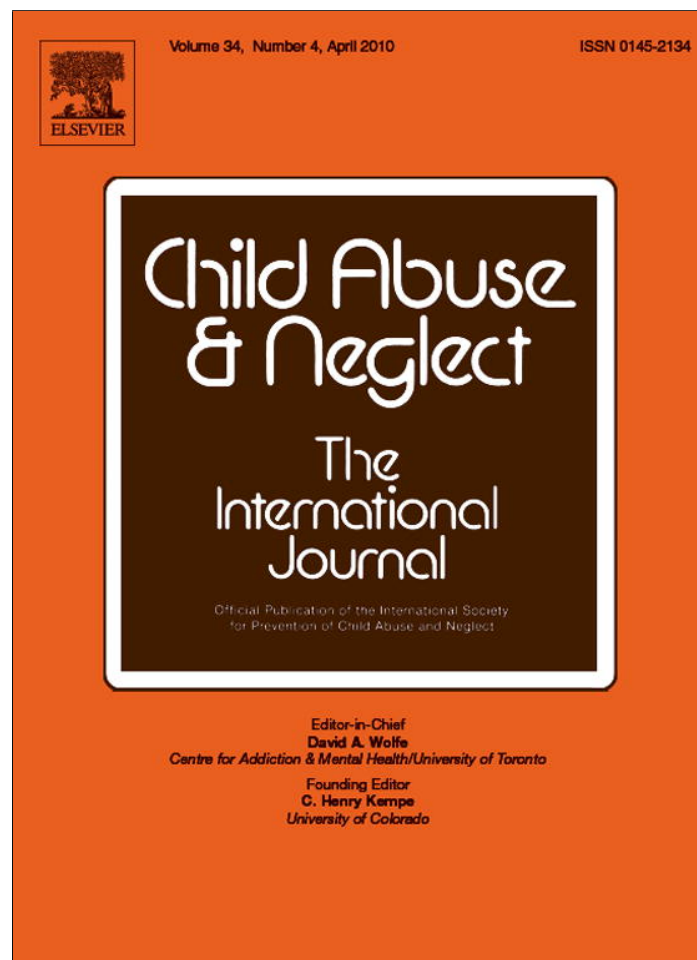


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Child Abuse & Neglect



The impact of childhood abuse history and domestic violence on the mental health of women in Japan[☆]

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ABSTRACT

Objective: To understand the independent and interactive effects of childhood abuse history (CAH) and domestic violence (DV) on the mental health status of women in Japan.

Methods: A self-administered questionnaire survey was conducted among a sample of 340 women staying in 83 Mother-Child Homes in Japan to assess the women's CAH and DV experiences, along with their current mental health problems, including dissociated, depressed, and traumatic symptoms.

Results: Independent from DV, CAH, especially psychological abuse, had a significant impact on all of the women's mental health symptoms. DV was found to have an independent effect on traumatic symptoms. Weak interactive effects of CAH and DV were found on dissociated and traumatic symptoms. Among those women without CAH, DV was significantly associated with dissociated and traumatic symptoms; however, DV had no impact on dissociated and traumatic symptoms if CAH was present.

Conclusions: The findings suggest the significant impact of CAH on women's mental health problems, independent from DV. CAH and DV weakly interact on women's mental health.

Practice implications: In psychological therapy for battered women with mental health problems, if the cases were abused during childhood, it is recommended that therapy be focused on childhood abuse, especially if the client was psychologically abused. In addition, mental health care and welfare providers should be aware that the mental health problems of mothers without CAH might be exacerbated by DV; thus, appropriate resource allocation should be considered.

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Introduction

Child abuse is an emerging problem in Japan (Fujiwara, 2007). An estimated 35,000 children are abused annually, which is 1.54 cases per 1,000 children aged 0 through 17 years (Kobayashi, 2002). Previous studies have shown a link between child abuse history (CAH) and mental health consequences when the victim becomes an adult (Beitchman et al., 1992; Dykman et al., 1997; Horwitz, Widom, McLaughlin, & White, 2001; MacMillan et al., 2001; Reinherz, Paradis, Giaconia, Stashwick, & Fitzmaurice, 2003; Widom, 1999; Widom, DuMont, & Czaja, 2007). It is also considered that the impact of child abuse

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on mental health problems varies by the type of abuse (i.e., physical abuse, sexual abuse, neglect, and psychological abuse) (Bensley, Van Eenwyk, & Wynkoop Simmons, 2003).

