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## Relationship of Obsessive-Compulsive Behaviors of Primary Caregivers with a History of Sexual Abuse and Perfectionism in their Sexually Abused Children

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# Relationship of Obsessive-Compulsive Behaviors of Primary Caregivers with a History of Sexual Abuse and Perfectionism in their Sexually Abused Children

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## **Abstract**

Childhood sexual abuse (CSA) is associated with many short- and long-term sequelae including obsessive-compulsive behaviors (OCB) and perfectionism. Research suggests that the expression of child perfectionism may be influenced by caregivers' OCB and CSA history. Caregivers with a CSA history may engage in dysfunctional parenting styles associated with child perfectionism, while children of caregivers with OCB may exhibit increased perfectionism due to genetics and/or the internalization of their parents' perfectionist tendencies. However,

given the high prevalence of OCB among those with a CSA history, the relationships among caregivers' expression of OCB, caregivers' CSA history, and child perfectionism is unclear. Thus, the purpose of this study was to explore these relationships. Results indicated that, consistent with existing literature, caregivers with a CSA history had significantly greater OCB than caregivers without a CSA history. However, caregiver OCB was not associated with perfectionism in youth who experienced CSA. Alternatively, children whose caregivers had a history of CSA exhibited significantly greater perfectionism than children of caregivers without a CSA history. Moreover, regression analyses revealed that caregiver CSA history significantly contributed to a model predicting child perfectionism.

**Keywords:** Obsessive-compulsive behaviors, perfectionism, childhood sexual abuse

Each year, approximately 1 in every 166 children between the ages of 2 and 17 will be sexually abused by a known perpetrator (Rheingold et al., 2007). This number increases greatly when assaults by unknown perpetrators are taken into account, as research has estimated that nearly one in four girls and one in ten boys may suffer from sexual victimization (Finkelhor, 1993). The high prevalence of childhood sexual abuse (CSA) is especially alarming considering the increased risk those who have been victimized have to an assortment of short- and long-term sequelae including depression, anxiety, obsessive-compulsive behaviors (OCB), perfectionism, and post-traumatic stress symptomatology (e.g., Kong & Bernstein, 2008; Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992; Tyler, 2002).

Recent research suggests that genetics may account for 47-58% of the variance in the expression of OCB (Hudziak et al., 2004), while nearly half of the variance may be due to other factors such as emotional neglect, intrusive parenting (Cavedo & Parker, 1994), and a history of sexual victimization (e.g., Burnam et al., 1988; Cath, van Grootheest, Willemsen, van Oppen, & Boomsa, 2008; Murrey, Bolen, Miller, & Simensted, 1993; Saunders et al., 1992). Cath and colleagues (2008) examined the differences in OCB in adult monozygotic twins and found that the most striking difference in individuals with varying levels of OCB was a history of sexual abuse, such that those with a history of sexual victimization had significantly greater OCB. Similarly, Murrey and colleagues (1993) found that, among women with obsessive-compulsive disorder, rates of CSA were unexpectedly high. In fact, individuals with a history of CSA are five times more likely to experience OCB than those without a sexual victimization history (Saunders et al., 1992).

OCB arises from dysfunctional beliefs that interfere with daily living. Such beliefs include the persistent need to be in control of one's thoughts, the need for perfectionism and certainty, and an overestimation of danger and a duty

to prevent it (Taylor, Afifi, Stein, Asmundson, & Jang, 2009). These symptoms often interfere with work, social, and family lives, as many people with OCB find it difficult to keep their jobs, complete household tasks, maintain friendships, and remain satisfied with life overall (Huppert, Simpson, Nissenson, Liebowitz, & Foa 2009; Mancebo et al., 2008).

