The impact of childhood abuse history, domestic violence and mental health symptoms on parenting behaviour among mothers in Japan

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Abstract

Background To assess the impact of childhood abuse history, domestic violence experiences and mental health symptoms on the parenting behaviour of mothers in Japan who have separated from violent husbands or partners.

Methods A self-administered questionnaire survey was conducted on a sample of mothers (n = 304) and their children (n = 498) residing in 83 mother–child homes in Japan. The survey assessed the mothers' childhood abuse history (physical, psychological and sexual abuse and neglect history), domestic violence experiences, current mental health symptoms (dissociative, depressive and traumatic symptoms) and parenting behaviours after moving into the homes to separate from a violent husband or partner.

Results The mothers' childhood abuse history and experience of domestic violence were not associated with their not playing with their children. In contrast, the mothers' dissociative and depressive symptoms were significantly associated with not playing with their children. Although there was no association between the mothers' total childhood abuse history and not praising their children, their childhood physical abuse history was significantly associated with their not praising their children. The dissociative and depressive symptoms were also associated with no praise. Interestingly, the experience of domestic violence showed an inverse association with no praise.

Conclusions Mental health symptoms, more specifically dissociative and depressive symptoms, are associated with a decrease in parenting quality. Mothers who were physically abused as children are less likely to praise their own children, independent of maternal mental health symptoms. In contrast, mothers who experienced domestic violence but subsequently separated from their violent husbands or partners are more likely to praise their children. The treatment of mental health symptoms, particularly dissociative and depressive symptoms, therapy for childhood abuse history and separation from violent husbands or partners might be effective ways to enhance the quality of parenting in Japan.
Introduction

One of the most well-known reasons for child maltreatment is the parents’ history of physical abuse during childhood; that is, the abusing parents were themselves abused as children. This enhances the belief in the continuity of abuse across generations, which has been reported since the late 1960s (Steele & Pollack 1968). A reasonable assumption is that the parents’ childhood abuse history might be associated with their parenting behaviour, for example, not playing with or not praising their child, which might not be categorized as maltreatment but could retard child development. The findings of previous research have shown that parents with a childhood abuse history have a poorer quality of interaction with their infants or younger children (Browne & Saqi 1988; Banyard et al. 2003; Schuetze & Eiden 2005). However, only a few recent studies have investigated the persistent impact of childhood abuse history on parenting behaviour in older children (Dixon et al. 2005; Barrett 2009). In addition, most research in this area has been on Western society, and only a few researchers have investigated the intergenerational continuity of child abuse in Asian society.

One possible cause for the association between childhood abuse history and parenting behaviour is the deterioration of the parents’ mental health. For instance, it has been reported that parents with a childhood abuse history are more likely to present dissociative symptoms than those without such a history (Egeland & Susman-Stillman 1996). Since a childhood abuse history can lead to other mental health symptoms such as depression or traumatic symptoms (Dubowitz et al. 2001; Horwitz et al. 2001; Banyard et al. 2003; Schuetze & Eiden 2005; Mapp 2006; Widom et al. 2007), further research encompassing a wider assessment of the mental health symptoms of parents with and without a childhood abuse history is warranted. In addition, since each type of childhood abuse history (i.e. physical, psychological and sexual abuse and neglect) and mental health symptoms might contribute differently to the various types of parenting behaviour (Rieker & Carmen 1986; Briere & Runtz 1988; Newcomb & Locke 2001), research is necessary to assess the impact of childhood abuse history and mental health symptoms on the quality of parenting.

If mental health problems can affect the parenting behaviour of those with a childhood abuse history, the existence of domestic violence should be considered in the analysis model. This is because individuals with a childhood abuse history have a greater propensity to be involved with violent partners (Ross 1996; Fantuzzo et al. 1997; Tajima 2000; Schuetze & Eiden 2005). Furthermore, both a childhood abuse history and domestic violence experiences are associated with mental health problems (Campbell 2002; Widom et al. 2007). Few studies have simultaneously investigated the impact of childhood abuse history and domestic violence on parenting behaviour (Schuetze & Eiden 2005).

In Japan, mothers who have been victims of domestic violence or who want to separate from their husbands or partners because they abuse their children can stay at mother–child homes. Through such homes, we can assess the impact of a childhood abuse history and domestic violence experiences on parenting behaviour (not playing with and not praising the child). Therefore, the purpose of this study was to assess the impact of childhood abuse history (including its different types), domestic violence and mental health symptoms on the parenting behaviour of mothers who have separated from their violent husbands or partners in Japan.