Domestic violence (DV) is another emerging issue in Japan. The estimated rate of DV is 14.3% among women by the age of 30 years (Yoshihama, Horrocks, & Kamano, 2007). A recent international study on DV showed that during the past 12 months, the prevalence rate of DV in Japan parallels those of Western countries (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). In accordance with the increased recognition of DV in Japan, legislation to protect DV victims was enacted in the year 2000 (Domestic Violence Prevention Act [Law No. 31]) and amended in 2004 to include post-divorce partner violence. Numerous studies have reported that DV has a significant impact on mental health problems, especially depression and post-traumatic stress disorder (PTSD) (Bland & Orn, 1986; Campbell, Kub, Belknap, & Templin, 1997; Campbell, 2002; Cascardi, O'Leary, & Schlee, 1999; Gleason, 1993; Golding, 1999; Jaffe, Wolfe, Wilson, & Zak, 1986; Kaslow et al., 1998; McCauley et al., 1995; Ratner, 1993; Silva, McFarlane, Soeken, Parker, & Reel, 1997; Thompson et al., 2000).

Previous studies have shown the link between CAH and DV; that is, women with CAH are more likely to be victims of DV (Bell & Chance-Hill, 1991; Bensley et al., 2003; Browne, 1993; Coid et al., 2001; Wingood & DiClemente, 1996; Wyatt, Axelrod, Chin, Carmona, & Loeb, 2000), because CAH violates expectations of relationships with loved ones (Wyatt et al., 2000). Thus, the reported association between DV and mental health problems might be confounded by CAH. However, few studies have investigated the independent effects of CAH and DV on women's mental health problems.

In addition, CAH and DV might generate interactive effects on the mental health of women. Previous studies have shown interactive effects between child abuse and DV on a child's mental health. Child abuse was associated with internalizing and externalizing problems and traumatic stress only when mothers reported higher levels of physical DV. This condition is not true for youths whose mothers did not experience DV (Kaslow & Thompson, 2008). However, few studies have investigated the interactive effects of CAH and DV on women's mental health.

Based on this previous research, it is hypothesized the following: (1) CAH and DV have independent associations with women's mental health problems and (2) CAH and DV have interactive effects on women's mental health problems; that is, women with CAH are more vulnerable to DV than women without CAH. The purpose of this study is to investigate the independent and interactive effects of CAH and DV on the mental health status of women in Japan.

Methods

Sample

Questionnaires were sent to a sample of 421 mothers in 83 Mother-Child Home facilities that agreed to participate in the study. Mother-Child Home is a welfare facility in Japan, where mothers and children experiencing family problems (e.g., DV, child abuse by the father, a single mother with financial problems) can stay and get assistance to become self-supporting. In a Mother-Child Home, residents are able to receive professional support, including psychiatric or psychological therapy, guidance on parenting and daily life, and legal advice. As the facility accepts not only the mother-child family which is a victim of DV but also the mother-child family that seeks help for other reasons (such as financial difficulties), it is possible to compare the mental health of DV victims and non-victims in the same setting. Women who were likely to participate in the study were asked to do so by the staffs of the Mother-Child Homes, and 421 mothers agreed. A total of 340 mothers completed the survey (80.1%). To maintain anonymity, respondents were instructed to work on the survey, which required no formal consent, alone; thus, no support was provided in the completion of the survey. The survey was conducted in December 2005.

