This publication reviews the literature examining the impacts of a history of maternal childhood sexual abuse on parenting capacities and the impacts on children. It specifically examines the domains of mental health, intimate partner violence, substance abuse and homelessness and the overlap with a history of maternal childhood sexual abuse, highlighting the difficulties faced by these women when engaging with statutory and welfare agencies.

KEY MESSAGES

- Research highlights that a maternal history of childhood sexual abuse often underpins many of the complex issues that lead to compromised parenting capacities.
- The complex interplay of these issues in known as complex trauma, and is understood to have an impact on the capacity to provide empathic and consistent care, which inevitably impairs the mother–child relationship.
- Victim/survivors of childhood sexual abuse who become shared clients of child statutory agencies and allied health service providers are often difficult to engage in services due to issues of trust and safety.
- By expanding our understanding of the indirect effects of childhood sexual abuse in areas such as mental health, intimate partner violence, substance abuse and homelessness, we can become more informed of the stressors that affect some women’s parenting capacities and create service responses that enhance their own lives and the lives of their children.
Exposure to ongoing violence and abuse as a child has been shown to influence some people’s capacity to exhibit requisite parenting skills if they have not received adequate and early ongoing support (Banyard, Williams, & Siegel, 2003; van der Kolk, McFarlane, & Van Der Hart, 1996). As females are much more likely to be sexually assaulted than males (Australian Institute of Health and Welfare [AIHW], 2009b; Price-Robertson, Bromfield, & Vassallo, 2010), this issue is especially pertinent to mothers. In 2005, nearly 1 million Australian women experienced some form of childhood sexual abuse before the age of 15 (Australian Bureau of Statistics [ABS], 2005).1

Shelly’s story

Shelly has been in and out of the care system since she was 6 months old. Her family has a history of domestic violence and sexual abuse. Shelly was sexually abused by her cousin, from when she was 10 years old until she was 14. She left her family for good at the age of 14, when she went to school and refused to return home to the violence. After that, she went into state care.

At 15 Shelly and a friend started hanging around a group of older males in St Kilda. One of them became her boyfriend. He was addicted to heroin. He introduced Shelly to heroin and soon after, to sex work. During this time, Shelly would give all her earnings to her boyfriend, and he would supply her with drugs and food and a place to stay. They were together for 8 years, until finally she managed to leave him. After that, Shelly found herself in a violent relationship, from which she escaped after spending some time in a women’s refuge.

Shelly is one of five children, and she is deeply concerned for her 16-year-old sister, who is currently in DHS care. Shelly has two children, a boy who is 3 and a girl who is 16 months. They are both in state care.

Source: Childwise (2004)

1 Before the age of 15, 4.5% (337,400) of men reported experiencing sexual violence, compared to 12% (956,600) of women (ABS, 2005).
Many suffered this abuse at the hands of family members, and research has shown that the majority of childhood sexual abuse victims do not disclose the abuse (Quadara, 2008).

In addition, because 97% of mothers in Australia are the primary caregivers of their biological children (Baxter, Gray, Alexander, Strazdins, & Bittman, 2007), those with a history of childhood sexual abuse are also at greater risk of having contact with child protection agencies as a result of notifications of their neglect of their own children (AIHW, 2011; Carolan, Burns-Jager, Bozek, & Escobar Chew, 2010).

The impact of childhood sexual abuse on women's parenting skills—and consequently the potential risk factors for their children—need to be understood and addressed by policy-makers and service providers if we are to:

- sustain well-informed foundations to combat violence against women and their children by creating communities that are safe and free from violence;
- administer services that meet the needs of women and their children experiencing violence, as per the National Plan to Reduce Violence Against Women and Their Children 2010–2022 (Department of Families, Housing, Community Services and Indigenous Affairs [FaHCSIA], 2011); and
- break the cycle of intergenerational risk factors associated with child abuse and neglect, as per the National Framework for Protecting Australia’s Children 2009–2020 (FaHCSIA, 2009).

