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**To cite this article:** Rebecca L. Babcock Fenerci, Ann T. Chu & Anne P. DePrince (2016) Intergenerational Transmission of Trauma-Related Distress: Maternal Betrayal Trauma, Parenting Attitudes, and Behaviors, *Journal of Aggression, Maltreatment & Trauma*, 25:4, 382-399, DOI: [10.1080/10926771.2015.1129655](https://doi.org/10.1080/10926771.2015.1129655)

**To link to this article:** <http://dx.doi.org/10.1080/10926771.2015.1129655>



Published online: 13 Apr 2016.



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## Intergenerational Transmission of Trauma-Related Distress: Maternal Betrayal Trauma, Parenting Attitudes, and Behaviors

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### ABSTRACT

The purpose of this study was to elucidate mechanisms involved in the intergenerational transmission of trauma-related distress. This study investigated whether betrayal trauma (BT; abuse by a person close to the victim) and specific parenting attitudes and behaviors among mothers with child abuse histories predicted internalizing and externalizing symptoms in their children. Mothers and children (ages 7–11) were recruited for a project on parenting and stress ( $N = 72$ ). Maternal betrayal trauma predicted both internalizing ( $\beta = 0.33, p < .01$ ) and externalizing symptoms ( $\beta = 0.25, p < .05$ ) even when controlling for mothers' trauma-related symptoms. Negative attitudes toward limit setting predicted externalizing symptoms ( $\beta = -0.33, p < .05$ ). Poorer communication ( $\beta = -0.39, p < .05$ ) but higher parenting satisfaction ( $\beta = 0.38, p < .01$ ) predicted internalizing symptoms. These findings demonstrate the importance of assessing maternal trauma and parenting characteristics as part of interventions with symptomatic children.

### ARTICLE HISTORY

Received 19 April 2015  
Revised 4 November 2015  
Accepted 21 November 2015

### KEYWORDS

Betrayal trauma; child abuse; development of psychopathology; intergenerational transmission of trauma; maltreatment; parent–child relationships; parenting

Child abuse presents an enormous public health problem, given links to serious, negative mental health outcomes across the life span—for abuse survivors and their children (National Child Traumatic Stress Network, 2015). Research shows that children of mothers with a history of childhood abuse are at an increased risk for developing a host of early symptoms; this occurrence has been referred to as the intergenerational transmission of trauma (Bierer et al., 2014; Dekel & Goldblatt, 2008; Hulette, Kaehler, & Freyd, 2011; Schwerdtfeger, Lazelere, Werner, Peters, & Oliver, 2013). A substantial body of research has demonstrated that both mothers' childhood abuse experiences (e.g., physical, sexual, and emotional abuse and neglect) and trauma-related psychopathology (e.g., depression, posttraumatic stress disorder [PTSD]) are significantly associated with the development of a broad array of symptoms in children, from mood and behavioral problems to dissociation and PTSD (e.g., Bosquet Enlow et al., 2011; Chemtob et al., 2010; Chu &

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DePrince, 2006; Lambert, Holzer, & Hasbun, 2014; VanDeMark et al., 2005). Such findings represent notable progress in the field of traumatic stress by providing empirical evidence about the incidence and prevalence of the intergenerational transmission of trauma-related distress. Yet, to better inform early intervention strategies with abuse survivor parents and their children, a more nuanced understanding of the specific aspects of mothers' child abuse histories (e.g., relationship to the perpetrator) and parenting factors that might contribute to transmission is needed. This study addresses current gaps in the literature by examining whether mothers' betrayal trauma experiences along with specific parenting attitudes and behaviors predict internalizing (i.e., mood) and externalizing (i.e., behavioral) symptoms in their children, while controlling for maternal trauma-related symptoms.

### **Maternal betrayal trauma and intergenerational transmission**

Research on the intergenerational transmission of trauma and trauma-related distress has emphasized the importance of understanding how different types of trauma (e.g., physical, sexual, emotional abuse; interpersonal vs. combat trauma) contribute to the development of broad trauma-related symptomology in the next generation (Berzenski, Yates, & Egeland, 2014; Lambert et al., 2014). A meta-analysis conducted by Lambert and colleagues (2014) on the correlation between parents' PTSD symptoms and children's mood and behavioral problems found larger effect sizes for parent-child dyads who were exposed to interpersonal trauma than for parents who were exposed to combat or for parent-child dyads who were exposed to war. Such research demonstrates how the interpersonal nature of parents' trauma histories can influence the transmission of trauma-related distress. This study aimed to advance research in this area by studying a different childhood abuse characteristic among mothers that could differentially predict intergeneration transmission; that is, mothers' relationship to their childhood abuse perpetrator or the degree of "betrayal trauma" (Freyd, 1994).