Measurements

Childhood abuse history (CAH). CAH was assessed using the following 7 questions: (1) I was a victim of violence from my parents (including step-parents); (2) I was ignored or refused attention by my parents; (3) My parents insulted me verbally; (4) I experienced violence from my parents severe enough to require hospital treatment; (5) I have been deprived of food or warm clothes; (6) I have experienced forced sexual contact by a parent (sexual contact includes sexual intercourse, petting, exposure of genitals, and taking naked pictures); and (7) I have experienced forced sexual contact by an adult other than a parent. Each question was answered on a 1–4 Likert scale, ranging from 1, not at all; 2, rarely; 3, sometimes; to 4, frequently. These questions were created based on the Childhood Trauma Questionnaire (Bernstein et al., 1994), but modified to suit the Japanese language and minimized to 7 questions to reduce the burden of the respondents. The total history of childhood abuse was calculated by the summation of the responses to these 7 questions. Cronbach's alpha for this scale is 0.78. Further, to dichotomize whether respondents had CAH or not, those who answered "rarely," "sometimes," or "frequently" for (4), (5), (6), and (7) and "sometimes" or "frequently" for questions (1), (2), and (3) were coded as having CAH.

Furthermore, the CAH was subdivided into physical abuse, neglect, psychological abuse, and sexual abuse. Survey questions (1) and (4) were used for physical abuse, (5) was used for neglect, (2) and (3) were used for psychological abuse, and (6) and (7) were used for sexual abuse. If each subscale had 2 questions, the responses for each item were added. The same cut-off was used for dichotomization of each subtype of CAH, as mentioned above.

Experience of DV

Experience of DV was assessed by the following four questions: (1) My husband or partner was sufficiently violent towards me to cause injury, (2) My husband or partner insulted me strongly enough to cause psychological harm, (3) I perceived a strong threat from my husband or partner, and (4) My husband or partner forced me to have sexual contact. Each question was answered on a 1–4 Likert scale, ranging from 1, not at all; 2, rarely; 3, sometimes; to 4, frequently. These questions were created based on the Index of Spouse Abuse (Hudson & McIntosh, 1981), but modified to suit the Japanese language, and minimized to 4 questions to reduce the burden of the respondents.

Summation of the responses to these questions was used as a scale to indicate the respondent's experience of DV. Cronbach's alpha for this scale is 0.86. Further, to dichotomize whether respondents had experienced DV or not, those who answered "not at all" for all 4 questions were coded as not having DV.

Women's mental health problems

Women's mental health problems were classified by dissociated, depressive, or traumatic symptoms. Questions used for this assessment were created based on DSM-IV, and are shown in Appendix A. Symptoms of dissociation when women take care of children were assessed by summation of responses to 10 questions answered using a 1–4 Likert scale, ranging from 1, not at all; 2, rarely; 3, sometimes; to 4, frequently. Similarly, depressive and traumatic symptoms were assessed by 11 and 8 questions, respectively. Cronbach's alpha for dissociated, depressive, and traumatic symptom assessments are 0.82, 0.88, and 0.85, respectively. The presence of dissociated symptoms when women took care of children was queried because taking care of children can be a trigger of dissociation if women have experienced CAH.

Covariates

Potential confounders were assessed in the questionnaire, including: mother's age, marital status, working status, length of stay in the facility, legal involvement, and professional support (i.e., medical or legal support, including psychological therapy). Details of the items used to assess these covariates are shown in Table 1.

Institutional Review Board (IRB) approval

The IRB at the National Center for Child Health and Development approved this study. Return of the completed survey was considered the respondent's consent to participate in the study.

Analysis

First, bivariate analysis was performed to see the crude association of CAH and DV with each woman's mental health problems (i.e., dissociated, depressive, or traumatic symptoms). Second, Spearman's correlation was performed to show the association between CAH and DV, as these variables were not normally distributed. Third, the independent effects of CAH and DV on women's mental health problems were investigated by multiple linear regression, adjusted for the covariates. In model 1, CAH was treated as the full range of the scale. In model 2, subtypes of CAH were put into a multiple linear regression model. To compare the effect of each variable, standardized coefficients were calculated and reported. Fourth, to see the interaction effect between CAH and DV on women's mental health problems, the *p*-values of the interaction terms were calculated. In addition, the effects of DV on women's mental health problems were investigated, stratified by CAH status, and adjusted for covariates. The subtypes of CAH were also stratified. We did not compare the mental health of mothers by subgroups of who experienced CAH only, DV only, and both CAH and DV, because some mothers did not experienced either (*n* = 38) and the sample size of mothers with CAH only was too small to employ multiple regression analysis (*n* = 14). A *p* < 0.05 was considered significant. All analyses were performed using the statistical software package, Stata SE 9.0.