Methods

Sample

Details of the procedure used in this study have been previously described by Fujiwara and colleagues (2010). The setting of this study included all the mother–child homes in Japan (n = 83); these are welfare facilities where mothers and children who are experiencing family problems (e.g. domestic violence, child abuse by the father, single mothers with financial problems) can reside and receive assistance in becoming self-supporting. All the mothers (n = 1369) at the mother–child homes, including those who were residing for reasons other than child abuse and domestic violence, were invited to participate in the study, and questionnaires were posted to the 421 mothers who agreed to participate (30.8%). A total of 340 mothers completed the survey (80.1%). In addition, the mothers were asked to complete the questionnaires for each of their children; that is, if a mother had two children, she completed two questionnaires: one for each child. In total, 665 children’s questionnaires were collected. The questionnaire completed by a mother on behalf of her child was labelled with a maternal ID and mixed with the other mothers’ questionnaires. To maintain anonymity, the respondents were instructed to work individually on the survey, which required no formal consent. Thus, the mothers received no assistance when completing the survey.

Measurements

Childhood abuse history

The childhood abuse history was assessed using the following seven questions: (1) I was a victim of abuse from my parents...
(including step-parents); (2) I was ignored or refused attention by my parents; (3) I was verbally insulted by my parents; (4) I experienced severe violent abuse from my parents for which I needed hospitalization; (5) I was deprived of food or warm clothing; (6) I experienced forced sexual contact by a parent (sexual contact includes sexual intercourse, petting, exposure of genitals and taking naked pictures); and (7) I experienced forced sexual contact by an adult other than my parent. Each question was answered on a 1–4 Likert scale, with 1 being not at all, 2 rarely, 3 sometimes and 4 frequently. These questions were developed on the basis of the Childhood Trauma Questionnaire (CTQ; Bernstein et al. 1994), but modified to suit the Japanese language and condensed to seven questions to decrease the respondents’ burden. In order to capture the mild to severe form of childhood abuse, five physical abuse questions, six neglect questions, 12 psychological abuse questions and six sexual abuse questions from the CTQ were condensed to two, one, two and two questions respectively. These questions were the result of focus group discussions among experienced Japanese child abuse specialists (authors of this paper: M. O., M. I. and T. F.), to ensure that the questions were culturally acceptable (e.g. a question such as neglect due to the parents’ use of illegal drugs was omitted because illegal drug use by parents is quite rare in Japan). The total history of childhood abuse was calculated by a summation of the responses to these seven questions. Cronbach’s alpha for this scale was 0.78.

Furthermore, the childhood abuse history was subdivided into physical, psychological and sexual abuse and neglect. Survey questions (1) and (4) were used to assess physical abuse, (5) to assess neglect, (2) and (3) to assess psychological abuse, and (6) and (7) to assess sexual abuse. For subscales that included two questions, the responses to both questions were summed.

Experience of domestic violence

The experience of domestic violence was assessed using the following four questions: (1) My husband or partner was violent enough to injure me; (2) My husband or partner insulted me strongly enough to cause psychological harm; (3) I perceived a strong threat from my husband or partner; and (4) My husband or partner forced me to have sexual contact. Each question was answered using the previously mentioned 1–4 Likert scale. These questions were developed on the basis of the Index of Spouse Abuse (ISA; Hudson & McIntosh 1981), but modified to suit the Japanese language and condensed to four questions: one each on physical assault, psychological insult, threat and forced sexual contact. These questions were also the result of the focus group discussions mentioned above. A summation of the responses to these questions was used as a scale to indicate the respondent’s experience of domestic violence. Cronbach’s alpha for this scale was 0.86.

Mothers’ mental health symptoms

The mothers’ mental health symptoms were classified as dissociative, depressive or traumatic. The questions used in this assessment were developed on the basis of the symptoms list in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition and from focus group discussions between an experienced Japanese child psychiatrist and a psychologist (M. O. and M. I.). Questionnaires measuring mental health symptoms were described previously by Fujiwara and colleagues (2010). The symptoms of dissociation when mothers take care of their children were assessed by the summation of responses to 10 questions answered using the 1–4 Likert scale. Similarly, depressive and traumatic symptoms were assessed using 11 and eight questions respectively. Cronbach’s alpha for the dissociative, depressive and traumatic symptom assessments were 0.82, 0.88 and 0.85 respectively.

