

Intergenerational Child Abuse and Coping

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Abstract

Many studies have investigated the consequences of child sexual abuse (CSA) but few have examined the intergenerational effects of poly-victimization and maladaptive coping. The purpose of this investigation was to examine patterns of maltreatment and maladaptive coping among second-generation CSA survivors. It is hypothesized that: (a) maternal CSA history would be associated with a higher incidence of poly-victimization and maladaptive coping and (b) experiencing more forms of abuse would mediate the relation between maternal CSA history and maladaptive coping behaviors. The method used was a chart review of 139 sexually abused females aged 12 to 17, examining maternal abuse history, maladaptive coping behaviors, and child maltreatment. The results showed that poly-victimization differed as a function of maternal CSA history but maladaptive coping did not. Experiencing more types of abuse was associated with both self-injurious behaviors and substance use. In conclusion, results support the hypothesis that second generation CSA survivors are more likely to experience poly-victimization. Future research should address how intergenerational patterns of abuse might affect presenting symptomatology and treatment outcome.

Keywords

child abuse, intergenerational transmission of trauma, mental health and violence, sexual abuse, with Hx of abuse

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Child maltreatment is a widespread problem, exerting a heavy toll on individuals, communities, and society. According to the U.S. Department of Health and Human Services, Children's Bureau, 3.5 million allegations of child abuse were investigated in 2007. Of those, 794,000 children (10.6 in 1,000) were found to be the victims of child abuse or neglect. Among the substantiated cases, 59.0% of children were neglected, 10.8% were physically abused, 7.6% were sexually abused, 4.2% were emotionally abused, and 5.2% were the victims of other forms of abuse. An additional 13.1% of maltreated children were the victims of multiple forms of abuse (U.S. Department of Health and Human Services, 2007).

Children who experience one form of maltreatment are more likely to experience multiple forms of victimization (Finkelhor, Ormrod, & Turner, 2009). For example, children exposed to domestic violence (DV) are more likely to be physically and sexually abused (Appel & Holden, 1998; McCloskey, Figueredo, & Koss, 1995; Neubauer, Deblinger, & Sieger, 2007) and maltreated children are more likely to experience community violence, such as witnessing or hearing about shootings, stabbings, murders, and drug deals in the community (Lynch & Cicchetti, 1998). This has serious implications, as research has repeatedly demonstrated that cumulative traumatic experiences can negatively affect both psychological and physical health (Briere, Kaltman, & Green, 2008; Brown et al., 2009; Follette, Polusny, Betchtle, & Nangle, 1996; van der Kolk, 1996; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Child abuse and neglect are associated with a host of deleterious effects on psychological and interpersonal functioning. Abused children may show a wide range of internalizing and externalizing behaviors such as anxiety, depression, posttraumatic stress disorder (PTSD), sexualized behavior, and conduct disorder (Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Stauffer, & Steer, 2001; Gil, 1991; Wolfe, 1998). The earlier, more severe, and more chronic the abuse, the more likely the child is to show a range of symptoms that persist into adulthood (van der Kolk, 1996; van der Kolk et al., 2005). Some children, especially sexually abused children, show a delayed reaction to the abuse. Seemingly resilient maltreated children may have poorer outcomes as they reach adolescence or adulthood (Kelly & Odenwalt, 2006). Adults with child abuse histories might suffer from depression, anxiety, substance use disorders (SUD), eating disorders, suicide ideation and attempts, violent or abusive behavior, and borderline personality disorder (Briere & Scott, 2006). These effects are exacerbated by adult victimization, which is more likely to occur in individuals with a history of child abuse (Briere & Scott, 2006; Messman-Moore & Brown, 2006).

One form of child maltreatment which has received substantial research attention is child sexual abuse (CSA). Maltreated children can develop PTSD in childhood or adulthood, but the long-term consequences of CSA are often more extensive than PTSD from other forms of trauma (Briere & Scott, 2006; Nader, 2007; van der Kolk, 1996). In addition to PTSD, victims of CSA are more likely to develop comorbid psychopathologies such as anxiety and dissociative disorders, depression, SUDs, eating disorders, and borderline personality disorder (Briere & Runtz, 1988; Briere & Scott, 2006; Finkelhor, 1988; Schore, 2003; van der Kolk, 1996). Furthermore, children who are sexually abused are more likely to experience other forms of child abuse (Finkelhor, Ormrod, & Turner, 2007; Neubauer et al., 2007) and adult revictimization (Cloitre, Cohen, & Scarvalone, 2002; Griffing et al., 2005; Messman-Moore & Brown, 2006).