Results

Characteristics of the sample are shown in Table 1. The women's age was normally distributed, with a mean of 35.7 (Standard Deviation [SD] = 7.0), ranging from 19 to 56 years. The husbands or partners' age was slightly higher than the women's age, with a mean of 39.4 (SD = 9.6). The majority of the sample (72.7%) had divorced their husbands. Almost 80% of the sample was working either full-time or part-time. Their reasons for staying in the Mother-Child Home were mainly DV or child abuse from the husband or partner. The mean duration of stay in the Mother-Child Home was 2.45 years (SD = 2.68), with a maximum of 18 years. Forty-three percent of the sample required legal involvement at one time, and 9.4% were still receiving legal services. Professional support, including psychiatric or psychological therapy, support by a public health nurse, or legal consultation, was used by 34.7% of the sample. DV was reported from 288 mothers (84.7%), and 155 mothers (45.6%) reported CAH. Mothers who experienced both CAH and DV and DV only were 141 (41.5%) and 147 (43.2%), respectively.

Table 2 describes the crude association of CAH and DV with the respondent's mental health problems. As shown, CAH was significantly associated with all of the symptoms, while DV was associated mainly with traumatic symptoms. Among the

Table 1
Characteristics of sample (N = 340).

	Mean (SD) or N (%)	Range
Women's age (years)	35.7 (7.0)	19–56
Husband or partner's age (years)	39.4 (9.6)	21–70
Marital status		
Married	48 (14.2)	
Lived together, not married	44 (13.1)	
Divorced	245 (72.7)	
Working status		
Vocational training	13 (3.8)	
Working part-time	179 (52.7)	
Working full-time	91 (26.8)	
Unemployed	57 (16.8)	
Reason for staying at Mother-Child Home (multiple choice)		
Domestic violence	189 (55.6)	
Abuse to child(ren) by male partner	68 (20.0)	
Other	180 (52.9)	
Length of stay in Mother-Child Home (years)	2.45 (2.68)	0.08–18
Legal involvement		
Finished	107 (33.4)	
On going	30 (9.4)	
Not needed	183 (57.2)	
Professional support		
Yes	115 (34.7)	
Childhood abuse history		
Yes	155 (45.6)	
No	185 (54.4)	
Experience of domestic violence		
Yes	288 (84.7)	
No	52 (15.3)	
Combination of childhood abuse history and domestic violence		
Neither child abuse history or domestic violence	38 (11.1)	
Child abuse history only	14 (4.1)	
Domestic violence only	147 (43.2)	
Both child abuse history and domestic violence	141 (41.5)	

subtypes of CAH, psychological abuse was the one most likely associated with women's mental health problems, followed by physical abuse and neglect. In our sample, a history of childhood sexual abuse was not likely associated with women's mental health problems.

Table 3 shows the association between CAH and DV. The total score of CAH was significantly associated with DV ($r = 0.120$, $p < 0.05$). Among subtypes of CAH, childhood physical abuse was significantly associated with DV ($r = 0.112$, $p < 0.05$). Other subtypes of CAH were not significantly associated with DV. Subtypes of CAH were moderately correlated with each other; coefficients varied from 0.240 to 0.623.

Results of the linear multivariate regression to assess the independent effects of CAH and DV on women's mental health, adjusted for covariates (women's age, marital status, working status, length of stay at the Mother-Child Home, legal involvement status, and existence of professional support) are shown in Table 4. In model 1, the total score of CAH showed a significantly independently higher score for dissociated, depressed, and traumatic symptoms (standard coefficient [β]: 0.132, 0.200, and 0.190, respectively). DV was significantly independently associated with traumatic symptoms (β : 0.207), while no

Table 2
Bivariate analysis to show the associations of childhood abuse history and domestic violence with women's mental health problems.

