# Intergenerational continuity of child sexual abuse: A mixed methods study of risk and protective factors

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**Abstract**

Child sexual abuse (CSA) is a prevalent traumatic experience worldwide. The negative effects of CSA can put children on a trajectory where they are likely to experience later abuse (revictimization) and to have children who may also experience sexual abuse (intergenerational continuity). Both theoretical and empirical research on CSA continuity is lacking. There are limited theoretical frameworks that have been developed to conceptualize intergenerational maltreatment, and more specifically to understand the factors that are associated with intergenerational CSA, as well as individuals' experiences of (dis)continuity. Additionally, there are few empirical studies that have specifically examined intergenerational cycles of CSA to identify distinguishing factors that can be targeted to reduce the risk of continuity. Qualitative research documenting individuals' lived experiences of CSA and continuity is also clearly lacking in the literature, as well as mixed method designs. To address the limitations in the literature and enrich our understanding as to how CSA may continue within families, three studies were developed. The objective of Study 1 was to identify theories on intergenerational maltreatment to better understand the mechanisms that explain CSA continuity. A systematic review was proposed for Study 1 to identify and synthesize the literature on theoretical and/or conceptual frameworks that have been used to explain victim-to-victim cycles of abuse, the most prevalent type of continuity for CSA where a parent and a child are victims of CSA, but the abused parent is not the perpetrator of their child's abuse. Searches were executed in PsychINFO, Medline and Scopus; 15 papers were selected from a total of 617 articles. There were only five papers identified on the continuity of CSA specifically, highlighting a lack of focus on the theoretical explanations of this issue. As a result of this systematic review, a unified model of maltreatment continuity, more specifically victim-to-victim cycles, was proposed,

which has the benefit of guiding future investigations of CSA continuity and provides key intervention targets for clinicians. To address gaps in empirical knowledge, Study 2 was developed to document the role of individual (e.g., mental health, child maltreatment history), relational (e.g., attachment), and socioenvironmental factors (e.g., socioeconomic characteristics) in intergenerational cycles of CSA. Specifically, Study 2 aimed to compare cycle maintainers, cycle breakers, cycle initiators, and a control group within a sample of mother-emerging adult dyads ($N$ = 186). The convenience sample was recruited across Canada to participate in an online study. The results support prior research in showing that there is a higher risk of CSA in dyads where the mother experienced CSA ($OR$ =1.38, 95% CI: 1.13, 1.67). Compared to cycle initiators, maintainers reported greater psychological distress ($M$ = 27.23, $SD$ =17.72 vs $M$ = 35.18, $SD$ = 23.71), and lower mother-rated parent-child attachment ($M$ = 115.83, $SD$ = 23.00 vs. $M$ = 111.43, $SD$ = 17.48). Maintainers reported more post-traumatic stress symptoms only in comparison to the control group ($M$ = 24.82, $SD$ = 16.86 vs. $M$ = 10.13, $SD$ =10.95). Mothers in cycle maintaining dyads were exposed to more acts of domestic violence in childhood than those in cycle breaking dyads ($OR$ = 2.43, 95% CI: 1.09, 5.39). The objectives of Study 3 were to describe sexually abused mothers' experiences of parenting a child with and without a history of child maltreatment, and to identify the features of parenting in the context of continuity and discontinuity of child maltreatment. This study involved conducting individual qualitative interviews with 23 mothers who experienced CSA (12 continuity, 11 discontinuity). A traditional content analysis with a hybrid approach was used to analyze the data and generate themes, which showed that mothers described a variety of experiences related to parent-child and romantic relationships and parenting behaviours (e.g., difficulties with expressing emotions and affection, boundary setting, lack of confidence as a parent). A mixed method integration was completed

which helped to clarify and expand upon quantitative findings. Several promising directions for research, prevention, and clinical interventions for parents with histories of CSA were identified.

**Résumé**

L'abus sexuel dans l'enfance (ASE) est une expérience traumatisante répandue à l'échelle mondiale. Les conséquences négatives des ASE peuvent mettre les individus à risque de subir d'autres abus (revictimisation) et d'avoir des enfants qui subiront également des abus sexuels (continuité intergénérationnelle). Les études théoriques et empiriques sur la continuité de l'ASE sont rares. Peu de cadres théoriques ont été élaborés pour conceptualiser la maltraitance intergénérationnelle et, plus spécifiquement, pour comprendre les mécanismes sous-jacents à la continuité intergénérationnelle de l'ASE. De plus, peu d'études empiriques ont spécifiquement examiné les cycles intergénérationnels de l'ASE afin d'identifier les facteurs distinctifs qui peuvent être ciblés pour réduire le risque de continuité. Également, peu d'études qualitatives documentent l'expérience subjective des individus victimes d'ASE et leur compréhension des enjeux associés à la continuité intergénérationnelle; très peu d'études à devis mixte sont disponibles. Ainsi, trois études ont été développées pour répondre aux limites de la littérature scientifique et enrichir notre compréhension de la façon dont les ASE peuvent se transmettre au sein des familles. Une recension systématique a été effectuée dans le cadre de l'étude 1 afin d'identifier et de synthétiser les écrits scientifiques sur les cadres théoriques et/ou conceptuels qui ont été mobilisés pour expliquer les cycles intergénérationnels de victime à victime, le type de continuité le plus répandu pour l'ASE (c.-à-d., lorsqu'un parent et un enfant sont victimes d'ASE mais que le parent survivant n'est pas l'auteur de l'abus de son enfant). Les bases de données PsychINFO, Medline et Scopus ont été scrutées; 15 articles ont été retenus dans l'échantillon final. Seuls cinq articles portaient spécifiquement sur la continuité de l'ASE, ce qui met en exergue le manque d'études offrant des explications théoriques de cet enjeu. Cette recension systématique a permis de proposer un modèle unifié de la continuité, plus précisément des cycles

de victime à victime, qui a l'avantage d'orienter les recherches futures et les interventions cliniques ciblant la continuité des ASE. L'étude 2 vise à documenter empiriquement le rôle des facteurs individuels (ex., santé mentale et antécédents maternels de maltraitance), relationnels (ex., attachement) et socio-environnementaux (ex., statut socioéconomique) dans la continuité intergénérationnelle de l'ASE. Plus précisément, l'étude 2 visait à comparer les personnes qui maintiennent le cycle, celles qui interrompent le cycle, celles qui initient le cycle, et un groupe témoin au sein d'un échantillon de dyades mères-adultes émergents (N = 186). L'échantillon a été recruté à l'échelle du Canada pour participer à une étude en ligne. Les résultats confirment les recherches antérieures en montrant qu'il y a un risque plus élevé d'ASE dans les dyades où la mère a vécu une ASE (*OR* = 1,38, 95% CI: 1,13; 1,67). Par rapport aux initiateurs du cycle, les mainteneurs ont signalé une plus grande détresse psychologique (*M* = 27,23, *SD* = 17.72 contre *M* = 35,18, *SD* = 23,71), et un attachement parent-enfant plus faible selon l'évaluation de la mère (*M* = 115,83, *SD* = 23,00 contre *M* = 111,43, *SD* = 17,48). Les participant.e.s qui maintiennent le cycle ont signalé davantage de symptômes de stress post-traumatique comparativement au groupe témoin (*M* = 24,82, *SD* = 16,86 contre *M* = 10,13, *SD* = 10,95). Comparativement aux dyades qui rompent le cycle, les mères des dyades qui maintiennent le cycle ont été davantage exposées à la violence conjugale dans leur enfance (*OR* = 2,43, 95% CI: 1,09; 5,39). Pour mieux comprendre ces résultats quantitatifs, l'étude 3 s'appuie sur un devis qualitatif et a été réalisée auprès d'un sous-échantillon de 23 mères ayant subi une ASE (12 en continuité, 11 en discontinuité). Une analyse thématique révèle chez les mères une variété d'expériences relatives aux relations parent-enfant et romantiques et aux comportements parentaux (ex., difficultés à exprimer leurs émotions et leur affection, à fixer des limites, à se faire confiance comme parent). L'intégration des données qualitatives et quantitatives a permis de nuancer et d'approfondir les

résultats quantitatifs. Plusieurs orientations prometteuses pour la recherche, la prévention et l'intervention clinique auprès des parents ayant des antécédents d’ASE sont proposées.

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## Contribution to Original Knowledge

All parts of this dissertation represent original scholarship and provide novel contributions to the literature on intergenerational continuity of CSA. Through a mixed methods design, the dissertation highlights the roles of family status and exposure to intimate partner violence during childhood, as well as mothers' experiences of parenting, mental health, and attachment. All published and unpublished papers are acknowledged and are referenced according to the 7th edition of the American Psychological Association (APA).

## Contribution of Authors

This dissertation consists of one systematic review which represents my comprehensive examination, as well as two manuscripts representing empirical research. The research questions, design, and planned analyses were developed with the support from my supervisor. Data were obtained through a larger project conducted within the Resilience, Adversity, and Childhood Trauma Research Lab and funded by the Social Sciences and Humanities Research Council (SSHRC) and the Fonds de Recherche du Québec – Société et Culture (FRQ-SC). I participated in recruitment and data collection. I have conducted all the statistical and qualitative analyses involved in Studies 2 and 3 and am the first author on all manuscripts. Dr. Langevin (principal investigator on the SSHRC and FRQ-SC grants) and co-authors on these manuscripts contributed by supporting the interpretation of results and making edits during the writing process. I was supported by various scholarships throughout my doctoral studies, including the Joseph-Armand Bombardier Canada Graduate Scholarship awarded by SSHRC, and awards offered by l'Équipe Violence Sexuelle et Santé, and l’Institut Universitaire Jeunes en Difficulté.

## CHAPTER I: Introduction

Child sexual abuse (CSA) is a complex form of trauma that is highly prevalent worldwide (e.g., Barth et al., 2013) and is associated with a host of negative consequences for children. Children who have been victimized by a perpetrator can face a multitude of emotional, behavioural, and relational consequences, such as an increased risk of adolescent dating violence (Hébert et al., 2017), sexual assault revictimization (Papalia et al., 2021), increased contact with the healthcare system for physical health problems (Fergusson et al., 2013), and welfare dependence (Fergusson et al., 2013). They can also experience a multitude of mental health problems, such as anxiety (Gardner et al., 2019; Maniglio, 2013), post-traumatic stress (Adams et al., 2018), and decreased self-esteem and life satisfaction (Fergusson et al., 2013).

The harmful repercussions that may be experienced following CSA are critical to understanding survivors' developmental trajectories as well as why abuse may persist in families in the form of intergenerational continuity of maltreatment, which broadly encompasses victim-to-victim and victim-to-perpetrator cycles of abuse. A victim-to-perpetrator cycle has been defined as when parents who have a history of maltreatment perpetuate abuse against their child (Marshall et al., 2022), which has also been referred to as intergenerational transmission of maltreatment (Schelbe & Geiger, 2017). A victim-to-victim cycle occurs when the parent with a history of maltreatment is not the perpetrator of their child's abuse (Marshall et al., 2022; Schelbe & Geiger, 2017). In particular, studies have documented that children are at a greater risk of experiencing sexual abuse if their mother also experienced CSA (e.g., Grunsfeld, 2018; Trickett et al., 2011), representing an example of intergenerational continuity. This can also be considered a victim-to-victim cycle of maltreatment if both the mother and child experienced CSA and the mother was not the perpetrator of the sexual abuse. There are incidences of mothers

sexually abusing their own children, though this is reported less frequently (Sancak et al., 2021), and would be considered an example of a victim-to-perpetrator cycle if the mother has a history of CSA. More frequently, the perpetrators of CSA are acquaintances or relatives of the family (Davies et al., 2013). There is a wide range of documented prevalence rates for the intergenerational continuity of CSA, varying from 26.6% to 51% (Grunsfeld, 2018; Leifer et al, 2004; McCloskey & Bailey, 2000; Oates et al. 1998; Testa et al., 2011), which can be in part explained by methodological factors such as the measurement of CSA.

Both theoretical and empirical research on the intergenerational continuity of CSA is limited (Langevin et al. 2021; Marshall et al., 2022). A comprehensive and integrative theoretical framework to explain CSA continuity would help guide future research on this topic and support the identification of clinical targets for intervention with families. Several mechanisms have been proposed to explain the ways in which maltreatment may continue within families, including compromised parent-child attachment and parenting behaviours (Langevin et al., 2021), impairments in mental and physical health (Maniglio, 2009), and adverse educational and occupational outcomes that may confer risk to the next generation, such as lower levels of education and income (Currie & Widom, 2010). However, the intergenerational continuity of CSA specifically has been understudied in terms of documenting psychosocial risk and protective factors that may serve to continue or discontinue this abuse across generations, which is the overarching goal of this dissertation. A focus on CSA will allow for in-depth investigation pertaining to the specificities of how this type of abuse may be reproduced. In particular, there are few studies that have compared groups of parent-child dyads in terms of individual, relational, and socioenvironmental factors that may differentiate continuity and discontinuity trajectories. Another disparity in the literature is the shortage of qualitative studies on this topic,

which adds rich personal accounts of a phenomenon, and provides an opportunity to expand upon quantitative findings. Qualitative research that allows for an exploration of individuals' lived experiences of intergenerational CSA would provide great insight into the challenges that families face to prevent continuity. Identifying the factors that may explain CSA (dis)continuity and understanding the experiences and perspectives of those who have been personally affected is crucial to inform systemic interventions to prevent intergenerational cycles of CSA.

**Current Dissertation**

This dissertation aims to address some of the current limitations in the literature by firstly completing a systematic review on the theoretical frameworks that have been used to explain the intergenerational continuity of maltreatment, with a specific aim of integrating theories that can be used to conceptualize victim-to-victim cycles of child maltreatment, where the parent is not the perpetrator of their child's abuse, which is more common with CSA than other maltreatment types (Marshall et al., 2022). This review was used to inform the selection of factors to be further investigated in the empirical studies of this dissertation. The empirical studies are based on dyadic data obtained from a cross-sectional survey of mothers and their emerging adult children (18-25 years old), and individual interviews conducted with mothers. The overarching goal is to document the factors which differentiate mothers in different CSA continuity groups – continuity, discontinuity, initiators, and controls; as well as to explore mothers' lived experiences of CSA and the perceived impacts that this abuse may have had on their mental health and relationships with their children. The choice of a mixed methods design is particularly advantageous for understudied and complex topics to overcome the methodological limitations of using only quantitative or qualitative designs, allowing for a comprehensive investigation of this research problem. CSA continuity is a complex phenomenon that appears prevalent and has

serious ramifications, yet little is understood in terms of how this abuse is perpetuated and what can be protective to families to prevent intergenerational trauma. Findings from this mixed methods study will support interventions and preventative strategies tailored to those who have experienced CSA to reduce the risk of continuity. This dissertation presents a detailed literature review (Chapter II), a description of the mixed methods methodology (Chapter III), followed by Studies 1 (systematic review; Chapter IV), 2 (quantitative results; Chapter V), and 3 (qualitative results; Chapter VI), with bridging statements in between studies. The final chapter presents the mixed method integration; strengths, limitations, and future directions; as well as implications for research and clinical practice.

# CHAPTER II: Literature Review

The following section reviews the literature on child sexual abuse, intergenerational continuity, and the empirical and theoretical findings that point towards mental health, relational, and socioenvironmental context as potential factors in explaining continuity.

## Child Sexual Abuse

### *Definition and Prevalence*

Child sexual abuse is a prevalent and detrimental form of trauma that is widespread. This dissertation is informed by a comprehensive conceptual model of CSA proposed by Mathews et al. (2019) who noted many limitations in the literature concerning how CSA is defined and measured across studies. The definition that these authors propose requires that: 1) the individual must be a child (below the legal age of adulthood or considered to be a child in terms of developmental level); 2) true consent is absent (i.e., the child cannot give consent due to developmental stage or capacity, or is able to but did not consent); 3) the act is of a sexual nature (perpetrator seeks physical, mental, or sexual gratification, or it is legitimately experienced by the child as a sexual act); and 4) the act constitutes "abuse", meaning the act is performed by someone in a superior position, within a relationship of power, which exploits the child's vulnerability (Mathews et al., 2019).

Based on a systematic review and meta-analysis of 24 studies published between 2002 and 2009, Barth et al. (2013) documented that between 8% to 31% of girls and 3% to 17% of boys experienced CSA (under the age of 18). This study provided estimates based on four specific types of CSA: non-contact abuse (inappropriate sexual solicitation, indecent exposure), contact abuse (touching/fondling, kissing), forced intercourse (oral, vaginal, anal, attempted), and mixed sexual abuse. In another study of worldwide prevalence, it was estimated that 20.1%

of girls and 8.0% of boys in the United States and Canada (combined) experienced sexual abuse before the age of 18 (Stoltenborgh et al., 2011), with a global prevalence of 11.8%. In a more recent meta-analysis of 48 studies that used the short form of the Childhood Trauma Questionnaire, the worldwide prevalence of CSA among females was 24% (pooled estimate), with a higher rate among female sex workers (41%), and clinical samples of females with a mental illness (32%) (Pan et al., 2021). The prevalence of CSA can be influenced by methodological factors as well as a lack of a shared definition of what constitutes CSA, which has implications for research, legal principles, and prevention programs (Mathews et al., 2019). Of note, reviews highlight heterogeneity between the included studies in terms of prevalence estimates for different types of sexual abuse (e.g., non-contact abuse, forced intercourse). The method for assessing CSA can also impact obtained prevalence estimates. For instance, some reviews have shown higher prevalence among girls reporting CSA through interview versus questionnaire (Barth et al., 2013), whereas other reviews have reported higher CSA prevalence for self-report questionnaires compared to face-to-face interviews or telephone interviews (Chen et al., 2006). Variability in prevalence is also noted across geographic location, with lower rates in Europe and Asia compared to the United States (Pan et al., 2021). As well, prevalence rates can differ depending on the sample recruited, as the review conducted by Pan et al. (2021) included a mixed sample of individuals with and without mental health problems, prisoners, and sex workers, whereas the estimates based on Stoltenborgh et al. (2011)'s review reflects a nonclinical sample.

### *Risk Factors and Consequences Associated with CSA*

The risk factors for CSA victimization and the associated long-term consequences have been quite extensively documented in the literature. Based on meta-analytic findings, some of

the documented factors that may increase the risk of CSA include prior victimization of the child or other family members, a parent's history of maltreatment victimization, a non-nuclear family structure (e.g., presence of a stepparent), intimate partner violence victimization, family problems (e.g., social isolation), child characteristics (e.g., female gender), and child-related difficulties (e.g., mental or physical conditions) (Assink et al., 2019). Other research supports the findings that female gender seems to be a risk factor for CSA, as well as alcohol or drug use, psychiatric history, self-harm, attempted suicide, learning disability and physical disability (Davies et al., 2013; Brown et al., 1998). Harsh punishment and mothers' negative perceptions of pregnancy (e.g., unwanted pregnancy) have also been associated with greater CSA risk (Brown et al., 1998). Based on meta-analytic findings of 80 studies, it is estimated that about half (47.9%) of CSA survivors experience sexual revictimization (Walker et al., 2019), further compounding their initial traumas and potentially increasing the likelihood of experiencing long-term difficulties, such as with parenting.

Equally important as identifying factors that contribute to the risk of CSA is the study of how CSA can then commence a cascade of negative events that span into adulthood. CSA is associated with increased internalizing and externalizing symptoms (Lewis et al., 2016; Muniz et al., 2019), sexualized behaviour problems (Wamser-Nanney & Campbell, 2020), sleep difficulties (Langevin et al., 2022a), and insecure attachment behaviours (Ensink et al., 2020). Difficulties following CSA also have the potential of interfering with children's academic functioning (Mitchell et al., 2021). Importantly, it has been reported that over two-thirds of CSA victims will not tell an adult or will delay disclosing the abuse (Mohler-Kuo et al., 2014). If children do not feel comfortable to disclose the abuse, and if social support and interventions are not provided, these challenges may extend into adolescence and adulthood, potentially in more

severe forms, including anxiety, depression and post-traumatic stress disorder (PTSD) (Gardner et al., 2015; Khadr et al., 2018), dissociation (Bernier et al., 2011, 2013; Hébert et al., 2017), self-harm (Nagtegaal & Boonmann, 2022), as well as negative impacts on sexual functioning (e.g., early onset of sexual intercourse, sexual shame, risky sexual behaviours, sexual dysfunctions) (Jones et al., 2013; Homma et al., 2012; Pulverman & Meston, 2020; Staples et al., 2012; Vaillancourt-Morel et al., 2015). Among those who have experienced CSA, there is also an increased risk of suicidal ideations and attempts (Fergusson et al., 2013), physical and sexual revictimization experiences (Papalia et al., 2020), health conditions (e.g., autoimmune disorders, gastrointestinal symptoms, and pain) (Bradley et al., 2019; Irish et al., 2010; Khadr et al., 2018; Wilson, 2010), and increased health service utilization (Daigneault et al., 2017). Mental health problems, like depression, can in fact emerge years after the onset of CSA, such as during the emerging adulthood period (Teicher et al., 2009). Given these substantial and long-term adverse effects, CSA can negatively impact adult relationships and parenting.

Experiencing increased symptoms of depression, anxiety, PTSD, and dissociation following experiences of CSA can reflect complex or developmental trauma, which refers to multiple, chronic, prolonged, and developmentally adverse traumatic events that are interpersonal in nature (e.g., physical, sexual) and often occurring within the child's caregiving system (D'Andrea et al., 2012; Spinazzola et al. 2021; van der Kolk, 2005). Child sexual abuse as a form of complex trauma can set the stage for chronic difficulties in response to subsequent stress (Cicchetti, & Toth, 1995). The neurodevelopment of children, for which the caregiving environment is crucial, is disrupted by maltreatment of any kind (Perry, 2002). Studies have found alterations in "social brain" structures such as the hippocampus, amygdala, and anterior cingulate cortex in individuals who have experienced maltreatment (e.g., Dannlowski et al.,

2012; Thomaes et al., 2010; Weniger et al., 2008). In cases where there is intergenerational continuity of CSA, the caregiver may find parenting and relationships especially difficult, given their own history of trauma and whose own neurodevelopment may have been affected in ways that have contributed to mental health and relational challenges. The next section will address how CSA is a unique type of child maltreatment deserving dedicated and increased attention.

### *Unique Features of Child Sexual Abuse*

Although there is co-occurrence of child maltreatment types (Kim et al., 2017), meaning that children often experience polyvictimization (Le et al., 2018), there are unique features of CSA trauma that distinguishes it from other types of maltreatment (physical and emotional abuse, physical and emotional neglect, and exposure to intimate partner violence), and which make it deserving of further dedicated investigation. Regarding theoretical conceptualizations of CSA, researchers have argued that because of the sexual nature of this type of abuse, survivors may need interventions that are more specific to addressing the sexual boundary violations they have experienced, powerlessness, and trust (Finkelhor & Browne, 1986). As described by Finkelhor and Browne (1986), a combination of four traumagenic dynamics, or trauma-causing factors (traumatic sexualization, betrayal, powerlessness, and stigmatization) are particularly relevant to understanding the traumatic impacts of sexual abuse. The authors note that while these dynamics are relevant to other kinds of trauma, their combination in one set of circumstances is why sexual abuse trauma is unique (Finkelhor & Browne, 1986).

Traumatic sexualization, which is defined as the alteration of a child's development of sexual feelings and attitudes as a result of sexual abuse, refers to the ways in which a child may learn to use sexual behaviour to meet their needs; certain parts of their anatomy become distorted in importance and meaning; they are given conflicting messages about sexual behaviour by the

offender; and frightening memories can become associated with sexual activity (Finkelhor & Browne, 1986). In response to sexual trauma, some sexual abuse survivors may display a preoccupation with sex (e.g., sexually intrusive thoughts), as well as feelings of shame regarding sexual activity (Noll et al., 2003). Furthermore, there is research to suggest that sexual abuse is associated with a younger age of consensual intercourse, adolescent motherhood (Noll et al., 2019), and a lower birth control efficacy (Noll et al., 2003). Sexualized behaviour problems are reportedly more common in children who experience CSA compared to normative groups (e.g., sexual aggression, developmentally inappropriate imitations of sexual activity) (Briere & Elliott, 1994; Friedrich et al., 1992). Adults may continue to be further affected sexually by their experiences of CSA. In a qualitative study using grounded theory, participants reported that CSA shaped aspects of their adult sexuality (e.g., sexual development, identity, behaviours, relationships, attitudes), such as contributing to high-risk sexual behaviours, having many sexual partners, having frequent or unprotected sexual activities, and having sex while using drugs or alcohol (Roller et al., 2009).

Within Finkelhor and Browne (1986)'s model, betrayal is defined as a child's realization that someone who they have relied on has caused them harm, whether this is the perpetrator themselves, or non-perpetrating family members who may not have intervened to protect them (Finkelhor & Browne, 1986). Feelings of betrayal could contribute to difficulties trusting others. For instance, woman-identifying adults have reported being fearful or distrustful of men (Roller et al., 2009), which could ultimately impact the quality of their romantic relationships. In addition, children can lose trust in their caregivers if they feel that that they were not protected by them.

Powerlessness refers to a child's disempowerment through the acts of sexual abuse and physical violations of their body. Feelings of powerlessness may leave children with anxiety (e.g., nightmares, hypervigilance), and a lack of self-efficacy and coping skills (Finkelhor & Browne, 1986). A scoping review of the literature supported that CSA survivors report powerlessness in terms of learned helplessness, remaining silent about sexual issues, feeling disempowered and defenseless as a result of power differentials and pressure to keep the abuse a secret, feeling trapped, and fearful of disclosing the abuse and not being believed (Henning et al., 2018).

Finally, stigmatization refers to the shame and guilt surrounding CSA that can become internalized as part of a child's self-image (Finkelhor & Browne, 1986). CSA victims may come to see themselves as flawed, damaged, and unworthy. This can occur through direct communication by the perpetrator through pressuring them to keep the acts a secret and blaming the child for the CSA (Finkelhor & Browne, 1986). In comparison to other forms of maltreatment (e.g., physical and emotional abuse by caregiver, and neglect), CSA survivors may also be more reluctant to disclose their abuse (Lev-Wiesel & First, 2018). If disclosures are attempted and met with disbelief by adults, this can further increase children's feelings of shame by reinforcing their self-image as bad and unacceptable. Perceptions of stigma around sexual abuse and self-blaming have been found to mediate the association between women's experience of CSA and later psychological distress (Coffey et al., 1996), highlighting the potential long-term impacts of CSA on an individual's self-worth. The social stigma surrounding CSA is also unique to this type of maltreatment. For instance, survivors may view themselves as damaged, less sexually desirable, defective, dirty, more likely to be labelled as a whore, and fear of being rejected by others (Henning et al., 2018).

In addition to these four traumagenic dynamics that distinguish CSA from other maltreatment types, there are other empirical findings suggesting that CSA is associated with unique psychological outcomes. For example, in a national sample of males (n = 14,564; CSA prevalence rate of 5.3%), those who had experienced CSA only or CSA and other types of maltreatment (harsh physical punishment, physical abuse, exposure to IPV, physical neglect, emotional abuse, and emotional neglect) had higher odds of reporting a mental disorder, as compared to those who had a history of abuse without CSA (Turner et al., 2017).

In conclusion, theoretical and empirical research supports CSA as a type of maltreatment that is associated with unique outcomes for survivors compared to other maltreatment types, providing justification for more focused research on the risk factors, outcomes, and experiences of CSA survivors.

**Intergenerational Continuity of Child Sexual Abuse**

The psychological and relational impacts of CSA can be long-term, extending into adulthood (e.g., Noll, 2021), which may unfortunately increase the risk for CSA in the next generation. This has been documented by studies showing that there is an increased risk of children experiencing sexual abuse if their mothers were also subjected to sexual abuse during childhood (e.g., Avery & Hutchinson, 2002; McCloskey, 2013; Testa et al., 2011; Wearick-Silva et al., 2014). While there are limited studies on the intergenerational continuity of CSA, the literature on the continuity of child maltreatment as a combined category points to variables that should be investigated further in the context of CSA. In a study on the intergenerational maltreatment hypothesis, Madigan et al. (2019) conducted a meta-analysis of 142 studies and reported evidence for intergenerational CSA ($k$ = 18, $d$ = 0.39, 95% CI [0.24, 0.55]). No

significant moderators of CSA continuity emerged from this study, though the authors urged further research into the mechanisms and factors that can break cycles of abuse.

The prevalence of the intergenerational continuity of any type of maltreatment has been found to range between 7% and 88%, depending on a range of methodological factors (e.g., sample size, design, questionnaires to measure maltreatment) (Langevin et al., 2021). Specific to CSA continuity, prevalence rates have varied from 26.6% to 51% (Grunsfeld, 2018; Leifer et al, 2004; McCloskey & Bailey, 2000; Oates et al. 1998; Testa et al., 2011). While there are studies documenting the prevalence of this cycle, there are few studies that have quantitatively or qualitatively investigated CSA continuity. Further, there are few theoretical models that have been proposed to explain this type of continuity.

To our knowledge, the only identified theoretical model conceptualizing the intergenerational continuity of CSA specifically was published by Baril and Tourigny (2015). It is a comprehensive and detailed model that is based on traumatic stress models (i.e., the known effects of trauma on functioning) and attachment theory. The risk of CSA continuity is theorized as stemming from psychological difficulties, parenting problems, and adult intimate partner violence victimization. While it is a valuable model to inform our understanding of this problem, it may not be as easily applied in research or clinical settings because of its complexity and the number of variables that can be feasibly studied based on sample sizes. Further, the model does not place great emphasis on socioenvironmental factors (e.g., education, income, family status), which are indeed important to consider in studying maltreatment (Conger et al., 2010; Jaffee et al., 2013). There is much to be learned still about the specific parenting and attachment difficulties that CSA survivors face which may contribute to continuity or discontinuity.

Other theoretical explanations that have been used to conceptualize the risk for the continuity of maltreatment include attachment theory (Bowlby (1969/1982), traumatic stress models (Baril & Tourigny, 2015; Courtois & Ford, 2009; De Bellis, 2001; Maker & Buttenheim, 2000; Sperlich et al., 2017), the Complex PTSD model (Courtois & Ford, 2009), the ecological framework (Bronfenbrenner, 1979; Belskey, 1980, Cicchetti & Rizley, 1981), family systems theory (Bowen, 1978), developmental models (see Alink et al. 2019 for review), and biological models (e.g., Alink et al., 2019; Reijman et al., 2015). These theories were not originally put forth to explain maltreatment, though they have informed our understanding of the factors that lead to a greater risk for maltreatment, the consequences of such trauma, and explaining how or why parents who have experienced maltreatment are at a greater risk of having children who will also be maltreated. The link between traumatic stress, mental health, and parenting is what many of these theoretical explanations have in common when it comes to how they have been used to describe maltreatment continuity. Trauma impacts the stress response system and the development of a child (e.g., Trickett et al., 2010), leading to an increased risk of developing mental health problems. The wide range of effects that trauma has on one's functioning, as well as the presence of a mental health problem, can then affect relationships and parenting. A limit to our current understanding pertains more specifically to the theoretical knowledge of intergenerational continuity of CSA which is a unique form of child maltreatment deserving separate analysis. Theoretical frameworks have not been consistently applied and integrated to understand why CSA continuity occurs and the mechanisms that may best conceptualize (dis)continuity. A precise and simplified model would benefit researchers to focus on exploring specific factors or experiences that may contribute to CSA continuity. Such a model would also be useful for clinicians to inform case conceptualization and identify predisposing factors (i.e.,

things that cannot be changed, such as developmental history), perpetuating factors that may be keeping the problem alive and could be targeted with specific interventions (e.g., lack of resources, internal or external triggers, attachment difficulties), and the client's protective factors that could be leveraged to foster therapeutic progress (e.g., social support, coping, living environment).

In addition to a lack of theoretical understanding of how CSA continues within families, there are also a limited number of empirical studies that have investigated this topic. This was made evident by a systematic review (Langevin et al., 2021), which found that only five out of 51 identified studies on the risk and protective factors involved in intergenerational maltreatment were focused on CSA (Baril & Tourigny, 2016; Grunsfeld, 2018; Leifer et al., 2004; McCloskey & Bailey, 2000; Testa et al., 2011). These studies are limited in terms capturing risk factors and understanding individuals' experiences across a longer timespan, such as by including a sample of mothers and their adult children, qualitative studies, examining multi-level risk and protective factors, and measuring lifetime reports of CSA.

Since the publication of Langevin et al. (2021)'s review, there have been few other studies that have examined the continuity of CSA. As an example of hetereotypic continuity of CSA (e.g., parent and child experienced different types of abuse), Martoccio et al. (2022) conducted a longitudinal study of 499 mothers who were recruited during pregnancy, as well as their children (between birth and 3.5 years). They found that mothers' histories of physical and sexual abuse doubled the risk of the child experiencing any type of maltreatment by 43 months, as verified by child protection records. Importantly, mothers' sexual abuse history posed a significantly greater risk (2.26 times) than physical abuse (2.01 times). Through structural equation modelling they also found that the effect of mothers' sexual abuse was mediated

primarily through substance abuse problems (Martoccio et al., 2022). As another example, Langevin et al. (2023) recently documented evidence for both homotypic (parent and child experienced the same type of maltreatment) and heterotypic continuity of CSA based on mother and father maltreatment histories, and using substantiated cases of child maltreatment involved with Child Protection Services in Montreal, Quebec. Mothers' histories of CSA increased the odds of their child experiencing CSA by 1.42 times, while fathers' histories of abandonment increased the risk of second-generation CSA by 2.74 times (Langevin et al., 2023). Though studies clearly show associations between a parent's history of CSA and their child's risk for CSA, more work needs to be done to understand this increased risk and how it can be reduced. The following sections will provide an overview of the mental health, relational, and socioenvironmental factors that have been researched in the context of intergenerational continuity.

### *Mental Health*

One of the most researched risk factors for intergenerational cycles of child maltreatment broadly has been mothers' psychopathology (such as depression, anxiety, and post-traumatic stress symptoms), as noted in a scoping review by Langevin et al. (2021). Baril and Tourigny (2015) conducted a study with 45 mothers who had experienced CSA and who had at least one child who had been sexually victimized before the age of 18. In comparison to a group of mothers who had experienced CSA but whose child(ren) had not been abused, mothers who experienced continuity were more likely to have high PTSD symptoms, to report physical intimate partner violence, and to have experienced sexual abuse before the age of 6 or during adolescence (Baril & Tourigny, 2015). In another longitudinal study of 891 mothers and their children between the ages of 4 and 12, Grunsfeld (2018) found that maternal anxiety was a risk

factor for CSA continuity. Out of the five studies identified by Langevin et al. (2021) which examined risk and protective factors pertaining to CSA continuity, only two represent longitudinal designs and only one included a sample of older children in the emerging adulthood period. As reported by Langevin et al. (2020), mothers in cycle maintaining dyads were more likely to report clinical levels of distress, followed by mothers in cycle initiating (child but not the mother experienced CSA) and cycle breaking dyads. PTSD symptoms reported by mothers varied in this study, with mothers in the cycle maintaining dyads reporting greater symptoms than other groups (Langevin et al., 2020). The fact that the children participated in this study soon after the CSA had been disclosed is an important feature. With more time passing between CSA disclosure and research participation, group disparities amongst dyads may become clearer. In addition to mental health problems, drug use is a documented risk factor involved in CSA continuity, which was found through a cross-sectional study of 179 women who had at least one child between the age of 6 and 12 (McCloskey and Bailey, 2000). In a recent study of mothers and their sexually abused children, Langevin et al. (2022) found that mothers' psychological distress, PTSD symptoms, and dissociation mediated the relationship between mothers' CSA experiences and their children's mental health problems (i.e., internalizing, externalizing, and dissociation symptoms).