The effects of CSA can persist for generations. For example, there is evidence that the children of CSA survivors are at a higher risk for sexual victimization (Finkelhor, Moore, Hamby, & Straus, 1997). This may occur for a variety of reasons. Research has demonstrated that women who were abused as children are more likely to be involved in DV relationships (Briere & Scott, 2006), and children who witness DV are more likely to be physically and sexually abused (Black, Heyman, & Slep, 2001). In fact, studies have found that the children of women in DV relationships with histories of CSA are more likely to be sexually abused than those whose mothers were not abused (Avery, Hutchinson, & Whitaker, 2002). Women who were sexually abused as children are also more likely to engage in risky sexual behavior, one of the consequences of which might be teen pregnancy (Smith, Leve, & Chamberlain, 2006), and children of teen mothers are at a greater risk of being abused (Benoit, 2007).

Trauma symptomatology can also be transmitted across generations. One study found that the children of Holocaust survivors with PTSD were more likely to experience childhood trauma than participants whose parents did not have PTSD or were not Holocaust survivors (Yehuda, Halligan, & Grossman, 2001). Studies have also found that second-generation trauma survivors show greater trauma symptomatology than children who have experienced equivalent trauma but whose parents have no trauma history (Nader, 1998; Yehuda et al., 2001). Even the nonmaltreated children of trauma survivors can show the effects of their parents' trauma (Hesse, Main, Abrams, & Rifkin, 2003). Research has found that parents with an unresolved trauma or loss showed higher levels of frightening or dissociative behavior in interactions with their infants than parents without unresolved trauma or loss (Abrams, Rifkin, &

Hesse, 2006). Infants who had never been abused but were exposed to these behaviors were more likely to be classified as having disorganized attachment, an attachment status most commonly associated with child maltreatment (Carlson, Cicchetti, Barnett, & Braunwald, 1989). The exact mechanisms that perpetuate patterns of intergenerational child abuse are unknown. However factors such as poverty, violence in the home and in the community, domestic violence, and teen pregnancy are associated with child maltreatment (Benoit, 2007; Black et al., 2001; Drake & Zurvain, 1998; Lynch & Cicchetti, 1998) and may contribute to intergenerational cycles of abuse.

While the effects of child maltreatment have been widely examined, there is a paucity of research on the underlying dynamics of intergenerational sexual abuse. For example, we do not know whether second-generation sexual abuse survivors are at an even higher risk of being multiply victimized than CSA survivors whose mothers were not abused. In addition, we do not know whether these children are more vulnerable to psychopathology and CSA-related trauma. The present study will examine the intergenerational effects of CSA by way of a chart review performed at a child abuse assessment center. The charts of sexually abused adolescents were reviewed for trauma-related symptomatology (i.e., self-mutilation, suicidality, eating disturbances, and drug and alcohol use), CSA history of nonoffending mothers, and exposure to other forms of abuse. The purpose was to determine whether second-generation sexual abuse survivors were more likely to be multiply victimized and whether they showed more trauma-related coping symptoms than their counterparts (whose mothers had not been sexually abused).

We hypothesized that youth whose mothers had a history of sexual abuse would have experienced more forms of abuse and revictimization than youth whose mothers were not abused and that the amount of abuse experienced would mediate the relation between maternal history of CSA and symptom expression in adolescent survivors of CSA.

Method

Participants

Participants were adolescent girls, aged 12 to 17 years ($M = 14.5$, $SD = 1.5$), seen for forensic evaluation of sexual abuse at a child abuse assessment center in the Pacific Northwest. A total of 1,242 children were seen at the center in 2007. Of those children, boys (34%) and girls younger than 12 (46%) were excluded. Girls 12 years and older were excluded if they were seen for any type of abuse other than sexual abuse (i.e., physical abuse, neglect, or threat of harm; 2%) or if the allegations of abuse were unsubstantiated or unlikely

to have occurred. Charts were also excluded if maternal abuse history was unavailable (24%). As such, 139 girls were included in the final analyses. Demographic characteristics are presented in Table 1.