The term *betrayal trauma* (BT) is derived from betrayal trauma theory (BTT; Freyd, 1994, 1996), which contends that the closer the child is to his or her perpetrator (e.g., parent vs. aunt or uncle vs. stranger), the greater the level of betrayal. BT occurs when a child is abused by someone on whom they are dependent. Dependence, which could include both physical (e.g., food, clothing, housing) and emotional needs, is likely to be higher in some victim-offender relationships (e.g., a parent, caregiver, and immediate family member) than others (a more distant relative, friend, neighbor). Thus, BT is often coded to try to capture such differences in dependence (Goldberg & Freyd, 2006). According to BTT, children who are abused by someone close, like a caregiver, are more likely to use mechanisms like dissociation, amnesia, or self-blame (Babcock & DePrince, 2012; DePrince & Freyd, 2014; Kaehler,

Babcock, DePrince, & Freyd, 2013) to preserve attachment to their abuser on whom they depend for survival. Such coping mechanisms (although initially adaptive for survival in an abusive family context where the child is otherwise helpless) can result not only in detrimental trauma-related symptoms in adult survivors, but also an increased likelihood for survivor parents to transmit trauma and its associated distress to the next generation (Bernstein, Laurent, Musser, Measelle, & Ablow, 2013; Goldsmith, Barlow, & Freyd, 2004).

In support of this premise, two studies have examined relationships between maternal BT experiences and risk for dissociation among children. Chu and DePrince (2006) assessed these relationships among a sample of 72 mother–child dyads and found that maternal BT predicted higher levels of child dissociation. Hulette and colleagues (2011) found that mothers who experienced BT and reported high levels of dissociation were more likely to have children who were also abused by someone they were close to (i.e., BT) and used dissociation as a mechanism to cope. This study sought to determine whether maternal experiences of BT could predict intergenerational transmission of trauma-related distress more broadly, by testing links between maternal BT and child internalizing and externalizing symptom domains. The purpose of these analyses was to provide a more comprehensive understanding of how BT can impact the next generation by delineating whether maternal BT might increase risk for not only dissociative symptoms, but also child mood and behavior symptoms more generally. This examination can provide specific evidence to clinicians about the role of BT in the etiology of child symptomatology.

### **Could parenting attitudes and behaviors contribute to transmission?**

Despite evidence that both mothers' trauma-related symptoms and child abuse histories increase the likelihood that their children will develop symptoms, the parenting attitudes and behaviors that might influence children's symptom development above and beyond mothers' symptoms and abuse histories remain unclear. Certain parenting attitudes and behaviors might add additional variance in predicting the intergenerational transmission of trauma-related distress, especially given that such attitudes and behaviors have been conceptualized as contributing to the overall parent–child relationship (Gerard, 1994), a factor that has been consistently linked to symptom development in children (Costa, Weems, Pellerin, & Dalton, 2006; Easterbrooks, Bureau, & Lyons-Ruth, 2012; Kim & Cicchetti, 2004; Reitman, Currier, & Stickle, 2002). Moreover, among non-abuse-survivor mothers and their children, specific parenting behaviors like “laxness” have been linked to child externalizing behaviors (Arnold, O’Leary, Wolff, & Acker, 1993; Del Vecchio & O’Leary, 2006); thus further investigation of

such attitudes and behaviors specifically among abuse-survivor mothers is warranted. By elucidating which parenting attitudes and behaviors among abuse-survivor mothers predict mood and behavior problems in their children, this study sought to provide a more in-depth understanding of which aspects of the parent–child relationship influence children’s socioemotional development beyond the general “poor relationship quality” factor.

Research on parenting factors and child symptoms among abuse-survivor mothers is relatively sparse; current literature has focused primarily on the role of parenting styles and attachment styles in the development of child mood and behavior disorders. Research investigating parenting styles has found that the role-reversal parenting style (Field, Muong, & Sochanvimean, 2013) and authoritarian parenting style (Schwerdtfeger et al., 2013) predicted increased anxiety, affective, and oppositional defiant disorders, respectively. Moreover, a series of prospective studies by Bosquet Enlow and colleagues (2014) examined the role of insecure and disorganized attachment patterns as predictors of child PTSD. These research studies found that maternal PTSD at 6 months postpartum was linked to an increased risk for insecure and disorganized attachment during infancy (Study 1), and disorganized attachment was linked to an increased lifetime expectancy of PTSD in adolescence (Study 2; Bosquet Enlow et al., 2014). This research literature provides invaluable information as to which broad-based parenting styles, attachment styles, or both can infer mental health risks in the children of abuse-survivor parents.

