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Running Head: PARENTING AND CHILD TRAUMA

THE RELATIONSHIP BETWEEN PARENTING AND CHILD TRAUMA:
AN INTERGENERATIONAL INVESTIGATION

by

MIRIAM AVIVA DREYER

A Dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the
requirements for the degree of Doctor of Philosophy.

City University of New York

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PARENTING AND CHILD TRAUMA

The Relationship between Parenting and Child Trauma:
An Intergenerational Investigation

by

Miriam Aviva Dreyer

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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ABSTRACT

**THE RELATIONSHIP BETWEEN PARENTING AND CHILD TRAUMA:
AN INTERGENERATIONAL INVESTIGATION**

by

MIRIAM AVIVA DREYER

Advisor: Denise Hien, Ph.D.

This study examined the intergenerational transmission of trauma by investigating the relationship between parental trauma and child trauma exposure by considering parenting variables including emotion regulation, aggression, monitoring, and punitiveness as potential mechanisms of transmission. Though ample research exists which suggests that experiences of trauma are passed down from one generation to the next, this intergenerational transmission is not inevitable, and the mechanisms of transmission need to be better understood. Parenting is a crucial construct to examine given that it shapes interactions between two generations and represents a forum for intervention.

The study was a secondary analysis of a selection of data from a cross-sectional, cross-generational study of the associations between maternal substance use, psychopathology, neuropsychological functioning, child rearing deficits and corresponding child outcomes, including aggressive behavior and substance use. The sample of the current study, 176 urban, low-income, predominantly African American mothers and their pre/early adolescent children (ages 9-15), represents an understudied and vulnerable population. The study proposed that maternal trauma, here measured by number of types of trauma mothers endorsed, would be associated with child exposure to trauma, and that relationship would be mediated by each of the parenting variables (aggression, monitoring, punitiveness, and emotion regulation). Given the

PARENTING AND CHILD TRAUMA

salience of emotion regulation in disorders of traumatic stress, as well as in parenting, it was hypothesized that when all of the parenting variables were considered together, maternal emotion regulation would be a significant predictor of child trauma exposure even after controlling for maternal aggression, punitiveness, and monitoring.

The study found a small but significant association between maternal trauma and child exposure to trauma, lending some support to the presence of intergenerational transmission of trauma. Also, the study found evidence that maternal trauma interferes with parenting, as a significant association between maternal trauma and increased aggression and punitiveness existed. Punitiveness was the only parenting variable that mediated the relationship between maternal trauma and child exposure to trauma. Counter to the proposed hypotheses, there were no significant findings related to maternal emotion regulation and its association with child exposure to trauma. Findings suggest the need for support for parents with trauma histories around healthy, effective disciplinary practices for their pre/early adolescent children that are culturally informed, as well as further investigation of the role in which emotion regulation may influence parenting.

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TABLE OF CONTENTS

Chapter 1: Introduction1

Chapter 2: Review of the Literature4

Childhood Trauma4

Intergenerational Transmission of Trauma11

 Attachment Theory15

 Cognitive Models of Intergenerational Transmission of Trauma17

 Trauma-Based Model of Intergenerational Transmission of Violence19

 Empirical Research on Parenting with a Trauma History20

Parenting as a Mechanism of Trauma Transmission23

 Parenting Pre/Early Adolescents25

 Parental Emotion Regulation27

 Parental Aggression28

 Parental Punitiveness30

 Parental Monitoring31

Hypotheses34

Significance35

Chapter 3: Methods36

Study Design36

Measures37

Statistical Analyses42

Missing Data43

PARENTING AND CHILD TRAUMA

Chapter 4: Results44

Demographic Characteristics of the Sample44

Summary Statistics of Measures44

Relationship of Demographic Variables to Mediating and Dependent Measures45

Non-Hypothesized Relationships Amount Mediating and Dependent Measures46

Preliminary Associations47

Test of Hypotheses47

Chapter 5: Discussion52

Overview52

Study Results53

 Punitiveness54

 Intergenerational Transmission of Trauma59

 Relationship between Maternal Trauma and Parenting63

 Emotion Regulation66

Limitations and Strengths of the Study67

Clinical Implications and Areas for Further Research70

Concluding Remarks71

Appendix A: Tables73

Appendix B: Figures85

Bibliography91

LIST OF TABLES

Table 1.	Factor Analysis Rotated Component Matrix.....	73
Table 2.	Demographic Characteristics of Sample.....	75
Table 3.	Types of Maternal Trauma.....	76
Table 4.	Trauma Exposure of Children in Sample.....	76
Table 5.	Reliability for Self-Report Measures.....	77
Table 6.	Missing Data.....	77
Table 7.	Summary Statistics for Valid Sample.....	78
Table 8.	Associations between Mediating and Dependent Variables to Child Sex: Independent <i>t</i> -tests.....	79
Table 9.	Associations between Mediating and Dependent Variables to Mother’s Age and SES: Pearson Correlations.....	80
Table 10.	Associations between Mediating and Dependent Variables to Mother’s Education Level: Spearman’s Rho.....	81
Table 11.	Relationship between Mediating and Dependent Variables to Mother’s Race: Analysis of Variance.....	82
Table 12.	Relationship between the Mediating and Dependent Variables: Pearson Correlations.....	83
Table 13.	Associations between Model Variables: Pearson and Spearman Correlations.....	84

LIST OF FIGURES

Figure 1. Hypothesized model of associations between maternal trauma exposure, maternal emotion regulation, maternal aggression, maternal punitiveness, maternal monitoring, and child exposure to trauma.....85

Figure 2. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by parental aggression (AGG) and controlled for covariates (maternal age, maternal ses, and maternal education).....86

Figure 3. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal punitiveness (PUN).....87

Figure 4. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal monitoring (MON).....88

Figure 5. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal emotion regulation (ER).....89

Figure 6. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal emotion regulation (ER), maternal monitoring (MON), maternal punitiveness (PUN), and maternal aggression (AGG).....90

INTRODUCTION

The intergenerational transmission of trauma is a complex phenomenon. Though research suggests that experiences of trauma can be passed down from one generation to the next, this intergenerational transmission is not inevitable, and the mechanisms through which transmission occurs need to be better understood. Many different theories, e.g. attachment theory (Bowlby, 2005), cognitive behavioral theories like Social Information Processing (Milner, 2003), and the Trauma-Based Model of Intergenerational Transmission of Violence (Haapasal & Pokela, 1999), posit that experiences of trauma, especially cumulative ones, can disrupt one's functioning and influence interpersonal relationships, including the relationship between parents and children. While there is some empirical research that demonstrates the intergenerational transmission of trauma (e.g. Bar-On et al., 1998; Dekel & Goldblatt, 2008), other research questions those findings (e.g. Sagi-Schwartz, van IJzendoorn & Bakermans-Kranenburg, 2008). The investigation of the construct is challenging because it requires looking across multiple generations. Additionally, there are many potential confounding variables that could influence the manifestation of trauma across generations. As some of the literature investigating the intergenerational transmission focuses on trauma related to traumatic events that are isolated in time, like the Holocaust, there is a need to better understand the ways in which trauma may be passed along from one generation to the next for individuals who experience complex forms of trauma and live in environments where social factors like poverty and racism continue to affect daily life.

The importance of understanding more about the intergenerational transmission of trauma is underscored by the pervasiveness of trauma and its profound and detrimental impact. Experiencing trauma such as neglect, physical and sexual abuse in childhood is a widespread

PARENTING AND CHILD TRAUMA

problem effecting millions of children in the United States (Finkelhor, Turner, Shattuck & Hamby, 2013). Experiencing trauma can cause a host of problems for children impacting functioning across academic, familial and social domains (van der Kolk, 2005). These traumatic experiences have long-lasting effects, especially when they are repeated and when they occur within interpersonal contexts (Cloitre et al., 2009). The effect of trauma can manifest in wide ranging psychiatric distress in adulthood (Felitti et al, 1998). Furthermore, experiencing trauma in childhood puts individuals at risk for additional victimization in adulthood (Kimerling et al., 2007). Therefore, learning more about factors that can ameliorate the detrimental effects of trauma is crucial.

One such factor that is important to examine when considering the potential transmission of trauma is parenting because of its primary role in shaping interactions between two generations and its potential to be a forum for intervention. Becoming a parent is a transformative experience in which one's life and identity shift (Stern, 1995). This shift presents an opening for change and also adds a range of additional stressors to negotiate. For parents who have experienced trauma, parenting may be challenged in several different ways. For example, higher levels of cumulative maternal trauma are related to negative parenting outcomes including child abuse potential, parental punitiveness, psychological aggression, and physical discipline (Cohen, Hien & Batchelder, 2008).

The current study examined the intergenerational transmission of trauma by investigating the relationship between parental trauma and child trauma exposure by considering parenting variables including emotion regulation, aggression, monitoring, and punitiveness as potential mechanisms of transmission. It was hypothesized that of all the parenting variables studied, parental emotion regulation will play a primary role in the intergenerational transmission of

PARENTING AND CHILD TRAUMA

trauma because it represents an essential component of the parent-child relationship and is negatively impacted by experiencing trauma. The current study used a cross-generational sample of 176 urban, low-income, predominately African American and Latina mothers and their pre-adolescent children (ages 9-15) to examine parenting factors associated with childhood exposure to trauma. Self-report measures and interviews were used to obtain data regarding trauma exposure and parenting variables in the group of mothers and children. The association between maternal trauma and child exposure to trauma was examined, and mediation analyses were conducted to understand both the unique contributions of each parenting variable and which variable was the best predictor of child exposure to trauma. Given the prevalence of childhood exposure to trauma in this country, understanding the aspects of parenting that may contribute to child maltreatment is imperative.

CHAPTER 2: REVIEW OF THE LITERATURE

Childhood Trauma

Childhood trauma is a widespread problem affecting millions of children and families in the U.S. each year (U.S. Department of Health and Human Services, 2012). Understanding exactly how widespread experiences of childhood trauma are is difficult given the high stakes for reporting forms of trauma like abuse, neglect, and other types of maltreatment. One way to measure the prevalence of child trauma is through data from Child Protective Services (CPS), the governmental agency tasked with receiving and responding to reports of child maltreatment. In 2012, CPS received an estimated 3.4 million referrals, involving approximately 6.3 million children. Of those cases, 2.1 million reports received a CPS response and a disposition after a screening process, yielding a national rate of 28.3/1000 children receiving a CPS report and disposition (US Department of Health and Human Services, 2012). The highest rate of victimization reported by CPS was for infants in their first year of life. Boys (48.7%) and girls (50.9%) were evenly represented in the reports, and in terms of race, 44.0% of the CPS cases were White children, 21.8% Hispanic, and 21.0% African American (US Department of Health and Human Services, 2012). The most common form of abuse reported was neglect (78.3%) then physical abuse (18.3%), and sexual abuse (9.3%) (US Department of Health and Human Services, 2012).

The federal Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as, “Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm” (CAPTA, 2010). Physical abuse of a child involves the intentional use of physical force against a child, e.g. hitting, shaking, biting, that

PARENTING AND CHILD TRAUMA

harms a child's wellbeing (Norman et al., 2012). Sexual abuse of a child, whether perpetrated by an adult or another child, is defined as involving children in sexual activity that they do not understand and cannot consent to and marks the violation of a position of responsibility, trust and power that the perpetrator has in relation to the victim (Norman et al., 2012). Emotional and psychological abuse, e.g. restriction of movement; or patterns of belittling, blaming, frightening or discriminating against; capture non-physical forms of harm to a child's mental, social and physical health (Norman et al., 2012). Neglect represents both single incidents, as well as patterns of lack of care over time in the following domains: emotional development, health, education, nutrition, shelter and safety (Norman et al., 2012).

While the data from CPS gives a picture of reported and substantiated cases of child maltreatment, other researchers have tried to obtain prevalence data from sources outside CPS in order to capture unreported cases of maltreatment. Using data from the Second National Survey of Children Exposed to Violence (N=4,503), a household survey of adults and children conducted over the phone, Finkelhor, Turner, Shattuck, and Hamby (2011) found higher national rates of maltreatment than the CPS data indicated: in 2011, more than 1 in 10 children (13.7%) experienced some type of maltreatment by a caregiver. 41.2% experienced physical assault, and 2% experienced sexual assault or sexual abuse in the last year, and the rate of sexual abuse was 10.7% for girls 14-17 (Finkelhor, Turner, Shattuck, & Hamby, 2013). Despite the discrepancy between these numbers and the CPS reports, Finkelhor, Vanderminden, Turner, Hamby, and Shattuck (2014) found that often authority figures, e.g. teachers or police, were aware of the maltreatment. Furthermore, the responses to the survey from children and adults regarding abuse were similar, suggesting internal validity of the study (Finkelhor et al., 2014). Therefore,

PARENTING AND CHILD TRAUMA

traumatic experiences in childhood are even more common than the CPS data indicates, and they constitute a major public health problem in this country.

Exposure to traumatic events in childhood has a wide-ranging impact on a child's life and functioning. While a single experience of a traumatic event in childhood might lead to symptoms of PTSD, repeated abuse and neglect, especially when it occurs within the caregiving system, lead to complex trauma, defined in childhood as developmental trauma disorder (van der Kolk, 2005). Developmental trauma disorder is characterized by triggered patterns of dysregulation (e.g. affective, somatic, behavioral, cognitive, relational and self-attributional) in response to trauma cues; persistently altered attributions and expectancies (e.g. distrust of protective caregiver, inevitability of future victimization); and functional impairment in educational, familial, peer, legal, and vocational settings (van der Kolk, 2005). Therefore, the consequences of repeated trauma in childhood are significant and wide-ranging: virtually all aspects of a child's life and many developmental processes are affected by repeated abuse and neglect. As Herman (2002) states,

The psychological environment of childhood abuse forces the development of extraordinary capacities, both creative and destructive. It fosters the development of abnormal states of consciousness in which the ordinary relations of body and mind, reality and imagination, knowledge and memory no longer hold. These altered states of consciousness permit the elaboration of a prodigious array of symptoms, both somatic and psychological. And all of these symptoms simultaneously conceal and reveal their origins; they speak in disguised language of secrets too terrible for words, (p. 96).

Here, Herman emphasizes the deviations from typical developmental trajectories that children grappling with traumatic experiences undergo in order to cope. Her characterization of symptoms as “conceal[ing] and reveal[ing]” speaks to another challenge in identifying and understanding trauma in children: symptoms of complex trauma manifest in multiple ways and overlap with symptoms of other childhood disorders.

PARENTING AND CHILD TRAUMA

Different factors impact the symptomatic presentation of traumatic stress in children. In their description of traumatic stress in childhood and adolescence, Pynoos, Steinberg, and Goenjian (in van der Kolk, 1996) write that children experience a full range of posttraumatic stress symptoms. Their level of exposure to traumatic events is correlated with severity and course of their symptoms, and experiences of grief, posttraumatic stress, depression and separation anxiety are independent but related presentations (Pynoos, Steinberg, & Goenjian in van der Kolk, 1996). Childhood trauma also results in other psychiatric illnesses in childhood. Often traumatized children present with PTSD, separation anxiety disorder, oppositional defiant disorder, phobic disorders, and ADHD (van der Kolk, 2005). For example, exposure to interpersonal trauma in childhood can lead to internalizing and externalizing disorders like depression, anxiety, substance abuse, aggression and self-harm behaviors (D'Andrea, Ford, Stolbach, Spinazzola, and van der Kolk, 2012). Because of comorbidity, it can be hard to delineate trauma symptoms from symptoms that are related to other diagnoses. Differentiating between ADHD and a trauma diagnosis is a good example of this diagnostic complexity: for example, a child may present with ADHD symptoms, e.g. distractibility, impulsivity, and poor executive functioning, which may be the product of an attentional disorder. However, these same symptoms could also be explained by cognitive dysregulation produced by exposure to trauma. Furthermore, there may be interactive effects between the disorders; individuals with ADHD are at higher risk for developing PTSD, and people with both PTSD and ADHD are at risk for more complicated courses of the disorders (Biederman, Petty, Spencer, Woodworth, Bhide, Zhu, and Faraone, 2013). Therefore, the symptoms associated with traumatic stress in childhood and adolescence are multifold, complicated diagnostically, and highly correlated with other psychiatric disorders.

PARENTING AND CHILD TRAUMA

Experiences of childhood trauma also influence development. Prolonged exposure to stress from maltreatment leads to neurobiological events that impact brain development on neurohormonal, structural, and functional levels. A wide range of areas and circuits in the brain are affected by prolonged maltreatment, especially those systems that regulate arousal, emotions, and memory systems (Teicher, Andersen, Polcari, Anderson, Navalta & Kim, 2003). Related to neurobiological development, repeated traumatic stress manifests in a wide-range of developmental processes: attention, cognition, learning, emotion regulation, perceptions of self-efficacy, impulse control, moral development, biological maturation, and representations of self and other are all influenced by childhood trauma (Pynoos et al. in Van der Kolk, 1996). Youth with multiple victimization experiences have greater psychological maladjustment, social and academic difficulties, e.g. lower grades, than children with a single trauma exposure (Holt, Finkelhor, and Kaufman Kantor, 2007). The combined disruptions of these developmental processes have lasting effects on one's health and personality. In terms of personality development, people who have endured repeated traumatic stress develop expectations that the world is unsafe and that the self is constantly at risk of harm (Pynoos et al in van der Kolk, 1996). Consequently, repeated traumatic experiences in childhood and their developmental effects, become ingrained in a child's experience such that basic, internal schema about the world are altered, with long-lasting impact.

Therefore, exposure to childhood trauma is a pervasive and severe problem. While it is challenging to capture exactly how many children experience maltreatment or abuse given the complexity of defining these terms and the difficulties gathering accurate data, it is clear that prevalence is high. Furthermore, the negative impact of experiencing trauma in childhood, especially when it is repeated and perpetrated by a caregiver, is profound. Traumatic stress

PARENTING AND CHILD TRAUMA

interferes with the course of development across biological, cognitive and psychological realms, interfering with learning and growth. The consequences of this developmental interference ripple throughout one's lifetime, impacting adolescence, early adulthood, and later adult life.