Given the cumulative difficulties that those with a history of CSA and OCB may experience, it is likely that these problems impact the lives of other family members and are not solely limited to the individual (e.g., Baynard, 1997; Calvocoressi et al., 1995; Roberts, O'Connor, Dunn, Golding, & ALSPAC Study Team, 2004). Because research has consistently found a link between dysfunctional and/or stressful family environments and the emergence of unhealthy coping techniques and psychopathology in youth (Stark, Humphrey, Crook, & Lewis, 1990), children may be especially prone to emotional difficulties (e.g., perfectionism) if their caregivers exhibit OCB and have a history of CSA (e.g., Armsworth & Stronck, 1999).

Research suggests that caregivers with a history of CSA have reduced confidence in their parenting abilities, experience greater negativity in relationships with their children (Roberts et al., 2004), are prone to becoming emotionally overwhelmed by their parenting responsibilities (Armsworth & Stronck, 1999), and are more likely to engage in physical punishment and permissive or authoritarian parenting styles (DiLillo, Tremblay, & Peterson, 2000; Maker & Bутtenheim, 2000). Studies have linked such permissiveness and authoritarianism to greater perfectionism tendencies in children (e.g., Craddock, Church, & Sands, 2009; Flett, Hewitt, & Singer, 1995). For example, Flett et al. (1995) found that parental permissiveness was associated with greater socially prescribed perfectionism in daughters, while parental authoritarianism was associated with greater socially prescribed perfectionism in sons. More recently, research indicated that child perfectionism is associated with authoritarian parenting styles and high levels of family enmeshment (e.g., extreme closeness) (Craddock et al., 2009).

Similar to caregivers with a history of CSA, mothers who exhibit OCB are also more likely to be emotionally over-involved with their children and exhibit less warm and affectionate parenting styles than healthy controls (Challacombe & Salkovskis, 2009). Among families in which a family member exhibits OCB, individuals often have to change personal routines to accommodate the obsessions and compulsions, including performing rituals for the obsessive-compulsive family member (Challacombe & Salkovskis, 2009). Additionally, Frost and Steketee (2002) found that children exhibit more perfectionism if their parents also exhibit perfectionist tendencies (e.g., those with OCB), as these children internalize their parents' behaviors and attempt to meet their stringent demands. Thus, while research has indicated that perfectionism is higher among individuals who have experienced CSA (Kong & Bernstein,

2008), it is possible that the extent of perfectionist symptomatology in children may be influenced by caregivers' history of CSA and OCB.

Though perfectionist behaviors can be functional (e.g., achievement striving), perfectionism is a multidimensional construct that includes both adaptive and maladaptive components (Frost, Marten, Lahart, & Rosenblate, 1990). For instance, perfectionism is associated with maladaptive coping mechanisms and emotional regulation techniques such as self-blame (Hewitt & Flett, 1991), depression (Rudolph, Flett, & Hewitt, 2007), worry of negative evaluation by others (Stöber & Joormann, 2001), and self-doubt (Kawamura, Hunt, Frost, & DiBartolo, 2001). Additionally, Santanello and Gardner (2007) found that those with greater perfectionism were more likely to engage in avoidance behaviors such as suppressing unwanted memories and avoiding unpleasant events and/or encounters in order to prevent themselves from experiencing uncomfortable emotions. Lastly, those with high levels of self- and other-oriented perfectionism have significantly lower feelings of self-efficacy, suggesting that these individuals often feel ineffective and uncertain of their ability to meet situational demands (Hart, Gilner, Handal, & Gfeller, 1998). Due to these maladaptive coping mechanisms and emotional regulation techniques, it is not surprising that perfectionism is associated with a number of negative emotional and behavioral outcomes such as anxiety, depression, and eating disorders (Bardone-Cone et al., 2006; Kawamura, Hunt, Frost, & DiBartolo, 2001; Hewitt & Flett, 1991).