### *Relationships*

Both CSA trauma and mental health difficulties can further impact a person's functioning through their effects on how they relate to others. The literature on the intergenerational continuity of CSA and the role of mother-child attachment relationships is limited, particularly with mothers of emerging adults. Importantly, reliance on relationships and attachment figures is crucial following traumatic events. Attachment bonds offer the greatest protection against threat,

and having a good support network is one of the most powerful guards against becoming traumatized (van der Kolk, 2015). However, the security of the attachment relationship is compromised in situations of abuse or neglect because the primary caregiver, who is responsible for providing safety and protection, also becomes a source of threat or fails to protect the child against a threat (Cloitre et al., 2011). Consequently, children who have experienced maltreatment commonly develop insecure attachments with their caregivers (Cyr et al., 2010). This insecure attachment is one of the components which may be involved in the continuity of CSA. Children who have a secure attachment and have developed a sense of competency are considered to have an internal locus of control, which is crucial for effective coping (Main, 1996; van der Kolk, 2015). Notably, securely attached children gain a sense of agency and learn to distinguish between circumstances they can control and circumstances that call for assistance (van der Kolk, 2015). Evidence suggests that children who have experienced CSA are more likely to show extreme strategies of attachment (e.g., extreme coercive or compulsive strategies) compared to children of non-abused mothers (Kwako et al., 2010). In a recent study, Shen and Soloski (2022) showed that child attachment (measured by the Inventory of Parent and Peer Attachment; Armsden & Greenberg, 1987) predicted adult attachment (measured by the Experience in Close Relationships Scale; Brennan et al., 1998). Further, child attachment moderated the relationship between CSA and anxious adult attachment, such that CSA survivors who showed secure attachment during childhood were less likely to develop anxious attachment as adults (Shen & Soloski, 2022).

In addition to attachment difficulties, mothers who have experienced CSA can inadvertently display a range of problematic parenting behaviours with their own children, which may stem from unresolved trauma. For instance, there are reported challenges with breastfeeding

(Lange et al., 2020a), role reversals, difficulties bonding with their children and having discussions about sex (Lange et al., 2020b); experiencing lower levels of warmth (Newcomb & Locke, 2001) and parenting satisfaction (MacIntosh & Ménard, 2021); use of psychological aggression and corporal punishment (Barrett, 2009); and challenges with providing their children structure (Kim et al., 2007). More research is needed to determine the roles of parenting and attachment in CSA continuity.

In terms of parenting in the context of CSA continuity, in a cross-sectional study with 96 children between the ages of 4 and 12 and their mothers, Leifer et al. (2004) found that the CSA continuity group reported insecure attachment and fewer years spent living with their mother. In the same study, mothers who experienced continuity were more likely to report adult abuse victimization and difficulties in romantic relationships (Leifer et al., 2004). This was also supported by MacIntosh and Ménard (2021)'s systematic review, which found that CSA survivors were more likely to show insecure attachment relationship in adult couple relationships and were more likely to divorce. Based on longitudinal research of 913 adolescent females and their mothers, risk factors for CSA continuity included lower perceived monitoring by a parent, and greater perceived approval of adolescent sexual activity (Testa et al., 2011). In this study, mothers completed measures of their lifetime experiences of sexual victimization, and their daughters (baseline age of 18) reported on their unwanted sexual experiences before the age of 14 (Testa et al., 2011).

Drawing from both attachment and parenting research, trauma stemming from CSA can interfere with mothers being able to cultivate positive and secure relationships with their children. Problems within the attachment relationship and difficulties with parenting (e.g., withdrawal among mothers who experienced CSA), could contribute to a context in which sexual

abuse of the child may occur. Despite the numerous reported challenges that can affect both a mother and her child's lives, there is also evidence of coping and resilience (e.g., Lange et al., 2020b), which emphasizes the need to consider protective factors, as well as socioenvironmental factors that have a significant impact on one's life.

### *Socioenvironmental Factors*

One of the broader-level factors that influences individual and family functioning, and that may be important to consider in intergenerational CSA research, is socioeconomic status (SES) (Conger et al., 2010), which is commonly measured using variables such as income, family structure, housing, employment, and educational opportunities. Importantly, each of these variables related to one's socioeconomic standing cannot only increase the risk of developing traumatic stress, but they also affect access to services that would help to address it (van der Kolk, 2015). Low income, unemployment, welfare assistance, parents' level of education, and single parenthood have been related to the risk of child maltreatment (Drake & Jonson-Reid, 2014). On the other hand, having higher SES has been shown to provide a protective effect against the intergenerational transmission of child maltreatment (Jaffee et al., 2013). St-Laurent et al. (2019) reported that mothers who experienced maltreatment and continued this cycle with their own children were more likely to experience sociodemographic risk, operationalized as no high school diploma, single-parent status, adolescent motherhood (being under the age of 20 at the birth of their first child), and to receive social welfare assistance. In comparison to CSA discontinuity (mothers who broke the cycle), mothers classified in a continuity group have been shown to have lower levels of income and were more often the head of a single-parent family (Langevin et al., 2020). While evidence supports the role of SES in child maltreatment, such that factors related to SES introduce increased levels of stress within families, the role of these

factors in intergenerational CSA have not been frequently explored. For instance, one of the limitations of the theoretical framework of CSA continuity proposed by Baril and Tourigny (2015) is that socioenvironmental factors such as SES are not included.

In addition to representing a risk for maltreatment, socioenvironmental factors are also related to attachment. Children from lower socioeconomic backgrounds are likely to exhibit behaviours characteristic of disorganized attachment styles, where they have learned that there is no secure base to rely on, and their parents are severely stressed by financial difficulties (van Ijzendoorn et al., 1999; van der Kolk, 2015). Complementary to these research findings, clinical cases demonstrate the complex contexts that maltreated children often face. As an example, the sexual abuse of a young child may be more likely to take place in situations of single parent families where the mother works full-time at a minimum wage job to take care of her children, unable to afford childcare, and while not intentionally neglectful, is exhausted, overwhelmed, and struggles to meet her child's emotional needs (Perry & Szalavitz, 2017). There are evident links between socioenvironmental factors, trauma, mental health, and parenting, which are also reflected by attachment theory, the ecological framework, traumatic stress models, and traumagenic dynamics. However, further empirical support is needed to determine how various socioenvironmental factors (e.g., single parenthood, income, education) could distinguish mother and emerging adult dyads who experienced CSA (dis)continuity. This research would contribute to identifying targets for clinical intervention as well as broader policy-level plans.

**Emerging Adulthood**

Given the long-term impacts of CSA on mental health and relationships, it is pertinent to study the experiences of emerging adults, particularly in the context of intergenerational continuity. Including a sample of emerging adults as opposed to a child sample allows for

researchers to document a complete history of CSA occurring under the age of 18, as well as potential adult victimization experiences. This dissertation is based on dyadic data of mothers and their children between the ages of 18 and 25, a period that has been defined as emerging adulthood (Arnett, 2000). An additional rationale for recruiting emerging adults in this age range comes from literature supporting this as a developmentally distinct period in industrialized societies. Arnett (2000) conceptualizes this period as neither adolescence nor adulthood, rather a period that is theoretically and empirically different from others, such that individuals have moved on from dependency in childhood but have not yet taken on the more enduring responsibilities characteristic of adulthood. The use of the term "youth" will be refrained, instead participants will be referred to as emerging adults, as "youth" has typically been used to reference childhood and adolescence (Arnett, 2000; Ben-Amos, 1994), or the period between adolescence and adulthood (Keniston, 1970). The emerging adulthood period is theorized by five defining aspects: identity explorations, instability, feelings of being "in-between", self-focus, and exploring possibilities and different directions in life (e.g., work, relationships, education) (Arnett, 2004a, 2004b). Characterizing features of this period include significant transitions such as leaving home, pursuing education and employment, shaping a career path, pursuing intimate relationships, and redefining relationships with caregivers (Arnett & Mitra, 2020). Stressful life transitions and events on their own have been linked to an increased risk of later psychopathology (e.g., depression) (Hammen, 2005; 2015). It is possible that individuals who have experienced CSA may face compounded levels of stress associated with their trauma on top of navigating these normative life transitions, which may include starting a family and learning how to parent.

**Knowledge Gaps**

There are notable areas in which our understanding of the intergenerational continuity of CSA is limited. Firstly, there are few proposed theoretical frameworks that have integrated theory and empirical findings to conceptualize CSA continuity. Theoretical models are needed to inform research efforts, and if practical, can benefit clinicians who work with families to break cycles of CSA by providing a summarized model of the most salient factors for the focus of intervention. Although several existing theories may be relevant to understanding CSA continuity (e.g., attachment theory, family systems), they have yet to be analyzed, integrated, and applied to this problem.

The empirical research on the intergenerational continuity of CSA needs further development. As highlighted, most studies on this topic are limited by cross-sectional designs and samples of mother-child dyads with young children. Including samples of emerging adults would allow for the assessment of experiences of CSA up until the age of 18. Mental health has been one of the most documented risk factors for the continuity of CSA. However, there are mixed findings in the literature and further examination of stress symptoms is needed (e.g., psychological distress, post-traumatic stress). The handful of papers that have been published on CSA continuity are quantitative studies that are largely based on bivariate analyses, unrepresentative samples, and unvalidated measures (Langevin et al., 2021). Implementing stronger methodologies will allow for a more robust and comprehensive investigation to explain what puts families at risk for CSA continuity, and what factors may differentiate families in which discontinuity is observed. To date, to our knowledge, there are no published qualitative studies exploring mothers' experiences of CSA continuity or discontinuity within their families. Qualitative research would add rich data to the literature on individual's lived experiences of

CSA and (dis)continuity, mental health, and relational challenges. Mothers' experiences and perceptions of risk and protective factors are invaluable to contribute to the empirical and theoretical knowledge of this problem, provide important guidance for future research studies, as well as to provide suggestions for prevention and intervention targets. Although surveys have the advantage of being a relatively quick, cheap, and easy method for participants to complete, qualitative studies have the advantage of exploring topics more in-depth that may not be queried in surveys, as well as allowing for more detailed elaborations of parenting and attachment. While the impact of CSA on attachment relationships and parenting has been documented, this has not been studied to identify how attachment (parent-child and romantic) and parenting are implicated in continuing or discontinuing CSA across generations, and further has not been investigated using diverse methodological designs. A mixed method design that examines and describes the experiences of mother and emerging adult dyads in terms of their mental health, attachment, parenting, and socioenvironmental contexts would be especially beneficial to advance the research on this understudied topic.

**Dissertation Objectives**

To address these knowledge gaps, this dissertation is composed of a systematic review (Study 1) of theoretical frameworks that can be used to explain the intergenerational continuity of maltreatment, as well as mixed methods research representing Study 2 and Study 3. The empirical papers are based on a dyadic sample of mothers and their emerging adult children (18-25 years old) to quantify the psychosocial factors that may play a role in the intergenerational continuity of CSA, as well as qualitative data to deepen our understanding of individuals' lived experiences of CSA continuity. Valid and reliable measures of psychopathology, CSA, attachment, and socioeconomic risk were used, and measures to enhance trustworthiness of the

qualitative findings were implemented. The following quantitative research questions were addressed:1) is there an association between mothers' histories of CSA and their emerging adult child's history of CSA? 2) Are there differences between cycle maintainers and cycle breakers in terms of mothers' maltreatment history? 3) Are there differences between cycle maintainers, cycle breakers, and control groups in terms of maternal mental health (psychological distress, post-traumatic stress symptoms) and relational variables (intimate partner attachment, parent-child attachment)? 4) Are there differences between groups based on socioenvironmental variables? The qualitative research question explored was: what are mothers' perceptions of how CSA impacted their psychological well-being, parenting behaviours, and attachment with their children in ways that may have contributed to continuing or discontinuing abuse within their families? The overarching mixed methods research objective was to determine the factors that may explain the (dis)continuity of CSA and explore mothers' perceptions regarding their experiences of CSA and intergenerational (dis)continuity.

The proposed research project is particularly pertinent to families in which at least one parent has a history of abuse, as well as emerging adults who have histories of abuse. By informing relevant stakeholders (e.g., clinicians, policy makers, health workers) and disseminating these research findings, one of the aims of this research project is to translate findings into effective services that will address cycles of sexual abuse and encourage healthy developmental trajectories of children and families. With services that reduce the likelihood of sexual abuse continuity within families we can better prevent the long-lasting trauma that results from such an abuse and cascades into difficulties across multiple areas of functioning.

# CHAPTER III: Mixed Method Methodology

This chapter will introduce the rationale for a mixed methods study, as well as the study paradigm, design, and the plan for integrating the quantitative and qualitative findings.

## Rationale

The research problem of understanding the intergenerational continuity of CSA is best suited for a mixed methods design since this is an understudied and complex topic that would be insufficiently addressed by only one data source (Creswell & Plano Clark, 2018). While there are many qualitative studies exploring various issues related to CSA, for example, disclosures of abuse (Fong et al., 2020), qualitative and mixed methods studies exploring CSA intergenerational continuity and discontinuity are lacking. In addition to quantitatively investigating differences between CSA (dis)continuity groups, qualitative research is particularly beneficial to complement quantitative data in order to better understand individuals' subjective experiences. The guiding definition of mixed methods research for this project is defined by Creswell and Plano Clark (2018) as when a researcher collects and analyzes quantitative and qualitative data to ultimately combine the sets of data to address their research question. Importantly, Creswell and Zhang (2009) claim that studies that have incorporated both quantitative and qualitative methods are often not labelled as mixed methods, and do not use systematic mixed methods procedures.

The advantage of using a mixed methods design is to draw on the strengths and minimize the limitations of both types of research. For instance, quantitative research does not account for the context of individuals' lives nor the voices of the participants. Qualitative research, on the other hand, is criticized for lack of generalizability (Creswell & Plano Clark, 2018).

## Paradigm

The paradigm that guided this mixed methods study is pragmatism, which has been endorsed as an optimal paradigm for mixed methods research (Teddlie & Tashakkori, 2003), and is suitable particularly for convergent designs. Pragmatism takes a pluralistic stance to research, representing a paradigm that is focused on the outcomes of research, the importance of the research question that is being addressed rather than the methods used or the underlying philosophical worldview of the method, and using multiple methods of data collection (Creswell & Plano Clark, 2018). The assumptions of pragmatism are well-suited to guiding this design through which the researcher aims to compare quantitative and qualitive findings to develop a more complete understanding of the problem (Creswell & Plano Clark, 2018).

## Design

The mixed methods design chosen for this study is the convergent design, which involves collecting separate data and then merging the data for the purpose of comparing or combining results. Integration is accomplished such that the researcher analyzes quantitative and qualitative data sets separately and then merges the findings. The parallel-databases variant is the specific type of convergent design employed for this study, which involves collecting parallel strands of data, independently analyzing these data, and then bringing the results together for interpretation. In this way, two types of data are used to examine aspects of the same problem (Creswell & Plano Clark, 2018).

## Integration of Quantitative and Qualitative Findings

Study 2 and 3 present the quantitative and qualitative findings in separate manuscripts. This dissertation provides a mixed methods integration of these results in the Chapter VII Discussion section. Integration in a convergent mixed methods design was accomplished using a

table combining the quantitative and qualitive results, called a joint data display (Creswell & Plano Clark, 2018), which links qualitative themes to the quantitative results. Data analysis and integration procedures for a convergent design such as the one used in this study involve separately analyzing quantitative and qualitative data and looking for common concepts across the results, then representing the integration of results such as by developing side-by-side comparisons, and finally, interpreting the integration of results by considering how the results (confirming, disconfirming, expansion) can provide insight into the research question (Creswell & Plano Clark, 2018).

# CHAPTER IV: Manuscript 1

## Victim-to-Victim Intergenerational Cycles of Child Maltreatment: A Systematic Scoping Review of Theoretical Frameworks

**Marshall, C.,** Langevin, R., Cabecinha-Alati, S. (2022). Victim-to-victim intergenerational cycles of child maltreatment: A systematic scoping review of theoretical frameworks. *The International Journal of Child and Adolescent Resilience, 9*(1). https://doi.org/10.54488/ijcar.2022.283

**Abstract**

**Objectives:** Child maltreatment is a serious problem worldwide associated with numerous developmental and psychological problems that can impede children's short and long-term functioning. The negative effects of maltreatment may put children on a trajectory where they are likely to experience later abuse and even abuse their own children. While studies have focused primarily on the intergenerational transmission of maltreatment (victim-to-perpetrator cycles), there are studies, albeit fewer, documenting cycles of intergenerational continuity of maltreatment (victim-to-victim cycles; e.g., child sexual abuse). Clear theoretical frameworks are lacking from studies on intergenerational maltreatment. This review aimed to systematically identify theories, theoretical or conceptual frameworks that have been used to explain the victim-to-victim cycles of maltreatment. **Methods:** Searches were executed in PsychINFO, Medline, and Scopus. Fifteen papers were included in this review. **Results:** The most common theories used to explain the intergenerational continuity of maltreatment victimization were attachment theory and traumatic stress models. Other identified theories include those from social, developmental, and biological domains. Notably, there were only five papers on the intergenerational continuity of child sexual abuse, highlighting a lack of focus on the theoretical explanations of this issue. Based on the findings, a unified model of victim-to-victim cycles of maltreatment is proposed to guide future studies. **Implications:** Future research in this area could include testing and comparing theoretical explanations and advancing the current state of the literature by using qualitative and mixed methods.

*Keywords:* victim-to-victim cycles of maltreatment, intergenerational continuity, theory, theoretical framework, conceptual framework.

## Victim-to-Victim Intergenerational Cycles of Child Maltreatment: A Systematic Scoping Review of Theoretical Frameworks

Intergenerational continuity of maltreatment describes situations wherein an individual experiences some form of childhood abuse or neglect and later has a child who also experiences abuse or neglect, regardless of the perpetrator's identity (e.g., Berlin et al. 2011). The prevalence of cycles of maltreatment over generations ranges from 7 to 88% (Langevin et al., 2021); the wide range reflecting differences between maltreatment subtypes and methodological factors. The effects of child maltreatment have frequently been explained using a conceptualization of complex trauma. Complex trauma involves exposure to stressors that are repetitive and prolonged, the harm is typically caused by caregivers, occurs at developmentally vulnerable times, and sets off a cascade of negative consequences including dissociation, emotion dysregulation, and somatic stress (Courtois & Ford, 2009). These negative sequelae may derail a child's developmental trajectory and impact their adult life in ways that contribute to maltreatment victimization continuity. However, just as children who have experienced abuse can demonstrate resilience in various areas of functioning (e.g., Yoon et al., 2020), it is important to identify factors contributing to resilience with regard to ending cycles of maltreatment victimization.

There is well-developed theoretical knowledge on cycles of violence focused on physical abuse. As noted by Kim et al. (2007), investigation of the intergenerational transmission of physical abuse is largely focused on how a victim becomes a perpetrator (i.e., victim-to-perpetrator cycles), whereas the intergenerational continuity of other types of abuse (e.g., sexual abuse or exposure to intimate partner violence) can represent victim-to-victim cycles wherein the maltreated parent is not the perpetrator. To illustrate, child sexual abuse (CSA) victimization is a

prevalent problem that can lead to victim-to-victim cycles, such as when a non-offending parent experienced CSA and later their child experiences this same kind of abuse perpetrated against them (Cyr et al., 2013). On the other hand, a victim-to-perpetrator cycle of abuse would be when an individual experiences abuse and then goes on to abuse their own child, whether it be physically, emotionally, or sexually. The importance of ending victim-to-victim cycles of abuse is evidenced by the negative impacts of child maltreatment victimization on individuals' lives. For example, CSA is associated with devasting consequences for children's development, as documented by an increased risk of psychopathology and physical health problems (e.g., Fergusson et al., 2013; Hailes et al., 2019; Hébert et al., 2017). The negative ramifications of CSA can persist into adulthood in the form of experiencing intimate partner violence (IPV) and adult sexual assault revictimization (Papalia et al., 2020), as well as mental health problems, such as anxiety (Gardner et al., 2019) and post-traumatic stress (Adams et al., 2018).

Prevalence rates of victim-to-victim cycles of maltreatment are not well documented. As an example, of the few studies providing prevalence rates, estimates of CSA continuity vary from 26.6 to 51.0% (Grunsfeld, 2018; Leifer et al., 2004; McCloskey & Bailey, 2000; Testa et al., 2011). Regarding the intergenerational continuity of child maltreatment in general, a recent a systematic review showed that rates can range from 7 to 88% depending on sample characteristics, maltreatment types examined, definitions of maltreatment, age range of participants, and measures (Langevin et al., 2021). With respect to victim-to-perpetrator cycles, researchers have estimated that around 30% of maltreated parents are likely to abuse their own children (Kaufman & Zigler, 1987), while other studies have documented prevalence rates ranging from 1% to 38% (Ertem et al., 2000). In order to distinguish victim-to-victim cycles

from victim-to-perpetrator cycles, it is imperative that researchers collect information about perpetrator identity and clarify the types of intergenerational cycles they are investigating.

Although exact prevalence estimates of victim-to-victim cycles are not known, understanding the mechanisms involved in these cycles is crucial. Several mechanisms have been proposed to explain the ways in which any type of abuse may continue within families including compromised parent-child attachment and parenting behaviours (see Langevin et al., 2021 for review), impairments in mental and physical health (Maniglio, 2009), and adverse educational and occupational outcomes that may confer risk to the next generation (Currie & Widom, 2010). Since the literature pertaining to victim-to-victim cycles of maltreatment is limited and scattered, a systematic review of the theories related to this topic will provide guidance for future research methodology and ultimately, encourage more comprehensive investigations that strive to explain this problem. An enhanced theoretical base could also contribute to improved intervention and prevention efforts by highlighting specific factors that could be targeted by practitioners to enhance families' resilience with the goal of ending cycles of child maltreatment.

The present systematic review will summarize the theoretical literature on the intergenerational continuity of child maltreatment, focusing on victim-to-victim cycles, and integrate the findings into a unified and parsimonious – hence clinically relevant – model. Selecting a few key targets that have been incorporated in theoretical models, as well as empirically supported, would contribute to clinicians' work with individuals and families to reduce the risk of maltreatment continuity, as well as to work with families to enhance coping skills and resilience when victim-to-victim cycles have been reported. A simplified model would

also be practical for clinicians to integrate in their practice, as compared to more complex and comprehensive models which may be harder to implement.

## Method

A systematic scoping review was determined to be appropriate to address the objective of identifying and summarizing theories, as this research objective is broad and qualitative. Scoping reviews are useful when the aim is to provide an overview of research without providing an answer to a specific research question (Arksey & O'Malley, 2005).

### Article Search and Selection

The initial search was built in PsycINFO (Ovid, 1806 to Present) in collaboration with a subject expert librarian and was subsequently adapted to Medline (Ovid MEDLINE(R) ALL, 1946-) and Scopus. Retrieved articles were organized into Endnote and Rayyan (Ouzzani et al., 2016), the latter of which was used to apply inclusion and exclusion criteria. The search combined terms related to abuse, intergenerational relations, and theory (Table 1). Family and marital conflict were included as search terms in order to obtain papers that might have included an examination of exposure to intimate partner violence. Hand searching was also conducted to identify articles outside of the main database search.

**Table 1**

*PsycINFO (Ovid, 1806-Present) Search Strategy Executed on April 21, 2020*

| # | Search Statement | Results |
|---|---|---|
| 1 | battered woman.mp. | 285 |
| 2 | battered women.mp. | 3216 |
| 3 | exp Battered Females/ | 3128 |
| 4 | *Partner Abuse/ | 10080 |
| 5 | exp Intimate Partner Violence/ | 11516 |
| 6 | exp Marital Conflict/ | 3055 |
| 7 | *Family Conflict/ | 1812 |
| 8 | exp Exposure to Violence/ | 926 |
| 9 | exp Domestic Violence/ | 11400 |
| 10 | physical victimization.mp. | 378 |
| 11 | physical aggression.mp. | 3775 |
| 12 | physical assault.mp. | 1146 |
| 13 | exp Physical Abuse/ | 5877 |
| 14 | exp Verbal Abuse/ | 508 |
| 15 | psychological victimization.mp. | 56 |
| 16 | emotional maltreatment.mp. | 328 |
| 17 | psychological maltreatment.mp. | 610 |
| 18 | psychological violence.mp. | 447 |
| 19 | exp Emotional Abuse/ | 2578 |
| 20 | exp Child Neglect/ | 4102 |
| 21 | exp Child Abuse/ | 29485 |
| 22 | exp Sexual Abuse/ | 27781 |
| 23 | exp Incest/ | 2580 |
| 24 | exp Rape/ | 5925 |
| 25 | exp Sex/ | 115719 |
| 26 | exp Victimization/ | 21340 |
| 27 | exp Violence/ | 78244 |
| 28 | 25 and 26 | 1501 |

| | | |
|---|---|---|
| 29 | 25 and 27 | 3688 |
| 30 | exp Crime Victims/ | 4910 |
| 31 | 25 and 30 | 256 |
| 32 | exp Sex Offenses/ | 35792 |
| 33 | exp Pedophilia/ | 1594 |
| 34 | (sex$ adj3 abuse$).mp. | 31546 |
| 35 | incest$.mp. | 5220 |
| 36 | (sex$ adj3 child$).mp. | 37783 |
| 37 | (sex$ adj3 offens$).mp. | 10982 |
| 38 | molest$.mp. | 1864 |
| 39 | rape$.mp. | 11393 |
| 40 | (sex$ adj3 crim$).mp. | 5369 |
| 41 | (sex$ adj3 assault$).mp. | 7379 |
| 42 | (sex$ adj3 exploit$).mp. | 1348 |
| 43 | (sex$ adj3 victim$).mp. | 7243 |
| 44 | (sex$ adj3 coerc$).mp. | 2016 |
| 45 | (sex$ adj3 maltreat$).mp. | 574 |
| 46 | (groom$ adj3 sex$).mp. | 418 |
| 47 | (sex$ adj3 violen$).mp. | 10675 |
| 48 | (sex$ adj3 trauma).mp. | 2622 |
| 49 | pedophil$.mp. | 2448 |
| 50 | (sex$ adj3 revictim$).mp. | 280 |
| 51 | revictimisation.mp. | 21 |
| 52 | revictimization.mp. | 732 |
| 53 | re-victimisation.mp. | 13 |
| 54 | re-victimization.mp. | 106 |
| 55 | victimization.mp. | 28952 |
| 56 | victimisation.mp. | 999 |
| 57 | 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 28 or 29 or 31 or 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 | 140052 |
| 58 | exp Theories/ | 291343 |

| | | |
|---|---|---|
| 59 | exp Psychological Theories/ | 65355 |
| 60 | (theoretical adj3 framework$).mp. | 29081 |
| 61 | (theoretical adj3 model$).mp. | 21410 |
| 62 | (psychological adj3 theor$).mp. | 18470 |
| 63 | 58 or 59 or 60 or 61 or 62 | 339263 |
| 64 | exp Generational Differences/ | 2196 |
| 65 | exp Transgenerational Patterns/ | 3375 |
| 66 | exp Intergenerational Relations/ | 4035 |
| 67 | (Intergenerational adj3 relation$).mp. | 4748 |
| 68 | (Intergenerational adj3 continuit$).mp. | 237 |
| 69 | (Intergenerational adj3 trans$).mp. | 3043 |
| 70 | (Intergenerational adj3 cycle$).mp. | 190 |
| 71 | (Intergenerational adj3 pattern$).mp. | 326 |
| 72 | (Generation$ adj3 difference$).mp. | 3311 |
| 73 | (Transgeneration$ adj3 pattern$).mp. | 3408 |
| 74 | (Transgeneration$ adj3 relation$).mp. | 52 |
| 75 | (Transgeneration$ adj3 trans$).mp. | 4472 |
| 76 | (Transgeneration$ adj3 continuit$).mp. | 6 |
| 77 | (Transgeneration$ adj3 cycle$).mp. | 18 |
| 78 | (Multigenerational adj3 trans$).mp. | 87 |
| 79 | (Multigenerational adj3 cycle$).mp. | 10 |
| 80 | (Multigenerational adj3 pattern$).mp. | 42 |
| 81 | (Multigenerational adj3 relation$).mp. | 63 |
| 82 | (Multigenerational adj3 continuit$).mp. | 3 |
| 83 | 64 or 65 or 66 or 67 or 68 or 69 or 70 or 71 or 72 or 73 or 74 or 75 or 76 or 77 or 78 or 79 or 80 or 81 or 82 | 13640 |
| 84 | 57 and 63 and 83 | 135 |

**Inclusion and Exclusion Criteria**

Articles were included if authors presented a clear summary of a theory, theoretical framework, or conceptual framework used to explain victim-to-victim cycles of maltreatment within the introduction, results, or discussion sections. The maltreatment types examined include neglect, physical, emotional, and sexual abuse, as well as exposure to domestic violence. As described by Creswell and Creswell (2018), "a theory in quantitative research is an interrelated set of constructs (or variables) formed into propositions, or hypotheses, that specify the relationship among variables (typically in terms of magnitude or direction)" (p. 52). The definition of a theoretical framework guiding this review is that a framework is the application of a theory or set of concepts drawn from a theory to explain a phenomenon (Imenda, 2014). No restrictions were placed in terms of publication date. However, articles needed to be useful and relevant to the current state of evidence in order to contribute to future research and were therefore excluded if too outdated. In particular, one article (Ney, 1988) was excluded because all three authors concluded that the model was not in line with the current conceptualization of victim-to-victim cycles and reflected antiquated ideologies that could be interpreted as victim blaming, thereby limiting its use to orient future research and intervention on intergenerational cycles of maltreatment. Only published research articles and book chapters (English and French) were included to maximize the quality of included theories. Quantitative, qualitative, and review papers were included. To address the gap in the literature that is more specific to victim-to-victim cycles of child maltreatment and to account for the potentially different mechanisms involved, articles were excluded if the theories presented focused solely on explaining victim-to-perpetrator cycles. Victim-to-perpetrator cycles have largely been explained so far using social learning theories (e.g., Tomsich, 2015). After title and abstract screening was conducted by the

first author, both the first and third author reviewed the 45 full-text articles for possible inclusion. Discrepancies were discussed among all authors to agree upon the final sample.

### Data Extraction and Analysis

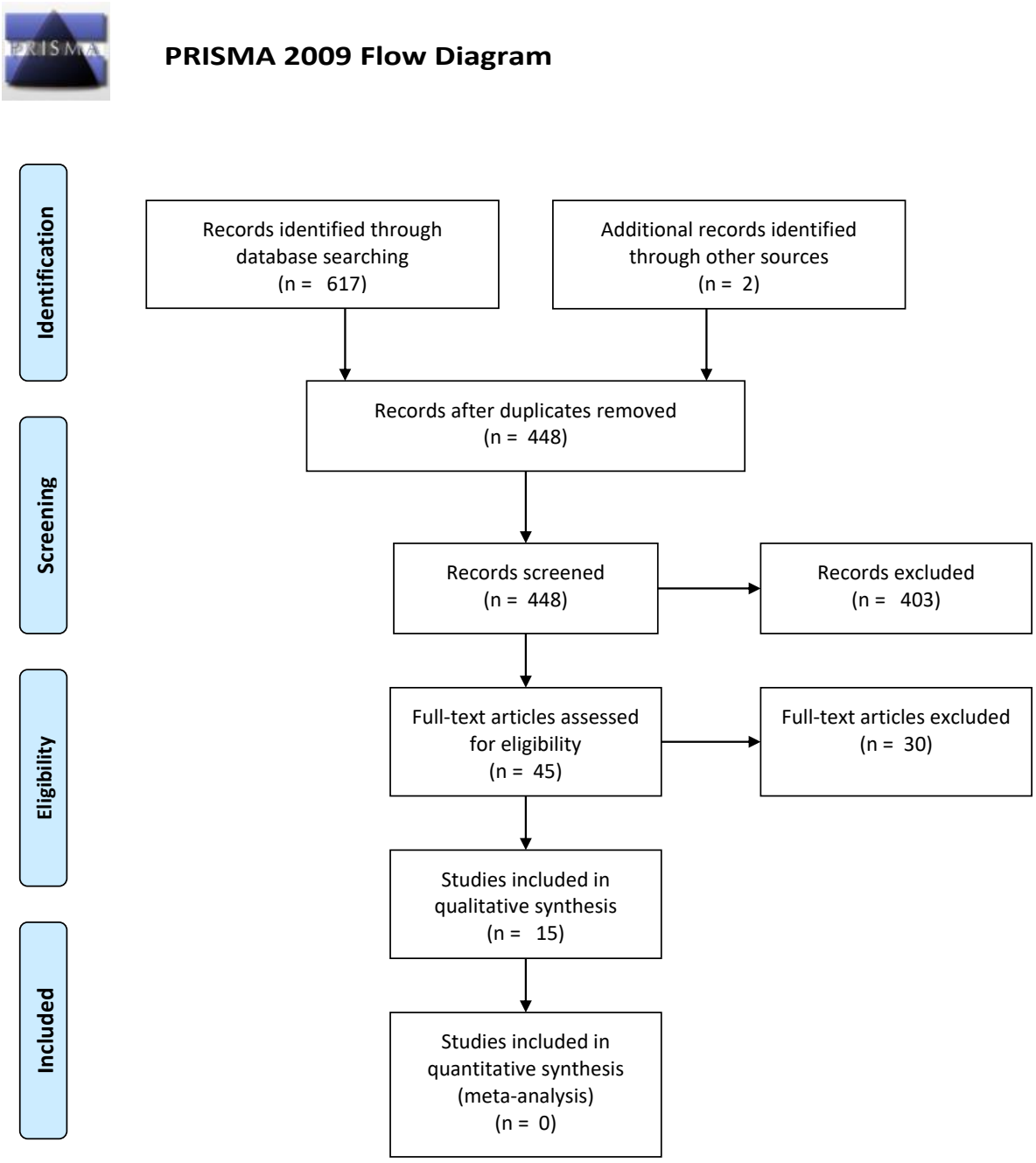
Data were systematically extracted from full-text articles. Tables 2 and 3 were used as organizing grids to present the information from each article including the type of paper (e.g., review, empirical), the name of theory or framework, the applicability of the theory in explaining the continuity of maltreatment (i.e., how did the authors use the theory to explain this problem), and the type of maltreatment that was examined.

## Results

A total of 617 articles were identified through database searching. After duplicates were removed 448 articles remained, and the titles and abstracts were screened. Two articles (one published in French) that were identified through hand searching were included. After this screening process, 403 articles were excluded, leaving 45 articles eligible for full-text assessment. Thirty full-text articles were excluded. A total of 15 articles were eligible for inclusion in this review (Figure 1). Five included articles presented theories relevant to the study of CSA specifically. Nine articles presented theories to explain child maltreatment more broadly (without focusing on specific types) and one article was focused specifically on the intergenerational transmission of betrayal trauma and dissociation. The following section summarizes the main theories presented in these articles (see Tables 2 and 3).

**Figure 1**

*PRISMA Chart*



**Attachment Theory**

Attachment theory was the most commonly reported framework, as seven articles summarized this theory and its relation to explaining victim-to-victim cycles of maltreatment (Alexander, 2015; Alink et al., 2019; Geiger et al., 2015; Levendosky et al., 2012; Morton & Browne, 1998; Sperlich et al., 2017). While Tuohy (1987) explicitly uses psychoanalytic perspectives (psychoanalysis, ego psychology, object relations theory, and self-psychology) to describe the assessment and treatment of children, the intergenerational cycle of abuse is described largely based on attachment issues between parent and child. Attachment theory, originally put forth by Bowlby (1969/1982), provides valuable insight into how things may go awry in parent-child relationships, thereby contributing to lifelong struggles and an increased risk of later victimization. More specifically, attachment styles represent patterns of interactions and behaviours between caregivers and their children, are established early in life, and set the stage for how individuals perceive and interact in future relationships. Attachment theory postulates that the quality of the attachment relationship between a child and their caregiver depends on the caregiver's level of sensitivity and responsiveness towards the child (Bowlby, 1969/1982). Ainsworth et al. (1978) described attachment classifications as secure and insecure (i.e., anxious-avoidant and anxious-resistant). Main and Solomon (1990) later added the disorganized-disoriented insecure attachment style. A secure attachment style is a protective factor for children's development, while insecure attachment styles are associated with various difficulties including internalizing and externalizing problems (Colonnesi et al., 2015; Fearon et al., 2010). The security of the attachment relationship is compromised in situations of abuse or neglect because the primary caregiver, who is responsible for providing safety and protection, may fail to protect the child against a threat or pose a threat to the child through their own

actions (Cloitre et al., 2011). Consequently, children who have experienced maltreatment commonly develop insecure attachment with their caregivers (Cyr et al., 2010), and may go on to have insecure attachments with their own children when they become parents themselves (van IJzendoorn et al., 2019). For example, Trickett and colleagues (2011) argue that attachment relationships following CSA are important for a child's adjustment, as sexual abuse activates a child's attachment system leading them to seek comfort and security from non-abusive caregivers. Parental support plays a critical role when children do disclose their own sexual abuse, as perceived positive support is associated with adaptive psychological and relational outcomes (adult attachment, psychological symptoms, and dyadic adjustment related to relationship quality and satisfaction) (Godbout et al., 2014). Thus, in victim-to-victim cycles, where parents are not the perpetrators of the abuse, a child may rely on their parent for support. However, in cases of intergenerational continuity, where parents also have a history of CSA, the ability to bond with their child and engage in responsive parenting behaviours may be negatively affected by their own distress (Courtenay et al., 2015), rendering it such that the child may not receive optimal support. Therefore, the child might learn that they cannot rely on their parent for physical and/or emotional comfort, leaving them to seek proximity to others in an effort to meet their attachment needs, which could put them in vulnerable situations and increase the risk of victimization.