This paper looks at the impacts of childhood sexual abuse on maternal parenting and the indirect outcomes of childhood sexual abuse on women as mothers. Specifically, it summarises research findings that examine mental health, intimate partner violence, substance abuse and homelessness, highlighting how a mother’s history of childhood sexual abuse often underpins many of the complex and overlapping issues that lead to compromised parenting capacities.

Finally, the paper will discuss how a trauma-informed perspective could affect system responses to women and their children.

What do the effects of childhood sexual abuse on mothers look like?

The capacity of women to parent in line with social expectations is severely compromised when their lives are characterised by abuse and violence (Carolan et al., 2010; Newman, Stevenson, Bergman, & Boyce, 2007). Some of these mothers may only be teenagers—their pregnancies may have resulted from coerced intercourse and they themselves may be subject to child protection intervention. For many in this cohort, their abuse histories combine with significant factors of social disadvantage, setting a trajectory that reinforces poor outcomes that will potentially affect their children across a number of domains, such as relationships, health and education (AIHW, 2007; Cannon, Bonomi, Anderson, Rivara, & Thompson, 2010; DiLillo, Giuffre, Tremblay, & Peterson, 2001). Recent research has confirmed what many service providers know through experience—that the issues of women survivors of childhood sexual abuse are complex and multiple. For instance, studies consistently demonstrate that adult female survivors of childhood sexual abuse manifest high rates of mental illness, suicidality, substance abuse, homelessness and domestic violence (AIHW, 2007; Bromfield, Lamont, Parker, & Horsfall, 2010; Henderson & Bateman, 2010; Higgins & McCabe, 2000; Lamont, 2010).

The complicated interplay of issues affecting some people’s lives has come to be defined as “complex trauma”. Complex trauma is understood as being prolonged and repeated trauma,
particular during critical developmental periods (such as early childhood), that can have broad
impacts on neurobiological, psychological and social development (van der Kolk, 2005). It
is understood as the culmination of potentially overwhelming or horrific life events that so
disrupt a person’s wellbeing that it taints all other experiences (Connor & Higgins, 2008). The
consequence of prolonged early trauma is a “complex” disorder, sometimes referred to as a
“complex trauma response”. Among victims of childhood sexual and physical abuse, borderline
personality disorder complex and post-traumatic stress disorder are often overlapping diagnoses.

The outcome of complex trauma can be described as enduring, consistent and ongoing
victimisation throughout the lifespan. It has been shown to impede the ability to trust, create
meaningful boundaries and relationships, self-regulate, self-process, and gauge safety for self
and others (Astbury & Cabral, 2000). Clinical literature has cited numerous psychosocial and
parenting implications for mothers with self-identified childhood sexual abuse histories (Banyard
et al., 2003; Berlin, Appleyard, & Dodge, 2011; Newman & Stevenson, 2005, 2008; Newman et
al., 2007; Oates, Tebbutt, Swanston, & Lynch, 1998; Polusny & Follette, 1995; Walker, Holman, &
Busby, 2009). Commonly, women suffering complex trauma often have difficulties with sensitive
Stevenson (2008) stated that “parents with histories of attachment disruption and trauma, when
this is unresolved, are at risk of re-enacting or replicating these distortions of interaction with
their children” (p. 506).

Impaired emotional functioning—characterised by impulsivity, poor anger control and mood
instability—leads to difficulties in social functioning and compounds personal distress (Newman
& Stevenson, 2005). These features of complex trauma are recognised as having an impact on
the capacity to provide empathic and consistent care, which inevitably impairs the mother–child
include parent–child role reversal, lack of boundary setting, poor communication skills, use of
physical chastisement and under- or over-protectiveness (Coid et al., 2001; Cross, 2001; DiLillo
& Damashek, 2003).