Parenting behaviour

Parenting behaviour was assessed by two questions – ‘Currently, do you play with or enjoy talking with your child?’ and ‘Currently, do you praise your child?’ – using the 1–4 Likert scale. The scores were reverse-coded. These questions were developed on the basis of the Home Observation for Measurement of the Environment scale (Caldwell & Bradley 1984), but modified to suit the Japanese language and condensed to two questions. These two parenting behaviours were selected following focus group discussions among Japanese child abuse specialists (M. O., M. I. and T. F.), recognizing that positive parenting behaviours should be captured.

Covariates

Potential confounders were also assessed in the questionnaire. The mothers’ age, current marital status, current working status, length of stay at the facility and professional support (i.e.
medical or legal support, including psychological therapy) were assessed. For the children, their age, sex, birth order, medical treatment and other welfare/educational support were included. Mothers were also required to mention whether the children residing with were their biological children. Details of the items used to assess these covariates are shown in Table 1.

### Institutional review board approval

The institutional review board at the National Center for Child Health and Development approved this study. The return of a completed questionnaire was accepted as the respondent’s consent to participate in the study; therefore, the institutional review board approved the present study without any prior formal consent from the participants.

### Analysis

Since childhood abuse history, domestic violence, mental health symptoms and parenting behaviour are major explanatory and outcome variables, the mothers and children who responded to all the questions on these variables were included for further analysis (mothers, $n = 304$; children, $n = 498$). To assist in the interpretation of the regression coefficients, the childhood abuse history, domestic violence experiences, mental health symptoms and parenting behaviour scores were converted to fall within a 0 to 10 range (i.e. standardization).

First, the bivariate association of childhood abuse history (including subtypes), domestic violence experiences and mental health symptoms with parenting behaviour was estimated using a generalized estimating equation (GEE) model which adjusts the clustering of outcomes within siblings. Then, as Model 1, the independent association of total score of childhood abuse history, domestic violence experiences and mental health symptoms with parenting behaviour was estimated using a GEE (in full) model. The mental health symptoms could not be simultaneously included in the same model owing to their high correlation with each other (0.50–0.74). Furthermore, the subtypes of childhood abuse history (i.e. physical, psychological and sexual abuse and neglect), domestic violence experiences and mental health symptoms were included in the same model (Model 2), and the coefficients were calculated using a GEE model. All regression coefficients were adjusted for the child’s age and sex, birth order, medical treatment and welfare/educational support status, and for the mother’s age, marital status, working status, length of stay and professional maternal support.

### Results

The sample characteristics are shown in Table 1. The mean age of the mothers was 35.8 years (SD = 7.1), and their ages ranged from 19 to 56 years. Their husbands were slightly older, with a mean age of 39.4 years (SD = 9.6). The majority of the mothers (72.7%) had divorced their husbands. Almost 80% of the mothers were working either full time or part time. Their reasons for staying in the mother–child home were primarily domestic violence or child abuse by the husbands or partners. The mean duration of residence at the mother–child home was

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2.39 years (SD = 2.49), with a maximum of 18 years. Professional support including psychiatric or psychological therapy, support by a public health nurse or legal consultation was utilized by 35.5% of the mothers.

The mean age of the children was 7.8 years (SD = 4.5), ranging from a 1-month-old infant to a 20-year-old adolescent. The sex ratio was almost equal (boys accounted for 50.9%). The majority were the mothers’ first children (60.6%), and the lowest in the birth order was the fifth child (0.6%). The majority of the children were the biological children of the mothers (99.8%). Some children (14.7%) received medical treatment due to their chronic or mental problems. In addition, 18.5% of the children received welfare or educational support to address developmental or mental disabilities.

Table 2 shows the regression coefficients of maternal childhood abuse history, domestic violence experience and mental health symptoms on not playing with children. Childhood abuse history including the subtypes and domestic violence was not associated with the mothers currently not playing with their children. Among the mental health symptoms, the dissociative and depressive symptoms were significantly associated with the mothers not playing with their children: a 10% increase in dissociative or depressive symptom scores increased the lack of playing with children by 2% and 1% respectively. Traumatic symptoms were not associated with not playing.

The regression coefficients of maternal childhood abuse history, domestic violence experiences and mental health symptoms on the absence of praise for children are shown in Table 3. In the bivariate model, one subtype of childhood abuse history (physical childhood abuse) was found to be associated with no praise of the children, although the total score and the other childhood abuse history subtypes (i.e. psychological and sexual abuse and neglect) were not associated. Interestingly, in the bivariate model, the experience of domestic violence showed an inverse association with no praise of the children. Dissociative and depressive symptoms were positively associated with no praise. In the multivariate model (Model 2), a physical childhood abuse history remained statistically significantly associated with no praise of the children, after adjustment for domestic violence experiences and mental health symptoms. Experience of domestic violence remained inversely associated with no praise, after adjustment for childhood abuse history and mental health symptoms. That is, a 10% increase in domestic violence experiences reduced the likelihood of not praising children by approximately 1%, after separation from a violent husband or partner. On the other hand, mental health symptoms, particularly dissociative symptoms, showed an independent association with no praise: a 10% increase in dissociative symptoms increased the likelihood of no praise by approximately 3%. Traumatic symptoms were not associated with no praise for their children.