Another attachment mechanism through which victim-to-victim cycles may perpetuate themselves is through internal working models. Internal working models are cognitive representations of individuals' views of themselves, others, and expectations in relationships (Bowlby 1969/1982). According to Levendosky et al. (2012), the effects of IPV on parents' and children's internal working models may lead to an increased vulnerability for later victimization.

In contexts in which abuse occurs, children may grow up more helpless and less competent, and develop interpersonal schemas (thoughts, feelings, and behaviours concerning relationships) that contribute to victimization (e.g., by selecting partners who re-enact abusive behaviours or relationship dynamics experienced in childhood) (Cloitre et al., 2011). Thus, the attachment styles and internal working models of maltreated children ultimately affect adult relationships and can lead to problematic parenting behaviours, high levels of conflict, and even IPV in the household (Alink et al., 2019; Levendosky et al., 2006; Reijman et al., 2017), thereby continuing a cycle of victim-to-victim maltreatment wherein children in the next generation are exposed to IPV.

**Traumatic Stress Models**

Theories conceptualizing trauma and its sequelae were integrated into five papers (Baril & Tourigny, 2015; Courtois & Ford, 2009; De Bellis, 2001; Maker & Buttenheim, 2000; Sperlich et al., 2017). Traumatic stress models can be used to explain victim-to-victim cycles of maltreatment as resulting from the negative and long-lasting impacts that trauma has on psychological functioning. Maker and Buttenheim (2000) presented a clinical case to illustrate the repetition of a parent's abuse with their own child. The authors focused on how CSA impacts parenting, which ultimately increases the risk of CSA in the next generation. For example, abuse can trigger feelings of fear and shame in the child that may be re-experienced in the parental role, particularly when individuals are confronted with their child's developmental challenges pertaining to sexuality and aggression (Maker & Buttenheim, 2000). In these situations, parents may be flooded with emotions that were present in the original traumatic situation and these symptoms can persist in the form of intrusive flashbacks, nightmares, and dissociative symptoms that interfere with parenting. Shame and fear related to trauma have also been associated with

beliefs about parenting such that individuals who experienced CSA might fear becoming bad parents, perceive themselves as less competent in the parental role, or have unrealistically high expectations concerning their child's level of autonomy (Bailey et al., 2012; Cohen, 1995; Herman, 1981). Thus, these parenting difficulties, such as inaccurate risk assessment, may lead some children to end up in risky situations where abuse could be perpetrated by someone else. It is important to note that these difficulties with the parenting role as well as problems with parent-child attachment are the result of the original perpetrators' actions.

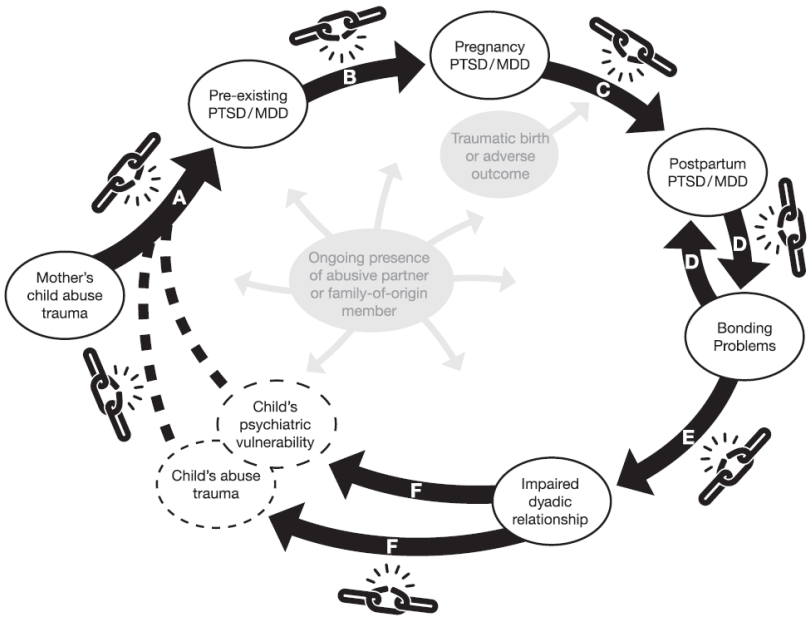
De Bellis (2001) proposed a developmental traumatology model based on a post-traumatic stress disorder (PTSD) model, highlighting that PTSD is commonly seen in maltreated children. Intergenerational maltreatment is described as being transmitted primarily through parental mental illness resulting from the experience of traumatic stress during childhood, which impacts biopsychosocial development. The central argument is that the negative effects of trauma on mental health can lead to maladaptive parenting. In support of this notion, PTSD resulting from child maltreatment has been associated with caregiver-infant bonding impairments (Muzik et al., 2016) and lower levels of parental sensitivity (Muzik et al., 2013). Similarly, CSA has been associated with depressive symptoms that can interfere with parental engagement, sensitivity, and responsiveness (Lovejoy et al., 2000; Zvara et al., 2017) as well as parenting difficulties such as lower levels of parental warmth, higher levels of psychological aggression, and corporal punishment (Barrett, 2009). The mental health problems that emerge as a consequence of child maltreatment may contribute to an increased risk of abusing or neglecting one's own children (victim-to-perpetrator cycle) or to victim-to-victim cycles that may arise from parental disengagement as a consequence of the trauma they have personally experienced. A similar argument was outlined by Chu and DePrince (2006), who discussed the role of betrayal

trauma history in the development of dissociative symptoms. The authors proposed that child maltreatment can lead to dissociation, which in turn, can contribute to alterations in processing social rules and safety cues, thereby impairing the parent's ability to monitor the safety of their child's environment.

Sperlich et al. (2017) used theories on both attachment and trauma to propose a cycles-breaking framework with the intention of guiding perinatal research and interventions (Figure 2). This was the only identified model that placed an emphasis on the perinatal period. Evidence supporting such a framework comes from findings that early exposure to stress and trauma can have long-lasting impacts on an individual's stress response and vulnerability to psychiatric disorders (Glaser, 2000). Highlighted in this model are the links between impaired mother-infant bonding, depression, problems in the dyadic relationship, and greater risk of maltreatment (van Ijzendoorn et al., 1999). At all stages of this cycle, it is acknowledged that there could be the presence of an abusive partner or family member. The utility of this model is the focus on breaking cycles of maltreatment and mental health problems, which is illustrated at various points in the cycle to emphasize optimal times for intervention.

**Figure 2**

*Reproduction of Sperlich et al. (2017)'s Cycles-Breaking Framework*



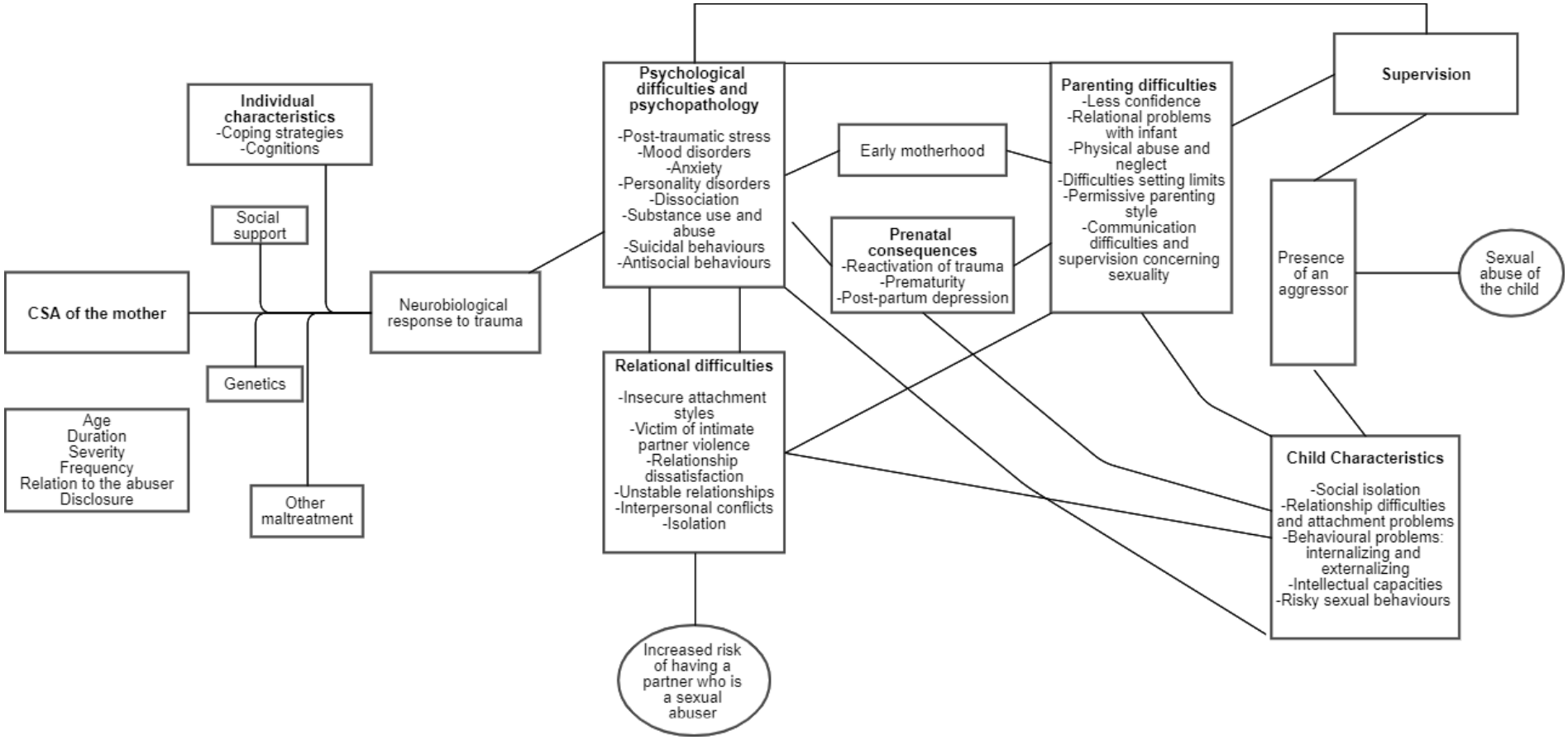

The Complex Post-Traumatic Stress model (CPTSD; Courtois & Ford, 2009), which was identified through hand-searching, is also applicable. The CPTSD model highlights the numerous and lasting impacts that chronic exposure to interpersonal violence, especially early exposure, can have on an individual's functioning and mental health. This model is particularly relevant to explaining victim-to-victim cycles since child maltreatment is associated with negative psychological consequences that can impact interpersonal functioning, including parenting and bonding with one's own children (e.g., Zvara et al., 2015).

Lastly, Baril and Tourigny (2015) published a comprehensive model explaining the intergenerational continuity of CSA (Figure 3). Though this model is said to be based on traumatic stress models, there are also elements of attachment theory that are incorporated. The model suggests that the long-term effects of CSA, including psychological difficulties, parenting

problems, and IPV primarily explain the increased risk of a child's sexual victimization. Other factors are also included, such as genetic factors, coping strategies, prenatal care, and children's characteristics, however, the emphasized mechanism of continuity concentrates more on mental health and relational issues that can impair parenting.

**Figure 3**

*Reproduction of Baril and Tourigny's (2015) Model of the Intergenerational Continuity of CSA*



**Family Systems Theory**

Three papers (Alexander, 2015; Bennett, 1992; Greenspun, 1994) explained victim-to-victim cycles of maltreatment using family systems theory, originally proposed by Bowen (1978). Family systems theory conceptualizes the family as a multigenerational system of emotional interaction. Alexander (2015) highlighted evidence of the family role in continuing cycles of maltreatment, such as through parental conflict, poor mother-daughter relationships, and lower socioeconomic status (SES). In the paper by Bennett (1992), two aspects of family systems theory are particularly relevant to explaining a clinical case of incest: differentiation of self, which is an individual's emotional independence and maturity, and multigenerational transmission, which is the notion that people tend to marry others with similar levels of differentiation of self. Essentially, it is hypothesized that individuals who grew up in families with a lack of interpersonal boundaries may enter relationships with rejecting and abusive partners, which may contribute to the continuity of abuse in the next generation. Further, when incest is present, family members may accept the notion that it is appropriate for adults to abuse children. Acceptance of these notions can impact the parent-child relationship (Seltzer & Seltzer, 1983), and may be passed onto the next generation through continued parent-child boundary issues (Kerr, 1998). In support of this notion, evidence suggests that survivors of CSA may have more difficulty establishing hierarchical boundaries with their children or may be more likely to engage in role reversals whereby they rely on their children for emotional support (DiLillo & Damashek, 2003). As such, children who are placed in this parentified role may be given levels of autonomy that are not developmentally appropriate, making them more vulnerable as targets to potential perpetrators.

**The Ecological Framework**

Building from the ecological model for human development originally put forth by Bronfenbrenner (1979), and later Belsky (1980), Cicchetti and Rizley (1981) describe the use of an ecological framework to explain the intergenerational continuity of child maltreatment. The framework proposed in this paper is broad in describing maltreatment and focuses on factors that confer risk or, conversely, can have a buffering effect against intergenerational continuity. More specifically, potentiating factors that increase the probability of child maltreatment include vulnerability factors, which are enduring features that increase risk, as well as challengers, which are transient but significant stresses. For instance, vulnerability factors may include personality attributes, such as poor frustration tolerance or situational variables such as poverty, while challengers may include significant stressors like the loss of a loved one, physical illness or injury, marital problems, problems with disciplining children, or legal difficulties. In contrast, compensatory factors that decrease the risk of maltreatment include protective factors, which are enduring conditions or attributes that decrease risk, and buffers, which are defined as transient conditions that defend against transient increases in stress. Protective factors may include traits such as an easy temperament, intelligence, physical health, and interpersonal skills, while buffers may include financial savings and social support. The proposition made by the authors is that child maltreatment is transmitted across generations primarily through the transmission of risk factors. They assert that maltreatment can only occur when potentiating factors override compensatory ones.

**Developmental Theories**

Developmental psychopathology models have also been used to explain intergenerational cycles of maltreatment. As summarized by Alink et al. (2019), these models propose that

maltreated children might have trouble negotiating developmental tasks, which could result in cognitive, social, emotional, and neurophysiological deficits that ultimately lead to psychopathology. In turn, psychopathology can increase parenting stress (see Hugill et al., 2017 for review), which may contribute to negative parenting behaviours or increase parents' risk for maltreating their own children. Negative parenting behaviours may also unintentionally put children in risky situations where abuse could occur, for example if parental supervision is limited or absent.

## Biological Models

### *Neurophysiological Models*

These models highlight that stress regulation is affected by early maltreatment and argue that dysregulated stress response in adulthood can affect parenting behaviours (Alink et al., 2019). This has been supported by research that shows altered stress regulation in maltreating parents (Reijman et al., 2016), which has been related to disengaged parenting (Reijman et al., 2015). This would suggest that altered stress regulation and its effects on parenting could serve as a mechanism by which child maltreatment could continue within families. In support of this notion, other research has shown the importance of gene-environment interactions in predicting stress reactivity, such that youth who have experienced adverse life events and who also have certain genetic variants exhibit enhanced heart rate reactivity to psychosocial stressors compared to those who have fewer genetic susceptibility variants (Allegrini et al., 2019). Therefore, those who have underlying genetic vulnerabilities that are compounded by experiences of child maltreatment may demonstrate greater stress reactivity in adulthood, which could interfere with the parental role.

### *Heritability Models*

Patterns of intergenerational child maltreatment and problematic parenting can also be explained by heritable factors, though these models were only referenced in one paper. Alink et al. (2019) summarized some of the behavioural genetic findings supporting the use of these models. Most research on heritability models has come from animal studies, though there is some research showing partial heritability of abuse and neglect in humans (Fisher et al., 2015). Based on a longitudinal study of twins followed until the age of 18, Fisher et al. (2015) reported significant but modest heritability for crime victimization, peer or sibling victimization, and internet or mobile phone victimization. Sexual victimization in adolescence did not seem to be under genetic influence, rather environmental risk factors better accounted for this abuse (Fisher et al., 2015). The authors highlight that their genetic findings support the notion that victimization experiences appear to be more strongly related to being exposed to risky environments as opposed to heritable characteristics. Part of a risky environment could indeed be difficulties with the parenting role. A meta-analysis conducted by Kendler and Baker (2007) supports the role of genetics in partially explaining parenting behaviour, as they report on heritability estimates for certain parenting traits, such as parental warmth (34-37%), protectiveness (20-26%) and control (12-17%). With respect to victim-to-victim cycles, parents may have a combination of genetic and environmental risk factors, along with the symptoms and consequences resulting from their own trauma, that can interfere with adaptive parenting.

**Table 2**

*Included Papers – Organized by Maltreatment Type*

| Reference | Type of Paper | Theory/ Framework | Type of Maltreatment |
|---|---|---|---|
| Alexander (2015) | Book chapter – narrative review | Attachment and family systems theories | CSA |
| Baril & Tourigny (2015) | Review and presentation of explanatory model | Trauma theory | CSA |
| Maker & Buttenheim (2000) | Narrative review and presentation of a clinical case | Trauma theory | CSA |
| Greenspun (1994) | Description of integrated theoretical model and case studies. Transmission is explained using projective identification | Psychoanalytic and family system theories | Father-daughter incest |
| Bennett (1992) | Narrative review and presentation of clinical case study | Murray Bowen's family system theory | Incest |
| Alink et al. (2019) | Narrative review – introduction to special section | Attachment theory<br>Neurophysiological models<br>Developmental psychopathology models<br>Heritability models | Child maltreatment in general |
| Cicchetti & Rizley (1981) | Narrative review | Ecological framework | Child maltreatment in general |
| De Bellis (2001) | Narrative review and presentation of data | Developmental traumatology model | Child maltreatment in general |
| Geiger et al. (2015) | Book chapter – narrative review | Attachment theory<br>Ecological framework<br>Risk and resilience frameworks | Child maltreatment in general |
| Levendosky et al. (2012) | Narrative review | Attachment theory | Child maltreatment in general |

| | | | |
|---|---|---|---|
| Morton & Browne (1998) | Narrative review | Attachment theory | Child maltreatment in general |
| Sperlich et al. (2017) | Review and presentation of conceptual framework | Attachment and trauma theory | Child maltreatment in general |
| Courtois & Ford (2009) | Guide for treating complex stress disorders | Trauma theory | Child maltreatment in general |
| Tuohy (1987) | Review of the role of defense mechanisms of parents who experienced abuse | Psychoanalytic theory | Child maltreatment in general |
| Chu & DePrince (2006) | Empirical study investigating the role of maternal dissociation, betrayal trauma and parenting in the development of dissociation among their children | Trauma betrayal theory | Betrayal trauma and dissociation |

**Table 3**

*Included Papers – Explaining Victim-to-Victim Cycles*

| Reference | Applicability to Explaining Victim-to-Victim Cycles of Maltreatment (reported by original authors) | Summary of Evidence (reported by original authors) |
|---|---|---|
| Alexander (2015) | Risk for revictimization and cycles of CSA is best captured using an attachment and family dynamics framework. Pathways to cycles of violence are associated with a break down in family structure and attachment relationships. Trajectories of risk include early onset of puberty, risky behaviour, partner relationships, parenting, and sexual revictimization. | -CSA associated with timing of puberty. Family related factors also affect timing of puberty: parental conflict, poor mother-daughter relationship, lower socioeconomic status (e.g., Alvergne et al., 2008; Downing & Bellis, 2009).<br>-CSA history increases the risk of partner violence (Babcock & DePrince, 2013).<br>-CSA survivors are more likely to be aggressive and display less warmth toward their own children (e.g., Banyard, 1997; Barrett, 2010). |
| Baril & Tourigny (2015) | Explanatory model of intergenerational CSA suggesting that the long-term effects of CSA, including psychological difficulties, parenting problems, and intimate partner violence, increases the risk of a child's sexual victimization. Intergenerational CSA is defined as both parent and child experienced CSA, and the parent is not the abuser. | Research supporting parenting problems in CSA survivors (Banyard, 1997; Barrett, 2010; DiLillo & Damashek, 2003). |
| Maker & Buttenheim (2000) | Trauma theory is used to illustrate the repetition of a mother's abuse with her own child – the focus is on how sexual abuse affects parenting, ultimately increasing the risk of sexual abuse in the next generation. Trauma theory: abuse triggers fear and shame; trauma may be re-experienced and the individual is flooded with affect that was present in the original traumatic situation. | Clinical case illustrates a mother who experienced CSA and difficulties parenting her son. Her concern was that her son would sexually abuse her daughter, just as she experienced growing up. Sexually abused patients fear becoming bad parents and have unrealistically high expectations of parenting (Herman, 1981) *(trauma-related shame and guilt).* |
| Bennett (1992) | The family is viewed as a multigenerational system of emotional interaction. Differentiation of self: an individual's emotional independence and maturity. | Low differentiation in a family is associated with elevated levels of anxiety and depression (Bowen, 1978). |

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| | Multigenerational transmission: people tend to marry others with similar levels of self-differentiation. | Myths within families maintain low self-differentiation, and can impact the mother-child relationship (Seltzer & Seltzer, 1983); undifferentiation may be transmitted to the next generation (Kerr, 1988). |
| Alink et al. (2019) | **Attachment theory**: attachment relationships depend on the parenting a child receives. Attachment styles of maltreated children affect adult relationships and problematic parenting behaviours of their own children. **Neurophysiological models**: stress regulation is affected by early maltreatment. Increased stress response in adulthood can affect parenting behaviours. **Developmental psychopathology models**: maltreated children experience difficulty with developmental tasks, resulting in cognitive, social, emotional and neurophysiological deficits; this can ultimately lead to psychopathology. Psychopathology can influence parenting behaviours as well as a parents' risk of maltreatment. **Heritability models** – heritable factors may explain transmission of maltreatment and parenting. | -Maltreatment is related to deficits in social information processing (Keil & Price, 2009).<br>-Attachment styles of maltreated children are often insecure (Cyr et al., 2010). Insecure attachment is related to parenting problems and maltreatment (Reijman et al., 2017). **(attachment theory)**<br>-Altered stress regulation found in maltreating parents (Reijman et al., 2015; Reijman et al., 2016). **(neurophysiological models)**<br>-Maternal depression mediates childhood experiences of physical abuse and subsequent insensitive parenting (depression (Madigan et al., 2015). **(developmental psychopathology models)**<br>-Behavioural genetic studies have shown partial heritability of abuse and neglect (Fisher et al., 2015). |
| Cicchetti & Rizley (1981) | Examines etiology and transmission of child maltreatment with a focus on risk factors. Two categories of risk: 1) potentiating factors and 2) compensatory factors. Maltreatment is transmitted across generations through the transmission of risk factors for maltreatment. | Factors that reduce vulnerability or stress, or that increase buffers or protective factors, should decrease the probability of maltreatment occurring, as well as its transmission across generations. |
| De Bellis (2001) | Maltreatment is transmitted across generations primarily through its effect on parental psychopathology - PTSD symptoms affect mental health in infancy, childhood, and adolescence. | -Post-traumatic stress disorder (PTSD) is commonly seen in maltreated children (Famularo et al., 1994).<br>-PTSD can influence behavioural and emotional regulation development and later mental health problems (Pynoos et al., 1995). |

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| | | -Increased rates of depression, PTSD, substance abuse and antisocial behaviours in parents of maltreated children have been reported (Famularo et al., 1992). |
| Geiger et al. (2015) | Reviews theories and how they pertain to the intergenerational transmission of child maltreatment. **Bowlby's attachment theory** is described – attachment relationship serves as the basis of a child's development and foundation for future relationships. Insecure attachment styles can contribute to difficulties in parent-child relationships. **Ecological framework** – there are multiple mechanisms involved in explaining continuity of child abuse at multiple and interacting levels; risk and protective factors interact with each other (e.g., personality, family factors, societal factors). **Risk and resilience** – literature on resilience and protective factors to prevent child abuse are reviewed (e.g., financial stability and social support, education, marriage, partner violence, history of abuse, maternal warmth). | -Insecure attachment styles may be passed on to the next generation (Crittenden & Ainsworth, 1989). **(attachment theory)** -Dixon et al. (2009) – financial stability and social support reduce risk of maltreatment. **(ecological framework)** -Example of protective factor in breaking the cycle of maltreatment: safe, stable, and nurturing relationships (Conger et al., 2013). **(resilience framework)** |
| Greenspun (1994) | Description of integrated theoretical model and case studies. Transmission is explained using projective identification | Experiences of victimization are internalized by daughters who have experienced sexual abuse by their father. These experiences contribute to abuse in the next generation (e.g., poor family boundaries, role reversals). Projective identification is defined as transferring intolerable parts of one's self onto an object – this part is split-off and seen as residing in another person. Individuals choose partners that resemble split-off parts of the self. |
| Levendosky et al. (2012) | Proposes a model using attachment theory to explain how intimate partner violence (IPV) may affect children and to explain the intergenerational transmission of IPV. The betrayal involved in experiencing IPV damages an individual's internal | Children of parents who have experienced IPV are at an increased risk of both later victimization and perpetration (Levendosky et al., 2006). Increased vulnerability is explained by the effects that IPV has on parents' and children's internal working models, which disrupts |

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| | working models of relationships, which influences parenting behaviours, consequently affecting the child's development of internal working models, as well as behavioural and emotional regulation. | attachment representations and parenting behaviours (Levendosky et al., 2006). |
| Morton & Browne (1998) | Maltreatment can be seen as insensitive parenting - infants form internal representations of caregivers as being unresponsive and unreliable. Maltreated children may be unable to form secure attachments with their own children – this is hypothesized as the process by which maltreatment continues in the next generation. | Maltreating parents are harsher, more interfering, controlling, and negative in interacting with their children (e.g., Crittenden, 1981). |
| Sperlich et al. (2017) | Proposes a cycles-breaking framework to guide perinatal research and interventions to break cycles of maltreatment and psychiatric vulnerability: 1) mother's child abuse trauma; 2) pre-existing PTSD/MDD; 3) pregnancy PTSD/MDD; 4) postpartum PTSD/MDD; 5) bonding problems; 6) impaired dyadic relationship; 7) child's abuse trauma and psychiatric vulnerability. | Early exposure to stress and trauma can have long-lasting impacts on an individual's stress response (Glaser, 2000). Documented links between impaired bonding, postpartum depression, problems in the dyadic relationship and greater risk of maltreatment (van Ijzendoorn et al., 1999). |
| Courtois & Ford (2009) | Complex PTSD results from a series of events or prolonged exposure to trauma. Somatization, dissociation, and affect dysregulation are proposed as being three main symptoms of complex PTSD. | This model conceptualizes PTSD as beyond a list of symptoms in order to more comprehensively understand the consequences of repeated trauma exposure, such as often the case with maltreatment. |
| Tuohy (1987) | Child abuse is conceptualized as resulting from impaired separation and individuation of the child from the parent. If parents use repression and isolation of painful affect, situations where abuse could occur may be more likely, while having access to childhood pain may deter them from repeating behaviours. | Fraiberg (1975) describes problems with parent-child attachment as resulting partly from maladaptive defense mechanisms. Defense mechanisms are highlighted as contributing to perpetuating intergenerational cycles of abuse. |

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| Chu & DePrince (2006) | Authors use betrayal trauma theory (Freyd, 1996) and Discrete Behavioral States model (Putnam, 1997) in guiding their study. Betrayal trauma proposes that when violence is experienced from someone close to the victim, memory disruption, dissociation and cognitive dysfunction are resulting consequences that maintain attachment between the victim and perpetrator. Dissociation is hypothesized as a mechanism by which trauma-related information is blocked. | Child maltreatment may lead to dissociation which can lead to impairments in processing safety cues and social rules, potentially resulting in decreased parental monitoring of the child's environment. |

## Discussion

Nearly four decades ago, Cicchetti and Rizley (1981) emphasized the importance of documenting differential risk patterns to understand the continuity of different types of child maltreatment across generations. The aim of this scoping review was to identify and summarize theoretical explanations pertaining to the victim-to-victim cycles of maltreatment, as well as to integrate these findings into a model that could illustrate the theoretical and empirical explanations related to victim-to-victim cycles. An overview of theories related to these cycles is a necessary contribution to the literature, as there is evidence for their existence (e.g., Grunsfeld, 2018), yet the mechanisms explaining them are not well documented or understood, particularly in comparison to the literature documenting how individuals who experienced maltreatment may become perpetrators. It is evident from this review that the literature on victim-to-victim cycles needs more theoretical and empirical development. Out of the 15 papers included in this review, five articles discussed CSA specifically, while the remaining articles explained the intergenerational continuity of maltreatment more broadly.

### Critique of Theories

One of the most documented theoretical frameworks used to explain victim-to-victim cycles identified through this review was attachment theory. Both attachment and traumatic stress models were used to create a cycles-breaking framework proposed by Sperlich et al. (2017). This model offers strengths in terms of guiding perinatal research and the depiction of a diagram with reference to points in the cycle where interventions could be implemented to break the cycle of abuse. Though the focus of Sperlich's paper is on the perinatal period, the study of pre- and postnatal influences in victim-to-victim cycles could be further investigated. The role of mental health in victim-to-victim cycles is a recurring theme in the literature, therefore,

implementing early interventions with pregnant mothers demonstrating specific risk factors (e.g., mental health problems, history of child maltreatment, experiences of IPV) could have the potential to break these cycles.

De Bellis's (2001) developmental traumatology model relies primarily on the notion that early onset PTSD and subsequent difficulties with mental health and parenting may explain the intergenerational continuity of child maltreatment. However, more empirical investigations are needed to determine how the model could be applied to enhance our understanding of victim-to-victim cycles more specifically. While PTSD is a documented outcome of child maltreatment (e.g., Messman-Moore et al., 2017), there are many other factors involved in explaining continuity and discontinuity that this model does not thoroughly capture (e.g., SES and relational factors).

Regarding biological explanations of victim-to-victim cycles of maltreatment, Pittner et al. (2020) reported heritability estimates for experiencing maltreatment ranging from 30% for neglect to 62% for severe physical abuse. Genetic factors as they relate to the risk of experiencing maltreatment and negative parenting behaviours need further investigation in samples of children who have experienced various types of maltreatment. These factors could be integrated into theoretical frameworks to explain victim-to-victim maltreatment. This would encourage researchers to consider biological factors in the study of this issue, as well as the role of gene-environment interactions in the mental health and resilience of survivors of abuse (e.g., Normann & Buttenschøn, 2020).

While the ecological framework identified in this review is useful in studying child maltreatment more broadly, risk and protective factors may differ or have greater importance depending on the type of maltreatment being studied. Although parenting, attachment, and other

family-related factors are implicated in cases of maltreatment and play a role in maltreatment continuity (e.g., Egeland et al., 1988), there are several risk and protective factors that likely interact with each other to explain why abuse may continue across generations.

Although Belsky's (1980) ecological model of child maltreatment was not identified through the article search, it is worth highlighting that this conceptual framework has been widely used to identify risk and protective factors at multiple, interactional levels of functioning. Belsky (1980) describes the role of factors at various levels, including the ontogenetic (individual; e.g., maltreatment history, child rearing); microsystem (child, family, and peers; e.g., parenting behaviours, family interactions); exosystem (neighbourhood characteristics; e.g., community resources); and the macrosystem (social and cultural influences; e.g., societally acceptable parenting practices, observation of violence through media). In investigations of victim-to-victim cycles of maltreatment, it is important to consider risk and protective factors at these multiple levels.

Through this review, it was evident that the theoretical models pertaining to victim-to-victim cycles of abuse do not typically highlight the role of the perpetrator, though this is an essential feature to consider. Individuals can face innumerable negative consequences after experiencing child abuse, at multiple levels of functioning. These consequences can make it more likely that a victim-to-victim cycle continues, however, these cascading effects are the result of the actions of the perpetrator who inflicted the abuse in the first place. Individuals are then left to face the aftermath as children and as adults, possibly across generations. It is also worth noting that much of the published research on this topic has focused on mothers (Langevin et al., 2021), which may lead to an overemphasis on the role of women in intergenerational

cycles of maltreatment, and victim-blaming. Future studies need to engage more with the role the perpetrators themselves and of other parents and caregivers.

**Unifying Model of Victim-to-Victim Cycles of Maltreatment**

A unified and more parsimonious model highlighting the key factors that are recurrently appearing in the literature as being involved in victim-to-victim cycles of maltreatment was needed. Such a model should highlight entry points for interventions that aim to foster resilience by breaking victim-to-victim cycles of maltreatment and should also benefit researchers. While the model proposed by Baril and Tourigny (2015) is comprehensive, it is specific to CSA and it may not be the most easily applicable model in terms of research and clinical practice because of its complexity. In comparison to more complex theoretical models, a unified parsimonious model allows researchers to flexibly choose different methodologies and measures to examine the most salient variables involved in victimization cycles to address this issue from multiple perspectives and further our understanding of the mechanisms involved. Thus, conceptual models can be helpful in guiding future research, especially an understudied topic such as victim-to-victim cycles of maltreatment. The model presented in Figure 4 was developed through trimming, summarizing, and integrating the theoretical knowledge identified through this review. The model is a starting point and may be amended to incorporate new findings, as the number of investigations into this research problem increase.

Within our proposed model, the outcome is second-generation child maltreatment. Child maltreatment is depicted as having negative impacts on relationships and mental health (mediators), both of which can affect the other. In turn, relationships and mental health can influence parenting, which can lead to an increased risk of maltreatment victimization. Parenting difficulties are represented as an outcome of child maltreatment, and mental health issues and

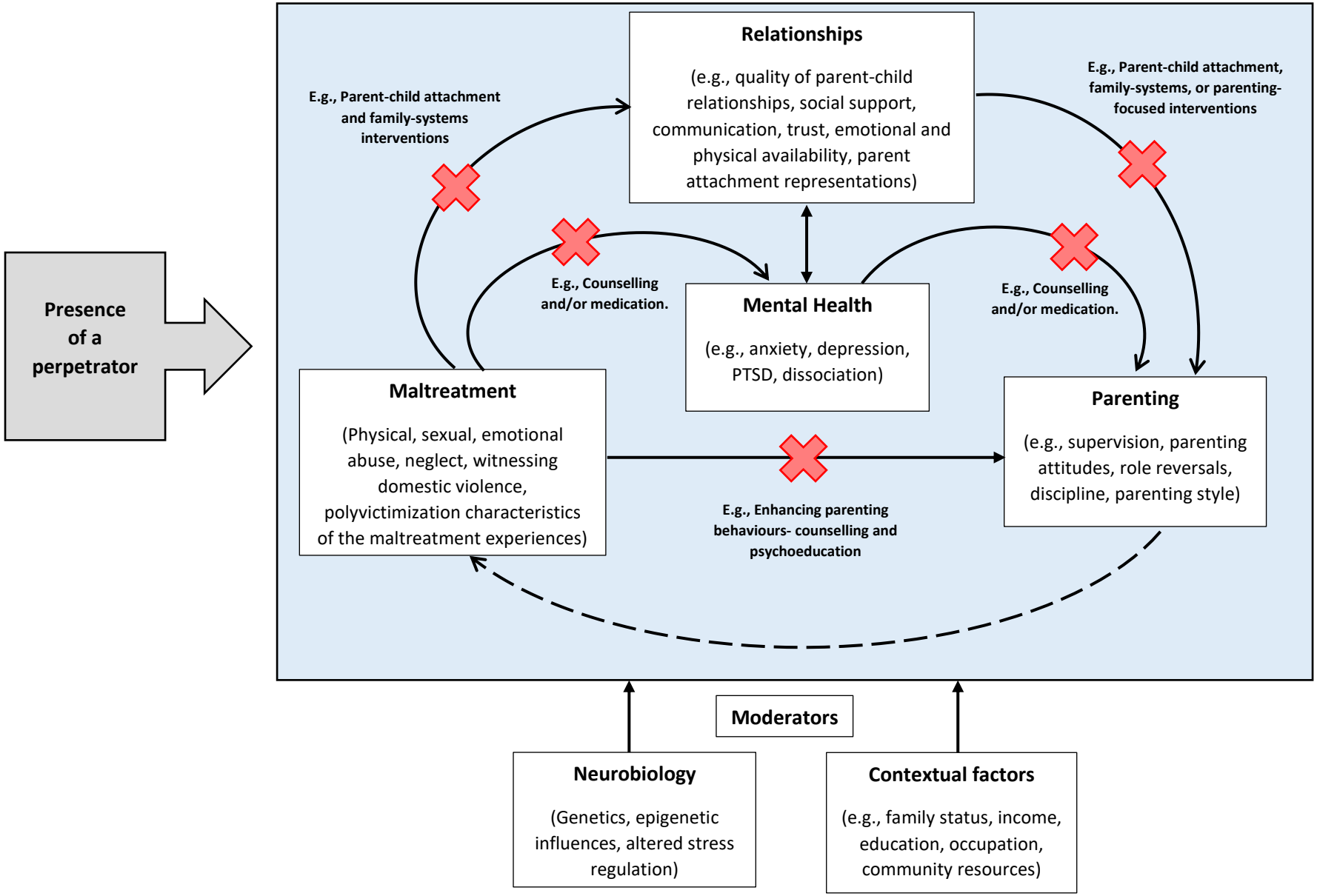
relational issues, and can predict second-generation maltreatment. On a broader level, there are also contextual risk and protective factors (e.g., macrosystem-level, such as cultural beliefs and values, and exosystem-level, for instance, neighbourhood and community-level factors), and neurobiological components (moderators) that can impact each of these variables and their relationships. Researchers may wish to use this model to guide their investigations of the mechanisms contributing to the continuity of maltreatment within families, by including relationships (e.g., intimate partner, parent-child), parental mental health, and parenting-related factors as mediators that can lead to second generation maltreatment, and how neurobiological and contextual factors may moderate the relationships within this model (e.g., socioeconomic factors moderating the association between parental histories of child maltreatment and adult mental health). The moderating role of positive relationships could also be further investigated in studies of resilience, since the role of safe, stable, and nurturing relationships have been documented as a protective factor against intergenerational cycles of abuse (Jaffee et al., 2013). Additionally, the model could be enriched through clinicians' modifications based on their experiences with families who have experienced intergenerational maltreatment. In this way, the model could be informed and strengthened by both empirical evidence, and practice-based evidence.