Yet, parenting and attachment styles are often complex and multifaceted, requiring a practitioner to target multiple parent and child cognitions and behaviors for intervention. Clarifying which specific parent attitudes and behaviors are particularly problematic for children’s socioemotional development can aid practitioners by providing evidence as to which parent attitudes and behaviors to prioritize for intervention. This study sought to further research in this area by providing a more nuanced examination of specific parenting attitudes and behaviors (satisfaction with parenting, maternal social support, involvement, communication, limit setting, autonomy, and gender role orientation) as they relate to risk for internalizing and externalizing symptoms in children; evidence that can help practitioners in taking a strategic, targeted approach in providing parenting interventions to abuse-survivor mothers and their children.

## **This study**

This study examines the relative contributions of maternal trauma-related symptoms, BT histories, and several parenting attitudes and behaviors to child internalizing and externalizing symptoms among 72 mother–child dyads (children 7–11 years old) from a large metropolitan area in the Rocky Mountain West. We hypothesized that higher levels of BT and

trauma-related symptoms (i.e., anxiety, PTSD, depression) among mothers would predict more internalizing symptoms and externalizing symptoms in their children. Next, we explored the following parenting attitudes and behaviors in terms of their links to child internalizing and externalizing symptoms: satisfaction with parenting, maternal social support, involvement, communication, limit setting, autonomy, and gender-role orientation. Last, we evaluated whether specific parental attitudes and behaviors remained significant predictors of child internalizing or externalizing symptoms when a broad parent–child relationship variable (mothers' reports of parent–child dysfunctional interactions) was added to the models.

## Method

### *Participants*

Female guardians with children (7–11 years old;  $M = 8.7$  years) from a metropolitan area in the Rocky Mountain West were recruited for participation in a larger project on parenting and stress ( $N = 72$ ). The majority of women were the biological mothers of the child participant, although the sample also included 2 adoptive mothers and 1 grandmother. Analyses indicated no significant differences between biological mothers and female guardians on any key variables; therefore, female guardians were included in all analyses although they will be referred to as mothers for the remainder of the article. Mother participants' ages ranged from 25 to 61 years old; the average age was 37. Mothers had a range of 1 to 4 children ( $M = 2$  children), and 47% of mothers were married or living with a partner. Mothers reported the following about their own racial and ethnic backgrounds: 44.9% White, 15.9% Black, 20.3% Hispanic or Latino, 2.9% American Indian or Alaskan Native, and 15.9% other race or bi- or multiracial. Mothers reported having the following levels of education: 33% some high school or general equivalency diploma, 54% some college or college degree, and 13% graduate degree. In terms of yearly family income, mothers reported the following: 61.5% earned less than \$30,000, 17% earned between \$30,000 and \$50,000, and 21.5% earned more than \$50,000.

### *Measures*

#### *Maternal betrayal trauma*

The Trauma History Questionnaire (THQ; Green, 1996) is a 24-item self-report questionnaire with good reliability and validity that measures the history of exposure to traumatic events. The THQ measures the lifetime occurrence of a range of potentially traumatic events, including interpersonal violence (e.g., physical or sexual abuse). The THQ also gathers information on the number of times and approximate age at which each traumatic event

occurred. Six items assessing physical and sexual abuse were used to classify childhood BT level (Goldberg & Freyd, 2006). To collect data on the perpetrators for each physical and sexual abuse item, the THQ was modified further to include the inquiry “Who did this to you?” The relationship between the participant and the perpetrators (e.g., father, aunt, teacher, etc.) was assessed in terms of closeness to the victim to distinguish between levels of BT for each type of abuse. Sample items for the THQ and other key variables are displayed in Table 1.

