

Intergenerational Continuity and Life Course Trajectory in a Child Protection Sample: Implications for Social Work Practice¹

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Abstract

A significant relationship exists between disadvantaged families and the child protection system, which is frequently maintained across generations. Studies have identified the relationship between low income, unemployment, exposure to violence, substance abuse, maternal depression, and child maltreatment that may bring subsequent generations of the same family to the attention of child protection. Of particular concern to child protection workers is the cycle of abuse from one generation to the next, which is associated with children being admitted to child protection. This study examines family and child characteristics associated with parents who had previous child protection involvement as children. It also compares the profiles of child protection consumers in 1995 and 2001. Reports on outcomes for children's social, emotional, and educational development and risk factors relevant in child protection are provided. The results indicate a significant proportion of children in the care of the Children's Aid Society (CAS) had a primary caregiver who had previous contact with the CAS when they were children. Recommendations are presented that are related to disrupting this cycle of child protection involvement across generations.

KEYWORDS: child maltreatment, intergenerational continuity, life course

Introduction

A large number of families receive services within the child protection system from one generation to the next. These families are easily identified by seasoned social workers and represent a stable client base, frequently over many generations. Conditions that give rise to intergenerational continuity have been documented and consist of a number of risk factors for child abuse and neglect including poverty, a parental history of abuse, exposure to violence, substance abuse, lack of social support, job loss, and other acute stressors (Belesky, 1988; Cicchetti & Olson, 1990).

Previous research has indicated that a caregiver's inability to provide appropriate parenting is related to inadequate care received as a child (Egeland et al., 1989; Polansky, 1984). Egeland (1993) documented that a history of abuse as a child is a risk factor in parents abusing their own children. An extensive review of the literature by Pears & Capaldi (2001) suggests rates of transmission of abuse varies from 18% to 40%.

1.2 The Experience of Childhood Violence and Subsequent Abuse Victimization

Experiencing maltreatment as a child is associated with subsequent problems with aggression and parenting in adult life (Egeland, Jacobvitz & Sroufe, 1988). Further, the more severe the childhood abuse experienced by the parent, the more abusive they were likely to be toward their own children (Pears & Capaldi, 2001; Zaidi et al., 1989). Pears & Capaldi (2001) suggested "higher levels of abuse in childhood predicted higher levels of abusive towards the next generation...even when other risk factors were included in the model" (p. 1456). In a recent meta-analysis reviewing the intergenerational transmission of spousal abuse, growing up in an abusive family was positively related to becoming involved in a violent marital relationship (Smith et al., 2000).

Research relating childhood experiences with physical abuse and exposure to family violence has furthered the understanding regarding the cyclical nature of families seen by child protection services. Trocmé et al. (2002) identified that childhood maltreatment is the single largest factor accounting for children coming to the attention of child protection and subsequently admitted to care. Newcomb & Locke (2001) noted there is now strong evidence to support the intergenerational transmission of child

maltreatment. The purpose of this study was to address issues related to caregivers who had experienced child protection involvement as children compared to caregivers without child protection involvement.

1.3 Personality Characteristics

A broad set of personality characteristics is associated with child maltreatment. These include: low self-esteem, poor impulse control, and antisocial behaviour (Pianta, Egeland & Erickson, 1989), growing up in an abusive home (Belesky & Vondra, 1989), disrupted early childhood attachment (Main & Goodwin, 1984), character disorders in mothers (Polansky, 1984), maternal depression (Lee & Gotlib, 1989; Jacob & Johnson, 1997; Leschied et al., 2001), and cognitive deficits (Coiro, 1998; Zuravin, 1988).

1.4 Mediating Variables

Some research suggests that systemic factors combine with personality variables to increase the potential for subsequent childhood maltreatment to occur. These factors include poor living conditions, frequent moves, teenage pregnancy, unemployment, family conflict, and substance abuse (Kotch, Muller & Blakley, 1999; Gelles, 1998; Trickett et al., 1991). Parental rejection (Egeland & Sroufe, 1981), a lack of social supports (Egeland, 1988), poor disciplinary practices in parents abused as children (Pears et al., 2001; Knutson & Bowers, 1994) and domestic violence (Cappell & Heiner, 1990; O'Keefe, 1995) have also been identified.

Notwithstanding the research indicating the link between parental childhood abuse experiences and maltreatment of their own child(ren), there are studies suggesting this link may not be as direct (Buchanan, 1996; Simmons et al., 1991; Hotaling & Sugarman, 1990; McEwer & Borling, 1988). Kaufman & Zigler (1987) noted that most children who experience abuse do not grow into abusive adults. The challenge for research is to identify those adults who have experienced abuse and may have an increased probability of victimizing their own children. One line of research examining this link relates multi-causal life course events that influence this outcome.