Victim/survivors of childhood sexual abuse who become the shared clients of child statutory
agencies and allied health service providers may be difficult to engage due to their previous
experiences surrounding issues of trust and safety. They may also experience barriers accessing
appropriate services that will effectively meet their complex needs. These challenges are
captured by a domestic violence worker in a study by Macy, Giattina, Parish, and Crosby (2009):

A lot of times when somebody's in crisis, it's hard to know if they're a substance
abuser or if they have mental health issues. You know, what came first and what
you're dealing with ... So [there's] substance abuse and people who are really
struggling with mental health and are battered and probably were sexually abused as
children. (p. 24)

Responses to complex trauma are often dealt with in a siloed approach (Henderson & Bateman,
2010). An individual’s housing, mental health and drug abuse issues are likely to be dealt with in
isolation by separate agencies. While the limitations of siloed service responses has been
acknowledged through a shift towards interagency collaboration, this can be a formidable task
for time-poor service providers with high caseloads if the roles and responsibilities of each
organisation are not clearly defined. Combined with the chaotic lifestyles of some clients, this
leads to a failure to attend appointments or issues with transient housing that result in clients
being disconnected from service delivery. Clients often “fall through the cracks”, which makes
engagement with this cohort difficult and complex.
In an Australian context, Henderson and Bateman (2010) comprehensively drew together the implications of using siloed approaches to address the inter-related problems of this particular cohort of women. Their study in 2006 evaluated existing service delivery to examine the capacity of NGO services to assist women survivors of childhood sexual abuse with complex needs. It identified gaps, inequalities and barriers to accessing service delivery, as well as developing an understanding of the trust and safety issues for these clients and the way in which health services are delivered. Subsequently, a second stage of the project was funded aimed at assisting those working in a broad range of community services to understand the dynamics of childhood sexual abuse, and assisting them to make sense of the context in which problems affecting their clients developed. The From Shame to Pride report (Thorpe, Solomon, & Dimopoulos, 2004) and The Aboriginal and Torres Strait Islander Women’s Task Force on Violence Report (Robertson, 2000) also brought together work that reflected, in an Indigenous context, the significance of the intergenerational impacts of childhood sexual abuse, the complexity and multiplicity of the issues facing some survivors, and how these stressors affect their parenting styles.

What are the indirect effects of childhood sexual abuse on maternal parenting?

Understanding the experiences and behaviours of survivors of childhood sexual abuse in the parenting role is important, as parental wellbeing is central to children’s social, physical and mental health (FaHCSIA, 2011). Theoretical frameworks and empirical evidence suggest that an individual’s developmental history, especially if it includes childhood sexual abuse, plays a significant role in the development of one’s parenting skills (Belsky & Vondra, 1989; Berlin et al., 2011; Bromfield et al., 2010; Chiang, 2009; Cross, 2001; DiLillo & Damashek, 2003; Ehrensaft et al., 2003; Kim, Trickett, & Putnam, 2010). Women in these circumstances are at greater risk of perpetrating neglect or abuse toward their own children if adequate intervening protections—such as community or family support and financial resources—are not made available (Levendosky & Graham-Bermann, 2001).

By expanding our understanding of the indirect effects of childhood sexual abuse in areas such as substance abuse, mental health, homelessness and domestic violence, we can become more informed of the stressors that affect some women’s parenting capacities. Knowledge about childhood sexual abuse survivors’ parenting styles and relationships with their children can also illuminate avenues for intervention to help mothers cope with parenting difficulties. Service responses to current behaviours, such as substance misuse, and its impacts on parenting can also be placed in a broader historical context, potentially disrupting the intergenerational ripple effects that may emanate from maternal experiences of childhood sexual abuse.

The following subsections examine some of the significant domains in which the negative outcomes of childhood sexual abuse are understood in research. By providing a background to the complex issues faced by some survivors of childhood sexual abuse, a broader context can then be employed in understanding the effects of such abuse on parenting abilities.