Despite the high prevalence of OCB among those with a history of CSA, current literature lacks a comprehensive understanding of the relationships among caregivers' expression of OCB, caregivers' CSA history, and child perfectionism. Thus, the purpose of the current study was twofold. First, the relationship between a primary caregiver's history of CSA and OCB was examined. It was hypothesized that, consistent with existing literature, caregivers with a history of CSA would report experiencing more OCB than those without a history of CSA. The second purpose of the study was to examine a caregiver's CSA history and OCB in relation to perfectionist tendencies in children who have been sexually abused while accounting for child characteristics (e.g., avoidance, self-blame, worry, and ineffectiveness). It was hypothesized that children with caregivers who had been sexually abused would report greater perfectionist tendencies than children with caregivers who did not have history of CSA. Similarly, it was hypothesized that children with caregivers who reported greater OCB would report greater perfectionist tendencies than children with caregivers who reported fewer OCB. It was also hypothesized that a caregiver's OCB and history of CSA would uniquely contribute to a model predicting child-reports of perfectionist tendencies, even when accounting for child characteristics already known to be associated with perfectionism.

## Methods

### *Participants*

Participants included 121 youth who had been sexually abused and their non-offending caregivers who were referred for treatment from Project SAFE (Sexual Abuse Family Education), a 12-week standardized cognitive-behavioral group therapy for families who have experienced CSA. The non-offending caregivers ranged in age from 23 to 72 years ( $M = 37.23$ ,  $SD = 7.82$ ), with 80.3% identifying as the biological mother, 12.0% as biological father, 3.4% as grandmother, 2.6% as step or adoptive mother, 0.9% as step or adoptive father, and 0.9% as foster mother. The majority of non-offending caregivers identified themselves to be of European-American descent (85.8%), with the remaining identifying as Hispanic-American (6.7%), Bi-racial (4.1%), African-American (2.5%), or Native American (0.8%). Sixty-one non-offending caregivers (50.4%) reported a history of CSA, while 60 individuals (49.6%) did not report a history of CSA.

The majority of the youth were female (82.0%) and ranged in age from 6.92 to 18.58 years ( $M = 11.84$ ,  $SD = 2.83$ ). The youth identified primarily as European-American (78.5%), with the remaining identifying as African-American (8.3%), Hispanic-American (5.0%), Bi-racial (5.8%), or Native American (2.5%).

### *Caregiver Measures*

*Childhood Trauma Questionnaire* (CTQ; Bernstein et al., 2003). Caregiver history of sexual victimization was assessed utilizing the CTQ. The CTQ is a 28-item self-report survey designed to assess five types of negative childhood experiences including emotional neglect, emotional abuse, physical neglect, physical abuse, and sexual abuse. There are five items specified to assess each of the five childhood experiences, and three additional items to determine the tendencies of respondents to minimize negative experiences. Each item is answered on a one to five scale (1 = *never true* to 5 = *very often true*) regarding experiences the respondent had during childhood. The CTQ has demonstrated internal reliability (coefficient of .91) and good criterion-related validity (Bernstein et al., 2003; Scher, Stein, Asmundson, McCreary, & Forde, 2001).

*Symptom Checklist-90-Revised* (SCL-90-R; Derogatis, 1994). Caregiver reports of OCB were assessed utilizing the SCL-90-R. The SCL-90-R is a 90-item self-report measure designed to assess an expansive array of psychopathic symptomatology in individuals over the age of 13. The inventory consists of three global distress scales (Global Severity Index, Positive Symptom Distress Index, and Positive Symptom Total) and nine symptom scales (Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility,

Phobic Anxiety, Paranoid Ideation, and Psychoticism). Respondents rate how much of a problem a symptom has posed for him or her within the past week using a five-point Likert scale, from (0) *not at all* to (4) *extremely*. The SCL-90-R has demonstrated acceptable test-retest reliability (coefficients ranging from .80 to .90), internal reliability (coefficients ranging from .77 to .90), and concurrent validity (coefficients ranging from .69 to .73) (Derogatis, 1994).