While there is not an extensive amount of research on victim-to-victim cycles of maltreatment, the model aligns nicely with empirical findings synthesized in a recently published systematic scoping review on psychosocial risk and protective factors involved in intergenerational cycles of child maltreatment (Langevin et al., 2021). For instance, in this review the authors documented the role of individual, relational, and contextual factors that have been investigated as mediators or moderators of intergenerational cycles of maltreatment.

Specifically, parental mental health was a well-documented risk factor in perpetuating maltreatment, in addition to relational factors, including couples' adjustment, attachment and social support, and contextual factors such as socioeconomic status and community violence (Langevin et al., 2021).

**Figure 4**

*Unified Model of Victim-to-Victim Cycles of Maltreatment*



**Strengths and Limitations**

A strength of this review is the comprehensive summary of theoretical explanations pertaining to the intergenerational continuity of maltreatment, with a specific focus on identifying theories relevant to the understudied issue of victim-to-victim cycles. While a systematic scoping review was appropriate for the objective of describing and synthesizing research, there are a number of limitations associated with this approach. For example, scoping reviews do not typically evaluate quality of evidence; they may be based on broad and less defined search strategies requiring hand searching; and they do not provide a concrete answer to a specific research question (Sucharew & Macaluso, 2019). Despite our systematic approach and the inclusion of strategies to minimize bias (e.g., having two people screen articles), there is always a risk of bias involved in scoping reviews.

In terms of the included studies, most papers provided a general narrative overview of theories and their application to victimization cycles. Only two papers presented a concrete theoretical framework depicted with a diagram in addition to providing the narrative overview (Baril & Tourigny, 2015; Sperlich et al., 2017). Only two papers provided concrete clinical case examples to complement theoretical explanations (Bennett, 1992; Maker & Buttenheim, 2000). Most of the time, the discussion of theories or theoretical frameworks in the papers included in this review were lacking in specificity in terms of accounting for victim-to-victim cycles of maltreatment.

**Future Directions**

One avenue for future investigation and consideration when formulating theoretical frameworks include examining the role of fathers, which would provide further support for the use of attachment and family systems theories. The proposed unified model has the advantage of

being applicable with fathers who have histories of child maltreatment as well. Additionally, many of the theories reviewed in this paper have not provided an extensive discussion of the role of SES or other contextual factors (e.g., neighbourhood characteristics, social and cultural influences), apart from the ecological framework.

Future qualitative research may be particularly beneficial in terms of generating theory or complementing existing theoretical explanations, such as with the grounded theory methodology. While there are many qualitative studies exploring various issues related to child abuse (e.g., Fong et al., 2020), qualitative and mixed method studies exploring themes related specifically to continuity and discontinuity of victim-to-victim maltreatment cycles are lacking. These methodologies have the advantage of answering research questions that quantitative studies alone cannot, in order to identify gaps in research and practice.

Ultimately, it is imperative that future studies explicitly identify theoretical frameworks used to explain victim-to-victim cycles of maltreatment, as this is not always the case (Schelbe & Geiger, 2017).

**Implications**

Child maltreatment and the issue of victim-to-victim cycles has consequences for the family as a unit. In the spirit of taking a family-based approach to victim-to-victim cycles of maltreatment, it could be helpful for clinicians to search for resilience – what the family has done well in the past and how they have successfully solved problems (Nichols & Davis, 2017). Families who have experienced adverse events, as in the case of a parent dealing with a disclosure of their child's sexual abuse when they themselves experienced this abuse as a child, may be overcome with frustration, discouragement, as well as blame or guilt. Even the most discouraged families have been successful at times (Nichols & Davis, 2017), which makes it

even more important for clinicians to identify and enhance the positive things this parent has done for their child, in addition to working on the factors that have been summarized in our unified model, such as attachment, parenting, mental health, and access to resources (i.e., the contextual level). As illustrated in the model, interventions could be planned to target parent-child attachment relationships to develop more secure bonds (e.g., "Child-Parent Psychotherapy", Cicchetti et al., 2006; "Minding the Baby", Sadler et al., 2013). Parental mental health problems could be addressed through counselling and/or medication, with an emphasis on early prevention and intervention, such as during the prenatal period. As parenting has been documented as a problematic area among survivors of abuse (Lange et al., 2020a; Wark & Vis, 2018), psychoeducation and therapy could also be beneficial in terms of cultivating more positive parenting practices (e.g., by targeting appropriate parent-child roles, parenting styles, communication strategies, discipline, and supervision) to reduce the likelihood of maltreatment victimization continuity and foster resilience.

## Conclusion

Promotion of individual and family level factors have indeed been documented as components that can contribute to resilience in children who have experienced maltreatment (Meng et al., 2018). Prominent themes in the literature surrounded the role of parenting, attachment, and mental health in the pathway to maltreatment continuity. Based on these findings, a unified model of these results is proposed, which has the advantage of research and clinical practicality. However, future studies employing diverse samples are needed to test this model for its use in research and clinical populations across cultures.

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## Bridging Between Study 1 and Study 2

The results from Study 1 identified several published theoretical frameworks that have been applied by researchers to understand and explain the intergenerational continuity of child maltreatment, with a particular emphasis on victim-to-victim cycles whereby the parent is not the perpetrator. Six theoretical models were identified, of which attachment theory and traumatic stress models were more commonly used to understand victim-to-victim cycles. Importantly, only five out of the 15 included studies reported on theoretical frameworks pertaining specifically to CSA, while the remaining papers examined maltreatment more broadly. The results were interpreted and synthesized to explicitly understand how the experience of child maltreatment may confer risk to victimization in the next generation. The proposed unified model conceptualizes second-generation maltreatment as being influenced by a parent's history of maltreatment which can negatively impact mental health and relationships, both of which can in turn affect parenting and the quality of attachment to others. Difficulties with mental health, relationships, and parenting can increase the risk for maltreatment, along with the contributing effects of trauma on neurobiology, and broader contextual factors (e.g., community resources, socioeconomic status). The simplified model has the advantage of being easily applicable to guide clinical interventions and future studies on victim-to-victim cycles, such as CSA continuity, where there continues to be a large gap in empirical literature. Study 1 findings were used to inform the selection of variables for analysis in Study 2, which included factors at the individual (mothers' mental health), relational (attachment), and socioenvironmental levels (e.g., education, income, family status). Study 2 extends the findings of Study 1 by providing empirical support to the proposed theoretical model through quantitatively testing associations that might provide clues as to how the likelihood of intergenerational CSA can be reduced.

# CHAPTER V: Manuscript 2

## Intergenerational Continuity of Child Sexual Abuse: Comparison of Mother and Emerging Adult Dyads

**Marshall, C.,** Fernet, M., & Langevin, R. (2022). Intergenerational continuity of child sexual abuse: comparison of mother and emerging adult dyads. *Journal of Child Sexual Abuse*, 1-20. https://doi.org/10.1080/10538712.2022.2147888

**Abstract**

Sexual abuse trauma can have long-term implications for individuals in terms of psychological functioning, relationships, and socioenvironmental circumstances, all of which are elements that could explain the CSA intergenerational continuity phenomenon. There are few empirical studies drawing comparisons between families to identify factors associated with the intergenerational (dis)continuity of CSA. The objectives of this study are to compare mother and emerging adult dyads to determine differences between cycle maintainers, cycle breakers, cycle initiators, and a control group in terms of maternal maltreatment histories, mental health, attachment, and socioenvironmental characteristics. A sample of 186 dyads was recruited across Canada to participate in an online study. The study represents a cross-sectional design and bivariate and multivariate analyses were used. The results support prior research that there is a higher risk of CSA in dyads where the mother experienced CSA (*OR =1.38).* Compared to cycle initiators, maintainers reported greater psychological distress (*M* = 27.23; 35.18), and lower mother-rated parent-child attachment (*M* = 115.83; 111.43). Maintainers reported more post-traumatic stress symptoms only in comparison to the control group (*M* = 24.82; 10.13). Mothers in cycle maintaining dyads were exposed to more acts of domestic violence than those in cycle breaking dyads (*OR* = 2.43). No group differences were observed for intimate partner attachment. Findings should be replicated using robust methodological designs (e.g., longitudinal, mixed methods). Preventative efforts should target at-risk families to reduce the chance of intergenerational CSA.

*Keywords:* child sexual abuse, intergenerational continuity, dyads, emerging adults

# Intergenerational Continuity of Child Sexual Abuse: Comparison of Mother and Emerging Adult Dyads

Childhood trauma is an experience that has lasting and substantial psychosocial and somatic impacts on a child including on school functioning (e.g., lower grades, educational attainment; Mitchell et al., 2021), attachment styles (C. Cyr et al., 2010), and emotion regulation (Langevin et al., 2020). Mental health problems, such as symptoms of anxiety, depression, sleep problems, and post-traumatic stress are common following CSA (Gardner et al., 2019; Langevin et al., 2022). These symptoms, especially if intervention and support are not received, may set children on a challenging developmental trajectory, characterized by a risk for sexual assault revictimization (Papalia et al., 2021) and dysfunctions in adulthood (Noll, 2021). These paths may result in a cycle of maltreatment that can be difficult for child maltreatment survivors to break, and the long-term ramifications of a parent's experience of CSA may implicate their children.

Studies on intergenerational cycles of CSA have reported on the prevalence of this problem, ranging from 26.6% (Leifer et al., 2004) to 51% (Testa et al., 2011). Importantly, while there have certainly been investigations demonstrating the increased risk of CSA across generations, these studies are few in number (e.g., Grunsfeld, 2018; Leifer et al., 2004; Testa et al., 2011), particularly with respect to the identification of risk and protective factors (Langevin et al., 2021). More research is needed to identify characteristics that distinguish parent-child dyads where (dis)continuity of CSA is observed in order to inform interventions that are aimed at breaking cycles of maltreatment (Langevin et al., 2021). The goal of this study of mothers and emerging adult dyads is to examine individual, relational, and socioenvironmental characteristics in four intergenerational trajectories of CSA: cycle breakers, maintainers, initiators, and controls.

"Cycle maintainers" are mother-child dyads where both members reported CSA; "cycle breakers" refers to dyads in which the mother but not their child reported CSA; "cycle initiators" refers to dyads in which the child but not the mother reported CSA; and controls are dyads where both members did not report CSA. Intervening to prevent cycles of sexual abuse requires investigation into multilevel risk and protective factors that characterize parent-child dyads in which abuse has been maintained or discontinued.

**Sexual Abuse Trauma**

CSA is a distinct form of maltreatment. As described by Finkelhor and Browne (1985), a unique combination of four traumagenic dynamics or trauma-causing factors (traumatic sexualization, betrayal, powerlessness, and stigmatization) is relevant to understanding the impacts of CSA. Empirical findings support these traumagenic dynamics in showing that some CSA survivors may display more preoccupation with sex (e.g., sexually intrusive thoughts), experience feelings of shame regarding sexual activity, and may be more reluctant to disclose their abuse (Lev-Wiesel & First, 2018). While it is important to conduct investigations into the unique effects of CSA, polyvictimization (experiencing more than one type of abuse) is a common and serious issue. For example, in a populational study of Quebec children, the lifetime rates were 49% for 1–3 victimizations, 18% for 4–6 victimizations, and 9% for 7 or more victimizations (K. Cyr et al., 2013). Furthermore, experiencing multiple forms of maltreatment (neglect, physical abuse, sexual abuse) has been related to the intergenerational transmission of child maltreatment (e.g., mothers' history of polyvictimization predicting infant neglect) (see, Langevin et al., 2021 for review). Studies of CSA (dis)continuity should therefore consider evaluating multiple forms of victimization experiences.

**Intergenerational (Dis)continuity of Child Sexual Abuse**

In terms of intergenerational continuity, CSA often represents a victim-to-victim cycle of maltreatment, in which the abused parent is not the perpetrator of their child's abuse (e.g., K. Cyr et al., 2013). Through a systematic review, Marshall et al. (2022) aimed to summarize theoretical frameworks that explain victim-to-victim cycles of maltreatment. The authors integrated theories from the disciplines of attachment, traumatic stress, family systems, developmental psychopathology, and biological models to present a coherent framework that can be used for understanding the intergenerational continuity of CSA. This cyclical model highlights that maltreatment is perpetuated across generations through its effect on mental health, relationship functioning, and indirectly through parenting behaviors, all of which may be moderated by neurobiological (e.g., genetics, stress regulation) and contextual factors (e.g., income, education).

As identified in a scoping review by Langevin et al. (2021), the role of mothers' psychopathology (e.g., depression, anxiety, post-traumatic stress symptoms) in intergenerational cycles of child maltreatment has been one of the most studied risk factors. For example, mothers' general symptoms of anxiety have been identified as a risk factor for CSA continuation (Grunsfeld, 2018). Mothers in cycle maintaining dyads were more likely to report clinical levels of distress, followed by mothers in the cycle initiating and cycle breaking dyads. Mothers in this study also differed in their reports of post-traumatic stress disorder (PTSD) symptoms, with mothers in the cycle maintaining dyads reporting more symptoms than other groups (Langevin et al., 2020). An important aspect of Langevin et al.'s (2020) study is that the children who experienced sexual abuse were recruited shortly after the abuse was disclosed. Therefore, mothers in the initiator dyads may have exhibited more distress in response to their child's disclosure. Group differences between dyads may be further clarified with a longer duration

between CSA disclosure and study participation. While the results reported by Langevin et al. (2020) provide essential information regarding the intergenerational (dis)continuity of CSA, a major limitation is the use of a child sample, leading to a risk of false negatives where children that were classified in the discontinuity trajectory might be sexually victimized later in childhood or adolescence. Furthermore, this study did not examine differences in parent-child attachment, which might distinguish dyads. Theoretical and empirical evidence converge in showing that CSA may be more likely to occur in future generations through its long-lasting effects on mental health (e.g., Marshall et al., 2022; Testa et al., 2011). As described in Marshall et al. (2022), mental health and caregiving may interact to increase the risk of intergenerational continuity of CSA.

Although there are few studies that have specifically evaluated attachment security in the context of intergenerational cycles of CSA, constructs related to attachment have been investigated for cycles of maltreatment in general. Employing a prospective design with a representative sample of participants, Jaffee et al. (2013) showed that safe, stable, and nurturing relationships with intimate partners and between mothers and their children contributed to breaking these cycles. A study by Thornberry et al. (2013) also supported this finding, highlighting that relationship satisfaction, parental satisfaction, and attachment to the child functioned as moderators of intergenerational maltreatment. Moreover, studies are needed to explore the significance of attachment connections beyond childhood (Theisen et al., 2018).

In addition to parent-child attachment, the effects of CSA can persist into adulthood in the form of intimate partner violence victimization (Papalia et al., 2021), and an insecure romantic attachment has been found to mediate this association (Macke, 2010). Furthermore, children living in homes where partner violence is present are more likely to experience CSA

(Bidarra et al., 2016). As noted by Labadie et al. (2018), the documentation of adult attachment problems in survivors of CSA has not received substantial attention and studies are needed to better understand the role of both parent-child attachment and romantic attachment in the intergenerational continuity of CSA.

In addition to individual and relational-level characteristics, socioeconomic status (SES) is one of the broader-level factors that influences individual and family functioning (Conger et al., 2010) and the intergenerational continuity of maltreatment (Marshall et al., 2022). Factors such as low income, unemployment, welfare assistance, parents' level of education, and single parenthood have been related to the risk of child maltreatment and intergenerational continuity of maltreatment as a broad category (Dixon et al., 2009; Langevin et al., 2021). Having a higher SES, on the other hand, was found to be protective (Jaffee et al., 2013). St-Laurent et al. (2019) studied cycle maintaining and cycle breaking dyads based on whether mothers and children had experienced any type of maltreatment (physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect). The authors found that mothers in cycle maintaining vs. cycle breaking dyads were more likely to present sociodemographic risk (i.e., no high school diploma, single parent- hood, adolescent motherhood, receiving social assistance). Greater socioeconomic risk may be due to mothers in cycle maintaining dyads experiencing multiple adversities (e.g., maltreatment, low socioeconomic status, and a lack of readily available or accessible resources), which exacerbate the effects of trauma and could make it more difficult to prevent the perpetuation of maltreatment. In comparison to CSA cycle breaking dyads, mothers classified as cycle maintaining had lower levels of income and were more likely to be the head of single-parent families in Langevin et al.'s (2020).

In summary, studies have supported an association between mothers' histories of CSA and their child's experience of CSA. Factors contributing to intergenerational cycles of maltreatment include maternal histories of poly- victimization, mental health, attachment, and broader socioenvironmental elements. However, there are mixed findings concerning these variables and insufficient evidence especially pertaining to CSA (dis)continuity.

**Current Study**

The current study is based on dyadic data of mothers and their emerging adult children between the ages of 18 and 25. Emerging adulthood is characterized as a distinct developmental period marked by identity explorations, instability, feelings of being "in-between," self-focus, and exploring possibilities and different directions in life (e.g., work, relationships, education; Arnett, 2004). This period has not received great attention in the context of CSA continuity despite the fact that the impacts of CSA may extend into adulthood (Noll, 2021). Furthermore, including a sample of emerging adults allows for documenting experiences of CSA between the ages of 0 and 18, reducing the risk of false negatives. It also reduces the risk of recall bias, as individuals are closer to their childhood and adolescence at the time of study participation.

The objectives of the current study are to document: 1) the association between mothers' and emerging adults' histories of CSA; 2) the differences between cycle maintainers, cycle breakers, and cycle initiators in terms of maternal maltreatment history; 3) group differences based on maternal mental health and relational variables; and 4) socioenvironmental group differences. A control group was included to draw comparisons with dyads in which neither member had experienced sexual abuse trauma, though it is possible they experienced other forms of maltreatment. Based on previous research, it was hypothesized that there would be an association between mothers' and emerging adults' reported CSA experiences. Hypotheses

regarding differences between dyads in mental health and attachment were not specified given the limited and conflicting theoretical and empirical findings related to CSA continuity.

## Method

### Participants and Procedures

Mothers (M = 51.16 years old, SD = 5.82) and their emerging adult children (90% woman-identifying; M = 20.87, SD = 2.17) were recruited to complete online questionnaires. Before data cleaning, the sample included 1,218 individuals (409 mothers and 809 emerging adults). Data screening measures as recommended by DeSimone et al. (2015) were implemented to screen for careless responses that would affect the validity of the results. Data were excluded if participants completed less than 75% of the survey (n = 36); did not provide a valid identification number (participant ID used for confidentiality and matching of dyads in the final dataset) (n = 39); or indicated at the end of the survey that their data should not be used (n = 36). Data were also removed for duplicate identification numbers (n = 68); mothers with missing ages or age differences between dyads less than 13 years (n = 68); if participants failed to correctly answer at least three out of five attention check questions (n = 121) (e.g., did you select “often” to show that you are paying attention?); or completed the survey in 15 minutes or less (half the mode completion time) (n = 17). The final sample included 253 mothers and 578 emerging adults for a total of 186 complete dyads. Based on CSA status, there were 22 continuity dyads, 31 discontinuity dyads, 30 initiator dyads, and 103 control group dyads (see Table 1 for sample characteristics).

French and English-speaking participants were recruited across Canada through convenience sampling by online social media advertisements and through universities. The majority of the sample reported residing in Ontario or Quebec (60%). The questionnaires took

approximately 45 minutes to complete on Qualtrics and were available in both English and French. If both members of the dyad completed the survey, they each received an e-gift card for five dollars. Every participant was entered into a draw for the chance to win one of two iPads. The study was approved by the institutional Research Ethics Boards of all authors.

**Table 1**

*Sample Characteristics*

| Variable | Mothers | | Emerging Adults | |
|---|---|---|---|---|
| | *M or n* | *SD or %* | *M or n* | *SD* or % |
| Age | 51.16 | 5.82 | 20.87 | 2.17 |
| Gender[a] (1=female) | - | - | 167 | 89.8% |
| ***Maltreatment History***[b] | | | | |
| Child sexual abuse | .81 | 1.57 | .69 | 1.40 |
| Physical abuse | .96 | 1.40 | .81 | 1.18 |
| Emotional abuse | 1.18 | 1.71 | 1.35 | 1.77 |
| Neglect | .52 | 1.02 | .62 | .96 |
| Exposure to domestic violence | .63 | 1.07 | .56 | .92 |
| ***Mental Health Factors*** | | | | |
| Post-traumatic stress symptoms | 14.55 | 15.75 | - | - |
| Psychological distress | 25.91 | 18.63 | - | - |
| ***Relational Factors*** | | | | |
| Parent-child attachment | 118.72 | 1.32 | - | - |
| Romantic attachment | | | - | - |
| Attachment anxiety | 3.17 | 1.51 | - | - |
| Avoidant attachment | 2.57 | 1.29 | - | - |
| ***Socioenvironmental Factors*** | | | | |
| Education | | | | |
| High School | 31 | 16.8% | 63 | 33.9% |
| CEGEP or professional school | 42 | 22.8% | 25 | 13.4% |
| Undergraduate | 75 | 40.8% | 84 | 45.2% |
| Graduate | 33 | 17.9% | 14 | 7.5% |
| Ethnicity | | | | |
| Caucasian | 131 | 72.0% | 128 | 68.8% |
| Black | 4 | 2.2% | 4 | 2.2% |
| Asian | 35 | 19.2% | 35 | 18.8% |
| Hispanic | 3 | 1.6% | 3 | 1.6% |
| Indigenous | 3 | 1.6% | 2 | 1.1% |
| Arab/Middle Eastern | 4 | 2.2% | 4 | 2.2% |
| Mixed race | 1 | .5% | 10 | 5.4% |
| Other | 1 | .5% | - | - |
| Family Status | | | | |

| | | | | |
|---|---|---|---|---|
| Still with parent of at least one child | 121 | 66.1% | - | - |
| Separated/divorced | 6 | 3.3% | - | - |
| Widowed | 4 | 2.2% | - | - |
| Other/unknown | 52 | 28.4% | - | - |
| Annual Household Income | | | | |
| Less than 40,000 | 22 | 13.4 | 63 | 41.4 |
| 40,000–$79,999 | 39 | 23.8 | 25 | 16.5 |
| 80,000–$119,999 | 50 | 30.5 | 36 | 23.7 |
| 120,000 or more | 53 | 32.3 | 28 | 18.4 |

[a]1= female, 2 = male, 3 = non-binary, 4 = gender-fluid, 5 = transgender
[b]Continuous maltreatment scores

## Measures

### *Demographics*

Basic demographic information was requested in the survey for both mothers and emerging adults, including family of origin status, education, and annual income.

### *Child Sexual Abuse*

Mothers' and emerging adults' responses on the Early Trauma Inventory – Short Form (ETI; Bremner et al., 2007) were used to assess histories of CSA. Six items, requiring a "1 = yes" or "2 = no" response were used (e.g., "being touched in intimate parts in a way that was uncomfortable"). Internal consistency for this scale in the current study was good for both mothers' ($\alpha$ = .87) and emerging adults' responses ($\alpha$ = .83). To create the four groups of dyads, child sexual abuse was dichotomized as 1 = 1 or more items coded as "yes," and 0 = "no" to all items. The continuous count score for mothers' CSA history, which ranges from 0 to 6 to measure the frequency of sexual abuse experiences, was used as a predictor in the logistic regression.

### *Maltreatment History*

Mothers reported their history of other types of maltreatment, including physical abuse (five items) and emotional abuse (five items), which were also assessed using the Early Trauma

Inventory – Short Form (ETI; Bremner et al., 2007). For example, they responded to questions, such as "before the age of 18, were you often put down or ridiculed by a parent or caregiver?" The internal consistency demonstrated good reliability for physical (α = .80) and emotional abuse (α = .87) in this study. Childhood physical/supervisory neglect was measured using the 5-item subscale of the ICAST-R, developed by the International Society for the Prevention of Child Abuse and Neglect. Participants responded to items, such as "have you ever not been given food to eat and/or drink even though your parent(s) or caretaker(s) could afford it?" Internal consistency in the current study was acceptable (α = .71). Three questions, adapted from the Conflict Tactics Scale (CTS; Straus, 1979), were used to assess exposure to domestic violence, for example: "have you ever seen your mother or father shove, hit, or throw things at their partner?" Participants responded "yes" or "no" to these items. This measure demonstrated good reliability in the current study (α = .85). Count scores for physical abuse, neglect, and emotional abuse ranged from 0 to 5, and from 0 to 3 for exposure to domestic violence, representing the total number of abusive acts experienced by the mothers.

***Psychological Distress***

The PSI-14 – Psychiatric Symptoms Index – Short version (Préville et al., 1992) was used to assess mothers' psychological distress (anxiety, depression, irritability, cognitive problems) in the past week (14 items) using a Likert-scale ranging from 0 (never) to 3 (almost always). For example, items include: "did you feel hopeless about the future? Did you feel nervous or shaky inside?" The internal consistency in the current study was excellent (α = .93). A total psychological distress score ranging from 0 to 100 was computed, with higher scores indicative of greater distress.

### *Post-traumatic Stress Symptoms*

Mothers completed the PCL-5 – Post-Traumatic Stress Disorder (PTSD) Checklist for DSM-5 (Weathers et al., 2013), which is a 21-item questionnaire that examines how often post-traumatic stress symptoms troubled participants in the previous month. A total PTSD score was computed, which is a continuous variable ranging from 0 to 80, with higher values indicating more PTSD symptoms. This measure demonstrated excellent internal consistency in the current study ($\alpha = .96$).

### *Parent-Child and Romantic Attachment*

To rate parent-child attachment, mothers completed The Revised Inventory of Parental Attachment (R-IPA; Johnson et al., 2003), a 30-item measure which is a revised version of The Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987). Participants responded on a Likert-scale ranging from 1 (almost never) to 5 (almost always). The R-IPA has two subscales including trust/avoidance (e.g., "my child accepts me as I am"), and communication (e.g., "I tell my child about my problems"; Johnson et al., 2003). A composite score was calculated by summing the items, with higher scores indicative of more positive attachment relationships from the mother's point of view ($\alpha = .92$).

To assess romantic attachment, mothers completed The Experiences in Close Relationships – Short Form (Lafontaine et al., 2015). This measure consists of 12 items to which mothers responded on a scale ranging from 1 (strongly disagree) to 7 (strongly agree). For example: "I feel comfortable depending on romantic partners; I worry about being alone." Scales of avoidant attachment (six items) and attachment anxiety (six items) are derived from the questionnaire by taking the mean of these items. In the current study, both scores of avoidant attachment and attachment anxiety showed good reliability ($\alpha = .83$).

## Data Analytic Plan

Descriptive statistics and preliminary analyses were performed for all variables under investigation. In examining multivariate normality between the continuity variable and the continuous variables of interest, the Shapiro-Wilk values suggested that multivariate normality was violated. However, the literature suggests that MANOVA tends to be robust against departures from normality (MANOVA Assumptions, 2020). Additionally, the assumption of multivariate normality can be partially checked by examining normality, linearity, and homoscedasticity, all of which met the MANOVA assumptions (Tabachnick & Fidell, 2013). Instead of removing outliers completely, significant outliers were addressed by reducing the value to their closest non-outlier value identified in the boxplots. Chi-square analyses, logistic regression, negative binomial regressions, and MANOVA analyses were performed to address the research objectives. Negative binomial regressions were chosen to compare mothers' history of other types of maltreatment using count scores (i.e., the number of acts of violence endured, as opposed to a dichotomous score). These comparisons were made between cycle breakers and maintainers, both representing dyads in which the mother experienced CSA; and between cycle initiators and the control group, where the mothers did not report CSA.

## Results

Bivariate correlations showed that all variables were correlated with each other ($p < .01$; Table 2). Sexual abuse was significantly correlated with increased mental health symptoms and decreased quality of parent-child attachment. Potential covariates to include in the logistic regression model were investigated. T-test, chi-square, and ANOVA analyses showed no significant differences between mothers with and without a history of CSA regarding level of

education, annual household income, ethnicity, age, or age at the birth of their first child. Therefore, these variables were not added as covariates in the analyses.

**Objective 1: Intergenerational Continuity of CSA**

Significant chi-square results ($\chi 2$ (1, N = 186) = 6.76, p < .01) showed that emerging adults whose mothers experienced CSA were more likely to report a history of CSA (41.5%) as compared to emerging adults whose mothers did not experience CSA (22.6%).

A logistic regression was performed using continuous scores of mothers' history of CSA included in the first block, and other forms of maltreatment (continuous scores) included in the second block (Table 3). The results showed that the model with mothers' CSA offered an improvement compared to the constant-only model, $\chi 2$ (1, N = 185) = 10.54, $p < .001$. The addition of mothers' other maltreatment types in the second block did not significantly improve the model, $\chi 2$ (4, N = 185) = 2.60, $p = .63$. The Wald test showed that in both blocks a history of CSA reported by mothers was a significant predictor of emerging adult CSA. In block 1, with each one unit increase of CSA count score in mothers, emerging adults were 1.38 times more likely to be sexually abused. In other words, for every additional act of CSA experienced by mothers, the risk of emerging adults' CSA increased by 38% (*OR* = 1.38, 95% CI: 1.13, 1.67). In block 2, the risk of emerging adults experiencing CSA increased by 32% for each additional act of CSA reported by mothers (*OR* = 1.32, 95% CI: 1.06, 1.63), with no significant contribution of mothers' other maltreatment types. Finally, the Nagelkerke pseudo R2 indicates that blocks 1 and 2 respectively explained 8% and 10% of the variance of emerging adults' CSA. In block 1, 73.5% of cases were accurately classified by the model, and in block 2, this classification was 76.8%.

**Objective 2: Maternal Maltreatment Histories**

Negative binomial regressions were carried out to test for differences in maternal maltreatment history between cycle maintaining and cycle breaking dyads.

There were no significant differences between these two groups in terms of mothers' histories of neglect, physical abuse, and emotional abuse. A significant difference was observed for exposure to domestic violence, such that mothers in the cycle maintaining dyads were exposed to 2.43 times more acts of domestic violence than mothers in the cycle breaking dyads ($p$ = .03, 95% CI: 1.09, 5.39). Comparing cycle initiators with the control group (both groups including mothers without a history of CSA), negative binomial regressions showed no significant differences in mothers' histories of maltreatment (Table 4).

**Objective 3: Maternal Mental Health and Attachment**

As presented in Table 2, the variables of interest were significantly correlated with each other, confirming the appropriateness of conducting MANOVAs. Two separate MANOVA analyses were performed, one with mental health variables and one with attachment variables. Post-hoc analyses (Fisher's LSD) were performed to examine individual mean difference comparisons across the four groups. The first MANOVA, including PTSD and psychological distress, was significant, Wilks's $\Lambda = .87$, $F(6, 362) = 4.53$, $p < .001$. The multivariate partial $\eta 2$ based on Wilks's $\Lambda$ was .07. Mothers classified as cycle maintainers reported more PTSD symptoms compared to initiator dyads and dyads in which neither member experienced CSA. Mothers in cycle maintaining dyads reported greater psychological distress compared to dyads in which neither member had experienced CSA. No other group differences were significant (Table 5).

A second MANOVA was conducted to evaluate group differences based on mothers' ratings of attachment to their child and romantic attachment. The MANOVA was not statistically

significant, Wilks's $\Lambda = .96$, $F(9, 430.92) = .86$, $p = .56$. The multivariate partial $\eta 2$ based on Wilks's $\Lambda$ was .01. Examining pairwise comparisons, there were no significant group differences in mothers' ratings of avoidant or anxious romantic attachment. Mothers in the neither-CSA dyads had higher parent-child attachment ratings than mothers in the cycle maintaining dyads.

**Objective 4: Socioenvironmental Group Differences**

To investigate differences in socioenvironmental variables between the four groups, chi-square analyses and an ANOVA were conducted. The chi-square showed significant results between family status and the four groups, $\chi 2$ (9, N = 186) = 21.36, $p = .01$. Cycle maintainer mothers were more likely to be separated, divorced, or widowed than the other groups. No differences emerged in mothers' annual income, $\chi 2$ (15, N = 186) = 21.74, $p = .11$, nor in their level of education, $\chi 2$ (12, N = 186) = 7.53, $p = .82$. There were no differences in mothers' ethnicity, $\chi 2$ (9, N = 186) = 9.42, $p = .40$. ANOVAs showed no differences in mothers' age, $F(1, 51) = 0.03$, $p = .87$), nor mother's age at the birth of their first child, $F(1, 51) = 0.12$, $p = .73$.