Childhood trauma has long-term effects and manifests in multiple impairments in adulthood. Herman (2002) writes, "The survivor is left with fundamental problems in basic trust, autonomy, and initiative. She approaches the tasks of early adulthood – establishing independence and intimacy – burdened by major impairments in self-care, in cognition and memory, in identity, and in the capacity to form stable relationships. She is still a prisoner of her childhood; attempting to create new life, she reencounters the trauma," (p. 110). Her interpersonal schema formulated in childhood persist and are concretized into adulthood with pervasive consequences. Using a developmental lens, Cloitre et al. (2009), found that exposure to multiple traumas in childhood results in complex trauma in adulthood and that childhood experiences significantly influence the severity and breadth of adult symptoms. In addition to predicting adult complex trauma, childhood trauma influences other adverse health outcomes in adulthood. There is a strong relationship between the amount of exposure to trauma (abuse or household dysfunction) during childhood and multiple risk factors for disease in adulthood: people who experienced 4 categories of childhood exposure verses those who experienced no trauma had a 4-12 fold increase in health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2-4 fold increase in smoking, poor self-rated health, >50 sexual partners, and sexually transmitted disease; a 1.4-1.6 fold increase in physical inactivity and obesity; and also an increased risk of adult diseases like cancer, chronic lung disease, skeletal fractures and liver disease (Felitti et al, 1998). Additionally, women who have experienced childhood trauma are at increased risk of adulthood victimization: in a large (n=11,056), diverse sample, women who

PARENTING AND CHILD TRAUMA

experienced childhood physical or sexual abuse were 5.8 times more likely to experience adulthood physical or sexual victimization (Kimerling et al., 2007). These statistics underscore that childhood trauma is detrimental throughout the lifespan especially when prolonged and repeated.

Especially relevant for this study, one area of impairment for adults who have experienced childhood trauma is their ability to regulate emotions. Gross (1998) defines emotion regulation as the “processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions” (p. 275). In Gross’s model, these processes are both conscious and unconscious, and they include regulation strategies that operate both before an emotion is fully generated and after the emotional response occurs. Individuals use emotion regulation strategies on a daily basis to function in the world. When they are adaptive, emotion regulation strategies develop awareness, understanding and acceptance of emotions, and they help individuals use strategies that control impulsivity and engage in goal directed behavior even when dealing with negative affect (Gratz & Roemer, 2004). Problems with emotion regulation are conceptualized as a key component of many types of psychopathology (for a review see Aldao, Nolen-Hoeksema, & Schweizer, 2010) including PTSD and complex trauma (van der Kolk, 1996). For example, both adult onset PTSD and complex trauma are associated with alexithymia (Taylor, Bagby & Parker, 1991; Yehuda et al, 1997; Zlotnick, Mattia, & Zimmerman, 2001). Furthermore, post-traumatic stress symptom severity is associated with restricted and inflexible use of emotion regulation strategies, the inability to control impulsive behaviors, and more global emotion regulation deficits, e.g. the lack of acceptance of emotional experiences, lack of clarity of emotional responses, and difficulty engaging in goal-directed behavior when upset (Tull, Barrett, McMillan, & Roemer,

PARENTING AND CHILD TRAUMA

2007). There is also evidence that impairments in emotion regulation, along with interpersonal functioning, predict functional impairment above and beyond other PTSD related factors in a population of women with child abuse histories (Cloitre, Stovall-McClough & Han, 2005) which underscores the primacy of emotion regulation deficits for individuals with complex trauma.

Therefore, childhood trauma is a widespread and severe public health problem in this country. Not only do experiences of trauma in childhood, especially those that are repeated and perpetrated by caregivers, have harmful effects on a child's life and functioning in the present, they disrupt the trajectories of physical and emotional development, and have long-lasting sequelae that deleteriously impact individuals throughout their lifetime. One significant area of adult functioning that is impacted by childhood trauma is emotion regulation. Disruptions of an individual's ability to use emotion regulation strategies effectively underlie a plethora of psychiatric disorders and negatively impact a person's ability to create and maintain interpersonal relationships. Maltreatment in childhood does not only impact the individual who endures abuse; traumatic experiences can be passed down from one generation to the next, such that their impact influences the children of the victims.

Intergenerational Transmission of Trauma

In addition to its lifelong impact, trauma is transmitted from one generation to the next so its effects reverberate beyond individuals' lifetimes. The intergenerational transmission of trauma occurs within family systems and is also influenced by larger social contexts, as oppression of racial, ethnic and religious groups impacts development and can endure between generations (e.g. Braveheart and DeBruyn, 1998). Literature about the intergenerational transmission of trauma is rooted in psychoanalytic theory from the 1960s, which focuses on the

PARENTING AND CHILD TRAUMA

children of Holocaust survivors who even though they did not live through the Holocaust, experienced symptoms of trauma including impaired self-esteem and identity problems; cognitive problems, including preoccupation with death; stress when exposed to symbols of the Holocaust; affective dysregulation, including annihilation anxiety; vulnerability to stressful events and dysphoric mood; and interpersonal functioning, e.g. difficulties with intimacy and disruptions in attachment relationships (Kellerman, 2001). These observations raise questions about how traumatic events like the Holocaust influence the psychology of not only those directly affected, but their offspring as well, leading to the conceptualization of the intergenerational transmission of trauma.

Additional research investigating the intergenerational transmission of trauma in other populations examines the mechanisms through which transmission takes place. Focusing on American Indian populations, Brave Heart and DeBruyn (1998) theorize that one such mechanism is disenfranchised grief, i.e. where experiences of loss cannot be openly acknowledged or mourned. For the Native American populations, the trauma first generations experienced included genocide and large scale assimilationist policies designed to destroy cultural and spiritual practices (Brave Heart & DeBruyn, 1998). These traumatic events have strong affective costs including anger, guilt, sadness and helplessness, which are passed along to subsequent generations and compounded by on-going oppression, spiritual persecution, and new traumas, e.g. the devastating effects of substance abuse in the Native American community (Brave Heart & DeBruyn, 1998). Without the opportunity to openly mourn the trauma of past generations, and with active discrimination taking place, subsequent generations experience the trauma of their parents and grandparents without having been directly victimized during the initial period of oppression.

PARENTING AND CHILD TRAUMA

The concept of disenfranchised grief and the perpetuation of trauma through ongoing systems of discrimination applies to many other oppressed populations. Sotero's (2006) model of historical trauma offers a theoretical framework from a public health perspective for understanding the intergenerational transmission of trauma. In the model, a mass trauma experience, e.g. segregation, physical or psychological violence, economic destruction or cultural dispossession, is perpetuated by a dominant group to a subjugated group. The generation that directly experiences the subjugation has a trauma response that Sotero (2006) describes in three main components: physical, social, and psychological. Physical responses include nutritional stress, compromised immune systems, and gene impairment/expression resulting in malnutrition, infectious diseases, and other health problems. Social responses include increased domestic violence, unemployment, and poverty resulting in the breakdown of community and family structures, and loss of resources. The psychological responses include PTSD, depression and anxiety disorders, resulting in anger/aggression, shame, grief and social isolation (Sotero, 2006). While resilience factors can protect the primary generation from these responses, Sotero (2006) argues that they also can be passed along to secondary and subsequent generations through physiological, genetic, environmental, psychosocial, social/economic/political systems, and legal and social discrimination creating health disparities in individuals who did not directly experience the initial mass trauma experience.

Most relevant for the predominantly African-American population of this study, both Sotero's (2006) model of historical trauma and Brave Heart and DeBruyn's (1998) conceptualization of disenfranchised grief help explain the intergenerational transmission of the trauma of American slavery. The subjugation of African Americans during the slave trade and institutional dominance of slavery in America involved all of the examples of mass trauma that

PARENTING AND CHILD TRAUMA

Sotero (2006) outlines, i.e. segregation/displacement, physical/psychological violence, economic destruction, and cultural dispossession. As Gump (2010) describes, the extreme violence and power differential between Whites and Blacks during slavery institutionalized the annihilation of humanity. America was transformed into a slave society such that the economy of the entire country was based on slavery and the subjugation of African-Americans (Berlin, 2003 summarized by Gump, 2010). Even after slavery was abolished and civil rights laws were enacted to prevent discrimination, institutionalized racism persisted. The manifestations of institutionalized racism are complex. One present day example involves the mass incarceration of African American males. In *The New Jim Crow* (2010), Michelle Alexander argues that the explanation for the disproportionate number of Black males in the prison system is that the legacy of slavery and the Jim Crow Laws of the post-Civil War era still operate despite civil rights laws enacted to protect against racial discrimination. Therefore, even though slavery was abolished decades ago, the trauma of subjugation is actively propagated to modern generations. Brave Heart and DeBruyn's (1998) concept of disenfranchised grief is especially pertinent to the perpetuation of the trauma of slavery: "Though exhaustively studied, there is some way in which slavery has been denied: to know it requires knowing its affective, traumatic aspect" (Gump, 2010, p. 42). The denial of knowing the traumas of slavery is even apparent within trauma literature, as the intergenerational transmission of trauma related to slavery and discrimination of African-Americans is not widely represented (Gump, 2000).

Other theoretical approaches regarding mechanisms of the intergenerational transmission of trauma focus on intrafamilial dynamics. One such approach is the cycle of violence theory. Based in social learning theory (Bandura, 1977), the cycle of violence theory posits that children are socialized within their families to become abusive and then will be at risk for using greater

PARENTING AND CHILD TRAUMA

physical punishment when they become parents. However, while people who have been abused during childhood are at higher risk for becoming abusers themselves, this trajectory is neither inevitable nor direct. Despite being at risk, there is no direct, causal pathway between being abused as a child and becoming an abuser as a parent (Widom, 1989). The link between the two is more complex.

Attachment Theory. One avenue for exploring the intergenerational transmission of trauma within families is attachment theory. Attachment theory posits that emotional security derives from confidence in the availability of an attachment figure that is internalized through early childhood experiences (Bowlby, 2005). Each individual's attachment style is comprised of patterns learned through one's relationship history with primary caregivers that form internal working models of self and other that, in turn, shape relationship patterns throughout one's lifetime. Bowlby (2005) theorized that caregivers have an internal working model of the caregiving role, which comes from their own mental representations of their parental attachment. This internal caregiving model determines a parent's thoughts and feelings related to her child, and influences parenting behavior.

Parents who have experienced childhood trauma, especially physical or sexual abuse at the hands of their caregivers, develop caregiving schemas that can be based on the abusive relationship. In parent-child dyads where abuse is happening, a paradox exists for the child who is hurt by her parent yet dependent on this parent for survival: "The bond with the caretaker becomes an affective and cognitive contradiction: the source of safety is also the source of danger" (Cloitre, Cohen & Koenen, 2006, p. 14). People who are abused as children often experience repeated victimization throughout their lives since an early interpersonal schema is created in the context of the abusive relationship. Proximity to care leads to physical or sexual

PARENTING AND CHILD TRAUMA

abuse, creating the schema “to be attached means to be abused” and “abuse is one way of attaching” (Cloitre, Cohen & Koenen, 2006, p. 16). Since these schemas become a template for future relationships, they lead to repeated abusive relationships, revictimization, and problems with intimacy and trust. From a psychodynamic perspective, Fraiberg, Adelson and Shapiro (1975) conceptualize the internalized schemas as “ghosts in the nursery” and posit that repetition of abuse in family systems happens when parents identify with their childhood aggressor: “these are the parents who, earlier, in the extremity of child terror, formed a pathological identification with the dangerous and assaultive enemies of the ego” (p. 419). Repetition of abuse happens when affects associated with a traumatic past, such as shame and guilt, are repressed and then re-enacted over and over again.

In order to understand further the mechanisms through which trauma is passed down in attachment relationships, Main and Hesse (1990) propose that a parent who has experienced childhood trauma contains unresolved parental loss/trauma, and this unresolved loss leads to disorganized attachment in their infants. They explain that loss or trauma of a parent in the context of her own interpersonal relationships necessitates reorganization of her internal representations of the lost figure. If these mourning and reorganizational processes are not completed, then multiple conflicting representations of the attachment figure will exist that are not integrated (e.g. parent as loved vs. parent as abuser etc.). These multiple, conflicting representations perpetuate unintegrated anxieties and fears based in early belief systems, which lead to frightened or frightening behavior exhibited by the parent. This frightened or frightening behavior is what causes the disorganized attachment in the infant (Main & Hesse, 1990).

Therefore, it is a parent’s own adaptations to her traumatic experiences in childhood that interfere with her ability to parent her children. As Slade and Sadler (2013) describe, the post-

PARENTING AND CHILD TRAUMA

traumatic adaptations of mothers with complex trauma can disrupt their connections to their babies and can make it hard for mothers to attend to their own health needs, as well as those of their children. Lyon-Ruth and Block (1996) also found that childhood trauma was associated with increased maternal withdrawal, flatness of affect, covert hostility and interference with infant goal-directed activity. Like Slade and Sadler (2013), they hypothesize that these disruptions of responsiveness in mothers who have experienced childhood trauma comes from their own psychological adaptations, e.g. dissociation, against re-experiencing fear, helplessness and rage associated with their traumatic pasts. Furthermore, these adaptations are also activated by new attachment relationships with children (Lyons-Ruth & Block, 1996). Therefore, a child's disorganized attachment is an attempt to cope with the sequela of the mother's trauma and her attempts to adapt to it. Since children with disorganized attachments lack strong self-regulatory capacities, they are then vulnerable to experiencing their own trauma. In a review of studies looking at PTSD/complex trauma and attachment styles, Brown (in Courtois & Ford, 2013) found that instances of complex PTSD are best predicted by insecure, especially disorganized attachments aggravated by childhood abuse.

Cognitive Models of Intergenerational Transmission of Trauma. Cognitive behavioral theory also examines parenting as a mechanism in the intergenerational transmission of trauma. Similar to the internal working models in attachment theory, cognitive behavioral theory posits that abuse during childhood leads to the creation and maintenance of maladaptive schemas centered on negative views of the self and others. These schemas shape the caregiving role and parenting behaviors (Azar, Nix & Makin-Byrd, 2005) such that child abuse has negative effects on parenting. For example, mothers who experienced physical abuse as children were found to have less differentiated views of their child's negative behavior and a tendency to "filter

PARENTING AND CHILD TRAUMA

out” negative aspects of the child’s behavior (Gara, Allen, Herzog & Woolfolk, 2000). One hypothesis to support this finding is that women who were abused as children fear that they will repeat the behavior of their own abusive parents such that they defensively see their own child’s behavior in a blanket positive light. This undifferentiated view becomes problematic because different behaviors on the part of the child require different responses, e.g. a time out for hitting another child vs. no punishment for accidentally spilling food, but a parent who cannot differentiate is more likely to revert to inflexible parenting strategies she was exposed to while growing up (Gara et al., 2000). Part of the cognitive behavioral tradition, the Social Information Processing model (SIP; Milner, 2003) conceptualizes the influence of maltreatment in childhood on parenting behavior in a four-stage model of cognitive processing. Milner (2003) explains that parents have pre-existing cognitive schema related to parenting that influence their perceptions of children. More specifically, parents have both global beliefs about all children and specific beliefs about their own children. These beliefs guide their parenting behavior, such that parenting is both theory and context driven, as situational factors interact with preexisting beliefs. Parents who are at high risk of child maltreatment have aggression- related schemata associated with negative affects, and they are more likely to use these schemata than situational cues when they are presented with challenging child-rearing situations. Following from the preexisting schema, the first stage of the SIP model involves perception. Parents who experienced trauma in their childhoods are likely to have more distortions, biases and errors in their perceptions of their children’s behavior because they are likely to engage in selective attention following their preexisting schemas. For example, high-risk and abusive parents may be more likely to expect negative behavior from their children, and therefore, may misinterpret the actions, expressions, and intensity of a child’s behavior because their pre-existing schema based

PARENTING AND CHILD TRAUMA

on their own abuse biases them to detect negative behaviors (Milner, 2003). The second stage of the model involves interpretation and evaluation of children's behavior. Like in the first stage, the preexisting schemata of a parent with a trauma history can cause miscues in the parents' interpretations, e.g. a parent can view negative behavior of their children as motivated by hostile intent rather than situational factors. In the third stage of information integration and response selection, parents at risk of being abusive can fail to integrate information related to their children and fail to use mitigating information to respond to events when faced with stress. During the fourth stage, response implementation and monitoring, at risk parents can have difficulty implementing child-directed responses and maintaining flexibility (Milner, 2003). Like attachment theory, the SIP model demonstrates how the post-traumatic responses of parents with complex trauma interfere with their abilities to be responsive and attuned to their children.

Trauma-Based Model of Intergenerational Transmission of Violence. A third theoretical model for understanding the intergenerational transmission of trauma conceptualizes posttraumatic stress symptoms as a mechanism of transmission. Haapasalo and Pokela (1999) theorize that negative parenting experiences in childhood, i.e. abuse, neglect, and witnessing violence in the home, lead to post traumatic stress symptoms, and these symptoms can lead to violent behavior in adulthood. In other words, symptoms such as intrusive memories and dissociation, along with anxiety, avoidance and arousal symptoms, caused by maltreatment in childhood can persist into adulthood; it is these symptoms that put people who have experienced childhood trauma at risk for being violent adults (Haapasal & Pokela, 1999). Support for the trauma-based model of intergenerational transmission of violence comes from studies indicating that veterans with PTSD are at higher risk for committing violent acts than those without PTSD (e.g. McFall et al., 1999 and Kulka, 1990). Milner et al (2010) tested the trauma model of

PARENTING AND CHILD TRAUMA

violence in a large (n=5,394) sample of US Navy recruits and college students (n=716). The groups were varied in terms of gender and SES, and included some racial diversity. In both samples, the odds of being at risk for committing physical assault towards children in adulthood were 2-3 times higher for people who experienced childhood physical assault than those who had not, and the magnitude of the association was constant across gender, race/ethnicity, age, marital and parenting status (Milner et al., 2010). Furthermore, trauma symptoms mediated the relationship between experiencing childhood physical assault and being at risk for committing physical assault toward children in adulthood for 90% of the association in the Navy sample and 79% of the college sample. The trauma symptoms that most strongly predicted adult childhood physical assault risk were impaired self-reference, tension reduction behavior and defensive avoidance (Milner et al, 2010). Therefore, the study gives support to the idea that trauma symptoms are a mechanism of abuse since they mediated the relationship between childhood history and adult potential for violence.