Table 1. Sample Demographic and Behavioral Characteristics

Variable	M (SD)/%
Age	14.5(1.5)
Race/ethnicity	
White	53.6%
Hispanic/Latina	26.8%
African American	5.8%
Other	13.8%
Maternal history	
CSA	34.6%
Other abuse	5.5%
Total abuse	
Past sexual	24.6%
Physical	30.2%
Neglect	20.9%
Witness DV	48.2%
Sexual exposure	26.6%
Family substance use	54.7%
Symptoms	
Cutting	29.5%
Suicidality	25.4%
Problem eating	25.2%
Substance use	
Alcohol	23.7%
Marijuana	15.1%
Stimulants	3.6%
Depressants	2.9%
Hallucinogens	1.4%

Note: *n* = 139. Percentages do not sum to 100% as categories were not mutually exclusive.

Measures and Procedure

Charts for this review were identified through an electronic database search of all evaluations conducted in 2007. An electronic copy of each file was then coded for the variables of interest to this investigation by the first

author. In any case where the implementation of the coding procedure was unclear, specific information pertaining to the coding scheme was discussed with on-site research staff and the second author, a licensed psychologist.

Each chart contained information provided by the parent, the child, the medical examiner, and the forensic interviewer. A summary of relevant findings was provided at the end of the chart by the interviewer and medical examiner. Allegations of abuse were deemed *no indication*, *possible*, and *diagnostic* by the evaluation team. Charts were included if they were determined to be *highly concerning* for, or *diagnostic* of abuse.

Occasionally, there was conflicting information about a child. For example, the child might report engaging in self-harming behavior in the absence of parental report of the behavior. In cases like these, if the behavior was reported by any source, it was coded as present. In some charts, past abuse history was also difficult to assess. Some families had extensive histories with the Department of Human Services (DHS) but few confirmed incidences of abuse. Past abuse was deemed to be present if DHS had substantiated the abuse, if it was reported by the parent or child, or if it had been confirmed by the assessment center in a previous visit.

Records were dichotomously coded for current sexual abuse, past sexual abuse, physical abuse, neglect, witnessing DV, inappropriate sexual exposure (i.e., pornography, unmonitored exposure to sexually explicit content in the media or on the internet, age-inappropriate exposure to sexual knowledge or acts), family substance use, and current abuse other than sexual abuse (Table 1).

Maladaptive coping behaviors were also assessed on a present versus absent scale. The coping behaviors of interest were self-mutilation (e.g., cutting, burning, scratching, hitting oneself, etc.), eating disturbances (i.e., anorexia, bulimia, overeating, lack of appetite), and substance use (e.g., alcohol, marijuana, depressants, stimulants, and hallucinogens). All coping behaviors were coded for lifetime use. Maternal history of sexual abuse (0 = *no*, 1 = *yes*, 2 = *other abuse*) was also included. Finally, race/ethnicity and age at evaluation were assessed. Rates of these behaviors are listed in Table 1.

Initially, variables were coded and analyzed individually. They were combined into continuous variables for the final analyses. The coping mechanisms (cutting, suicidality, problem eating) were combined into a *symptoms* variable and a substance use variable including alcohol (alcohol, stimulants, depressants, hallucinogens, and marijuana) formed a *substance use* summed composite variable. Past abuse experiences (physical and sexual abuse, witnessing DV, inappropriate sexual exposure, and family substance use) were combined into a *total abuse* score.

Table 2. Prediction of Total Forms of Abuse Experienced as a Function of Maternal CSA History

Variables	<i>B</i>	<i>SE</i>	β	<i>p</i>
Age	0.06	0.10	.05	.57
Race/ethnicity				
African American	-0.52	0.67	.07	.44
Hispanic American	-0.29	0.36	-.07	.42
Other	-0.12	0.46	-.02	.79
Maternal history				
CSA	0.71	0.32	.20	.03
Other abuse	-0.56	0.60	-.08	.35

Note: $n = 139$. Reference group for race/ethnicity comparisons was Caucasian. Reference group for maternal history was no abuse history. Significant effects are highlighted in bold.

Results

We predicted that the adolescent girls of abused mothers would be more likely to have experienced other forms of abuse and/or revictimization when compared to those whose mothers had not been sexually abused. Regression analyses demonstrated that maternal history was significantly associated with total forms of abuse experienced when accounting for age and race of the child. Significant effects were found comparing youth with a maternal sex abuse history versus those with no maternal history, such that girls whose mothers were CSA survivors had experienced more forms of abuse than children of mother's without such history (Table 2). No significant differences emerged between adolescents whose mothers had no abuse history and those whose mothers had experienced other forms of abuse. Neither age nor race predicted total abuse scores.