1.5 Life Course Theories

Life course theories identify the familial effects of certain processes from one generation to the next examining the transmission of offending behaviour in families across

generations. Farrington & Loeber (2000) investigated abuse with inter-relationships among three generations of relatives. This sample consisted of 1,395 parents of delinquent boys ages 8-10. Results indicated that over 60% of boys considered very high risk between the ages 8-10 were antisocial at age 32 (Farrington & Loeber, 2000). Widom (1989) identified that child abuse is linked to adult criminal behaviour. Lansford et al. (2002) reported that child physical maltreatment occurring within the first five years of life was related to psychological and behavioural problems 12 years later. Adolescents in this study who had experienced early maltreatment had levels of aggression, anxiety/depression, dissociation, delinquent behaviours, post traumatic stress disorder, social problems, thought problems, and social withdrawal twice the rate of their non maltreated counterparts.

1.6 Integrated Models

Belesky & Vondra (1989) proposed an ecological framework for child maltreatment that combines parent developmental history, characteristics of the child and family and contextual sources of stress and support. This model is helpful to conceptualize the complex relationships between early abuse experience, subsequent personality problems and the propensity to repeat abuse experiences as adults. Parenting is viewed as interactive and reciprocal in nature as parent's behaviour influences the child's personality and behaviour, which in turn determines the parent's response to the child. Hence, the marital relationship, social support network, and even work-related factors are viewed as having an impact on parenting.

Research related to the intergenerational transmission of child abuse is relevant in identifying factors related to the increase in the use of child protection services. The following section summarizes the current utilization rate of child welfare services in North American jurisdictions, with particular emphasis on the Ontario context.

1.7 Increased Use of Child Protection Services

Since the mid 1990s there have been dramatic increases in both referrals and admissions to child welfare services throughout North America (Anglin, 2001). This includes increases in referrals and admissions to Children's Aid Societies in Ontario as well. Investigations by child protection agencies regarding the number of children suspected of

being abused or neglected in Ontario increased by 44% between 1993 and 1998 across fifty-two Children's Aid Societies (CASs) (Trocmé et al., 1998). At the CAS of London and Middlesex Children's, a large child protection agency situated in Southwestern Ontario, the number of children admitted to care more than doubled over the past ten years (King et al., 2003).

The present study addressed a number of questions related to the intergenerational transmission of child maltreatment that results in the use of child welfare services. Data representing children referred to the Children's Aid Society (CAS) in 1995 and 2001 were collected at two points in time over a six-year period. Variables associated with child maltreatment were examined as well as child and family risk factors. Files on children admitted to CAS care from 2001 were reviewed and comparisons on relevant data related to life course histories were examined. Comparison groups consisted of families in which a parent had been involved with the CAS as a child and those families that did not have a parent involved with CAS as a child. The following hypotheses were examined:

1. There will be an increase in the number of intergenerational child welfare families accessing services at CAS in 2001 compared to 1995, and an increase in the number of children admitted to care.
2. Families with a parent who was involved with CAS as a child will have higher rates of psychosocial problems than those parents who were not involved with CAS. These include unemployment, drug and alcohol abuse, exposure to violence, psychiatric problems and dependency on social assistance.
3. Children living in families where a parent was involved with CAS as a child will have a) higher rates of admission to care, and b) higher rates of emotional and mental health concerns than children whose parents were not involved with CAS as a child;
4. Children with a parent who was involved with CAS as a child will have higher risk scores on the Risk Assessment tool than those parents who did not have experience with the CAS.

Method

2.1 Participants

Participants in this study are 1,042 children randomly selected from 2,316 child protection cases from the Children's Aid Society of London and Middlesex from 1995 and 2001. Cases from 1995 and 2001 were chosen representing two points in time allowing for comparisons to address factors that might contribute to a knowledge related to the increase frequency of children being taken into care. While the sampling was random, this method of sampling does not guarantee that the composition of the combined samples for each year is representative of the proportion of children seen at CAS for child protection reasons. In order to compensate for this, the data are weighted in each year such that the sample, as analysed, contains the same proportion of children taken into care, as was the case for the total population of cases for the years from which they were drawn.

To examine the relationship of the caregiver's history with the child protection system on child outcomes, we identified from case history information, caregivers who were involved with a children's aid society (CAS) as a child² (i.e., under the age 16). The nature of the caregiver's previous child protection involvement ranged from personal or family counselling, to some form of service that resulted in the caregiver (who was then a child) being removed from the home, such as foster care or adoption.