Poor mental health

A large body of literature has linked survivors of childhood sexual abuse with poor long-term mental health outcomes (AIHW, 2007; Banyard et al., 2003; Berlin et al., 2011; Bromfield et al., 2010; Cannon et al., 2010; Chiang, 2009; Childsafety, 2008; Classen et al., 2002; Covington, 2008; DiLillo & Damashek, 2003; Ehrensaft et al., 2003; Haskell & Randall, 2009; Higgins & McCabe,
For example, adult women with childhood sexual abuse histories have been found to have a higher risk of mental health problems such as depression, anxiety, substance abuse and self-harm when compared to community populations, a point discussed further in this paper (Cutajar et al., 2010; Henderson & Bateman, 2010; Horvarth, 2010; Mullen & Fleming, 1998). Many women who seek mental health treatment report histories of long-term emotional, physical and sexual abuse (Australian Social Inclusion Board [ASIB], 2011; Haskell & Randall, 2009).

In Australia, childhood sexual abuse is responsible for nearly 1% of the total burden of disease and injury among women (AIHW, 2007). Of the 14 major risk factors examined by the AIHW researchers, childhood sexual abuse was found to be the second leading cause of disease in females under the age of 45; that is, within the age parameters of childbearing. Anxiety, depression, suicide, self-harm and substance abuse accounted for 94% of this burden (AIHW, 2007). In a study of Australian mothers that examined the intergenerational transmission of childhood sexual abuse and the effects on parenting abilities, Oates et al. (1998) found a higher incidence of mental health problems among mothers with histories of childhood sexual abuse, compared to those in the control group.

Impacts on parenting

Evidence suggests that maternal experiences of childhood sexual abuse and mental health issues are indirectly linked to parenting outcomes. For example, Schuetze and Das Eiden (2005) and Banyard et al. (2003) found that women with a history of childhood sexual abuse are more likely to experience depression, which in turn affects parenting, including maternal attitudes toward their parenting ability and the use of punitive discipline strategies (AIHW, 2009a; Banyard et al., 2003; DiLillo & Damashek, 2003; Goodman, Fels, & Glenn, 2006; Kim et al., 2010). Based on a qualitative analysis of mothers with identified histories of childhood sexual abuse, Gross (2001) found that these mothers had the parenting deficits of having inappropriate developmental expectations for their children, role-reversal relationships (i.e., with the child assuming the parenting role) and difficulty balancing discipline and affection (see also Banyard et al., 2003; DiLillo & Damashek, 2003; Kim et al., 2010). However, these authors also found that mothers with mental health issues and a history of childhood sexual abuse did not have more significant parenting deficits than mothers with mental health issues and no history of childhood sexual abuse. This suggests that women with poor mental health may experience parenting problems, and childhood sexual abuse can be understood as an additional significant contributor to mental health issues that, in turn, lead to poor parenting outcomes.

Intimate partner violence

Studies show an association between childhood abuse and adverse relationship outcomes in adulthood for women, including intimate partner violence (Banyard & Williams, 1996; Berlin et al., 2011; Cannon et al., 2010; Goid et al., 2001; DiLillo & Damashek, 2003; DiLillo et al., 2001; Ehrensaf et al., 2003; Higgins & McCabe, 2000; Johnson, 2004). Experiences of childhood sexual abuse in particular, are found to substantially increase the risk of re-victimisation in adulthood, with women who have experienced multiple forms of childhood abuse being most
at risk (Banyard & Williams, 1996; Browne & Bassuk, 1997; Cannon et al., 2010; Classen et al., 2002; Coid et al., 2001; DiLillo & Damashek, 2003; DiLillo et al., 2001). Studies have consistently showed that, compared to participants who have not experienced abuse as children, women with histories of childhood sexual abuse are three times more likely to experience incidents of intimate partner violence, including physical assault and rape (Cannon et al., 2010; Coid et al., 2001; DiLillo et al., 2001; McCloskey & Bailey, 2000; Trask, Walsh, & DiLillo, 2011).