To examine the possible relation between maternal history and severity of the abuse on coping symptoms, regression analyses were conducted to examine the impact of background variables (race/ethnicity, age at evaluation), maternal history of abuse, and the number of forms of abuse experienced on coping behaviors (*symptoms* and *substance use*). In Step 1, race/ethnicity and age at time of evaluation were included within the model and significantly predicted 8% of the variance in symptoms ($p = .0005$), such that Hispanic girls endorsed fewer symptoms, $B = -0.35$, $SE = 0.17$, $p = .04$, and later age of evaluation predicted greater symptomatology, $B = 0.10$, $SE = 0.05$, $p = .03$. The inclusion of maternal history of abuse at Step 2 was nonsignificant.

However, the addition of the total abuse score in Step 3 accounted for an additional 10% of variance in symptom counts, over and above the other predictors, total model: $F(7, 130) = 4.18, R^2 = .18, p < .001$. Mediation analyses of the relation between maternal CSA history and symptoms were not performed, as there was no significant direct relation between these variables.

Using a similar strategy, we examined the prediction of substance use. Patterns were similar such that age, $B = 0.21, SE = 0.07, p = .003$, and being Hispanic, $B = -.59, SE = 0.25, p = .02$, differentially predicted substance use in Step 1, accounting for 9% of the variance. Again, maternal history of abuse was not predictive of substance use in Step 2, and poly-victimization was predictive of substance use in the final step, $B = 0.19, SE = 0.06, p = .02$. The total model accounted for 19% of the variance in substance use, $F(7, 130) = 4.30, p < .001$. Without the direct relation between maternal history and substance use, mediation was not supported.

Discussion

As hypothesized, an association was found between maternal sex abuse history and poly-victimization. Adolescents with maternal CSA history had experienced more forms of child maltreatment than those whose mothers had not been abused. Contrary to the hypothesis, maternal abuse history was not related to self-injurious behaviors, including self-mutilation, suicidal behavior and eating disturbances, or polysubstance use. However, girls who had experienced more forms of abuse were more likely to endorse these maladaptive coping behaviors. Older adolescents showed higher levels of symptomatology, which might be expected, given that older adolescents are more likely to engage in these behaviors (National Eating Disorders Association, n.d.; National Institute on Drug Abuse, 2009), and Hispanic girls were less likely to endorse the target behaviors than adolescents in any other racial/ethnic grouping. This finding is consistent with lower rates of substance use among Hispanic youth when compared to White youth (Johnston, O'Malley, Bachman & Schulenberg, 2009). However, the reasons why this ethnic difference emerged for self-injurious behaviors is unknown and would need to be replicated with a larger sample of youth.

Our findings are consistent with the theory of complex trauma, positing that severe, interpersonal childhood abuse is associated with a vulnerability to future victimization and a more complex symptom presentation (Briere et al., 2008; Briere & Scott, 2006; van der Kolk, 2003). There is robust evidence that sexually abused children are at risk for other forms of abuse in childhood (Finkelhor et al., 2007; Lynch & Cicchetti, 1998) and in adulthood (Cloitre &

Rosenberg, 2006; Messman-Moore, & Brown, 2006). Interpersonal traumas, such as child abuse, are often associated with a more complex symptom presentation than noninterpersonal or one-time traumas, such as car accidents or natural disasters (van der Kolk et al., 2005). This form of trauma is also associated with self-destructive behaviors such as substance abuse, self-mutilation, and eating disorders, often occurring as comorbid conditions (Claes & Vandereyckan, 2007; Harned, Najavitz, & Weiss, 2006; Messman-Moore & Garrigus, 2007; van der Kolk, 1996). While not a direct test of these assertions *per se*, our findings are consistent with the existent literature on complex trauma.

This study had a number of strengths. Study procedures allowed for an evaluation of all cases of CSA among adolescent girls assessed in a given year in an acute assessment facility. While this methodology relied on a records review, limited to the assessment protocols included within a forensic evaluation of child abuse, the study allowed for a naturalistic estimate of CSA among girls seen in acute care. In many cases, this evaluation was conducted almost immediately following the allegations of abuse, reducing some of the biases inherent in retrospective reports of abuse. This benefit is also a liability, as these reports are often taken in periods of crisis and therefore may be biased by high levels of negative affect. Another strength of this methodology was the inclusion of data from a number of sources, including the child, nonoffending parents/caregivers, caseworkers, the police, and specialist staff of the center (physicians, psychologists, social workers, etc.). Another limitation of the records review was that the clinic did not administer validated measures of the coping behaviors. This information was often obtained through self-report by the child or report of the behavior by an accompanying adult. However, when it was available, clinic staff also had access to psychological evaluations, therapists' notes, medical reports, and records from child welfare.