Discussion

In this study, mental health symptoms, more specifically dissociative and depressive symptoms, were associated with a decrease in the quality of parenting, which is consistent with the findings of previous studies (Smith 2004; Dixon et al. 2005).

Table 2. Regression coefficient of maternal child abuse history, domestic violence and mental health symptoms on not playing with children by generalized estimating equation analysis

<table>
<thead>
<tr>
<th>Childhood abuse history</th>
<th>Bivariate</th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total score</td>
<td>0.02</td>
<td>0.01</td>
<td>-0.02</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0.01</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>0.02</td>
<td>0.03</td>
<td>0.04</td>
</tr>
<tr>
<td>Neglect</td>
<td>-0.01</td>
<td>-0.03</td>
<td>-0.04</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>-0.03</td>
<td>-0.02</td>
<td>-0.03</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health symptoms</th>
<th>Bivariate</th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociative symptoms</td>
<td>0.21</td>
<td>0.22</td>
<td>0.21</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>0.12</td>
<td>0.13</td>
<td>0.12</td>
</tr>
<tr>
<td>Traumatic symptoms</td>
<td>0.08</td>
<td>0.09</td>
<td>0.09</td>
</tr>
</tbody>
</table>

All independent and dependent variables were in the range 0–10.
Mother’s age, marital status, working status, length of stay and receipt of professional support, and child’s age, sex, birth order and receipt of medical treatment and welfare/educational support status were adjusted.
Bold value means significance level P < 0.05.
Mothers with a history of physical childhood abuse and present mental health symptoms are less likely to praise their children. Conversely, mothers who experienced domestic violence but subsequently separated from their violent husbands or partners are more likely to praise their children.

To the best of our knowledge, this study is the first in Japan to confirm the association between physical childhood abuse history and parenting behaviour, measured as praise. The findings of this study contrast with those of a study on African-American women in the USA, with whom no association was demonstrated between a physical childhood abuse history and parenting warmth, measured in terms of body contact and praise (Barrett 2009). It is, however, not easy to compare these results because the measurement scales of childhood abuse history and parenting behaviour are different. The cultural differences between the USA and Japan might explain this inconsistency: Japanese parents with a history of physical abuse are more likely to think that their children should fend for themselves, without any parental interaction such as praise. This is because parents who were themselves physically abused might consider this abuse to be a form of discipline necessary to promote child independence. In other words, Japanese parents believe that if they praise their children too much, especially in the presence of others, they will spoil them, owing to the high value placed on modesty in the Japanese culture (Bornstein et al. 1998). In contrast, parents in the USA praise their children regardless of their abuse history; this is because praising children is a parenting norm in the USA, designed to encourage independence, self-reliance and autonomy (Weisner 2009).

An interesting finding was that domestic violence was inversely significantly associated with no praise of the child after separation from a violent husband or partner. A previous study reported that living with an adult who is violent tends to increase the likelihood of poor caregiving quality at both 4–6 weeks and 3–5 months compared with not living with a violent adult (Dixon et al. 2005). This finding suggests that the quality of maternal parenting is affected by the relationship between the mother and her husband or partner; to be more precise, the existence of domestic violence results in the decreased quality of maternal parenting. This explains the inverse association between domestic violence and no praise: the impact of domestic violence on parenting behaviour can be diluted during the course of living in the mother–child home. Therefore, from a strength-based perspective, separation from a violent husband or partner empowered the mothers to shift their energy from looking after their husbands or partners to caring for their children, which enhanced the quality of parenting. Mothers who suffer from domestic violence could be advised to shift their focus from their husbands or partners to their children in order to enhance their parenting quality.