**Table 1.** Sample Items for Measures of All Key Variables.

Variable	Measure	Sample items
Maternal betrayal trauma	Interpersonal items from THQ + query about the perpetrator	-Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? -Has anyone ever beaten, “spanked,” or pushed you hard enough to cause injury? -If yes, please indicate nature of relationship with person (e.g., stranger, friend, relative, parent, sibling).
Maternal trauma-related symptoms	TSC-40	Sadness, anxiety attacks, nightmares, flashbacks (sudden, vivid, distracting memories), bad thoughts or feelings during sex, feelings of inferiority, feeling that things are “unreal”
Maternal social support	PCRI Parental Support subscale	-I get a great deal of enjoyment from all aspects in my life. -I sometimes feel overburdened by my responsibilities as a parent.
Satisfaction with parenting	PCRI Satisfaction with Parenting subscale	-I regret having children. -Being a parent is one of the most important things in my life.
Involvement	PCRI Involvement subscale	-My child keeps many secrets from me. -I feel I don't really know my child.
Communication	PCRI Communication subscale	-My child rarely talks to me unless he or she wants something. -I feel I can talk to my child on his or her level.
Limit setting	PCRI Limit Setting subscale	-I have trouble disciplining my child. -I sometimes give into my child to avoid a tantrum.
Autonomy	PCRI Autonomy subscale	-I can't stand the thought of my child growing up. -I have a hard time letting go of my child.
Gender-role orientation	PCRI Role Orientation subscale	-A woman can have a satisfying career and be a good mother, too. -A father's major responsibility is to provide financially for his children.
Dysfunctional parent-child interactions	PSI-SF Dysfunctional Parent-Child Interaction subscale	-Sometimes my child does things to bother me just to be mean. -Most times I feel that my child does not like me and does not want to be close to me.
Child internalizing symptoms	CBCL School-Aged Form, Internalizing domain	Unhappy, sad, or depressed; too fearful or anxious; feels he or she has to be perfect; there is very little he or she enjoys
Child externalizing symptoms	CBCL School-Aged Form, Externalizing domain	Argues a lot; gets in many fights; can't sit still, restless, or hyperactive; can't concentrate, can't pay attention for long; temper tantrums or hot temper

Note: THQ = Trauma History Questionnaire; TSC-40 = Trauma Symptom Checklist-40; PCRI = Parent-Child Relationship Inventory; PSI-SF = Parenting Stress Index-Short Form; CBCL = Child Behavior Checklist.



The BT scheme, similar to that used by DePrince, Chu, and Pineda (2011), was as follows: high BT = abuse perpetrated by someone who was very close like a caregiver (e.g., father, mother, or legal guardian), immediate family member (e.g., stepparents or siblings), or dating partner (e.g., spouse, significant other); low BT = abuse perpetrated by extended family members (e.g., aunt, uncle, cousin, grandparent), other individuals who were somewhat close (e.g., friend, neighbor, teacher, babysitter, casual dating partner, etc.), someone who was not close, like an acquaintance or stranger; no BT = the participant marked “no” for all physical and sexual abuse items on the THQ, or abusive experiences occurred only when the participant was age 18 or older. If the victim indicated that she was abused by more than one person, the perpetrator with which the victim had the closest relationship was used to classify the level of BT. If the level of betrayal varied across different types of abuse (e.g., high BT physical abuse, but low BT sexual abuse) the highest level of BT across all six items was used to classify the overall level of BT. Age of the victim at the time of the abuse was used to determine whether the victim was a child (under the age of 18) or adult when the abuse occurred or began. Only events that occurred when the survivor was a child were classified as BT. Weights for BT levels were assigned as follows: no BT = -1, low BT = 0, and high BT = 1.

### *Maternal trauma-related symptoms*

The Trauma Symptom Checklist-40 (TSC-40; Briere, 1996) is a 40-item self-report measure of posttraumatic stress and other symptom clusters found in some individuals who have experienced trauma. The TSC-40 has good psychometric properties and assesses several symptom clusters, including anxiety, depression, dissociation, sexual problems, and sleep disturbance (Briere, 1996). The TSC-40 total score was used to assess mothers' current levels of trauma-related symptoms. Cronbach's alpha for this sample was .94.

### *Parenting attitudes and behaviors*

The Parent-Child Relationship Inventory (PCRI) is a 78-item self-report measure that assesses attitudes about parenting and attitudes or behaviors parents have or display toward their children (Gerard, 1994). The PCRI has good psychometric properties, including construct validity, internal consistency (.82), and test-retest reliability (.81; Gerard, 1994). The PCRI is made up of seven content scales that were used to assess mother participants' parenting attitudes and behaviors in this study: Parental Support (referred to as “maternal social support” in data analyses), Satisfaction with Parenting, Involvement, Communication, Limit Setting, Autonomy, and Gender Role Orientation. Items from each content scale



were summed to determine the score for each parenting attitude or behavior variable.

### ***Dysfunctional parent–child interactions***

The Parenting Stress Index–Short Form (PSI–SF; Haskett, Ahern, Ward, & Allaire, 2006) is a 36-item parent-report questionnaire that assesses parents' perceptions of sources of parenting stress, including child behaviors and the parent–child relationship. Current levels of dysfunctional parent–child interactions were assessed by summing the items from the Parent–Child Dysfunctional Interaction subscale of the PSI–SF. The PSI–SF has good psychometric properties; Cronbach's alpha for the Parent–Child Dysfunctional Interaction subscale in this sample was .80.