The sample of children in 1995 consisted of 447 children, of whom 116 (26%) have a CAS involved caregiver. The sample of children in 2001 consisted of 590 children, of whom 204 (35%) have a CAS involved caregiver. Five cases were excluded from the analysis because data were missing regarding the caregiver's previous child welfare involvement ($n = 1037$). Consistent with expectations about the vulnerability of these families over time, there is a significant increase in children with CAS involved caregivers in 2001 (35%) compared to 1995 (26%) ($\chi^2 = 8.87$, $df = 1$, $p < .01$) (Table 1).

Children with CAS involved caregivers do not differ significantly in age between the two years [$F(1, 1,029) = .099$, $p > .1$] (Table 1). On average, children with CAS

² From herein, caregivers with previous child welfare involvement as a child are referred to as CAS involved caregivers compared to CAS non-involved caregivers. Eight-seven percent of these caregivers across both years were the child's mother.

involved caregivers are significantly younger compared to children with CAS non-involved caregivers [$F(1, 1029) = 75.73, p < .001$].

The sub-sample of children in 1995 ($n = 447$) consisted of 176 (39%) children considered to be in need of protection and admitted to CAS care and 274 (61%) who were considered to be in need of protection, but received service from the CAS and other community agencies while living at home. Of the 176 children admitted to CAS care in 1995, 63 (36%) had a CAS involved caregiver. The sub-sample of children in 2001 ($n = 590$) consisted of 381 (64%) children considered to be in need of protection and admitted to CAS care and 211 (36%) children considered to be in need of protection, but received service from the CAS and other community agencies while living at home. Of the 381 children admitted to care in 2001, 160 (42%) had a CAS involved caregiver. Interestingly, CAS admissions to care of children with CAS involved caregivers do not differ between years ($\chi^2 = 2.0, df = 1, p > .1$) (Table 1). There are no statistically significant differences in age [$F(1, 563) = .248, p > .1$], or gender of children admitted to care between the two years ($\chi^2 = 1.73, df = 1, p > .1$). Subsequent analyses on child and caregiver outcomes are performed on the data collected in 2001 ($n = 591$).

Table 1

Summary of Descriptive Data for Children with CAS Involved and Non-involved Caregivers

	1995	2001
CAS involved caregivers**	26%	35%
Child's Age ^a	5.6 (4.9)	5.7 (4.7)
Children in care	36%	42%
CAS non-involved caregivers	74%	65%
Child's Age ^a	8.6 (5.2)	8.5 (4.9)
Children in care	64%	58%

Note: ^a = child's age in years; standard deviations in parentheses

** $p < .01$

2.2 Materials

A standardized coding instrument was created by the authors to guide the extraction of information from each case file. The information recorded included current and historical family information, as well as the history of the family's mental health,

violence and access to social services. Information on children included past and present access to mental health services, delinquency, and outcomes related to psychological, behavioural, and academic concerns. The coding instrument contained an established risk assessment instrument currently in use by the province (Ontario Association of Children's Aid Societies, 2000). Figure 1 summarizes areas addressed by the risk assessment. A manual was created that detailed the inclusion and exclusion criteria for each item to be recorded.

Figure 1

Summary of Areas for Risk Assessment

1. Caregiver Influence
 - Abuse – Neglect
 - Alcohol/Drug Use
 - Expectations of child
 - Acceptance of child
 - Physical capacity to care for child
 - Mental/Emotional/Intellectual Capacity

 2. Child's Influence
 - Child's vulnerability
 - Child's response to caregiver
 - Child's behaviour
 - Child's mental health and development
 - Physical health and development

 3. Family Influence
 - Family violence
 - Ability to cope with stress
 - Availability of social supports
 - Living conditions
 - Family identity and interactions

 4. Intervention Influence
 - Caregiver's motivation
 - Caregiver's cooperation with intervention

 5. Abuse/Neglect
 - Access to child by perpetrator
 - Intention and acknowledgement of responsibility
 - Severity of abuse/neglect
 - History of abuse/neglect/Neglect committed by present caregivers
-

2.3 Procedure

Five trained researchers working under the supervision of a project manager collected the data. To enhance reliability, the researchers received training prior to the beginning of data collection. Senior managers of the CAS of London and Middlesex and the research team met on a weekly basis to review concerns related to the file information, risk assessment analysis, or data collection procedures to ensure consistency in data interpretation and collection.

Results

3.1 Participants Characteristics

CAS involved caregivers are significantly younger [$F(1, 488) = 13.382, p < .001$], than are CAS non-involved caregivers (Table 2). Mothers are more likely to be the primary caregiver among CAS involved caregivers ($\chi^2 = 5.216, df = 1, p < .05$), compared to CAS involved non-caregivers. However, CAS involved caregivers are no more likely to be single mothers ($\chi^2 = .55, df = 1, p > .1$), than are CAS non-involved caregivers. Children of CAS involved caregivers are significantly younger than are children of CAS non-involved caregivers [$F(1, 585) = 45.18, p < .001$] (Table 2).