### *Child Measures*

*Child Depression Inventory* (CDI; Kovacs, 1992). Child reports of feelings of ineffectiveness were assessed using the CDI. The CDI is a 27-item self-report questionnaire designed to assess depressive symptomatology in children between the ages of 7 and 17. The measure consists of five subscales (Negative Mood, Interpersonal Difficulties, Negative Self-Esteem, Ineffectiveness, and Anhedonia) which are summed for a total score. The respondent is required to choose one of three responses based on how he or she has felt in the prior two weeks. Item responses are written and scored in order of increasing severity (e.g., "I feel like crying once in a while," "I feel like crying many days," "I feel like crying every day"). The CDI has demonstrated internal reliability (coefficients ranging from .71 to .87) and test-retest reliability (coefficients ranging from .43 to .84) (Kovacs, 1992).

*Child Manifest Anxiety Scale-Revised* (CMAS-R; Reynolds & Richmond, 1978). Child reports of worry were assessed using the CMAS-R. The CMAS-R is a 37-item self-report questionnaire designed to identify whether or not a wide range of anxiety symptoms are present in children ranging in age from 6 to 18 years. The measure yields a Total Anxiety and a Lie score. Individuals respond with a yes or no depending on whether or not they have experienced the symptom. The CMAS-R has demonstrated internal reliability (coefficient of .84) and concurrent validity (coefficients ranging from .24 to .85) (Reynolds, 1980; Reynolds & Richmond, 1978).

*Children's Impact of Traumatic Events Scale-Revised* (CITES-R; Wolfe, Gentile, Michienzi, Sas & Wolfe, 1991). Child reports of avoidance and self-blame/guilt were assessed using the CITES-R. The CITES-R is a 78-item self-report questionnaire designed to evaluate the outcomes and effects of CSA in children ranging in age from 8 to 16 years old. The measure consists of four scales and 11 subscales: PTSD (Intrusive Thoughts, Avoidance, Hyperarousal, and Sexual Anxiety); Social Reactions (Negative Reactions from Others and Social Support); Abuse Attributions (Self-Blame and Guilt, Empowerment, Personal Vulnerability, and Dangerous World); and Eroticization. Each item is answered on a three-point Likert scale: (0) *not true*, (1) *somewhat true*, and (2) *very true*. The CITES-R scales have demonstrated internal reliability (coefficients ranging from .60 to .78) and convergent and divergent validity (Wolfe et al., 1991).

*Multidimensional Anxiety Scale for Children* (MASC; March, 1998). Child reports of perfectionist tendencies were assessed utilizing the MASC. The MASC is a 39-item self-report measure designed to identify and assess the major dimensions of anxiety symptomatology in children ranging in age from 8 to 19 years. The MASC is comprised of four scales and six subscales: Physical Symptoms (Tense/Restless and Somatic/Autonomic), Separation Anxiety/Panic, Social Anxiety (Humiliation/Rejection and Public Performance Fears), and Harm Avoidance (Anxious Coping and Perfectionism). Respondents rate each on a four-point Likert scale, ranging from (0) *never applies to me* to (3) *often applies to me*. The MASC has demonstrated internal reliability (coefficients ranging from .73 to .89), test-retest reliability (coefficients ranging from .79 to .93) and acceptable convergent validity (Baldwin & Dadds, 2007; March, Parker, Sullivan, Stallings, & Conners, 1997).

### **Procedure**

Participants in this study received treatment from Project SAFE, a 12-week cognitive behavioral, parallel group treatment for youth who had experienced CSA and their non-offending caregivers. Youth and caregivers completed an assessment battery as part of a larger study examining outcomes of CSA, effects on the family, and treatment effectiveness. Project SAFE is offered through a Midwestern Child Advocacy Center and utilizes a variety of techniques (e.g., psychoeducation, emotion regulation, stress management, and assertiveness training) to reduce overall symptomatology of sexually abused youth and their non-offending caregivers.