### ***Child symptoms***

Mothers reported on their child's current levels of internalizing and externalizing symptoms using the Child Behavior Checklist, School-Age Form (CBCL; Achenbach & Rescorla, 2000). The CBCL is one of the most widely used parent-report measures of social-emotional and behavioral problems in children with strong psychometric properties (Achenbach & Rescorla, 2000). The School-Aged form of the CBCL is a 120-item measure used to assess symptoms among children ages 6 to 18 years old. Standardized T-scores for the Internalizing and Externalizing domains were used to assess internalizing symptoms and externalizing symptoms for each child participant.

### ***Procedure***

As part of a larger project, mothers and their children were recruited to participate in a parenting and stress study through flyers posted at local agencies, community centers, and the University's Developmental Subjects Pool. Mothers and their children were scheduled for a 2-hour study session at a research office. Consent information was provided both verbally by research personnel and on written forms. A consent quiz was administered to ensure that all mothers understood the consent information. Mothers and their children were asked to answer questionnaires as part of this larger study, which included mothers completing demographic questions, the THQ, TSC–40, PCRI, PSI–SF, and CBCL. Mother and child participants were debriefed and compensated \$30 for their time.

### ***Results***

Seventy-two mother–child dyads were tested; 2 mothers did not complete questionnaire packets, resulting in a final sample of 70 mother–child dyads.

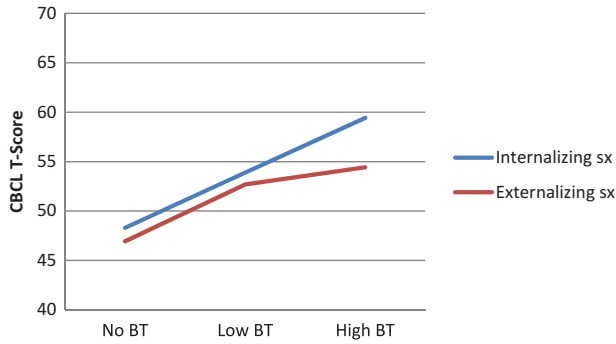
**Table 2.** Bivariate Correlations Among Variables Used in Multiple Regression Analyses.

	1	2	3	4	5	6	7	8	9	10	11
Maternal betrayal trauma < 18	.28*	-.12	-.06	-.15	-.15	-.05	-.13	-.07	.09	.42***	.34**
Maternal trauma symptoms		-.24 <sup>^</sup>	.00	-.04	-.34**	-.25 <sup>^</sup>	.02	-.50***	.23	.46***	.47***
Satisfaction with parenting			.58***	.45***	.45***	.32**	.02	.30*	.10	.06	-.18
Involvement with child				.73***	.39***	.15	.16	.14	.02	-.02	-.19
Parent-child communication					.22 <sup>^</sup>	.14	.11	.19	-.03	-.19	-.22 <sup>^</sup>
Limit setting						.25*	.06	.46***	.06	-.27*	-.50***
Child autonomy							-.07	.25*	-.01	-.10	-.13
Gender-role orientation								-.04	.03	-.10	-.06
Maternal social support									-.08	-.37**	-.40***
Dysfunctional parent-child interactions										.28*	-.03
Child internalizing symptoms											.66***
Child externalizing symptoms											

<sup>^</sup> $p < .10$ . \* $p < .05$ . \*\* $p < .01$ . \*\*\* $p < .001$ .

Differences in degrees of freedom reflect missing data on some questionnaires. Before beginning analyses, distributions of all continuous variables were assessed for skew, kurtosis, and outliers. Skew and kurtosis were satisfactory for all variables. Table 2 displays the results of bivariate correlations performed to explore relationships between all variables included in the multiple regression analyses. These variables include maternal BT before age 18 (-1 = none, 0 = low, 1 = high), maternal trauma-related symptoms, child internalizing symptoms, child externalizing symptoms, dysfunctional parent-child interactions, and maternal parenting attitude and behavior variables, including satisfaction with parenting, involvement with one's child, parent-child communication, limit setting, child autonomy, gender-role orientation, and maternal social support. Mothers' reports of parenting stress were in the clinically elevated range, on average (PSI-SF total score:  $M = 133.62$ ,  $SD = 17.51$ ). In terms of the rates of maternal BT experiences among the sample, 41% of mothers reported no BT, 24% reported low BT, and 35% reported high BT.

Figure 1 depicts the relationship between maternal BT and both child internalizing symptoms and externalizing symptoms. A significant linear relationship was found between maternal BT and both symptom domains.