	Dissociated		Depressed		Traumatic	
	β	p	β	p	β	p
Childhood abuse history (total score)	0.217	<0.001	0.273	<0.001	0.265	<0.001
Childhood physical abuse history	0.177	0.001	0.251	<0.001	0.212	<0.001
Childhood neglect history	0.096	0.076	0.175	0.001	0.194	<0.001
Childhood psychological abuse history	0.250	<0.001	0.264	<0.001	0.269	<0.001
Childhood sexual abuse history	0.037	0.496	0.078	0.153	0.072	0.184
Domestic violence	0.101	0.062	0.092	0.092	0.256	<0.001

Table 3
Spearman's correlation matrix between childhood abuse history and domestic violence.

	1	2	3	4	5	6
1. Childhood abuse history (total score)	1.000					
2. Childhood physical abuse history	0.778**	1.000				
3. Childhood neglect history	0.521**	0.414**	1.000			
4. Childhood psychological abuse history	0.920**	0.623**	0.487**	1.000		
5. Childhood sexual abuse history	0.451**	0.259**	0.240**	0.253**	1.000	
6. Domestic violence	0.120*	0.112*	0.031	0.087	0.091	1.000

* $p < 0.05$.
** $p < 0.001$.

Table 4
Multivariate analysis to show the independent effects of childhood abuse history and domestic violence on women's mental health problems.

	Dissociated		Depressed		Traumatic	
	β	p	β	p	β	p
Model 1						
Childhood abuse history (total score)	0.132	0.026	0.200	<0.001	0.190	0.001
Domestic violence	0.070	0.264	0.057	0.344	0.207	0.001
Model 2						
Childhood physical abuse history	-0.005	0.948	0.080	0.287	0.012	0.875
Childhood neglect history	-0.063	0.368	0.020	0.771	0.044	0.508
Childhood psychological abuse history	0.244	0.002	0.161	0.032	0.191	0.009
Childhood sexual abuse history	-0.080	0.190	-0.051	0.391	-0.048	0.408
Domestic violence	0.075	0.230	0.063	0.297	0.214	<0.001

All results were adjusted for women's age, marital status, working status, length of stay at Mother-Child Home, legal involvement status, and existence of professional support.

significant independent association was observed with other symptoms. In model 2, childhood psychological abuse history showed significant association with 3 women's mental health problems.

Table 5 describes the interactive effects between CAH and DV on women's mental health problems. For dissociated symptoms, a weak but significant interactive effect was observed ($p = 0.045$). DV showed a significant positive association with dissociated symptoms among women without CAH. This finding did not hold true for women with CAH. Interaction terms between total CAH and DV were not significantly associated with depressed and traumatic symptoms. However, in stratified analysis, DV showed significant association with traumatic symptoms for women without CAH.

When CAH is broken down into subtypes, the interaction effect of psychological abuse history and DV on dissociated symptoms was significant ($p = 0.003$). That is, the impact of DV on dissociated symptoms among those who did not experience

Table 5
Interactive effects between childhood abuse history and domestic violence on women's mental health problems and standardized coefficient of domestic violence on women's mental health problems stratified by childhood abuse history.

	Dissociated		Depressed		Traumatic	
	β	p	β	p	β	p
Any childhood abuse history ($N = 155$)	-0.072	0.353	0.054	0.560	0.154	0.096
No childhood abuse history ($N = 185$)	0.197	0.035	0.062	0.499	0.243	0.006
P for interaction term (childhood abuse history \times domestic violence)	0.045		0.632		0.177	
Childhood physical abuse history ($N = 83$)	0.159	0.247	0.034	0.804	0.110	0.418
No childhood physical abuse history ($N = 257$)	0.064	0.384	0.091	0.203	0.270	<0.001
P for interaction term (physical abuse history \times domestic violence)	0.953		0.658		0.121	
Childhood neglect history ($N = 29$)	-0.109	0.719	-0.107	0.739	-0.096	0.743
No childhood neglect history ($N = 311$)	0.113	0.093	0.094	0.149	0.264	<0.001
P for interaction term (neglect history \times domestic violence)	0.145		0.630		0.362	
Childhood psychological abuse history ($N = 107$)	-0.105	0.337	0.170	0.134	0.220	0.050
No psychological abuse in childhood ($N = 233$)	0.155	0.051	0.017	0.823	0.202	0.008
P for interaction term (psychological abuse history \times domestic violence)	0.003		0.711		0.341	
Childhood sexual abuse history ($N = 61$)	-0.058	0.723	0.010	0.944	0.101	0.504
No childhood sexual abuse history ($N = 279$)	0.110	0.118	0.095	0.172	0.253	<0.001
P for interaction term (sexual abuse history \times domestic violence)	0.599		0.587		0.326	