Empirical Research on Parenting with a Trauma History. As discussed through the lens of attachment, cognitive behavioral, and trauma theory, experiencing childhood maltreatment can deleteriously influence parenting practices in adulthood. A large body of empirical research is dedicated to investigating these theories and found data to support their underlying assumptions. Parents who experienced harsh and physically abusive parenting in childhood are more likely to become physically abusive parents (Whipple & Webster-Stratton, 1991). Furthermore, experiencing childhood sexual abuse in particular has been shown to have a negative impact on parenting (Roberts, O'Connor, Dunn & Golding, 2004). In another study of the impact of childhood sexual abuse, Banyard (1997) found a unique effect of childhood sexual abuse in parents beyond other negative family experiences like physical abuse, neglect, and

PARENTING AND CHILD TRAUMA

negative relationships with primary caregivers. More specifically, parents who experienced sexual abuse demonstrated negative parenting outcomes like low parenting self-esteem and use of physical strategies in conflicts with children (Banyard, 1997; Dilillo, Tremblay & Peterson, 2000). Poor attachments in parents were also related to dysfunctional parenting practices and higher child abuse potential (Rodriguez & Tucker, 2011). In a study using the same data as the proposed investigation, Cohen, Hien and Batchelder (2008) report that higher levels of cumulative maternal trauma are related to negative parenting outcomes including child abuse potential, parental punitiveness, psychological aggression, and physical discipline.

The current study aimed to expand the empirical literature about parenting and the intergenerational transmission of trauma by addressing several limitations in previous studies. Several past studies examined the relationship between having a trauma history and negative parenting (e.g. Banyard, 1997; Dilillo, Tremblay & Peterson, 2000; Cohen, Hien & Batchelder, 2008), and there are other studies that consider the effects of negative parenting (e.g. using harsh punishments, being abusive, poor monitoring) on children (e.g. McKee et al. 2007, Criss et al. 2002; Bender et al., 2007). However, there are not many studies that consider the two generations at once by looking at parenting variables as mediators between parents with experiences of trauma and child exposure to trauma, which the current study did. Additionally, this study aimed to fill a pervasive gap in the literature by focusing on an urban, low SES, minority population, as well as a cohort of pre/early adolescents. Also, the current study aimed to bring together the literature about trauma and emotion regulation deficits (e.g. Tull, Barrett, McMillan & Roemer, 2007) and the centrality of emotion regulation in parenting (e.g. Schore, 2001) in considering emotion regulation as a potential mechanism in the intergenerational transmission of trauma.

PARENTING AND CHILD TRAUMA

In sum, the intergenerational transmission of trauma is a complicated phenomenon that is understood by different theorists on both a societal level and within family contexts. For groups that experience trauma on a mass scale, e.g. slavery of African Americans in the United States, the trauma can be passed along to subsequent generations through disenfranchised grief (Brave Heart & DeBruyn, 1998) and other physical, psychological, and social responses (Sotero, 2006) that influence future generations through on-going systems of discrimination and oppression. Other theoretical approaches focus on mechanisms for transmission that operate within family systems. Attachment theory, cognitive behavioral theory, and the trauma-based model of intergenerational transmission of violence all posit that a primary generation's adaptations to trauma are mechanisms of transmission to offspring. Attachment and cognitive behavioral theories describe internal working models or schemas that individuals who experience repeated maltreatment, especially abuse from caretakers during childhood, develop. These models shape interpersonal relationships, especially impacting the parent-child relationship. The trauma-based model also emphasizes that adaptations to traumatic experiences impact later generations, such that post-traumatic stress avoidance and arousal symptoms put a person with a history of childhood abuse at greater risk for committing violent acts, thereby perpetuating the transmission of trauma to future generations. All three approaches also highlight the role of emotion regulation in the intergenerational transmission: attachment theory posits that an insecure attachment between a parent and child is one where the parent's ability to be emotionally responsive to the child is disrupted by her own traumatic experiences, which in turn interferes with the child's ability to develop the necessary emotion regulation capacities. Cognitive behavioral theory describes ways in which parents who have experienced childhood maltreatment develop aggression-related schemas that are activated when they are faced with

PARENTING AND CHILD TRAUMA

their child's negative affects so that abuse and neglect are perpetuated, i.e. parents' ability to regulate their own emotions is weakened by their own abuse histories and then challenged in the context of caring for their own children. The trauma-based model focuses on post-traumatic stress symptoms, including difficulties with emotion regulation such as dissociation, hyper-arousal and impulsivity, as a mechanism for the transmission of violence. Therefore, strong support from multiple theoretical orientations and empirical research exists that emphasizes both the role of parenting and the saliency of diminished emotion regulation capacities in the intergenerational transmission of trauma. The next section will explore parenting as a mechanism for transmission in greater depth, introducing the parenting variables that the present study will investigate, as well as setting forth a rationale for studying the intergenerational transmission of trauma and parenting with a population of mothers and their pre/early adolescents.

Parenting as a Mechanism of Trauma Transmission

The tenets of the different theoretical approaches that conceptualize and study the intergenerational transmission of trauma all emphasize that a person's adaptations to trauma can interfere with parenting their own children. Given the developmental consequences of childhood exposure to trauma discussed earlier, it follows that the ripples of traumatic stress impact the course of the lifespan and interact with present events as they unfold, influencing later developmental stages. Parenting can be conceptualized as a developmental stage since it marks a major shift in one's identity. Stern (1995) describes the early interplay between a new mother's organization of her infant's world through regulating the baby's cycles of sleep and hunger, and the baby's reorganization of the mother's own representational world: "The networks of schemas

PARENTING AND CHILD TRAUMA

that undergo reworking are the mother's self as a woman, mother, wife, career-person, friend, daughter, granddaughter; her role in society; her place in her family of origin; her legal status; herself as the person with cardinal responsibility for the life and growth of someone else; as the possessor of a different body; a person 'on call' 24 hours a day; as an adventurer in life, a creator, a player on evolution's grand scheme, and so on – in short, almost every aspect of her life," (p. 24). The major shift in a woman's identity that comes with becoming a parent represents an important forum for intervention and change. While "ghosts in the nursery" (Fraiburg et al., 1975) can reemerge during this critical period, becoming a parent also presents a crucial opportunity for breaking the repetition of relational patterns that developed in the context of the traumatic past and reconfiguring a parent's identity within the new relationship. Many programs trying to halt the intergenerational transmission of trauma target new mothers and infants so that interventions happen as early as possible for the dyad. While these early interventions target the period in which attachment patterns first emerge, given the idea of parenting as a developmental period in which identities and relational patterns can shift, the potential for change in parenting behaviors is not limited to early interventions. As children and parents grow, their relationship changes based on the developmental demands of the stage. Therefore, being a parent represents a host of opportunities for reconfiguring one's identity given the shifts in roles as one parents across the lifespan.

The current study aims to examine parenting during pre/early adolescence to understand more about the ways in which trauma experienced by mothers impacts their children. Parenting variables including emotion regulation, parental aggression, parental punitiveness, and parental monitoring will be examined using a sample of mothers and their pre-adolescent children in order to determine how they may or may not be associated with exposure to trauma in the child

PARENTING AND CHILD TRAUMA

group. First, parenting pre/early adolescents will be explored and then each parenting variable investigated in the present study will be discussed in order to delineate the rationale for their inclusion in the study.

Parenting Pre/Early Adolescents. Adolescence is a tremendous time of upheaval for children and their parents. Blos (1967) described the stage as the second separation-individuation period where adolescents go through the often messy process of defining and consolidating their own identities while undergoing a tremendous developmental surge. A central paradox of adolescence is that at the same time as children get stronger and obtain greater cognitive capacities, they are extremely vulnerable: mortality rates increase 200% from early school age to late adolescence, and these instances of death and injury are often the result of difficulties in control of behavior and emotion (Dahl, 2004). There are high rates of accidents, suicide, homicide, depression, alcohol and substance abuse, violence, reckless behavior, and risky sexual behavior among adolescents. Pre/early adolescence is a particularly vulnerable stage within adolescence as it is a period of marked brain development. One theorized reason for the vulnerability of the developmental stage is that while the development of areas of the brain that are sensitive to risk and reward comes online early in adolescence, the development of executive functions and of the frontal cortex comes later (Gogtay et al., 2004; Toga et al. 2006). This means that early adolescents are less likely to have the executive controls necessary to monitor and guide impulsive behaviors, making them more vulnerable to risky behavior.

In addition to factors relating to brain development, pre/early adolescence is an important period to study given that more and more children are going through puberty at a younger age, and children who go through puberty earlier are at greater risk for later psychopathology. In a population of early maturing girls (onset of menarche at age 11 or earlier), both internalizing and

PARENTING AND CHILD TRAUMA

externalizing symptoms, including depression, bulimia, psychosomatic symptoms, anxiety, drinking, substance use, smoking, bullying and truancy, were reported in middle adolescence more frequently the earlier puberty occurred; and in a population of early maturing boys (onset of oigarche at age 11 or earlier), externalizing symptoms were associated with early puberty (Kaltiala-Heino, Marttunen, Rantanen & Rimpela, 2003). Pre/early adolescence is also a stage when children are vulnerable to substance use and abuse, which can have negative ramifications in later life. For example, in terms of alcohol use, 25-35% of high school students begin drinking before the age of 13 (CESAR, 2006), and people who begin drinking before age 15 are four times more likely to develop alcohol dependency or abuse later in life (CDC, 2014).

Parenting pre/early adolescents in particular can be a difficult period for many families. Levy-Warren (1996) describes early adolescence as a time when children are growing and shedding their familial ties. As adolescents “shift from being small to being big” (18), they experience a change in body ownership and a de-idealization of their parents. Puberty begins in early adolescence, and a primary task of the stage, lasting into other stages as well, is the integration of the new physical, cognitive and psychological changes that come with development. A meta-analysis of conflicts between children and their parents during adolescence found that conflicts occur most during early adolescence (Laursen, Coy & Collins, 1998), which makes sense given the differentiation between parents and child that takes place during the stage. In a review of the literature on parent-adolescent relationships, Steinberg (2001) summarizes four broad conclusions regarding the pre/early adolescent period: 1. conflict increases during the early adolescent years; 2. the increase in conflict comes with a decrease in reported parent-child closeness; 3. these new dynamics in the parent-child relationship impact both the mental health of parents, as well as the psychological development of children; and 4.

PARENTING AND CHILD TRAUMA

after the disruption of the parent-child relationship in early adolescence, a less conflict-laden relationship develops in the later stages of adolescence. Therefore, the transformation of the parent-child relationship that takes place during pre/early adolescence represents a particularly stressful period for all family members. For parents with trauma histories, parenting during adolescence has the potential to recall their own difficult experiences at that age. For mothers who are survivors of sexual abuse, seeing the burgeoning sexuality of their adolescent daughters can cause over identification and a recollection of their sexual experiences and acting out at that time (Hien et al, 2009). While mothers can be eager to prevent their daughters from going through the same experiences, they often need help with responding given how activating their own distress may be. Consequently, parenting pre/early adolescents presents challenges for all parents, and is particularly stressful for parents with complex trauma.

Parental Emotion Regulation. Emotion regulation is a key mechanism in the attachment relationship. A primary job of the caregiver is to help her child learn to understand and differentiate affective experiences, and this process provides the basis for the child's emotion regulation capacities throughout life (Hien et al., 2009). Schore (2001) outlines numerous ways in which early relational contexts influence development. He defines development as "the transformation of external into internal regulation" (205) and describes how "experience-dependent maturation" (205) occurs in the context of the attachment relationship. Relational trauma during this time impacts the growth of regulatory brain circuits, which has long term repercussions in terms of an individual's capacity to maintain interpersonal relationships, cope with stressful stimuli, and regulate emotions (Schore, 2001). As mentioned earlier, emotion dysregulation is a hallmark of developmental trauma disorder (van der Kolk, 2005), as well as complex trauma (van der Kolk, 1996). Parents with complex trauma likely have emotion

PARENTING AND CHILD TRAUMA

regulation deficits, and these deficits can be overwhelming to the caregiver such that is difficult to handle a child's distress (Shaver & Mikulincer, 2007). A primary job of a caretaker is to help a child differentiate and understand affective experiences. This can be challenging for parents with complex trauma who are using defenses that attempt to circumvent affect, such as dissociation, and have poor emotion regulation capacities. In fact, studies indicate that parents with poor emotion regulation capacities are at a higher risk for harming their children (e.g. Fitz-Dottan & Harel, 2014). In this way, emotion regulation deficits in parents with trauma histories can contribute to and exacerbate the difficulties inherent in parenting.

Parental Aggression. There is a large body of literature investigating the relationship between parental aggression and health outcomes in children; however, many different definitions of parental aggression exist, making comparisons in the literature challenging. Miller-Perrin, Perrin and Kocur (2009) delineate three types of parental aggression: child physical abuse (CPA), corporal punishment (CP), and psychological aggression (PA). Child physical abuse is defined by National Center on Child Abuse and Neglect as “acts of commission that involve demonstrable harm or endangerment of a child” (U.S. Department of Health and Human Services, 2012). Similarly, there is a large body of research demonstrating a wide range of cognitive, behavioral and socio-emotional difficulties associated with CPA. For example, in a prospective longitudinal study, Lansford et al (2002) found that early physical maltreatment predicts adolescent psychological and behavioral problems, as adolescents who were physically abused in childhood are less likely to attend college, and demonstrate high levels of aggression, anxiety/depression, dissociation, PTSD symptoms, social problems, thought problems and social withdrawal. A more recent meta-analysis found significant associations between childhood

PARENTING AND CHILD TRAUMA

physical abuse and depressive disorders, drug use, suicide attempts, and risky sexual behavior (Norman et al, 2012).

The second form of parental aggression, corporal punishment, is defined as the use of physical force intended to change a child's behavior but not intended to cause harm or injury (Straus et al, 1998). Spanking is the most common form of corporal punishment and has been used by over 90% of American parents at some point (Simons, Johnson, & Conger, 1994). There is much debate in the literature about effects of corporal punishment on children. The research that focuses specifically on corporal punishment is limited and what does exist has mixed findings: while some studies find a significant relationship between corporal punishment and later psychopathology, others find no relationship (summarized in Miller-Perrin et al, 2009).

One variable that moderates the relationship between physical discipline and future negative outcomes is race. In a study that controlled for parents' marital status, socioeconomic status, child temperament, child gender, and neighborhood safety, the experience of physical discipline in the first five years of life was associated with higher levels of externalizing behavior problems in adolescents of European American decent and lower levels of behavior problems for African American adolescents (Lansford, Criss, Dodge, Shaw, Pettit, & Bates, 2009). The authors argue that different parenting styles are adaptive for different ethnic groups based on context (Lansford et al., 2009). This argument is supported by Rohner's (2004) parental acceptance-rejection theory, which states that it is a child's interpretation of a parent's behavior that determines whether or not it has a negative effect. For example, a physical discipline practice like spanking could be understood by a child as a protective and limit setting by a parent rather than overly harsh and rejecting, such that the spanking did not constitute abuse. This interpretation would be especially true for cultures where physical punishment is the norm.

PARENTING AND CHILD TRAUMA

Studies of African American families have found that physical punishment is used more frequently than in European American families (Hurd, Moore, & Rogers, 1995), which helps explain the findings above regarding the discrepancy of negative outcomes for spanking in the two populations.

Psychological aggression, the third form of parental aggression, is also challenging to quantify. Hart, Brassar and Karlson (1996) define parental psychological aggression as a “repeated pattern of behavior that conveys to children that they are worthless, unloved, unwanted, only of value in meeting another’s needs, or seriously threatened with physical or psychological violence” (Hart, Brassard & Karlson, 1996, p. 73). Limited research exists that isolates psychological aggression from other forms of parental aggression. The studies that do investigate psychological aggression in families find several negative effects including low self-esteem, substance abuse, anxiety, depression and suicidal behavior (Miller-Perrin et al, 2009). Beyond problems with isolating and defining these three types of variables, parental aggression is a difficult construct to study since parents may be reluctant to disclose child maltreatment, especially given mandated child abuse reporting.

Parental Punitiveness. Another dimension of parenting that overlaps in part with elements of parental aggression is parental punitiveness, a construct assessing parental disciplinary style and potential for violence. Baumrind’s (1966) theory of parenting establishes that control is an important factor in parenting; either too much control, defined as authoritarian, or too little control, defined as permissive, can lead to dysfunctional parenting, while authoritative parenting entails a healthy balance of control in the parent-child relationship. Child abuse potential has been associated with observational measures of authoritarian parenting (Haskett, Scott, & Fann, 1995), indicating that it might be a type of parenting that puts children

PARENTING AND CHILD TRAUMA

at risk for maltreatment, and parent-child aggression was associated with authoritarian parenting style and also correlated with parental child abuse potential (Rodriguez, 2010). There is also some evidence that experiences of interpersonal violence, like domestic violence, are associated with parental use of greater harsh punishment (Osofsky, 2004). Furthermore, parents' use of harsh discipline was correlated with greater adolescent depression and externalizing behavior and interfered with developmental task in adolescence of developing autonomy and relatedness (Bender et al, 2007). Baumrind's (1966) three-factor model of parenting has been criticized from a cultural perspective. Lin and Fu (1990) argue that the model only applies to the White, European American population and that it has not been studied enough in other populations. Even Baumrind (1972) herself found that in the small African American population she included in her research authoritarian parenting styles were not associated with negative behavioral outcomes. However, subsequent research with African American families (Querido, Warner & Eyberg, 2002) and other cultural groups (Hall & Bracken, 1996) has concluded the opposite: that authoritative parenting is the most beneficial parenting style regardless of ethnic or cultural background. Despite this debate, like the different types of parental aggression, parental punitiveness is associated with negative outcomes for children.