The null association between childhood abuse history or domestic violence and not playing with children is also interesting. Playing and talking with children are considered relatively undemanding tasks. Previous studies have reported that not all abused parents abuse their children (Kaufman & Zigler 1987; Widom 1989); that is, some abused parents can take care of their children if the parenting task is easy. A detailed analysis of parenting behaviours suggests that the habit of playing or

### Table 3. Regression coefficient of maternal child abuse history, domestic violence and mental health symptoms on not praising children by generalized estimating equation analysis

<table>
<thead>
<tr>
<th></th>
<th>Bivariate</th>
<th>Model 1</th>
<th>Model 2</th>
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<tbody>
<tr>
<td></td>
<td>$\beta$</td>
<td>$P$</td>
<td>$\beta$</td>
</tr>
<tr>
<td>Childhood abuse history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total score</td>
<td>0.08</td>
<td>0.201</td>
<td>0.07</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>0.13</td>
<td>0.032</td>
<td></td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>0.05</td>
<td>0.195</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>0.03</td>
<td>0.567</td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>−0.06</td>
<td>0.434</td>
<td></td>
</tr>
<tr>
<td>Experience of domestic</td>
<td>−0.11</td>
<td>0.003</td>
<td>−0.11</td>
</tr>
<tr>
<td>violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociative symptoms</td>
<td>0.28</td>
<td>&lt;0.001</td>
<td>0.27</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>0.11</td>
<td>0.027</td>
<td>0.10</td>
</tr>
<tr>
<td>Traumatic symptoms</td>
<td>−0.01</td>
<td>0.880</td>
<td></td>
</tr>
<tr>
<td>$\chi^2$</td>
<td>84.3</td>
<td>70.9</td>
<td>65.7</td>
</tr>
</tbody>
</table>

All independent and dependent variables were in the range 0–10.

Mother’s age, marital status, working status, length of stay and receipt of professional support, and child’s age, sex, birth order and receipt of medical treatment and welfare/educational support status were adjusted.

Bold value means significance level $P < 0.05$. 

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talking with children is not transmitted intergenerationally, probably because playing and talking with children are not difficult tasks.

Several limitations of this study need to be acknowledged. First, since the childhood abuse history and domestic violence experiences were assessed retrospectively and were self-reported, the measurement of these experiences might have recall bias and might be affected by mental health symptoms (i.e., a woman with a childhood abuse history might not be able to remember her abuse history due to dissociation while responding). Second, the questionnaire on mental health symptoms was self-administered and not assessed in person or through a telephone interview. Third, we did not use a standard scale, such as the CTQ (Bernstein et al. 1994), ISA (Hudson & McIntosh 1981) or Home Observation for Measurement of the Environment scale (Caldwell & Bradley 1984), to assess the childhood abuse history, domestic violence experience and parenting behaviour, although these scales were referenced for the development of measurements. It is extremely difficult to utilize lengthy standard scales to enquire into the childhood abuse history and domestic violence experiences of battered women, particularly in Japan. Our survey on childhood abuse history and domestic violence was constructed with a minimal number of questions; thus, further research is warranted to assess the validity and reliability of the scales used in this study. Fourth, the study sample was one of convenience—a sample of mothers who have lived with violent husbands or partners. Thus, it is difficult to generalize the results even to a mother-child home, owing to sampling bias. Future research using the general population is needed to confirm the link between childhood abuse history, domestic violence experiences, mental health symptoms and parenting behaviour.

Nonetheless, this study suggests the importance of mental health symptoms, particularly dissociative and depressive symptoms, as independent risk factors in parenting behaviour. Professional support by psychiatrists or psychologists addressing these two symptoms might be an effective way to enhance the quality of parenting. It is recommended that parenting training providers become sensitive to the mental status of the recipients of parenting programmes, as some parents might have dissociative or depressive symptoms that prevent them from acquiring effective learning skills for parenting.

In conclusion, mental health symptoms, more specifically dissociative and depressive symptoms, are associated with a decrease in the quality of parenting. Mothers who have a history of physical childhood abuse and present mental health symptoms are less likely to praise their children. Mothers who experienced domestic violence but have separated from their violent husbands or partners are more likely to praise their children after the separation. The treating of mental health symptoms, particularly dissociative and depressive symptoms, and therapy for childhood abuse history might be effective ways to enhance the quality of parenting in Japan.

Key messages

• Professional support from psychiatrists or psychologists addressing dissociative and depressive symptoms may be an effective way to enhance parenting quality.
• It is recommended that parenting training providers become sensitive towards the mental status of the recipients of parenting programmes, as some parents might have dissociative or depressive symptoms that prevent them from acquiring effective learning skills for parenting.
• Further study is necessary to replicate the association between childhood abuse history, domestic violence and mental health symptoms on parenting behaviour in other cultures.
• There is a need to investigate the effectiveness of mental health treatment for mothers with childhood abuse history or domestic violence experiences, to improve the parenting quality.

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