**Figure 1.** Child symptoms by maternal betrayal trauma level. *Note:* CBCL = Child Behavior Checklist; BT = betrayal trauma. One-way analysis of variance results were significant for internalizing sx,  $F(2, 63) = 6.89, p < .01$ , and externalizing sx,  $F(2, 63) = 4.40, p < .05$ . Post-hoc Tukey tests indicate significant differences between high BT and no BT groups for both internalizing sx ( $p < .001$ ) and externalizing sx ( $p < .05$ ). A linear relationship was found between the BT variable and internalizing sx,  $F(1, 63) = 13.76, p < .001$ , as well as externalizing sx,  $F(1, 63) = 8.06, p < .01$ .

### **Predictors of child symptoms: Maternal BT, trauma symptoms, and parenting**

Table 3 displays the results of the first set of two multiple regression analyses with child internalizing symptoms and child externalizing symptoms as outcomes. Both multiple regressions modeled whether seven specific parenting attitudes or behaviors (satisfaction with parenting, involvement, communication, limit setting, child autonomy, gender-role orientation, and maternal social support) predicted child symptoms in addition to the variance predicted by maternal BT and maternal trauma-related symptoms. Both of the models were significant overall: Child Internalizing Symptoms,  $R^2 = 0.52, F(9, 45) = 3.85, p = .001$ ; Child Externalizing Symptoms,  $R^2 = 0.44, F(9, 45) = 5.47, p = .001$ . Maternal BT and maternal trauma-related symptoms both significantly predicted child internalizing symptoms ( $\beta = 0.33, p < .01$ ;  $\beta = 0.33, p < .01$ , respectively). For the child externalizing symptoms model, higher levels of maternal BT were significantly associated with higher levels of externalizing symptoms ( $\beta = 0.35, p < .05$ ), and the maternal trauma-related symptoms regression coefficient showed a trend toward significance ( $\beta = 0.24, p < .10$ ). In both multiple regression models, certain parenting attitudes and behaviors arose as significant predictors of child symptoms in addition to the variance accounted for by maternal BT and maternal trauma-related symptoms. In the child internalizing symptom model, higher levels of parenting satisfaction and more negative attitudes toward communication both significantly predicted higher levels of child internalizing symptoms ( $\beta = 0.38, p < .01$ ;  $\beta = -0.39, p < .05$ , respectively). In the child externalizing symptom model, more negative attitudes toward

**Table 3.** Regression Coefficients for Simultaneous Regressions of Maternal Betrayal Trauma and Parenting Attitudes Predicting Internalizing and Externalizing Symptoms in Children.

Outcome measure	Predictor variable	<i>B</i>	<i>SE B</i>	$\beta$	<i>R</i> <sup>2</sup>
Internalizing symptoms	Maternal betrayal trauma < Age 18	4.24	1.40	0.33**	0.52***
	Maternal trauma symptoms	0.19	0.07	0.34**	
	Satisfaction with parenting	0.42	0.15	0.38**	
	Parent involvement with child	0.22	0.18	0.22	
	Parent-child communication	-0.41	0.16	-0.39*	
	Limit setting	-0.17	0.17	-0.13	
	Child autonomy	0.001	0.16	0.001	
	Gender-role orientation	-0.08	0.12	-0.07	
	Maternal social support	-0.12	0.13	-0.13	
Externalizing symptoms	Maternal betrayal trauma < Age 18	2.71	1.32	0.25*	0.44***
	Maternal trauma symptoms	0.11	0.07	0.24 <sup>^</sup>	
	Satisfaction with parenting	0.17	0.14	0.18	
	Involvement with child	0.03	0.17	0.04	
	Parent-child communication	-0.14	0.15	-0.16	
	Limit setting	-0.36	0.16	-0.33*	
	Child autonomy	0.01	0.15	0.004	
	Gender-role orientation	0.01	0.11	0.02	
	Maternal social support	-0.14	0.12	-0.17	

<sup>^</sup>*p* < .10. \**p* < .05. \*\**p* < .01. \*\*\**p* < .001.

limit setting was significantly associated with higher levels of child externalizing symptoms ( $\beta = 0.26$ ,  $p < .05$ ).

### ***Parenting attitudes and behaviors: Significant beyond parent-child interactions?***

Table 4 displays results of a second set of two multiple regression analyses that assessed whether parenting attitudes or behaviors found significant in the first set of models (for child internalizing symptoms these attitudes or behaviors are parenting satisfaction and parent-child communication; for externalizing symptoms the attitude or behavior is limit setting) would remain significant predictors once a dyadic relationship variable—dysfunctional parent-child

**Table 4.** Regression Coefficients for Simultaneous Regressions of Parenting Attitudes and Dysfunctional Parent-Child Interactions Predicting Child Symptoms.