Parental Monitoring. Parental monitoring, defined as “a set of correlated parenting behaviors involving attention to and tracking of the child's whereabouts, activities and adaptations” (Dishion & McMahon, 1998, p. 61), reduces the opportunity for anti-social behavior and increases the chances that it will be detected. Parental monitoring is a construct rooted in the Social Developmental Model (Catalano & Hawkins, 1996), which identifies socialization processes that lead to social and antisocial behavior. These socialization processes happen within families and also in other contexts like school and peer groups. The processes

PARENTING AND CHILD TRAUMA

that lead to antisocial behavior are opportunities for antisocial behavior, inappropriate or absent costs for involvement in antisocial behavior, bonding to others who engage in antisocial behavior, acceptances of beliefs that support antisocial behavior, and lack of external constraints against such behavior (Catalano & Hawkins, 1996). Poor parental monitoring has been identified as a primary predictor of adolescent anti-social behavior (Loeber and Dishion, 1983), though later research made an important distinction between parental knowledge and monitoring, arguing that there is a difference between knowledge of a child's whereabouts and actions versus active monitoring (Stattin & Kerr, 2000). They found that while greater parental knowledge was negatively associated with child conduct problems, higher levels of child disclosure and parental control, lower levels of parental solicitation predicted lower levels of conduct problems (Stattin & Kerr, 2000), which seems to indicate that not all monitoring is as effective, i.e. if parental monitoring is too intrusive, it can be problematic.

While parental aggression, punitiveness, and monitoring have been identified as three discrete variables that may be at play in the intergenerational transmission of trauma, each variable can also be conceptualized as being impacted or influenced by parental emotion regulation. Acts of aggression by parents, whether physical or emotional, could be a result of a parent's weak emotion regulation capacities. For example, a parent could use harsh physical discipline in a situation where a non-physical type of punishment could suffice because the parent is having difficulty modulating anger. Increased punitiveness could also be the result of struggles regulating emotions that are stirred up by a child's challenging behavior such that the parent impulsively reverts to an overly punitive stance that she may have experienced herself as a child. With regards to parental monitoring, a parent who is overwhelmed by her own

PARENTING AND CHILD TRAUMA

emotional experiences and becomes activating by caring for a child could become neglectful in terms of monitoring or by being overly intrusive.

In sum, childhood trauma is a widespread problem affecting millions of children and families each year. Exposure to traumatic events in childhood, especially when this exposure occurs repeatedly within a family system, deleteriously impacts children's functioning and development (van der Kolk, 2005), and can manifest in significant adulthood impairment (Herman, 2002; Cloitre et al., 2009; Felitti et al., 1998). Furthermore, when violence occurs within a family, it is often passed down from one generation to the next, such that the effects of childhood abuse perpetuate throughout the generations. While people who have been abused during childhood are at higher risk for becoming abusers as parents, this trajectory is neither inevitable nor direct (Widom, 1989). Given the complexities inherent in understanding the intergenerational transmission of trauma, the purpose of the study is to examine the mechanisms through which parenting practices might contribute to or protect from childhood trauma. Parenting is a challenging and complex role with a host of associated stressors, and for individuals with complex trauma, parenting can activate and exacerbate post-traumatic defenses as parents attempt to cope with the stress of caregiving (Lyons-Ruth & Block, 1996). While parenting can serve as a stressor and a channel through which the deleterious effects of trauma perpetuate within a family, it also represents an important forum for intervention. Parenting support programs that target the parent-child relationship have been shown to transform attachment relationships, helping parents become better attuned to their children. Furthermore, many trauma-based treatments are designed to strengthen emotion regulation in individuals with complex trauma.

Hypotheses

Therefore, the current study aims to understand another link in the intergenerational transmission of trauma by investigating the relationship between maternal trauma, parenting, and child trauma exposure using an urban sample of at-risk mothers and their pre/early-adolescent children. The mechanisms through which parenting practices might contribute to or protect from child trauma will be examined through the following parenting variables: parental aggression, parental punitiveness, parental monitoring, and parental emotion regulation.

We hypothesized that

- a) Increased number of types of maternal trauma will be associated with increased child trauma exposure
- b) the association between increased number of types of maternal trauma and increased child trauma exposure will be mediated by several parenting variables as follows:
 - i) increased number of types of maternal trauma will be correlated with higher levels of parental aggression, which will be associated with increased child trauma exposure
 - ii) increased number of types of maternal trauma will be correlated with higher levels of parental punitiveness, which will be associated with increased child trauma exposure
 - iii) increased number of types of maternal trauma will be correlated with lower levels of parental monitoring, which will be associated with increased child trauma exposure

PARENTING AND CHILD TRAUMA

- iv) increased number of types of maternal trauma will be correlated with lower levels of parental emotion regulation, which will be associated with increased child trauma exposure
- c) Also, when all of the parenting variables are considered together, it was hypothesized that maternal emotion regulation will be a significant predictor of child trauma exposure even after controlling for parental aggression, punitiveness and monitoring.

Significance

This study will help contribute to the literature seeking to understand the mechanisms through which the intergenerational transmission of trauma occurs. It will contribute to the existing literature by exploring the pathway between maternal trauma and child exposure to trauma through mediating parenting variables. Understanding more about the relationship between parental monitoring, disciplinary style, parental aggression and child trauma will help inform interventions for parents who are at risk of becoming abusive. Given the high prevalence of child abuse in this country, understanding the aspects of parenting that might contribute to child maltreatment is imperative. Additionally, given the central role emotion regulation plays in trauma-related disorders, understanding how impairments in maternal emotion regulation contribute to potential abusive behaviors and ineffectual parenting is also important. Interventions for at-risk parents could incorporate emotion regulation strategies, which are an essential component of many trauma-related treatments, with parenting education.

CHAPTER 3: METHODS

Study Design

This study is a secondary analysis of a selection of data from a cross-sectional, cross-generational study of the associations between maternal substance use, psychopathology, neuropsychological functioning, child rearing deficits and corresponding child outcomes including aggressive behavior and substance use. The larger study is based on a developmental and biopsychological exploratory model of the relationship between maternal impairments, child rearing deficits, and adverse child outcomes. Subjects were recruited for the study from a large, urban hospital in New York City from a public obstetrics and gynecological clinic. The hospital serves a predominately poor, ethnic minority population. Inclusion criteria for the study were the age of the mother had to be between 18 and 55 years, the mother had to have at least one child between the ages of 9-15, and the mother had to be willing to participate in 6 hours of interview for the mother and 3 hours for the child. Participants were excluded from the study if they had a clear history of severe organic symptomatology, active AIDS, history of head trauma to mother or child, any serious physical ailment, or a history of psychotic or bipolar disorder. One hundred and seventy-six mother-child pairs were recruited. Each mother had at least one child between the ages of 9-15. 68.9% (131) of the participants were African American, 20.5% (39) were Latina, 4.7% (9) were Caucasian, .5% (1) were Asian, and 3.7% (7) fit another racial category.

Mothers came in for an initial 3-hour interview and then returned for a second interview with the child. Participants were given \$100 and compensated for round trip travel expenses. The mothers answered a variety of self-report questionnaires about parenting practices and their child's functioning. They also were given measures of crystalized intelligence, psychiatric functioning, substance use, and treatment history, and provided a urine sample. The Structured

PARENTING AND CHILD TRAUMA

Clinical Interview for DSM-III-R/IV (SCID) was administered for each participant by trained interviewers in order to obtain diagnoses. Children were also given a variety of self-report measures, and mothers and teachers completed reports about the children's behavior. Children also were administered measures of executive functioning and were interviewed by a trained clinician using the Diagnostic Interview Schedule for Children Version 4.0.

This specific investigation will examine the relationship between maternal trauma, parenting variables, and child trauma. The specific parenting variables that will be examined are parental emotion regulation, monitoring, punitiveness, and aggression. The goals of these analyses are to further parse out the intergenerational transmission of trauma by looking at the pathway from parent to child and examining parenting variables as mechanisms of transmission of trauma. It is hypothesized that parental emotion regulation will mediate the relationship between maternal trauma and child exposure to trauma above and beyond the other parenting variables because of its salience in the parent-child relationship and the ways in which it is negatively impacted by increased exposure to trauma. See Figure 1 for mediation model.

Measures

Maternal Trauma was measured by a composite score representing the number of types of trauma participants endorsed. Types of trauma included childhood sexual abuse, childhood physical abuse, witnessing violence as a child, experiencing partner violence as an adult, and adulthood physical assault (see Table 3 for frequency of types of trauma in current sample). The scale ranged from 0-5: 0 being a mother who did not endorse any trauma, 1 representing a mother who endorsed one type of trauma etc. The rationale behind using a composite score is

PARENTING AND CHILD TRAUMA

that it captures women's experience of cumulative trauma and allows for taking into account trauma experienced in childhood and adulthood.

Parental Aggression (AGG) was assessed using Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998), which considers parental discipline practices. The Parent Child Conflicts Tactics Scale is a self-report measure designed to capture the way parents resolve conflicts with their children. The measure is divided into four subscales defined by different types of conflict resolution: non-violent discipline (e.g. explained why something was wrong), psychological aggression (e.g. said you would send him/her away or kicked him/her out of the house), physical assault (e.g. slapped on the face, head or ears), and neglect (e.g. had to leave your child home alone, even when you thought some adult should be with him/her). Each item on the scale is scored based on frequency on the following scale: 1 = once in the past year, 2 = twice in the past year, 3 = 3-5 times in the past year, 4 = 6-10 times in the past year, 5 = 11-20 times in the past year, 6 = more than 20 times in the past year, 7 = not in the past year but it has happened before, 0 = this has never happened. The psychological aggression and physical assault subscales were used for this study, and items on the scales where a positive endorsement would have necessitated child abuse reporting were omitted. Straus et al (1998) found good internal consistency of the psychological aggression (.68) subscale and weaker internal consistency of the physical assault (.58) subscale (Straus et al. 1998). Furthermore, construct validity of the measure was determined using prevalence rates, as well as correlations between sub-scales of the measure. For example, following the escalation theory of violence, which says that verbal aggression increases the likelihood of physical assault, the psychological aggression and corporal punishment scales are positively correlated (.56) (Straus et al., 1998). In this sample, the internal consistency for the psychological aggression subscale

PARENTING AND CHILD TRAUMA

was weak (.58) and the physical assault subscale was acceptable (.73). The low alpha of the psychological aggression subscale is a result of the increased rarity of the events the scale measures and is due to a skewed distribution and unequal variance between the items.

Another measure of parental aggression was obtained using the Child Abuse Potential Inventory (CAPI, Form VI; Milner 1994). The CAPI is a 160-item, self-report questionnaire that assesses risk for child physical abuse. The questions are phrased in force-choice, agree-disagree format, and within the 160 items, there is a 77-item physical child abuse scale that assesses distress, rigidity, unhappiness, problems with child and self, problems with family and problems with others. The scale has internal consistency estimates of between .92 and .95 for general, at risk, neglectful and physically abusive populations (Milner, 2004). In the general population, test-retest reliability for 1 day, 1 week, 1 month and 3 months were .91, .90, .83 and .75 respectively (Milner, 2004). The measure also has strong predictive validity: in a sample of 220 physical child abusers and matched control subjects the CAPI correctly classified 85.4% of the subjects with 82.7% of the abusers and 88.2% of the controls (Milner, Gold & Wimberley, 1986). In this sample, the internal consistency of the CAPI was excellent (.93).

In the current study, aggression was measured as a latent variable using three indicator variables measured by the psychological aggression (PAG), physical aggression (PAS), and child abuse potential (CAPI) scales. The goal of using a measure of child abuse potential along with the psychological aggression and physical assault scales was to circumvent problems of potential low frequency reporting of behavior, here instances of psychological aggression and physical assault, with a measure that captures another aspect of abusiveness, i.e. being at risk for these types of aggressive behaviors.

PARENTING AND CHILD TRAUMA

Parental Punitiveness (PUN) was measured using the Parental Punitiveness Scale (PPS; Blane, Miller & Leonard, 1988), which is a 21-item self-report measure modified from a child version of the scale (Epstein & Komorita, 1965). In the PPS, the parent estimates her most frequent responses on a Likert-type scale to a variety of hypothetical situations of child misbehavior, e.g. disobeying, stealing, damaging property, verbal aggression, and other disrespectful behavior. Respondents must choose from seven disciplinary responses: do nothing, yell at them, spank them with an open hand, spank or hit with a belt or a switch, and hit them with a fist (Blane, Miller & Leonard, 1988), though items that could constitute abuse and would have necessitated mandated child abuse reporting were omitted from the scale in this study. Factor analysis of the scale demonstrated one factor with all items loading above 0.8 so the total score is used as an outcome variable and construct validity of the measure was determined as a high score on the PPS was significantly related to a reported history of child abuse or neglect ($p < .05$) (Hien & Honeyman, 2000). In this sample, the internal consistency of the PPS was excellent (.90).

Parental monitoring (MON) was assessed using the Supervision/Involvement Scale from the Pittsburgh Youth Study Survey (PYSS). The Pittsburgh Youth Study is a prospective longitudinal study, which began in 1987 with three samples ($n=500$) of inner-city boys in grades 1, 4 and 7. The study aimed to investigate the development of juvenile mental health problems, delinquency, drug use and risk factors (Loeber et al., 2001). The Supervision/Involvement Scale of the PYSS measures parental supervision. It is a self-report measure completed by the parent and child with 20 items that participants rank on a Likert scale. Reliability estimates of the scale are $\alpha=.59$ for the mother's report and $\alpha = .64$ for the child's report (Loeber et al., 2008). In analyses examining 14 years of data from the study, poor parental supervision was strongly

PARENTING AND CHILD TRAUMA

related to behavioral problems in the oldest cohort of boys (OR=3.3), quite strongly related in the middle cohort of boys (OR=2.0) and not significantly related in the youngest cohort (Loeber et al., 2001). In this sample, the internal consistency of the measure was acceptable (.71).

Maternal emotion regulation (ER) was measured by a composite scale created by a factor analysis of items related to emotion regulation on the Novaco Anger Inventory (NAI: Novaco, 2003), the Dimensions of Temperament Scale-Revised – Adult version (DOTS-R; Windle & Lerner, 1986), the Toronto Alexithymia Scale (TAS; Bagby, Parker, & Taylor, 1994), the Coping Orientations to Problems Experienced Scale (COPE; Carver, Scheier, & Weintraub, 1989), and the Affect Intensity Measure (AIM; Larsen, 1984). A quartimax factor rotation was used and three factors were selected based on an examination of the scree plot (See Table 1). The first factor explained 19.8% of the variability and all three factors together explained 39.5%. The scores range from -2.39 to 2.59 (mean=-.01, SD=.99) with higher scores indicating worse regulation.

Child trauma (C_TRA) was measured by the Exposure to Violence Scale (My ETV; Buka, Selner-O'Haga, Kindlon & Earls, 1996). My ETV is a highly structured, interviewer-administered instrument that covers a subject's lifetime and past-year exposure to 18 different violent events that have either been witnessed or personally experienced by the subject, e.g. sexual assault, shooting, someone chased, attacked with a weapon. Frequency of exposure is measured on a six-point scale and higher scores represent more frequent exposure (Selner-O'Hagan et al., 1998). Test-retest reliability for Total ETV on the lifetime scale was .88 and in the past year scale .81. There is strong internal consistency for the lifetime total ETV (alpha = .93) and past year ETV (alpha = .89) (Selner-O'Hagan et al., 1998). In this sample, the internal

PARENTING AND CHILD TRAUMA

consistency of the measure was acceptable (.77). See Table 4 for frequencies of the types of trauma the children in the current sample experienced and witnessed.

Statistical Analyses

The first step of the quantitative analysis involved an examination of descriptive statistics and bivariate associations to examine the relationship between study variables and demographic variables. Reliability for self-report measures and missing data were also assessed. The second step of the analysis tested the model proposed in the hypotheses using Pearson and Spearman correlations and structural equation modeling (SEM). Pearson and Spearman correlations were first used to determine if simple correlations existed among all the variables in the model. Then SEM mediation models tested each of the mediation paths separately. Finally, SEM was used to examine all of the mediating variables simultaneously.

SEM is a comprehensive statistical approach that tests the relationships within a specified multivariate model, which includes observed (measured) and unobserved (latent) constructs. SEM was used in this study because it allows for analyzing the relationships amongst a group of variables (here, maternal trauma, the four parenting variables, and child exposure to trauma) simultaneously to test the structure of a model to see whether it fits a proposed model, while most other analyses can only accommodate one predicted variable. Additionally, SEM accommodates latent variables, e.g. maternal aggression in this study, which is a variable that is not directly measured but which is represented by multiple other variables. In this study, aggression was measured by three self-report measures capturing different aspects of the larger construct.

PARENTING AND CHILD TRAUMA

In the SEM figures (see Figures 2-6), variables are represented in boxes. A line between two variables is an association. The number outside the parentheses on the association line is the beta coefficient, which tells the strength and direction of the association, and the number inside the parentheses is the standard error of the beta coefficient, which represents the accuracy of the prediction. Arrows pointing to a variable that are not coming from another variable indicate “disturbance,” the error/residual for the endogenous variables, i.e. the values on that arrow represent the amount of unexplained variability in the variable.