## **Results**

A between-groups analysis of variance (ANOVA) was performed to examine the relationship between a caregiver's history of CSA and OCB. As hypothesized, there was a significant difference in the level of OCB reported by caregivers with and without a history of CSA,  $F(1,119) = 9.64, p = .002$ . Specifically, caregivers with a history of CSA reported experiencing significantly greater OCB ( $M = 49.12, SD = 11.23$ ) than caregivers without a history of CSA ( $M = 43.66, SD = 9.96$ ).

A between-groups ANOVA was performed to investigate the relationship between caregivers' history of CSA and their children's reports of perfectionism. As hypothesized, there was a significant difference in perfectionism scores between children with caregivers who had a history of CSA and those whose caregivers did not have a CSA history,  $F(1, 119) = 5.09, p = .026$ . Chil-

**Table 1.** Correlation Coefficients with MASC Perfectionism Scores

	Perfectionism	Caregiver CSA	Caregiver OCB	Self- Blame	Ineffectiveness	Worry
Caregiver CSA	.21*	—				
Caregiver OCB	.03	.18*	—			
Self-Blame	.16	.15	-.02	—		
Ineffectiveness	.29**	.12	.03	.28**	—	
Worry	.26**	.20*	.16	.28**	.15	—
Avoidance	.37**	.14	.25**	.05	-.18	.25**

\*  $p < .05$ , \*\*  $p < .01$

dren whose caregivers had a CSA history reported significantly greater levels of perfectionism ( $M = 50.48$ ,  $SD = 10.91$ ) than those whose caregivers did not have a history of CSA ( $M = 46.00$ ,  $SD = 10.94$ ).

Additionally, a correlation analysis was used to investigate the relationship between caregiver reports of OCB and youth reports of perfectionism. Contrary to the hypothesis, no relationship was found between caregiver OCB and child perfectionism (see Table 1). A series of correlations were also used to examine the relationship between child characteristics and perfectionism. Consistent with existing literature, child reports of ineffectiveness, worry, and avoidance were significantly correlated with child perfectionism. However, child reports of self-blame/guilt were not significantly correlated with child perfectionism (see Table 1).

A multiple regression model was performed to examine whether or not a caregiver's history of CSA, as well as their OCB, uniquely contributed to a model predicting their child's perfectionism scores, while taking into account avoidance, self-blame/guilt, feelings of ineffectiveness, and worry. The model significantly accounted for 30.2% of the variance in predicting the perfectionism scores of children who have experienced CSA,  $R^2 = .302$ ,  $F(6,112) = 7.64$ ,  $p < .001$  (see Table 2). As hypothesized, a caregiver's history of CSA significantly and uniquely contributed to the model. However, contrary to the research hypothesis, caregiver OCB did not uniquely contribute to the model. As expected, child reports of ineffectiveness, avoidance, and self-blame/guilt were significant contributors.

**Table 2.** Regression Weights in a Model Predicting Perfectionism in Sexually Abused Youth

Variable	b	SE $\beta$	$\beta$
Caregiver CSA	3.83*	1.91*	.170*
Caregiver OCB	-.08	.09	-.075
Self-Blame	.46	.23*	.174*
Ineffectiveness	.32***	.08***	.338***
Worry	.40	.21	.170
Avoidance	.96**	.32**	.260**

Caregiver CSA is coded as 0 = *no history of CSA* and 1 = *history of CSA*

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

## Discussion

The current study examined the relationships among primary caregiver history of CSA, caregiver OCB, and child perfectionism. Overall, the findings from this study provided additional support for the link between a history of CSA and subsequent OCB. Additionally, the results provide a more comprehensive understanding of the relationship between caregivers' OCB and history of CSA and the perfectionist tendencies of their children who have been sexually victimized. Specifically, the findings of the current study suggest that it is a caregiver's history of CSA, more so than their OCB, that is associated with greater perfectionist tendencies in children who have experienced CSA.