3.2 Child Mental Health Outcomes

Two behavioural outcomes and one psychological outcome are considered: identification of an attention deficit hyperactivity disorder (ADHD), conduct disorder, and the primary psychological (emotional) concern of the child. We also have information on whether the child was currently (or previously) on medication for an adjustment-related disorder.

Children with CAS involved caregivers do not differ significantly on the proportion diagnosed with ADHD ($\chi^2 = .28, df = 1, p > .1$), or conduct disorder ($\chi^2 = .07, df = 1, p > .1$), compared to children of CAS non-involved caregivers. There are no significant differences between children with CAS involved caregivers on the proportion identified with a primary psychological (emotional) concern ($\chi^2 = .50, df = 1, p > .1$), or on medication for an adjustment-related disorder ($\chi^2 = 2.58, df = 1, p > .1$), compared to children with CAS non-involved caregivers (Table 2).

3.3 Child Outcomes Related to Academic Concerns

To determine whether the caregiver's previous CAS involvement was related to the child's school history, three variables are used to characterize the child's academic experience: 1) evidence that the child has repeated a grade; 2) chronic truancy from school; and 3) whether the child was ever expelled from school. School history was obtained from school records in the child-protection files. Children under 6 years of age are excluded from this analysis because they are not attending school. Thus, the sub-sample is comprised of 344 school-aged children.

Consistent with expectations, a larger proportion of children with CAS involved caregivers are expelled from school ($\chi^2 = 5.74$, $df = 1$, $p < .05$), compared to children with CAS non-involved caregivers. Children with CAS involved caregivers do not differ significantly on the proportion having repeated a grade ($\chi^2 = .01$, $df = 1$, $p > .1$), or experiencing chronic absence from school ($\chi^2 = 2.81$, $df = 1$, $p < .1$), compared to CAS non-involved caregivers (Table 2).

Table 2

Summary of Child Outcomes for CAS Involved and CAS Non-involved Caregivers

Outcome	CAS involved caregiver (n = 204)	CAS non-involved caregiver (n = 387)
Participant Characteristics		
Primary caregiver mother*	85.8%	78%
Single motherhood	25%	22.3%
Age of caregiver ^a **	22.9 (5.51)	24.9 (5.92)
Age of child ^a	5.7 (4.7)	8.5 (4.9)
Child psychopathology		
ADHD	17.2%	18.9%
Conduct Disorder	7.8%	7.3%
Psychological Concern	6.9%	5.4%
Medication	13.7%	19%
School History (n=344)		
Expelled*	2.2%	0%
Chronic Absence	29.2%	20.6%
Repeated Grade	7.8%	7.9%
Risk Assessment^b		
Cumulative Risk Assessment Score**	32.66 (12.12)	26.24 (12.56)

Note: ^a = age represented in years; standard deviation in parentheses. ^b = mean risk assessment ratings; higher scores indicates greater intensity and nature of risk; standard deviations in parentheses; * $p < .05$; ** $p < .001$.

3.4 Child Outcomes Related to the Intensity and Nature of Risk

The level of risk to which the child is exposed was measured by the *Risk Assessment Tool* (Ontario Association of Children's Aid Societies, 2000), an instrument that is part of the provincial strategy to assess and predict the level of risk of harm to the child. The instrument consists of five distinct areas of assessment (Figure 1). Each risk element includes a five-point Likert scale of severity ranging from zero to four. The result yields a cumulative risk assessment score comprised of a total of the ratings from each of the five areas. The cumulative risk assessment scores within each area of risk form a reliable scale: Cronbach's alpha ranges from .71 - .79.

Analysis of covariance (ANCOVA) is used to show the caregiver's previous child welfare involvement relates to the child's risk assessment scores. Age is used as a covariate because children with CAS involved caregivers tend to be significantly younger than children with CAS non-involved caregivers.

As expected, children with CAS involved caregivers score higher on cumulative risk [$F(1, 584) = 28.42, p < .001$], compared to children with CAS non-involved caregivers (Table 2).

To determine the relative contribution of the individual risk assessment items that account for the higher risk scores of children with CAS involved caregivers, a stepwise discriminant function analysis on the scores of the 22 risk items is performed. When these variables are forced into a discriminant function, six items are able to accurately classify 77% of the participants overall (Canonical correlation of .529, Wilk's lambda of .72; $p < .001$). These six items accurately classify 129 (63%) of the children with CAS involved caregivers, compared to the 102 (50%) that would be correctly classified by chance alone. The discriminant function based on these six items incorrectly classify 15% of the children with CAS involved caregivers when, in fact, their caregivers have no previous CAS involvement. Table 3 provides the results of this analysis and the correlations between the risk assessment item scores and the discriminant function.