**Table 2**

*Correlations between Maternal Variables*

| Variable | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. Post-traumatic stress symptoms | | .750** | -.404** | .412** | .428** | -.467** | .473** | .441** | .441** | .301** |
| 2. Psychological distress | | | -.485** | .395** | .446** | .431** | .428** | .380** | .313** | .268** |
| 3. Parent-child attachment | | | | -.333** | -.463** | -.467** | -.362** | -.327** | -.176* | -.217** |
| 4. Romantic avoidant attachment | | | | | .213** | .219** | .224** | .234** | .071 | .211** |
| 5. Romantic attachment anxiety | | | | | | .360** | .422** | .374** | .205** | .235** |
| 6. Neglect | | | | | | | .591** | .596** | .297** | .451** |
| 7. Physical abuse | | | | | | | | .697** | .411** | .554** |
| 8. Emotional abuse | | | | | | | | | .303** | .532** |
| 9. Sexual abuse | | | | | | | | | | .235** |
| 10. Exposure to domestic violence | | | | | | | | | | |

** $p < .01$

**Table 3**

*Logistic Regression of Mothers' CSA Predicting Emerging Adult CSA*

| | **Emerging Adult CSA** | | | |
|---|---|---|---|---|
| **Mothers' Maltreatment**[a] | *B* | *SE* | *OR* | *95% CI* |
| **Block 1** | | | | |
| Child sexual abuse | .32** | .10 | 1.38 | [1.13, 1.67] |
| **Block 2** | | | | |
| Child sexual abuse | .27* | .11 | 1.32 | [1.06, 1.63] |
| Emotional abuse | -.18 | .15 | .84 | [.62, 1.13] |
| Physical abuse | .18 | .19 | 1.20 | [.83, 1.72] |
| Neglect | .15 | .21 | 1.16 | [.77, 1.76] |
| Exposure to domestic violence | .07 | .19 | 1.07 | [.74, 1.56] |

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

[a]Continuous maltreatment scores

**Table 4**

*Negative Binomial Regression Comparisons*

| Mothers' Maltreatment[a] | Cycle Maintainers and Breakers | | | Cycle Initiators and Control | | |
|---|---|---|---|---|---|---|
| | *B* | *SE* | *OR* | *B* | *SE* | *OR* |
| Emotional abuse | -.03 | .34 | .97 | .17 | .30 | 1.18 |
| Physical abuse | .16 | .45 | 1.54 | .15 | .32 | 1.16 |
| Neglect | .43 | .41 | 1.54 | .35 | .37 | 1.42 |
| Exposure to domestic violence | .89* | .41 | 2.43 | -.32 | .38 | .72 |

*$p < .05$

[a]Continuous maltreatment scores

**Table 5**

*Group Differences in Mother-Rated Mental Health and Attachment*

| Variable | Cycle Maintainers | | Cycle Breakers | | Cycle Initiators | | Control | |
|---|---|---|---|---|---|---|---|---|
| | *M* | *SD* | *M* | *SD* | *M* | *SD* | *M* | *SD* |
| Post-traumatic stress symptoms | 24.82[a] | 16.86 | 18.29[a,b] | 15.37 | 14.00[b,c] | 14.30 | 10.13[c] | 10.95 |
| Psychological distress | 35.18[a] | 23.71 | 28.50[a,b] | 18.85 | 27.23[a,b] | 17.72 | 22.38[b,c] | 15.57 |
| Parent-child attachment | 111.43[a] | 23.00 | 120.13[a,b] | 16.86 | 115.83[a,b] | 17.48 | 120.51[b,c] | 16.87 |
| Romantic attachment anxiety | 3.62[a] | 1.50 | 3.24[a] | 1.47 | 3.37[a] | 1.52 | 3.00[a] | 1.51 |
| Romantic avoidant attachment | 2.90[a] | 1.30 | 2.37[a] | 1.02 | 2.70[a] | 1.21 | 2.52[a] | 1.38 |

Note. Different superscripts indicate significant group differences

## Discussion

The goal of this study was to examine intergenerational cycles of CSA in mothers and emerging adult dyads to find key elements that could further our understanding of CSA (dis)continuity. The initial research objective was to determine if there was evidence of CSA continuity between generations in this cohort. In line with the literature, an association between mothers' and emerging adults' experiences of CSA was confirmed (e.g., McCloskey, 2013; Testa et al., 2011). Emerging adults whose mothers experienced CSA were more likely to also experience CSA (OR = 1.38). Using longitudinal data, Grunsfeld (2018) reported a similarly high odds ratio of 2.29. However, none of the mental health and attachment variables distinguished cycle breakers from cycle maintainers.

As polyvictimization is prevalent (K. Cyr et al., 2013) and has been related to an increased risk of intergenerational continuity (Langevin et al., 2021), it was vital to determine if there were any disparities in child maltreatment experiences of mothers amongst the groups of interest. The only type of maltreatment that revealed significant differences between cycle maintainers and breakers was exposure to domestic violence. Mothers in the cycle maintaining dyads were exposed to 2.43 times more acts of domestic violence than mothers in cycle breaking dyads. Increased exposure to domestic violence is consistent with past findings showing that exposed children have a higher risk of experiencing CSA (Bidarra et al., 2016; Graham-Bermann et al., 2012). Based on systematic review findings, IPV and intrafamilial CSA may co-occur at rates between 12% to 70% (Bidarra et al., 2016). Factors which may explain this co-occurrence, and which should be studied in future research on CSA continuity, include family functioning and conflict, parent drug use, community violence, and disclosure of sexual abuse, as children exposed to IPV may not feel safe to disclose other abuse (Bidarra et al., 2016). Mothers exposed

to domestic violence as children may internalize this behavior as normal, which could lead to acceptance of violence in adult relationships, and unintentionally expose their children to risk factors for CSA. The role of parent-child and romantic partner attachment needs to be investigated further.

The goal of comparing mother and emerging adult dyads, particularly cycle maintainers and breakers, is to learn about the factors that are involved in breaking CSA cycles. We did not find significant differences between these groups based on mothers' reported psychological distress or post-traumatic stress symptoms. The mental health differences found in our study only represent the known differences between sexually abused and non-sexually abused adults. This attests to the mixed literature on the role of mental health in the intergenerational (dis)continuity of maltreatment. As the scoping review by Langevin et al. (2021) pointed out, some research found that mental health was a significant component in the transmission of maltreatment (e.g., Dixon et al., 2009), while others found no such effect (e.g., Williams, 2015). It appears that additional studies are required to better understand how mental health could play out in the intergenerational (dis)continuity of CSA. Moderating variables have not been thoroughly considered in this context, such as safe, stable, and nurturing relationships (Thornberry et al., 2013), or participating in therapeutic interventions (e.g., Pasalich et al., 2019).

Although the level of mothers' distress and posttraumatic stress symptoms is lower in the cycle breaking dyads, this was not a statistically significant difference compared to cycle maintaining dyads. This could reflect a certain level of resilience on the part of cycle breaking dyads, where mothers have managed to cope with CSA trauma and the cycle of maltreatment has discontinued, but they do not come out of this experience completely unscathed. This may also explain why distress remained higher in cycle breaking dyads compared to the control group.

Breaking cycles of maltreatment can be an extremely challenging and stressful process to navigate, one which requires available and accessible supports.

In line with the model of victim-to-victim cycles of maltreatment presented by Marshall et al. (2022), the current study investigated the roles of mothers' mental health and attachment, but parenting, another central feature of this model, was not included. As mothers in cycle maintaining dyads reported high levels of distress and post-traumatic stress symptoms, it would be pertinent for future research to examine how these symptoms may impact their parenting in a way that may increase the risk of intergenerational continuity of CSA.

In terms of attachment, there were no significant differences in mothers' ratings of romantic attachment between any groups. Amongst cycle maintainers and neither-CSA dyads, there were variations in parent-child attachment. These findings do not support a distinction between cycle maintainers and breakers in terms of attachment, but they are consistent with the literature showing that CSA may disrupt parent-child attachment (e.g., Ensink et al., 2020). This should be studied further in qualitative research to explore the mechanisms that may have contributed to mothers forming more positive or secure relationships with their children despite their traumatic history.

Family status differed across the four groups in the present study with fewer cycle maintaining mothers indicating that they were still with the parent of at least one of their children. This is in line with existing literature supporting the role of family status in the risk for CSA victimization (Jaffee et al., 2013; Langevin et al., 2020). While there were no significant differences between groups in terms of romantic attachment in this study, this result suggests that mothers with a history of CSA may face other difficulties in relationships that can lead to single parenthood (e.g., problems with intimacy, interpersonal conflicts; Nielsen et al., 2018). As well,

in cases of intrafamilial CSA, some mothers may have left their partners if their partners were the ones who perpetrated the abuse of their child, or perpetrated violence toward themselves, in the case of intimate partner violence. Future research could focus on identifying available sources of support to families. Other socioenvironmental indicators did not differ between groups, which could be explained in part by the low diversity of our sample in terms of income and education.

**Strengths and Limitations**

This study contributes to the literature on an understudied topic, the intergenerational (dis)continuity of CSA. It is hoped that further investigations will be devoted to exploring the association between mothers' and emerging adults' CSA experiences. The dyadic design and the collection of multi-informant data using validated and reliable questionnaires are notable strengths of this study. The rigorous data cleaning procedures used in this study meant that missing data was a minor concern. Although our strict approach to data cleaning and the inclusion criteria of participant data was a strength, we acknowledge that this may have led to the exclusion of some eligible individuals. The use of convenience sampling is a weakness. While extensive efforts were made to recruit a diverse sample of participants across Canada, the majority represents well-educated and high-income mother-emerging adult dyads. Furthermore, because most of the emerging adults are woman-identifying, it is crucial to highlight that the results may not be representative of the experiences of man-identifying survivors of CSA. The data should be interpreted in light of the cross-sectional design of the study, the use of self-report questionnaires, and a lack of sample diversity. Efforts should be made to include fathers in similar investigations.

**Implications and Future Directions**

The current study's findings can be viewed as supporting interventions which target parents' histories of maltreatment, mental health symptoms, and parent-child relationships. Mothers who have experienced CSA, regardless of which dyad group they belonged to, exhibited greater levels of psychological distress and post-traumatic stress symptoms. Individual therapy and psychoeducation could be used to address the mental health symptoms of parents before progressing to attachment work. Based on our findings, it is also important to target families in which there is co-occurrent intimate partner violence and CSA, and to intervene with emerging adults to break cycles of victimization.

Our study adds to the growing body of evidence that having at least one parent with a history of CSA increases the probabilities of CSA in the next generation (Grunsfeld, 2018; Leifer et al., 2004; Testa et al., 2011). This association needs to be examined and explained further to identify which factors contribute to this intergenerational risk. Longitudinal studies or population-based surveys with large samples of mother-child dyads would allow for path analyses to be conducted and the identification of temporal relationships. Additionally, populational studies would have more power to detect statistically significant differences that were not observed in the current study. As there are mixed findings in the literature regarding the effects of CSA on adult relationships, future studies may benefit from using measures which may tap into different aspects of attachment relationships (e.g., reflective functioning and attachment to children and intimate partners). We recommend that future research also collect data on parenting behaviors, which would be informative and consistent with the model proposed by Marshall et al. (2022). In addition to methodologically strong quantitative studies, more qualitative exploration with survivors and the practitioners working with them will be

particularly informative on this topic. Such studies would provide a wealth of insight into the quantitative data on CSA continuity and contribute to bridging the gap between research and practice.

## Conclusion

The intergenerational (dis)continuity of CSA victimization was explored in this study of mothers and emerging adults to analyze individual, relational, and socioenvironmental variations among dyads. Although there were no significant differences between cycle maintaining and cycle breaking dyads in this study in terms of maternal mental health and attachment, the findings highlight the important long-term effects of CSA on these variables. In-depth analyses using varied measures of both attachment and parenting behaviors are encouraged to better understand the potential roles of parent-child and intimate partner attachments in CSA continuity. We also suggest examining more specific mental health symptoms (e.g., borderline personality disorder, depression, anxiety, PTSD), and the role of polyvictimization and family violence, particularly to clarify the link between exposure to domestic violence and CSA continuity. Employing methodological designs to clarify non-significant findings through the use of longitudinal, population-based, qualitative, and mixed methods studies is urged.

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## Bridging Between Study 2 and Study 3

Study 2 provides support to the existing literature that there is an increased risk of CSA occurring when at least one parent has a history of this type of abuse (e.g., Avery & Hutchinson, 2002; McCloskey, 2013; Testa et al., 2011; Wearick-Silva et al., 2014). The purpose of Study 2 was to further understand this association and identify factors that may differentiate dyads in terms of breaking this cycle. In a comparison between cycle maintainers, cycle breakers, initiators, and control dyads, Study 2 found that mothers in cycle maintaining dyads were exposed to more acts of domestic violence as children compared to cycle breakers, which is consistent with literature that children exposed to domestic violence are at an increased risk of experiencing CSA (Bidarra et al., 2016; Graham-Bermann et al., 2012), as well as research indicating a co-occurrence of IPV and CSA (Bidarra et al., 2016). Another significant difference in Study 2 was related to family status – mothers in cycle maintaining dyads were less likely to be with the parent of at least one of their children, underlining that single parenthood could be a risk factor for CSA continuity, which supports previous studies (Drake & Jonson-Reid, 2014; Langevin et al., 2021). Although research supports that CSA can negatively impact psychological and relational functioning (e.g., Noll, 2021), Study 2 did not establish any significant differences between the four groups of dyads based on mothers' mental health and relationship self-report measures. The study is limited by a cross-sectional design which cannot elucidate underlying mechanisms, establish causal relations, or identify longitudinal associations. Study 3 explores through a qualitative design the personal accounts of mothers who experienced CSA and intergenerational continuity in the hope of elucidating some of the non-significant findings of Study 2. The findings from Study 2 and 3 represent a mixed methods design, which was considered necessary to develop this understudied topic.

# CHAPTER VI: Manuscript 3

## "I was trying to be the mother to her that I didn't have": Mothers' Experiences of Child Sexual Abuse and Intergenerational Maltreatment

**Marshall, C.,** Fernet, M., Brassard, A., Langevin, R. (Submitted). "I was trying to be the mother to her that I didn't have": Mothers' Experiences of Child Sexual Abuse and Intergenerational Maltreatment. *Violence Against Women.*

**Abstract**

Child sexual abuse (CSA) can have lasting negative impacts on one's sense of safety and trust, ultimately affecting the quality of relationships, and increasing the likelihood of future victimization experiences. The present study provides a qualitative description of the themes that were generated through interviews conducted with 23 mothers who experienced CSA (dis)continuity (12 continuity, 11 discontinuity). The mothers described a variety of experiences related to parent-child and romantic relationships and parenting behaviours, which could be further researched and targeted by interventions to reduce the risk of intergenerational cycles of maltreatment.

*Keywords:* intergenerational continuity, intergenerational transmission, child sexual abuse, qualitative

## “I was trying to be the mother to her that I didn't have”: Mothers’ Experiences of Child Sexual Abuse and Intergenerational Maltreatment

Child sexual abuse (CSA) is a type of developmental trauma that affects 8 to 31% of girls and 3 to 17 % of boys worldwide (Barth et al., 2013). When a perpetrator sexually abuses a child, their actions interfere with the acquisition of developmentally important competencies on multiple levels (e.g., attachment, self-concept, executive functioning, frustration tolerance) (Ensink et al., 2020; Lund et al., 2020). CSA compromises healthy developmental trajectories, putting children at risk of immediate and long-term challenges, for example, anxiety, post-traumatic stress disorder (PTSD), depression, eating disorders, and self-harm (Bradley et al., 2019; Khadr et al., 2018), and can increase the risk of further intimate partner violence (IPV) victimization (Brassard et al., 2020). The long-term repercussions of CSA can also increase the risk of intergenerational maltreatment. However, there is limited research on cycles of CSA, especially using qualitative methodologies that explore and document individuals’ experiences and perspectives of intergenerational maltreatment. The current paper presents the findings of a qualitative study that was conducted to better understand mothers’ perceptions regarding their personal experiences of CSA and the impacts that this may have had on their attitudes, behaviours, and relationships with their children.

Cycles of violence can be defined and studied in different ways. Intergenerational continuity broadly encompasses victim-to-victim and victim-to-perpetrator cycles of abuse. Researchers studying victim-to-perpetrator cycles focus on parents who have a history of maltreatment and who are the perpetrators of abuse against their child; this has also been referred to as intergenerational transmission of maltreatment (Schelbe & Geiger, 2017). A victim-to-victim cycle is when a parent has a history of maltreatment but is not the perpetrator of their

child's abuse (Schelbe & Geiger, 2017). Further, the term *homotypic continuity* is used when both the parent and the child have experienced the same type of abuse during childhood, as opposed to *heterotypic continuity*, which describes how a parent's childhood experience of one type of abuse may predict a different type of abuse reported by their child (e.g., parent experienced CSA and their child experienced physical abuse) (Berzenski et al., 2014). Discontinuity is when the maltreated parent has a child who does not experience maltreatment.

There are in fact limited studies on the continuity of CSA specifically, thus our understanding of the ways in which this type of abuse may continue is limited. Recently, we presented findings from a cross-sectional study on mothers and their emerging adult children to identify factors that distinguished CSA continuity, discontinuity, and initiator dyads (only the emerging adult reported CSA) (Marshall et al., 2022). We found that mothers' psychological distress, PTSD symptoms, and mother-rated attachment to their child, but not romantic attachment, differentiated continuity and initiator dyads. There were no significant findings between continuity and discontinuity groups, thus the results are limited in identifying the characteristics that may help clinicians and families to prevent intergenerational CSA. Other studies have also documented mixed results pertaining to risk and protective factors involved in intergenerational maltreatment more generally (e.g., Dixon et al., 2009; Williams, 2015). To illuminate insignificant and mixed findings in the literature and bring greater clarity to understanding the intergenerational impacts of CSA, qualitative investigations that highlight personal accounts are essential (e.g., Langevin et al., 2021; Marshall et al., 2022).

Qualitative studies on the experiences of CSA survivors have provided insight into mental health and parenting challenges. Mothers who experienced CSA have described various parenting difficulties, including a fear or discomfort with their partners' contact with children,

educating their children about abuse and being strict to prevent such abuse, and difficulties bonding with male children (Cavanaugh et al., 2015). Negative perceptions of motherhood, struggles with breastfeeding (e.g., triggering memories of abuse or being unable to view parts of their body as more than sexual objects), difficulties bonding with their children, and with having open conversations about sexual education have also been reported (Lange et al., 2020a, 2020b). It is important to note, however, that some women also reported positive adaptation, in that they felt that having experienced CSA resulted in a more open and caring relationship with their child, viewed breastfeeding as an empowering experience through which they gained back control over their body, and avoided using corporal punishment (Lange et al., 2020a, 2020b).

Despite the many reported difficulties resulting from CSA that can span over the course of both a mother's and their child's life, there is evidence of coping and resilience, which emphasizes the need to consider protective experiences that support individuals to cope with the consequences of maltreatment, and which help them prevent the cycle from continuing with their children. Quantitative studies showing an increased risk of a child experiencing CSA if their mother reported a history of CSA have been limited to cross-sectional studies using bivariate and multivariate analyses (e.g., Baril & Tourigny, 2016; Marshall et al., 2022). The use of other methodological designs that allow for in-depth exploration of experiences is needed to better understand this problem. Qualitative data will enrich this area of research by expanding upon quantitative findings in the literature, and by providing explanations for insignificant results. Further, with a better understanding of individuals' lived experiences of CSA and of intergenerational maltreatment, important processes and behaviours can be identified and targeted through psychosocial interventions.

### Current Study

In line with the victim-to-victim model of intergenerational maltreatment proposed by Marshall et al. (2022), the current study examines the roles of mental health, relationships (parent-child and intimate partner), and parenting in the intergenerational continuity of CSA through a qualitative design. The objectives of the study were to: 1) describe sexually abused mothers' experiences of parenting a child with and without a history of child maltreatment; and 2) to identify the features of parenting in the context of continuity and discontinuity of child maltreatment. A qualitative analysis of the narratives of mothers who experienced CSA homotypic continuity, CSA heterotypic continuity, and discontinuity of maltreatment is made in order to identify potential nuances in their experiences of intergenerational maltreatment. Qualitative data were gathered through individual interviews with mothers – all reporting a history of CSA – of emerging adults (18 to 25 years old).

## Methodology

### Author Positionality

Scharp and Thomas (2019) contend that researchers should reflect on their own positions and experiences and how these can influence their interpretations of peoples' lived experiences. This project was personally and professionally meaningful as researchers, psychologists, and trainees devoted to the well-being of children and families. The interviewers who co-generated the presented data are PhD students in counselling psychology, sexology, or child psychology programs at English or French universities, with research and clinical experience related to intimate relationships and trauma. We acknowledge our standpoints and social identities as educated individuals with varying professional experiences with victims/survivors of abuse.

## Design

The chosen design for this study was qualitative description (Neergaard et al., 2009; Sandelowski, 2000). This is an effective design for gaining a detailed understanding of a process, particularly the how and why of specific behaviours, and it is commonly used when researchers want to describe an understudied phenomenon (Sandelowski, 2000). To ground this study, we drew from theoretical and empirical literature on the (dis)continuity of CSA and other types of abuse (e.g., Marshall et al., 2022; Langevin et al., 2021). The current study is based on social constructivism as an epistemological assumption that there is not one but many realities (Daly, 2007). These realities are thought to shape individual's experiences of CSA, and there are a variety of factors that might contribute to CSA (dis)continuity.

## Recruitment

Participants were recruited from 2020 to 2021 through a convenience and purposeful sampling strategy (i.e., participants across Canada who were willing to participate and indicated a history of adverse childhood experiences). Those who already completed a quantitative component of our study indicated whether they agreed to be contacted for future studies. Efforts were made to recruit participants from diverse groups who have complex histories of trauma, such as through contacting community organizations (e.g., sexual assault centers, women's shelters) and posting advertisements in targeted Facebook groups (e.g., parent groups, survivors of abuse). A total of 40 mothers participated in individual interviews, for which they received CAD$30. The study was approved by the institutional Research Ethics Boards of all authors.

## Participant Selection

As the objective of this research was to study the intergenerational continuity of CSA, all 23 mothers who reported a history of CSA during their interviews were included (Table 1).

Twelve mothers who reported experiencing intergenerational continuity of abuse (regardless of type) were included in this study as the "continuity" group, which was then further divided into homotypic and heterotypic continuity types, depending on the type of maltreatment their emerging adult child experienced, according to the mothers. Eleven mothers who reported that their emerging adult child did not experience any type of abuse were included as the "discontinuity" group. Based on prior qualitative studies on CSA that used individual interviews, a group of 23 participants was deemed acceptable (Mason, 2010; Lange et al., 2020a). Each interview lasted approximately one to two hours (mean of 90 minutes), which provided a rich dataset. It was considered that information sufficiency to address the research questions was achieved (MacDonald, 2022). Participant recruitment occurred over the span of one year, the majority of which occurred during the COVID-19 pandemic.

**Data Generation and Analysis**

A semi-structured interview protocol was designed through a combined effort of experts in qualitative research methodology, domestic violence, and sexual abuse. The literature on intergenerational transmission/continuity of maltreatment, and the effects of CSA on mental health, attachment, and parenting was also consulted to develop the interview protocol. The interviewers explored participants' experiences of child maltreatment (before the age of 18), as well as their perceptions of parenting and attachment while growing up and raising their children, for example, mothers were asked: "Do you think the event(s) that you experienced during your childhood has/have had an impact on how you felt and behaved towards your child when they were growing up?" Webex™ Video Conferencing software was used to record the interviews. A traditional content analysis using a hybrid approach was used to analyze the data (Hsieh & Shannon, 2005; Fereday & Muir-Cochrane, 2006). This analysis involves both deductive coding

(coding the interview transcripts based on the predefined coding scheme) and inductive coding (coding directly from the data to allow new codes and themes to emerge). Themes, categories, and codes were developed to summarize and classify interview extracts. A preliminary analysis using team coding took place from November 2020 to March 2022. Five graduate students, three of which were also interviewers, classified and labelled the raw transcript data using the predetermined coding grid supported by NVivo software (QSR international Pty Ltd, 2018). The coding grid was modified by adding or deleting codes based on content from new transcripts. Data were revisited for a process of categorization from April 2022 to August 2022, at which point, codes reflecting similar concepts were grouped to form conceptual categories and sub-categories. The analysis was an iterative process whereby the researchers continually revisited the codes, categories, and raw data. Strategies to enhance the trustworthiness of the qualitative data were employed throughout the study. Investigator triangulation was implemented through multiple researchers coding the data to establish inter-coder agreement. Team meetings were held to discuss the coding process and an audit trail was used to track modifications to the coding grid. Pseudonyms for the participants were chosen by the researchers to maintain anonymity, and no identifying information is presented. Extracts from French interviews were translated for publication.

## Results

Mothers in the current study were 48 years old on average. The majority of participants identified as White (87%, $n = 20$) and had obtained high levels of education, with 91% ($n = 21$) reporting a level of education above high school. Thirty-nine percent ($n = 9$) reported an annual family income of CAD$100,000 or more, and 26% ($n = 6$) had an income between CAD$60,000 and CAD$79,000. The remainder reported an income below CAD$60,000. In addition to

experiencing CSA, 19 out of 23 mothers (8 continuity; 11 discontinuity) reported at least one other type of maltreatment, highlighting their experiences of polyvictimization. Of the 12 mothers who experienced continuity, five reported CSA homotypic continuity, as their emerging adult child had experienced CSA (Table 1). To understand how CSA may continue within families, the focus of this section is on how mothers' experiences of CSA may have contributed to how they parented and bonded with their children as they grew up, as well as how they relate to intimate partners (see Figure 1 for features of continuity and discontinuity mothers). Both mothers who experienced continuity or discontinuity shared the desire for discontinuity and wanted to be a different parent than their own parents, as Rae expressed here: "I told my daughter that I was trying to be the mother to her that I didn't have" (Discontinuity).

> Blake: I think that was really what motivated me, that I had been so badly off that I wanted to make sure that I was available one hundred percent of the time for them. I wanted to make sure that they didn't have to go through this with me, that I could give them everything I could. (Heterotypic Continuity)

## Parenting Challenges Related to Experiencing CSA

Mothers' experiences as parents with histories of CSA were shared, as well as their perceptions of how CSA may have played a role in intergenerational maltreatment. The conceptual categories comprising the parenting challenges theme are presented below.

### *Relational Challenges*

#### Mothers' Negotiation of Autonomy and Protection.

***Feeling Protective of Children.*** Some mothers shared their difficulties in fostering autonomy in their children as a result of their maltreatment histories. Mothers who experienced continuity and discontinuity expressed being strict and placing many limits on their children.

> Sam: When he tells me he needs to go somewhere I'm that kind of very strict mom, and for him he doesn't always understand the reason, but in a way, it feels like I'm protecting him, it feels like he cannot take care of himself. (CSA Homotypic Continuity)
>
> Blake: Well, sure, with my kids, I never let them go to sleep anywhere else. For me, that was a big no. It's like "your friends, you can spend the day with them, but go to sleep, we sleep at home". I wasn't putting them in a situation where that [sexual abuse] could happen. (CSA Heterotypic Continuity)

Mothers who experienced heterotypic CSA continuity, specifically Blake, Olivia, Sophie, and Jordan, also discussed efforts to support their children's decisions and actions, negotiating autonomy with a reassuring presence, encouraging their children to stand on their own two feet, as well as being protective but adjusting in order to give their child tools.

> Jordan: A friend of mine used to say, keep her [daughter] in a little absorbent cotton box. And maybe that's not the best way to raise a child. Maybe it's better to give them tools. So that's what I'm doing, I'm giving tools. (CSA Heterotypic Continuity)

***Supervision and Monitoring.*** Zoey described feeling an insufficient amount of supervision from her mother when she was young, which led to her feeling unprotected and alone. Although she did not feel comfortable with allowing sleepovers, which is similar to some moms who experienced continuity, she extended this by making sure that she knew where and with whom her daughters were at all times. We propose that her childhood memories of feeling alone, leading to increased supervision and monitoring of her children, may have been protective against maltreatment continuity in her family.

> Zoey: I've always said to myself that I would never want that [sexual abuse] to happen to my children. Is that what makes me bossy? Maybe. I wanted my girls to be there. I didn't let them go out, you know, sleep over at friends' houses a lot. So, did that have an influence, I would say yes, probably. And I wanted to know where my daughters were at all times with whom at all times. (Discontinuity)

Along similar lines, one mother expressed that she monitored the clothes that her daughter wore to prevent her from being abused.

> Shay: I would say that with my daughter, I'm very protective, because I don't want her to be in an abusive situation where, I'm like too often commenting on how she dresses… "Ah! Ah! Can you change your shorts? Your shorts are too short." Things like that. (Discontinuity)

Although Shay and Zoey shared being protective of their children, they may have not been strict to the point of completely preventing their children from participating in social activities. Rather, they exercised caution and asked to be informed of their children's whereabouts, which appears to be a specific narrative characterizing mothers who experienced continuity.

***Establishing Interpersonal Boundaries*.** Riley and Luca, two mothers who experienced homotypic continuity, as well as Nora (heterotypic continuity) and Reese (discontinuity) discussed the importance of boundaries. Mothers with experiences of continuity or discontinuity expressed diligence in drawing boundaries between their children and certain individuals to reduce the risk of intergenerational CSA.

> Riley: There were really clear boundaries in terms of...well, maybe when we were together, he would come and sleep in our bed, and then everyone else, we were all together in the family bed, but when we separated, there were really limits that "no,

> your bed is your bed". They [daughters] would tell me "oh, I wanted to go to sleep with daddy, then he really didn't want to, he forced me to go to my bed". So, it was like, okay, I see that clearly he set boundaries. To protect, probably, so there wouldn't be any doubt. (CSA Homotypic Continuity)
>
> Nora: With one of the uncles, that he was kind of sexually touching one of his nieces. So I was really careful with him because he's very friendly, very social. And so, I never left them [children] alone with him. (CSA Heterotypic Continuity)

Reese (discontinuity) also spoke about being careful with boundaries, specifically around bath time and not having her husband share baths with their daughter. Boundaries may be more difficult to establish for mothers who experienced continuity if they grew up in an environment where this was not enforced. Luca, who experienced CSA homotypic continuity, shared her struggles with setting boundaries and limits for her son, as this was not something she learned as a child. For instance, when she said, "I can't offer what I didn't have," she described the difficulty in providing certain parenting behaviours which she did not receive.

### *Individual-Level Challenges as a Parent*

**Promoting Positive Educational Approaches.** Mothers who experienced homotypic continuity (Luca), heterotypic continuity (Blake, Nora, Olivia) or discontinuity (Julia, Alex, Reese, Zoey) felt that it was important for them to share certain knowledge with their children and teach their children without using violence.

***Providing Sex Positive Education*.** There were specificities between mothers regarding the sexual education they transmitted to their children. Some mothers described making efforts to communicate with their children about the importance of paying attention to what they feel is right, as well as having open communication about sex and consent. One mother felt that these

conversations were difficult, and experienced feelings of guilt regarding the non-disclosure of her sexual abuse history.

> Blake: [talking about sexual abuse] As a child, you know, you tell them to trust themselves, you teach them to listen to their intuition, that if they don't feel right, it's important not to do something they don't feel right. (CSA Heterotypic Continuity)

In contrast, Luca communicated feelings of guilt related to her son's experience of sexual abuse and blamed herself for not talking about her own CSA history.

> Luca: Well, I have to say that. If it happened to my son, it's because I didn't talk about mine (sexual abuse). I put it under the carpet all my life. (CSA Homotypic Continuity).

Beyond providing information related to sexual abuse, what may have supported Reese and Zoey to break the cycle of maltreatment is the open communication around healthy sexuality they reported having with their children. For instance, Reese reported a positive generational pattern of discussing contraceptives with her mother when she was a child, as well as with her daughter. One of the nuances between the narratives provided by Blake and Zoey is that Zoey explicitly mentioned having conversations about sexual consent at an early age with her children and shared her experiences of wanting to have open communication with her children.

> Zoey: I was definitely educating them, you know I told them from a very early age in a sense, it's your body, nobody touches it, there's no secret. (Discontinuity)

***Educating Children without Violence*.** Blake, Alex, Julia, and Reese, mothers who experienced discontinuity, also shared their perspectives about the importance of education and

being a positive role model. These mothers felt that it was important to teach their children without being physical, and they expressed their thoughts about their own emotion regulation.

> Alex: I was determined to teach my children, approach them in a teaching manner. You know, you're there to coach, and teach, and help your kids, and promote physical and mental wellbeing. And you want to have better for them than what you had yourself. (Discontinuity)
>
> Julia: Even if my kids were at their worst, I could not imagine taking a belt to them. I think I was very conscious of if I didn't let my emotion escalate, and even when I did, because I'm an emotional person, I would be able to stop before. (Discontinuity)

**Self-Concept as a Parent.** Mothers with experiences of homotypic continuity (Riley, Luca), heterotypic continuity (Olivia), and discontinuity (Alex, Julia, and Amelia) all expressed that their self-concept as a parent was important to them, while also sharing difficulties with this aspect of themselves.

***Being Authentic to Oneself.*** Both Olivia and Amelia felt a lack of authenticity in parenting behaviours, for example, engaging in behaviours which were interpretated by their children as compensatory or being inauthentic in their relationship. One mother noted a mismatch between her thoughts or feelings and her behaviours with her child, such that she was acting in ways to not hurt or lose her daughter. This could be interpreted as acting out of a fear of abandonment.

> Olivia: I think we [daughter] have a good relationship, but it lacks depth, I would say. You know, I'm not able to be totally authentic with her, because I'm still...you

> know, I'm on my guard, not to hurt her, not to lose her. (CSA Heterotypic Continuity)

Although Amelia experienced maltreatment discontinuity, she struggled with a similar issue as Olivia.

> Amelia: She's [daughter] already told me, I'm maybe trying too hard to be better. She already told me that, what she would like is for me to be myself. (Discontinuity)

***Confidence in Parenting.*** One of the aspects that differed between mothers who experienced continuity and discontinuity of maltreatment was their felt lack of confidence in themselves as parents.

> Riley: Insecurity, feeling insecure in the way I do my things, always questioning myself, is this the right thing. Maybe a little bit of insecurity too, as a parent. (CSA Homotypic Continuity)

On the other hand, two mothers who experienced discontinuity, namely Alex and Julia, reported positive aspects related to self-concept, specifically distinguishing their identities from that of their parents, which could have protected them against maltreatment continuity. An important point that Alex made is related to social learning – she gained confidence by looking to her friends who had children and observed how they were as parents. Therefore, she sought other positive role models of relationships that she then relied upon when she became a parent, which could have supported her in discontinuing the physical and emotional abuse that she had experienced.

> Alex: I wanted my kids, I'm gonna teach them, I'm gonna play with them. Whether or not my parents play with me, that was them. But me, I'm not them, I'm another

> person. So my outlook on things, my positiveness, that's just who I became. (Discontinuity)

**Self-Reflection about Parenting.** Engaging in reflection about childhood experiences of maltreatment and current parenting behaviours was discussed by Nadia, Shay, and Quinn, mothers who experienced discontinuity. Given that this was only discussed by those who experienced discontinuity, this type of self-reflection could be seen as having a supportive role in preventing violence in families.

> Shay: That's something I witnessed my father doing to my mother (denigrating her in front of the children). And it was part of a very unhealthy dynamic of conjugal violence. So at a certain point I took the time to think about it and to say "Oh, okay. I don't like the way I'm acting", this behavior really reminds me of how my father behaved with my mother and it wasn't healthy. It wasn't a good example to set for the kids either. (Discontinuity)

Quinn believed that she became more aware when she had her first child about the things she had experienced during her childhood and how she wanted to educate her children differently, stating that she "spotted the patterns." On the other hand, when asked about parenting difficulties or concerns about reproducing certain patterns, Marcia, a mother who experienced continuity, did not engage in the same kind of reflection.

> Marcia: No! I didn't have any difficulties at all at all. No, no, no, no! No, no, no! I taught my son well. I taught him the right things. I had good times with him. I talked to him, good! I raised him as best I could. In my opinion I raised him well. I'm sure I did! (CSA Heterotypic Continuity)

**Summary of Parenting Experiences**

As part of the parenting experiences, mothers described relational and individual-level parenting challenges, specifically related to negotiating autonomy and protection, establishing ways of educating children, their self-concept as a parent, and reflecting on themselves and their actions as parents. The results underline that regardless of the intergenerational pattern, all mothers experienced complexities related to feeling protective of their children. Mothers who experienced discontinuity noted more specifically that they engaged in monitoring and supervision of their children, rather than disallowing them to attend events. Uniquely, those who experienced discontinuity expressed confidence in their parenting and encouraging self-confidence in their children. Feeling confident as a parent might have been supportive and protective for mothers in terms of reducing the risk of maltreatment, for instance, by engaging in other positive parenting behaviours that these mothers mentioned, such as encouraging open communication and avoiding negative behaviours like physical abuse as a means to discipline. Imparting information about healthy relationships and sexuality and sexual consent at an early age and discouraging secrets was also exclusively mentioned by a mother who experienced discontinuity. All mothers felt the need to set boundaries and limits for their children, though only mothers who faced maltreatment continuity shared that they had difficulty setting limits with their children, potentially because of their own upbringings or histories of CSA. This challenging experience of implementing limits could have unintentionally contributed to situations in which abuse may be more likely to occur. Exceptionally, only mothers who experienced discontinuity reported engaging in reflection about their own maltreatment experiences and parenting practices. Such awareness and reflection could have offered these mothers more choices when it came to parenting their children, leading to discontinuity of maltreatment.

**Mothers' Perceptions of Parent-Child Relationships**

The quality of parent-child relationships was explored in this study. The aim was to describe mothers' perceptions about how they may have been impacted by their histories of CSA, and to understand how these impacts might have contributed to continuity or discontinuity of maltreatment. This theme was discussed by four mothers who experienced homotypic continuity (Jade, Riley, Luca, Mia), three who experienced heterotypic continuity (Blake, Sophie, Marcia), and five who experienced discontinuity (Amelia, Nadia, Reese, Shay, Logan).