Missing Data

All measures used in the study were reviewed for missing data (Table 6). All measures besides the ER scale and the CAPI had less than 5% missing data. The ER scale had data missing from 17 participants (8.9%), and the CAPI had data missing from 21 participants (11.1%). Cases with data missing ($n = 3$) on the predictor variable (number of types of maternal trauma) were excluded in the SEM models. Data was not imputed.

CHAPTER 4: RESULTS

Demographic Characteristics of the Sample

Descriptive statistics of participant characteristics (see Table 2) are as follows: 186 mother-child pairs participated in the study. All subjects were recruited for the study from a large, urban hospital in New York City from a public obstetrics and gynecological clinic. The mean age of the mothers was 37.44 (SD = 6.37) and the mean age of the children was 11.53 (SD = 1.88). Ninety-five (50.8%) of the children were male and 91 (48.7%) were female. In terms of the mothers' race, 131 (68.9%) participants were Black/African-American, 20.5% (39) were Latina, 9 (4.8%) were Caucasian, 1 was Asian (.5%) and 7 (3.7%) identified as "Other". In terms of marital status, 59 (52.4%) of the mothers were single, 46 (24.6%) of the mothers were married or living with a partner, 39 (20.9%) were divorced or separated, and 4 (2.1%) were widowed.

The mothers' education levels ranged from obtaining post-graduate training to not completing high school; the majority (100) did not attend college. Fifty-nine (31.5%) mothers had some high school education, 41 (21.9%) completed high school, 76 (40.6%) had some college education, 8 (4.3%) completed college, and 3 (1.6%) had post-graduate training. Of the 176 mothers, 132 (70.6%) were working either full or part time, 32 (17.1%) were not working, 18 (9.6%) were homemakers, and 3 (1.6%) were students. The majority of the mothers (48.6%) earned less than \$1000 in the month before participating in the study, indicating the low SES of the majority of participants.

Summary Statistics of Measures

Means, standard deviations, skew, and kurtosis statistics for all of the measures used in the study can be found in Table 7. The MYETV, ER, MON, TRAUMA, CAPI, and PAG scales

PARENTING AND CHILD TRAUMA

were all normally distributed. For the PUN scale, the Kurtosis Index (KI) is 5.88. According to Kline (2011), absolute values of $KI < 8$ are not considered extreme, and “a conservative rule of thumb ... absolute values or $KI > 10$ suggest a problem” (p. 63). Therefore, this level of kurtosis is acceptable. Also, the PUN scale is not skewed, indicating the data is roughly symmetrical.

Relationship of Demographic Variables to Mediating and Dependent Measures

Independent sample *t*-tests, Pearson correlations, Spearman rhos, and one-way analyses of variance (ANOVA) were used to examine potential associations among demographic variables (child’s gender, mother’s age, mother’s education, mother’s SES, mother’s race), mediating variables (parental aggression, parental punitiveness, parental emotion regulation, and parental monitoring) and the dependent variable (children’s exposure to trauma).

Independent sample *t*-tests were conducted to determine whether there were differences on the mediating and dependent variables based on children’s sex (Table 8). T-test results showed no significant differences between the sexes.

Pearson correlations were conducted among mother’s age, SES factor scores, and mediating and dependent variables (Table 9). Mother’s age showed a negative correlation with physical abuse (PAS) scores ($r = -.15, p = .04$) indicating that older mothers had lower physical abuse scores. SES was negatively correlated with mothers’ emotion regulation (ER) ($r = -.32, p < .001$) and aggression (CAPI) ($r = -.25, p = .00$). These negative correlations indicate that as mothers’ SES increased both their emotion regulation scores and their aggression scores decreased. Spearman’s rho correlations were conducted between mother’s education and mediating and dependent variables (Table 9). Mother’s education was negatively associated with mother’s emotion regulation ($r = -.34, p < .001$) and mother’s aggression ($r = -.21, p < .001$), and positively correlated with mother’s monitoring ($r = .20, p < .001$). These associations

PARENTING AND CHILD TRAUMA

indicate that as the mothers' education level increased, their emotion regulation and aggression scores decreased, and their monitoring score increased.

One way ANOVAs were conducted to determine whether there were differences on mediating and dependent measures based on mother's race (Table 11). Results revealed no significant effect of mother's race on the mediating or dependent measures.

Non-Hypothesized Relationships Between Mediating and Dependent Variables

Pearson correlations were conducted among the dependent and mediating variables (see Table 12 for a full summary of Pearson correlations for all variables). Emotion regulation (ER) was significantly positively correlated with child abuse potential (CAPI) ($r = .63, p = .00$) indicating that as emotion regulation got worse (higher ER scores indicate worse regulation), child abuse potential increased. Emotion regulation was also significantly negatively correlated with psychological aggression (PAG) ($r = -.16, p = .03$) meaning that as emotion regulation got worse, psychological aggression decreased. Monitoring (MON) was significantly positively correlated with number of types of maternal trauma (M_TRA) ($r = .16, p = .03$) and child abuse potential (CAPI) ($r = .24, p = .00$) and was significantly negatively correlated with punitiveness (PUN) ($r = -.19, p = .01$). Number of types of maternal trauma (M_TRA) was significantly positively correlated with child abuse potential (CAPI) ($r = .32, p = .00$), psychological aggression (PAG) ($r = .26, p = .00$), and physical assault (PAS) ($r = .24, p = .00$), and significantly negatively correlated with punitiveness (PUN) ($r = -.17, p = .02$), since higher scores on the PUN scale indicate less punitiveness. These correlations indicate that as mothers experienced more types of trauma, their child abuse potential, psychological aggression, physical assault and punitiveness increased. Child Abuse Potential (CAPI) was significantly negatively

PARENTING AND CHILD TRAUMA

correlated with punitiveness (PUN) ($r = -.21, p = .01$), meaning that as child abuse potential increased, punitiveness increased. Punitiveness (PUN) was significantly negatively correlated with psychological aggression (PAG) ($r = -.33, p = .00$) and physical assault (PAS) ($r = -.28, p = .00$), which indicates that more punitiveness was associated with increased psychological aggression and physical assault. Finally, psychological aggression (PAG) was significantly positively correlated with physical assault (PAS) ($r = .48, p = .00$).

Preliminary Associations

In a preliminary step prior to testing the hypotheses, the simple correlations between the variables of interest were performed (see Table 13). As hypothesized, there is a significant relationship between number of types of maternal trauma (M_TRA) and child exposure to trauma (C_TRA) ($\rho = .152, p = .03$). Number of types of maternal trauma was also significantly related to psychological aggression (PAG) ($\rho = .234, p = .00$), physical assault (PAS) ($\rho = .196, p = .01$), punitiveness (PUN) ($\rho = -.158, p = .03$), and child abuse potential (CAPI) ($\rho = .342, p = .00$). In other words, as number of types of maternal trauma increased, child exposure to trauma, psychological aggression, physical assault, punitiveness, and child abuse potential all increased. In terms of the dependent variable, punitiveness (PUN) ($r = -.191, p = .01$) and child abuse potential (CAPI) ($r = .238, p = .00$) were significantly related to child exposure to trauma (C_TRA).

Test of Hypotheses

The following hypotheses examined the relationship between maternal trauma exposure, maternal emotion regulation, maternal parenting variables (including aggression, punitiveness and monitoring), and child exposure to trauma. It was predicted that maternal trauma exposure

PARENTING AND CHILD TRAUMA

would be significantly associated with child exposure to trauma. It was also predicted that the association between maternal trauma exposure and child trauma exposure would be mediated by maternal emotion regulation, aggression, punitiveness and monitoring. Finally, it was predicted that when considering all of the parenting variables in the model (emotion regulation, aggression, punitiveness and monitoring), emotion regulation would explain the relationship between maternal trauma exposure and child trauma exposure more than the other mediating variables. In all of the tests of hypotheses, demographic variables, which were associated with the predictor and mediating variables, were controlled and will be specified analysis by analysis.

Hypothesis 1: Increased number of types of maternal trauma will be associated with increased child trauma exposure. It was predicted that maternal trauma will statistically predict child exposure to trauma scores. This hypothesis was tested with a simple correlation between the maternal trauma composite score and the child MY ETV score, and found a small but significant correlation of $\rho = .152, p = .03$. This correlation supports the first hypothesis: increased number of types of maternal trauma is significantly associated with increased child trauma exposure.

Hypothesis 2: the association between increased number of types of maternal trauma and increased child trauma exposure will be mediated by several parenting variables as follows:
(a) increased number of types of maternal trauma will be correlated with higher levels of parental aggression, which will be associated with increased child trauma exposure. SEM was used to test the mediating effects of the parental aggression on the relationship between maternal trauma and child trauma exposure controlling for three covariates: maternal age, maternal SES, and maternal education (Figure 2). Aggression was measured as a latent variable in the model that was measured using three indicator variables: psychological aggression (PAG), physical

PARENTING AND CHILD TRAUMA

aggression (PAS), and child abuse potential (CAPI). No paths in the model were significantly associated, and aggression did not significantly mediate the relationship between maternal trauma and child exposure to trauma (indirect effect = .071, $p = .48$). Therefore, hypothesis 2a was not confirmed: parental aggression did not mediate the relationship between number of types of maternal trauma exposure and child trauma exposure.

(b) Increased number of types of maternal trauma will be correlated with higher levels of parental punitiveness, which will be associated with increased child trauma exposure. SEM was used to test the mediating effects of the parental punitiveness on the relationship between maternal trauma and child trauma exposure (Figure 3). In this model, the association between maternal trauma and punitiveness was significant ($b = .245, p = .00$), and the association between punitiveness and child exposure to trauma was significant ($b = .919, p = .01$). In terms of the effect size for the significant association between maternal trauma and punitiveness, for every standard deviation increase in maternal trauma, punitiveness increases .313 standard deviations. The effect size for the association between punitiveness and child exposure to trauma is as follows: for every standard deviation increase in punitiveness, child exposure to trauma increases by .205 standard deviations. Additionally, parental punitiveness significantly mediated the relationship between maternal child and child trauma exposure (indirect effect = .225, $p = .02$). In terms of effect size in this model, the total effect between maternal trauma and child exposure to trauma is for every standard deviation increase in trauma, child exposure to trauma increases by .16 standard deviations, of which .064 standard deviations are due to the indirect effect, such that 39.8% of the total effect of the association between maternal trauma and child exposure to trauma is accounted for by the indirect effect of punitiveness. Therefore, hypothesis 2b was

PARENTING AND CHILD TRAUMA

confirmed: parental punitiveness mediated the relationship between number of types of maternal trauma and child trauma exposure.

(c) Increased number of types of maternal trauma will be correlated with lower levels of parental monitoring, which will be associated with increased child trauma exposure. SEM

was used to test the mediating effects of the parental monitoring on the relationship between maternal trauma and child trauma exposure with maternal education covaried (Figure 4). While there was a significant association between maternal trauma and child exposure to trauma ($b = .582, p = .03$), there were no other significant paths in the model, and parental monitoring did not significantly mediate the relationship between maternal trauma and child exposure to trauma (indirect effect = $-0.005, p = .74$). Therefore, hypothesis 2c was not confirmed: parental monitoring did not mediate the relationship between maternal trauma and child exposure to trauma.

(d) Increased number of types of maternal trauma will be correlated with lower levels of parental emotion regulation, which will be associated with increased child trauma exposure.

SEM was used to test the mediating effects of the parental emotion regulation on the relationship between maternal trauma and child trauma exposure using maternal SES and maternal education as covariates (Figure 5). There were no significant paths in the model, and parental emotion regulation did not significantly mediate the relationship between maternal trauma and child exposure to trauma (indirect effect = $.047, p = .28$). Therefore, hypothesis 2d was not confirmed: parental emotion regulation did not mediate the relationship between maternal trauma and child exposure to trauma.

Hypothesis 3: When all of the parenting variables are considered together, it is hypothesized that maternal emotion regulation will be a significant predictor of child trauma exposure even

PARENTING AND CHILD TRAUMA

after controlling for parental aggression, punitiveness and monitoring. SEM was used to test the mediating effects of all the parenting variables (emotion regulation, aggression, monitoring, and punitiveness) on the relationship between maternal trauma and child trauma exposure to determine which mediating variable best explained the relationship while controlling for the following covariates: maternal age, maternal SES, and maternal education (Figure 6). When all the parenting variables were considered together, there was a significant relationship between maternal trauma and punitiveness ($b = -.206, p = .02$), as well as between maternal trauma and aggression ($b = .217, p = .01$). However, there were no significant indirect effects in the model, indicating that none of the parenting variables mediated the relationship between maternal trauma and child exposure to trauma. Therefore, hypothesis 3 was not confirmed: maternal emotion regulation was not a significant predictor of child trauma exposure after controlling for aggression, punitiveness and monitoring. Furthermore, after controlling for maternal age, SES and education as covariates, none of independent and mediating variables significantly predicted child exposure to trauma.

CHAPTER 5: DISCUSSION

Overview

While there is evidence in the literature that trauma can be passed down from one generation to the next (e.g. Braveheart & DeBruyn, 1998), the intergenerational transmission of trauma is not inevitable (Widom, 1989) and the mechanisms through which trauma may be transmitted are not clear. Intergenerational transmission can be examined in groups that experience trauma on a societal level, e.g. slavery of African Americans in the United States (Sotero, 2006), as well as within family systems, as described by attachment (e.g. Main & Hesse, 1990), cognitive behavioral (e.g. Milner, 2003), and trauma (e.g. Haapasal & Pokela, 1999) theorists. Given the wide-ranging and detrimental repercussions of early and repeated exposure to trauma (Herman, 2002), both in childhood (van der Kolk, 2005) and adulthood (Cloitre et al., 2009), it is important to study intergenerational transmission to understand the ways in which one generation's trauma may impact the next. Furthermore, given the high prevalence of childhood exposure to trauma in the US (Finkelhor et al., 2014), it is imperative to study the phenomenon in order to provide effective interventions and support for at-risk families.

One theorized mechanism for the intergenerational transmission of trauma is parenting. Different understandings exist for the ways in which a parent's adaptations to her own trauma can disrupt her relationship with her child. A mother who is experiencing the sequela of trauma, e.g. dissociation, difficulty with emotion regulation and re-experiencing fear responses, may find her own ability to attend to tasks of parenthood such as regulating a child's physical and emotional states impaired (Schoore, 2001; Lyon-Ruth & Block, 1996). Furthermore, as an example of a way in which trauma can negatively impact parenting, individuals who were abused by their own parents may adopt inflexible and aggression-related schema for child

PARENTING AND CHILD TRAUMA

rearing that are activated when they themselves take on a parenting role (e.g. Milner, 2003 and Banyard, 1997). Emotion regulation is a central component of the parent-child relationship and also can be significantly impaired by experiencing trauma. Therefore, the potential role that emotion regulation plays in intergenerational transmission is especially of interest.

The current study examined parenting as a potential mechanism in the intergenerational transmission of trauma in a population of urban, low-income, predominately African American and Latina, mothers and their preadolescent children. This study aimed to fill a gap in the literature by studying individuals of minority racial and ethnic backgrounds, as well as pre and early adolescents who all represent understudied and vulnerable populations. The study investigated whether or not maternal trauma is associated with exposure to trauma in children and whether parenting variables including aggression, punitiveness, monitoring, and emotion regulation mediated intergenerational transmission. This discussion will summarize and interpret results, outline limitations of the study, consider clinical implications of the results, and propose questions for future research.

Study Results

Consistent with the first hypothesis and the literature, the study found a significant but small association between maternal trauma and child exposure to trauma, lending some support to the idea of intergenerational transmission of trauma. Additionally, the study found evidence that maternal trauma interferes with parenting, as a significant association between maternal trauma and increased aggression and punitiveness existed. Punitiveness was the only parenting variable that mediated the relationship between maternal trauma and child exposure to trauma, and counter to the proposed hypotheses, there were no significant findings related to maternal

PARENTING AND CHILD TRAUMA

emotion regulation and its association with child exposure to trauma. Each of these findings will be discussed in greater detail below.

Punitiveness. Of the four parenting variables hypothesized to mediate the relationship between maternal trauma and child exposure to trauma, punitiveness was the only one with a significant indirect effect. This result lends support to the idea that punitiveness may explain the relationship between maternal trauma and child trauma, and supports prior research indicating an association between maternal trauma and more punitive parenting style (Banyard, 1997; Banyard, Williams, & Siegel, 2003). Punitiveness is a measure of a parent's use of harsh disciplinary responses to a child's misbehavior. Following from Baumrind (1966), punitiveness, also characterized as authoritarian parenting, is hypothesized to put children at a risk for maltreatment and is associated with parental child abuse potential (Rodriguez, 2010; Haskett, Scott, & Fann, 1995). In contrast to the other parenting variables considered in this study – aggression, monitoring and emotion regulation – punitiveness is a behavioral measure of parental disciplinary actions. On the self-report measures used in this study, the mothers endorsed specific disciplinary behaviors like “spank” and “yell at them,” (PPS; Blane, Miller & Leonard, 1988) rather than items on the scales that measured aggression, e.g. “A parent must use punishment if they want to control a child's behavior” and “Sometimes I fear that I will lose control of myself” (CAPI, Form VI; Milner 1994). Therefore, understanding why punitiveness might mediate the relationship between maternal trauma and child exposure to trauma, involves considering the effects of harsh punishments.