All results were adjusted for women's age, marital status, working status, length of stay at Mother-Child Home, legal involvement status, and existence of professional support.

psychological abuse was significantly higher than those who had a history of psychological abuse. Although interaction terms were not significant, DV was significantly associated with traumatic symptoms for women without childhood physical, psychological, or sexual abuse, or neglect.

Discussion

CAH was shown to be independently associated with women's dissociated, depressed, and traumatic symptoms. DV was independently associated with traumatic symptoms, but not with dissociated and depressed symptoms. An interactive effect between CAH and DV was found on dissociated symptoms: DV more likely increases dissociated symptoms among women without CAH, which is not true for women with CAH.

The present study is consistent with previous studies, showing the significant impact of CAH on women's mental health problems (Bensley et al., 2003; Horwitz et al., 2001). In bivariate analysis, physical and psychological abuse and neglect were associated with women's mental health; in an adjusted model, psychological abuse remained significantly associated with mental health problems. This suggests that a history of psychological childhood abuse history is the strongest predictor of women's mental health problems among the subtypes of CAH. A previous study reported the importance of psychological abuse on mental health problems (Allen, 2008). In addition, our finding suggests that previous studies showing the association between physical and sexual abuse and neglect on mental health might be mediated by childhood psychological abuse. The null association between childhood sexual abuse on mental health was consistent with a previous study (Campbell et al., 1997).

The findings that DV had significant association with traumatic symptoms are consistent with a previous meta-analysis (Golding, 1999), although 11 studies used in this meta-analysis did not control the history of childhood abuse among the samples. The current study augments previous studies and concludes the significance of DV on traumatic symptoms, independent of CAH.

This current study showed null association between DV and depression, even in the bivariate analysis. This is not consistent with previous studies (Campbell et al., 1997; Golding, 1999). This may be explained by the fact that our study used Japanese women, who had fled to the Mother-Child Home, and who had already been separated from their husbands or partners for several months or years; thus the impact of DV on the women's depressive symptoms might have been diminished. Previous studies have reported that rates of depression declined during the follow-up period, at least after 6 months (Campbell, Sullivan, & Davidson, 1995; Surtees, 1995). As our sample's mean duration of stay at the facilities was 2.5 years, depressive symptoms due to DV might have declined.

A similar explanation might be possible for the null association of DV with dissociated symptoms. Dissociation was not independently associated with DV, although a previous study reported higher dissociation symptoms among battered women (Abel, 2001). Dissociation symptoms, as well as depressive symptoms, might have diminished during the time spent in the Mother-Child Home.

The present study shows an interesting interaction of CAH and DV on dissociated symptoms. That is, contrary to our hypothesis, the effect of DV on dissociated symptom for women without CAH was stronger than for women with CAH. This suggests that women with CAH are already so distressed that additional trauma, such as DV, does not increase the dissociated symptoms. In addition, as the questions regarding dissociated symptoms were asked specifically for times when the women take care of children, this measurement is more sensitive to CAH. It was reported that among DV survivors, those who experienced childhood sexual abuse were more likely to rely on disengaged coping strategies (wishful thinking, self-criticism, and social withdrawal) (Griffing et al., 2006). Further research to investigate the mechanism on how CAH mediates the impact of DV on women's mental health is warranted.