**Expressing Emotions**. Communicating and showing emotions was a struggle for Luca (CSA homotypic continuity mom): "I'm a tough parent. I can't offer what I didn't have there. It's the acceptance of tears, that's what's difficult." Similarly, Mia shared that it was challenging to express emotions and affection with her children:

> Mia: I know there were times where I was pretty checked out. I think overall I was fairly present. No, I wasn't the best with emotions. They still sometimes make me uncomfortable. I still don't like to be hugged, like saying I love you I have to make a concerted effort to remember to say that. (CSA Homotypic Continuity)

The difficulties lived by mothers who experienced intergenerational CSA point to the possibility that attachment insecurity in a parent-child relationship, and a lack of trust to be welcomed by a parent in times of difficulty or negative emotions, could have contributed to CSA continuity in these cases. Further, a parent's emotional unavailability could deter a child from disclosing abuse to them, such as with Luca, who had delayed knowledge of her child's sexual abuse and was unsure if he had experienced other assaults.

In contrast, a distinguishing narrative of mothers who experienced discontinuity is that they were able to overcome challenges in expressing emotions, suggesting that this could be protective in preventing intergenerational maltreatment.

> Shay: I decided to take a different path and to be there emotionally for my children, maybe too much so! I may have gone to the other extreme, but for me it was important that they felt loved at all times. I never heard "I love you" as a child either. (Discontinuity)

Logan mentioned trying to give her daughter what she did not receive by communicating emotions and having a deeper relationship:

> Logan: I try not to reproduce what my mother does with me, and I wrote to my daughter, I love you, while I never did that with my mother. I miss her, when I don't have that with my mom, I write to [daughter's name], Hello, how are you? Even though it's only been two days, how are you? So I've deepened my relationship with [daughter's name] while I don't have that with my mother. (Discontinuity)

**Role Reversals.** Another quality of parent-child relationships that was only discussed by mothers who experienced discontinuity (Nadia and Shay) was the challenge of role reversals and efforts that were made to avoid this with their children. Shay experienced role reversal behaviours with her children sometimes, although she had sought therapy and personal development to work on this, which could have contributed to maltreatment discontinuity.

> Shay: Sometimes I can have very childish reactions. It's like sometimes, I don't know, sulking or wanting to be comforted or whatever. And at that time, it's as if I would like my husband to be there more often or my children to comfort me and take care of me, all that. Before I did all that work on myself, if I hadn't done

> anything, I would have found that, yeah, I would have fallen into the trap of wanting to be my children's friend. (Discontinuity)

**Experiences of Intimate Partner Relationships**

Both mothers who lived through continuity and discontinuity shared the desire to be affectionate with their children and to have a close bond with them, but also felt attachment-related difficulties in their intimate relationships, which were perceived as playing a role in the continuity of maltreatment. For instance, the prioritization of one's own emotional needs at the expense of the child's was recognized by one mother:

> Sophie: I would say that it wasn't fair that I stayed with somebody who really was not good for me. You know, and there was a bond. It was like, I felt good, you know, like, it was good between the two of us, we didn't argue during that, but the rest of it was shit. My children saw the shit all the time, and that wasn't fair. (CSA Heterotypic Continuity)

Chloe's experiences of CSA led her to seek protection from others, which resulted in another abusive relationship:

> Chloe: It was never exactly consensual with my kids' dad at the start of that relationship, that was not, it didn't start off consensual. So, I mean, I basically just gave up. (Heterotypic Continuity)

Although Mia, a mother who experienced CSA continuity, expressed feeling regret for not having ended an abusive relationship as early as she wished, she demonstrated strength for eventually leaving this relationship to discontinue her children's exposure to violence.

**Summary of Parent-Child and Intimate Partner Relationships Experiences**

The parent-child and intimate partner relationships experiences summarized mothers' desire to have close relationships with their children. Mothers with lived experiences of maltreatment continuity reported specific difficulties related to IPV victimization and inadvertently exposing their children to violence, as well as difficulties expressing emotions and affection with their children. The relational processes which may support the discontinuity of maltreatment, as they were uniquely discussed by mothers with discontinuity experiences, include overcoming challenges in emotional communication, displaying affection, and working to avoid role reversals with their children.

**Table 1**

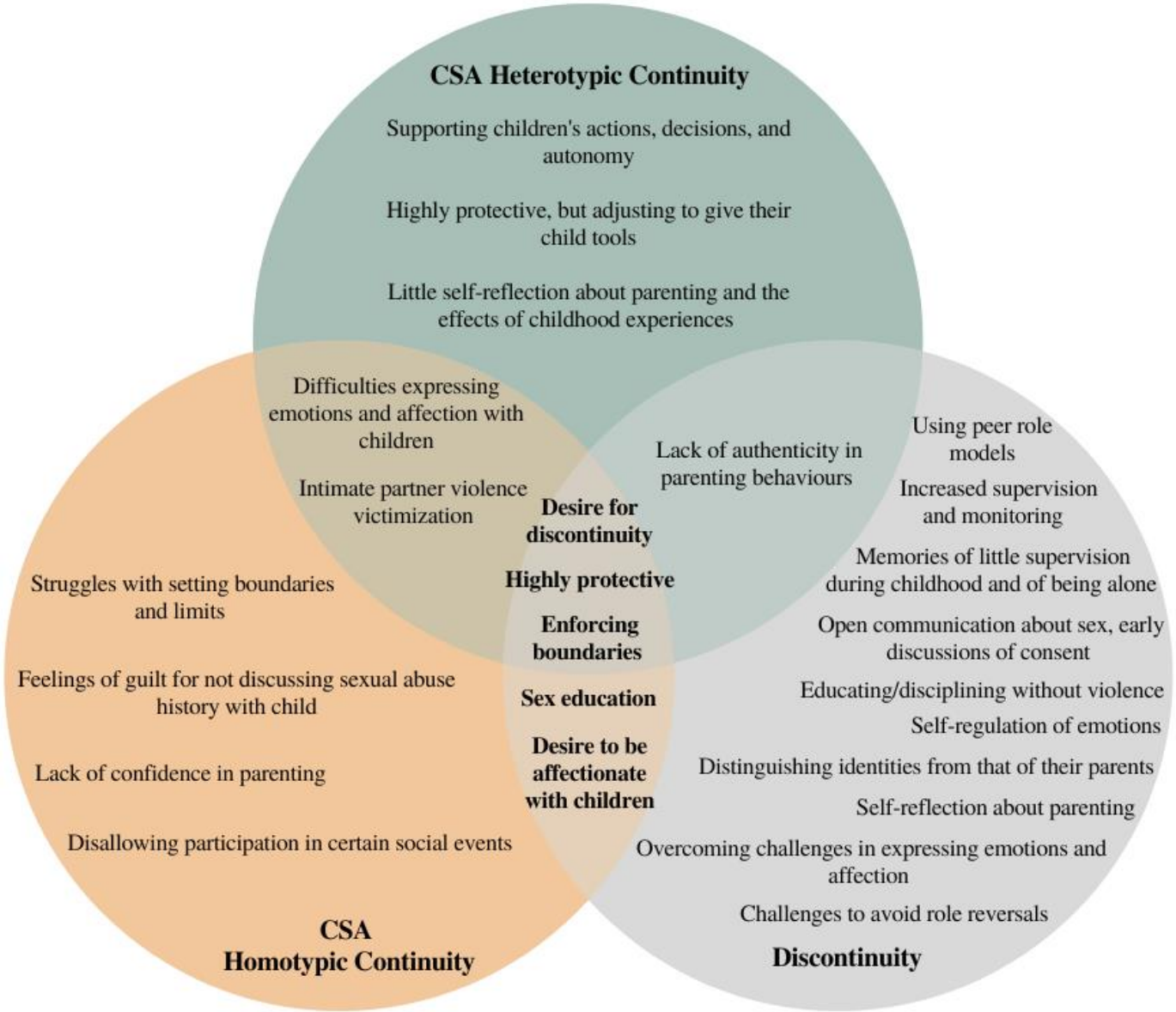
*Maltreatment Types and Intergenerational Classification*

| Mother Pseudonym | Mothers' Childhood Maltreatment | Emerging Adults' Childhood Maltreatment | Continuity /Discontinuity |
|---|---|---|---|
| Sam | Sexual abuse, by close relative, physical and psychological abuse by parents, neglect, exposure to intimate partner violence | Sexual abuse by an aunt, physical and psychological abuse by father | Homotypic Continuity |
| Chloe | Sexual abuse by teacher, house guest, and boyfriend; exposure to intimate partner violence, physical abuse by mother, harassment (stalking) by partner | Physical and psychological abuse by father, exposure to intimate partner violence (mother and father) | Heterotypic Continuity |
| Jade | Sexual abuse (did not disclose identity of perpetrator) | Sexual abuse by peer, physical and psychological abuse by mother, exposure to family violence (brother towards mother) | Homotypic Continuity |
| Riley | Sexual abuse by father | Sexual abuse (unwanted sexual experience with boyfriend), physical abuse by both parents (corporal punishment) | Homotypic Continuity |
| Blake | Sexual abuse by cousin | Physical abuse by mother | Heterotypic Continuity |
| Nora | Sexual abuse by babysitter, physical and psychological abuse by parents | Physical abuse by mother (spanked children) | Heterotypic Continuity |
| Mia | Sexual abuse (inappropriate touching my manager at 16), physical and psychological abuse by parents, witnessed inappropriate sexual behaviour between teacher and student | Sexual abuse (raped at 16; perpetrator not specified), psychological abuse (grandparents towards the emerging adult) | Homotypic Continuity |
| Olivia | Sexual abuse by brother and friend, physical and psychological abuse by father, psychological abuse from teacher, physical assault at 18, family violence (father violent towards pets) | Physical and psychological abuse (perpetrator not specified) | Heterotypic Continuity |
| Sophie | Sexual abuse by cousin, bus driver, stranger | Exposure to intimate partner violence, emotional neglect by mother | Heterotypic Continuity |

| | | | |
|---|---|---|---|
| Marcia | Sexual abuse (inappropriate touching by father), physical abuse (slapped by father) | Exposure to intimate partner violence | Heterotypic Continuity |
| Jordan | Sexual abuse (eve teasing), physical abuse by mother (spanking) | Physical abuse by parents (spanking) | Heterotypic Continuity |
| Luca | Sexual abuse by extended family member, possible abuse by mother, raped by stranger | Sexual abuse by multiple strangers | Homotypic Continuity |
| Rae | Sexual abuse, physical abuse, neglect | Discontinuity – no maltreatment experienced by emerging adults | |
| Vanessa | Sexual abuse, physical abuse, psychological abuse | | |
| Alex | Sexual abuse, physical abuse, psychological abuse | | |
| Julia | Sexual abuse, physical abuse | | |
| Reese | Sexual abuse, neglect, exposure to intimate partner violence, abandonment | | |
| Shay | Sexual abuse, emotional neglect, exposure to intimate partner violence | | |
| Zoey | Sexual abuse, exposure to family violence | | |
| Amelia | Sexual abuse, exposure to psychological intimate partner violence | | |
| Nadia | Sexual abuse, neglect | | |
| Quinn | Sexual abuse, psychological abuse | | |
| Logan | Sexual abuse, physical abuse | | |

**Figure 1**

*Comparison of Mothers' Experiences of Intergenerational Maltreatment*



## Discussion

The aim of this qualitative study was to better understand mothers' experiences of intergenerational continuity of CSA and to identify how mothers with histories of CSA perceive and explain (dis)continuity. Despite maltreatment continuing in their families, the qualitative results highlight mothers' best intentions to protect their children and prevent this cycle. The narratives of mothers who experienced continuity underline the difficulties they faced regarding various parenting behaviours and in close relationships. Polyvictimization is evident in our qualitative results, which is in line with the literature showing that experiences of more than one type of abuse is unfortunately common (Le et al., 2018). A relation between CSA and intimate partner violence victimization was reflected upon by some mothers, specifically how CSA may have contributed, from their perspective, to staying in an abusive relationship, which was then associated with feelings of guilt and regret for exposing children to violence.

### Parent-Child Attachment and Parenting

Mothers' experiences of their relationships with their children and intimate partners were explored in this study. Results show nuances in the experiences of attachment to and of parenting their children. Those who reported continuity described challenges with expressing emotions and affection with their children, which is consistent with insecure attachment (e.g., avoidant attachment) (Powell et al., 2016). Mothers who experienced discontinuity shared their efforts to overcome challenges with expressing emotions, as well trying to avoid engaging in role reversals, which is a documented theme among families in which sexual abuse has occurred (Alexander, 1992). Role reversals can also be indicative of disorganized and anxious attachment (Katz et al., 2009; Lecompte & Moss, 2014). A more secure parent-child relationship, one which

is characterized by meeting the child's emotional needs, may have supported the discontinuity of CSA.

Attachment reflects procedural implicit memories of how to be in relationship with others and is something that develops before language (Powell et al., 2016). Despite wanting a secure attachment with their children, many parents struggle to do so because they did not receive the responsive and consistent parenting early in life that would have given them this implicit relational knowing of secure attachment (Powell et al., 2016; Lyons-Ruth, 1998). The difficulty with emotional closeness that mothers in our study described could reflect their state of mind and procedural memories of their own upbringings. For example, a child who attempts to seek comfort to meet their emotional needs from a parent who continuously rejects or redirects these attempts may eventually adopt an avoidant attachment strategy. As a parent, their responses to their children can be influenced by this unconscious procedure for avoiding rejection by similarly denying their children emotional connection (Powell et al., 2016). Future research is needed to explore what supported mothers in overcoming these challenges with emotions and closeness in relationships. As attachment security is associated with a host of positive outcomes for children (e.g., self-esteem, emotion regulation, problem-solving; Sroufe et al., 2005), it could serve as a mechanism through which maltreatment is discontinued.

In terms of parenting, the results support the literature that mothers with a history of CSA experience a wide range of difficulties as a parent (Lange et al. 2020a, 2020b). Mothers who experienced continuity especially struggled with how they see themselves as parents, with fostering the autonomy of their children, and with feeling protective and inhibiting their children's participation in certain events, likely to prevent them from experiencing CSA. We believe that individuals who have experienced abuse are highly committed to avoid replicating

this cycle. Even with the best intentions, many mothers in our study still experienced intergenerational continuity. Unfortunately, desire to do better may only guide them in what *not* to do with their children but does not necessarily help them with what *to* do to support them in their journey. In fact, knowing what not to do can result in the pendulum swinging too far in the other direction (Circle of Security International, 2020), as was seen with some mothers in our study who admitted to being highly protective or overcompensating to the extent that they felt a lack of authenticity as a parent. Mothers' attachment styles and more specifically their state of mind (i.e., how they think, feel, and who they are in relationship with others; Main et al., 1985) would ultimately influence how they behave with and parent their children, such as how they interpret and respond to their child's behaviours.

**Intimate Partner Attachment and Victimization**

The connection between maltreatment and attachment was a recurrent theme in this study and should continue to be further explored in the context of intergenerational continuity research. Seven mothers in our study reported being exposed to intimate partner violence in childhood, and four reported that their children were exposed to the same type of violence. Further, mothers expressed feelings of guilt associated with not leaving a violent partner as soon as they wished. They also noted experiences related to their own attachment insecurity, such as prioritizing their romantic relationship over the emotional needs of their children and realizing that this was not fair. Thus, difficulties related to intimate partner relationships could lead to an increased risk of intergenerational continuity of maltreatment where the emerging adult child was exposed to intimate partner violence during childhood.

In adulthood, it is conceivable that mothers' experiences of childhood maltreatment, exposure to intimate partner violence as children, and further adult IPV victimization are

experienced as familiar, comfortable, and even validating in a sense (Perry & Winfrey, 2021). This normalization of violence may occur through the effect that trauma can have on negatively impacting one's expectations of others in relationships (i.e., their state of mind or internal working model). Exposure to domestic violence during childhood is associated with an increased risk of adult IPV victimization (Kimber et al., 2018). Attachment may partly explain this intergenerational cycle of witnessing domestic violence as a child and experiencing IPV victimization as an adult. Research has shown that children exposed to domestic violence are more likely to exhibit insecure attachment (Noonan & Pilkington, 2020). If support is not received to modify an insecure attachment during childhood, this insecurity in adult relationships (e.g., preoccupied attachment, attachment anxiety) may lead to an increased risk for IPV victimization (Sandberg et al., 2019) and perpetration (Spencer et al., 2021).

The qualitative results add to the literature that cycles of CSA or other maltreatment types likely continue through complex effects on attachment behaviours and parenting (Marshall et al., 2022). Prospective longitudinal or population-based studies are needed to quantitatively examine the multigenerational patterns of maltreatment within families. Future qualitative research exploring the continuity of specific maltreatment types would be an interesting contribution to the literature. Themes pertaining to IPV exposure as children and adult IPV victimization, polyvictimization, parenting, and attachment behaviours might be further explored in studies that are explicitly focused on CSA continuity. Qualitative research on parents' help-seeking behaviours and their perceptions of recommendations to break cycles of maltreatment would be invaluable, as well as the inclusion of fathers or other caregivers (e.g., foster parents). Further research could be conducted to triangulate the qualitative narratives of both mothers and their emerging adult children.

## Strengths and Limitations

Strengths of this qualitative research include the implementation of strategies to enhance trustworthiness of the data (e.g., team coding, audit trail), as well as the researchers' engagement in reflexivity throughout the process of data collection and analysis. A semi-structured interview was collaboratively developed and discussed before beginning interviews. The analysis proceeded through an iterative process of deductive and inductive coding. A potential limitation of the qualitative design is that qualitative data generation and analysis did not occur concurrently (i.e., the interview protocol was not modified based on the analysis of new transcripts).

The results are based on a predominantly White, cis-gender sample of mothers with a high level of income and education. Future studies should aim to recruit diverse participants in terms of socioeconomic standing. Recruiting more diverse participants could have valuable research and clinical implications that speak to others' lived realities (e.g., Black youth). It should be noted that the classification of continuity and discontinuity was established by relying only on mothers' interviews, during which they reported on what they knew of concerning their child's history of CSA or other maltreatment. Not all mothers may be aware of their child's CSA experiences, therefore, some mothers may have been inaccurately classified as mothers who experienced discontinuity.

## Clinical Implications

One of the clinically relevant findings from the qualitative study is that many mothers sought professional support as adults. It is pertinent for clinicians to keep in mind that by the time individuals reach adulthood, their reasons for seeking psychological services may appear unrelated to their history of CSA. PTSD is noted as a rare chief complaint and families may not

connect trauma history with current symptoms (Keeshin, 2021). Given the wide range of symptoms that can result from CSA (Bradley et al., 2019), clinicians should assess for trauma and abuse history when clients seek support. Early intervention is crucial to building healthy attachments. The perinatal period is one which may reignite memories of CSA trauma (e.g., Lange et al., 2020a), therefore, working with mothers during this time could be an effective way to break the cycle of abuse. Other supportive interventions could include home-based and respite services and parent coaching. Examples of attachment-based interventions that could be helpful to support positive relationships and parenting behaviours include the Circle of Security (Hoffman et al., 2017), and the Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) (Juffer et al., 2017). Providing psychosocial support and education to children within school settings could also help to prevent maltreatment. If CSA has occurred, working with the child and caregiver together using an evidence-based intervention like Trauma-Focused Cognitive Behavioral Therapy could be considered. As mothers in our study noted both psychological difficulties and trouble with expressing emotion and affection with their children, an intervention like Emotion Focused Therapy might help with this processing. Ultimately, supportive relationships, therapy of six months or longer, and supportive partners are factors that have been documented as making a difference in parents not passing on abuse to their child (Sroufe et al., 2005).

## Conclusion

In summary, this qualitative inquiry provides valuable insight into the long-term impacts of CSA, which may impact mothers' lives, perceptions, and behaviours in ways that contribute to contexts in which continuity of maltreatment may be more likely to occur. Mothers in this study described facing numerous challenges, as well as overcoming difficulties in their relationships.

Their interviews allowed us to identify experiences and processes that characterized continuity and discontinuity dyads, which ultimately have important clinical implications for working with survivors of maltreatment and their families. Further research exploring individuals' experiences of intergenerational continuity of CSA is needed, especially using diverse and robust methodological designs.

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# Chapter VII: Discussion

Research on the intergenerational transmission of violence has predominantly focused on how a victim of maltreatment may later become a perpetrator, such as in the case of cycles of physical abuse (e.g., parent experiences physical abuse as a child and then physically abuses their child). Less attention has been devoted to understanding the intergenerational continuity of specific forms of maltreatment victimization, especially those cycles where a parent is not the perpetrator of their child's abuse. This is often, though not always, the case with CSA. Although studies have in fact supported an increased risk of a child experiencing sexual abuse if their parent has a history of CSA (Avery & Hutchinson, 2002; Grunsfeld, 2018; Madigan et al., 2019; McCloskey, 2013; Testa et al., 2011; Wearick-Silva et al., 2014), it was clear with the publication of Langevin et al. (2021)'s systematic review that very few studies have actually studied this cycle to explain this increased risk. We know from other areas of literature that CSA is associated with devasting and long-term impacts on mental health (Adams et al., 2018; Gardner et al., 2019; Maniglio, 2013), and relationships (Ensink et al., 2020), which permeate into every aspect of an individual's life. There are many multilevel risk and protective factors that could be studied to determine their role in perpetuating or breaking cycles of CSA, however, having an informed theoretical conceptualization of CSA continuity would provide guidance in terms of selecting the most relevant variables for research investigation and highlight key targets for clinical intervention.

Study 1 was designed to systematically review the literature to identify theoretical frameworks that have been used to explain the intergenerational continuity of maltreatment broadly. Specifically, theories that focused on victim-to-victim cycles of maltreatment were included, while theories focused solely on explaining victim-to-perpetrator cycles (e.g., physical

abuse and social learning theory) were excluded. The continuity of CSA was too narrow of a focus for Study 1 given the very limited published literature. Nonetheless, the findings from this review allowed for an integration to propose a unified model of victim-to-victim cycles of maltreatment, one which conceptualizes continuity as largely stemming from the impacts of maltreatment on psychological (e.g., PTSD symptoms, anxiety, depression) and relational functioning (e.g., parent-child attachment, romantic attachment, parenting), with neurobiological and contextual factors as potential moderators.

The selection of variables in Study 2 was informed by the model developed in Study 1. In Study 2, 186 dyads were categorized into one of four groups based on continuity status: cycle maintainers (n = 22 dyads), cycle breakers (n = 31), cycle initiators (n = 30 dyads), and control (n = 103) dyads. These groups were compared based on various factors – mothers' maltreatment history, posttraumatic stress symptoms, psychological distress, parent-child attachment ratings, romantic attachment, and socioenvironmental variables (e.g., income, education, family status). The study supported an increased risk of intergenerational CSA – mothers' histories of CSA predicted their emerging adult child's experiences of CSA, while other types of maltreatment reported by the mother did not. However, none of the mental health and attachment variables significantly differentiated cycle maintainers from cycle breakers. Two significant findings emerged from this study: 1) mothers in the cycle maintaining group reported being exposed to more acts of domestic violence as children compared to mothers in cycle breaking dyads; and 2) fewer cycle maintaining mothers indicated that they were still with the parent of at least one of their children. Although there were no significant differences, in comparison to the three other groups, mothers in cycle maintaining dyads reported higher means of posttraumatic stress, psychological distress, romantic attachment anxiety, romantic avoidant attachment, and lower

ratings of parent-child attachment. It is possible that significant findings might occur with a larger sample of dyads who have experienced CSA.

To clarify insignificant quantitative findings and better understand the personal experiences of mothers, Study 3 included qualitative interviews conducted with mothers who reported a history of CSA. The qualitative study illuminated several challenges not captured through the quantitative design. In this study, we found themes related to polyvictimization, relational challenges with parenting and romantic partners (e.g., autonomy and protection; role reversals; expressing affection; experience of intimate partner violence), and challenges at the individual level (e.g., confidence as a parent). We compared themes among mothers who experienced CSA homotypic and heterotypic continuity, and discontinuity. Certain experiences were more commonly reported in some groups. For example, mothers who experienced discontinuity expressed engaging in self-reflection about their parenting, using peer role models, having open discussions about sex and consent with their children at an early age, and overcoming their challenges with expressing emotions and affection with their children.

**Mixed Method Integration**

The prevalent and serious issue of CSA continuity is highlighted by both strands of this study. Polyvictimization is evident in our qualitative results, which is in line with the literature showing that experiences of more than one type of abuse is unfortunately common (Le et al., 2018). Parent-child attachment and intimate partner violence are two variables that were examined in both strands of our research and allow for comparison and integration (see Table 1).

Regarding parent-child attachment, the quantitative strand identified that mothers in the control dyads (neither member experienced CSA) had higher ratings of attachment quality than mothers in the CSA continuity dyads (Marshall et al., 2022). While the results highlight the

negative impacts that CSA can have on attachment quality, there were no significant differences between continuity and discontinuity dyads for parent-child or intimate partner attachment. The qualitative study was helpful to further explore mothers' experiences of their relationships with their children, as well as to examine more specific aspects of close relationships. The themes which emerged do not corroborate the non-significant findings from the quantitative study. In fact, the qualitative results provide support that continuity mothers experienced difficulties related to attachment with their children and that there are differentiating relational themes between continuity and discontinuity mothers that could not be captured by quantitative measures. Mothers who reported CSA continuity described challenges with expressing emotions and affection with their children, which is consistent with insecure attachment (e.g., avoidant attachment) (Powell et al., 2016). Mothers who experienced discontinuity noted working to overcome challenges with expressing emotions, as well trying to avoid engaging in role reversals, which is a documented theme among families in which sexual abuse has occurred (Alexander, 1992). Role reversals can also be indicative of disorganized and anxious attachment (Katz et al., 2009; Lecompte & Moss, 2014). A more secure parent-child relationship, one which is characterized by meeting the child's emotional needs, may have supported the discontinuity of CSA. Among the many benefits of a secure attachment is that it promotes emotion regulation, social cognition, and a positive integrated self-concept (Thompson, 2016). It is possible that the quantitative strand resulted in non-significant attachment findings because participants could not elaborate beyond the items of the questionnaires they completed. For instance, during interviews, participants could discuss and provide examples of their attachment with their children, as well as make associations between how childhood experiences may have affected their relationships. The qualitative strand provided an opportunity to ask mothers about parenting and the impacts of

CSA, which was not examined in the quantitative study. The results support the literature that mothers with a history of CSA experience a wide range of difficulties as a parent (Lange et al. 2020a, 2020b), and these may be implicated in (dis)continuity.

In the quantitative strand, mother and emerging adult dyads were compared based on mothers' maltreatment history to determine if experiencing more than one type of abuse might differentiate continuity and discontinuity groups. In fact, a significant difference between continuity and discontinuity dyads was observed, such that continuity mothers were exposed to more acts of intimate partner violence as children. Similarly, in the qualitative strand, seven mothers reported being exposed to intimate partner violence in childhood, and four reported that their children were exposed to the same type of violence. Further, mothers expressed feelings of guilt associated with not leaving a violent partner as soon as they wished. They also noted themes related to their own attachment insecurity, such as prioritizing their relationship over the emotional needs of their children and realizing that this was not fair. Thus, difficulties related to intimate partner relationships could lead to an increased risk of intergenerational continuity of maltreatment where the emerging adult was exposed to acts of domestic violence during childhood. It is noteworthy that in Study 2, mothers in the CSA continuity group rated themselves higher on romantic attachment anxiety and romantic avoidant attachment, though not statistically significantly, compared to discontinuity, initiator, and control group dyads. Significant differences between continuity groups might emerge with diverse and larger samples, and methodological designs such as longitudinal studies. Research supports that among parents and children with histories of CSA, a majority of children are also exposed to domestic violence (Avery et al., 2002). Both exposure to domestic violence and CSA can contribute to the development an insecure attachment (Ensink et al., 2020; Noonan & Pilkington, 2020), which

can subsequently increase the risk of intimate partner victimization (Sandberg et al., 2019). Women with histories of CSA are at an increased risk for revictimization, such as through different types of IPV victimization (e.g., sexual coercion by a partner; Jaffe et al., 2012; and physical and psychological abuse; Banyard et al., 2000). As proposed by Davis and Petretic-Jackson (2000), CSA survivors may be at risk for IPV victimization because of difficulties with emotional intimacy, sexuality, and/or a strong need for relationships that takes priority over safety. When CSA survivors experience IPV and there are children involved, it is possible that they are exposed to this domestic violence, and a cycle is perpetuated. Given that Study 2 showed a significant difference in childhood exposure to domestic violence among mothers who experienced CSA continuity compared to other groups, and the Study 3 qualitative results highlighted mothers' experiences of CSA and intimate partner victimization, there may be important links between CSA, exposure to domestic violence, attachment, intimate partner violence, and intergenerational CSA continuity that need to be further clarified.

In summary, the mixed method results add to the literature that cycles of CSA or other maltreatment types likely continue through complex effects on attachment behaviours and parenting (Marshall et al., 2022). Figure 1 maps the mixed method results onto the theoretical model presented in Study 1.

**Table 1**

*Joint Display of Quantitative, Qualitative, and Mixed Methods Interpretations*

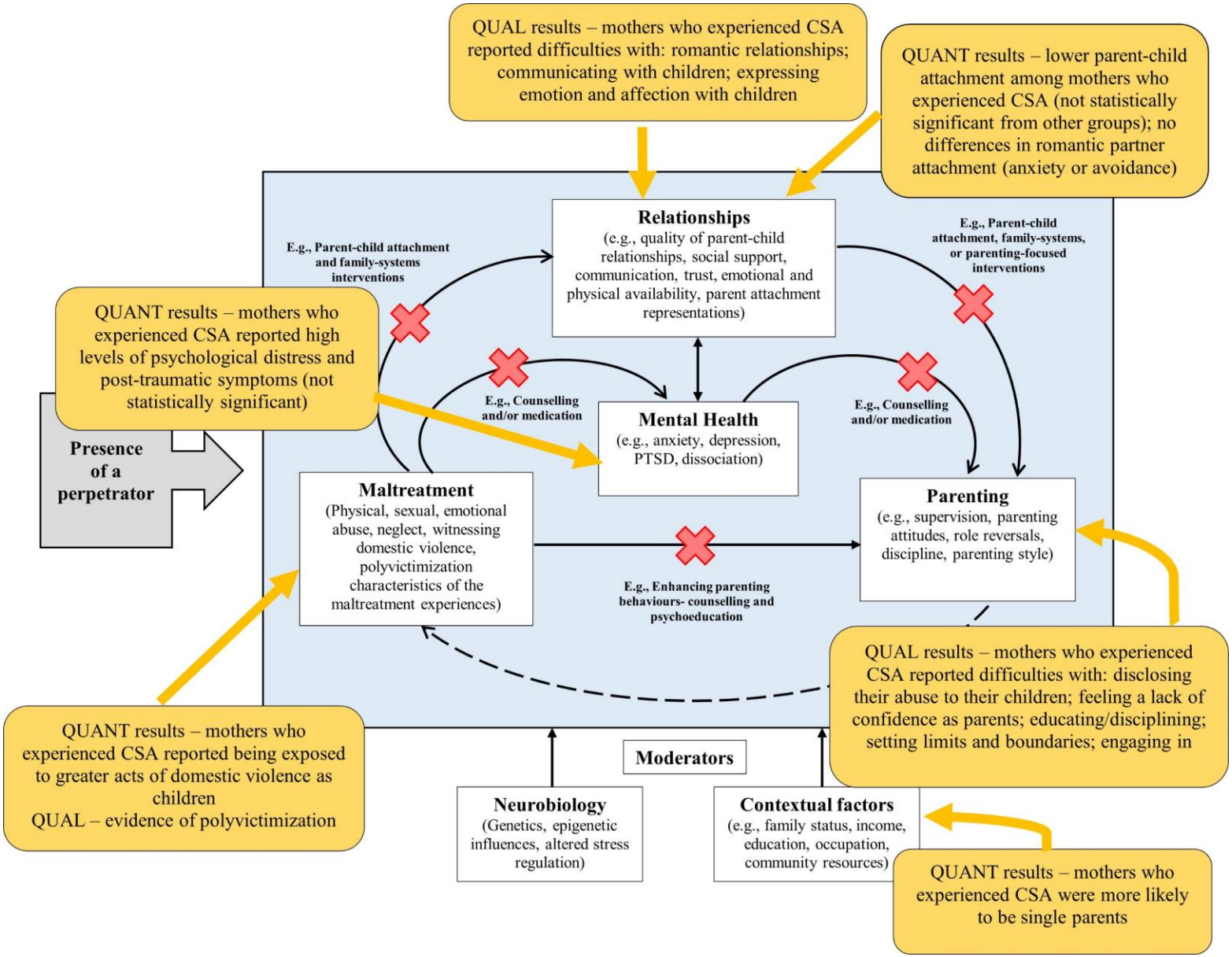
| | **Quantitative Strand** | **Qualitative Strand** | **Mixed Methods Interpretations** |
|---|---|---|---|
| Intergenerational continuity of CSA | - Mothers' history of CSA increased the odds of emerging adults experiencing CSA by 1.38, and 1.32 times when controlling for mothers' other maltreatment experiences (emotional abuse, physical abuse, neglect, exposure to domestic violence). | - Out of 23 mothers, 12 reported intergenerational continuity of maltreatment, representing about half of the sample.<br>- 5/12 continuity mothers reported homotypic continuity of CSA; remaining 7 reported heterotypic continuity. | - Results are consistent with the literature that there is an increased risk of intergenerational continuity of CSA among mothers who have a history of CSA (e.g., Grunsfeld, 2018). |
| Maternal maltreatment histories | - Only significant difference: mothers in the continuity dyads were exposed to 2.43 times more acts of domestic violence than mothers in the discontinuity dyads. | - 19/23 mothers reported experiencing CSA and at least one additional type of abuse (8 continuity, 11 discontinuity)<br>- 7 mothers (3 continuity; 4 discontinuity) reported exposure to intimate partner violence or family violence during childhood.<br>- 4 emerging adults were exposed to domestic violence (reported by heterotypic and homotypic continuity mothers)<br>- Themes related to mothers' attachment security were discussed, such as prioritizing their intimate relationships and their own | - Quantitative and qualitative strands both highlight polyvictimization experiences, which is consistent with the literature indicating that this is a common and significant problem (Le et al., 2018)<br>- All 11 mothers who experienced discontinuity and 8/12 mothers who experienced continuity reported more than one type of abuse.<br>- Difficulties with romantic relationships could contribute to situations where maltreatment is continued intergenerationally through children |

| | | | |
|---|---|---|---|
| | | emotional needs over their children's needs; feelings of guilt and regret; and realizations that it was not fair to expose their children to an abusive partner. | witnessing domestic violence.<br>- The impact of child maltreatment trauma on attachment quality may partly explain the increased risk of IPV victimization and maltreatment continuity. |
| Maternal rated parent-child and intimate partner relationships | - Mothers in the control dyads had higher attachment ratings than mothers in the continuity dyads.<br>- No significant differences between CSA continuity and discontinuity for any attachment measure (parent-child or intimate partner). | - Mothers who experienced continuity expressed difficulties with emotions and affection with their children.<br>- Mothers who reported discontinuity mothers noted working to overcome challenges in emotional expression and working to avoid role reversals with their children. They also described positive aspects of self-concept; using peer role models; differentiating themselves from their parents; and engaging in self-reflection about parenting. | - Although the quantitative strand found no significant results between continuity and discontinuity dyads in terms of parent-child or intimate partner attachment, the qualitative results point toward differences in parent-child relationships and parenting between continuity and discontinuity mothers.<br>- Qualitative results are also in line with the literature that CSA survivors have difficulties with attachment and parenting (e.g., Ensink et al., 2020; Lange et al. 2020a, 2020b).<br>- Challenges with emotional expression and affection may reflect insecure childhood attachment behaviours which are then replicated later with their children (Powell et al., 2016)<br>- Attachment and parenting behaviours can be targeted by clinicians to reduce the |

| | | | |
|---|---|---|---|
| | | | risk of maltreatment continuity. |

**Figure 1**

*Integrated Findings from Scoping Review, Quantitative, and Qualitative Studies*




Note: QUAN refers to the quantitative results from Study 2, and QUAL refers to the qualitative results from Study 3

**Strengths, Limitations, and Future Directions**

Our understanding of intergenerational cycles of CSA is limited by a lack of dedicated research on this topic. CSA is a unique type of maltreatment that needs further investigation to identify and understand the factors that contribute to the increased risk of this abuse repeating in families, and the areas that can be targeted to discontinue it. This dissertation provides an important step towards better understanding why CSA may continue across generations. A notable strength of this dissertation is the advanced methodological design of employing mixed methods, combining the advantages of both quantitative and qualitative methods to gain understanding on an underdeveloped topic. The results are based on dyadic data, highlighting the use of a multi-informant approach to collect both mothers' and their emerging adult child's experiences of CSA. Recruitment efforts contributed to obtaining a large sample of participants, who completed validated and reliable questionnaires on maltreatment experiences, mental health, and relationships. The qualitative interviews further provided more in-depth information about CSA and (dis)continuity experiences. Methods to ensure trustworthiness of these data were carefully implemented throughout this process.