Harsh disciplinary responses by parents are generally found to have negative psychological consequences for children. Both harsh verbal and physical punishment are associated with higher levels of child externalizing disorders (Criss et al. 2002) and internalizing

PARENTING AND CHILD TRAUMA

problems (Laskey & Cartwright-Hatton, 2009). Similar findings are present in studies that focus on adolescents, as harsh disciplinary tactics are associated with depression and externalizing behavior in adolescents (Bender et al., 2007). In trying to understand why parental punitiveness may influence children to develop internalizing and externalizing problems, Weiss, Dodge and Bates (1992) posit that harsh physical discipline may cause a child to become aggressive and develop a maladaptive style of processing information, which in turn causes them to see the world as a hostile place and then access aggressive responses in coping with that hostility. While the effects of punitive parenting may be mediated by other aspects of parenting -- for example, some studies find that high levels of positive parenting can reduce or moderate the association between harsh discipline and child behavior problems (Deater-Deckard and Dodge 1997) others, however, found an association between harsh punishment (both verbal and physical) and child externalizing behaviors regardless of the presence of positive parenting (McKee et al., 2007) emphasizing how detrimental harsh discipline may be regardless of the presence of other more protective types of discipline.

These negative outcomes of punitive discipline may lead to exposure to trauma in children in a variety of ways. Externalizing disorders and aggression might lead to exposure to trauma because externalizing behavior in adolescents is associated with episodes of peer violence in school settings (Arseneault et al., 2006), as well as anti-social and delinquent behaviors, such as drug abuse, which can lead to legal, economic and social problems (Jimenez, Barbero et al., 2012). Furthermore, externalizing disorders are associated with impulsivity, which may predispose individuals to mistrust others, and to feelings of anger, which in turn promote expression of aggressive behavior (Vigil-Colet and Codorniu-Raga, 2004). In these ways, the sequela of parental punitiveness involving externalizing behaviors in their children can create a

PARENTING AND CHILD TRAUMA

greater likelihood of exposure to trauma. The same is true for internalizing behaviors associated with experiencing parental punitiveness. For example, depression in adolescence is correlated with social deficits (Gotlib, Lewinsohn & Seeley, 1998) which can cause individuals to feel lonely, be isolated, and have a diminished support system, thereby removing protective aspects of life which may shield them from trauma. Additionally, internalizing disorders are associated with academic difficulties and increased rates of school dropout (Quiroga, Janosz, Bisset and Morin, 2013), as well as substance abuse and suicidality (Avenevoli et al., 2015), all of which may increase the chance of being exposed to or directly influenced by violence and other traumatic forces.

Despite robust findings regarding the negative consequences of harsh discipline, there is a debate in the literature regarding the parameters of harsh disciplinary responses and their negative outcomes. Relevant for the population of the present study, some argue that parenting and punishment are culturally bound (Gershoff, 2002), and since the initial studies of the negative effects of authoritarian parenting were only conducted with white subjects, those findings are not applicable to non-white populations (Lin & Fu, 1990). The punitiveness scale used in this study includes corporal punishment as one of the higher ranked punitive responses. More recent research indicates that race moderates the detrimental effects of corporal punishment: while physical discipline, e.g. spanking, was associated with higher levels of externalizing behavior in adolescents of European American decent, it was associated with lower levels of behavior problems for African American adolescents (Lansford, Criss, Dodge, Shaw, Pettit & Bates, 2009), and that corporal punishment was associated with problem behavior in White and Latino children, in comparison to African American children (McLeod & Nonnemaker, 2000).

PARENTING AND CHILD TRAUMA

Why might these racial differences exist? Ecological-transactional models of youth adjustment consider the interaction between family, cultural and contextual factors in trying to understand differences in the outcome of punitive discipline (Cicchetti & Rizely, 1981). Therefore, it is important to consider levels of neighborhood disorder when studying punitive parenting in low SES communities of color: for youth and families of color living in more dangerous neighborhoods, punitive discipline may be seen as a way of ensuring youth's survival, and therefore, may have fewer adverse effects on youth in disordered neighborhoods (Mosby, Rawls, Meehan, Mays & Pettinari, 1999). For example, Roche, Ghazarian, Little, and Leventhal (2011) found that with less neighborhood disorder, punitive discipline was associated with increased delinquency for boys and increased depression for girls. This study used a similar parental self-report measure as the present investigation and used a large sample of urban, predominantly African American and Latino, low SES families. Roche and colleagues (2011) argue that level of neighborhood disorder may moderate the effects of punitive discipline because adolescents perceive punitive punishment as justified in neighborhoods with more disorder, and the adolescent value of autonomy may be less of a priority if there are more concerns for safety, i.e. parental authority is perceived as protective. In addition, in neighborhoods with less disorder, increased punitiveness could lead to externalizing and internalizing behaviors because adolescents feel overly regulated and respond by turning anger inwards or outwards.

Given the predominately African American and low SES population of the present study, the finding that punitiveness did partially explain the relationship between maternal trauma and child exposure to trauma is surprising in the context of the research on the moderating effects of race and neighborhood disorder on the deleterious effects of harsh punishment. This finding

PARENTING AND CHILD TRAUMA

could be related to the theory that the effects of harsh discipline are not as harmful based on children's perception of the discipline, e.g. if the type of discipline is perceived to be culturally normative (Lansford et al., 2005) and protective (Roche, 2006). Perhaps the punitiveness reported in the study was experienced as overly harsh and not normative because of the overlay of factors of traumatic stress that might be at play. In other words, maybe the ways in which maternal trauma disrupted aspects of parenting contributed to their children feeling rejected, such that what might have been considered protective or normative without the overlay of trauma was experienced as rejecting.

In addition, punitiveness may have mediated maternal trauma and child exposure to trauma in the present study due to the particular effect punitiveness may have in the pre/early adolescent population of the child cohort. Adolescence is a vulnerable time for an individual to experience punitive parenting, as punitive parenting practices in adolescence are associated with many adverse outcomes (Bronstein et al., 1996). A punitive parental approach during pre/early adolescence is particularly detrimental in early adolescence because of the greater salience of parenting at that stage (Collins & Steinberg, 2006) and the increased vulnerability of the stage (Dahl, 2004). Increased punitiveness with pre/early adolescents could serve to weaken the protective factors of the parent-child relationship and increase the adolescents' vulnerabilities during an already risky developmental period. Adolescence is also a critical time for the establishment of social relationship skills necessary in adulthood, as brain structures tied to adult social functioning, such as the prefrontal and parietal cortex, take on their final forms during the stage (Blakemore & Choudhury, 2006). Furthermore, maintaining a supportive relationship with parents in adolescence is challenging (Allen et al., 1994), as an essential task of adolescence is to establish autonomy. Therefore, the finding that punitiveness mediated the relationship between

PARENTING AND CHILD TRAUMA

maternal trauma and child exposure to trauma may also be explained by the developmental stage of the child cohort and the vulnerabilities inherent in pre/early adolescence.

Therefore, the finding that of all the parenting variables examined, punitiveness was the only one found to mediate the relationship between maternal trauma and child exposure to trauma makes sense in the context of the negative consequences of harsh discipline, the ways in which these consequences lead to exposure to trauma in children, and the particular vulnerabilities punitive discipline may pose to pre/early adolescents. Punitiveness also may have significantly mediated the relationship between maternal trauma and child exposure to trauma because unlike the other variables in the study, which involve self-report of emotion and cognition, punitiveness is a behavioral measure. Given that one aspect of experiencing complex trauma can be a diminished capacity to express and reflect upon internal cognitive and emotional states (van der Kolk, McFarlane, & Weisaerth, 1996) it could be that the self-report measures are unreliable for a population who may struggle to name and report their own affective states.

Intergenerational Transmission of Trauma The study lent some support to the theory that trauma can be passed from one generation to the next, as increased maternal trauma was associated with increased child trauma exposure, albeit with a small effect size. Preliminary analyses indicated that the association between maternal trauma and child exposure to trauma existed regardless of demographic variables including mother's race, education level, SES, age, and child's sex, which is consistent with Milner et al's (2010) finding that demonstrated the intergenerational transmission of trauma across gender, race/ethnicity, age, marital and parenting status. It is important to contextualize this finding within the literature regarding the intergenerational transmission of trauma, which underscores the complexity inherent in studying the construct.

PARENTING AND CHILD TRAUMA

While the conceptual framework for understanding the intergenerational transmission of trauma is robust and present across multiple theoretical orientations in psychology, e.g. psychodynamic, attachment, and cognitive behavioral theory, the construct is more challenging to study empirically given the multiple time points and possible confounding variables involved. Some strong empirical evidence exists supporting the intergenerational transmission of trauma, though other studies have mixed outcomes. For example, while some studies of Holocaust survivors found heightened psychological distress in children and grandchildren of survivors (Bar-On et al., 1998), others have not found psychopathology in the second or third generation (Sagi-Schwartz, van IJzendoorn, & Bakermans-Kranenburg, 2008). In a meta-analysis of war veterans exposed to trauma, Dekel and Goldblatt (2008) found evidence of the intergenerational transmission, noting that the more severe veterans' distress and trauma, the greater distress observed in their children. They express the need to understand more about other factors that might contribute to the transmission of trauma including the role of partners, the larger cultural and social environments, as well as understanding protective factors e.g. the quality of the parenting, birth order, and the child's temperament. The conflicting findings of the literature, as well as the wide-range of potential confounding variables, emphasize the complexity inherent in understanding the mechanisms through which trauma may be passed along from one generation to the next.

The complexities inherent in studying populations such as Holocaust survivors and war veterans also underscores the challenges of examining the intergenerational transmission of trauma in populations with complex trauma where the source of trauma is not isolated to a specific era like the population of the present study. In historical events like the Holocaust and other wars, traumatization directly impacts one generation and is often isolated to that

PARENTING AND CHILD TRAUMA

generation, such that studying the intergenerational effects is easier because the younger generations were not exposed to the original trauma. However, as the literature reviewed above suggests, even in populations who do experience trauma via a more discrete event like the Holocaust, it is still complicated to study whether and how that trauma maps onto their offspring. Therefore, it is even more complex to study the intergenerational transmission of trauma in populations where there are multiple sources of trauma that may be situated within a family system, as well as a larger societal context, and/or impact multiple generations at the same time, i.e. the population in the current study.

Another important variable to consider when interpreting the small association between types of maternal trauma and child exposure to trauma in the present study are larger societal variables including racism and poverty that could have influenced the presence of trauma in both of the generations in the study. Factors like racism and poverty could increase the likelihood of maternal trauma, as well as child trauma, creating a spurious association. While the current investigation did control for race and SES in the analyses, the sample was relatively homogenous, and therefore, did not allow for comparison within groups of participants with different races or socioeconomic classes.

One relevant section of literature that does focus on the intergenerational transmission of trauma in populations where the source of trauma is not a specific traumatic event is research that examines transmission of child abuse across family generations. Many such studies find that parents with their own histories of this kind of abuse are more at risk for abusing their children, though many parents with abuse histories do not abuse their own children (Widom, 1989). For example, physical and sexual child abuse victims abuse their own children at higher rates than national average (Dixon, Hamilton-Giachritsis, & Browne, 2005), and parental

PARENTING AND CHILD TRAUMA

exposure to maltreatment in childhood is also associated with maltreatment of children (e.g. Bosquet, Enlow, Englund, & Egeland, 2016; Lieberman, Chu, Van Horn, & Harris, 2011). Again, it is evident in these studies that not all parents with abuse or maltreatment histories end up abusing or neglecting their own children. For examples, Dixon, Hamilton-Giachritsis and Brown (2005) found several factors -- including parenting under 21 years of age, having a history of mental illness or depression, residing with a violent adult, and using negative parenting styles -- that fully mediated the relationship between parents' abuse histories and children's exposure to abuse. In other words, their study directly addresses the question of why abuse is transmitted through the generations in some instances but not others, and finds that other risk factors elevate the chances of transmission. Therefore, while there are some mixed findings in the literature regarding the intergenerational transmission of trauma, the current study lends empirical support to the presence of the phenomenon.

Another component of the methodological challenges inherent in studying the intergenerational transmission of trauma is the question of how to measure trauma in the second generation. The present study examines exposure to trauma in the child cohort, however many other studies measure trauma more broadly as forms of psychological distress. For example, studies will consider outcomes such as depression and anxiety (Leen-Feldner, Feldner, Bunaciu, & Blumenthal, 2011); oppositional defiant disorder and behavioral problems (Zajac & Kobak, 2009); insecure or disorganized attachment (Bosquet, Enlow, Egeland, Carlson, Blood, & Wright, 2014); emotion regulation difficulties (Pat-Horenczyk et al., 2015); and PTSD (Yehuda, Bell, Bierer, & Schmeidler, 2008). Using exposure to trauma as an outcome variable in the present study extends the literature by focusing on traumatic exposure rather than psychiatric distress. This choice of the outcome variable compliments the existing literature by focusing on

PARENTING AND CHILD TRAUMA

a more concrete measure of trauma in the second generation, rather than looking at more global forms of psychological distress, which may lead to or contribute to traumatic stress but do not equal trauma in and of themselves. However, by choosing an outcome variable that does not take into account a wider range of symptomatic presentations, the current study is likely not capturing all of the potential negative sequela of trauma in the second generation.

Therefore, the current study contributes to understanding the presence of the intergenerational transmission of trauma in an understudied population with complex forms of trauma. As reviewed here, the literature emphasizes the complexities in studying the intergenerational transmission of trauma and the current study adds to the literature by investigating forms of trauma that are not isolated to a specific historical event, as well as taking into account multiple confounding variables. This is an important contribution given the ubiquity of complex trauma and the ways in which it presents a significant public health concern. Additionally, the variables measured in the current study aim to broaden the scope of types of trauma studied by looking at cumulative maternal trauma and child exposure to trauma rather than more general forms of psychological distress as manifestations of trauma.

Relationship between Maternal Trauma and Parenting The present study also indicated that maternal trauma negatively impacts parenting, as analyses showed that maternal trauma was associated with increased punitiveness and aggression. This finding is in concert with multiple theoretical orientations' frameworks for understanding the effects of trauma through different generations and illustrates the theoretical basis for understanding why maternal trauma would be associated with aggression and punitiveness. For example, attachment theory sees aggression and harsh punishment by a parent as a manifestation of unresolved traumatic loss and conflicting internal representations in mothers who have experienced relational trauma that make them

PARENTING AND CHILD TRAUMA

vulnerable to perpetuating disorganized attachment styles in their babies (Lyons-Ruth, Bronfman & Atwood, 1999). Cognitive behavioral theories, such as Social Information Processing Theory, hold that parents who have trauma histories have pre-existing cognitive schema related to parenting that influence how they perceive and treat their children, e.g. parents who have been abused have aggression related schema related to negative affect that trigger them to use aggression when faced with challenging parenting situations (Milner, 2003). Additionally, the trauma-based model of intergenerational transmission of trauma posits that trauma symptoms, like avoidance, arousal and anxiety, cause aggression in parenting (Haapasal & Pokela, 1999). Therefore, the association between maternal trauma and aggression and punitiveness in the current study can be understood through a diverse set of theoretical models for the intergenerational transmission of trauma.

In addition to supporting a variety of theoretical models, the association found between maternal trauma and aggression and punitiveness, is also in line with empirical findings about the disruptive effects of trauma on parenting. Cohen, Hien and Batchelder (2008) used the same data set as the present investigation and also found an association between higher levels of cumulative maternal trauma and negative parenting outcomes. In addition, one subset of the research on the ways in which trauma interferes with the ability to parent argues that traumatized parents can be less emotionally or functionally available for their children (Walker, 1999) and that past trauma may lead to dissociation, which in turn, leads to inconsistencies in parenting (Collin-Vézina, Cyr, Pauze, & McDuff, 2005). Others posit that trauma can disrupt the ways in which parents perceive their children, i.e. parents with trauma histories can interpret children as acting with malicious intentions and therefore respond with harsher discipline (Slep & O’Leary, 1998). Furthermore, a number of studies link parental posttraumatic stress symptoms to

PARENTING AND CHILD TRAUMA

decreased parenting satisfaction and parent–child relationship quality (e.g., Berz, Taft, Watkins, & Monson, 2008; Ruscio, Weathers, King, & King, 2002; Samper, Taft, King, & King, 2004), suggesting parental traumatic stress may have harmful effects on the ways in which parents view and potentially treat their children. Therefore, the association found between maternal trauma and parenting variables such as aggression and punitiveness, is in-line with multiple theoretical orientations, as well as a large body of empirical research.

While the present study found an association between maternal trauma and aggression and punitiveness, it found no association between maternal trauma and monitoring. Given this review of the research, it is puzzling why the present study did not find any association between maternal trauma and monitoring. If trauma disrupts one’s capacity to parent because of symptoms of traumatic stress such as dissociation, it would seem like higher reported trauma should be associated with lower monitoring, though this was not the case. One variable that may have influenced this seemingly contradictory finding is neighborhood context; given that the sample is predominately low-income, racial/ethnic minority mothers, their neighborhood contexts might necessitate increased monitoring to protect their children such that for this population experiencing trauma did not disrupt monitoring capacities. Another explanation might be that other symptoms of traumatic stress, like hypervigilance, were more present for the sample studied so that monitoring was not as disrupted. Also, Collin-Vézina et al’s (2005) study about trauma, dissociative symptoms, and parenting concluded that dissociation can lead to inconsistencies in monitoring rather than overall weaknesses in monitoring, so it could be that the mothers’ self-reports in the present investigation reflected their ability to monitor some of the time, which is why monitoring did not significantly mediate maternal trauma and child exposure to trauma.

PARENTING AND CHILD TRAUMA

Emotion Regulation Contrary to the central hypothesis of this study, emotion regulation did not mediate the relationship between maternal trauma and child trauma exposure, and did not explain the association between maternal trauma and child trauma exposure above and beyond the other parenting variables examined. The lack of a finding related to emotion regulation is surprising given the substantial theoretical and empirical evidence pointing to the centrality of emotion regulation in parenting (for a review see Rutherford, Wallace, Laurent & Mayes, 2015) and the numerous ways in which emotion regulation capacities are disrupted by trauma (e.g. Cloitre, Stovall-McClough & Han, 2005). One possible reason for the lack of findings related to emotion regulation is that the composite scale used in this study did not fully capture the construct. The composite scale was used because this study is a secondary data analysis, and while many of the measures in the primary study asked about emotion regulation, none of them were specifically emotion regulation scales. Perhaps had an emotion regulation scale with greater construct validity been available and used, the results would have shown that emotion regulation mediated the relationship between maternal and child trauma.

