ever been on any type of medication for a psychiatric illness?
If yes, what medication/for what illness? ______________________________
If on anti-psychotic medication, reject now.

8. Have any of their children ever been sexually abused or been evaluated by a team of professionals for sexual abuse? ____________________

9. The aim of study is to better understand how the experience of sexual abuse impacts parenting behaviors. This study will involve us meeting for two times. Each interview session should last about 2 hours. I will be asking you questions about how your experiences affected your relationship with your parents as you grew up and how it affects your relationship with them now. I'm also interested in finding out how these experiences affect your relationship with your own children. There is also a possibility that we can meet for a third session. This session would be just to talk about the experiences of the interviews and participating in the study. It would be up to you and is not required. At the completion of the study, you will receive $50.00 for your time.

10. Does this sound like something you would like to participate in?

11. I would just like to review some things about confidentiality at this time. All interviews will remain confidential. Your name will appear only on a consent form that I will go over with you at our first session. I will ask you to sign two copies of the form; one is for me to keep and the other is for you to take with you. The copy that I keep will be the only record with your name. All other forms will be identified by a code number that I'll assign to you. The two interviews will be tape-recorded and afterwards I will be transcribing them. Any names or other identifying information that you say during the course of the interviews will be edited out by me.

12. Do you have any questions for me?

13. Let's see if we can try and schedule the first appointment now? Tell me what your schedule looks like.

Appointment scheduled for ______________________________

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APPENDIX G

The Graduate School and University Center of
The City University of New York
City College

VOLUNTEER CONSENT FORM

Project Title: An Attachment Theory Study of the Experience of Sexual Abuse and Parenting

Project Investigator: Natalie Fisher

Subject Name: ___________________________

I.D. Number: ____________________________

You are being asked to participate in a doctoral dissertation study on whether your experience of childhood sexual abuse has any influence on your children. I hope to learn more about how this kind of an experience affected your relationship with your own parents and how it now influences your relationship with your children. You have been selected as a possible participant in this study because you were sexually abused before the age of 16. As a participant, you will be asked to take part in two interviews focusing on past and present relationships with family members and to complete a few questionnaires.

If you decide to participate, I will ask you to answer questions about your relationship with important people in your life and about your experiences of sexual abuse. These interviews will be conducted over the course of two separate sessions and each session will last about 2 hours. Each of these interviews will be audio taped. You may also choose to attend a third session to talk about the interview experience.

You may experience some distress from talking about personal issues during these interviews. You do not have to answer any question that particularly upsets you and you may stop the interview any time you wish. While some people find it helpful to talk about their experiences, I cannot promise you will receive any benefit from participating in this interview. If you take part, however, the main benefit is to the community. The results of this study will be used to inform professionals about the long-term consequences of childhood sexual abuse and its possible influence on future generations.

At the end of the interview sessions, you will be paid $50.00 for your time and for any transportation costs you may have incurred. If the need arises at any time during

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the course of the interview or between interviews, I will offer you a referral for psychological or psychiatric treatment. However, this study does not provide compensation for additional medical or other costs. A referral list for treatment centers that specialize in working with sexual abuse victims is also available to all interested participants. If there

is a waiting list of more than three weeks at an appropriate referral site, I will be available to meet with you on a weekly basis until your first appointment.

The information obtained during these interviews will be kept confidential. You will not be identified by name in any publication or report. Your name will not be included on any form other than this consent form. Instead, you will be identified only by an identification code. I will keep your code number and name in a locked filing cabinet. Information that you give me will not be shared with anyone. If you tell me that you or your child(ren) are in danger of great physical harm, I will need to report this information to the appropriate authorities in order to assure your and your child's safety. The same thing would happen if you gave the same information to a doctor, nurse or counselor.

Your decision as to whether or not to participate in this research study will not prejudice your relationship in any way with any professor, the college, or the CUNY system.