Despite several strengths of this dissertation, there are limitations and areas that will be important for future research. The quantitative results are based on a convenient sample with self-selection bias. The results are limited by a lack of sample diversity. Specifically, there was a disproportionate number of woman-identifying emerging adults in the quantitative strand, limiting the generalizability of these findings. Differing results may be obtained for man-identifying or non-binary individuals. Generally, less research seems to be available on male victims or survivors of sexual abuse. Studies have shown differences between girls and boys following sexual abuse, for instance, girls are reportedly more likely to develop internalizing

symptoms, such as higher PTSD symptoms, disordered eating, and anxiety problems (Collin-Vézina et al., 2011; Kobulsky, 2017), whereas boys may be more likely to develop externalizing symptoms (e.g., sexual risk taking, suicide attempts, and substance abuse) (Rhodes et al., 2011), as well as to receive public mental health services (Daigneault et al., 2017). However, there are mixed results in the literature, as other studies have found no gender differences following CSA in terms of substance use and subsequent risky sexual behaviors (Abajobir et al., 2017). While CSA may equally severely affect both boys and girls, there is limited research available on how CSA impacts fatherhood. A limitation of this dissertation is that the quantitative and qualitative results are based largely on a White, cis-gender sample of participants who reported relatively high levels of income and educational attainment. In addition to gender differences, there are documented differences in CSA victimization based on race and ethnicity. Research has shown that Indigenous, Hispanic, and Black individuals report higher rates of sexual abuse compared to White participants (Atkinson et al., 2022; Mersky et al., 2021). Using data obtained from the Notre Dame Adolescent Parenting Project, a longitudinal study conducted in the United States, Valentino et al. (2012) found that among mothers who had a history of child abuse, greater exposure to community violence and lower authoritarian parenting were significant risk factors for intergenerational maltreatment continuity. However, the protective effect of authoritarian parenting was only significant for African American mothers. Although not specific to CSA continuity, this study underlines potential differences that may be uncovered in future research using more diverse samples. Through efforts to recruit diverse samples, as well as conducting cross-cultural research on CSA continuity, we can better identify similarities and differences in terms of risk and protective factors that may be involved in continuity with different populations. Recruitment could be expanded beyond online advertisements and university departments to also

include community organizations and shelters. The recruitment of individuals who experienced CSA was challenging, therefore, future recruitment efforts might also focus on advertising the study specifically as research on sexual abuse or maltreatment, as opposed to childhood adversity. Collaborations with organizations catered to supporting CSA survivors could facilitate recruitment.

Another potential limitation of this study is that the questionnaires were completed online, requiring access to the internet and a computer and/or phone. Consequently, participants with a lower socioeconomic status may not have had an opportunity to participate. The questionnaires and qualitative interviews also required that participants were willing to answer questions about maltreatment or other trauma. It is possible that those who participated in this study had found ways of coping and integrating their trauma as part of their history, whereas individuals more traumatized by their maltreatment experiences might not have participated in this study. Social desirability bias may have played a role in the amount and type of information disclosed, especially for those who completed the qualitative interviews. Relatedly, the measure of CSA could be limited by the fact that participants completed this at only one time point, using an online self-report questionnaire. Instruments used to measure CSA vary widely in studies in terms of the guiding definitions of CSA and the questions that are used (e.g., Dunne et al., 2009; Finkelhor et al., 2014). Although the measure used in this dissertation to assess child sexual abuse has demonstrated reliability and validity, there are only six items that assess histories of CSA specifically, requiring yes or no responses (the Early Trauma Inventory – Short Form; Bremner et al., 2007). The use of different measures may yield varying prevalence rates. For example, Stolenberg et al. (2011) reported that a larger number of questions about CSA provided higher prevalence estimates for girls but not boys, whereas lower prevalence rates were

documented in studies using computerized questionnaires compared to paper and pencil. Prevalence estimates obtained through conducting interviews, either face-to-face or by telephone, fell in between online and paper questionnaires (Stolenberg et al., 2011). It is important to acknowledge that the information provided by participants in this dissertation was based on retrospective recall, which may be viewed as a limitation. Research points to the potential of unreliable long-term reporting of CSA in the form of false negative responses, such that about 50% of individuals who report CSA or physical punishment at age 18 fail to subsequently report the abuse at age 21, unrelated to psychiatric conditions (Fergusson et al., 2000). It will be important to continue to examine the ways in which different approaches to data collection (e.g., face to face interviews, phone interviews, computerized interview, official child protection data) and various interviewing strategies (e.g., structured questionnaire, clinical interviews) lead to differences in outcomes and the stability of CSA reports. Future studies might employ multiple methods of gathering this information (e.g., questionnaires, interviews, child protection records) at several time points and using multiple informants (e.g., mother, emerging adult), as single assessments might lead to an underestimate of maltreatment. Further, this dissertation did not examine perpetrator identity, which is an important abuse characteristic that should be included in future studies, as there are documented differences between the impacts of intra and extrafamilial CSA (e.g., intrafamilial being associated with longer duration of abuse and greater emotional impacts; Fischer & McDonald, 1998). The role of family functioning (e.g., involvement, emotional support, closeness, shared activities, cohesion) also needs to be evaluated in CSA continuity studies. Future studies will benefit from recruiting diverse samples of individuals who have experienced child maltreatment. Valuable insight was gained from mothers, which needs to be further expanded by recruiting fathers and including other non-

biologically related caregivers (e.g., adoptive, foster parents) to better capture families who may experience CSA continuity.

It is important to note that the quantitative results from our study are based on a cross-sectional design that does not allow for investigating mechanisms through which CSA continues across generations, such as through the completion of mediation and moderation analyses with longitudinal data. Prospective, longitudinal designs would allow for the completion of more sophisticated data analytic methods (e.g., structural equation modelling) that would contribute to our understanding of putative causal mechanisms. Using longitudinal designs, it will be interesting for future studies to continue to elucidate the mechanisms through which experiencing sexual abuse contributes to an increased risk of sexual abuse victimization in the next generation (homotypic continuity), as well as how a caregiver's experience of other maltreatment types predicts CSA victimization (heterotypic continuity). For instance, Badenes-Ribera et al. (2020) conducted a study including three generations and found that Generation 1 (e.g., grand-parent) emotional abuse predicted Generation 2 (e.g., parent) physical abuse, which predicted Generation 3 (e.g., child) sexual abuse. The other identified trajectory leading to sexual abuse included Generation 2 emotional abuse. The importance of qualitative research cannot be underestimated. In addition to longitudinal designs, qualitative and mixed method studies are needed to continue examining CSA continuity. Themes pertaining to domestic violence exposure as children and adult IPV victimization, polyvictimization, parenting, and attachment behaviours should be further explored in studies that are explicitly focused on CSA continuity. Qualitative research on caregivers' help-seeking behaviours and their perceptions of recommendations to break cycles of maltreatment would be invaluable. Variations of qualitative and mixed methods designs could contribute novel research on this problem. For example, a sequential explanatory

mixed methods design would involve conducting the quantitative strand first, followed by the qualitative study, which would be designed specifically to connect with the quantitative results (Creswell & Plano Clark, 2018). This could allow for more targeted investigation into quantitative results that may be unclear or insignificant. A complex approach might be a longitudinal mixed methods design, which would involve multiple time points of quantitative and qualitative data collection and could be useful to thoroughly examine experiences over time, such as the occurrence of CSA, changes in parenting behaviours, mental health symptoms, and attachment (Plano Clark et al., 2015). This could also be an important design to examine the effectiveness of interventions employed to reduce the risk of CSA continuity.

**Implications for Clinical Practice**

The impacts of sexual trauma can be carried forward in life in many ways. As illuminated by the Adverse Childhood Experiences study, there are extreme public health costs of child maltreatment. It has been noted that eliminating child maltreatment in America would reduce the overall rate of depression by more than a half, alcoholism by two-thirds, and suicide, intravenous drug use and domestic violence by three-quarters (Felitti et al., 1998; van der Kolk, 2015). Identifying and understanding the psychosocial risk and protective factors that play a role in breaking cycles of sexual abuse is an area of research in need of more extensive study with methodological rigour. The mixed method findings presented in this dissertation point to the importance of providing timely and targeted psychological and social services for individuals and families to address intergenerational CSA. It is hoped that these results will inform relevant stakeholders who play an important role in the lives of youth, including policy makers and mental health providers. Clinicians need to be aware of how cycles of abuse can continue within families to support them in ways that can break this cycle. With services that reduce the

likelihood of sexual abuse continuity we can better prevent the perpetuation of sexual abuse trauma (see Figure 2).

As found through this dissertation, mothers who experienced CSA continuity reported higher (but not statistically significant) levels of post-traumatic stress symptoms and psychological distress. There are known government initiatives to address mental health needs, for example, the Government of Canada announced plans to invest $4.5 million to initiatives in Quebec to support the well-being of those who have experienced or may be at risk of gender-based and family violence (Public Health Agency of Canada, 2022). Despite efforts, there continues to be many issues with accessing mental health care. Many Canadians are unable to find or afford mental health services and there continues to be long waitlists (Moroz et al., 2020; O'Neill, 2023). It is problematic that mental health care is not covered by the Canada Health Act. Provincial health care plans do not cover private practice services offered by psychologists or other mental health professionals, such as psychotherapists or social workers (O'Neill, 2023). Problems with finding and accessing care can put extra pressure on hospital emergency rooms, as well as increased police response to mental health crises (O'Neill, 2023).

Increased funding to mental health services and better coverage of services is essential yet only represents part of the solution to address intergenerational CSA. Services need to be accessible, and strategies need to be implemented in a range of settings that enhance mental health and attachment, and screen for early life adversities. Both quantitative and qualitative results produced by this dissertation point to several relational difficulties that mothers reported with their children, and importantly, these difficulties are felt in adulthood – years after the CSA acts. Screening for Adverse Childhood Experiences can be implemented in health care settings, home visits, outpatient care, pediatric clinics, prenatal settings, and schools (Rariden et al.,

2021). Early screening represents a timely point of intervention with families that could identify those who may benefit from additional support to prevent maltreatment as well as intergenerational continuity. As mothers in the qualitative strand of our study highlighted parenting challenges, such as with educating or disciplining their children, setting limits, communication, and expressing emotions, additional supports offered might involve early participation in parenting classes that focus on positive parenting (e.g., Positive Discipline in Everyday Parenting; Durrant, 2016).

Systemic interventions and the collaboration of interdisciplinary teams will benefit individuals and families in which there is a history of CSA. Our quantitative results showed that socioenvironmental context is important to consider. CSA continuity was more likely in our study among single mothers, suggesting that intervention to provide additional social supports (e.g., respite care) might reduce the risk of continuity. Community resources, such as the organization of parenting groups and prenatal classes, might also be especially useful to single or first-time parents seeking social support and information about parenting. In addition to respite care, support offered by employers could assist single-parent families through on-site child care, flexibility in work hours, maternity leave benefits, and through supporting policies that benefit single parents (e.g., number of paid leave days to care for children). Mothers who experienced continuity reported being exposed to more acts of domestic violence during their childhood compared to mothers who experienced discontinuity. Efforts to reduce continuity might therefore focus on intervening to address intimate partner violence, which would also require screening and access to mental health, social, and community supports. Multilevel interventions combining parent-child intervention, nurse-home visitation programs (e.g., Mejdoubi et al., 2013), and teen dating violence education in schools (e.g., Safe Dates; De Koker et al., 2014) might be helpful to

reduce the risk of children's exposure to domestic violence and the continuation of IPV and CSA cycles. Systemic approaches that involve parent training and in-vivo coaching for reducing the risk of child maltreatment, as well as combinations of relationship education, family therapy programs, and CBT couples therapy to reduce IPV could be beneficial to reducing this cycle (Stith et al., 2021).

Preventative efforts through schools could contribute to better mental health and attachment among children, which could serve as a buffer to children who experience sexual abuse. Mental health professionals can further support schools to implement trauma-informed practices to better identify children displaying trauma symptoms and support families early on. One example of a program which may be implemented in schools is Circle of Security (Hoffman et al., 2017; Powell et al., 2016), which is an attachment-based program developed to support teachers with building secure relationships with their students. Although caregivers who have a history of CSA may have difficulty meeting all the relational needs of their children, protective effects could be offered within the relationships that children have with school personnel.

Psychological interventions provided individually to youth, as well as dyadic sessions involving a parent, or family therapy formats each have benefits for working with children who have experienced CSA. One example of an intervention that ideally involves participation of a non-offending caregiver for joint parent-child sessions is Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). This is a gold standard trauma intervention that has shown effectiveness for addressing trauma symptoms in youth between the ages of 3 and 18. Randomized controlled trials have demonstrated its effectiveness for a range of potentially traumatic experiences (e.g., maltreatment, natural disasters, motor vehicle accidents) (Cohen et al., 2017). For example, research has shown greater reductions in PTSD, anxiety, depression,

sexual problems, behaviour problems, shame, abuse-related attributions, and dissociation compared to those who participated in non-directive supportive therapy or child-centered therapy (Cohen et al., 2004, 2005; Hébert & Amédée, 2020). Although TF-CBT was not initially developed to address developmental trauma, it should be noted that those who participated in randomized controlled trials have reported experiencing multiple forms of trauma (e.g., Cohen et al., 2004; Hébert & Amédée, 2020). For complex trauma, the developers of TF-CBT recommend altering the proportions and duration of the phase-based treatment. Instead of spending one third of the time on each of the three treatment phases, it is recommended to spend half of the time on building coping skills, one quarter on trauma narration and processing, and one quarter on the integration/consolidation phase (Cohen et al., 2012). While this intervention is typically administered in 8 to 16 sessions, the duration of treatment for complex trauma cases may need to be extended to 16 to 25 sessions or beyond (Cohen et al., 2012). An intervention such as TF-CBT could help to reduce the mental health and trauma symptoms that were reported by mothers in Study 2 of this dissertation. If effective interventions are received in a timely manner, a reduction in these symptoms might contribute to reducing the risk of CSA continuity.

The Attachment, Regulation, and Competency (ARC) treatment framework (Blaustein & Kinniburgh, 2007) was developed to address complex trauma by offering a flexible framework of targets that can be incorporated into individual treatment as well as integrated within larger systems to support trauma-informed care. ARC offers treatment targets as opposed to emphasizing a model of intervention requiring adherence to specific phases (Blaustein & Kinniburgh, 2018). The three core domains are attachment (caregiver affect management, attunement, effective response), regulation (identification and modulation), and competency (executive functions, self-development and identity, relational connection). The framework does

not represent a manualized treatment approach, which takes into account that youth who experience complex trauma may not typically seek out or receive intervention in outpatient settings that offer individual treatment (Blaustein & Kinniburgh, 2018). ARC can be incorporated into larger systems such as schools and mental health clinics that service those who have experienced CSA. Given that this dissertation highlighted attachment and parenting challenges among mothers who experienced CSA, this type of intervention has the potential of reducing the risk of CSA continuity by addressing parents' mental health and complex trauma symptoms, strengthening relationships, and supporting parents to regulate their own and their child's emotions.

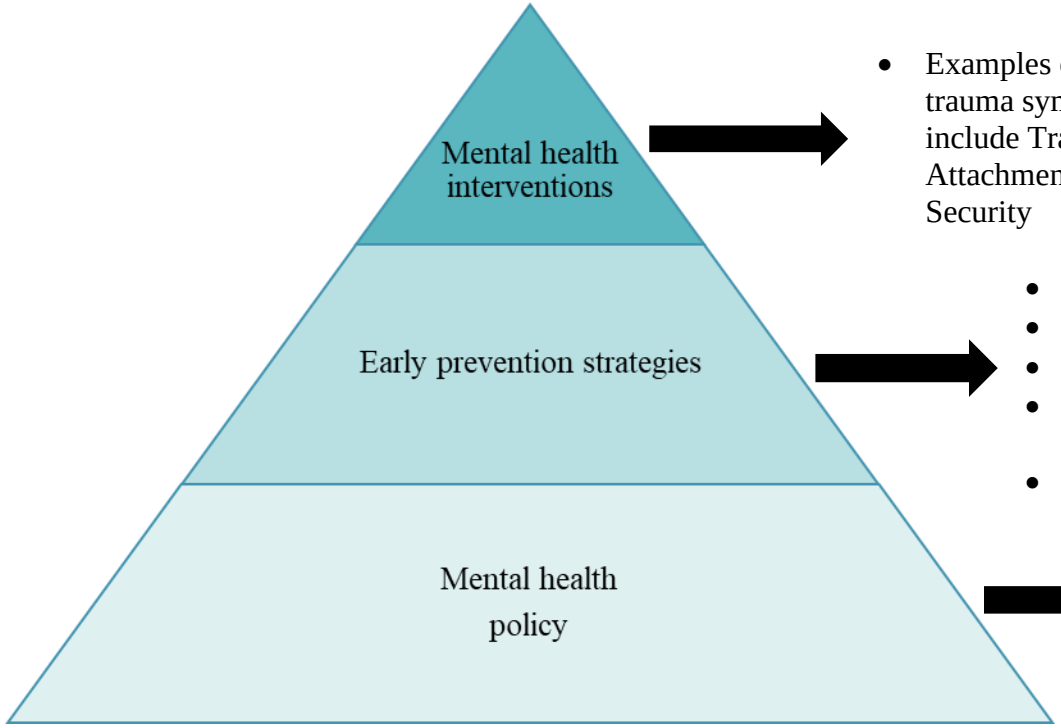
Our qualitative findings underline a significant theme of attachment difficulties following CSA. Parenting behaviours that foster a secure attachment represent an important and tangible clinical target. Circle of Security Parenting was developed as a preventative intervention for caregivers of children starting at 4 months old. It uses a manual and DVD-based protocol with a group of parents who are provided with psychoeducation about child development and attachment, with the goal of increasing self-reflection about their relationships and intergenerational patterns of interactions, and to develop behavioural observation skills of caregiver-child dynamics (Huber et al., 2019). Additionally, the Circle of Security – Intensive protocol is a psychotherapeutic and psychoeducational intervention that helps caregivers improve their attachment by using video-based assessment and feedback (Huber et al., 2019). Both the parenting group and intensive variants of this program are intended to act as preventative measures for families with young children who may be at risk (e.g., poor socioeconomic status, single parenthood), as well as those families who are having problems in their caregiver-child relationship (Huber et al., 2019). Research has shown that this intensive version reduces

attachment disorganization and increases attachment security (Cassidy et al. 2010; Hoffman et al. 2006; Huber et al. 2015).

Ultimately, allowing participants' voices to be reflected in research, such as through qualitative work and clinical planning, is fundamental to reducing the disparity between the kind of help individuals actually seek out, and the kind interventions that are endorsed by researchers or clinicians (van der Kolk, 2015). Trauma symptoms can be misperceived and misdiagnosed to the extent that by the time they have reached their 20's, CSA survivors may accumulate up to five or six unrelated diagnoses over the course of treatment (if they seek treatment) (van der Kolk, 2015). Hearing directly from individuals who have experienced CSA and who also face the stress of their child's sexual abuse disclosure will provide invaluable information concerning the individual, relational, and socioenvironmental factors at play, as well as the types of interventions that individuals who have been harmed consider to be meaningful and effective.

**Figure 2**

*Interventions to Address Intergenerational Child Sexual Abuse*




- Examples of psychological interventions for addressing trauma symptoms and relational consequences of CSA may include Trauma-Focused Cognitive Behavioural Therapy; Attachment, Regulation, and Competency (ARC); Circle of Security

- Early screening for adverse childhood experiences
- Nurse home visitation programs
- Parenting programs
- Classroom-based attachment programs (e.g., Circle of Security)
- Trauma-informed schools

- Funding towards mental health programs
- Increased accessibility of community-based mental health services
- Coverage of private mental health services by provincial health plans

## Conclusion

Child sexual abuse is a prevalent issue that has complex and long-lasting implications on multiple spheres of an individual's life. Especially concerning is the increased risk of children experiencing sexual abuse if their parent has a history of CSA as well. Using a mixed methods design, this dissertation provides further evidence for the occurrence of intergenerational continuity of CSA, as well as multilevel factors that may play a role in continuity, such as family status, exposure to domestic violence during childhood, and mothers' experiences of difficulties within relationships and parenting (i.e., intimate partner violence, attachment). Although results did not reach significance for mental health (i.e., psychological distress, PTSD symptoms), nor attachment in terms of quantitatively differentiating mothers who experienced continuity and discontinuity, these themes were further elaborated upon in the qualitative strand of this dissertation, where nuances in mothers' experiences based on continuity status were identified. Mental health, attachment, and parenting experiences should continue to be investigated in future studies on CSA continuity. The literature on this topic will also benefit from more diverse samples and the inclusion of reports from other caregivers (e.g., fathers). The qualitative work can be further expanded to include interview data obtained from the emerging adult dyad members, as well as clinicians who work with CSA survivors to gain their perspectives on intergenerational continuity. Social and psychological prevention and intervention strategies targeting mental health and attachment could be crucial for preventing a cycle of CSA victimization, along with policy-level initiatives and funding to increase accessibility of mental health care and parent programs.

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# Appendix A

## Ethical Approval and Amendment – Quantitative

**Research Ethics Board Office** Tel: (514) 398-
6831 James Administration Bldg.

845 Sherbrooke Street West. Rm 325 Website:
www.mcgill.ca/research/researchers/compliance/human/ Montreal, QC H3A 0G4

**Research Ethics Board II**

**Certificate of Ethical Acceptability of Research Involving Humans**

**REB File #:** 278-1118

**Project Title**: Intergenerational Continuity and Discontinuity of Family Violence: Exploration of Potential Risk and Protective Mechanisms

**Lead Investigator:** Professor Rachel Langevin

**Department:** Educational & Counselling Psychology

**Co-Investigators:** Prof. Mylène Fernet (Université du Québec à Montréal), Prof. Audrey Brassard (Université de Sherbrooke)

**Approval Period: December 12, 2018 – December 11, 2019**

The REB-II reviewed and approved this project by delegated review in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Participants and the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.

Georgia Kalavritinos

Ethics Review Administrator

* Approval is granted only for the research and purposes described.
* Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
* A Request for Renewal form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date.
* When a project has been completed or terminated, a Study Closure form must be submitted.
* Unanticipated issues that may increase the risk level to participants or that may have other ethical implications must be promptly reported to the REB. Serious adverse events experienced by a participant in conjunction with the research must be reported to the REB without delay.
* The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB

**McGill University**

**ETHICS REVIEW AMENDMENT REQUEST FORM**

This form can be used to submit any changes/updates to be made to a currently approved research project. Changes must be reviewed and approved by the REB before they can be implemented.

Significant or numerous changes to study methods, participant populations, location of research or the research question or where the amendment will change the overall purpose or objective of the originally approved study will require the submission of a complete new application.

**REB File #**: **278-1118**

**Project Title**: Intergenerational Continuity and Discontinuity of Family Violence: Exploration of Potential Risk and ProtectiveMechanisms

**Principal Investigator**: Rachel Langevin
**Email**: rachel.langevin@mcgill.ca **Faculty Supervisor (for student PI)**:

1) Explain what these changes are, why they are needed, and if the risks or benefits to participants will change.

We conducted a pilot project in Winter 2019 and based on some issues that arose during the pilot, we decided to revise some of our procedures. None of the proposed changes to the project will affect the risks or benefits to participants.

A) To improve the participation rates for the second member from the dyad (most often the mother), we decided to enroll participants using a two-step procedure. For the first step, individuals interested in participating in the research project will click on a link that will bring them to a Qualtrics screening survey. This screening survey will be structured to obtain the consent of the first respondent, the names of both members of the dyad, and the contact information (email address) of the first respondent. The first respondent will also provide the contact information for the second member of the dyad, specifying whether that person would be easier to reach via email or telephone. If the first respondent indicates that telephone is the preferred way to reach the second respondent, we will ask them to provide the phone number of this individual. Only prospective participants who provide the contact information for the second member of the dyad will be enrolled in the study. Subsequently, the first respondent will be sent a link via email to the full survey. Prior to filling out the full survey, participants will be asked to reiterate their consent (consent form will be displayed again). The second member of the dyad will then be invited to participate in the study via email (by sending a link to the complete survey) and a phone call if this is the preferred method of contact indicated by the first respondent.

B) Since the emotion recognition task (ERI) with the visual and vocal subtests was taking a lot of time to complete, we decided to get rid of the vocal subtest and only keep the visual subtest.

C) One of my students (Sarah Cabecinha-Alati, PhD student in Counselling Psychology) is interested in looking at a variable that was not included in the original version of the survey. As such, we added a new measure that will be filled out by both the mother and the young adult. This measure entitled the Coping with Children's Negative Emotions Scale (Fabes, Eisenberg & Bernzweig, 1990; Fabes & Eisenberg, 1998) is designed to assess mothers' emotion socialization practices. For the purposes present study, the questionnaire will be modified to be worded retrospectively (see Lugo-Candelas, Harvey, Breaux & Herbert, 2016 for precedent). More specifically, mothers will be asked to think back to when their child was a teenager and indicate how they responded to their adolescent's negative emotions (e.g. anger, anxiety, sadness). Similarly, young adults will be asked to think back to their adolescence and indicate how their mother responded to their negative emotions. The student is interested in looking at

whether mothers' experiences of family violence in childhood have an adverse effect on their emotion regulation abilities, and in turn, whether these two variables influence maternal emotion socialization practices.

D) To assist with screening out careless responders we will be adding 7 directed questions that will be randomly distributed on each page of the survey to assess whether participants are paying attention or answering randomly. Directed questions will be adapted based on the guidelines outlined by Maniaci and Rogge (2014) and will appear similar to the following:

*To show that you are reading these questions carefully, select 'Always' as your answer.*

Similarly, we will include one question that asks participants to report whether they feel that their data is valid enough to be used in our analyses. This question was adapted based on the guidelines outlined by Meade and Craig (2012) and will appear as the following:

*It is vital to our study that we only include responses from people that have devoted their full attention to this study. Otherwise, a great deal of effort (on the part of the researchers and the time of other participants) could be wasted. You will receive credit for this study (i.e., by being entered into the prize-winning draw) no matter what, however we would like to know whether you think the responses you gave in this survey are valid to use in our analyses. In your honest opinion, should we use your data in our analyses for this study? Yes/No*

2) Attach relevant additional or revised documents such as questionnaires, consent forms, recruitment ads.

See Appendix A. for the telephone script (applicable to the second member of the dyad for whom telephone is the preferred method of contact).

See Appendix B. for the Coping with Children's Negative Emotions Scale (both of the original and modified retrospective versions are provided)

See Appendix C. for revised consent forms – wording changed for the initial screening survey (Appendix C.1) vs. full survey (Appendix C.2).

**References**

Fabes, R.A., Eisenberg, N., & Bernzweig, J. (1990). *The Coping with Children's Negative Emotions Scale – Caregiver's Perception of Adolescents Version: Procedures and scoring.* Available from http://ccnes.org. Arizona State University.

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**Principal Investigator Signature**: _  _____

**Faculty Supervisor Signature**: _____ Date: ___June 4th, 2019_____
(for student PI)

**For Administrative Use**: REB#278-1118 **REB:** _____REB-I x REB-II _____REB-III

x Delegated Review ____Full Review

x This amendment request has been

Signature of REB Chair/ delegate: lynda.mcneil@mcgill.ca Digitally signed by lynda.mcneil@mcgill.ca DN: cn=lynda.mcneil@mcgill.ca Date: 2019.06.10 15:06:26 -04'00' Date: _____

Project Approval Expires: December 11, 2019

**Submit by email to lynda.mcneil@mcgill.ca. REB Office: James Administration Building, 845 Sherbrooke Street West suite 429, fax: 398-4644 tel: 398-6831/6193; www.mcgill.ca/research/researchers/compliance/human**

(August 2014)

## Appendix B

## Ethical Approval – Qualitative

McGill

**Research Ethics Board Office**
James Administration Bldg.
845 Sherbrooke Street West. Rm 325
Montreal, QC H3A 0G4

Tel: (514) 398-6831
Fax: (514) 398-4644
Website: www.mcgill.ca/research/research/compliance/human/

**Research Ethics Board 3**
**Certificate of Ethical Acceptability of Research Involving Humans**

**REB File #:** 20-07-016

**Project Title**: Intergenerational Continuity and Discontinuity of Family Violence: Exploration of Potential Risk and Protective Mechanisms (Qualitative)

**Principal Investigator:** Professor Rachel Langevin

**Department:** Educational and Counselling Psychology

**Co-investigators:** Professor M. Fernet (Université du Québec à Montréal);
Professor A. Brassard (Université de Sherbrooke)

**Funding:** SSHRC – Why does it run in some families? Individual and relational factors involved in intergenerational cycles of family violence

**Approval Period: July 10, 2020 – July 9, 2021**

The REB 3 reviewed and approved this project by full board review in accordance with the requirements of the McGill University Policy on the Ethical Conduct of Research Involving Human Participants and the Tri-Council Policy Statement: Ethical Conduct For Research Involving Humans.

Lynda McNeil
Associate Director, Research Ethics

lynda.mcneil@mcgill.ca
Digitally signed by lynda.mcneil@mcgill.ca
DN: cn=lynda.mcneil@mcgill.ca
Date: 2020.07.10 08:48:04 -04'00'

* Approval is granted only for the research and purposes described.
* Modifications to the approved research must be reviewed and approved by the REB before they can be implemented.
* A Request for Renewal form must be submitted before the above expiry date. Research cannot be conducted without a current ethics approval. Submit 2-3 weeks ahead of the expiry date.
* When a project has been completed or terminated, a Study Closure form must be submitted.
* Unanticipated issues that may increase the risk level to participants or that may have other ethical implications must be promptly reported to the REB. Serious adverse events experienced by a participant in conjunction with the research must be reported to the REB without delay.
* The REB must be promptly notified of any new information that may affect the welfare or consent of participants.
* The REB must be notified of any suspension or cancellation imposed by a funding agency or regulatory body that is related to this study.
* The REB must be notified of any findings that may have ethical implications or may affect the decision of the REB.

# Appendix C

## Research Consent Form – Quantitative



English

### Consent

*Please note that certain components of the survey are not compatible with Safari or Internet Explorer. To avoid any problems, please ensure that you fill out the survey using Mozilla Firefox or Google Chrome*

This study aims to examine the associations among childhood adversity, emotional and psychological well-being, and relationship quality in mother-young adult pairs. For the purpose of this study, you may have one of two roles - you must be either a young adult aged 18-25 or the mother of a young adult aged 18-25.

I am a...

- ○ Young adult aged 18-25
- ○ Mother of a young adult aged 18-25

#### GENERAL INFORMATION

**Institution**: Department of Educational and Counselling Psychology, Faculty of Education, McGill University

**Title of Project**: The Childhood Adversity Study

**Principal Investigator**: Dr. Rachel Langevin

**Collaborators**: This study is being conducted in collaboration with researchers from Université du Québec à Montréal and Université de Sherbrooke.

**Funding:** Fonds de recherche du Québec – Société & Culture (FRQ-SC); Social Sciences and Humanities Research Council (SSHRC)

Dear participant,

We invite you to participate in a research project that is aimed at understanding the impacts of childhood adversity on individuals and their emotions and relationships.

In this initial questionnaire, we will ask you to provide your contact information. If you are the first respondent, we will also ask you to provide the contact information (i.e., email address and telephone number) for the other member of your family (i.e., your young adult child or your mother). If you agree to participate in this study, you will be automatically redirected to the online survey after completing this initial questionnaire.

Please note that if you are the first respondent, we will send you a follow up email to confirm your unique participant ID. Please be sure to inform the other person in your family that we will be sending them an e-mail link inviting them to participate.

Please consider the following information before you agree to participate in this research project. This consent form explains the goal of the study, the procedures, advantages, risks and inconveniences, as well as listing people to contact should the need arise.

**What is the purpose of the study?**

This study aims to examine the associations among childhood adversity, emotional and psychological well-being, and relationship quality between mothers and young adults. The results of the study will provide a better understanding of the experiences of individuals exposed to adverse life events and will be used to develop and bonify interventions offered.

**What will you be required to do?**

Upon consenting to your participation in this study, you will take part in an online measurement session where you will be asked to fill out a series of questionnaires. The total time required to complete the survey will be approximately 45 minutes. Every participant who completes the full survey will be entered into a draw for the chance to win 1 of 2 iPads! Odds of winning are 2 in 1000. In addition, participants who complete the study in mother-young adult pairs will each receive a $5 e-gift card (redeemable at any Second Cup Coffee Co.). In order to receive your compensation, you must provide a valid email address. Suspicious looking email addresses (e.g., bXy1234@hotmail.com) will need to be verified with a follow-up email prior to distributing the $5 compensation. **Participants who receive a follow-up email will have 3 weeks to respond**. Otherwise, compensation will be issued within 30 days of the second member's participation.

**Risks and inconveniences**: You may experience discomfort in responding to questions concerning difficult experiences in your childhood and/or due to the other member of your family having responded to similar questions. Under these circumstances, the following resources are available to you should you need service.

Montreal/Quebec:

1. Tel-Aide: 514-935-1101. Tel-Aide is a free, anonymous, non-judgmental listening service for people in Montreal who are experiencing distress http://www.telaide.org/resources

2. Provincial Resource Line for Victims of Sexual Assault: 1-888-933-9007. This is a toll-free hotline, information, and referral service for residents of Quebec who have experienced sexual assault, as well as their loved ones and caregivers http://agressionsexuellemontreal.ca/urgence/ligne-ressource

3. CLSC: Your local CLSC provides common health and social services. Contact your local CLSC for more resources http://sante.gouv.qc.ca/en/repertoire-ressources/clsc/

If you have any further questions or concerns that need to be addressed, you may also contact Dr. Rachel Langevin who will see to it that you receive the help you need.

Canada-wide:

1. Crisis Services Canada: This website offers a list of local distress centres and crisis organizations that can offer support. Simply select your province and browse the list of resources that are available in your region. https://www.crisisservicescanada.ca/en/looking-for-local-resources-support/

2. Crisis Text Line: Text HOME to 686868 to text with a trained crisis responder to bring texters from a hot moment to a cool calm through active listening and collaborative problem-solving https://www.crisistextline.ca/

**Privacy and confidentiality**: Your personal information will be coded (ex. 2018P001) and will not be shared under any circumstances, including with the other participating member of your family. This information will only be known to the principal investigator (Dr. Rachel Langevin) and research coordinator who will be recording your coded ID. All study information will be designated by that number and therefore, identifying information will not be provided. Further, the primary investigator will ensure confidentiality with respect to specific information concerning your participation and will store all data files on a password-protected computer. Results of this study may be published in scientific journals and presented at professional conferences, but no one will be identifiable in any publication of results. Your identifying information will be destroyed 7 years after the end of the study, and only redacted information will be kept in our datasets following that period (e.g., answers to the questionnaires).

Funding agencies and publishers often ask researchers to make their research data accessible to other researchers upon completion of their study. Making research data available to others allows qualified researchers to reproduce scientific findings and stimulates exploration of existing data sets. In line with these requirements, we will preserve the data for future reuse. To ensure confidentiality, the shared data

will be stripped of any information that could potentially identify the participant.

**Declaration of the participant:** I have read the study description and have been fully informed about the procedures, demands, risks, and benefits of the study. Participation in this study is voluntary and I understand that I may decline to answer any questions or withdraw from the study at anytime, for any reason, without reprisals. By clicking "yes" I am confirming that I have read the above information and consent to participating in this study. I understand that agreeing to participate in this study does not waive any of my rights or release the researchers from their responsibilities. To ensure the study is being conducted properly, authorized individuals such as a member of the Research Ethics board may have access to my information. By clicking "yes" on this consent form, I am allowing such access.