While emotion regulation was not found to mediate the relationship between maternal trauma and child exposure to trauma, in preliminary analyses, there was a significant correlation ($r = .63, p = .00$) between emotion regulation and child abuse potential (CAPI), meaning that as emotion regulation scores got worse, child abuse potential increased. This association suggests a relationship between weaker emotion regulation capacities and disruptions of parenting, and is in line with findings from Hien et al's (2010) study that found that weakness in emotion regulation, measured as anger arousal and reactivity, predicted child abuse potential above and beyond other factors that may impair parenting such as depressive and substance use disorders.

Limitations of and Strengths of Study

The current study has both strengths and limitations related to the type of data, the study's population, and the design. The study uses self-report data from one time-point. Given that some of the questions related to child abuse and neglect and the consequences of reporting child maltreatment, mothers may not have reported accurately. Additionally, parenting is a complex construct often involving partners and other family members. In order to more accurately study the intergenerational transmission of trauma and better understand the protective and risk factors stemming from parenting, perspectives from all primary caregivers could be included. Since the data was collected at one-time point, causality of the variables measured cannot be addressed. While measuring maternal trauma by number of types of traumas experienced captured aspects of the construct of complex trauma more than a binary trauma variable would, it did not allow for a clear comparison with mothers who did not experience trauma. Such a comparison would have helped shed light on what part of the findings was due to the normative tumultuousness of parenting in pre/early adolescence and what could be related to strained parenting due to trauma.

Another limitation of the study related to the outcome variable – child exposure to trauma. Using child exposure to trauma as the outcome variable, captured the intergenerational construct in an explicit way, rather than measuring more global measures of distress or psychopathology in the children, e.g. externalizing or internalizing disorders. Given the review of the literature arguing that these measures of distress can lead to exposure to trauma, a limitation of the study is that there could be unmeasured variables, like the presence of internalizing and externalizing disorders in the children, that contributed to the relationship between maternal trauma and child exposure to trauma. Additionally, the study measured child

PARENTING AND CHILD TRAUMA

exposure to trauma using the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996). One methodological limitation of the Exposure to Violence Scale is that it is a measure of community violence, so while it does capture child exposure to trauma, it does so in a way that takes into account neighborhood disorder, thereby potentially introducing a spurious effect to the study. In other words, it could be that the exposure to trauma in both the mother and the child populations of the study came from exposure to neighborhood disorder informed by larger societal problems like racism and poverty that had a traumatic effect on each generation. In that case, it could be that trauma was not passed down from one generation to the next but rather was experienced by each generation due to exposure to similar traumas stemming from factors related to neighborhood disorder and discrimination.

A major strength of the study was the representation of an under-researched and underserved population. The findings of the study described a predominantly low-income, racial minority population, as well as a population of pre/early adolescents who comprise a vulnerable and understudied cohort. The sample size was also good in comparison to other similar studies. One limitation regarding the population was that it is relatively homogeneous, and therefore, comparisons between the racial, SES, and age groups present was not possible. Further research would benefit from including a more diverse sample, especially by including larger groups of different races and ethnicities, as well as SES groups, so that comparisons between groups could help shed more light on the ways in which race, ethnicity and class influence parenting and the manifestations of trauma. This is especially important given how embedded parenting and disciplinary practices are in culture.

In terms of the design, the analyses controlled for demographic variables, strengthening the substance of the findings. A weakness of the design was that some of the parenting variables

PARENTING AND CHILD TRAUMA

overlap, e.g. aggression and punitiveness. Also, although items on the aggression and punitiveness scales that would have constituted abuse, and therefore would have required mandated reporting by the investigators, were removed from the measures, there still may have been some overlap between some of the mediating variables and the outcome variable, i.e. a harsh punitive disciplinary tactic, like hitting, would constitute child exposure to trauma. The potential overlapping between the variables studied point to the challenges in parsing out the different potential mechanisms through which trauma may be transferred from one generation to the next. Also, while measuring aggression as a latent variable composed of measure of psychological aggression, physical assault, and child abuse potential allowed for capturing multiple facets of a construct that is challenging to measure due to the complexities in self-reporting aggression against a child, combining the two measures of actual aggressive acts with a measure of potential aggression could have diminished the construct validity of the variable. If each of the measures of aggression and the measure of child abuse potential had been examined separately in the model, rather than as a latent variable, other associations may have been present.

Another limitation of the study design involved the way in which emotion regulation was measured. Because the study was a secondary data analysis, emotion regulation was assessed using a composite scale rather than a scale with more established reliability and validity. Finally, an additional strength of the study was that the design also used data from two generations to capture the complex construct of intergenerational transmission of trauma. This built on other studies in the literature that focus on one link in the transmission, i.e. maternal trauma's relationship to parenting, or parenting's influence on children's exposure to trauma. While data from two generations was considered, the reverse path in which a child's behavior or

PARENTING AND CHILD TRAUMA

temperament might influence parenting, e.g. by necessitating greater punitiveness or monitoring, or provoking aggressive behavior, was not considered in the current study's proposed model.

Clinical Implications and Areas for Further Research

This study lends some support for the idea of intergenerational transmission of trauma and identifies a few ways in which trauma interferes with parenting, heightening appreciation for the vulnerabilities of parenting with a trauma history. Given the associations between maternal trauma and increased maternal aggression and punitiveness, this study suggests that support for parents coping with trauma around healthy discipline could be an important intervention. Programs focused on fostering secure attachments between mothers and babies offer support to mothers coping with trauma during their babies' infancies and early years. Similar programs could be developed for parents of pre and early adolescents. It could be that arming parents with strategies to cope with the challenges of adolescence could diminish aggressive and punitive parenting styles and serve to bolster the protective functions of parenting. Support for parents around discipline needs to be culturally sensitive and respect that styles of parenting and discipline are culturally bound.

Though the current study did not produce findings to support the role of emotion regulation in the intergenerational transmission of trauma, given its salience in the trauma and parenting literature, it behooves further investigation. Future studies could use measures such as the Difficulty in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) or the Emotion Regulation Questionnaire (ERQ; Gross & John, 2003), which may better capture the construct of emotion regulation than the composite scale used in this study. In order to understand more about the finding that punitiveness mediates the relationship between maternal trauma and child

PARENTING AND CHILD TRAUMA

exposure to trauma, a longitudinal study gathering data at multiple time points over childhood could be conducted. Longitudinal data would help clarify whether punitiveness is more or less detrimental during adolescence than other developmental stages and also allow for causal conclusions.

Concluding Remarks

This study contributes some significant information to the literature regarding the role parenting plays in the intergenerational transmission of trauma. Analyses demonstrate a small but significant association between maternal trauma and child exposure to trauma, lending support to the idea that trauma can be passed down from one generation to the next. Additionally, increased maternal trauma was associated with negative parenting practices, e.g. aggression and punitiveness, indicating that trauma can interfere with a mother's ability to parent her child. Finally, punitiveness was the only parenting variable studied shown to mediate the relationship between maternal trauma and child exposure to trauma indicating that using harsh disciplinary measures may be a mechanism in the intergenerational transmission. The present study focused on an under-researched, low SES and predominately African American population, as well as a cohort of pre and early adolescents, thereby extending the literature to an at-risk population. The study's design controlled for demographic variables and captured data from two generations, though limitations of the design included using all self-report data and only collecting data from one-time point. The study's hypotheses about the salient role emotion regulation plays in the transmission were not confirmed, however, given the strong theoretical and empirical data supporting emotion regulation's role in parenting and in coping with trauma, further research is necessary.

PARENTING AND CHILD TRAUMA

APPENDIX A: TABLES

Table 1. Factor Analysis Rotated Component Matrix^a

	Component		
	1	2	3
TAS_tot TAS total score	.806		
NAS_arous NAS arousal avg	.790		
TAS_descr TAS factor 2: difficulty describing feelings	.725		
NAS_cog NAS cognitive avg.	.720		
TAS_ident TAS factor 1: difficulty identifying feelings	.675		
dotm_flex DOT mother: flexibility.rigidity	-.667		
NAS_behav NAS behavior avg.	.666		.340
cope_bd COPE: behavioral disengagement	.621		
NAS_partB NAS part b average	.611		
cope_deny COPE: denial	.608		
TAS_extern TAS factor 3: externally oriented thinking	.524		
cope_md COPE: mental disengagement	.511	.298	
dotm_actgen DOT mother: activity level general	.463		
dotm_mood DOT mother: mood (pos = better)	-.429	.359	
dotm_aw DOT mother: approach/withdrawal	-.429	.299	
dotm_actslp DOT mother: activity level sleep	.355		
dotm_dist DOT mother: distractibility (pos=better)	-.307		
cope_su COPE: substance use			
cope_sca COPE: suppression of competing activities		.673	
cope_plan COPE: planning	-.294	.654	.261
cope_activ COPE: active coping	-.267	.618	.277
cope_prg COPE: positive reinterp and growth	-.345	.614	
cope_restr COPE: restraint		.535	
cope_humr COPE: humor		.493	
aim score-- affect intensity		.487	
cope_relig COPE: religious coping		.458	
cope_iss COPE: instrumental social support		.452	.421
dotm_pers DOT mother: persistence	-.302	.414	.344
cope_acc COPE: acceptance		.412	
dotm_rhy_slp DOT mother: rhythmicity - sleep			.674
dotm_rhy_eat DOT mother: rhythmicity- eating			.654
dotm_rhy_d DOT mother: rhymicity- daily habits			.622
cope_ues COPE: use of emotional social support		.375	.486
cope_fove COPE: focus on and venting emotions	.303		.442

PARENTING AND CHILD TRAUMA

Extraction Method: Principal Component Analysis.

Rotation Method: Quartimax with Kaiser Normalization.^a

a. Rotation converged in 4 iterations.

Note. TAS=Toronto Alexithymia Scale (Bagby, Parker, & Taylor, 1994), DOT=Dimensions of Temperament Scale-Revised Adult Version (Windle & Lerner, 1986), COPE = Coping Orientations to Problems Experienced Scale (Carver, Scheier, & Weintraub, 1989), AIM=Affect Intensity Measure (Larsen, 1984), NAS = Novaco Anger Inventory (Novaco, 2003)

PARENTING AND CHILD TRAUMA

Table 2. Demographic Characteristics of Sample

Variable	Category	<i>M</i>	<i>(SD)</i>
Mother's Age	-	37.44	6.37
Child's Age	-	11.53	1.88
		<i>n</i>	<i>(%)</i>
Mother's Race	Black	131	68.9%
	Latina	39	20.5%
	White	9	4.7%
	Asian	1	.5%
	Other	47	25.1%
Mother's Education	< High School	59	31.5%
	Completed High School	41	21.9%
	Some College	76	40.6%
	Completed College	8	4.3%
	Post Grad Training	3	1.6%
Mother's Marital Status	Single	98	52.4%
	Married/Living with Partner	46	24.6%
	Divorced/Separated	39	20.9%
	Widowed	4	2.1%
Mother's Employment Status	Working (full time and part time)	132	70.6%
	Student	3	1.6%
	Homemaker	18	9.6%
	Not Working (retired, disability)	32	17.1%
Mother's Income	0	5	2.6%
	>0 - 500	27	14.4%
	501 - 1000	59	31.6%
	1000 - 1500	46	24.6%
	1500 - 2000	20	10.7%
	2000 - 2500	11	5.9%
	> 2500	19	10.2%
Child's Sex	Male	95	50.8%
	Female	91	48.7%

PARENTING AND CHILD TRAUMA

Table 3. Types of Maternal Trauma

Type of Trauma	Experienced	
	<i>n</i>	(%)
Childhood sexual abuse	77	41.2%
Childhood physical abuse	68	36.4%
Witnessed violence as a child	34	18.2%
Experienced partner violence as an adult	48	25.7%
Adulthood physical assault	79	42.2%

Table 4. Trauma Exposure of Children in Sample

Type of Trauma	Experienced		Witnessed	
	<i>n</i>	(%)	<i>n</i>	(%)
Chased	30	16.0%	91	48.7%
Beaten up	60	32.1%	129	69.0%
Attacked with a weapon (not gun)	7	3.7%	41	21.9%
Shot	0	0%	21	11.2%
Shot at but not wounded	2	1.1%	19	10.2%
Heard gunfire nearby	110	58.8%		
Serious accident	25	13.4%	60	32.1%
Seen someone killed by violence	15	8.0%		
Sexually assaulted	9	4.8%		
Someone threaten to hurt	22	11.8%	38	20.3%
Found a dead body	4	2.1%		
Been in a natural disaster	15	8.0%		
Been in a situation where you thought you or another person would die	12	6.4%		
Told someone was shot and hurt	38	20.3%		
Told someone you knew was killed	49	26.2%		
Told someone you knew committed suicide	7	3.7%		
Someone you knew died or was injured suddenly	47	25.1%		
Told someone you knew was raped	25	13.4%		

PARENTING AND CHILD TRAUMA

Table 5. Reliability for Self-Report Measures

Measure	Cronbach's Alpha	N Items
C_TRA	.77	25
CAPI	.93	77
PUN	.90	21
MON	.71	8
PAG	.58	5
PAS	.73	6

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996); CAPI = Child Abuse Potential Inventory (Milner 1994); PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

Table 6. Missing Data

Measure	n (%) Missing	N (%) Valid
C_TRA	3 (1.5%)	187 (98.4%)
ER	17 (8.9%)	173 (91.1%)
CAPI	21 (11.1%)	169 (88.9%)
PUN	4 (2.1%)	183 (97.9%)
MON	5 (2.6%)	185 (97.4%)
PAG	6 (3.2%)	184 (96.8%)
PAS	6 (3.2%)	184 (96.8%)
M_TRA	3 (1.6%)	187 (98.4%)

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994); PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); M_TRA = Maternal Trauma Composite Scale

PARENTING AND CHILD TRAUMA

Table 7. Summary Statistics for Valid Sample

Measure	N	Min	Max	Mean	SD	Skewness	Kurtosis
ER	172	-2.39	2.59	-0.01	0.99	0.09	-0.17
C_TRA	184	0.00	27.00	5.74	4.23	1.15	2.53
MON	183	5.00	36.00	18.0	5.49	0.47	1.22
M_TRA	187	0.00	4.00	1.37	1.21	0.54	-0.63
CAPI	185	10.00	427.00	159.63	94.61	0.62	-0.43
PUN	183	31.00	147.00	107.14	14.22	-1.74	6.07
PAG	183	0.00	24.00	9.70	5.99	0.21	-0.88
PAS	183	0.00	20.00	3.51	4.45	1.50	1.99
Valid N (listwise)	183						

Note. ER = Emotion Regulation Composite Scale; C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); M_TRA = Maternal Trauma Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 8. Associations between Mediating and Dependent Variables to Child Sex: Independent *t*-tests

Variable	Male (<i>n</i> = 94)		Female (<i>n</i> = 89)		<i>t</i>	<i>df</i>	<i>p</i>
	<i>M</i>	(<i>SD</i>)	<i>M</i>	(<i>SD</i>)			
C_TRA	6.17	(4.49)	5.17	(3.75)	1.63	181	.10
ER	0.05	(0.98)	-0.09	(0.99)	0.92	169	.36
CAP	157.10	(91.96)	160.75	(97.21)	-0.26	182	.79
PUN	106.85	(15.10)	107.45	(13.30)	-0.28	181	.77
MON	18.03	(5.00)	17.87	(6.01)	0.21	181	.84
PAG	9.23	(6.32)	10.13	(6.32)	-0.96	181	.34
PAS	3.46	(4.51)	3.57	(4.42)	-0.18	181	.86

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAP = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 9. Associations between Mediating and Dependent Variables to Mother’s Age and SES: Pearson Correlations

	Mother’s Age			SES		
	<i>r</i>	(<i>n</i>)	<i>p</i>	<i>r</i>	(<i>n</i>)	<i>p</i>
C_TRA	-.012	(184)	.87	-.05	(178)	.50
ER	-.05	(172)	.52	-.32**	(167)	.00
CAPI	-.07	(185)	.35	-.25**	(179)	.00
PUN	.14	(183)	.05	.11	(177)	.13
MON	.10	(183)	.16	-.07	(177)	.38
PAG	.01	(183)	.95	.09	(177)	.24
PAS	-.15*	(183)	.04	.12	(177)	.11

* correlation is significant at the .05 level (2-tailed)

** correlation is significant at the .01 level (2-tailed)

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 10. Associations between Mediating and Dependent Variables to Mother’s Education Level: Spearman’s Rho

	Mother’s Education		
	<i>r</i>	(<i>n</i>)	<i>p</i>
C_TRA	-.06	(184)	.40
ER	-.34**	(172)	.00
CAP	-.21**	(185)	.00
PUN	.05	(183)	.54
MON	.20**	(183)	.00
PAG	.13	(183)	.09
PAS	.07	(183)	.35

** correlation is significant at the .01 level (2-tailed)

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAP = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 11. Relationship between Mediating and Dependent Variables to Mother’s Race: Analysis of Variance

Measure	Black	White	Other	<i>F</i>	<i>df</i>	<i>p</i>
	(<i>n</i> = 127)	(<i>n</i> = 9)	(<i>n</i> = 47)			
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)			
C_TRA	5.78 (6.51)	5.93 (4.24)	5.13 (3.72)	0.61	2, 180	.54
ER	0.02 (0.99)	0.04 (0.76)	-0.08 (1.03)	0.18	2, 179	.84
CAPI	168.19 (94.76)	149.56 (102.35)	136.26 (90.68)	2.03	2, 181	.13
PUN	106.23 (14.90)	108.75 (12.60)	109.30 (12.55)	0.84	2, 179	.43
MON	17.39 (4.79)	22.00 (4.42)	18.67 (7.04)	3.6	2, 179	.03
PAG	9.52 (6.08)	9.00 (3.84)	10.20 (6.16)	0.27	2, 179	.76
PAS	3.52 (4.23)	0.44 (1.01)	4.13 (5.26)	2.61	2, 179	.08