Table 3

Discriminant Function Risk Assessment Item Analysis Related to the Caregiver's Previous CAS Involvement

Step	Risk Items	Wilks' lambda	df	Univariate F	p	r
1	Caregiver Influence/Abuse-Neglect	.787	1	158.83	< .001	.834
2	Child's Influence/ Child's Vulnerability (i.e., age of child)	.757	2	94.06	< .001	.354
3	Caregiver Influence/Alcohol and Drug Abuse	.746	3	66.51	< .001	.383
4	Child's Influence/ Child's Mental Health and Development	.737	4	52.19	< .001	-.149
5	Intervention Influence/ Caregiver's Motivation	.730	5	43.19	< .001	.377
6	Abuse/Neglect Influence/ Severity of Abuse/Neglect	.720	6	37.74	< .001	.084

3.5 Outcomes Related to Caregiver Mental Health

To determine whether caregiver's with previous CAS involvement are more likely to suffer from mental health disorders, three dichotomous variables and one continuous measure are used to characterize the caregiver's mental health status. The dichotomous variables (yes/no) are: 1) caregiver has been identified with major depression; 2) caregiver has been identified with a substance abuse condition; and 3) caregiver has been diagnosed with a major mental disorder (e.g., schizophrenia, personality disorder). Major depression, substance abuse, and major mental illness are noted if they were identified by a formal diagnosis documented in the client's medical records. In some instances, the condition was coded as being present in the absence of formal diagnoses based on sufficient evidence from multiple sources of information such as the case manager's file notes, case history, or other mental health professionals who suggested the caregiver was

experiencing mental health concerns to an extent that interfered with parenting. The rationale for including these cases is that psychiatric and medical records of the caregivers are not commonly present in child-protection files; excluding these cases would under represent the range of psychopathology present in the caregivers.

The continuous variable associated with the caregiver's mental health is measured by the *Risk Assessment Tool* (Ontario Association of Children's Aid Societies, 2000). The caregiver's mental/emotional/intellectual capacity to care for the child is measured on a five-point Likert scale of severity ranging from 0 - 4. This continuous variable is a broad measure of a caregiver's emotional, mental, developmental or intellectual impairment(s) specifically as they relate to the capacity for caring for a child. The caregiver's mental/emotional/intellectual capacity to care for the child is measured on a scale from 0 - 4 for all cases. Since specific hypotheses are tested, one-tailed contrast analysis are employed.

As predicted, CAS involved caregivers are more likely to be diagnosed with depression ($\chi^2 = 6.20$, $df = 1$, $p < .05$), a major mental illness ($\chi^2 = 15.33$, $df = 1$, $p < .001$), and score higher in severity of their mental/emotional/intellectual capacity to care for the child [$t(588) = 4.532$, $p < .001$], compared to CAS non-involved caregivers (Table 4). Caregivers identified as CAS involved or CAS non-involved do not differ significantly in the proportion diagnosed with a substance abuse disorder ($\chi^2 = 2.84$, $df = 1$, $p < .1$) (Table 4).

Table 4*Summary of Family Outcomes for CAS Involved and CAS Non-involved Caregivers*

Outcome	CAS involved caregiver (n = 204)	CAS non-involved caregiver (n = 387)
Caregiver Mental Health		
Depression*	32.8%	23.3%
Major Mental Illness***	52.5%	35.8%
Substance Abuse	21.1%	15.5%
Mental/emotional/ intellectual capacity to care for child ^a ***	1.8 (1.27)	1.28 (1.36)
Family Violence		
Interadult Violence***	68.6%	45.1%
Children Exposed**	16.2%	26.2%
Physical Abuse	8%	11.9%
Sexual Abuse	1.5%	2.1%
Neglect	13.4%	11.1%
Socio-economic Status		
Social Assistance***	70.9%	44.1%
Unemployed***	74.7%	55.3%
Availability of Social Supports ^b ***	1.98 (1.1)	1.58 (1.1)

Note: ^a, ^b = mean risk assessment ratings; higher scores indicates greater severity of impairment; 0 minimum, 4 maximum; standard deviations in parentheses.

** $p < .05$; ** $p < .01$; *** $p < .001$.*

3.6 Outcomes Related to Family Violence

To determine whether the caregiver's previous CAS involvement is associated with family violence, two variables are used to characterize inter-adult violence and child maltreatment: 1) caregiver has experienced inter-adult violence; and 2) the presence of child maltreatment. Inter-adult violence is broadly defined and includes cases of excessive arguments or disagreements between pairs of household caregivers and aggressive physical action or sexual abuse towards a partner. Inter-adult violence is assessed with a single item in this study (yes/no) based on current and historical information present in the case file that corresponded to the definition of inter-adult violence. The presence of child maltreatment is assessed by four maltreatment groups: 1) neglect; 2) physical abuse; 3) sexual abuse; and 4) children exposed to inter-adult

violence. Children exposed to inter-adult violence is a broad measure of emotional harm and describes children living in homes where inter-adult violence is present.