If you have any questions, please ask me at any time. If you have any additional questions later, you can reach me by telephone at (212) 866-5621. You may also contact Professor Arietta Slade, Ph.D., Clinical Psychology Doctoral Program, NAC Building, Room 8/101, City College or call her at (212) 650-5658. If you have questions about your rights as a volunteer, please contact Ethel Breheny, IACUC/IRB Administrator, Office of Research Administration, Shepard Hall, Room S-16, City College or call her at (212) 650-7903. Please feel free to contact us at any time, even after the interviews are over if you would like.

You are making a decision about whether or not to participate in this study. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at anytime after signing this form should you change your mind later.

______________________________ __________

Signature of Participant Date

______________________________ __________

Natalie Fisher, Investigator **Date**

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APPENDIX H

NEW YORK UNIVERSITY MEDICAL CENTER
BELLEVUE HOSPITAL CENTER
&
HOSPITAL FOR JOINT DISEASES

INFORMED CONSENT TO PARTICIPATE IN RESEARCH

You are being asked to volunteer to be a subject in a research study. This form is designed to provide you with information about this study, which you should know and understand, as well as to answer any questions.

Project Director: April Kuchuk, Ph.D. Dept: Pediatrics/Psychology
Co-Director: Natalie Fisher, M.Phil. Telephone #: (212) 562-6321

TITLE OF RESEARCH STUDY: Experiences of Parenting Among Women Sexually Abused during Childhood

SUBJECT PARTICIPATION: Inpatient/_____ Outpatient/_____ Other/_____

We expect to enlist the following number of subjects for this study: 10

Your participation will involve this many visits: 2 or 3

Each of these visits will take the following amount of time: 2 hours

THE PURPOSE OF THIS RESEARCH IS: To better understand how the experience of having been sexually abused in childhood affected your relationship with your parents while you were growing up and how it now influences your relationship with your child(ren).

THE FOLLOWING PROCEDURES WILL BE INVOLVED (If limited to donation of blood, leave blank – See page 2)
As a participant you will be asked to take part in two interviews focusing on past and present relationships with family members and to complete a few questionnaires. We will also ask you to answer questions about important people in your life and about your experiences of sexual abuse. Each of these interviews will be tape-recorded. You may also choose to attend a third, one-hour session to talk about the interview experience.

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Consent to Participate in Research (continued)

DONATION OF BLOOD: None

THE POTENTIAL RISKS OR DISCOMFORTS TO YOU ARE: (If limited to donation of blood, leave blank) Participation in these interviews may involve some distress from talking about personal issues. It may be difficult to talk about some of your experiences and you may recall things that you have not thought about in a long time. You do not have to answer any question that particularly upsets you and you may stop the interview at any time.

While some people find it helpful to talk about their experiences, we cannot promise you will receive any direct benefit from participating in this interview. It is also possible that tapes or transcripts from these interviews could be subpoenaed.

THERAPEUTIC OBJECTIVE: (Check one)

_____ This research study includes procedures that may change the treatment you would otherwise receive. We hope the knowledge gained will be of benefit to you.

__X__ This research study includes procedures which may not give you immediate benefits. It is hoped the knowledge gained will be of benefit to others in the future.

_____ This research study is planned to select by chance your treatment. It is not known if the treatment you will receive will be of benefit to you.

THE POTENTIAL BENEFITS TO YOU OR OTHERS ARE:
Some people find it helpful to talk about their experiences, however the main benefit to participating in this study will be to future victims of sexual abuse. The results of this study will be used to inform professionals about the long-term consequences of childhood sexual abuse and it's possible influence on future generations. It may also be helpful for you to know that other women who have had similar experiences to you are participating in this study. You will be reimbursed a total of $50.00 for your time and out of pocket expenses. A referral list for treatment centers specializing in working with sexual abuse victims is also available to all interested participants.

IF YOU DO NOT PARTICIPATE IN THIS RESEARCH, YOU MAY RECEIVE THE FOLLOWING ALTERNATIVE TREATMENT(S):
Not applicable.

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Consent to Participate in Research (continued)

GENERAL CONDITIONS

1. Should you consent to participate, your identity will be kept confidential within the following limits. If investigational drugs and/or other devices subjected to U. S. Food and Drug Administration regulations are involved, it may be necessary for this consent form and other medical records to be reviewed by representatives of the FDA and the agency providing the test substance and/or the Sponsor of the study. In addition, if your participation in this research is for treatment or diagnostic purposes, a copy of the informed consent documentation will be included in your medical record maintained by your treating physician or hospital, as applicable, and will be subject to New York State and federal regulations concerning confidentiality of medical records.