As stated, the results of this study revealed that caregivers with a CSA history reported greater OCB than caregivers without a history of CSA. This finding is consistent with previous research which has found a higher prevalence of CSA among individuals with OCB than those without OCB (e.g., Burnam et al., 1988; Cath et al., 2008; Murrey et al., 1993; Saunders et al., 1992). In general, research shows that individuals with a history of CSA are at an increased risk of experiencing a variety of anxiety disorders, including obsessive-compulsive disorder (Caspi et al., 2008).

While the aforementioned finding replicates existing literature, there are a limited number of studies that examine the effect that a caregiver's history of CSA has on the outcomes of his/her child who has been sexually victimized. Furthermore, those that do examine this relationship focus primarily on

depression and anxiety (e.g., Koverola et al., 2005). This study, however, indicates that there are other child outcomes (i.e., perfectionism) that are influenced by a caregiver's history of CSA. Specifically, children who had been sexually abused and had caregivers with a history of CSA exhibited greater levels of perfectionist tendencies than those with caregivers who did not have a history of CSA. This finding was strengthened by the multiple regression results which indicate that a caregiver's history of CSA significantly predicted perfectionism even when accounting for child characteristics associated with perfectionism. This may be due to the parenting styles common among parents with a CSA history (e.g., authoritarian or permissive), which literature has shown can elicit perfectionist tendencies in children (Armsworth & Stronck, 1999; Craddock et al., 2009; Flett et al., 1995). It is also possible that other psychopathologies associated with the caregiver's CSA history (e.g., depression or anxiety) may have impacted their child's perfectionist behaviors.

Interestingly, the results of this study indicated that youth that experienced CSA and had caregivers who reported exhibiting more OCB were not more likely to exhibit perfectionist tendencies than children whose caregivers reported lower levels of OCB. Although the literature has made the link between caregiver OCB and child perfectionism (e.g., Frost & Steketee, 2002), the current study did not replicate previous findings. It is possible that this link was not found because none of the caregivers in this study exhibited clinical levels of OCB. As such, future research should examine the relationships between caregiver history of CSA, OCB, and child perfectionism among caregivers exhibiting clinical levels of OCB.

One of the limitations of the present study is the homogenous nature of the participants which may limit the generalizability of the findings to other populations. Specifically, the majority of the children and their caregivers identified as European-American. Second, while the majority of the sample was biological parents (92.3%), there were some caregivers that identified as a step parent, adoptive parent, or grandparent. Because research has indicated that OCB are highly heritable, it is important to keep this limitation in mind, as this may have impacted the results. Third, the caregivers chose to participate in the therapy for their children, and thus were likely to be highly motivated, very involved, supportive, and trusting of their child. Additionally, participants were only included if the non-offending caregiver was following a safety plan. Thus, while not a requirement to participate, all non-offending caregivers were supportive and believed the victim. As such, the conclusions regarding the impact of caregivers' OCB may have been limited using this sample. Nevertheless, the findings indicate that the treatment-seeking population is unique and should be examined with this in mind.

Future research should be conducted to determine whether the differences in OCB between caregivers with or without a history of CSA, as well as per-

fectionist tendencies in children, are minimized by the Project SAFE treatment program. Future research should also target a broader, more diverse population, but also more specific populations, such as those not seeking treatment. Further work should also seek to examine factors, such as child characteristics, which may be mediating or moderating the relationship between caregiver OCB and child perfectionism. Moreover, while it was beyond the scope of the current study to assess parenting styles in those caregivers with or without a history of CSA and those caregivers with or without OCB, future research should address this issue as parenting style may be another mediating or moderating variable. Lastly, the growing awareness of the ability for caregiver characteristics to impact the outcomes of sexually abused youth suggests that examination of the impact that other caregiver psychopathologies have on the outcomes of children who have been sexually victimized is an important direction of research.

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