Consistent with expectations, a greater proportion of CAS involved caregivers are the victims of inter-adult violence ($\chi^2 = 29.73$, $df = 1$, $p < .001$), compared to CAS non-involved caregivers (Table 4). Contrary to predictions, a smaller proportion of children with CAS involved caregivers are exposed to inter-adult violence ($\chi^2 = 7.587$, $df = 1$, $p < .01$), compared to children with CAS non-involved caregivers. There are no significant differences between children with CAS involved and CAS non-involved caregivers and the proportion of children experiencing neglect ($\chi^2 = .662$, $df = 1$, $p > .1$), physical abuse ($\chi^2 = 2.165$, $df = 1$, $p > .1$), or sexual abuse ($\chi^2 = .264$, $df = 1$, $p > .1$) (Table 4).

3.7 Outcomes Related to a Broader Social Context

The relationship of the caregiver's previous CAS involvement and variables that relate to socioeconomic adversity are investigated. Variables that relate to socioeconomic adversity are coded as: 1) source of income (welfare/social assistance); 2) employment status; and 3) availability of social supports. Source of income and employment status are measured as dichotomous (yes/no) variables. Availability of social supports is measured by the *Risk Assessment Tool* (see Figure 1). Availability of social support is measured as a continuous variable (range 0 - 4). A score of 4 indicates that the family is alienated and socially isolated from community supports whereas a score of 0 indicates that the family has multiple sources of reliable and useful support.

Consistent with expectations, a greater proportion of CAS involved caregivers are more likely to be receiving social assistance ($\chi^2 = 36.57$, $df = 1$, $p < .001$), and unemployed ($\chi^2 = 17.48$, $df = 1$, $p < .001$), compared to CAS non-involved caregivers. Additionally, CAS involved caregivers have less reliable and useful social supports [$t(588) = 4.16$, $p < .001$], compared to CAS non-involved caregivers (Table 4).

Discussion

Findings from this study indicate there is a significant proportion of intergenerational child welfare families who are receiving services from the Children's Aid Society. Some of the families in this study have been in the child protection system for at least two generations. They appear unable to escape the legacy of disadvantage from one

generation to the next. Within this population, there were a larger number of children admitted to CAS care in 2001 compared to 1995. Intergenerational families tend to have younger mothers with children under 6 years of age. Parental risk scores of intergenerational families were higher than for other children in care and the primary caregiver of these children reflected much higher rates of depression and mental illness. Similarly, exposure to family violence was much higher for intergenerational caregivers. Finally, the high rate of unemployment and families receiving social assistance, combined with a low level of social support contribute are part of the equation that leads many of these children to reside under child protection.

Conclusion

Important effective prevention and early intervention initiatives can be implemented in child protection agencies to lessen the degree of risk that is associated with intergenerational continuity and placement in child protection.

Children who have been maltreated and placed in care require improved access to clinical services and additional educational, social and community support. Late adolescence and early adulthood are vulnerable times for CAS graduates who may not have developed the life skills, educational abilities, and self regulatory skills that are necessary to cope with the demands of daily life. A related factor may also be the negative self-perception that has been identified as a consequence of child maltreatment (Muller & Lemieux, 2000).

Wolfe (1999) has outlined primary, secondary and tertiary prevention in child abuse. He suggests interventions “that target vulnerable populations, such as single and teenage parents, low socioeconomic status or isolated families, and parents undergoing crises” (p. 101), as particularly useful in reducing the reliance on child welfare. Many of the primary caregivers in this study were young mothers with children under the age of 6 years, which suggests a need for the earliest possible intervention with young high risk families.

Providing social supports to high-risk families is effective in reducing parental stress that is related to child maltreatment (Azur & Wolfe, 1998). In home-visiting with high-risk families in the pre- and post-natal period has been identified with a reduction in reports of child maltreatment (Leventhal, 2001; MacLeod & Nelson, 2000). Research on

the effectiveness of home visiting points to a combination of factors that are associated with success. These include the frequency of visits, involvement over a number of years, a therapeutic relationship, specific guidance, modelling, and assistance in accessing community resources (Leventhal, 2001). Even isolated and marginalized families at risk for child abuse and neglect can be engaged in prevention and early intervention in the immediate postnatal period (Fraser et al., 2000). Family preservation models that are well integrated with other services have shown reductions in admissions to child protection (Wells & Tracy, 1996). Actively working with families to increase their acceptance of helping agencies toward developing a strong helping alliance is helpful in reducing the likelihood of future child maltreatment (DePanfilis & Zuravin, 2002).