2. All forms of medical diagnosis and treatment – whether routine or experimental – involve some risk of injury. In spite of all precautions, you might develop medical complications from participating in this study. If such complications arise, the researchers will provide emergency medical treatment and will assist you in obtaining appropriate follow-up medical treatment but this study does not provide compensation for additional medical or other costs, unless otherwise stated in 2A.

2A. You will not be identified by name in any publication or report. Your name will not appear on any form other than this consent form. Instead, an identification number will identify you on all forms. Only the researchers listed on this form will have access to your name. Your code number and name will be kept in a locked filing cabinet. If you tell us that you or your child(ren) are in danger of great physical harm, we will need to report this information to the appropriate authorities in order to assure your and your child's safety.

3. You will be told of any new findings that may influence your willingness to continue to participate in the research. Your participation in this study may be terminated by the Project Director if in his/her judgement it is inadvisable for you to continue.

4. If you would like to discuss your rights as a research subject and/or your participation in this study with an institutional representative who is not part of this study, please call the Administrator, Institutional Board of Research associates, Telephone No. (212) 263-6705.

5. Should you agree to participate in this research, you may change your mind at any time. Refusal to participate will not harm your relationship with the faculty and attending staff, nor will it prejudice your further treatment.

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AGREEMENT TO PARTICIPATE

I have read the description of the research study and general conditions or it was read to me by: Natalie Fisher. Anything I did not understand was explained to me by: Natalie Fisher, any questions I had were answered by: Natalie Fisher. I certify that I am/ I am not (circle one) participating in another research project at this time and I have discussed the implications of such activity with the project director(s) of this project. In consideration of this understanding, I voluntarily agree to participate in this research at:

_____NYUMC __X__ Bellevue Hospital ______ Other (identify) ___________

WHEN THE SUBJECT IS AN ADULT

___________________________/_______
Print Name of Participant or Legal Representative — Date

___________________________/_______
Signature of Participant or Legal Representative — Date

___________________________/_______
Print Name of Person Obtaining Consent — Date

___________________________/_______
Signature of Person Obtaining Consent — Date

___________________________/_______
Print Name of Witness — Date

___________________________/_______
Signature of Witness — Date

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APPENDIX I

RESOURCES AND REFERRALS FOR VICTIMS OF CHILDHOOD SEXUAL ABUSE

Hotlines

New York State Child Abuse Hotline
(800) 342-7472
To report any suspicions of physical abuse, sexual abuse, and neglect of children under 18 years of age.

Domestic Violence Hotline
(800) 621-HOPE
Provides information on counseling, emergency shelters, legal, and other services for victims of domestic violence.

Steps to End Family Violence
(212) 410-4200
Provides services to victims of family violence. Court advocacy, group counseling, services to children who have witnessed family violence.

Crime Victims Board
270 Broadway
New York, NY
(212) 417-5160
Information provided about legal procedures. Applicant must have filed a police report to be eligible for services.

Family Violence Hotline
(718) 237-1337
Will provide crisis counseling and referrals for all members of families experiencing any type of abuse.

Victims Services Sexual Assault and Incest Hotline
(212) 227-5000
Provides 24 hour information and referral services for adults and children.

Therapy for Survivors of Sexual Abuse

Center for the Study of Psychological Trauma, Sexual Abuse Clinical Service
William Alanson White Institute
(212) 873-7070
Contact: Richard Gartner, Director
Provides interpersonal psychoanalytic therapy for men, women, and children who have been sexually abused.

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Children's Advocacy Center
New York Hospital
333 East 70th Street
New York, NY 10021
(212) 517-3012
Provides evaluations for children suspected of having been sexually abused. Also provides psychotherapy for children and their families.

Greenwich House
Children's Safety Project
27 Barrow Street
New York, NY 10014
(212) 242-4140
Provides individual, long-term treatment for children who are victims of abuse. Also runs groups for children of various ages to help them develop assertiveness and empowerment skills.