Outcome measure	Predictor variable	<i>B</i>	<i>SE B</i>	<i>B</i>	<i>R</i> <sup>2</sup>
Internalizing symptoms	Satisfaction with parenting	0.16	0.17	0.14	0.12 <sup>^</sup>
	Parent-child communication	-0.26	0.16	-0.24	
	Dysfunctional parent-child interactions	0.50	0.24	0.26*	
Externalizing symptoms	Limit setting	-0.48	0.12	-0.49***	0.24***
	Dysfunctional parent-child interactions	-0.01	0.18	-0.01	

<sup>^</sup>*p* < .10. \**p* < .05. \*\*\**p* < .001.

interactions—was added to the models. Overall, the child externalizing symptoms model was significant,  $R^2 = 0.24$ ,  $F(2, 55) = 8.72$ ,  $p = .001$ , and the child internalizing symptoms model showed a trend toward significance,  $R^2 = 0.12$ ,  $F(3, 54) = 2.52$ ,  $p = .07$ . Higher rates of dysfunctional parent–child interactions significantly predicted child internalizing symptoms ( $\beta = 0.26$ ,  $p < .05$ ); the parenting satisfaction and parent–child communication were no longer significant. However, dysfunctional parent–child interactions were not significantly associated with child externalizing symptoms, although limit setting attitudes remained a significant regression coefficient ( $\beta = -0.49$ ,  $p < .001$ ).

## Discussion

Mothers' BT histories predicted both internalizing and externalizing symptoms in their school-aged children, even after accounting for mothers' current trauma-related symptoms. These findings extend previous research (Chu & DePrince, 2006; Hulette et al., 2011) on the intergenerational transmission of trauma-related distress by demonstrating that high levels of BT among mothers can place their children at risk for not only dissociative symptoms, but a broad range of mood and behavior symptoms as well. This study highlights the relevance of parent survivors' relationship to their perpetrator in understanding how broad categories of trauma-related symptomology develop in the next generation.

In addition to maternal BT histories and trauma-related symptoms, this study found that specific parenting attitudes and behaviors were linked to distinct symptom domains in mothers' school-aged children. These parenting factors were significant predictors of children's symptoms even after accounting for mothers' BT and trauma-related symptoms, suggesting that certain parenting attitudes and behaviors might act as mechanisms that transmit trauma-related distress from parents to their children.

Specifically, mothers with more negative attitudes toward parent–child communication as well as mothers with high levels of parenting satisfaction were at increased likelihood of having children with internalizing symptoms. Moreover, negative maternal attitudes toward limit setting predicted child externalizing symptoms. These patterns of associations emphasize how mothers' manner of communicating with their children can substantially affect their child's social-emotional development, with globally negative communication styles increasing the likelihood of mood symptoms and failure in setting appropriate limits increasing behavioral problems. On the other hand, links between parenting satisfaction and child internalizing symptoms might run counter to colloquial

assumptions, as high levels of parenting satisfaction or “mothers loving being mothers” did not translate to children’s social-emotional well-being; in fact, the inverse relationship was found. It could be that high levels of parenting satisfaction, especially among mothers with a history of child abuse, might actually be a reflection of mothers’ attempts to fulfill their unmet needs through their child (e.g., mothers’ need for unconditional love, confirmation, self-esteem); such attitudes or behaviors often revolve around the mother and not the child himself or herself. Alternatively, it might be that children with mood symptoms are more obedient and easier to manage than children with behavior problems, and that mothers’ ratings of parenting satisfaction are a by-product of that dynamic. Additional research is necessary to clarify the role of parenting satisfaction in the intergenerational transmission of trauma-related distress.

These findings extend previous literature on parenting factors and symptom development among children of abuse-survivor parents (Bosquet Enlow et al., 2014; Field et al., 2013; Schwerdtfeger et al., 2013), by providing evidence regarding specific parenting attitudes and behaviors that increase risk for intergenerational transmissions beyond more broad-based parenting and attachment styles. These findings also offer valuable evidence for clinicians as to which exact parental attitudes and behaviors might be useful to target for intervention when working with abuse-survivor parents and their symptomatic children.

To evaluate the robustness of associations between parenting attitudes and behaviors and child symptoms, a second series of regression analyses were conducted in which a more broad relationship variable, parent–child dysfunctional interactions, was added to both the internalizing and externalizing symptom models. Findings show that maternal report of dysfunctional parent–child interactions was not significantly associated with children’s externalizing symptoms; limit setting remained a significant predictor. These results suggest that parents’ limit setting attitudes could act as a mechanism that transmits trauma-related distress from abuse-survivor parents to their children in the form of behavioral problems. We recommend practitioners address abuse-survivor parents’ attitudes toward limit setting as a strategy to reduce externalizing symptoms among their school-aged children.