Of major concern in the present study was the high rate of mental illness identified in the primary caregivers of abused children. This was consistent with findings of other studies. For example, the Ontario Health Supplement Survey identified that a parental history of psychiatric disorder was associated with an increased risk of child maltreatment and that prevention should focus on early identification and treatment of parents with psychiatric illness (Walsh, MacMillan & Jamieson, 2002). There is an urgent need for child and adult mental health services to be more closely involved with child protection services as the maltreated children in one generation are likely to be disproportionately represented in the psychiatric population in the next.

References

- Belsky, J. (1988). "Child Maltreatment and the Emergent Family System." In K. Browne, C. Davies & P. Strattan (Eds.). *Early Prediction and Prevention of Child Abuse*. New York: Wiley. 8, 291 - 302.
- Belsky, J. & Vondra, J. (1989). "Lessons from Child Abuse: the Determinants of Parenting." In D. Cicchetti & V. Carlson (Eds.). *Child Maltreatment: Theory and Research on the Consequences and Causes of Child abuse and Neglect*. New York: Cambridge University Press, 153 - 202.
- Buchanan, A. (1996). *Cycles of Child Maltreatment*. Chichester, UK: Wiley.
- Cappell, C. & Heiner, R.B. (1990). "The Intergenerational Transmission of Family Aggression." *Journal of Family Violence*, 5, 135 - 152.
- Cicchetti, D. & Olsen, K. (1990). "The Developmental Psychopathology of Child Maltreatment." In M. Lewis & S.M. Miller (Eds.). *Handbook of Developmental Psychopathology*. New York: Plenum. 261 - 279.
- Cummings, E.M. (1997). "Marital Conflict, Abuse, and Adversity in the Family and Child Adjustment: A Developmental Psychopathology Perspective." In D.A. Wolfe, R.J. McMahon & R. Dev Peters (Eds.). *Child Abuse: New Directions in Prevention and Treatment Across the Lifespan*. Thousand Oaks, CA: Sage. 1 - 24.
- Egeland, B. (1993). "A History of Abuse is a Major Risk Factor for Abusing the Next Generation." In R.J. Gelles & D.R. Loseke (Eds.). *Current Controversies on Family Violence*. Newbury Park, NJ: Sage. 197 - 208.
- Egeland, B. (1988). "Breaking the Cycle of Abuse: Implications for Prediction and Intervention," in K. Browne, C. Davies & P. Stratton, (Eds.). *Early Prediction and Prevention of Child Abuse*. Chichester, England: John Wiley.
- Egeland, B., Jacobivitz, J. & Paptola, K. (1989). "Intergenerational Continuity of Abuse." In J. Lancaster & R. Gelles (Eds.). *Biosocial Aspects of Child Abuse*. New York: Jossey-Bass. 255 - 266.
- Egeland, B. & Stroufe, L.A. (1981). "Attachment and Early Maltreatment." *Child Development*, 52, 44 - 52.

- Gara, M.A., Rosenberg, S. & Herzoq, E. (1996). "The Abused Child as Parent." *Child Abuse and Neglect*, 20, 797 - 807.
- Gelles, R.J. (1998). "The Youngest Victims: Violence Toward Children." In R. Bergen & R. Kennedy (Eds.). *Issues in Intimate Violence*. Thousand Oaks, CA: Sage. 5 - 24.
- Hunter, R.S. & Kilstrom, M. (1979). "Breaking the Cycle in Abusive Families." *American Journal of Psychiatry*, 136, 320 - 1322.
- Knutson, J.F. & Bower, M.E. (1994). "Physically Abusive Parenting as an Escalated Aggressive Response." In M. Potegal & J.F. Knutson (Eds.). *The Dynamics of Aggression: Biological and Social Processes in Dyads and Groups*. Hillsdale, NJ: Lawrence Erlbaum. 195 - 225.
- Kotch, J.B., Muller, G.O. & Blakely, C.H. (1999). "Understanding the Origins and Incidence of Spousal Violence in North American." In T.P. Gullotta & S.J. McElhaney (Eds.). *Violence in Homes and Communities*. Thousand Oaks, CA: Sage. 1 - 38.
- Lansford, J.E., Dodge, K.A., Pettit, G.S., Bates, J.E., Crozier, M.P.M. & Kaplan, J. (2002). "A 12 Year Prospective Study of the Long-term Effects of Early Child Physical Maltreatment on Psychological, Behavioral and Academic Problems in Adolescence." *Archives Pediatric Adolescence Medicine*, 156, 824 - 830.
- Lee, C.M. & Gotlib, I.H. (1989). "Maternal Depression and Child Adjustment: A Longitudinal Analysis." *Journal of Abnormal Psychology*, 98(1), 78 - 85.
- Lee, C.L. & Bates, J.E. (1985). "Mother-Child Interaction at Age Two Years and Perceived Difficult Temperament." *Child Development*, 56, 1314 - 1325.
- Loeber, R., Farrington, D.P., Stouthamer-Leober, M., Moffitt, T.E., Gaspi, A. & Lynam, D. (2001). "Male Mental Health Problems, Psychopathy, and Personality Traits: Key Finding From the First 14 years of the Pittsburgh Youth Study." *Clinical Child and Family Psychology Review*, 4(4), 273 - 297.
- Loeber, R., Farrington, D.P., Jolliffe, D., Stouthamer-Leober, M. & Kalb, L.M. (2001). "The Concentration of Offenders in Families and Family Criminality in the Prediction of Boys' Delinquency." *Journal of Adolescence*, 24(5), 579 - 596.