Karen Horney Clinic, Treatment Center for Incest and Sexual Abuse
329 East 62nd Street
(212) 838-4333
Provides individual, long-term, psychodynamic and psychoanalytically-oriented therapy. Women's groups also available. Groups meet one time weekly, in the evenings. Individual therapy also available for children. Fees are sliding scale and they accept Medicaid and managed care insurance plans.

Manhattan Institute for Psychoanalysis
Incest and Sexual Abuse Treatment Center
(212) 971-3123 general number
(212) 886-3727 Institute for Incest and Sexual Abuse

Mt. Sinai Medical Center, Rape Crisis Intervention Program
98th Street between Madison and Park Avenue
(212) 423-2140
Short-term (up to 12 weeks) individual therapy program. Services are free.

North Central Bronx Hospital, Rape Crisis Program
(718) 519-4912
Individual, family and co-survivor counseling. Group therapy for survivors. Referrals and information provided. Telephone counseling available.

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Payne Whitney Outpatient Clinic, Anxiety and Traumatic Stress Program
East 61st Street
(212) 821-0774 Traumatic Stress Program
(212) 821-0668 General Number, Center for Women's Studies
Contact: Amy Kossoy
Provides individual psychotherapy specializing in Post-Traumatic Stress Disorder. Medicaid and Medicare accepted. Sliding scale fee.

St. Luke's Rape Crisis Program
114th and Amsterdam Avenue
(212) 563-4726
Contact: Susan Xenarios
Assessment and referral service for survivors of childhood sexual abuse. Provide short-term groups for women and men. You must also be in individual therapy to participate in the groups. Also provide crisis intervention and on-going therapy for victims of rape. All services are free.

St. Vincent's Rape Crisis Program
East 11th Street
(212) 604-8068
Short-term individual counseling (up to 12 sessions). Also can provide resources and referrals. 24-hour crisis hotline and emergency medical care. All services are free. They have mostly daytime hours, with limited evening and weekend appointments.

Women's Therapy Institute
562 West End Avenue
721-7005
Specializes in women's issues including sexual abuse. Referral service costs $20.00. Private therapy for as low as $30.00 per session. Some short-term groups available on eating problems and body issues.

Support Groups for Victims of Physical Abuse

Victims Service Agency
(212) 874-0724
Contact: Maria

St. Luke's CVTC
114th Street and Amsterdam Avenue
(212) 523-4726

Anti-Violence Project
(212) 807-6761
Contact: Gail Cooper

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Center for Anti-Violence Education
421 5th Avenue
Brooklyn, NY 11215
(718) 788-1775

New York Hospitals: Emergency Room Services for Rape, Incest, and Child Sexual Abuse

Bellevue Hospital
27th Street at 1st Avenue
Regina Packard, Rape Crisis Coordinator
(212) 562-3435
Provides individual, family and co-survivor counseling for adult victims and survivors. Group therapy for adult survivors. Referrals and assistance with Crime Victims Compensation and entitlements.

Bellevue Hospital Child Protection Team
27th Street at 1st Avenue
(212) 562-6321
Contact: Mimi Lockes
Provides sexual abuse evaluations for children younger than 13. Short-term groups for children and parents. Individual therapy for children.

Beth Israel Hospital
East 17th Street
Department of Social Work
(212) 420-2840

Elmhurst Hospital, Rape Crisis Program
Queens, New York
(212) 241-7171

Mt. Sinai Medical Center, Emergency Room
Madison Avenue at 100th Street
(718) 334-1418

New York Hospital
East 68th Street at York Avenue
(212) 746-5026

St. Luke's/Roosevelt Medical Center
114th Street and Amsterdam Avenue
(212) 523-3335 Emergency Room

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St. Vincent's Hospital
Emergency Room (212) 604-8000
Rape Crisis (212) 604-8068

Long Island College Hospital, Brooklyn
(718) 780-1459

North Central Bronx, Bronx
Emergency Room (718) 519-3000
Rape crisis (718) 519-4814
Domestic Violence (718) 519-3100

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