Some studies indicate that exposure to multiple incidents of child abuse and intimate partner violence as a child are factors that account for the use of physical discipline and neglect in parenting in adulthood (Banyard et al., 2003; Cross, 2001; DiLillo & Damashek, 2003; Kim et al., 2010). While studies have shown that, on its own, a history of childhood sexual abuse does not relate directly to negative parenting outcomes, it is understood to be a factor that compounds re-victimisation, which can effect parenting styles and use of discipline (Banyard et al., 2003; Carolan et al., 2010; Levendosky & Graham-Bermann, 2001).

**Impacts on parenting**

Understanding a woman’s history of childhood sexual abuse and her adult experience of intimate partner violence can provide some insight into how her parenting style may emerge. Traumatic experiences in both childhood and adulthood are related to having difficulties in parenting (Banyard et al., 2003; FaHCSIA, 2008; Radford & Hester, 2006; Renner & Shook Slack, 2006). Renner and Slack’s study of 1,005 women found that exposure to childhood sexual abuse is one form of childhood violence that is highly predictive of women experiencing intimate partner violence in adulthood.

The continuing impact of violence may undermine the attachment between a mother and her child (FaHCSIA, 2008; Perry, 2001). Excessive physical discipline of children may also be a reflection of a mother’s diminished capacity and ability to cope with parenting stressors due to her own compounding trauma (Banyard & Williams, 1996; Banyard et al., 2003; Bromfield et al., 2010; DiLillo & Damashek, 2003; DiLillo et al., 2001).

It is often at this intersection that child protection authorities, police and the courts intervene in the mother–child relationship. Maternal capacities are examined, judgements made and parenting rights removed. Little attention is given to the seemingly insurmountable challenge required by these women to not only change who they are under a blanket of complex trauma, but to do this while meeting the expectations of systems that create formidable institutional barriers (Carolan et al., 2010).

**Substance abuse**

Studies focusing on women’s pathways to substance abuse, find that many of them have histories of childhood sexual, physical and emotional abuse (Covington, 2008; Messman-Moore & Long, 2002; Ouimette, Kimerling, Shaw, & Moos, 2000; Simpson & Miller, 2002; Ullman, Najdowski, & Filipas, 2009). Furthermore, women with childhood sexual abuse histories are more likely to be diagnosed with substance abuse issues than their non-abused counterparts, which has in turn been found to lead to an increased risk of re-victimisation (Covington, 2008; Johnson, 2004; Ouimette et al., 2000; Simpson & Miller, 2002). These studies indicate historically that substance-addicted women report a greater incidence of sexual, physical and emotional abuse by more perpetrators, more frequently and for longer periods of time than their non-addicted counterparts. For example, Polusny and Follette (1995) found that in community
samples, lifetime diagnoses of substance use disorders ranged from 14% to 31% for women with childhood sexual abuse histories, compared with 3% to 12% for women who had no reported experience of childhood sexual abuse. In clinical samples, the rates of lifetime substance use diagnoses among sexual abuse survivors ranged from 21% to 57%, compared with a range of 2% to 27% for women without such histories.

In Australia, Cutajar et al. (2010) investigated the rate and risk of suicide and accidental fatal drug overdose in more than 2,000 individuals—up to 44 years after experiencing childhood sexual abuse. They found females with a history of childhood sexual abuse were shown to have 88 times higher risk of accidental fatal overdose and 40 times higher risk of suicide.  

Simpson and Miller (2002) conducted a systematic review of studies that examined rates of childhood sexual abuse or childhood physical abuse among females with substance abuse problems. Across the studies they found women and girls with substance abuse issues were nearly two times more likely to have a history of childhood sexual abuse relative to the general population.

Women and girls with childhood sexual abuse histories are typically found to have elevated rates of substance use problems, regardless of whether they are sampled from populations of mental health treatment seekers, medical clinic attendees, or general community members.  