- Main, M. & Goldwyn, R. (1984). "Predicting Rejection of Her Infant from Mother's Representation of Her Own Experience: Implications for the Abused - Abusing Intergenerational Cycle." *Child Abuse and Neglect*, 8, 203 - 217.
- Main, M. & Goldwyn, R. (1994). "Interview Based Adult Attachment Classifications: Related to Infant-Mother and Infant-Father Attachment." Unpublished Manuscript. Berkely: University of California.
- Main, M. (2000). "The Organized ?? of Infant, Child and Adult Attachment." *Journal of the American Psycho-analytic Association*, 48, 1055 - 1096.
- Maxfield, M.G. & Widom, C.S. (1996). "The Cycle of Violence: Revisited 6 Years Later." *Archives of Pediatric and Adolescent Medicine*, 150, 390 - 395.
- Pears, K.C. & Capaldi, D.M. (2001). "Intergenerational Transmission of Abuse: A Two Generational Prospective Study of an At-risk Sample." *Child Abuse and Neglect*, 25, 1439 - 1461.
- Pianta, R., Egeland, B. & Erickson, M.F. (1989). "The Antecedents of Maltreatment: Results of the Mother-Child Interaction Project," in D. Cicchetti & V. Carlson, *Child Maltreatment*. Cambridge University Press.
- Polansky, N.A., Gaudin, J.M., Ammons, P. & Davis, K. (1985). "The Psychological Ecology of The Neglected Mother." *Child Abuse and Neglect*, 9(2), 265 - 275.
- Polansky, N.A., Chalmers, M., Bittenwieser, E. & Williams, D.P. (1991). *Damaged Parents*. Chicago, IL: University of Chicago Press.
- Simons, R.L., Whitbeck, L.B., Conger, R.D. & Chyi-In, W. (1991). "Intergenerational Transmission of Harsh Parenting." *Developmental Psychology*, 27, 159 - 171.
- Stith, S.M., Rosen, K.H., Middleston, K.A., Busch, A.L., Lundeberg, K. & Carlton, R.P. (2000). "The Intergenerational Transmission of Spouse Abuse: A Meta - Analysis." *Journal of Marriage and the Family*, 62, 640 - 654.
- Spatz Widom, C. (1989). "The Cycle of Violence." *Science*, 244, 160 - 166.
- Stroufe, L. Alan. (1996). *Child Development: Its Nature and Course*. McGraw-Hill Inc.
- Trickett, P.K., Aber, J.L., Carlson, V. & Cicchetti, D. (1991). "The Relationship of Socioeconomic Status to the Etiology and Development Sequelae of Physical Child Abuse." *Developmental Psychology*, 27, 148 - 158.

- Whitmore, R.A.W., Kramer, J.R. & Knutson, J.F. (1993). "The Association Between Punitive Childhood Experiences and Hyperactivity." *Child Abuse and Neglect*, 17, 357 - 366.
- Widom, C.S. (1989a). "The Cycle of Violence." *Science*, 244, 160 - 165.
- Widom, C.S. (1989b). "Does Violence Beget Violence? A Critical Examination of the Literature." *Psychological Bulletin*, 106, 3 - 28.
- Widom, C.S. (1989). "Child Abuse, Neglect, and Violent Criminal Behavior," *Criminology*, 1, 251 - 271.
- Wolfe, D.A. & Mosk, M.D. (1983). "Behavioral Comparisons of Children from Abusive and Distressed Families." *Journal of Consulting and Clinical Psychology*, 51, 702 - 708.
- Wolfe, D.A. (1999). *Child Abuse: Implications for Child Development and Psychopathology*. Sage Publications Inc
- Zuravin, S.J. (1988). "Child Abuse, Child Neglect and Maternal Depression: Is there a Connection?" *Research Symposium on Child Neglect*. Washington, DC: US. Department of Health and Human Services, National Center on Child Abuse and Neglect.