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 12. Relationship between the Mediating and Dependent Variables: Pearson Correlations

Measure/ Subscale	1.	2.	3.	4.	r (p) N	5.	6.	7.	8.
1. ER	---								
2. C_TRA	.12 (.11) 170	---							
3. MON	.04 (.62) 168	.02 (.82) 180	---						
4. M_TRA	.14 (.06) 172	.16* (.03) 184	-.05 (.52) 183	---					
5. CAPI	.63** (.00) 172	.24** (.00) 182	.03 (.71) 181	.32** (.00) 185	---				
6. PUN	-.07 (.37) 168	-.19** (.01) 180	.01 (.88) 181	-.17* (.02) 183	-.21** (.01) 181	---			
7. PAG	-.12 (.13) 168	.11 (.16) 180	-.05 (.54) 181	.26** (.00) 183	.11 (.16) 181	-.33** (.00) 182	---		
8. PAS	-.16* (.03) 168	-.02 (.78) 180	-.06 (.43) 181	.24** (.00) 183	-.02 (.76) 181	-.28** (.00) 182	.48** (.00) 183	---	

** Correlation is significant at the 0.01 level (2-tailed)

* Correlation is significant at the 0.05 level (2-tailed)

Note. ER = Emotion Regulation Composite Scale; C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O’Haga, Kindlon & Earls, 1996); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); M_TRA = Maternal Trauma Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994); PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

PARENTING AND CHILD TRAUMA

Table 13. Associations between Model Variables: Pearson and Spearman Correlations

	Maternal Trauma (IV)			Child Exposure to Trauma (DV)		
	ρ	(<i>n</i>)	<i>p</i>	<i>r</i>	(<i>n</i>)	<i>p</i>
MON	.021	(183)	.78	.014	(182)	.86
PAG	.234**	(183)	.00	.104	(181)	.16
PAS	.196**	(183)	.01	-.025	(181)	.74
PUN	-.158*	(183)	.03	-.191**	(182)	.01
CAPI	.342**	(185)	.00	.238**	(183)	.00
ER	.125	(172)	.10	.120	(171)	.12
C_TRA	-.156*	(184)	.03			

* correlation is significant at the .05 level (2-tailed)

** correlation is significant at the .01 level (2-tailed)

Note. C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996); ER = Emotion Regulation Composite Scale; CAPI = Child Abuse Potential Inventory (Milner 1994) ; PUN = Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); MON = Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998)

APPENDIX B: FIGURES

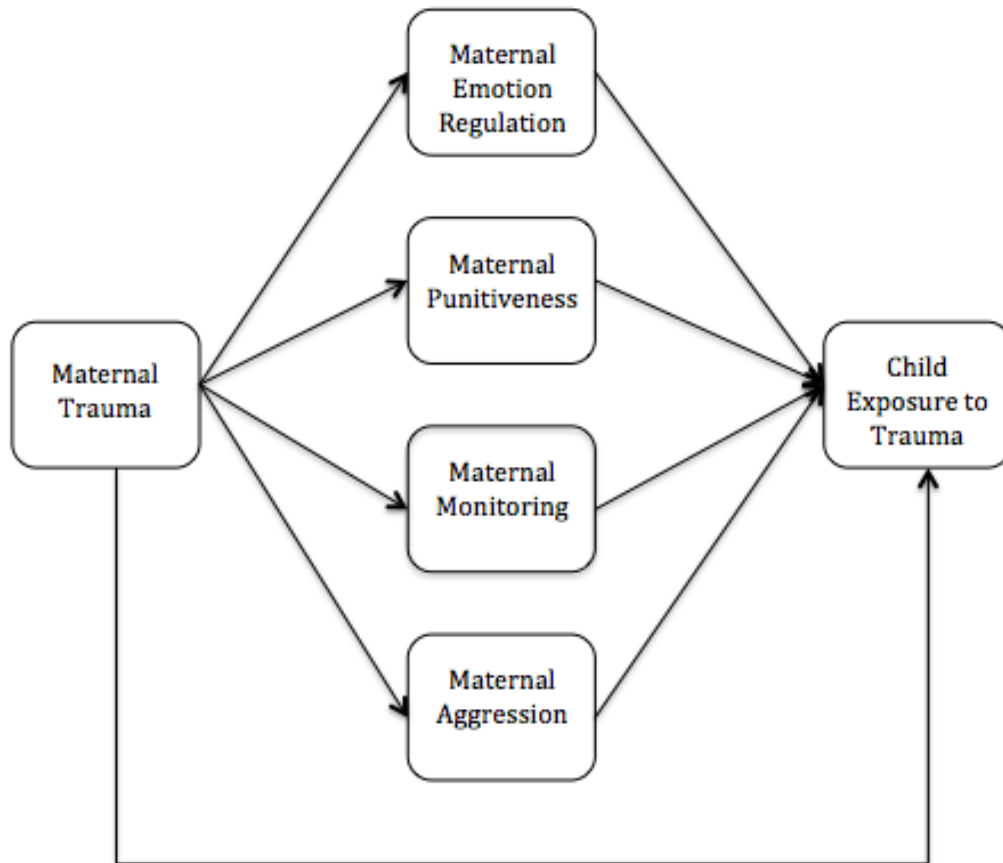


Figure 1. Hypothesized model of associations between maternal trauma exposure, maternal emotion regulation, maternal aggression, maternal punitiveness, maternal monitoring, and child exposure to trauma.

PARENTING AND CHILD TRAUMA

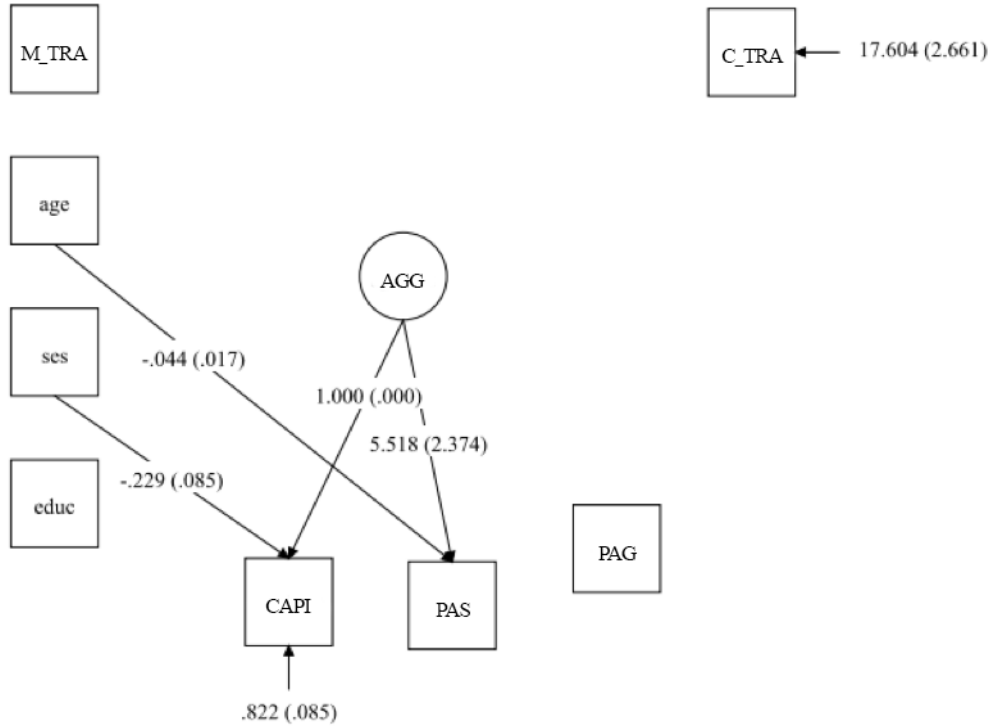


Figure 2. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by parental aggression (AGG) and controlled for covariates (maternal age, maternal ses, and maternal education). Coefficients are unstandardized.

Note. M_TRA = number of types of maternal trauma measured by the Trauma Composite Scale; age = maternal age; ses = maternal social economic status; educ = maternal education level; AGG = aggression latent variable; CAPI = Child Abuse Potential Inventory (Milner 1994); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996)

PARENTING AND CHILD TRAUMA

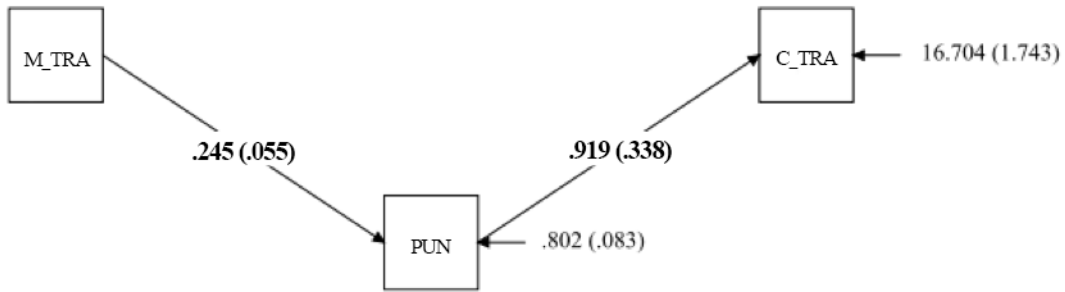


Figure 3. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal punitiveness (PUN). Coefficients are unstandardized.

Note. M_TRA = number of types of maternal trauma measured by the Trauma Composite Scale; PUN = maternal punitiveness measured by the Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996)

Significant findings are bolded, and there is a significant indirect effect = .255, $p = .02$

PARENTING AND CHILD TRAUMA

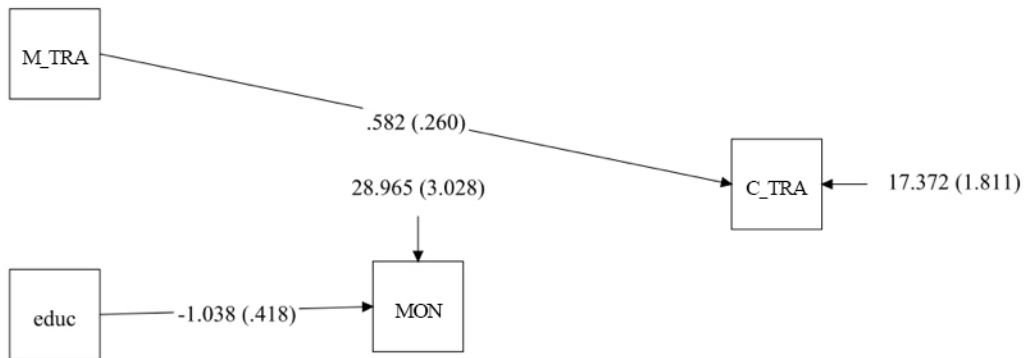


Figure 4. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal monitoring (MON). Coefficients are unstandardized.

Note. M_TRA = number of types of maternal trauma measured by the Trauma Composite Scale; MON = maternal monitoring measured by the Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996)

PARENTING AND CHILD TRAUMA

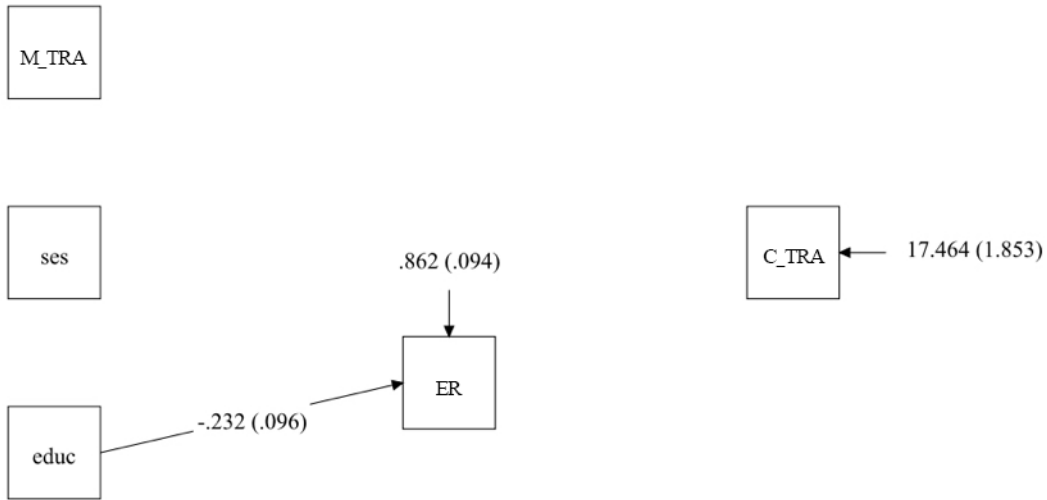


Figure 5. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal emotion regulation (ER). Coefficients are unstandardized.

Note. M_TRA = number of types of maternal trauma measured by the Trauma Composite Scale; ER = maternal emotion regulation measured by the Emotion Regulation Factor Scale; C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996)

PARENTING AND CHILD TRAUMA

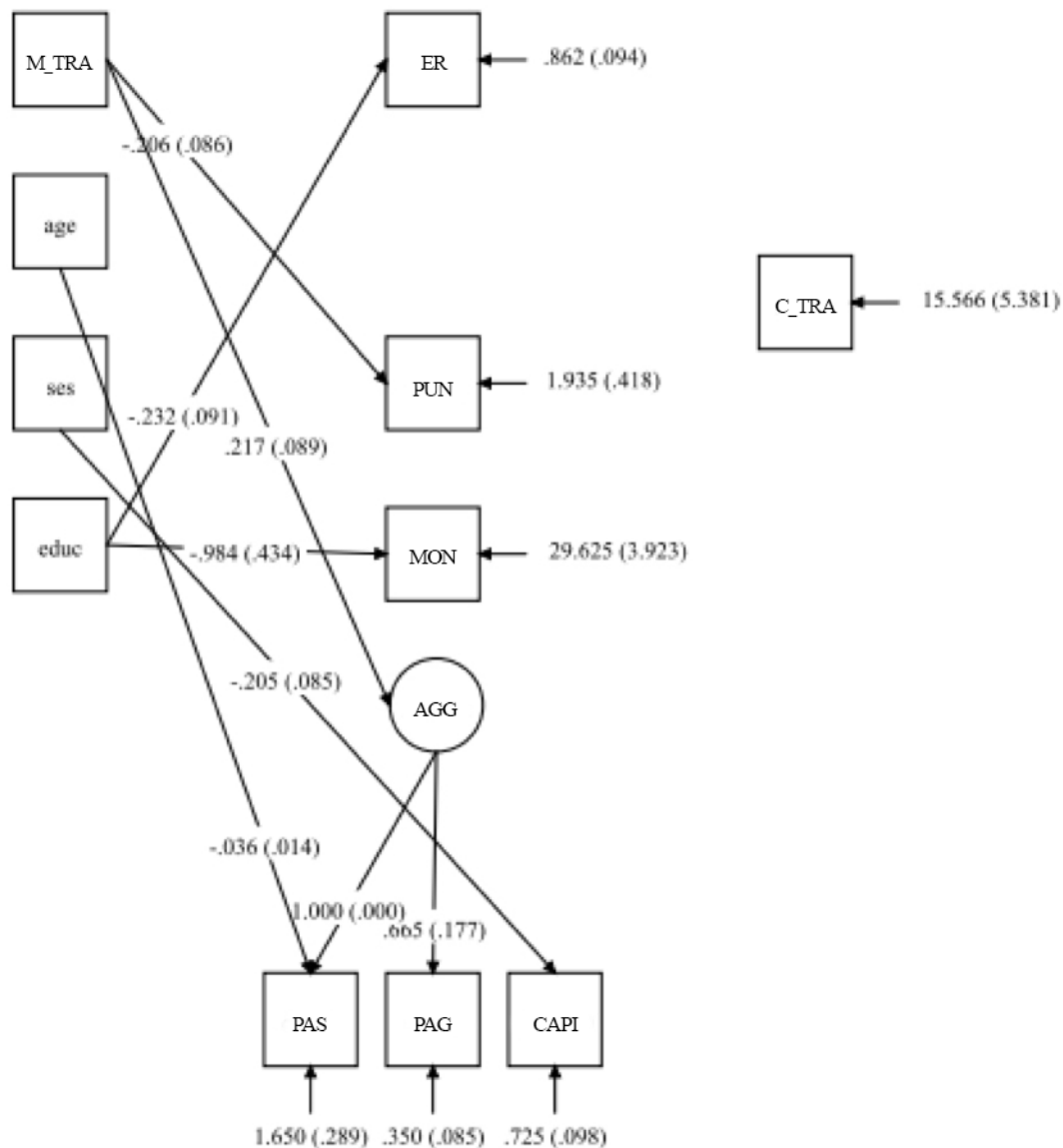


Figure 6. The relationship between maternal trauma (M_TRA) and child exposure to trauma (C_TRA) as mediated by maternal emotion regulation (ER), maternal monitoring (MON), maternal punitiveness (PUN), and maternal aggression (AGG). Coefficients are unstandardized.

Note. M_TRA = number of types of maternal trauma measured by the Trauma Composite Scale; ER = maternal emotion regulation measured by the Emotion Regulation Factor Scale; MON = maternal monitoring measured by the Parental Monitoring Scale, Pittsburgh Youth Study Survey (Loeber et al., 2001); PUN = maternal punitiveness measured by the Parental Punitiveness Scale (Blane, Miller & Leonard, 1988); AGG = aggression latent variable; CAPI = Child Abuse Potential Inventory (Milner 1994); PAS = Physical Abuse Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); PAG = Psychological Aggression Subscale, Parent Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998); C_TRA = child exposure to trauma measured by the Exposure to Violence Scale (Buka, Selner-O'Haga, Kindlon & Earls, 1996)

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