**Impacts on parenting**

Substance abuse by parents has been identified as one of the key risk factors for child abuse and neglect. As mothers are most commonly the primary caregiver of their children, intoxication and withdrawal may diminish their capacity to respond to a child’s emotional, physical and social needs, leading to abuse and neglect. Mood swings and inconsistent parenting styles may emerge for mothers with substance abuse issues, which may result in controlling and punitive parenting, or permissive and neglectful parenting (Bromfield et al., 2010). Substance abuse can also lead to role-reversal in the mother–child relationship, with children taking on duties such as caring for siblings and meal preparation (Bromfield et al., 2010; Jeffreys, Hirte, Rogers, & Wilson, 2009).

**Homelessness**

Homeless women often report multiple experiences of violent victimisation at the hands of multiple perpetrators, beginning in childhood and extending into adulthood (Morrison, 2009). Domestic and family violence has been identified as being the largest single cause of homelessness in Australia (FaHCSIA, 2008), placing women and their children at significant risk of housing instability. Two in every three women accessing homelessness services across Australia are accompanied by children and cite breakdowns in interpersonal relationships as the primary reason for seeking support (AIHW, 2009a).

US and Canadian research has shown that 43% of homeless women reported a history of childhood sexual abuse (Browne & Bassuk, 1997; Dunlap, Brazeau, Stermac, & Addison, 2004). The Australian study, *The Secret Life of Us* (Graham, 2005), examined the reasons for homelessness among 156 girls aged 13–18 years, and found that for 18% of this cohort, childhood sexual abuse was one of the underlying reasons why these girls left home.

---

4 In terms of mechanism or manner of suicide in the childhood sexual abuse cohort, women died as a result of carbon monoxide poisoning (3), hanging (1), decapitation (1) and drug overdose (1) (Cutajar et al., 2010).

5 This holds true despite the studies reviewed varying widely in methodology and sophistication; that is, the findings across studies appear to be generally robust, despite methodological differences.
Impacts on parenting

Research indicates that when a history of childhood sexual abuse co-occurs with mental health issues, intimate partner violence, substance abuse and homelessness, the costs to individuals and the community are multiplied (ASIB, 2011; Hayes, Gray, & Edwards, 2008; KPMG, 2009). Among the homeless population, complex issues—such as those associated with mental health, intimate partner violence and substance abuse—are commonly found to occur (AIHW, 2009a).

When the issue of homelessness compounds with the other potential harms associated with a maternal history of childhood sexual abuse, a mother’s ability to protect her children can be undermined. The volatility and chaos of homelessness means that it is virtually impossible to maintain consistently effective parenting practices (Paquette & Bassuk, 2009). Exposure to homelessness can lead to the removal of children through statutory intervention, largely due to the issues of neglect, which are often associated with poor mental health or substance abuse. The removal of children, while often cited as being in the best interest of the child, often further compounds the trauma, loss and distress of these mothers.

Once a woman enters supported accommodation, there is a tacit acknowledgement that all other avenues for support have been exhausted. In their struggle to exit homelessness, these women must navigate complex service systems. Mothers who parent in this environment are often stigmatised and heavily scrutinised, especially if child statutory agencies are involved, adding to the weight of stressors affecting their families (Paquette & Bassuk, 2009).

Intergenerational abuse

An important precursor to any discussion about the transmission of abuse is an understanding that the experience of childhood maltreatment is not a determinant of intergenerational abuse; nor has it been established that it leads to the transmission of abuse (Berlin et al., 2011; DiLillo & Damashek, 2003; McCloskey & Bailey, 2000).