This pattern was not found in the internalizing symptom model; when mothers’ reports of parent–child dysfunctional interactions were added with parenting satisfaction and parent–child communication, the two parenting attitudes or behaviors variables became insignificant. Because dysfunctional parent–child interactions accounted for the majority of the variance in child internalizing symptoms, mood symptoms might be more likely to arise from dyadic interactions indicative of poor parent–child relationship quality than from mothers’ individual parenting attitudes or

behaviors alone. These findings suggest that intervening at the level of the parent–child relationship might be the most effective strategy for reducing mood symptoms in children of abuse-survivor mothers, although targeting mothers’ attitudes toward communication and the role parenting plays in her fulfillment might still, nevertheless, aid in ameliorating parent–child discord.

### ***Limitations and future research***

This study is cross-sectional in design; therefore causal relationships cannot be inferred from these findings. Prospective research is necessary to establish temporal precedence of maternal trauma symptoms and parenting variables as they relate to the development of child mood and behavioral symptoms. Longitudinal research is also needed to understand the trajectory of intergenerational transmission, especially as school-aged children transition into adolescence. This study relied on parent- and self-report measures for assessment of all variables; such measures are subject to potential reporting biases or inaccurate recall. We recommend future studies examining the intergenerational transmission of trauma-related distress also use interview or behavioral observation methodology to further elucidate the role of parenting attitudes, behaviors, and parent–child interactions as mechanisms of transmission. This study examined links between abuse-survivor mothers’ limit-setting attitudes and child symptom development specifically. Future studies should also assess maternal harsh disciplinary behaviors to develop a more comprehensive, empirical picture of how abuse-survivor parenting attitudes and behaviors contribute to child symptomology. Additionally, theoretical models beyond BTT, such as social learning theory, are likely relevant to understanding intergenerational transmission of symptoms and should be integrated into future research. For example, social learning theory (Bandura, 1971) points to the importance of considering what mother survivors of BT who might not have learned effective communication and emotional regulation skills teach their own children about these skills. Future studies that incorporate perspectives from both BTT (Freyd, 1994, 1996) and social learning theory (Bandura, 1971) might be particularly useful in understanding mechanisms of intergenerational transmission of trauma-related distress.

The community sample of mothers were recruited for a study on parenting and stress and mean levels of parenting stress were in the clinically elevated range, so these results are likely not generalizable beyond mothers who are experiencing significant stress. Because only mother–child dyads were recruited, the role of fathers’ possible BT histories, symptomology, and parenting attitudes or behaviors were not evaluated. Moreover,



mothers reported on the level of betrayal for experiences of physical and sexual abuse only; BT was not assessed for emotional abuse, neglect, or witnessing domestic violence. Future studies that incorporate fathers as participants as well as the assessment of several forms of child abuse among parent survivors could provide additional evidence to further advance the field's comprehension of the intergenerational transmission of trauma-related distress.

## **Conclusion**

This study assessed the role of maternal trauma and parenting factors in children's development of psychopathology among a diverse sample of mother-child dyads. Results from this study add to the literature on the intergenerational transmission of trauma-related distress by providing evidence for how the relationship to the perpetrator or level of betrayal relates to the development of a broad range of symptoms in their school aged-children. Understanding how mother survivors' relationships to their child abuse perpetrator and mothers' experiences of betrayal can influence their children's social-emotional development can enhance practitioners' trauma-informed perspectives in working with abuse-survivor parents and their children. This investigation also provides empirical insight regarding how specific parenting attitudes and behaviors like limit setting, communication, and parent satisfaction might function as mechanisms promoting the transmission of trauma-related distress across generations. That parenting attributes of mothers emerged as predictive of children's mood or behavior symptoms beyond mothers' BT histories and current trauma-related symptoms, underscores the critical role parents' behaviors and attitudes toward their children have on their children's well-being. Mothers' attitudes toward and manner of communicating and setting limits with their children can be targeted for intervention by clinicians as a proactive strategy to prevent or ameliorate the intergenerational transmission of trauma-related distress among at-risk families. With evidence toward a more nuanced understanding of how the intergenerational transmission of trauma-related distress occurs, we hope the results of this study can assist clinicians in providing effective, empirically informed interventions to mother survivors and their children.

## **Funding**

This project was funded through a University of Denver Graduate Affairs Committee Research Grant (to Ann T. Chu) as well as through Denver University Psychology Department funds (Anne P. DePrince).

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