If you have any questions regarding the study, feel free to direct your queries to the principal investigator. If you have any ethical concerns or complaints about your participation in this study, and want to speak with someone not on the research team, please contact the McGill Ethics Manager (514) 398-6193 or deanna.collin@mcgill.ca. REB file #: 278-1118

Sincerely,

Principal Investigator

Rachel Langevin, PhD, PsyD
Assistant Professor

Counselling Psychology Program

Department of Educational and Counselling Psychology Faculty of Education
McGill University Telephone: (514) 398-8349 rachel.langevin@mcgill.ca

Do you agree to participate in this study? If so, please print or screenshot a copy of this consent form for your records.

○
Yes ○
No

Contact Information

Please provide **your first and last name** in the space below:

First name

Last name

Please provide **your e-mail address** in the space below:

This study aims to examine the associations among childhood adversity, emotional and psychological well-being, and relationship quality in mother-young adult pairs. For the purpose of this study, you must be either a young adult aged 18-25 or the mother of a young adult aged 18-25.

This study requires **both** members of the pair to complete questionnaires. Were you referred to this survey by the other member of your family?

- ○ No, I am the first respondent
- ○ Yes, I am the second respondent

If you are the first respondent, you must provide contact information for the second respondent so that they can be invited to complete questionnaires as well.

Please provide the **first and last name** of the **second respondent** in the space below:

First name

Last name

Please provide the **e-mail address** of the **second respondent** in the space below:

What would be the best way to reach the **second respondent**?

○ E-mail

○ Telephone

Please provide a **telephone number** for the **second respondent** in the space below:

**Directions**

**Below is your participant ID number.**

**Please copy this number and save it for future reference. You will need it to complete the online survey.**

${e://Field/RANDOM}

If you have any questions regarding the study, feel free to direct your queries to the principal investigator. If you have any ethical concerns or complaints about your participation in this study, and want to speak with someone not on the research team, please contact the McGill Ethics Manager (514) 398-6193 or deanna.collin@mcgill.ca. REB file #: 278-1118

Sincerely,

**Principal Investigator**
Rachel Langevin, PhD,
PsyD Assistant
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Counselling Psychology Program
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## Appendix D

## Research Consent Form – Qualitative

**Institution**: Department of Educational and Counselling Psychology, Faculty of Education, McGill University
**Title of Project**: The Childhood Adversity Study
**Principal Investigator**: Dr. Rachel Langevin
**Collaborators**: This study is being conducted in collaboration with Dr. Mylène Fernet from Université du Québec à Montréal, Dr. Audrey Brassard from Université de Sherbrooke, and Dr. Jean-Yves Frappier from Université de Montréal
**Funding:** Fonds de recherche du Québec – Société & Culture (FRQ-SC); Social Sciences and Humanities Research Council (SSHRC)

Dear participant,

We invite you to participate in a research project that is aimed at understanding the impacts of childhood adversity on individuals and their emotions and relationships. This project involves the participation of mother-young adult pairs. Each member of the pair will be invited to complete a brief online survey and to participate in separate, individual interviews. Participants who have not experienced childhood adversity will not be asked to participate in the qualitative interviews.

In the initial questionnaire, we will ask you to provide your contact information. If you are the first respondent, we will also ask you to provide the contact information (i.e., email address and telephone number) for the other member of your pair (i.e., your young adult child or your mother).

Please note that if you are the first respondent, we will send you a follow up email to confirm your unique participant ID. Please be sure to inform the other person in your family that we will be sending them an e-mail link inviting them to participate.

Following completion of this brief questionnaire, and once both members of the mother-young adult pair have agreed to participate, we will invite you to participate in an individual interview. Please consider the following information before you agree to participate in this research project. This consent form explains the goal of the study, the procedures, advantages, risks and inconveniences, as well as listing people to contact should the need arise.

### What is the purpose of the study?

This study aims to examine the associations among childhood adversity, emotional and

psychological well-being, and relationship quality between mothers and young adults. The results of the study will provide a better understanding of the experiences of individuals exposed to adverse life events and will be used to develop and bonify interventions offered.

**What will you be required to do?**

Upon consenting to your participation in this study, you will take part in a brief online survey where you will be asked to fill out a series of questionnaires on experiences of childhood adversity, other experiences of adversity, parent-child relationships, and psychological symptoms. This survey must be completed before participating in the interview. The total time required to complete the survey will be approximately 15-20 minutes. Upon completion of this survey, you will be invited to participate in an individual interview with a graduate student in psychology. The interview will last approximately 60 to 90 minutes and will require more in-depth discussion of experiences of childhood adversity and the impacts on your emotions and relationships, parent-child relations. We will also ask about your perceived met and unmet needs in terms of dealing with childhood adversity, and any suggestions you may have for others who have had similar experiences. A graduate student will contact you using the contact information you provide in the brief survey to arrange a convenient time and location for the interview. Until the COVID-19 situation improves, we will be conducting interviews online via McGill's Webex video conferencing system. In-person interviews will only be offered when conditions improve. The interviews will be audio recorded. You will receive $30 for your participation in the interview. Compensation will be delivered as cash when interviews take place in-person. During the COVID-19 context, when interviews take place online, compensation will be administered through interac-e transfer. Redacted information will be used for interac-e transfers, as is done in the quantitative phase.

**Risks and inconveniences**: You will be asked to discuss difficult experiences during the interview. You may experience discomfort in responding to questions concerning difficult experiences in your childhood and/or due to the other member of your family having responded to similar questions. You may ask to stop the interview at any point; this will not affect compensation. Support will be provided on the spot by the research assistant conducting the interview. If appropriate, the research assistant may recommend immediately following-up with a professional. If you consent, we will also contact you one week after the interview for a check-in. Under these circumstances, the following resources are available to you should you need service.

1. Tel-Aide: 514-935-1101. Tel-Aide is a free, anonymous, non-judgmental listening service for people in Montreal who are experiencing distress http://www.telaide.org/resources
2. Crisis Text Line: Text HOME to 686868 to text with a trained crisis responder to bring texters from a hot moment to a cool calm through active listening and collaborative problem-solving https://www.crisistextline.ca/

3. Provincial Resource Line for Victims of Sexual Assault: 1-888-933-9007. This is a toll-free hotline, information, and referral service for residents of Quebec who have experienced sexual assault, as well as their loved ones and caregivers http://agressionsexuellemontreal.ca/urgence/ligne-ressource
4. CLSC: Your local CLSC provides common health and social services. Contact your local CLSC for more resources http://sante.gouv.qc.ca/en/repertoire-ressources/clsc/

If you have any further questions or concerns that need to be addressed, you may also contact Dr. Rachel Langevin, who will assist you in finding the help you need.

**Privacy and confidentiality**: All data collected will be kept confidential. You are free to not answer any items, or to withdraw your consent at any time. Your personal information will be coded (e.g. 2018P001) and will not be shared under any circumstances, including with your partner. Interviews will be audio recorded and transcribed verbatim by a research assistant who will be hired for this. These files will be kept in a password protected file on the desktop computer of Dr. Langevin's research lab, located in the Education Building at McGill University. Identifying information (e.g. consent forms) will only be known to the PI, interviewers and research coordinator who will be creating the ID codes. Dr. Fernet will have access to audio files and will read interview transcripts to guide the analysis, but she will not have access to the names and email addresses of participants or any other sensitive pieces of information All study information will be labelled with the ID code, and therefore, identifying information will not be provided. The primary investigator will ensure that your participation in this study remains confidential, and will store all data files on a password-protected computer. Although all precautions are taken, there is always the possibility of third-party interception when using communications through the internet. Results of this study may be published in scientific journals and presented at professional conferences, but no identifying information will be published. Your identifying information will be destroyed 7 years after the end of the study, and only non-identifying information will be kept in our datasets after that period (e.g., answers to the questionnaires).

If you choose to withdraw from the study, the data collected up to that point will be destroyed unless you agree otherwise. However, if you choose to withdraw your data once the data has been combined for publication, it may not be possible to withdraw your data in its entirety. Once the file linking names to your study ID number is destroyed, data cannot be withdrawn. If you complete the online survey and are not asked to participate in the interview, you will be invited to participate the full quantitative survey that composes the other component of this study. Your data will be kept as part of the quantitative phase of the project. Additionally, compensation is only for participation in the interview. In addition, in order to receive compensation, a spreadsheet in which your participant number, and not your name, will be used to provide expense justification to the financing department.

**The only conditions that we cannot guarantee confidentiality are**: a) you are at serious risk of harming yourself or another person; or b) you or another person are at serious risk of any form of abuse – in which case the proper authorities and professionals would be notified in

order for you and/or the other person to be safe. Situations of physical or sexual abuse of minors must be reported to Youth Protection. If such situations arise, we will encourage you to contact one of the resources listed in this consent form to receive appropriate help, and to signal the situation to the appropriate authorities if relevant. A follow-up with you will be done by Dr. Langevin if necessary or desired.

Funding agencies and publishers often ask researchers to make their research data accessible to other researchers upon completion of their study. Making research data available to others allows qualified researchers to reproduce scientific findings and stimulates exploration of existing data sets. In line with these requirements, we will preserve the data for future reuse. To ensure confidentiality, the shared data will be stripped of any information that could potentially identify the participant.

**Declaration of the participant:** I have read the study description and have been fully informed about the procedures, demands, risks, and benefits of the study. Participation in this study is voluntary and I understand that I may decline to answer any questions or withdraw from the study at any time, for any reason, without reprisals. To participate, by clicking "yes" I am confirming that I have read the above information and consent to participating in this study. To be contacted for a follow-up, by clicking "yes" I am confirming that I agree to be contacted one week following the interview to discuss any concerns or difficulties that may have arisen since the interview. I understand that agreeing to participate in this study does not waive any of my rights or release the researchers from their responsibilities. To ensure the study is being conducted properly, authorized individuals such as a member of the Research Ethics board may have access to my information. By clicking "yes" on this consent form, I am allowing such access.

If you have any questions regarding the study, feel free to direct your queries to the principal investigator. If you have any ethical concerns or complaints about your participation in this study, and want to speak with someone not on the research team, please contact the McGill Ethics Manager (514) 398-6193 or lynda.mcneil@mcgill.ca

**Consent**

I agree to participate in this study:
Yes/no

I agree to be contacted one week after the interview for a general follow-up on my well-being:
Yes/no

I agree to be contacted a few months following the interview in the event that clarification is needed or follow-up questions arise:

Yes/no

**Contact Information:**
Please indicate your phone number and/or email address to indicate how you prefer to be contacted by a research assistant from the lab to schedule a time and location for the interview.

Phone number:

Email address:

Day/time that you prefer to be contacted:

Preferred day/time for an interview:

Sincerely,

*Principal Investigator*
Rachel Langevin, PhD, PsyD
Assistant Professor
Counselling Psychology Program
Department of Educational and Counselling Psychology
Faculty of Education
McGill University
Telephone: (514) 398-8349
rachel.langevin@mcgill.ca

## Appendix E

## Questionnaires

| | |
|---|---|
| 1. Date of birth (yyyy/mm/dd): | _____ / ___ / ___ |
| 2. Gender: | 1. Men<br>2. Women<br>3. Other<br>4. Decline to answer |
| 3. Number of children: | 1. Over 18 years old: _____<br>2. Under 18 years old: _____ |
| 4. Age when the first child was born: | ___ |
| 5. Relational status: | 1. Married or in registered partnership, living with your partner.<br>a. Specify the duration: ___ year(s) ___ month(s)<br>b. Gender of the partner: __ man __ woman __ other/decline to answer<br>2. In a relationship, living with your partner<br>a. Specify the duration: ___ year(s) ___ month(s)<br>b. Gender of the partner: __ man __ woman __ other/decline to answer<br>3. In a relationship, or a non-exclusive romantic or sexual partnership, not living with your partner<br>a. Specify the duration: ___ year(s) ___ month(s)<br>b. Gender of the partner: __ man __ woman __ other/decline to answer<br>4. Divorced/separated or single<br>5. Decline to answer |
| 6. Family status: | 1. I am still with the father/mother of my child/children<br>2. I am still with the father/mother of at least one of my children<br>3. I am separated/divorced from the father(s)/mother(s) of my children/child<br>a. I have full custody<br>b. We have shared custody<br>c. I do not have custody<br>d. My child/children are all over 18 years old<br>1. Decline to answer |

| | |
|---|---|
| 7. Country of birth: | 1. Canada<br>2. Other (specify): _____<br>3. Decline to answer |
| 8. Self-identified ethnic group membership: | 1. Caucasian<br>2. Black<br>3. Asian<br>4. Hispanic<br>5. Indigenous/ Native American<br>6. Arab/ Middle Eastern<br>7. Other (specify):_____<br>8. Decline to answer |
| 9. Education (diploma) | 1. Elementary school or less<br>2. High school<br>3. CEGEP or professional school<br>4. Undergraduate (bachelor, certificate)<br>5. Graduate (masters or doctoral)<br>6. Decline to answer |
| 10. Current occupation: | 1. Working for pay or profit<br>a. Full-time (35h/week or more)<br>b. Part-time (less than 35h/week)<br>2. Unemployed<br>3. Pupil, student, further training, unpaid work experience<br>4. In retirement<br>5. Permanently disabled<br>6. Parental leave<br>7. In compulsory military or community service<br>8. Fulfilling domestic tasks<br>9. Other (specify) _____<br>10. Decline to answer |
| 11. Current professional category: | 1. Manager<br>2. Professional<br>3. Technician and associate professional<br>4. Clerical support worker<br>5. Service and sales worker<br>6. Skilled agricultural, forestry and fishery worker<br>7. Craft and related trades worker<br>8. Plant and machine operator and assembler<br>9. Elementary occupation<br>10. Armed forces<br>11. No paid occupation<br>12. Other (specify):_____<br>13. Don’t know/decline to answer |

| | |
|---|---|
| 12. Annual family income | 1. Less than 20 000$<br>2. 20 000 to 39 999$<br>3. 40 000 to 59 999$<br>4. 60 000 to 79 999$<br>5. 80 000 to 99 999$<br>6. 100 000 to 119 999$<br>7. 120 000$ or more<br>8. Decline to answer |
| 13. Are you: | 1. Owner of your house, apartment, or condo<br>2. Renting your house, apartment, condo, or room<br>3. Living in someone else's house, apartment, or condo without monetary compensation<br>4. Other (specify):_____<br>5. Decline to answer |
| 14. First three digits of your postal code: | ___ ___ ___ |
| 15. Do you have any current confirmed medical diagnosis? | 1. No<br>2. Mental health (anxiety disorder, mood disorder, trauma and stressors-related disorder, etc.)<br>Specify: _____<br>3. Physical health<br>Specify: _____<br>4. Don't know/decline to answer |
| 16. Are you taking prescribed medication on a regular basis? | 1. No<br>2. Yes for a mental health issue<br>3. Yes for a physical health issue<br>4. Yes for mental and physical health issues.<br>5. Decline to answer |
| 17. Have you ever consulted a mental health professional (e.g., psychiatrist, psychologist, social worker, etc.)? | 1. Yes<br>2. No<br>3. Don't know/decline to answer |

**THE CTS2S SHORT FORM**



**Murray A. Straus, University of New Hampshire**
murray.straus@unh.edu http://pubpages.unh.edu/~mas2

COUPLE CONFLICTS

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please mark how many times you did each to these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, mark a "7" on your answer sheet for that question. If it never happened, mark an "8" on your answer sheet.

How often did this happen?
1 = Once in the past year
2 = Twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = More than 20 times in the past year
7 = Not in the past year, but it did happen before
8 = This has never happened

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. I explained my side or suggested a compromise for a disagreement with my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 2. My partner explained his or her side or suggested a compromise for a disagreement with me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 3. I insulted or swore or shouted or yelled at my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 4. My partner insulted or swore or shouted or yelled at me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 5. I had a sprain, bruise, or small cut, or felt pain the next day because of a fight with my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 6. My partner had a sprain, bruise, or small cut or felt pain the next day because of a fight with me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 7. I showed respect for, or showed that I cared about my partner's feelings about an issue we disagreed on | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 8. My partner showed respect for, or showed that he or she cared about my feeling about an issue we disagreed on | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9. I pushed, shoved, or slapped my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 10. My partner pushed, shoved, or slapped me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 11. I punched or kicked or beat-up my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 12. My partner punched or kicked or beat-me-up | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 13. I destroyed something belonging to my partner or threatened to hit my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 14. My partner destroyed something belonging to me or threatened to hit me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 15. I went see a doctor (M.D.) or needed to see a doctor because of a fight with my partner | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 16. My partner went to see a doctor (M.D.) or needed to see a doctor because of a fight with me | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 17. I used force (like hitting, holding down, or using a weapon) to make my partner have sex | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 18. My partner used force (like hitting, holding down, or using a weapon) to make me have sex | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 19. I insisted on sex when my partner did not want to or insisted on sex without a condom (but did not use physical force) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 20. My partner insisted on sex when I did not want to or insisted on sex without a condom (but did not use physical force) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |

## Early Trauma Inventory Self Report-Short Form (ETISR-SF)

**J. Douglas Bremner, Emory University School of Medicine, Atlanta GA**

Participant Name or ID:_____ DOB:_____ Age:____ Assessment Date:_____

**Part 1. General Traumas. <u>After the age of 18</u>**

| | | | |
|---|---|---|---|
| 1. | Were you ever exposed to a life-threatening natural disaster? | YES | NO |
| 2. | Were you involved in a serious accident? | YES | NO |
| 3. | Did you ever suffer a serious personal injury or illness? | YES | NO |
| 4. | Did you ever experience the death or serious illness of a parent or a primary caretaker? | YES | NO |
| 5. | Did you experience the divorce or separation of your parents? | YES | NO |
| 6. | Did you experience the death or serious injury of a sibling? | YES | NO |
| 7. | Did you ever experience the death or serious injury of a friend? | YES | NO |
| 8. | Did you ever witness violence towards others, including family members? | YES | NO |
| 9. | Did anyone in your family ever suffer from mental or psychiatric illness or have a a "breakdown"? | YES | NO |
| 10. | Did your parents or primary caretaker have a problem with alcoholism or drug or drug abuse? | YES | NO |
| 11. | Did you ever see someone murdered? | YES | NO |

**Part 2. Physical Punishment. <u>Before the age of 18</u>**

| | | | |
|---|---|---|---|
| 1. | Were you ever slapped in the face with an open hand? | YES | NO |
| 2. | Were you ever burned with hot water, a cigarette or something else? | YES | NO |
| 3. | Were you ever punched or kicked? | YES | NO |
| 4. | Were you ever hit with an object that was thrown at you? | YES | NO |
| 5. | Were you ever pushed or shoved? | YES | NO |

**Part 3. Emotional Abuse. <u>Before the age of 18</u>**

| | | | |
|---|---|---|---|
| 1. | Were you often put down or ridiculed? | YES | NO |
| 2. | Were you often ignored or made to feel that you didn't count? | YES | NO |
| 3. | Were you often told you were no good? | YES | NO |
| 4. | Most of the time were you treated in a cold, uncaring way or made to feel like you were not loved? | YES | NO |
| 5. | Did your parents or caretakers often fail to understand you or your needs? | YES | NO |

**Part 4. Sexual Events. <u>Before the age of 18</u>**

| | | | |
|---|---|---|---|
| 1. | Were you ever touched in an intimate or private part of your body (e.g breast, thighs, genitals) in a way that surprised you or made you feel uncomfortable? | YES | NO |
| 2. | Did you ever experience someone rubbing their genitals against you? | YES | NO |
| 3. | Were you ever forced or coerced to touch another person in an intimate or private part of their body? | YES | NO |
| 4. | Did anyone ever have genital sex with you against your will? | YES | NO |
| 5. | Were you ever forced or coerced to perform oral sex on someone against your will?. | YES | NO |
| 6. | Were you ever forced or coerced to kiss someone in a sexual rather than an affectionate way? | YES | NO |

***If you responded "YES" for any of the above events, answer the following for the one that has had the greatest impact on your life. In answering consider how you felt <u>at the time of the event</u>.***

| | | | |
|---|---|---|---|
| 1. | Did you experience emotions of intense fear, horror or helplessness? | YES | NO |
| 2. | Did you feel out-of-your-body or as if you were in a dream? | YES | NO |

*Revised on 11/04*

**PCL-5 with LEC-5 and Criterion A**

## Part 1

**Instructions:** Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

| Event | Happened to me | Witnessed it | Learned about it | Part of my job | Not sure | Doesn't apply |
|---|---|---|---|---|---|---|
| 1. Natural disaster (for example, flood, hurricane, tornado, earthquake) | | | | | | |
| 2. Fire or explosion | | | | | | |
| 3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash) | | | | | | |
| 4. Serious accident at work, home, or during recreational activity | | | | | | |
| 5. Exposure to toxic substance (for example, dangerous chemicals, radiation) | | | | | | |
| 6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up) | | | | | | |
| 7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb) | | | | | | |
| 8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm) | | | | | | |
| 9. Other unwanted or uncomfortable sexual experience | | | | | | |
| 10. Combat or exposure to a war-zone (in the military or as a civilian) | | | | | | |
| 11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) | | | | | | |
| 12. Life-threatening illness or injury | | | | | | |
| 13. Severe human suffering | | | | | | |
| 14. Sudden violent death (for example, homicide, suicide) | | | | | | |
| 15. Sudden accidental death | | | | | | |
| 16. Serious injury, harm, or death you caused to someone else | | | | | | |
| 17. Any other very stressful event or experience | | | | | | |

**R-IPA - Revised Inventory of Parent Attachment**

(MY RELATIONSHIP WITH MY CHILD)
(L. N. Johnson, S. A. Ketring, & C. Abshire, 2003)

| Items | Almost never | Not very often | Sometimes | Often time | Almost always |
|---|---|---|---|---|---|
| 1. I get frustrated with my child | 1 | 2 | 3 | 4 | 5 |
| 2. I am constantly yelling and fighting with my child | 1 | 2 | 3 | 4 | 5 |
| 3. My child trusts my judgment | 1 | 2 | 3 | 4 | 5 |
| 4. I trust my child | 1 | 2 | 3 | 4 | 5 |
| 5. My child respects my feelings | 1 | 2 | 3 | 4 | 5 |
| 6. I feel angry with my child | 1 | 2 | 3 | 4 | 5 |
| 7. I get upset easily around my child | 1 | 2 | 3 | 4 | 5 |
| 8. My child understands me | 1 | 2 | 3 | 4 | 5 |
| 9. My child cares about my point of view | 1 | 2 | 3 | 4 | 5 |
| 10. I don't like being around my child | 1 | 2 | 3 | 4 | 5 |
| 11. When I am angry my child often understands | 1 | 2 | 3 | 4 | 5 |
| 12. I don't get much attention or credit from my child | 1 | 2 | 3 | 4 | 5 |
| 13. I feel my child is good | 1 | 2 | 3 | 4 | 5 |
| 14. My child accepts me as I am | 1 | 2 | 3 | 4 | 5 |
| 15. My child expects too much of me | 1 | 2 | 3 | 4 | 5 |
| 16. I wish I had a different child | 1 | 2 | 3 | 4 | 5 |
| 17. I talk to my child about my difficulties | 1 | 2 | 3 | 4 | 5 |
| 18. If my child knows something is bothering me they ask me about it | 1 | 2 | 3 | 4 | 5 |
| 19. I tell my child about my problems | 1 | 2 | 3 | 4 | 5 |
| 20. I can count on my child when I need to get something off my chest | 1 | 2 | 3 | 4 | 5 |
| 21. My child can tell when I'm upset about something | 1 | 2 | 3 | 4 | 5 |
| 22. I like to get my child's point of view on things I am concerned about | 1 | 2 | 3 | 4 | 5 |
| 23. I get upset a lot more then my child knows about | 1 | 2 | 3 | 4 | 5 |
| 24. When I feel sad and lonely I spend time with my child | 1 | 2 | 3 | 4 | 5 |
| 25. My child helps me understand myself better | 1 | 2 | 3 | 4 | 5 |
| 26. I don't like my children to touch me | 1 | 2 | 3 | 4 | 5 |
| 27. Talking over my problems with my children makes me feel ashamed or foolish | 1 | 2 | 3 | 4 | 5 |
| 28. I feel it is no use letting my feelings show around my child | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 29. My child has their own problems so I don't bother them with my problems | 1 | 2 | 3 | 4 | 5 |
| 30. My child doesn't understand what I am going through these days | 1 | 2 | 3 | 4 | 5 |

**ICAST-R: A Retrospective Interview about childhood**

***Only the five neglect items which were included in the Study 2 analysis are presented below.**

*We would like to ask you questions about your early life, from when you were a child to before you were 18 years old. The questions are about violent or upsetting things that can happen to children and young people. Everything you say is private. Do not put your name on the paper. No one in your family, your neighborhood, or the authorities will know what you tell us. Please answer all of the questions even if you think some of them do not apply to you.*

***9. Were you ever not taken care of by your parent(s) or other responsible adult(s) when you were sick or injured even though they could afford it?***

□ *Yes* □ *No (Go to question 10)* □ *Cannot remember (Go to question 10)*

*If yes, at what times in your life did this happen to you? (Please mark all the years of age when it happened to you on the line below)*

*Birth 1yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18yrs*

*If yes, how often did this happen to you during your life?*

□ *Too many times to count* □ *Between 10-50 times* □ *less than 10 times*

*Which people did this to you? (put X in one or more boxes)*

□ *Parent or parents* □ *Other adult relative(s)*

□ *Sibling(s)* □ *Someone else in my home*

□ *Teacher(s)* □ *Friend(s) or peer(s) you know*

□ *People whom you work with* □ *Neighbor(s)*

□ *Stranger(s)* □ *Others(Please specify:_____)*

*How much did this experience hurt or harm you?*

□ *A great deal* □ *Seriously* □ *Mildly* □ *Not at all*

***10. Have you ever not been given food to eat and/or drink even though your parent(s) or other responsible adult(s) could afford it?***

□ *Yes* □ *No (Go to question 11)* □ *Cannot remember (Go to question 11)*

*If yes, at what times in your life did this happen to you? (Please mark all the years of age when it happened to you on the line below)*

*Birth 1yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18yrs*

*If yes, how often did this happen to you during your life?*

□ *Too many times to count* □ *Between 10-50 times* □ *less than 10 times*

*Which people did this to you? (put X in one or more boxes)*

□*Parent or parents* □ *Other adult relative(s)*

□*Sibling(s)* □ *Someone else in my home*

□*Teacher(s)* □ *Friend(s) or peer(s) you know*

□*People whom you work with* □ *Neighbor(s)*

□*Stranger(s)* □ *Others(Please specify:_____)*

*How much did this experience hurt or harm you?*

□ *A great deal* □ *Seriously* □ *Mildly* □ *Not at all*

***11. Were you made to wear clothes that were dirty, torn, or inappropriate for the season when your parent(s) or other responsible adult(s) could afford it?***

□*Yes* □ *No (Go to question 12)* □*Cannot remember (Go to question 12)*

*If yes, at what times in your life did this happen to you? (Please mark all the years of age when it happened to you on the line below)*

*Birth 1yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18yrs*

*If yes, how often did this happen to you during your life?*

□ *Too many times to count* □ *Between 10-50 times* □ *less than 10 times*

*Which people did this to you? (put X in one or more boxes)*

□*Parent or parents* □ *Other adult relative(s)*

□*Sibling(s)* □ *Someone else in my home*

□*Teacher(s)* □ *Friend(s) or peer(s) you know*

□*People whom you work with* □ *Neighbor(s)*

□*Stranger(s)* □ *Others(Please specify:_____)*

*How much did this experience hurt or harm you?*

□ *A great deal* □ *Seriously* □ *Mildly* □ *Not at all*

***12. Have you ever been hurt or injured because no adult was supervising you?***

□*Yes* □ *No (Go to question 13)* □ *Cannot remember (Go to question 13)*

*If yes, at what times in your life did this happen to you? (Please mark all the years of age when it happened to you on the line below)*

*Birth 1yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18yrs*

*If yes, how often did this happen to you during your life?*

□ *Too many times to count* □ *Between 10-50 times* □ *less than 10 times*

*Which people did this to you? (put X in one or more boxes)*

□*Parent or parents* □ *Other adult relative(s)*

□*Sibling(s)* □ *Someone else in my home*

□*Teacher(s)* □ *Friend(s) or peer(s) you know*

□*People whom you work with* □ *Neighbor(s)*

□*Stranger(s)* □ *Others(Please specify:_____)*

*How much did this experience hurt or harm you?*

□ *A great deal* □ *Seriously* □ *Mildly* □ *Not at all*

***13. Did your parent(s) or other responsible adult(s) not always provide a safe place to live even though they could afford it?***

□*Yes* □ *No (Go to question 14)* □ *Cannot remember (Go to question 14)*

*If yes, at what times in your life did this happen to you? (Please mark all the years of age when it happened to you on the line below)*

*Birth 1yr 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18yrs*

*If yes, how often did this happen to you during your life?*

□ *Too many times to count* □ *Between 10-50 times* □ *less than 10 times*

*Which people did this to you? (put X in one or more boxes)*

□*Parent or parents* □ *Other adult relative(s)*

□*Sibling(s)* □ *Someone else in my home*

□*Teacher(s)* □ *Friend(s) or peer(s) you know*

□*People whom you work with* □ *Neighbor(s)*

□*Stranger(s)* □ *Others(Please specify:_____)*

*How much did this experience hurt or harm you?*

□ *A great deal* □ *Seriously* □ *Mildly* □ *Not at all*

# Appendix F

## Interview Protocol for Mothers

### Procedures for the RA before the interview

1. Make sure to review the participant's completed screening questionnaires in order to summarize some of the results concerning during the interview when asking about **their experiences of trauma** (The Early Trauma Inventory – Short Form (ETI; Bremner et al., 2007); The PTSD Checklist and Life Events Checklist (PCL, LEC; Weathers et al., 2013); The Indice de détresse psychologique (IDP; Préville et al., 1992); and The Inventory of Parent and Peer Attachment (IPPA; Armsden & Greenberg, 1987)

### Before starting the interview

1. Introduce the participant to the research and interview environment. Thank them for their participation.
2. Briefly summarize the interview procedures: duration (approximately 60 to 90 minutes), digital audio recording and note-taking, confidentiality and other ethical considerations (risks and rewards involved, resources available in case the interview raises questions, concerns or worries)
3. Ask the participant for the phone number of an emergency contact and explain to them that this would only be used in cases of extreme emergency
4. If the interview is online, ask for a phone number in case you get disconnected.

***We're going to be talking about a lot of things today related to your childhood experiences, as well as your current experiences as a parent. These may be sensitive topics for you and I understand that you may be uncomfortable answering some of these questions. Your participation is extremely appreciated and will allow us to better understand how certain experiences during childhood can influence current relationships and emotions. Do you have any questions before we start? I may check-in with you throughout the interview to see how you're feeling. Could you rate your level of distress/discomfort right now on a scale of 0 to 10; 0 being no distress or discomfort and 10 being extremely distressed/discomforted***

**Current Life**

***To start . . .***

1. Can you tell me briefly about your current living situation?

- Occupation / Lifestyle
- Children (number of children, ages)
- Marital/relationship situation (nature of relationships)

**Parenting and Attachment**

***Now, I'd like to ask you some questions about parent relationships.***

2. Can you describe your relationship with your parents when **you** were growing up?

- *Parenting style*
- *Presence/absence of parent(s)*
- *Stability/structure of home environment*
- *Discipline*
- *Emotional and physical availability of parents*
- *Closeness of relationship with parents*
- *Reliance on parents for support/comfort when they were upset*

3. Now can you talk about what your relationship was like with your own children **when they were growing up?**

4. How would you describe your parenting style?

5. What is your **current** relationship like with your children?

- *Parenting style*
- *Presence/absence of parent(s)*
- *Stability/structure of home environment*
- *Discipline*
- *Emotional and physical availability of parents*
- *Closeness of relationship with parents*
- *Reliance on parents for support/comfort when they were upset*

**Childhood Experiences of Trauma**

***People can have difficult experiences in their lives that may or may not affect them.***

6. Can you tell me about the difficult experiences that you experienced during your childhood (under age 18). For example, if your parents separated, if you were abandoned or were placed in foster care, experienced an accident or serious illness, or the death of a loved one.

If the person does not mention it on their own: I noticed that you mentioned experiencing ***(name the adverse experiences from their completed questionnaires)*** in your childhood. Can you tell me a bit more about what happened?"
7. How did you feel about these experiences?

**Personal abuse**

8. Can you tell me about any abuse, neglect or family violence that you experienced as a child?

*(If they don't mention sexual abuse, for example, but they indicated this in their questionnaire, then you would also want to bring this up)*

Type of violence

- *Witnessed family violence*
- *Survivor of intimate partner violence*
- *Survivor of physical, emotional, or sexual abuse, or parental neglect*
- *Survivor of intimidation, harassment, bullying, harassment*

Context

- *Frequency/severity*
- *Age at the time of abuse*
- *Identity of perpetrator*

9. How did you feel about these events?

**Perceived consequences of personal abuse**

10. How did this affect you?

- *On a physical level*
- *Psychologically*
- *About your attitudes and behaviors*
- *Your relationships with others*

**Parenting and Attachment – investigated as a mechanism explaining continuity/discontinuity**

***Thank you for answering those questions. I understand that may have been difficult to talk about. How are you doing so far? Can you rate your level of distress/discomfort again on a scale of 0 to 10?***

***Earlier, we talked about your relationship with your parents growing up and your relationship with your child.***

11. Do you think the event(s) that you experienced during your childhood has/have had an impact on how you **felt** towards your child **when they were growing up?** If so, how? If not, can you explain why you think it did not have an effect?

12. Did this have any impact on how you **behaved** toward your child **when they were growing up**? If so, how? If not, can you explain why you think it did not have an effect?

13. Did this affect your **current relationship** with your child? If yes, can you describe this? If no, can you explain why not?

***We've talked about how you experienced (name of adverse experience(s)) when you were growing up. These kinds of experiences may repeat themselves in families for a variety of reasons.***

14. To your knowledge, did your child experience anything similar when they were a child or teenager under the age of 18? If yes, can you tell me about this?

**If yes, proceed to question 15 and 16. If no, proceed to question 17.**

15. How did you feel about this, given your own history?

16. Did this event affect your parenting behaviours? Your relationship with your child? If yes, how so? If not, can you describe why you think this did not influence your parenting or relationship with your child?

**Needs**

***For this next part, I'd like to ask you what you did following these events.***

17. Did you ever receive help for the events you experienced as a child?

**If yes:**

-with whom (friends, parents, significant adults, professionals)

-in what type(s) of resource(s) (community, psychosocial, judicial, medical)

- what response/reaction did you get? (positive, negative)

-did you encounter any obstacles in your search for help, and if so, what were they?

**If no, can you tell me why not? (then proceed to question 20 if their child also experienced some form of abuse. If their child did not experience abuse, proceed to question 22)**

18. What did you find the most helpful? Least helpful?

19. Were you satisfied with the response you received and the services you received?

20. **IF RELEVANT, if not, proceed to question 23:** Have you ever sought help for the events that your child experienced?

**If yes:**

-with whom (friends, parents, significant adults, professionals)

-in what type(s) of resource(s) (community, psychosocial, judicial, medical)

-what answer did you get? (positive or negative)

-Did you encounter any obstacles in your search for help, and if so, what were they?

21. What did you find the most helpful? Least helpful?

**Future Directions/Prevention and Intervention**

22. When you were a child, you experienced some really difficult things. If another child was in the same situation as you and needed help, what advice would you give him/her?

23. As a parent with a history of abuse, what advice would you give to other parents with similar backgrounds?

24. I mentioned before that sometimes abuse can continue on within families for a lot of different reasons. Do you have any ideas or suggestions that should be put in place to help children and families prevent this cycle from continuing?

***We've reached the end of the interview. Thank you very much for participating in this study. I want to reiterate how helpful your participation is. How are you feeling now? Can you rate your level of distress/discomfort on a scale of 0 to 10?***

**At the end of the interview**

- Thank the participant and ask if she has anything to add.
- Provide her with the list of resources (from consent form) and invite her to contact us if she needs help.
- If the participant agreed (as indicated in their consent form through the brief survey), specify that we will contact them in one week as a check-in to discuss general well-being
- Specify that they may be contacted in a few months if the RA needs to clarify information from the interview or to ask follow-up questions. Ask them how they would prefer to be contacted.
- Indicate again that they will receive $30 for their participation, but there may be a 24 hour delay to receive this via e-transfer.