Another limitation of this study was that maternal abuse history often relied on the mothers' self-report. This may have led to underreporting of abuse. Research has shown that CSA is highly underreported, often due the victim's fear of the repercussions, shame, and societal stigma against sexual violence (Finkelhor, 1988; Ullman, 2010). In fact, studies estimate that on average, only 32% of sexual crimes are ever reported (U.S. Department of Justice, 2002). It should be noted that maternal CSA history did not always rely on the mother's self-report. Sometimes a third party such as the father, a grandparent, or a caseworker reported this information. It is unknown whether third party report contributed to or detracted from the accuracy of the information. Information regarding maternal CSA history might be obtained more accurately through police reports, hospital records, records from child protective

services, and/or by administering a validated measure of childhood trauma to the mother.

There were a number of cases where maternal abuse history was unknown, most commonly because the mother did not have custody of the child at the time of assessment (i.e., DHS involvement, mother incarcerated, etc.). These cases were dropped from analysis, likely resulting in attenuated relations within this sample, as many of the children outside of maternal custody had more severe histories of abuse. Little research has investigated the rates of intergenerational child abuse among children in foster care, although one study found that parents with abuse histories were three times more likely to be involved in the child welfare system (Folsom, Christenson, Avery, & Moore, 2003). Future research should address this issue more thoroughly.

While this investigation cannot speak directly to the mechanism by which maternal CSA translates into increased abuse among offspring, one potential mechanism might be disrupted attachment relations between mother and child. Secure attachment is a fundamental part of healthy child development and predicts many levels of future functioning (Bendict, 2006; Siegel, 2003). Unresolved attachment disruptions among CSA survivors are associated with a higher incidence of sexual revictimization (Cloitre et al., 2002). Women who were sexually abused are also more likely to be involved in domestic violence relationships and more likely to cite emotional attachment to the perpetrator as the reason they stayed with or returned to an abusive partner (Griffing et al., 2005). Children exposed to sexual or domestic violence may also be at risk for abuse (Appel & Holden, 1998; Black et al., 2001; Neubauer et al., 2007). Furthermore, women who demonstrate attachment disruptions show decreased expectations for social support (Cloitre, Stovall-McClough, Zorbas, Charuvastra, 2008), and perceived social isolation is associated both with instigating child abuse and maintaining patterns of intergenerational abuse and neglect (Dixon, Browne, & Hamilton-Giachritsis, 2009).

Attachment disruptions are also associated with increased trauma symptomatology and emotional dysregulation (Cloitre et al., 2008; Stovall-McClough & Cloitre, 2006). While we did not find a direct link between maternal abuse history and coping, we did find that maternal history was associated with higher total abuse, and a higher level of abuse was associated with an increased use of maladaptive coping symptoms. This is consistent with past research, which has found that the children of parents who have experienced violence and trauma are not only more likely to experience violence themselves (Finkelhor et al., 1997; Yehuda et al., 2001) but also show more trauma-related symptomatology (Nader, 1998; Yehuda et al., 2001). It is possible that some traumatized parents are less able to support their children

adequately and that attachment difficulties, such as a volatile or distant parent–child relationship, may compromise a child’s ability to cope with traumatic events. Direct examination of attachment style is needed to more fully understand the impact of intergenerational child abuse on attachment and coping.

Most early interventions for sexually abused children involve the nonoffending parent(s) in some capacity (e.g., Cohen et al., 2004; Deblinger, Steer, & Lippman, 1999; Neubauer et al., 2007; van Fleet, Ryan, & Smith, 2005). Very often, the nonoffending, available parent is the mother. Clinicians working with maltreated children should also assess the mother’s history of child abuse; this may also be true for nonoffending fathers but is beyond the scope of this investigation. As parental reaction to CSA is the single most predictive factor for child outcome after the abuse is disclosed (Kelly & Odenwalt, 2006), the traumatized parent of a sexually abused child may need to address her own trauma in order to best support the child. To provide optimal treatment for abused children, we need to understand how parental abuse history may affect parents’ reactions to their child’s victimization and how best to support both parent and child in cases where intergenerational abuse is present.

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Bios

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