This study has a number of limitations. First, as CAH and DV were assessed retrospectively and self-reported, the measurement of these experiences might have recall bias, and might be affected by mental health problems (i.e., a woman with CAH might not be able to remember her CAH due to dissociation while responding). Second, mental health problems were not assessed by a standard assessment tool, such as Composite International Diagnostic Interview or Beck Depression Inventory. In addition, the questionnaire was self-administered, not assessed in person or by telephone interview. Third, to assess CAH and DV, a standard scale, such as Childhood Trauma Questionnaire (Bernstein et al., 1994) or Index of Spouse Abuse (Hudson & McIntosh, 1981), was not used, although they were referenced for development of measurements. It is extremely difficult to use lengthy standard scales to inquire about CAH and DV for battered women, especially in Japan. Our survey on CAH and DV was constructed with a minimal number of question, thus, further research is warranted to show the validity and reliability of the scale used in this study. Fourth, the study sample was a convenient one. Thus, it is hard to generalize the results even to a Mother-Child Home, due to sampling bias. Fifth, reasons for staying in the Mother-Child Home were not clear for every respondent. Some respondents might have had other difficulties, such as severe physical and mental disease, which were not controlled in the study.

Nonetheless, the finding that CAH has a stronger impact on women's mental health than DV needs to be considered in the clinical and welfare setting. In psychological therapy for battered women, it may be important to address issues of childhood abuse, specifically psychological abuse. In addition, it would be useful for mental health care and welfare providers to know that mothers without CAH might be more likely to display exacerbated mental health issues due to DV; thus, appropriate resource allocation should be considered.

In conclusion, CAH, more specifically childhood psychological abuse history, was shown to be significantly associated with women's mental health problems, independent of DV. DV did show an independent effect on traumatic symptoms, but not on dissociated and depressed symptoms. Interaction between CAH and DV was found for dissociated symptoms; DV was significantly associated with dissociated symptoms for women without CAH, but it was not for women with CAH. Further research is needed, using a nationally representative sample, by prospective design, employing established assessment scales for mental health problems and CAH and DV, to elucidate the complex mechanism of the impact of CAH and DV on women's mental health problems.

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Appendix A. Questionnaire to assess women's mental health problems

Part I. Do you have any of the following experiences these days? (Response options: "Not at all," "Rarely," "Sometimes," or "Frequently")

[Dissociated symptoms]

1. I find myself hitting or pinching my child when scolding him/her. I can't exactly remember the flow of events as to why or when I did it.
2. When I'm talking to the child, I notice that I do not hear what he/she has just said.
3. When I'm scolding my child, I act very differently than I usually do, and I feel like I'm two different people.
4. There are times when my child will not do as I wish, or will not follow my instructions.
5. Sometimes I feel as if I am standing on the side, watching myself take care of my child, and regarding my care-giving behavior as if I was another person watching.
6. In daily life, I cannot remember a part (or all) of what I did or how I took care of the child.
7. In the middle of care-giving, I stare into space, not thinking about anything, not noticing the passage of time, just sitting there doing nothing.
8. There are times when I am not sure if I actually did something or just thought about doing it (e.g., whether I actually scolded the child, or just thought about scolding him/her).
9. There are times when I feel that it is really tough to raise a child.
10. Sometimes I become totally engrossed in a daydream, so much so that I think it is real.

Part II. Did you experience any of the following in the past week? (Response options: "Not at all," "Rarely," "Sometimes," "Frequently")

[Depressive symptoms]

1. I wake up suddenly in the middle of sleep.
2. I feel like I have no energy.
3. I have difficulty falling asleep.
4. I think it would be better if I had never been born.
5. I have difficulty concentrating.
6. I cannot force myself to think about the future.
7. I feel irritable and easily angered.
8. I feel that everything is my fault.
9. I suddenly break out crying for no reason.
10. I feel sad.
11. I feel useless.

[Traumatic symptoms]

1. My body reacts when I remember a past bad experience, and I break into a sweat, experience difficulty breathing, or feel nauseous.
2. I try to avoid thinking about a past bad experience.
3. I can't help but think about a past bad experience, even though I have no intention of thinking about it.
4. I dismiss a past bad experience as if it never happened, or was not real.
5. I can't recall the emotion I felt during a past bad experience.
6. I avoid getting close to something that would make me remember a past bad experience.
7. I suddenly sense that I am acting or feeling exactly as if I did during a past bad experience.
8. I have dreams about a past bad experience.