While the causes of child abuse are multiply determined, a parental history of childhood maltreatment is repeatedly cited in the research literature as being a key risk factor for the intergenerational continuity of abuse. Several studies have emphasised that when mothers have unresolved childhood abuse experiences, they may subsequently transmit their maltreatment experiences to their children (AIHW, 2011; Banyard et al., 2003; Basham, 2007; Belsky & Vondra, 1989; Berlin et al., 2011; Chiang, 2009; ChildSafety, 2008; Coid et al., 2001; Cross, 2001; DiLillo & Damashek, 2003; Kim et al., 2010; Newman & Stevenson, 2005; Polusny & Follette, 1995; Renner & Shook Slack, 2006).6

Researchers have found that a maternal history of childhood sexual abuse is the single strongest predictor of sexual abuse in the next generation, with a daughter’s risk of abuse being nearly four times greater when their mother reports a history of sexual abuse (McCloskey & Bailey, 2000; Oates et al., 1998). When occurring in conjunction with maternal drug use, daughters whose mothers have a history of childhood sexual abuse are nearly 24 times more likely to experience sexual abuse themselves (McCloskey & Bailey, 2000).

---

6 While this research review focuses on mothers in discussion of the intergenerational transmission of abuse, it is important to note that notifications to the child protection system see an equal representation of women and men as abusers of their children. Women are represented in many of these reports as the primary caregivers (AIHW, 2011; ChildSafety, 2008).
In the Australian context, Oates et al. (1998) found that mothers of sexually abused children were more likely than comparison mothers to have been sexually abused as children (34% vs 12%). These findings can be understood through a number of different narratives. For example, mothers incapacitated by drugs or alcohol may be unable to adequately supervise or protect their children, leaving them susceptible to abuse by opportunistic perpetrators who develop relationships with the family or engage in some capacity with these children as members of the wider community. Social isolation, insecure housing arrangements, the presence of a stepfather in the home and intimate partner violence are also included among the risk factors for the intergenerational transmission of childhood sexual abuse (McCloskey & Bailey, 2000).

### Integrated perspectives

The traditional institutional and system responses to women with impaired parental functioning due to addiction, mental health or family violence issues have been often been siloed. Research in the field of trauma has, however, led to a greater understanding of the way in which trauma responses shape people’s lives. It provides an important lens for understanding alcohol and drug addiction and the subsequent mental health implications of depression, anxiety and hopelessness, and what this means for a childhood sexual abuse survivor who is dealing with parenting issues and statutory agencies.

A trauma-informed perspective is one that takes account of trauma histories and avoids triggering traumatic reactions and/or re-traumatising the individual. It also requires professionals to interact with individuals to support their coping capacity and afford them autonomy over their own therapeutic experience (Stathopolous & Quadara, in press).

In reviewing the theoretical models of parenting, Banyard et al. (2003) examined the conditions in which a woman’s childhood sexual abuse history contributes to negative parenting outcomes. This research also examined the domains in which protective factors prevail on parenting styles and outcomes. Of the 143 participants in the study, Banyard et al. found, overall, that healthy and supportive adult relationships, satisfying social and community networks, self-care strategies and lower self-reported loneliness were significant predictors of parenting outcomes. Indeed, McCloskey and Bailey (2000), Grauerholz (2000), and Cross (2001) all highlighted that some of the women in these studies were resilient and functioned well as adults and mothers. Other women, however, endured the compounding negative effects from their experiences of childhood trauma.

Complex trauma influences attachment, working memory and other areas of functioning and psychological life (Dawe, Harnett, & Frye, 2008; Perry, 2001, 2009). A brain conditioned to be easily triggered into a stress response is likely to become highly responsive to substances and behaviours that provide short-term relief; which helps to explain a neurological and psychological basis of many traumatised people’s dependence on alcohol (Dawe et al., 2008; Perry, 2009). The complex problems that can manifest for child sexual abuse survivors can be understood as a person’s best efforts to cope with the effects of these harmful external events; though it is the coping responses they develop to these events, such as the use of alcohol or drugs to calm overwhelming anxiety and self-soothe, that are the focus of statutory and agency responses.

Research has consistently shed light on the way in which traumatic events in early childhood can seriously and negatively affect human development across cognitive, psychological, neurological and physical dimensions, especially in the context of sustained experiences of trauma in childhood. (Haskell & Randall, 2009; McCloskey & Bailey, 2000; Messman-Moore &
Many childhood sexual abuse survivors cannot explain or even recognise their own psychological responses as being trauma-related and do not relate their difficulties in adulthood to much earlier traumatic life experiences (Carolan et al., 2010; Haskell & Randall, 2009; Henderson & Bateman, 2010). The inability to trust, seek hope and have self-esteem are often very difficult for the survivor to name (Berlin et al., 2011; Classen et al., 2002; Newman & Stevenson, 2008). As society is often devoid of a cultural narrative for these circumstances, their experiences are rendered invisible. People who have grown up being abused and observing the abuse within their family may normalise and integrate these responses into their own immediate culture, which is then reaffirmed through contact with agencies and statutory bodies, the outcomes of which are often punitive and victim-blaming (Berlin et al., 2011; Carolan et al., 2010):

It’s not just domestic violence or not just sexual assault, there’s this multitude of issues that are layered like an onion … That kind of stuff … that really affects [their] ability to live in [the] community. (Macy et al., 2010, p. 24)

Practices and policies across all sectors and agencies need to incorporate a greater understanding of the far-reaching implications of childhood sexual abuse as it affects maternal parenting capacity. Services need to provide long-term, consistent investment in programs, and these need ongoing financial commitment if any progress is to be made in redressing this issue, which often sits within the wider context of social exclusion and disadvantage.

Limitations of this review

The conclusions of this research review are limited by the varying methodologies employed in the studies that were examined. However, since previous research has found both direct and indirect links between childhood sexual abuse and long-term outcomes, it is possible to infer the impacts of childhood sexual abuse and complex issues on parenting abilities, given the commonality of themes that arise throughout the studies, regardless of methodology employed.

A further limitation worth considering when reviewing this material is that many of the participants identified in these studies, regardless of sampling or setting (clinical or community), were single mothers from low socio-economic backgrounds. However, of those studies that accounted for this variable in their research, socio-economic background was not found to have an impact on the outcome of their findings.

It is also acknowledged that the domains examined in this research summary are common to the core client base of many health, welfare and statutory agencies who do not have a history of childhood sexual abuse. There are often a complex matrix of factors that lead clients to become involved with community and welfare services.

Conclusion

Based on the literature reviewed, parenting interventions aimed at preventing and reducing child abuse and maltreatment should include a thorough family history to identify the potential history of maternal childhood sexual abuse. When assessing a woman’s ability to care for her children, services and agencies should be sensitive to the possible impact of complex trauma responses. The challenge for policy-makers and service providers is both to protect and care for
neglected and abused children and to ensure that proper care and attention is being provided to their mothers. This care involves attending to the mothers’ complex trauma histories.

The research data showed a connection between a maternal history of childhood sexual abuse and impaired parenting capacities. The impact of sustained and overwhelming trauma in childhood has been shown to affect some women’s experiences as mothers, despite their best underlying intentions to protect and nurture their children.

Impaired equilibrium, mental health issues, intimate partner violence and substance abuse are all understood to substantially impact parenting outcomes. While having a history of childhood sexual abuse does not relate directly to negative parenting styles, it is understood to be a significant stressor in parenting interactions.

A greater understanding is required as to how women with such a history juggle system demands as the clients of shared services while coping with the impacts of complex trauma. The current system response is not set up to support these women, most of whom have few resources and many needs and often take many backward steps in their efforts to move forward (Carolan et al., 2010). The ability of these women to recover and function in a manner that is acceptable to statutory welfare agencies takes time. It requires an acknowledgement of the significant strengths already employed by these women, and systemic support for them to move out of a cycle of simply coping, and into one that enhances their own lives and the lives of their children.

References


